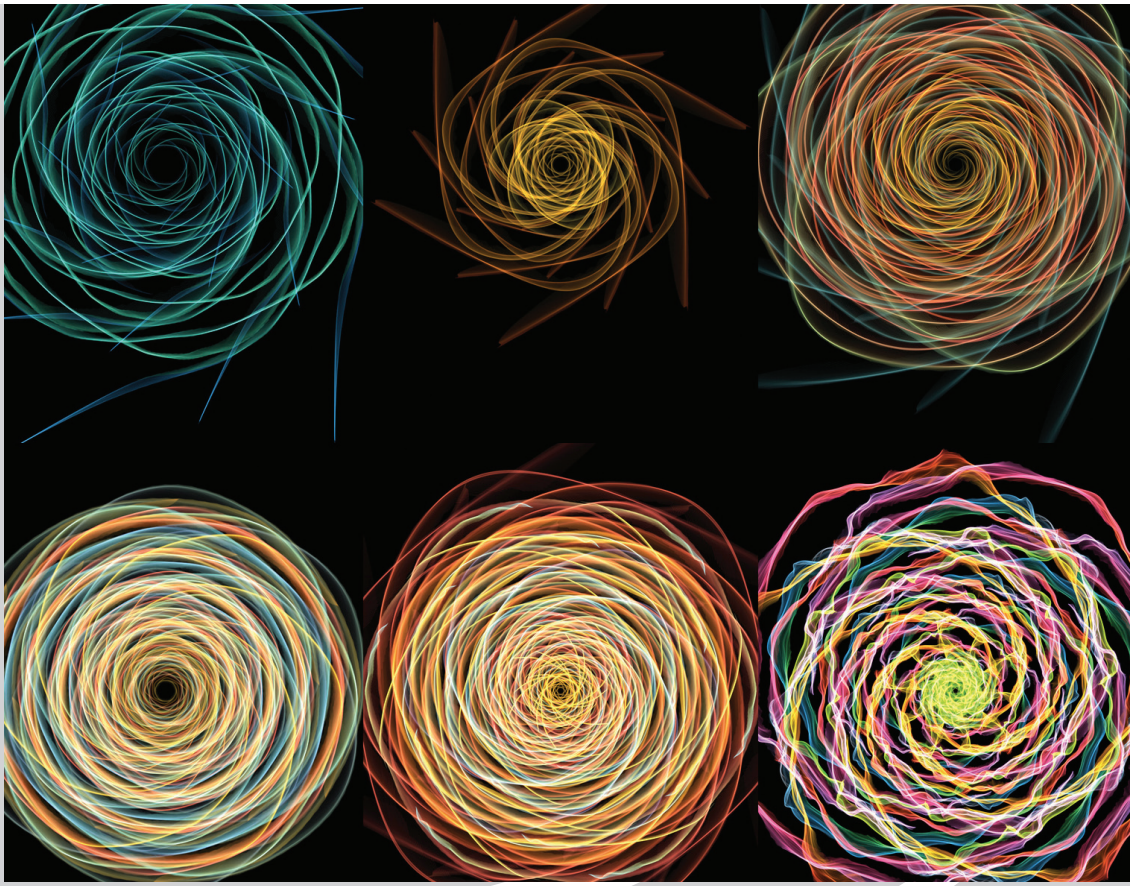
Mental Healthcare in Young People and Young Adults REPORT 3

A review of the quality of care provided to children and young people with mental health conditions admitted to a general health hospital or mental health facility and an assessment of healthcare utilisation in this group using routinely collected national datasets



NCEPOD

Improving the quality of healthcare

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Mental healthcare in children and young people: SUMMARY REPORT 3

A review of the quality of care provided to children and young people with mental health conditions admitted to a general health hospital or mental health facility and an assessment of healthcare utilisation in this group using routinely collected national datasets

A report published by the National Confidential Enquiry into Patient Outcome and Death (2019)

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The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body to which a corporate commitment has been made by the Medical and Surgical Royal Colleges, including the Royal College of Psychiatrists, Associations and Faculties related to its area of activity.

The Child Health Clinical Outcome Review Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

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Contents

Foreword

This study reviewed the quality of care received by 11 to 25 year olds (up to their 26th birthday in **REPORT I**) and the service utilisation by people aged 11 to 24 (up to their 25th birthday in **REPORT II**) with a mental health diagnosis of an eating disorder, anxiety, depression or who self-harm. This is an important age group as not only are people interacting with different services but likely to be transitioning between child and adult healthcare services. Patients admitted to an acute general hospital or secondary care mental health facility were included and interactions with primary care and community mental health services were reviewed where possible.

REPORT I provides information on the quality of clinical care provided to patients as assessed by NCEPOD case note reviewers using an in-depth peer review of clinical data. The utilisation of services was assessed by Swansea University, using analysis of existing, routinely collected national datasets, and this can be found in **REPORT II**.

This study follows a similar study undertaken by NCEPOD in 2017 called *'Treat as One'*. That study was a review of the way general hospital clinicians responded to the mental health needs of adult patients admitted to acute general hospitals for the management of their co-existing physical ill health. It concluded that adult patients with a mental health condition being treated for co-existent physical disorders were seriously disadvantaged in the service they received as mental health was not given the same priority as physical health.[1]

The findings in the reports presented here continue to reinforce the message that the parity of esteem between mental healthcare and physical healthcare services is often still not present. However the data do recognise the crucial role that acute general hospitals play in the complex system required to deliver mental healthcare. If mental healthcare in general hospitals is not given a higher priority then general hospitals and the staff who work in them will never be equipped to manage mental healthcare effectively.

At the heart of the work undertaken was the patients, their parents and carers. Patient views, highlighted through an online questionnaire at the start of the study, reported a requirement for better access to trained mental health staff to meet their needs, quicker access to mental health services and greater support, particularly 24-hour crisis support, like an 'emergency department for mental health'. It is important to keep the patient focus in mind and to remember how their views underpin the importance of this study and the recommendations made.

The studies have been led by clinicians who aimed to understand what could be done better to improve care and report this back to their peers. If the two reports from this study lead to a call for everyone involved in the care of patients presenting to our hospitals with a mental health condition that we can do better, then it will have been very worthwhile.

As with all NCEPOD reports I must acknowledge the enormous effort that has gone into this study and thank the many people who contributed. The teams at Swansea University and Cardiff University who were committed to gathering and analysing the available national datasets; comprising hundreds of thousands of data points. The multidisciplinary study advisory group who helped to design the study and the case reviewers who generously gave their time to review the cases. To each clinician who took pains to complete the lengthy questionnaires. The NCEPOD Local Reporters who identified the case review data for us, copied the notes and understood the need for making sure they were as complete as they could be. Further thanks are due to our NCEPOD Ambassadors who championed the topic

locally, the authors for writing such a detailed report, the researchers for their analysis and guidance on interpreting the data. The whole of the NCEPOD team for running the study to schedule and to our panel of lay representatives for their invaluable insight and non-clinical interpretation of the findings. Finally I thank my fellow Trustees and our clinical co-ordinators for all their support.

Ian C Martin NCEPOD Chair

Introduction

In 2013 the Royal College of Paediatrics and Child Health published their *'Overview of Child Deaths in the Four UK Countries'* report.[2] This report highlighted that 30-40% of 13-18 year olds, who died, were affected by mental health, learning difficulties or behavioural conditions. The reports presented here are a natural follow-on to this work, to look in detail at the mental healthcare provided to young people from the unique perspective of the overlap between physical and mental healthcare, the quality of physical and mental healthcare provided and how patients with mental health conditions use healthcare services. The overarching aim of this study was to identify areas of care that can be improved for all patients aged between 11 and 25 years (up to their 26th birthday for REPORT I and up to their 25th birthday for REPORT II).

REPORT I and **REPORT II** both focus on patients with three common mental health conditions and one behaviour: eating disorders, depression, anxiety and self-harm. The conditions/behaviour were chosen as exemplars of the whole spectrum of mental health conditions and behaviours, whilst recognising that there would be differences in incidence, common age for presentation and associated guidelines. However, the common issues between the different groups allowed a useful examination of the pathways of care for young people aged 11-17 years and 18-25 years (up to their 26th birthday for REPORT I and up to their 25th birthday for REPORT II), including the interface and transition between child and adult healthcare and the access to appropriate and timely input from specialist crisis and mental health liaison services.

REPORT I provides an in-depth qualitative overview of patients aged 11-25 years (up to their 26th birthday) who were admitted as an inpatient to an acute general hospital, or mental health facility, either via an emergency department or via referral from a community mental health team or primary care. It summarises the findings from across the UK, from clinical questionnaires and multidisciplinary case note reviews, to highlight improvements in clinical care.

REPORT II focuses on an analysis of routinely collected national datasets for patients aged 11-24 years (up to their 25th birthday) and how they used healthcare services over a ten-year period between 2004 and 2014. This report provides a population overview that could not be achieved from the review of clinical data in **REPORT I**. It helps to set the scene by supporting the qualitative findings with 'big data' from the four UK countries and completes aspects of the pathway that could not be achieved through case note review.

Since the case acquisition and data collection points (spring 2016 and 2004-2014 respectively) and the analysis and drafting of this report in early 2018 there has been a lot of focus on young people's mental health, and changes are already underway. The provision of mental healthcare varies across the four UK countries and each service provider will need to assess the service they provide against the recommendations made here to identify where to focus their quality improvement plans.

England

Since the study began there have been significant changes in England in both policy and delivery. *'Future in Mind'*[3], *'Five Year Forward View for Mental Health' (FYFVMH)*[4] and subsequent implementation programmes have seen improvements in service development, joint working and access to mental health care. The *'NHS Long Term Plan'*[5], published in January 2019, commits to the continued investment to expand access to community-based mental health services and commits to a new approach for young adult mental health services for people aged 18-25, to support the transition to adulthood.

For children and young people (CYP) under 18 years of age, Clinical Commissioning Groups (CCGs) working with partners across health, social care, the voluntary sector and experts by experience annually refresh whole system *'Local Transformation Plans'*.[6] These plans set out how local services work together to deliver improved outcomes for

children and young people. This includes improved access to treatment, with 324,724[7] children and young people being treated in 2017-18. Access to CYP urgent and emergency mental health care and intensive community support has also improved, with a recent 2018 audit showing that the majority of responding CCGs are offering as a minimum, crisis assessment and brief follow-up appointments. The NHS Long Term Plan states that children and young people experiencing a mental health crisis will be able to access the support they need with a single point of access through NHS 111, 24/7. Every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.

The NHS has committed that by 2021 all adults over 18 years of age will have access to 24/7 community-based crisis response and intensive home treatment as an alternative to an acute inpatient admission. In addition, all acute hospitals with 24/7 emergency departments will have a liaison mental health team, with at least 50% meeting the criteria for *'Core 24'*.[8] Findings from recent national surveys suggest that the NHS is on-track to meet this commitment, having invested £45m in 71 sites between 2017-2019. There has also been an increase of over 1000 (WTE) staff working in these teams since 2016.

In December 2017 the Department of Health and the Department of Education jointly published a Green Paper *'Transforming Children and Young People's Mental Health Provision' for England*.[9] As well as a proposal for a new waiting time standard for referral times to treatment, which acknowledged the significant differences across areas, other key elements included named leads in every school and college for mental health and wellbeing with links to child and adolescent mental health services (CAMHS) to provide rapid advice, consultation and sign-posting and Mental Health Support Teams for early intervention and on-going help.

In October 2018 the Government made an announcement on suicide prevention which included further measures on support for children and young people including a *'State of the Nation'* report every year on World Mental health Day highlighting trends and issues in young people's mental health alongside their physical health and educational attainment. It committed to providing tools to help schools measure their students' mental wellbeing, building on the commitment to make mental health literacy and resilience a compulsory part of the curriculum.

In November 2018 NHS Digital published the *'Children and Young People's Mental Health Survey'*[10] to examine the prevalence of mental disorders in England, the first since 2004. It showed that in 2017, 12.8% of 5 to 19 year olds had at least one mental disorder, with emotional disorders, such as anxiety and depression, being the most prevalent type of disorder (8.1%). Rates increased with age. Data from this survey revealed a slight increase over time in the prevalence of mental disorder in 5 to 15 year olds from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017.

Wales

'Together for Mental Health'[11] is the Welsh Government's 10 year cross-Government, all-age strategy, to improve mental health and well-being in Wales. The strategy was published in 2012, following significant engagement and formal consultation with key partner agencies, stakeholders, services users and carers. The strategy is supported by a series of delivery plans which encompasses a range of actions, from those designed to improve the mental well-being of all residents in Wales, to those required to support people with severe and enduring mental illness. To ensure progress against the delivery plans a cross-cutting approach has been taken, implemented jointly by partners, including the Welsh Government, health boards, local authorities, third and independent sector, Public Health Wales, police, ambulance and others. Progress against the delivery of the strategy is overseen by the Mental Health National Partnership Board (MHNPB) and seven Local Partnership Boards (LPBs), who provide a public facing statement on what has been achieved within their own area. Key activities since the publication of the 2016-19 *'Together for Mental Health Delivery Plan'*[12] highlighted that progress had been made across all priority areas and the National Partnership Board is currently shaping the core themes for the 2019-2022 delivery plan.

Scotland

Scotland's children and young people's mental healthcare is delivered through 14 Health Boards which are part of Health and Social Care Partnerships. This provides a variable degree of integration at children's services level, with considerable variation in local funding. Over the past couple of years there has been sharing of best practice and the development of community intensive treatment teams which has allowed the adolescent inpatient units to reduce the length of stay and improve access to beds.

All the actions from the 2017 *'Mental Health Strategy'*[13] relating to children and young people, the 'Rejected Referrals Audit',[14] 'Audit Scotland' report[15] and the *'Programme for Government'* in 2018[16] have been brought together in the newly established Children and Young People's Mental Health and Well-being Taskforce. This has been jointly commissioned by Scottish Government and Convention of Scottish Local Authorities (COSLA) to take a whole system approach to children and young people's mental health. It will bring together input from partners across a range of sectors and will focus on services for children and young people aged 0-25 years and will run until the end of 2020. This will build on the national multi-agency approach underpinning all children's services in Scotland; *'Getting It Right For Every Child (GIRFEC)'*[17]. There are four strands of work focusing on, generic, neurodevelopmental, specialist services and for those children and young people at risk. There will be accompanying work on the development of the workforce, improving data quality and the promotion, prevention and support for mental health within schools. This work will be supported by the established training and workforce development within NHS Education Scotland (NES), data collection by the Information Statistics Division (ISD) and the Mental Health Access Improvement Support Team (MHAIST) hosted by Healthcare Improvement Scotland.

Northern Ireland

The policy for child and adolescent mental health services (CAMHS) in Northern Ireland is stated in the *'Child and Adolescent Mental Health Services - A Service Model'* issued by the Department of Health in July 2012.[18] The model outlined an integrated approach that addressed equity, accessibility and early intervention. Transformation of CAMHS based on the implementation of the *'Stepped Care Model'* is a 'work in progress'. All Health and Social Care Trusts in Northern Ireland have seen the consistent establishment of Primary Mental Health Teams, Crisis Resolution and Home Treatment Teams and the development of a single point of entry to support effective service responses provided at the right time and right place and based on needs.

The developments in CAMHS have been consolidated through publication of the co-designed and co-produced care pathway for CAMHS – '*Working Together: A Pathway for Children and Young people through CAMHS'*[19] published in March 2018. The pathway sets out the journey through CAMHS from referral, through to treatment and discharge/ transition and the standards to be expected along that journey of care. A further important achievement is the revision to the CAMHS Minimum Dataset which now captures demand, need, activity outcomes and experience. Improvements to information systems continue to ensure consistent data returns across the region. The current data shows a sustained increase in demand and an increase in the percentage of children and young people being accepted (80% acceptance across the region for 18/19).

A key priority is the establishment of a Managed Care Networks for acute CAMHS to address the difficulties of providing support to young people presenting in crisis. The purpose of the network is to develop standardised approaches and consistency of care to improve service responses across key service interfaces such as secure care, forensic care and youth justice. The Managed Care Network is designed to bring the acute service response into a single system of care, delivered locally which supports a consistent approach as well as more timely access for support and advice. It is also important to note that the first ever prevalence study of children and young people's mental health in Northern Ireland is underway and publication of this may be anticipated mid-2020.

Study aims, method and data returns

STUDY AIMS

The primary aims of this study were to:

- Assess the quality of mental healthcare provided to people aged 11-25 years (up to their 26th birthday) (REPORT I)
- Review the pattern of mental healthcare utilisation across different healthcare settings to people aged 11-24 years (up to their 25th birthday) (REPORT II)
- Examine the interface between different care settings
- Examine the transition of care from child to adult mental health services

METHOD AND DATA RETURNS – REPORT I

Patients with an eating disorder, depression, anxiety or who self-harmed, aged 11-25 years (up to their 26th birthday) and who were admitted as an inpatient to a general hospital or emergency mental health facility during 8th February to 20th March 2016 were included. These pathways of care were chosen to examine the quality of physical and mental healthcare when accessing secondary care services. This aspect of the study is therefore not a sample of all young people accessing mental health services, but reflects a small sample of the population aged 11-25 with mental health conditions. By reviewing this sample of patients it was a test of a discreet pathway where policies and procedures for their care would be expected to be embedded. It also allowed assessment of what information, from the patient's wider mental healthcare, was available to secondary care staff, although this did mean that there was a second sample of data that was smaller still, as it was a sample of a sample. Data were collated from a number of sources to allow the aims to be met.

1. Clinical peer review using questionnaires and case notes – UK wide

Questionnaires were sent to the general hospital and mental health lead clinicians who were caring for the patients in the study. Copies of case note data were then requested along with contact information of community mental health teams. If information on the community teams were received then they were contacted with a questionnaire and a similar case note request. These questionnaires and case notes had all patient identifiers removed and were then reviewed by a multidisciplinary group of clinicians to assess the quality of care provided. Within the stratified sample, 1,269 patients were selected for inclusion:

- Acute general hospital admissions – up to 3 patients per hospital n=710
- Mental health inpatient admissions – up to 3 patients per hospital n=434
- Patients coded for an eating disorder – up to 3 per hospital n=125

2. Organisational survey – UK wide

An organisational questionnaire was sent to 249 organisations where mental healthcare may have been provided either with on-site or off-site services, to gather information on mental services available to patients. There were 140 questionnaires returned with data that could be used.

METHOD AND DATA RETURNS – REPORT II

The analysis of routinely collected national datasets has the potential to provide population-based quantitative information about the service utilisation of young people aged 11-24 years (up to their 25th birthday) with mental health conditions, including trends by age, sex, social economic status, over time and inter-country comparisons to inform policy and care. Therefore at a national level, and by UK country, data were obtained, where possible, for the time period 2004-2014 which included:

1. Secondary healthcare data from England and Wales
2. Primary care data from the Clinical Practice Research Datalink (CPRD) – this provided a 6.9% sample of primary care data from all four UK countries and linked secondary care data for a sample of GP practices in England
3. Linked primary and secondary healthcare data in Wales were available at a whole population level
4. Mental health facility, emergency care, education and intensive care data were also included where available from England, Wales, Northern Ireland and Scotland.

Key messages

KEY MESSAGES – REPORT I

	Key message	Key findings
1	Mental healthcare was not given the same level of importance as physical healthcare in general hospitals	• 106/491 (21.6%) patients did not have their existing mental health history recorded in the general hospital case notes at the initial assessment • 310/318 (97.5%) patients had adequate physical health monitoring plans made on the ward compared with 148/285 (51.9%) patients who had adequate mental health monitoring plans made • General health clinicians reported a lack of clarity as to who was leading the mental healthcare in 50/403 (12.4%) patients
2	General hospital staff were not receiving enough support from mental health professionals in the general hospital setting, particularly with regard to risk management	• 55/209 (26.3%) patients experienced a delay in the first assessment by a mental health professional in a general hospital • 47/56 (83.9%) patients had issues with physical health monitoring on the general hospital ward due to their mental health condition • General health clinicians stated that the patient's mental health condition impacted on the management of an acute medical condition for 64/449 (14.3%) patients • The peer reviewers were of the opinion that the problems in monitoring would have been avoidable through better training (21/43; 48.8%) and patient care (52/67; 77.6%) • Mental health nurses were available to routinely support the care of 11-25 year old patients with mental health conditions when they were admitted to a general hospital in 74/116 (63.8%) hospitals • 68/246 (27.6%) general hospital case notes reviewed highlighted a delay in response by mental healthcare to a referral, and the delay had an impact on the quality of both the physical and mental healthcare in 36/60 (60.0%) patients • The initial mental health assessment resulted in the formation of a collaborative risk management plan in 102/153 (66.7%) patients

	Key message	Key findings
3	Planning for the transition of care from child to adult mental health services, particularly in secondary care was not always done well	• 22/101 (21.8%) hospitals (general or mental health) had no framework to facilitate continuity of patient care at the point of transition from child to adult mental health services • Of the hospitals with on-site mental health services it was reported in only 46/96 (47.9%) that designated professional leads for transition were in place: - 26/58 (44.8%) hospitals where 11-17 year olds were treated - 20/38 (52.6%) hospitals where 18-25 year olds were treated • Only 23 patients had evidence that transition was occurring or had occurred in mental healthcare within the previous two years and there had been problems with transition planning or implementation in 6/20 (30.0%) patients (unknown in 3). The most common issues were delay in identifying a named clinician and/or acceptance into an adult service
4	Clinical information related to patients with known mental health conditions was not always communicated at the interface between healthcare providers or between the multidisciplinary clinical groups caring for the patient	• Less than half of all hospitals were reported as being a member of a clinical network of care* for people with mental health conditions (106/251; 42.2%) • At the time of arrival and/or admission to the general hospital, the admitting general health team were only able to access community mental health notes and summaries for 47/226 (20.8%) patients • The clinical notes from the general hospital setting were available to the admitting mental health inpatient team for 22/48 (45.8%) patients • Peer reviewers found evidence of adequate communication with the patient's wider multidisciplinary team in 161/280 (57.5%) of general hospital case notes reviewed • Communication with patients and other agencies was described overall as 'good' in 85/310 (27.4%) general hospital case notes reviewed, and in 53/310 (17.1%) it was described as 'poor' or 'unsatisfactory'. This seemed to be a particular problem for patients aged 11-17 years where in 35/53 (66.0%) communication was rated 'poor' or 'unsatisfactory'

KEY MESSAGES – REPORT 2

	Key message	Key findings
1	Routine, national data collection, including coding and ease of access, required improvement	• The processes around obtaining access to the routinely collected datasets, data cleaning and preparation for analysis proved to be complex and time consuming • UK countries differed in the quality, extent and type of routine national data collected. Whilst standard ICD-10 and READ codes were used, the variables collected differed. Different definitions and reporting systems were used (e.g. for admission or discharge) and outcome data was poorly recorded
2	For the conditions of interest there was variability in the presentation to primary and secondary care and admissions to hospital when the demographics of age, sex, country and index of deprivation were compared	a. Self-harm • There was little change in the overall presentation to or the recording of self-harm in primary care. It was more common in females, in people from deprived areas and increased significantly for 11-15 year olds over time • Rates of hospital admission for self-harm were the highest of all the conditions analysed, particularly in older females (16-24 years) • Trends in hospital inpatient admission rates for self-harm varied between countries, increasing in Wales and Northern Ireland, decreasing in Scotland and remaining relatively constant in England b. Depression • There was an overall decrease in recording of depression diagnosis in primary care, thought to be due to recording behaviours of GPs to code for symptoms (in order to avoid labelling or acting strategically in relation to the Quality Outcomes Framework) • Diagnosis of depression in primary care was more common in females and increased with deprivation index • There was a steep increase in hospital admissions associated with depression in females and in those aged 16-24 years • General hospital inpatient admission rates associated with depression increased significantly across all countries between 2004 and 2014, apart from Scotland where rates decreased marginally. This maybe an impact of policy changes in Scotland with the implementation of its mental health strategy 2012-2015, which aimed to strategically shift the mental healthcare of people from inpatient treatment to care in the community

	Key message	Key findings
2	Continued	c. Anxiety • There was an increase in recording of anxiety in 11-24 year olds presenting to primary care, as well as, an increase in hospital admissions across all countries associated with anxiety d. Eating disorders • Rates of eating disorder presentation to primary care remained relatively stable while hospital admissions for eating disorders increased over time, although numbers remain relatively small • Eating disorders were more common in females and demonstrated the reverse pattern for deprivation to other conditions – being most evident in least deprived areas for both primary care and hospital admissions
3	The proportion of referrals from primary care to secondary care for children and young people was highest for people from the least deprived areas despite levels of mental health conditions being higher in the most deprived areas but 'did not attend' rates were higher for those from the most deprived areas and for older males	• Proportionally more males than females were referred from primary to secondary care for 'all mental health' conditions. This may reflect severity on presentation to primary care given known sex differences in help-seeking behaviour • The proportion of referrals from primary care to secondary care for children and young people was highest for people from the least deprived areas despite levels of conditions being higher in the most deprived areas (except for in eating disorders where a pattern was unclear) • Mental health specialty outpatient attendances for individuals with new appointments increased over the study period • The rate of 'new to follow-up' appointments were higher for mental health conditions than for all specialties together i.e. people with mental health conditions were provided with more follow-up appointments implying a greater need for specialist support • In contrast to the number of appointments made, 'did not attend' (DNA) rates for mental health specialties were significantly higher than those for all specialties but had shown some improvements • Children and young people from the most deprived areas attended fewer follow-up appointments for every new appointment than people from the least deprived areas • 21-24 year old males consistently had the highest DNA rates for outpatient appointments

	Key message	Key findings
4	Emergency department attendance showed an increased presentation rate due to mental health conditions when compared with other health conditions, this was also associated with the demographics of sex and index of deprivation	• While there were fewer males overall with a record of self-harm or a mental health condition compared to females, a higher percentage of males presented to emergency departments for all conditions except eating disorders • There was a steep deprivation gradient for individuals attending emergency departments for self-harm or psychiatric conditions, with 50% of attendances from the two most deprived quintiles • Re-attendance rates to emergency departments were much higher for self-harm and mental health conditions than all attendances, particularly for people from the most deprived areas
5	All hospital admissions showed variation in length of stay when the demographics of sex and index of deprivation for patients with mental health conditions was compared	• For all the conditions of interest approximately a third to a half of individuals (range 31.9% (anxiety) - 55.7% (self-harm)) with a new diagnosis in primary care were admitted to a hospital (general or mental health) within the subsequent year • People from the most deprived areas were the most likely to be admitted with any of the conditions of interest recorded, except for eating disorders • Virtually all admissions for self-harm were unplanned emergency admissions • The mean length of stay for people with an associated 'all mental health' diagnosis was considerably longer than for 'any' admission in this age group (21 days vs. 8 days) • Males were more likely to be admitted to an ICU for self-harm than females, despite females having higher recorded rates of self-harm in primary and secondary care. This could reflect the severity of self-harm methods used by males • More males than females aged 11-24 years were admitted to inpatient mental health facilities. The excess of male admissions is in contrast to community prevalence where females out-number males • In England, transition from child to adult services in children and young people over 11 years with associated depression, anxiety, eating disorders or self-harm occurred later than all children and young people regardless of treatment specialty. Admissions for eating disorders transitioned later still than the other conditions

	Key message	Key findings
6	Deprivation was associated with a lack of access to psychological therapies and antidepressants were used frequently but varied when associated with the demographics of age, deprivation and sex	• A larger proportion of females than males were referred to Improving Access to Psychological Therapies (IAPT) (adult service in England) but once referred similar proportions of males and females received treatment • A larger proportion of children and young people aged 11-24 years from deprived areas were referred to IAPT (adult service) but they were less likely to attend at least one appointment and receive treatment • Of the annual incident cases of recorded depression between 2004 and 2014 in 11 to 24 year olds 80% received an associated prescription (12 months either side of the recorded diagnosis) for an antidepressant. In comparison for self-harm, anxiety and eating disorders, 43%, 41% and 34% were prescribed associated antidepressants respectively. The rates of antidepressants prescribed associated with the conditions of interest: • Decreased significantly for depression diagnosis between 2004 and 2014 • Increased significantly for anxiety between 2004 and 2014
7	Education data demonstrated variation in attainment in those under 18 years of age when compared with the conditions of interest and the demographic of sex	• The presence of any of the conditions of interest diagnosed in primary care between the ages of 11 and 18 years was associated with lower attainment at Key Stage 4, GCSE (except for in females with anxiety and/or eating disorders where there was no significant difference) and lower attendance • Males with self-harm recorded in primary care before they were 18 years old were more likely to be excluded from school than those with no record

Recommendations

RECOMMENDATIONS – REPORT 1

	Recommendations	Who should action
SUPPORT IN ACUTE GENERAL HOSPITALS TO ENSURE PARTITY OF ESTEEM FOR PATIENTS WITH MENTAL HEALTH CONDITIONS		
1	Develop and promote national guidance outlining the expectation required of general hospital staff in the care of children and young people with mental health conditions. Guidance should include: a. Training relevant to their role in the assessment, formulation and management for aspects of mental health conditions, including familiarity with specific terminology and language b. Routinely taking a physical and mental health history c. Undertaking and acting on simple and appropriate mental health risk assessments d. When and how a referral to mental health services should be made and what the content should be	• *Royal Colleges - RCPsych, RCP, RCPCH, RCN, RCEM and Specialty Associations* • *Executive Boards for Mental Health and for Physical Health and* • *Physical Healthcare Professionals for the implementation* *Supported by* • *Health Education England* • *Medical Training Bodies* • *NHS Improvement* • *Care Quality Commission* • *General Medical Council*
2	Nominate or appoint a clinical lead for children, and young people's mental health in all acute general hospitals to: a. Promote the integration of physical and mental healthcare b. Lead on implementation of existing training initiatives and future national guidance c. Identify staff training requirements in acute general hospitals to meet the needs of children and young people with mental health conditions d. Ensure policies and procedures are in place to provide: i. Continuity of care between general and mental health services ii. Care during transition from child to adult mental health services e. Promote the use, and regular review, of an agreed joint care and risk management plan between general and mental health, which is integrated into the nursing plan when patients who require inpatient mental healthcare are temporarily accommodated on a general hospital ward f. Promote clear documentation and monitoring of mental health history, mental state examination and management plans	• *Executive Boards for Physical Health* *Supported by* • *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* • *NHS Improvement* • *Regulators*

	Recommendations	Who should action
MENTAL HEALTHCARE IN THE ACUTE GENERAL HOSPITAL SETTING – ASSESSING RISK, TREATMENT AND PATIENT SAFETY		
3	Ensure children and young people admitted to acute general hospitals have prompt access to age-appropriate general hospital mental health liaison/crisis services when needed. These services should: a. Be staffed by clinicians fully trained in the specific needs of the age groups cared for b. Provide access to timely assessment, treatment and risk management during their episode of care, including those presenting in crisis both in or out of hours c. Enable general hospital staff to provide: i. Appropriate and safe care of patients with a mental health condition on an inpatient ward ii. Care for children and young people where psychosocial factors affect physical illness presentation, treatment compliance and/or safeguarding d. Facilitate access to a range of psychological and psychosocial interventions based on a full mental health assessment and clinical formulation e. Work with general hospital staff to plan the patients mental healthcare needs upon discharge f. Involve children, young people and carers in agreeing and communicating after-care interventions and risk plans	• *Commissioners* • *Executive Boards for Mental Health and for Physical Health* *Supported by* • *Physical Healthcare Professionals* • *Liaison Psychiatrists* • *Mental Healthcare Professionals for Adults and Children & Young People*
CONTINUITY OF CARE DURING TRANSITION FROM CHILD TO ADULT MENTAL HEALTH SERVICES		
4	Use NICE Guideline 43 – *'Transition from Children's to Adults' Services for Young People using Health or Social Care Services'* to support patients with mental health conditions during transition between child and adult physical and mental health services	• *Physical Healthcare Professionals* • *Liaison Psychiatrists* • *Mental Healthcare Professionals for Adults and Children & Young People* • *Commissioners*
5	Ensure continuation of mental health care within and across service providers, particularly at the transition from child to adult services including: a. The use of documented and joint care pathways b. The use of clinical networks of care* c. Auditing against national standards locally	• *Mental Healthcare Professionals for Adults and Children & Young People* • *Physical Healthcare Professionals* • *General Practitioners* *Supported by* • *Commissioners – local* • *Executive Boards for Mental Health and for Physical Health* • *Regulators*

	Recommendations	Who should action
JOINED UP CARE AND COMMUNICATION BETWEEN ACUTE GENERAL AND MENTAL HEALTHCARE		
6	Develop local clinical network arrangements between acute general health and mental health services to work more closely on: a. Identifying and remedying gaps in local care pathways to provide high quality mental healthcare in all settings b. Ensuring patient care records are effectively shared between care providers c. Considering whether there is sufficient capacity in inpatient mental health facilities to allow timely local admission d. Ensuring access to co-ordinated psychological and pharmacological interventions	• *Executive Boards for Mental Health and for Physical Health* *Supported by* • *Local and National Commissioners* • *Primary Care* • *Third Sector Providers and Social Care* • *Care Quality Commission* • *Service Users* • *Providers of Local Transformation plans in England*
7	Ensure mental health risk management plans are clearly available in all general hospital patient records for patients admitted with a current mental health condition. If a plan is not needed then this should also be recorded	• *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* *Supported by* • *Executive Boards for Mental Health and for Physical Health*
8	Utilise electronic patient records to improve record sharing between mental health hospitals and general hospitals within and outside the NHS. In the absence of electronic records, patients should not be transferred between the hospitals without copies of all relevant notes accompanying them and could be encouraged to carry a 'patient passport' outlining an agreed care plan	• *Executive Boards for Mental Health and for Physical Health* • *Physical Healthcare Professionals* • *Mental Healthcare Professionals for Adults and Children & Young People* *Supported by* • *Commissioners*
9	Provide children and young people with mental health conditions an opportunity for private confidential discussions with physical and/or mental health professionals where they are seen in an emergency department or ward within an acute general hospital or mental health facility. This should include a psychosocial assessment leading to an agreed, documented crisis and coping plan given to the patient	• Physical Healthcare Professionals • Mental Healthcare Professionals for Adults and Children & Young People Supported by • Executive Boards for Mental Health and for Physical Health • Service User Groups

	Recommendations	Who should action
10	Document the competence and capacity of children and young people to be involved in decision-making and also to give their consent to treatment or an admission	• Physical Healthcare Professionals • Mental Healthcare Professionals for Adults and Children & Young People Supported by • Executive Boards for Mental Health and for Physical Health

RECOMMENDATIONS – REPORT 2

	Recommendations	Who should action
DESIGN OF SERVICES for EQUITY of CARE		
11	Implement evidence-based interventions in all healthcare and educational settings and organisations	• *Executive Boards for Mental Health and for Physical Health* • *Commissioners* • *Public Health England/ Wales* • *Primary Care* • *Community Mental Health Leads* • *Schools, further and higher educational establishments*
12	Raise awareness, improve emotional literacy, tackle stigma and particularly engage with males in improving their help-seeking behaviour	• *Executive Boards for Mental Health and for Physical Health* • *Commissioners* • *Public Health England/ Wales* • *Primary Care* • *Community Mental Health Leads* • *Schools, further and higher educational establishments*
DESIGN OF SERVICES for EQUITY of CARE		
13	Design mental health services to: a. Promote access for children and young people from the most deprived communities b. Provide access to developmentally appropriate healthcare c. Provide training initiatives to promote staff awareness of the impact of inequalities, such as deprivation d. Monitor the impact of any change in service provision on such inequalities	• *Commissioners* *Supported by* • *Executive Boards for Mental Health and for Physical Health* • *Community Mental Health Leads* • *Public Health England* • *Health Education England*

	Recommendations	**Who should action**
14	Undertake local clinical audit of people with mental health conditions who 'do not attend' clinics to understand why and facilitate improvements thereafter through action plans and local quality improvement projects	• Executive Boards for Mental Health and for Physical Health • QI leads
DATA COLLECTION and CODING		
15	Harmonise the governance and application process to obtain faster and easier access to routinely collected national datasets in England, Wales, Scotland and Northern Ireland	• *NHS Digital* • *NHS Improvement* • *NHS Scotland* • *NHS Wales Informatics Service* • *Northern Ireland Statistics and Research Agency*
16	Ensure coding of mental health conditions in all healthcare records and routinely collected datasets is accurate and consistent. Service providers need to: a. Review and agree data metrics to determine what is relevant for families, clinicians and commissioners b. Train primary and secondary care staff and clinical coders c. Ensure hospitals have the appropriate IT and data collection/entry processes d. Ensure review of the data by local stakeholders e. Record and use outcome data to guide future care delivery	• *NHS Wales Informatics Service* • *NHS* • *England* • *NHS Improvement* • *Department of Health* • *NHS Scotland* • *NHS Wales* • *Northern Ireland Statistics and Research Agency* • *Commissioners*

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