CHILDREN'S COMMISSIONER

Children's and Young People's Mental Health Services: 2024-25

July 2026

CHILDREN'S COMMISSIONER

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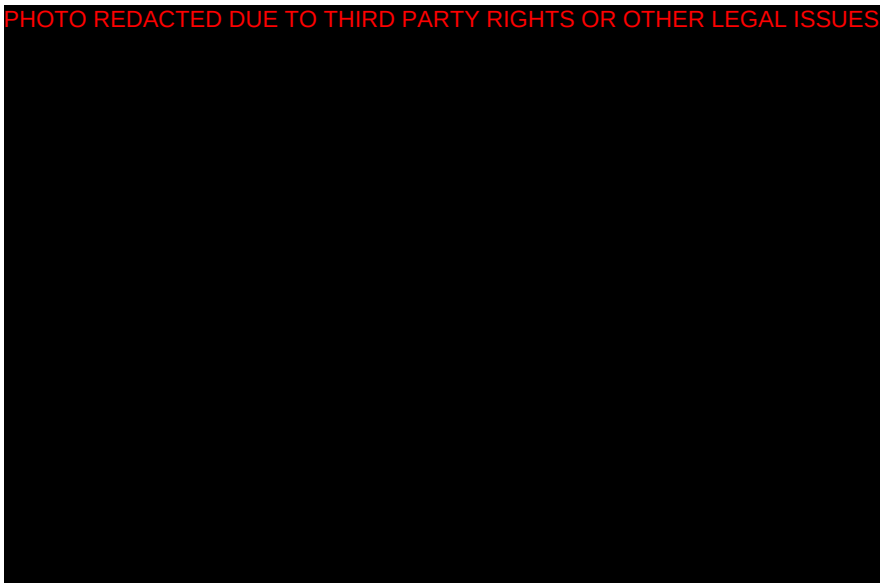
Foreword from Dame Rachel de Souza



As I enter my final year as Children's Commissioner, one thing is clear: before we make decisions that affect young people, we need to listen to young people. Children's mental health is no exception. I am in no doubt that we are facing a crisis in young people's mental health. The number of children with a referral to mental health services reached over a million – about 1 in 10 children – almost double the 564,000 in 2018-19.

The Independent review into mental health conditions, ADHD and autism's interim report, led by Professor Peter Fonagy, has found an increased rate of mental health conditions and rising distress particularly among young people. In my census of schools and colleges the most cited concern about the local area was mental health services. The government's reforms of the special educational needs and disabilities system recognise the current system isn't working.

But look beyond the data and the policy debates. These are real children in distress, reaching a point where the only option available to them is a referral to mental health services. These are young people whose lives are on hold waiting for vital treatment for months, sometimes years.

This is a crisis not confined to the NHS or our schools. The government has recently announced a ban on children's use of social media, citing the potential impact on children's mental health. The Milburn

Review has argued that mental health needs are a crucial factor driving the rising number of young people who are not in education, employment or training.

But I am optimistic. We have a once-in-a-generation opportunity to transform mental health services and improve the mental health and wellbeing of our children – and we must seize it.

The government recently announced a new mental health strategy. It is essential that there is a specific focus on children, jointly owned by the Department of Health and Social Care and the Department for Education, to ensure children with additional needs, neurodevelopmental and mental health conditions are receiving help at the earliest point possible.

We must also be able to confidently say in ten years' time whether children's needs have decreased, whether their access to treatment has improved, and crucially whether that treatment has worked. Because as things stand, there is far too little accountability on any of those measures.

Also key to preventing the escalation of children's needs are the government's reforms of the special educational needs and disabilities system. Evidence-based interventions in schools and support for children at the point of need will require joint working.

Undertaking cross government reforms in step is key to turning the tide against rising distress among children – whether that be educational reforms, support for those not in education, employment or training, and strategies to prevent the development of mental health needs. But this is only one part of the solution.

We cannot continue to accept that ever more children will reach a point where the only option available to them is a referral to mental health services. We must find a way through – one which acknowledges that children are suffering, and does not dismiss the reality of it, but also retains a hope that we can prevent that suffering, rather than just referring ever more children for treatment.

Diagnosis is necessary and life changing for some children. It enables health, social care and education professionals to provide better support, and can help children and their families with an understanding of how they experience the world and what they need. However, relying on diagnosis as the only key to access support often risks inequitable outcomes for children: including children whose needs do not fit into any diagnostic category (for example, those with serious social, emotional and behavioural

issues); or for children with syndromes so rare they never receive a diagnosis. It is not helping the children with suspected neurodevelopmental conditions who I highlight in this report are being referred in large numbers to CYPMHS but effectively being stuck in the system. No child should have to wait for a diagnosis before they get support.

We need a new vision for childhood, one that doesn't silo mental health away from education, care, or physical wellbeing. Young people need a whole state effort from government and local services for children and families. We need a system that works together to nurture, support, and empower every child from the start.

Most of all, we need to listen to young people. I am currently visiting towns and cities and speaking to young people as part of my Big Future survey. I am struck by how articulate young people are when it comes to their mental health. They know what makes them happy – they know what is affecting their wellbeing. The shocking figures in this report should also push us to improve the conditions of childhood, from the long tail of COVID, the harms of social media to the impact of the cost-of-living crisis.

Even the most skilled mental health and wellbeing practitioners cannot provide the antidote to these challenges alone: they are collective problems that require collective solutions with all the people in a child's life working together.

Throughout my tenure I have challenged Government to ensure that every child gets the support and help they need to thrive at the earliest opportunity, and each year I request NHS data on waiting times and investment in children's mental health services.

This fifth and final report into children's mental health services is perhaps the most important, as it comes at a moment of both crisis and opportunity. It is time to stop asking children to prove they are unwell enough to deserve help. We need to bring back joy, address barriers to wellbeing and worry less about diagnosis and more about support.

Content warning

This report is not intended to be read by children, but by professionals working to improve children's mental health and support services. This report makes reference to mental health conditions, including self-harm. The Children's Commissioner's office acknowledges that this content may be difficult to read. However, it is important to understand the level of need among children, to ensure services are set up to support them.

If you are affected by the issues discussed in this report, the following organisations can provide you with expert information, advice and support:

childline

ONLINE, ON THE PHONE, ANYTIME

childline.org.uk | 0800 1111

Childline is a free and confidential service for under-19s living in the UK: www.childline.org.uk | Call 0800 1111

NHS

NHS 111 Offers mental health support and advice, help to speak to a mental health professional, and can arrange an assessment to help decide on the best course of care. www.nhs.uk/service-search/mental-health/find-an-urgentmental-health helpline

SAMARITANS

Samaritans is a free listening service that offers 24/7 support. www.samaritans.org | Call 116 123

Executive Summary

The Children's Commissioner's fifth annual report looks at the journeys children take through mental health services in England, and how that differs depending on what they were referred for, their age, gender, ethnic background and, for the first time, the area-level deprivation where they live. It also spells out the sheer demand for these services, and for some, increasingly long average waiting times.

How is demand for CYPMHS changing?

1. **Demand is rising, and is rising faster**. Over **one million children had active referrals** to children and young people's mental health services in 2024-25 (1,048,965 children). Referrals have **almost doubled since 2018-19** (from 563,639 to 1,048,965). The of children with referrals to CYPMHS grew by 9.5% in the last year alone.

2. **This demand is growing especially for children referred with suspected Autism and neurodevelopmental conditions.** The referrals reasons with the biggest increase in numbers from 2023-24 to 2024-25 were suspected Autism (65,530 to 96,393 children), neurodevelopmental conditions excluding Autism (107,479 to 133,435 children) and anxiety (151,479 to 169,389 children). Increases of 30,863 (47% increase) 25,496 (24% increase) and 17,910 (12% increase) respectively.

Why were children referred?

3. Where known, the top five reasons children were referred to children's mental health services were for anxiety (16% of all referrals), neurodevelopmental conditions excluding Autism (13% of referrals), suspected Autism (9.2% of referrals), being in crisis (5.8% of referrals) and depression (3.9% of referrals).

Journeys through services

4. More children are receiving two contacts, 'treatment', from mental health services – over a third, 36% received treatment in 2024-25 compared with 36% (of fewer children) in 2023-24 and 32% in 2022-23.[1]

5. The trend of fewer children having their referrals closed has continued: 29% of children with referrals in 2024-25 had their referrals closed before treatment – down from 31% in 2023-24.

6. As a result, more children (35%) were still waiting for treatment at the end of the year, this is an increase from the 33% of children who were still waiting in 2023-24 and 29% who were still waiting in 2022-23.

7. In 2024-25, how children moved through the mental health system varied widely depending on why they were referred for treatment. **Children referred with suspected Autism and neurodevelopmental conditions were most likely to still be waiting for any treatment by the end of the year.** Only 13% of children with suspected Autism and only around one in five (19%) children with a neurodevelopmental condition went onto receive treatment in 2024-25.

8. **Findings make clear that demographic factors shape children's likelihood of being referred to mental health services**

    i. **Black and Asian children were underrepresented** among those referred and treated by CYPMHS, while White children were overrepresented. Despite making up 12% and 5.7% of the child population, Asian and Black children only made up 5.8% and 3.8% of those referred, respectively. However, once referred to CYPMHS, children are just as likely to receive treatment regardless of ethnic background.

[1] A child is counted as accessing treatment if they have two contacts with CYPMHS. In some cases, a child may have more than one contact before treatment begins, while others may not need further support from CYPMHS after one contact. Thus, we cannot confidently state in all cases that a child with fewer than two contacts did not have their needs met or that every child with two contacts has entered treatment. However, this remains the best proxy measure available due to a lack of other reliable data sources estimating the number of children receiving treatment at a single contact.

ii. **Children in both rich and poor areas are being referred in large numbers. However, children from more deprived areas were more likely to be referred and go on to be treated by mental health services than children from less deprived areas**. Children from the poorest 10% of areas made up 15% of those referred, compared to 7% from the least deprived areas. 36% of children from the 10% of most deprived areas entered treatment compared to 32% of those from the 10% richest areas. They were also more likely to have shorter waiting times before receiving treatment. This could point to the damaging effects of deprivation on children's mental health and wellbeing.[1]

iii. **Boys are marginally less likely to be referred than girls, and also slightly less likely to receive treatment once referred than girls**. An explanation of this could be that boys are more likely to be referred for suspected autism and other neurodevelopmental conditions, referral reasons with the longest waiting times.

iv. **Adolescents are much more likely than younger children to be referred and then go onto receive treatment from CYPMHS**. Children aged between 10 and 12 make up a quarter (25%) of all children receiving treatment. Children aged 13 to 15 years make up over a third (35%). Younger children (aged 0 to 6) are more commonly referred for neurodevelopmental conditions such as suspected Autism (amongst others) and are also more likely to wait longer for treatment. **Bigger proportions of children under 6 and older teens aged between 16 and 17 are also more likely than other ages to have their cases closed after referral.**

9. **Reasons for referrals varied by age, gender, and ethnicity**:

i. Children under 10 are more likely to be referred with neurodevelopmental conditions (specifically suspected autism for those age 6 and under), while for over 10s the most common referral reason was anxiety

ii. For boys, neurodevelopmental conditions were the most common reason for referral, whereas for girls, anxiety was the top reason for being referred.

iii. 25% of Black children and 16% of Asian children are referred in crisis compared to 7.4% of White children

Waiting times

10. **The weighted average waiting time (median) for all children in 2024-25 was 128 days**. For those who received treatment in 2024-5, children waited an average of 35 days (median), the same length of time as in 2022-23 and 2023-24. However, there was a notably increased waiting time for children who were still waiting to receive treatment within 2024-25. Children who did not receive treatment were on average waiting a median of 224 days.

11. Some children wait for years for support. **Of children who were still waiting to receive treatment at the end of 2024-25, 16% (60,041 children) had been waiting longer than two years, an increase from 14% (44,881 children) the previous year. Waits of over a year were common.**

12. **Waiting times varied by referral reason**. For children who received treatment (by which we mean two contacts) for suspected Autism, their median wait was a year. Children with diagnosed Autism had a shorter median wait of 67 days, but this is still double the median waiting time for all children who received treatment in 2024-25.

Spending

13. Real spend on children's mental health services reached £1,106 million in 2024-25, following the pattern of increased spend over time. Adjusted for inflation, this represents a 2% real increase on the previous financial year. This compares to the 9.5% increase on last year in the number of referrals.

14. Some ICBs like Kent and Medway spend under £600 per child while others like North West London spend as much as £2,400.

This report highlights that not enough is being done to prevent mental health conditions developing, as referrals to CYMPHS continue to rise. The system is struggling to keep up with demand, most notably when it comes to the increase in number of referrals for children with neurodevelopmental conditions.

To address this the Children's Commissioner is calling for changes that focus on the unique needs of children, that are truly ambitious in seeking to prevent mental ill health and severity of need and put

much needed emphasis on the conditions of childhood – family, community, education, opportunity – to turn the tide of rising distress in the younger generation.

1. **A joint national strategy and outcomes framework for children's mental health and wellbeing**: As part of the DHSC's strategy, **a specific strand focused on children should be undertaken jointly with the Department for Education** (DfE) and must include an outcomes framework to assess children's journey through mental health services. It must:

   i. Address the drivers of poor mental health and wellbeing., expanding early intervention that is well linked with health services through early support hubs, Mental Health Support Teams in schools and Young Futures Hubs.

   ii. Ensure a robust evidence base for treatments and interventions provided in schools, the community and inpatient settings, and drive investment to those interventions.

   iii. Create a shared, agreed framework across health and education for assessing children who present with neurodevelopmental needs, and develop a consistent, shared pathway between community paediatrics and CYMPHS for these children.

   iv. Develop alternative pathways which ensure suitable provision for children with complex social, emotional and mental health needs resulting from trauma, who currently fall between systems.

   v. Introduce better data and accountability for children's experience of mental health services. The strategy must include an outcomes framework that assesses children's journeys through the system and the effectiveness of treatment and interventions. Effective implementation of the single unique identifier for children will be essential to enable this

   vi. The Department's ambitions also need to include tackling the root causes of the development of mental illnesses, and the severity of certain mental illnesses.

   vii. Develop genuine alternatives to inpatient mental health settings, that provide the appropriate intensity of support while also allowing children to stay connected to their families.

2. **Effective implementation of reforms to the Special Educational Needs and Disabilities system**: To ensure children with additional needs, including neurodevelopmental and mental health conditions, are getting the required support it is essential that health is an equal partner in the reforms. That should include:

   i. A clear strategy for how Mental Health Support Teams, Experts at Hand and Inclusion Bases will work together to oversee and deliver evidence-based interventions

   ii. Joint local commissioning between health and education, and increased resources, for therapists and allied health professionals working in schools.

   iii. Health, social care and education must work together to ensure children with some of the most complex needs can attend school.

In the Children's Commissioner's role in overseeing the delivery of the SEND reforms, both the DfE and DHSC will be held to account and measurement of success will be underpinned by children's experiences.

Introduction

Children and young people's mental health services (CYPMHS) provide vital NHS diagnosis, treatment, and support to children in England. Children can be referred for mental health conditions, such as anxiety, depression, Bipolar Disorder and the first signs of psychosis, as well as for diagnosis or support for neurodevelopmental conditions, such as learning disabilities, Autism and Attention Deficient Hyperactivity Disorder (ADHD).[2] Children may also have both, as having a neurodevelopmental condition often increases the risk of developing a mental health condition.[2]

Demand for children's services continues to rise, and there have been extensive debates about whether this reflects changes in diagnostic criteria, better identification or social changes driving higher levels of mental health distress. The *Independent review into mental health conditions, ADHD and autism* was launched to understand these patterns, and its interim report has found that there are many different factors affecting different groups of children.[3] It suggests that available evidence indicates an increased rate of mental health conditions and rising distress particularly found among children and young people, a need which is reflected in the rise in referrals seen in the Children's Commissioner's annual reports. It also identified that the underlying prevalence levels of Autism and ADHD seem to be more stable but that stable underlying prevalence can coexist with sharply rising diagnosis, identification and service demand.

This suggests that there are no straightforward answers to what is driving the rise in referrals, and that there may be different answers depending on the conditions being considered.

The government is rightly therefore trying to consider children's mental health and neurodevelopmental needs in the round. They have recently announced a ban on children's use of social media, citing the potential impact on children's mental health.[4] The Milburn Review has argued that mental health needs are a crucial factor driving the rising number of young people who are not in education, employment or

[2] For children who have neurodevelopmental disorders, they may be referred for support via different routes, so many children are referred to community health services for support which is separate to children and young people's mental health services (CYPMHS). The following report does not include children seeking support via community health services, only those seeking support from CYPMHS.

training.[5] And the SEND reforms are in part an acknowledgement that the current system – of children waiting years for a diagnosis for learning needs, then longer for an EHCP – is often not working for children or schools.[6]

What is clear is that this is a critical issue that children's mental health services alone cannot fix, and requires cross-government effort to tackle.

In May 2026, the government announced its new strategy to drive a shift from crisis intervention to preventative care in mental health.[7] This presents a generational opportunity to transform both mental health services and generate the conditions necessary to improve mental health and wellbeing across the population. This report shows why the strategy is so urgent, and why it is essential that there is a specific focus on children within it to ensure children with additional needs, neurodevelopmental and mental health conditions are receiving help at the earliest point possible.

1. How many children were referred?

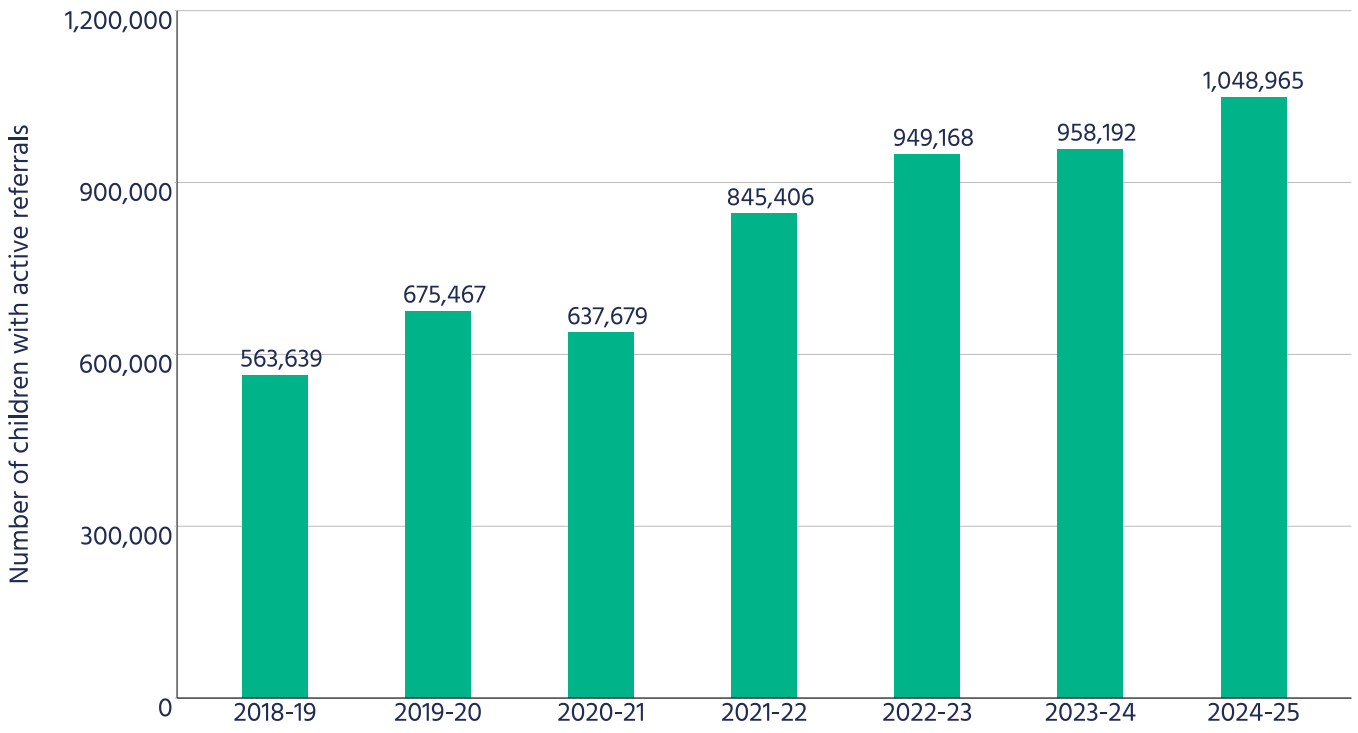
In England, huge numbers of children are now being referred for support and treatment from children's mental health services. The number of children with open referrals to CYPMHS has almost doubled since the office started conducting its annual reports into children's mental health services, from 563,639 children in 2018-19 to 1,048,965 children in 2024-25.

In the last financial year, the rate at which children were referred has sped up: There were 1,048,965 children with open referrals to CYPMHS in 2024-25. With an increase of 9.5% from 958,192 in 2023-24, (90,773 children), this means that, for the first time, over a million children in England have active referrals with children's mental health services, up from around half a million in 2018-19.[3]

The demand for mental health services is growing especially for children referred with suspected Autism, neurodevelopmental conditions and anxiety (a respective 47%, 24% and 12% increase in numbers referred from 2023-24 to 2024-25). The increase in suspected Autism and neurodevelopmental conditions account for almost two thirds (62%) of the overall increase in children referred. Crucially, children referred for these reasons were the least likely to go onto receive treatment and likely to face some of the longest waits before accessing CYPMHS services.

[3] This is not including children who were already in treatment at the beginning of 2024-25.

Figure 1: Number of children with active referrals to CYPMHS by financial year, 2022-23 to 2024-25.



2. Why were children referred to children's mental health services?

Children are referred to mental health services for a range of reasons. Where known, most children referred to children's mental health services were referred because of anxiety, neurodevelopmental conditions excluding Autism, suspected Autism, being in crisis and depression.

Due to data quality and recording issues, the NHS does not know why over a third of children were referred.

Table 1: Top 15 referral reasons to CYPMHS in 2024-25.

Primary referral reason	Number of children referred	Percentage of children referred in 2024-25
Unknown	367,149	35%
Anxiety	169,389	16%
Neurodevelopmental Conditions, excluding Autism	133,435	13%
Suspected Autism	96,393	9.2%
In crisis	60,889	5.8%
Depression	41,121	3.9%
Adjustment to health issues	34,949	3.3%
Conduct disorders	30,278	2.9%

Self harm behaviours	25,089	2.4%
Diagnosed Autism	15,656	1.5%
Eating disorders	14,673	1.4%
Relationship difficulties	10,739	1.0%
Self - care issues	10,686	1.0%
Unexplained physical symptoms	7,106	0.7%
Post-traumatic stress disorder	6,620	0.6%
Total	1,024,172	98%

In the last year, the biggest increase in referrals by number was as a result in children being referred for suspected Autism, with almost 100,000 children (9.2% of all referrals) being referred in 2024-25 – an increase of over 30,000 children on the year before. There was also a jump in referrals for neurodevelopmental conditions excluding Autism, with over 130,000 children (13% of all referrals) being referred in 2024-25 – an increase of over 25,000 children compared with the previous year.

The third largest increase in number of referrals was due to children being referred for Anxiety, with 169,389 children being referred in 2024-25 – an increase of over 17,000 compared to the previous year.

Proportionately, the biggest jumps in referrals were as a result of children being referred for behaviours that challenge due a learning disability, self care issues and ongoing or recurrent psychosis.

Table 2: Primary referral reasons with the largest percentage changes in the number of children referred from 2023-24 to 2024-25.

Primary referral reason	Number of children referred in 2023-24	Number of children referred in 2024-25	Change in number referred	Percentage increase (%)
Suspected Autism	65,530	96,393	30,863	47%
Neurodevelopmental Conditions, excluding Autism	107,939	133,435	25,496	24%
Anxiety	151,479	169,389	17,910	12%
Self - care issues	6,769	10,686	3,917	58%
Depression	38,319	41,121	2,802	7.3%
Behaviours that challenge due to a Learning Disability	1,685	3,217	1,532	91%
In crisis	59,720	60,889	1,169	2.0%
Eating disorders	13,827	14,673	846	6.1%
Gender Discomfort issues	3,649	4,381	732	20%
Adjustment to health issues	34,261	34,949	688	2.0%
Post-traumatic stress disorder	6,066	6,620	554	9.1%
Diagnosed Autism	15,247	15,656	409	2.7%
Obsessive compulsive disorder	3,109	3,501	392	13%
Attachment difficulties	4,234	4,556	322	7.6%
Organic brain disorder	962	1,269	307	32%
Ongoing or Recurrent Psychosis	490	743	253	52%
Relationship difficulties	10,547	10,739	192	1.8%
Phobias	680	761	81	12%
Conduct disorders	30,243	30,278	35	0.1%
(Suspected) First Episode Psychosis	2,164	2,191	27	1.2%
Gambling disorder	73	99	26	36%
Bi polar disorder	285	250	-35	-12%
Personality disorders	1,535	1,415	-120	-7.8%
Drug and alcohol difficulties	1,166	918	-248	-21%
Perinatal mental health issues	2,240	1,364	-876	-39%

Unexplained physical symptoms	8,409	7,106	-1,303	-16%
Self harm behaviours	27,362	25,089	-2,273	-8.3%

3. Who is being referred to children's mental health services?

3.1 Referrals by age

Adolescents are much more likely than younger children to be referred and then go onto receive treatment from CYPMHS. Children aged between 10 and 12 make up a quarter (25%) of all children receiving treatment. Children aged 13 to 15 years make up over a third (35%). Young people told the Children's Commissioner in *The Big Future,* in response to the question 'what would make your local area better?', that they want support for their mental health.

"More young people's mental health provision: the gap between 16 and 18 where CAMHS don't seem helpful, nor do NHS talking therapies." - Child, 17, The Big Future

How did children's age interact with their reason for being referred?

The reason why children were referred to CYPMHS varies depending on their age. Younger children are most commonly referred for neurodevelopmental conditions. Children aged 0-6 are most commonly referred for suspected Autism (followed by neurodevelopmental conditions excluding Autism) while those aged 7 to 9 are most commonly referred for neurodevelopmental conditions (excluding Autism) followed by anxiety. For both age groups, anxiety was one of the top three most common reasons.

After the age of 10, children's most common reason for referral was anxiety. The second most common reason for referral was neurodevelopmental conditions (excluding Autism) for those aged 10 to 15 and being in crisis for those aged 16 to 17.

3.2 Referrals by gender

Slightly more girls than boys are referred to CYPMHS (51% to 48%). As shown in Chapter 3, boys are also less likely to go onto receive treatment.

How did children's gender interact with their reason for being referred?

The top reason for referral varied based on children's gender. Notably for boys, neurodevelopmental conditions were the most common reason for referral, whereas for girls, anxiety was the top reason for being referred.

Waiting times for neurodevelopmental conditions excluding autism being longer could explain why boys are less likely to have received treatment in 2024-25 than girls.

3.3 Referrals by ethnicity

Asian and Black children are underrepresented among those referred to CYPMHS, making up around a tenth of those being referred and receiving treatment despite representing almost a fifth (18%) of the child population in England. By contrast, White children are overrepresented among those being referred and receiving treatment.

How did children's ethnicity interact with their reason for being referred?

There are some clear differences in the top reasons for referral between children of different ethnic backgrounds, notably that being in crisis is a common reason for Black and Asian children to be referred as compared to White children - 25% of Black children and 16% of Asian children are referred in crisis compared to 7.4% of White children, who are more likely to be referred for Anxiety, neurodevelopmental conditions and suspected Autism (see Table A4 in the annex).

As is shown in Chapter 5, Black and Asian children have markedly shorter waiting times between referral and treatment than White children, an explanation of which could be the higher rate of in crisis referrals for these children.

3.4 Referrals by area-level deprivation

For the first time this year, the office analysed the deprivation decile of referred children's home postcodes, where known.

The analysis shows that children from more deprived areas are likely to be referred and then go on to receive treatment than those living in less deprived areas – with 15% of children referred from the top ten percent most deprived areas being referred compared with 7% of children from the top ten percent least deprived areas.

The data the office request does not show children's decile of deprivation by their reason for referral.

4. What happened to children who were referred to mental health services?

To look at how children moved through children's mental health services, the office set out three outcomes children could have within a year based on the data provided by NHS England. The three outcomes the office has used are 'referral closed', 'received treatment' and 'still waiting'. These can be defined as:

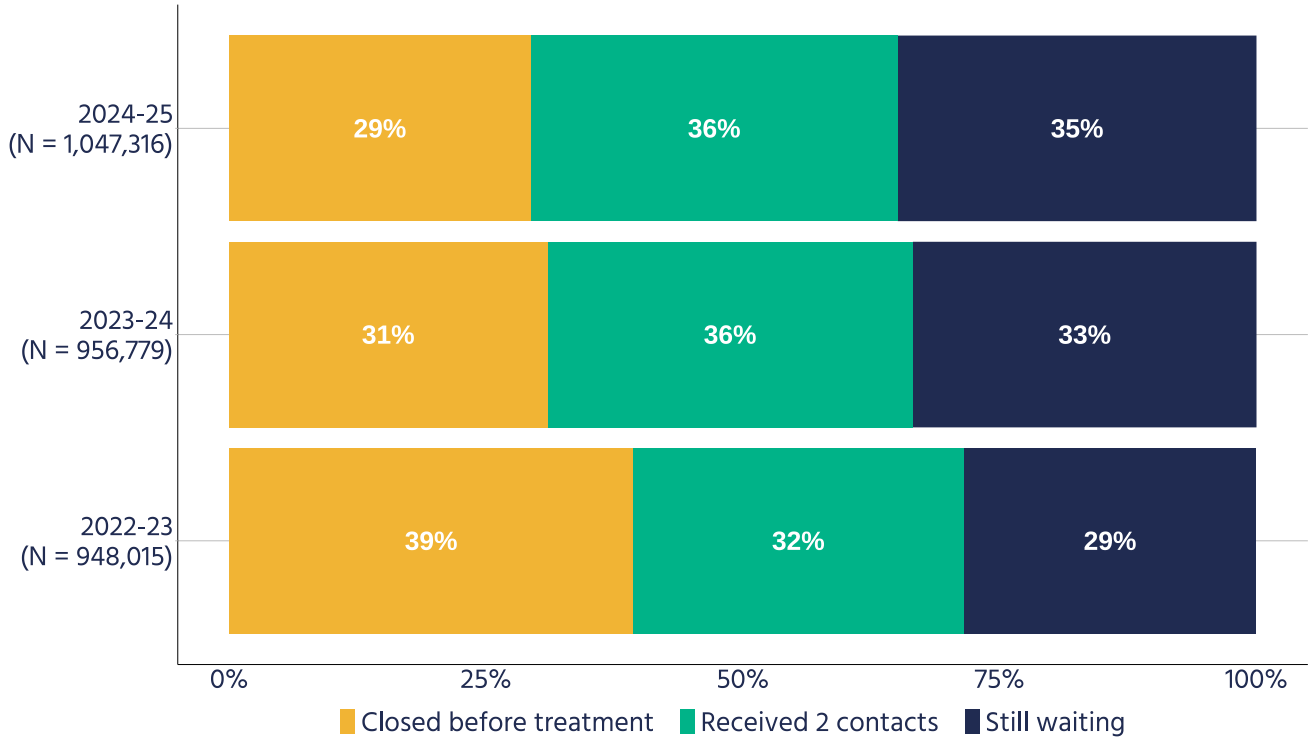
- **Referral closed**: This could mean children were turned away or were effectively signposted to services that better meets their needs. Currently, detailed data is not recorded on what, if any, services children who have their referral closed are referred onto.
- **Received treatment:** The office defines this as children who received two contacts from CYPMHS. While the office adopts two contacts with CYPMHS as a proxy for mental health treatment beginning, the NHSE tends to report CYPMHS access and waiting times statistics with a one contact measure. One contact can mean children did not see any professional, but rather professionals progressed their case without contact.
- **Still waiting:** Children had an active referral which started during or before 2024-25 who were still waiting for treatment at the end of the year.

Over a third of children (36%) referred to CYPMHS in 2024-25 received treatment. This is the same proportion as those who received treatment in 2023-24, and larger than the 32% of children who received treatment in 2022-23. With the numbers of children being referred increasing year on year from 2022-23 to 2024-25, this represents a larger number of children receiving treatment. Overall, this represents a positive shift in how services are responding to children's need for mental health services.

Children were also less likely to have their referral closed before they received treatment – 29% of children had their referral closed compared with 31% in 2023-24 and 39% in 2022-23. This could indicate a move away from children being referred elsewhere or having their case closed by CYPMHS, although how this affects outcomes for children is unclear.

However, a larger proportion of children were still waiting for support at the end of the year. 35% of children were still waiting in 2024-25, compared with 33% in 2024-25 and 29% in 2022-23.

Figure 2: Outcomes of children referred to CYPMHS from 2022-23 to 2024-25 – how many had their referrals closed, received two contacts or were still waiting by the end of the year.



4.1 What happened to children based on their reason for being referred to children's mental health services?

In 2024-25, how children moved through the mental health system varied widely depending on why they were referred for treatment.

71% of children referred for suspected Autism and 64% of children referred for neurodevelopmental conditions excluding Autism were still waiting for treatment at the end of 2024-25 – much higher than the 35% average of children still waiting at the end of the year across all referrals.

Only a small percentage (13%) of children with suspected Autism and only around one in five (19%) children with a neurodevelopmental condition went onto receive treatment in 2024-25.

Children also faced long waits for treatment for gender discomfort issues despite the relatively low number of children being referred for support via CYPMHS. 70% of children referred for gender discomfort issues were still waiting at the end of 2024-25. Children experiencing gender dysphoria (described in the data as gender discomfort) are referred through CYPMHS or community health services to children and young people's gender services and may also have a co-occurring mental health condition that they may need support for via CYPMHS. The data the office received does not necessarily bear this pathway out. Only a small proportion (15%) had their referral closed (referral closure can indicate a referral on to specialist gender services), and only a small proportion received treatment or assessment for co-occurring mental health needs (15%).

Some children with diagnosed conditions were more likely to have their referrals closed.

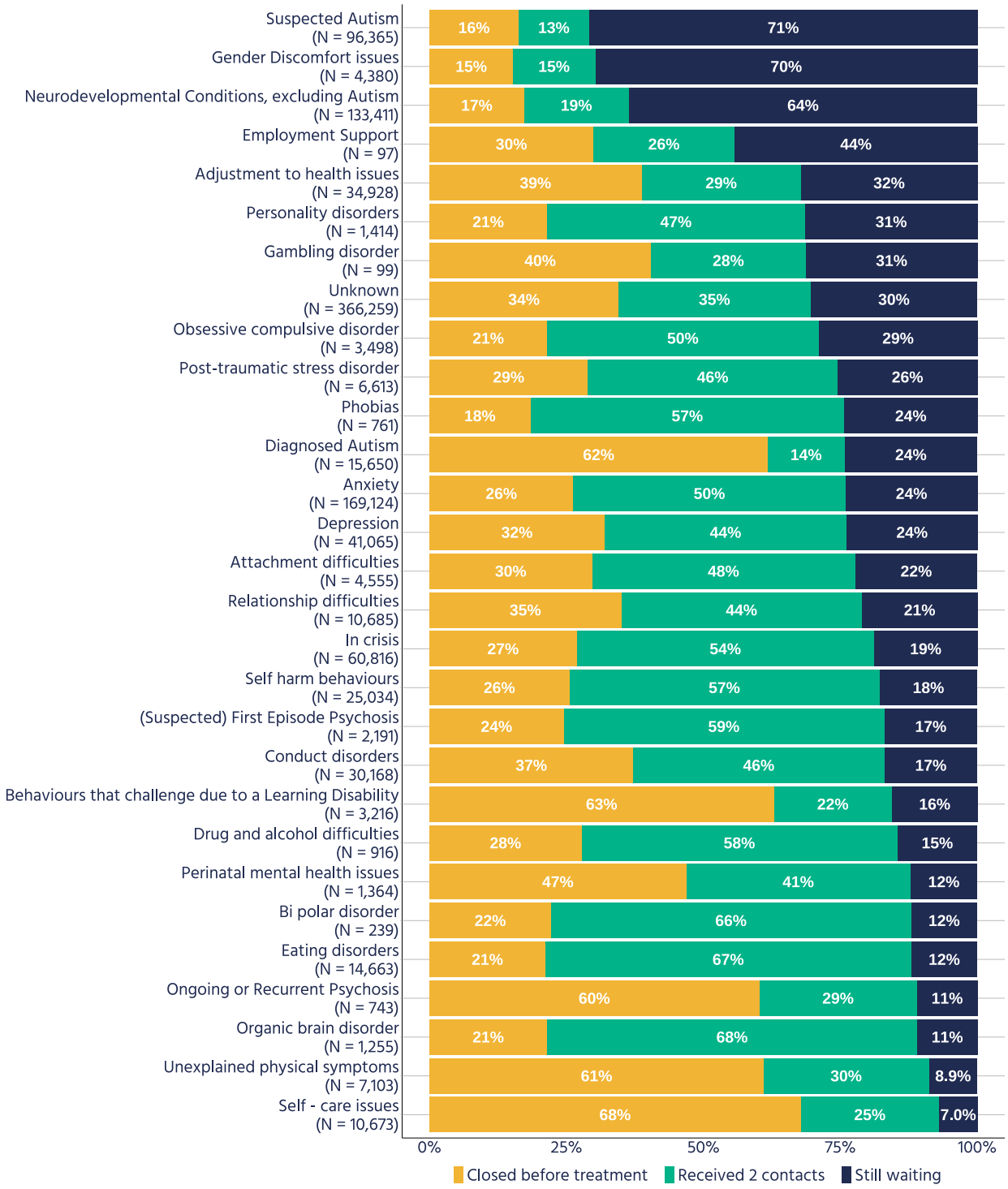
Children with neurodevelopmental conditions were also less likely to receive treatment compared to other reasons for referral. Around two thirds (62%) of children with diagnosed Autism and children with behaviours that challenge due to a learning disability (63%) had their referrals closed. This is a possible indication that children were referred onto more specialist services, but the data does not show if or where children are referred onto if their referral is closed.

Three in five (60%) children with ongoing or recurrent psychosis had their referrals closed. By comparison, children with other potentially mental illnesses (eating disorders, obsessive compulsive disorder and bipolar disorder) were more likely to go on to receive treatment.

The data suggests that many children referred to CYPMHS are either facing long waits, or are seeing their referrals being closed.

"The first time I was referred to CAMHS, it took a year to get a starter session, and the second time I was referred, I was dismissed after a few meetings purely because talking therapy does not suit me. This is ridiculous. Improve the lives of disabled and mentally unwell kids and teens in this country." - Girl, 14, The Big Future

Figure 3: Referral outcomes - percentage of children who had their referrals closed, received two contacts and were still waiting for a contact with CYPMHS in 2024-25, by primary referral reason.



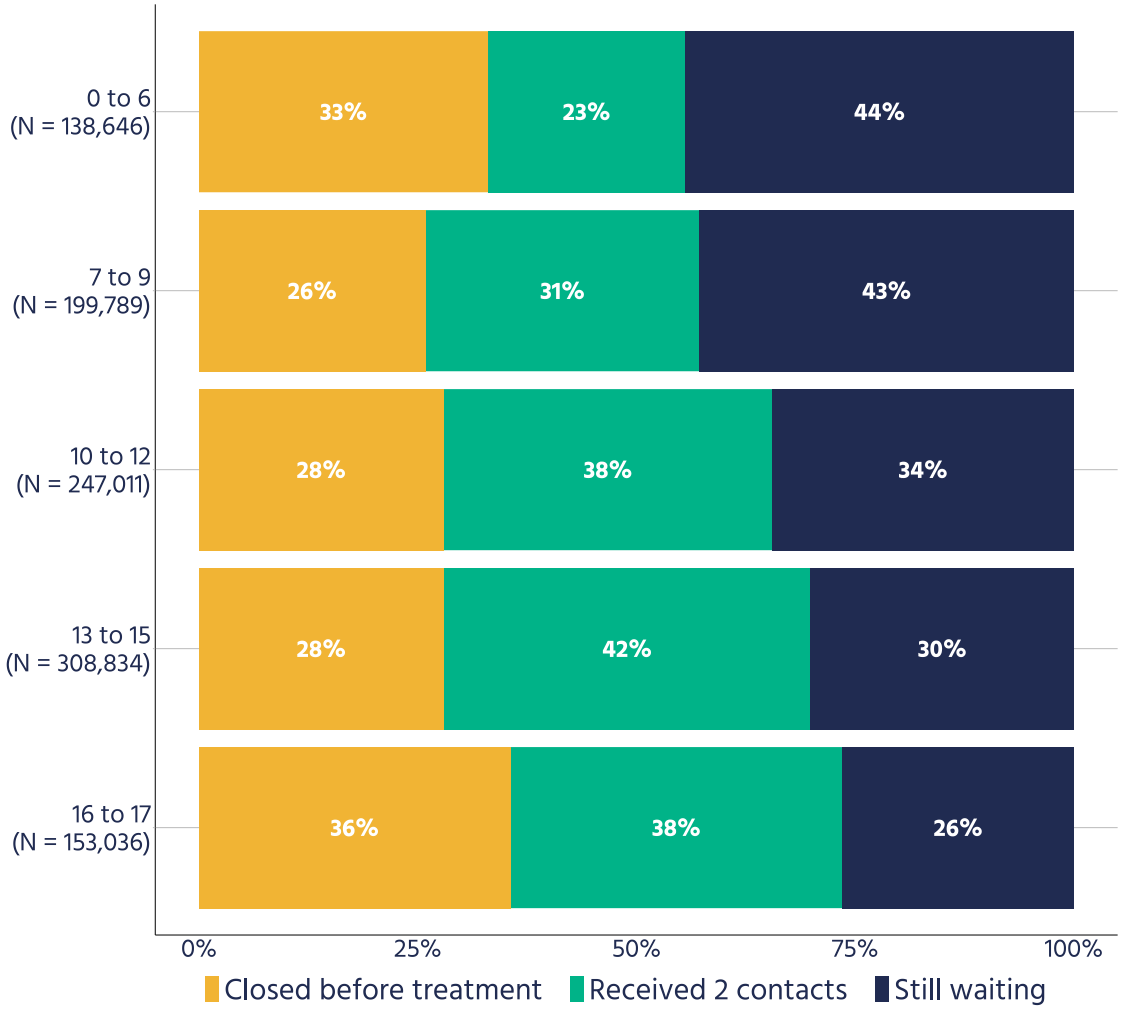
*Note: This is a list of all primary referral reasons provided to the CCo by the NHS except for those with low and disclosive patient numbers. As a result, two primary referral reasons have been excluded from this chart.

4.2 What happened to children depending on their age?

A greater proportion of those under 6 were discharged or turned away after being referred than for most older age groups. The only exception was older teens aged between 16 and 17 who were more likely than younger children to have their cases closed after referral.

The office has previously reported that children seeking support in community health services also face long waiting times. For example, the average wait time from referral to an autism diagnosis in community health services was 2 years 2 months in 2023-4.[8]

Figure 4. Referral outcomes - percentage of children who had their referrals closed, received two contacts and were still waiting for a contact with CYPMHS in 2024-25, by age group.



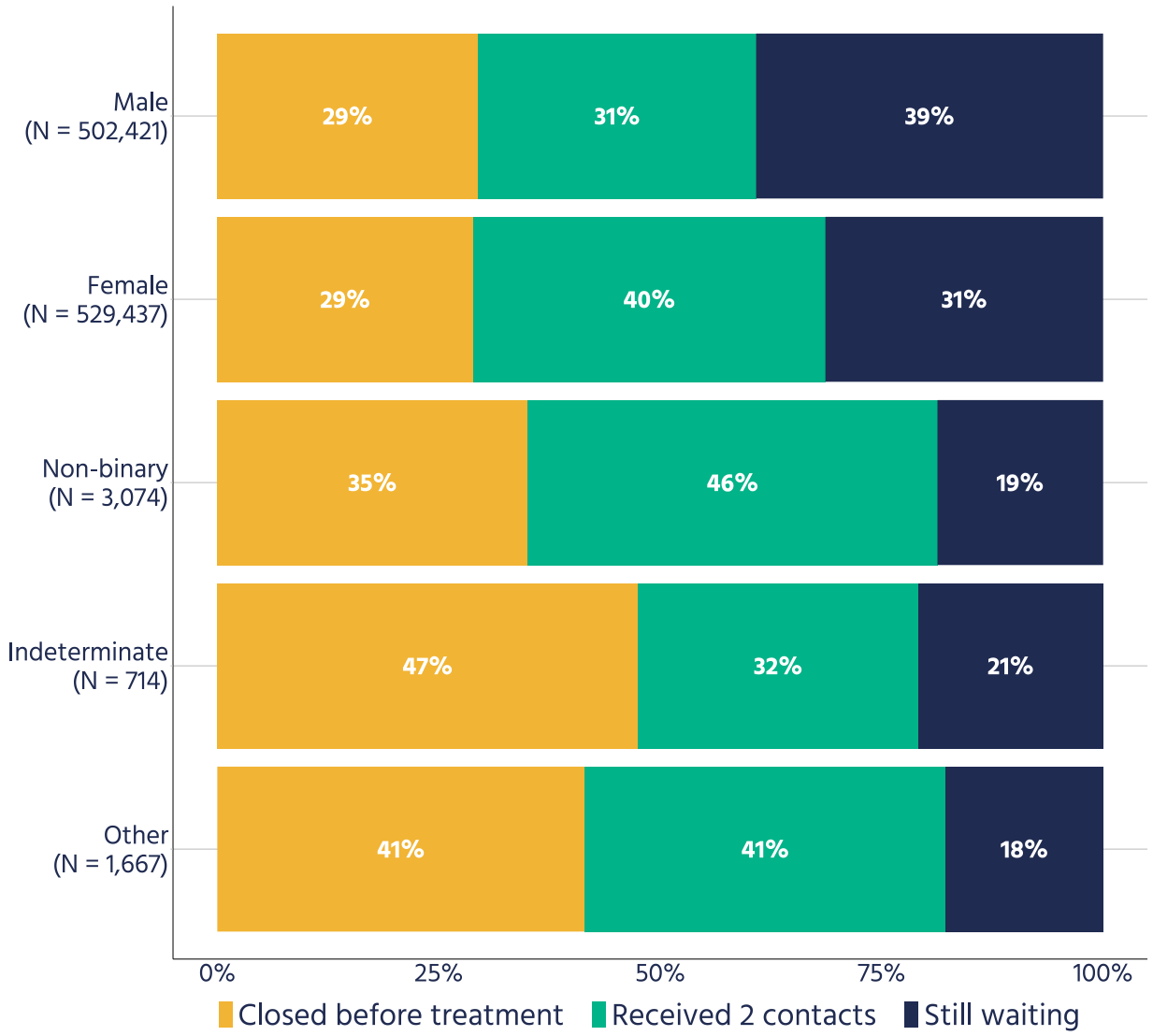
4.3 What happened to children depending on their gender?

Boys and girls had different experiences accessing children's mental health services, with boys being less likely to go onto receive treatment.

Slightly more girls than boys are referred to CYPMHS (51% to 48%). Of those children who then go onto receive treatment, proportionally fewer boys (31%) receive treatment than girls (40%).

As shown in Chapter 2, this could be explained by boys being more likely than girls to be referred because of a neurodevelopmental condition, a referral type which faces longer waiting times than common mental health conditions like anxiety that girls are more likely to be referred for.

Figure 5: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2024-25, by gender.



4.4 What happened to children depending on their ethnic group?

There are disparities between children from different ethnic groups in their referral to and then treatment received from CYPMHS.

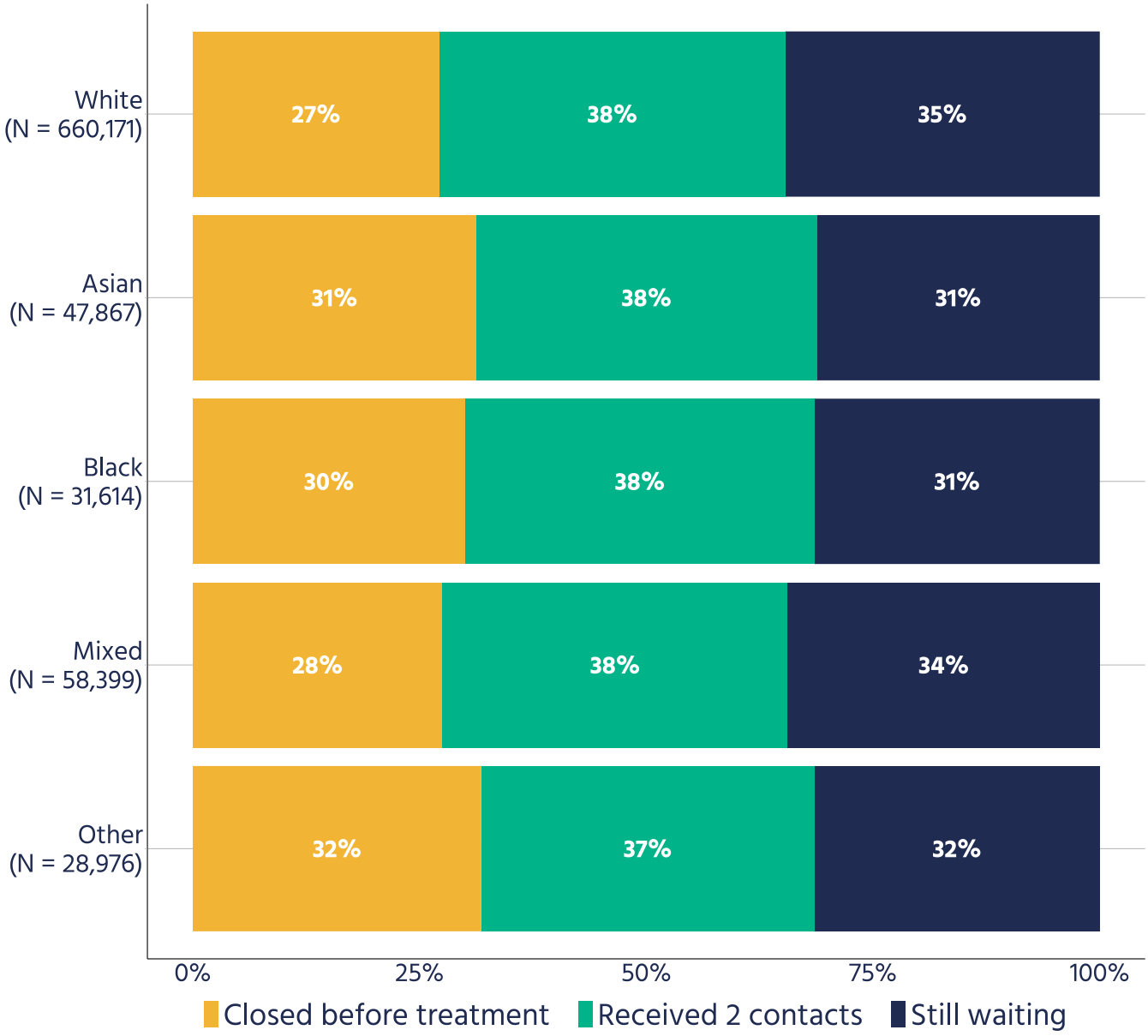
However, once children are referred to CYPMHS, there is no change in how they then move through the system in terms of proportions of those receiving treatment.

Table 7: Number of children referred to CYPMHS and how many went on to receive treatment in 2024-25, by ethnic group.

Ethnic group	Number of children referred	Percentage of children referred	Percentage of children receiving treatment (%)	General population benchmark-ONS Census 2021[9] (%)
White	661,333	80%	80%	73%
Asian	47,919	5.8%	5.7%	12%
Black	31,655	3.8%	3.9%	5.7%
Mixed	58,511	7.1%	7.1%	6.8%
Other	29,002	3.5%	3.4%	2.7%
Total	828,420	100%	100%	100%

Note: Children whose ethnicity was recorded as unknown has been excluded from this table for clarity and consistency with population benchmark statistics.

Figure 6: Referral outcomes - percentage of children who had their referrals closed, received two contacts and were still waiting for a contact with CYPMHS in 2024-25, by ethnic group.



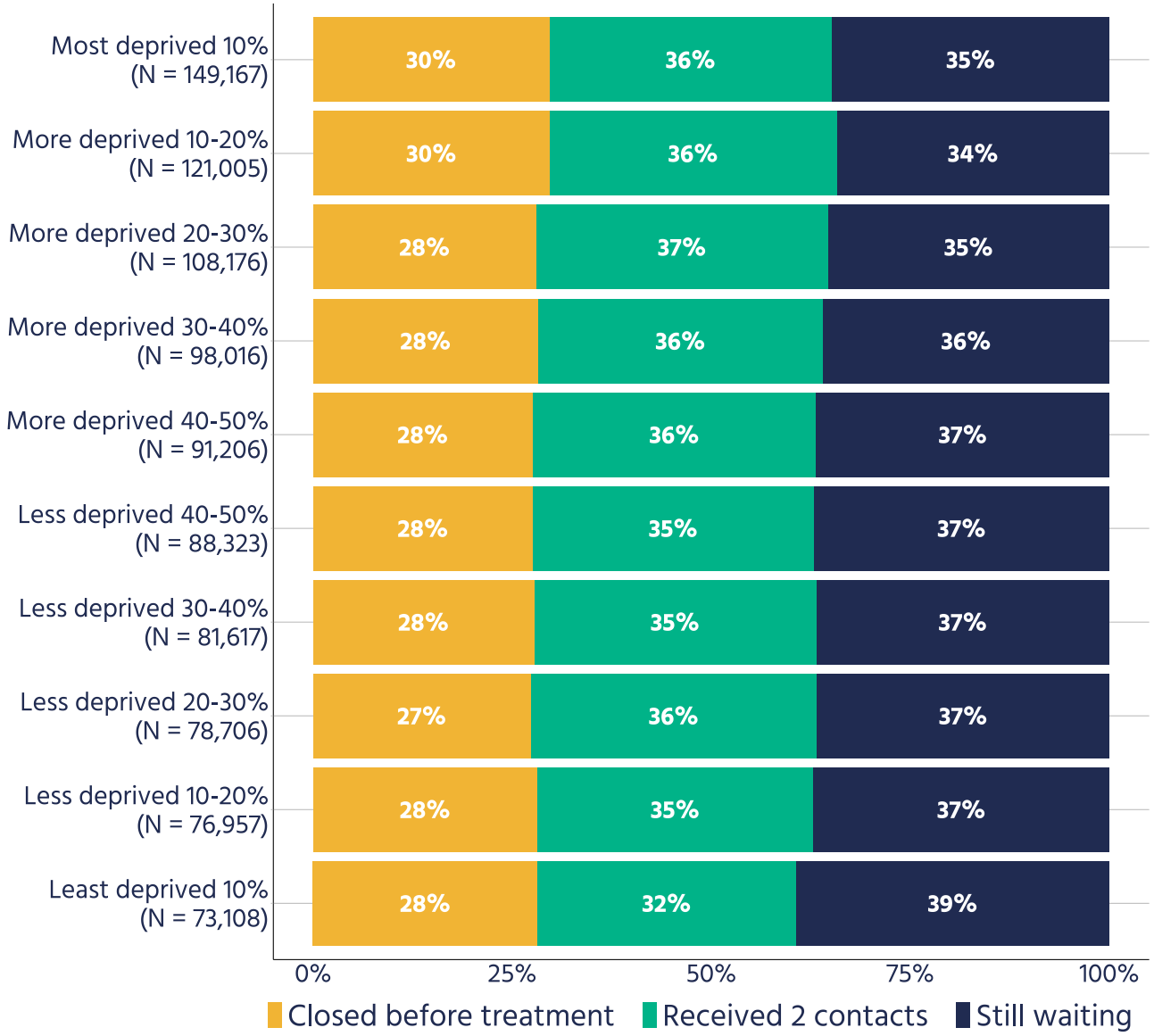
4.5 What happened to children depending on their socio-economic background?

Children from more deprived areas were more likely to be referred and then go on to receive treatment than those living in less deprived areas.

More children living in the poorest areas were referred to and received treatment from children's mental health services. Those in the most deprived 10% of areas made up 15% of all children entering treatment, while the least deprived make up 6.9%.

Once children are referred to CYPMHS, the same proportions of children from each area went on to receive treatment as were referred. Referral closures were also fairly even for children from all areas. This could suggest that while children from more deprived areas were more likely to be referred and receive treatment, levels of need once referred are similar for all children regardless of the deprivation level of the area they were from.

Figure 7: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2024-25, by deprivation (IMD) decile of child's home postcode.



5. How long were children waiting for children's mental health services?

The office has, for the first time, created an estimate for the overall average time children were waiting for CYPMHS in 2024-25. This figure is a weighted average of the median waiting times of both children who received treatment and children who were still waiting for treatment at the end of the year. This was done to provide a fuller picture of children's waiting times. Overall, the weighted average waiting time for children in 2024-25 was 128 days.

Namely, for those who received treatment in 2024-25, children waited an average (median) of 35 days, the same length of time as in 2022-23 and 2023-24. With the overall increased number of children being referred and receiving treatment from CYPMHS, this signifies that mental health services are managing to maintain this level of service for increasing numbers of children.

However, there was a notably increased waiting time for children who were still waiting to receive treatment within 2024-25. Children who were still waiting to receive treatment were on average waiting 224 days. This represents an upward trend from 2021-22 when the average waiting time of children who were still waiting was 179 days. There are also more children waiting overall– 365,731 children in 2024-25 compared with 173,399 in 2018-19.

As shown in the following tables, overall, this means that more children were waiting and were, on average, waiting longer in the system in 2024-25.

"Help more me, help with my diagnosis so I can get support as I'm on a massive waiting list and I struggle at school." - Girl, 7, answering The Big Future with help from an adult

Figure 8: Number of children still waiting and how that has changed from 2018-19 to 2024-25.

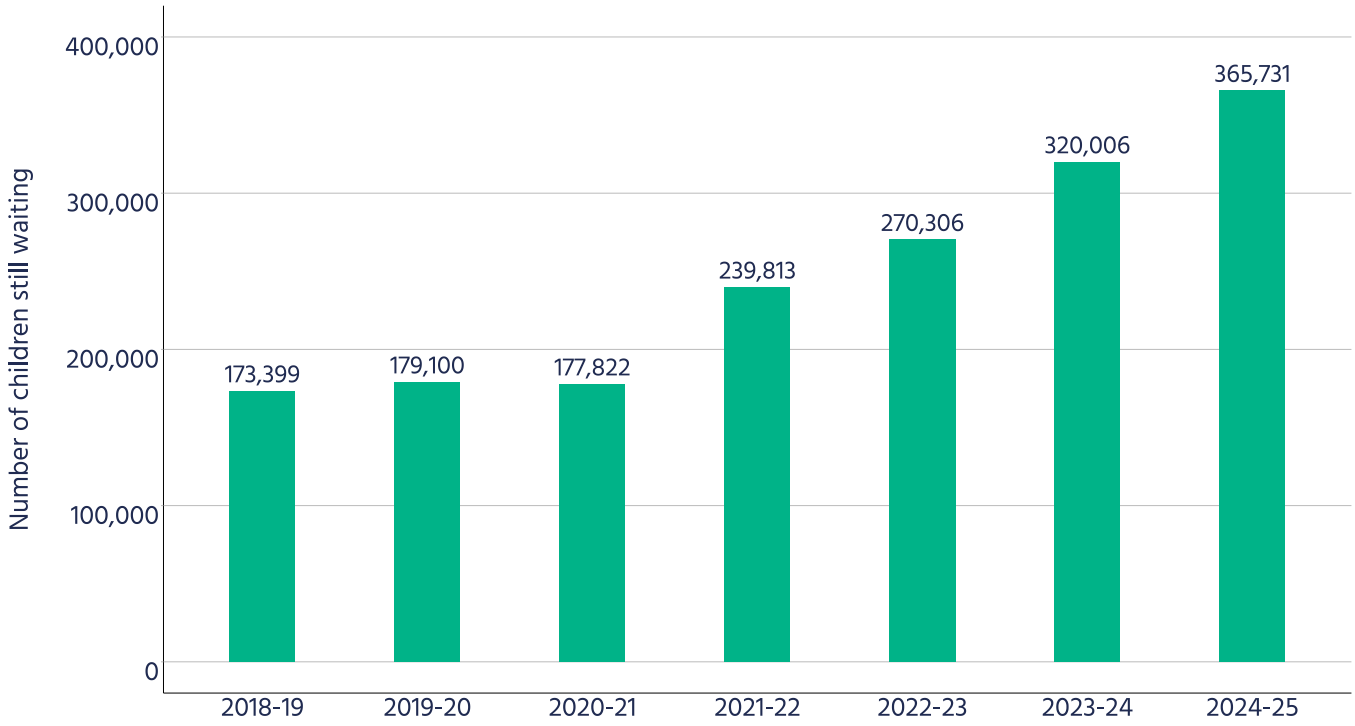
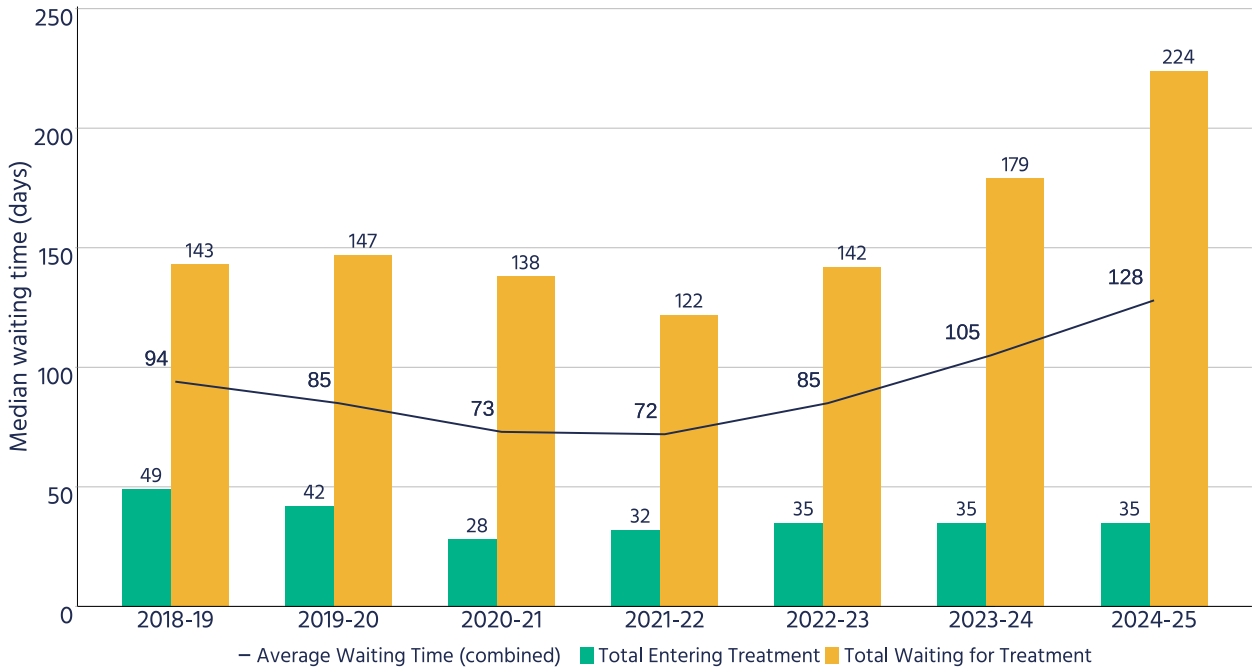
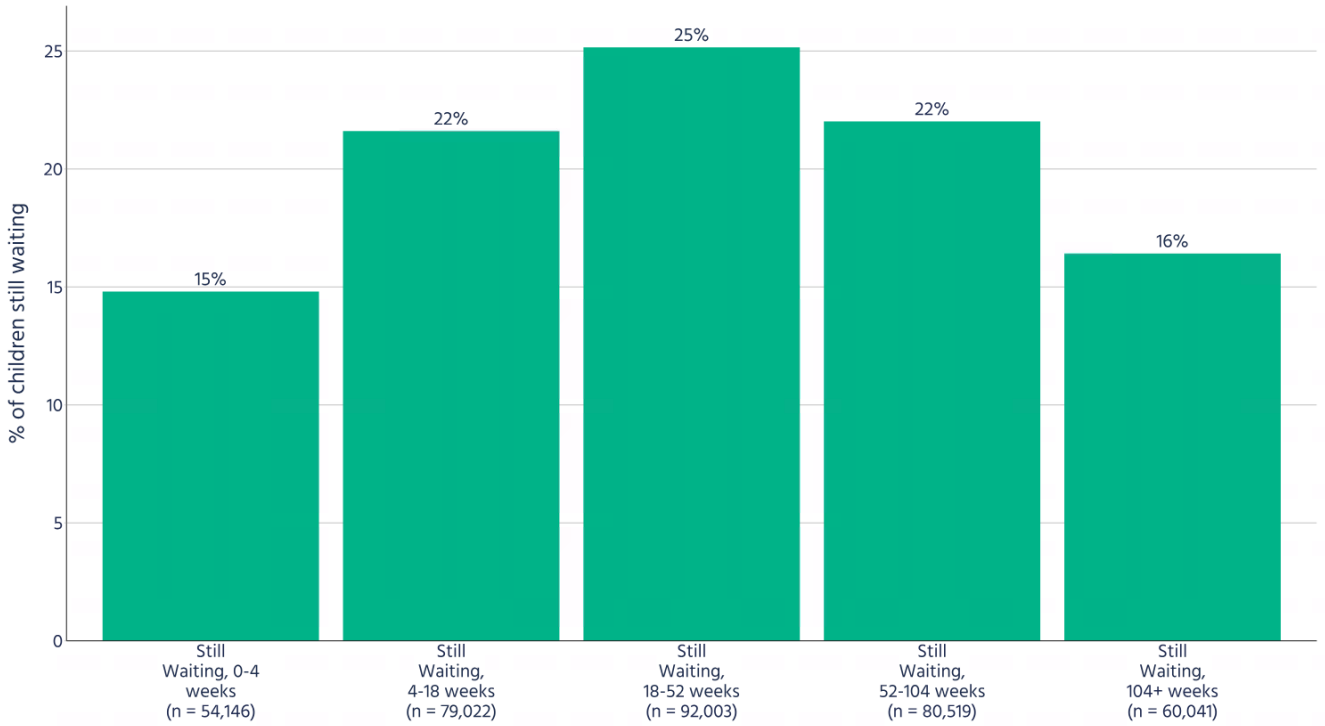


Figure 9: Median waiting times and how they have changed from 2018-19 to 2024-25, for those who entered treatment, those still waiting, and a weighted average of the two.



There were more children in 2024-25 experiencing some of the longest waits. Of children who were still waiting to receive treatment at the end of 2024-25, 16% had been waiting longer than two years. Waits of over a year were common.

Figure 10: How long children still waiting to receive two contacts with CYPMHS services at the end of 2024-25 have already been waiting.



5.1 How long did children wait for treatment depending on why they were referred?

Children's waits for treatment varied drastically depending on what they were referred to CYPMHS for.

When looking at the children who received treatment within 2024-25, those with the shortest waits for treatment were often referred while in crisis or experiencing a severe mental illness. This includes children being referred while in crisis, with Bipolar Disorder, drug and alcohol difficulties, self harm behaviours and a suspected first episode of psychosis.

Table 8: The top ten shortest waits for CYPMHS treatment for children who received treatment in 2024-25

Primary referral reason	Number of children who received treatment	Median wait in days	Mean wait in days
In crisis	33,012	4	39
Bipolar Disorder	157	7	40
Drug and alcohol difficulties	528	8	31
Self harm behaviours	14,171	9	62
(Suspected) First Episode Psychosis	1,282	14	45
Eating disorders	9,792	17	39
Self - care issues	2,696	24	64
Ongoing or Recurrent Psychosis	214	26	184
Perinatal mental health issues	558	28	57
Conduct disorders	13,824	29	64

Of those who received treatment, children who faced the longest waits were referred for suspected or diagnosed neurodevelopmental conditions, as well as Personality Disorders, Gambling Disorder and Obsessive Compulsive Disorder.

"I am a girl with anxiety waiting for an autism diagnoses, the government the mental health and special needs system has and is failing me." - Girl, 14, The Big Future

For children who received treatment (by which we mean two contacts) for suspected Autism, their median wait was a year long. Children with diagnosed Autism had a shorter median wait of 67 days, but this is still almost double the median waiting time for all children who received treatment in 2024-25.

Children with neurodevelopmental conditions, excluding Autism, also had a median wait of 176 days – almost 6 months.

The smaller numbers of children referred for Gambling Disorder, phobias, and gender discomfort issues also had long waiting times, possibly indicative of the type of specialist support required.

Over 3,000 children were referred to CYPMHS in 2024-25 for post-traumatic stress disorder (PTSD), and their median wait for support was over two months.

Table 9: The top ten longest waits for CYPMHS treatment for children who received treatment in 2024-25

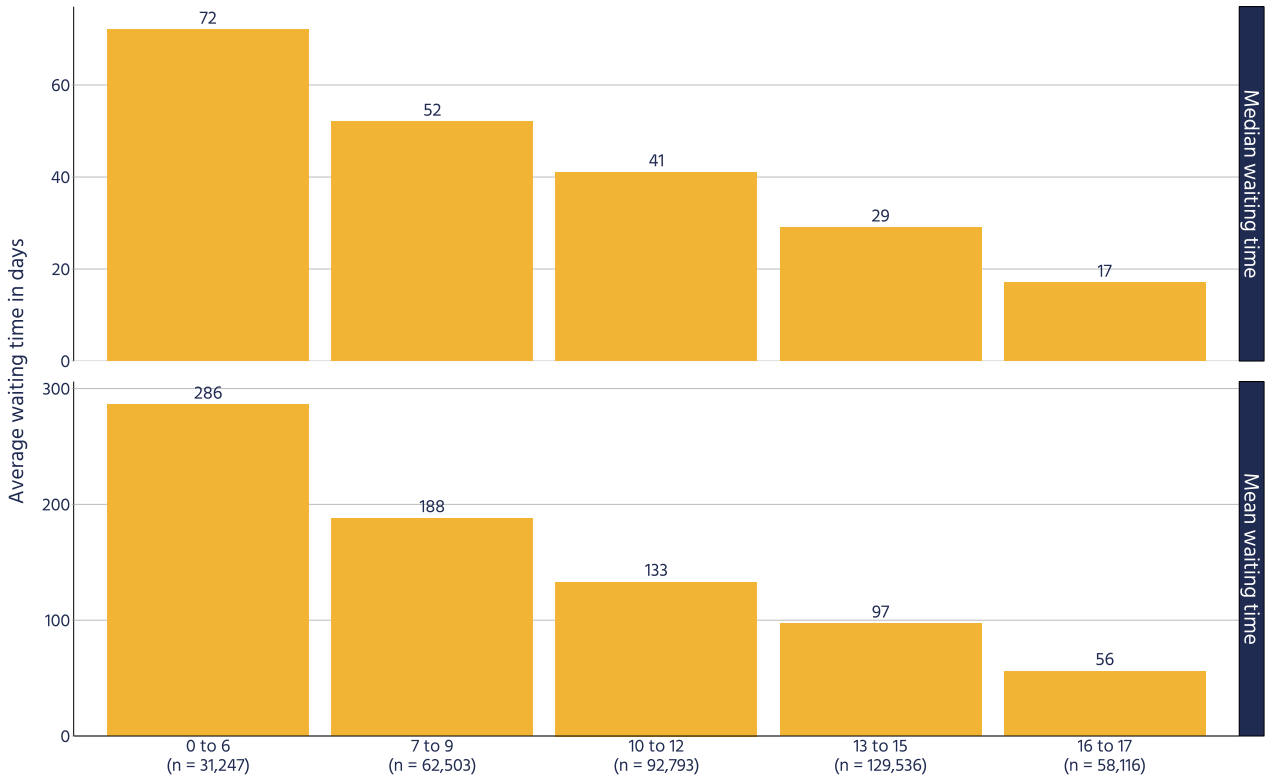
Primary referral reason	Number of children who received treatment	Median wait in days	Mean wait in days
Suspected Autism	12,402	356	510
Gambling disorder	28	184	216
Neurodevelopmental conditions, excluding Autism	25,469	176	312
Personality disorders	666	137	290
Community Perinatal Mental Health Partner Assessment	11	71	107
Diagnosed Autism	2,188	67	256
Obsessive compulsive disorder	1,735	67	132
Phobias	436	67	106
Post-traumatic stress disorder	3,015	64	117
Gender discomfort issues	657	62	117

5.2 How long did children wait for treatment, by age group?

The younger children were when they were referred to children's mental health services, the longer the wait they had to receive treatment, on average.

This could be explained by the larger number of referrals for suspected Autism and neurodevelopmental conditions among young children, a referral type with the longest waits for treatment. However, adolescents are also commonly referred for these conditions.

Figure 11: Children's median and mean waiting time (in days) by age group.



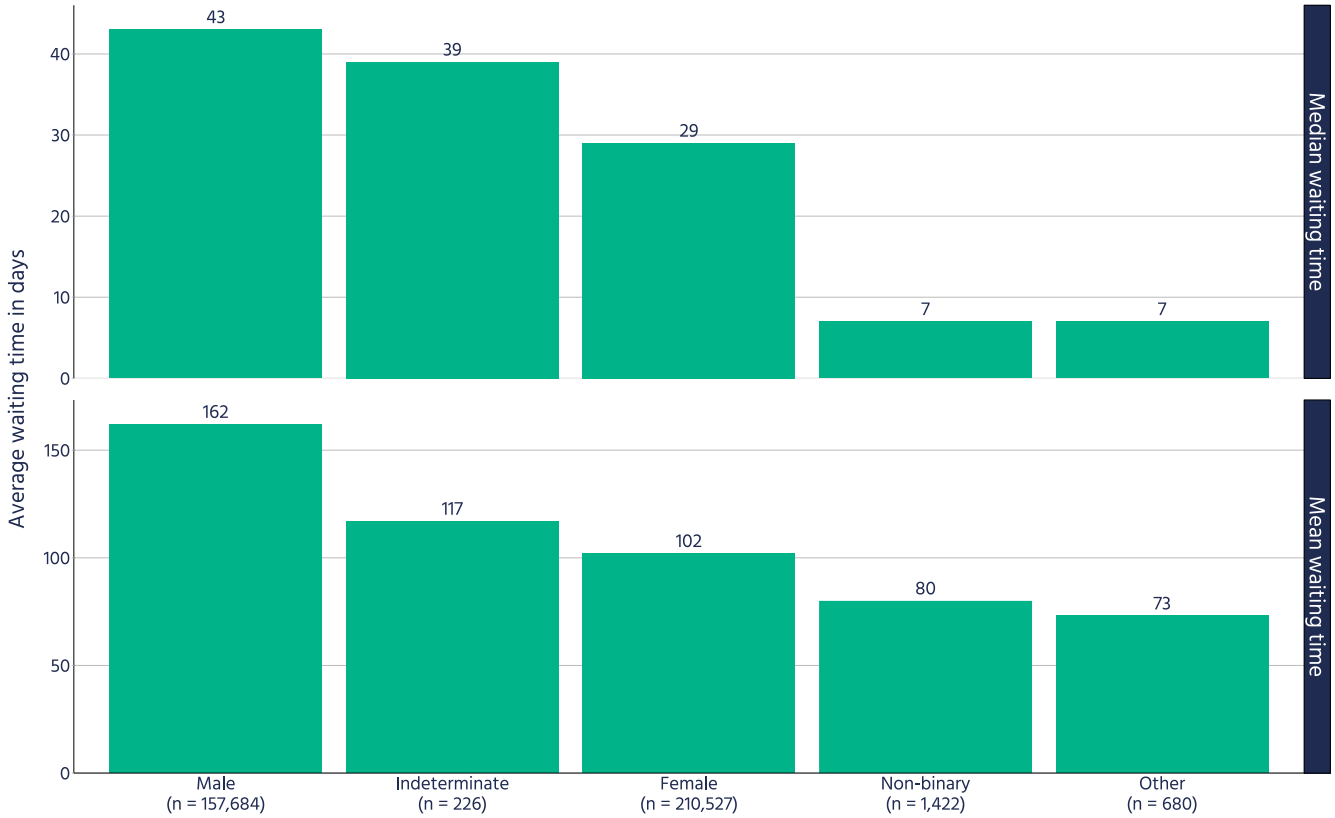
5.3 How long did children wait for treatment, by gender?

Of those receiving treatment in 2024-25, boys had markedly longer median and mean waiting times before receiving treatment than girls. Non-binary children had much shorter waiting times than both boys and girls.

This could be explained by boys' top referral reason being for neurodevelopmental conditions, which is a referral type with a much longer waiting time, and girls being for anxiety.

There were 1,422 non-binary children who received treatment from children's mental health services, and they were more commonly referred for being in crisis or having depression than boys and girls, giving a possible cause for the much shorter average waiting times they experienced.

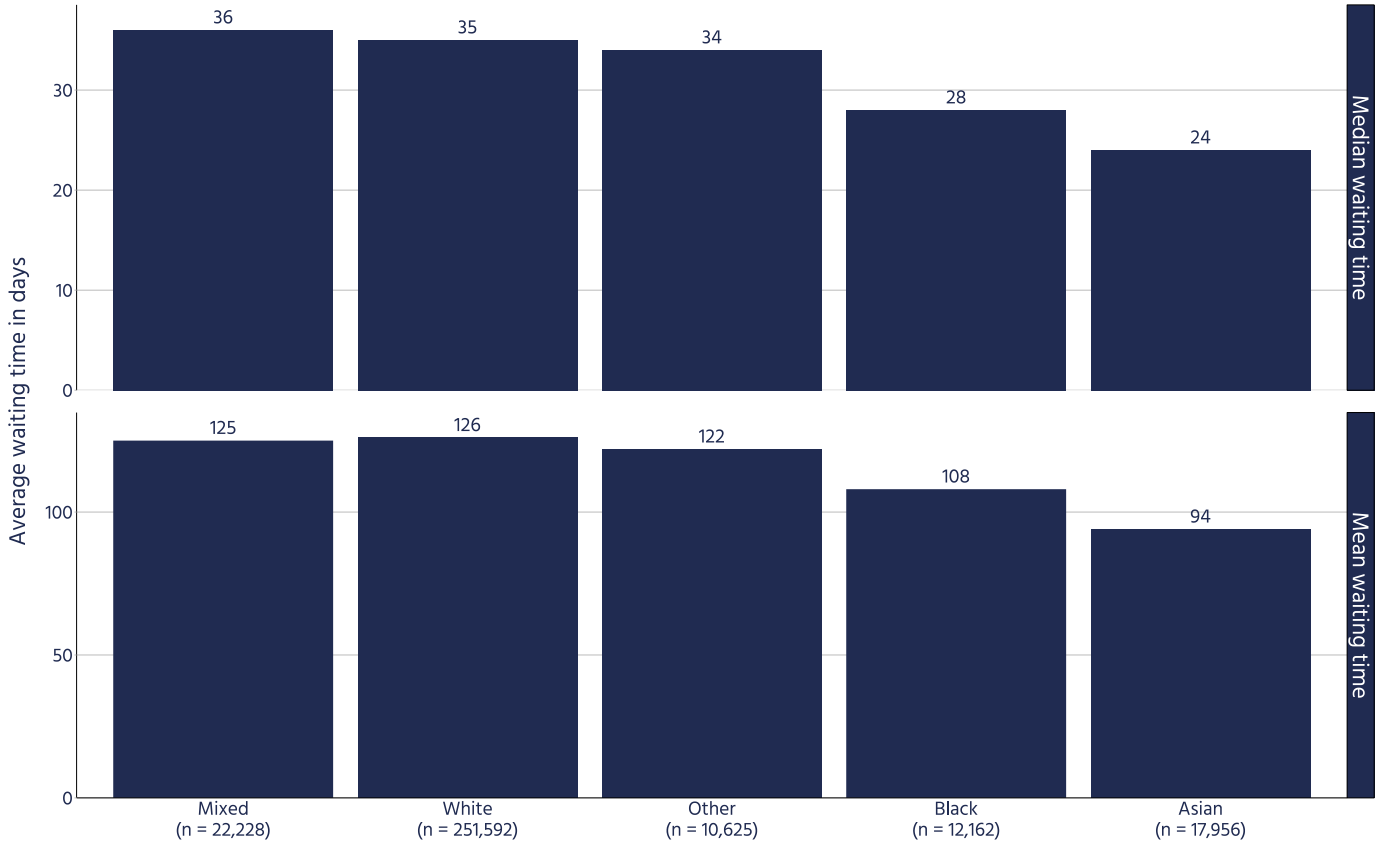
Figure 12: Children's median and mean waiting time (in days) by gender.



5.4 How long did children wait for treatment, by ethnic group?

Of children who received treatment in 2024-25, White children and children of mixed ethnicity had longer mean and median waiting times compared with Asian and Black children. This could be explained by Asian and Black children being more likely to be in crisis when referred to CYPMHS than White children.

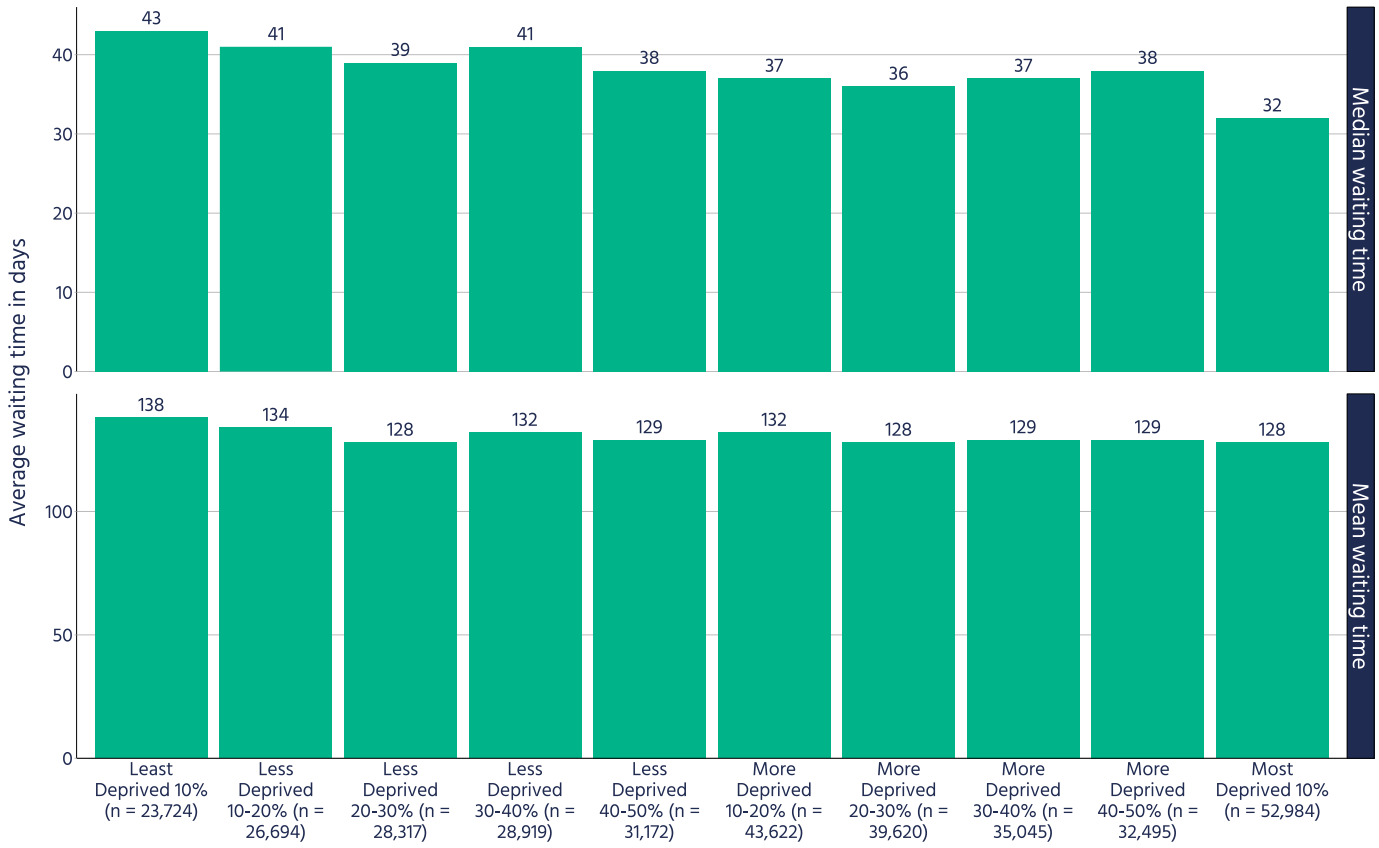
Figure 13: Children's median and mean waiting time (in days) by ethnic group.



5.5 How long did children wait for treatment, by deprivation?

Of children who received treatment, children from more deprived areas had somewhat shorter waiting times than children from less deprived areas. This is in addition to children from more deprived background being more likely to be referred and receive treatment than those from less deprived backgrounds.

Figure 14: Children's median and mean waiting time (in days) by deprivation (IMD) decile.



6. Spending on children and young people's mental health services

Real spend on children's mental health services reached £1,106 million in 2024-5, following the pattern of increased spend over time. Adjusted for inflation, this represents a 2% real increase on the previous financial year. This has not led to a decrease in waiting times although more children are receiving treatment than in previous years.

Table 10: Real and nominal spend on children's mental health services, 2018-19 to 2024-25

Year	Nominal spend (millions)	Nominal (cash) growth rate (%)	Real spend (millions)	Real growth rate (%)
2018-19	£724m		£884m	
2019-20	£799m	10%	£949m	7%
2020-21	£868m	9%	£981m	3%
2021-22	£922m	6%	£1,039m	6%
2022-23	£996m	8%	£1,048m	1%
2023-24	£1,085m	9%	£1,085m	4%
2024-25	£1,147m	6%	£1,106m	2%

Spending as a percentage of an ICB's total budget hovers around just 1% for all ICBs, even though total spend on CYPMHS varies widely between each area.

Looking at ICB spend per child referred, the variation becomes stark. Some ICBs like Kent and Medway spend under £600 per child while others like North West London spend as much as £2,400. Only some of this can be due to variation of salaries between urban centres like London and more rural areas where living costs can be lower.

Table 11: Spending on CYPMHS per child referred by ICB in 2024-25, top six ICBs.

ICB name (TOP 5)	Total spend on CYPMHS	Spend per child referred	% of budget spent on CYPMHS
NHS North West London ICB	£51m	£2,410	1.16%
NHS South East London ICB	£44m	£2,013	1.16%
NHS North East London ICB	£47m	£1,934	1.18%
NHS Dorset ICB	£15m	£1,920	0.93%
NHS North Central London ICB	£48m	£1,885	1.57%
NHS Bedfordshire, Luton and Milton Keynes ICB	£23m	£1,687	1.28%

Table 12: Spending on CYPMHS per child referred by ICB in 2024-25, bottom six ICBs.

ICB name	Total spend on CYPMHS	Spend per child referred	% of budget spent on CYPMHS
NHS Kent and Medway ICB	£28m	£569	0.79%
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£24m	£582	0.80%
NHS Coventry and Warwickshire ICB	£17m	£599	0.92%
NHS Nottingham and Nottinghamshire ICB	£18m	£614	0.80%
NHS Herefordshire and Worcestershire ICB	£13m	£767	0.85%
NHS Somerset ICB	£9m	£800	0.81%

7. How are Integrated Care Boards performing across England?

As in previous years, to provide an overall indication of how children's access to mental health services compares across ICBs, the office has created a summary score for each ICB based on four key indicators of CYPMHS performance. These indicators are:

1. Mental health spend per child referred - calculated using NHS Mental Health Dashboard spending figures and NHS England counts of children with active referrals for each ICB area (where higher spend per child referred means a higher score).

2. ICB expenditure on children's mental health as a percentage of an ICB's total spending (where higher spending means a higher score).

3. Median waiting time (in days) for children who receive a second contact (both direct and indirect contacts) with services (where lower average waiting times means a higher score).

4. The percentage of referrals that are closed before treatment (where a lower percentage of referrals closed means a higher score).

For each indicator, ICBs were ranked from best to worst (e.g. shortest waiting time to longest) and assigned to one of five equal-sized groups. Scores were then given to each ICB based on their group. The best performing 20% of ICBs received a score of 5 while the worst performing 20% received a score of 1. The Children's Commissioner's office then added these scores together into an overall score ranging from a minimum of four (worst) to a maximum of 20 (best) for each ICB. An overall score of four would mean being in the bottom (worst) group across all 4 measures while a score of 20 would mean being in the top (best) group across all measures.

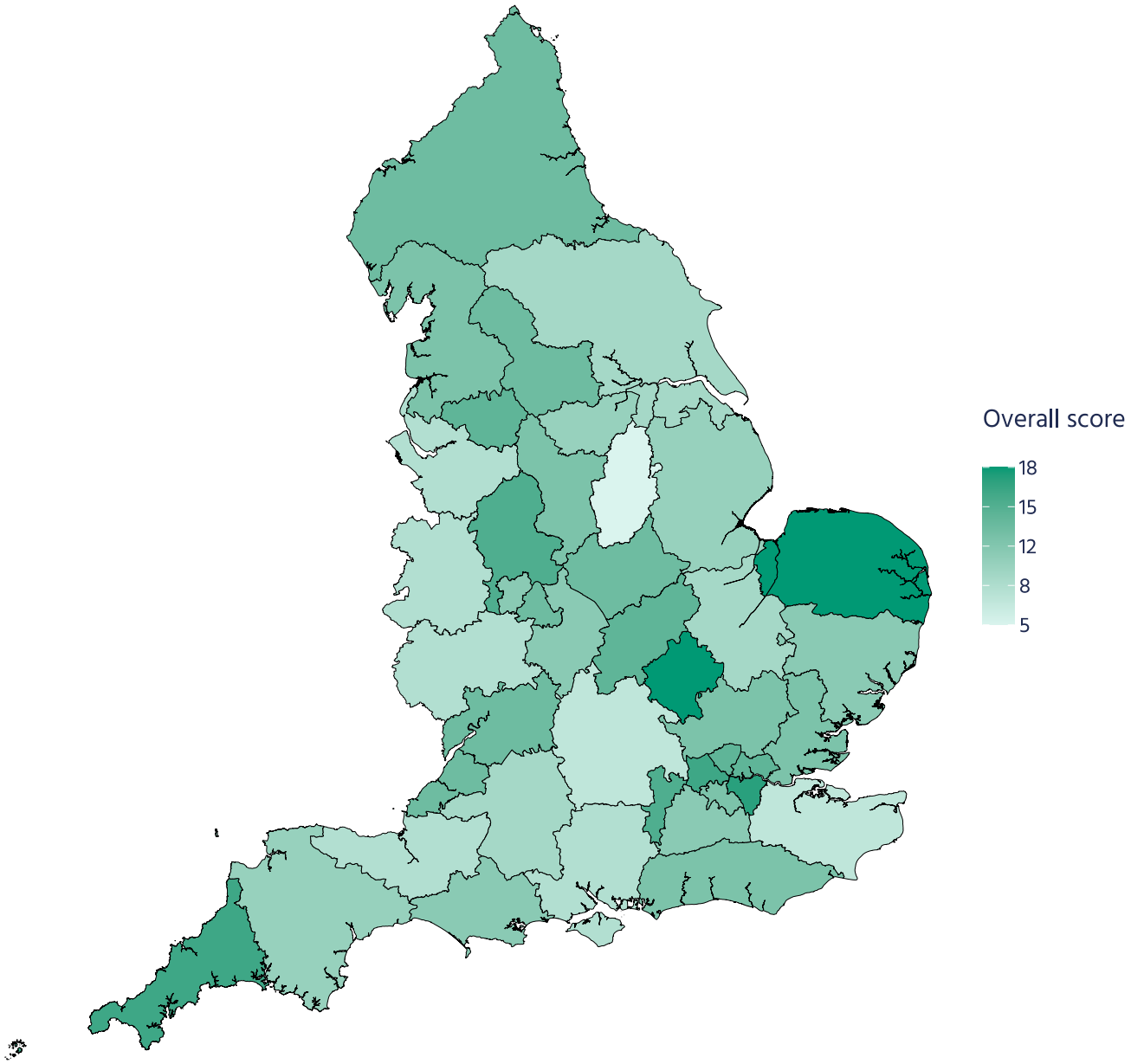
However, there could be positive reasons as to why an ICB could receive a low score on each of these indicators:

1. Some ICBs with particularly high child population counts may look worse across several metrics. For example, ICBs could spend larger total sums on CYPMHS, but could score worse on the

indicator "spend per child referred" simply because they have far more children in the area, but it may be that they are delivering efficiencies or economies of scale with that same level of spending. Some ICBs may simply be better at procuring effective services at lower cost.

2. Children whose referrals were closed may not have required specialist treatment with CYPMHS. This may vary by area because some areas commission and provide more appropriate lower level or other services for children to access in the area.

Figure 15: ICBs by overall score.



Note: Overall score is colour-coded with darker greens indicating a higher score.

8. Conclusion and Recommendations

There are now over a million children with active referrals in children's mental health services in England. While the work of CYPMHS has meant that more children are receiving treatment than in previous years, services have not kept pace with demand and more children are now waiting for treatment, and waiting for longer

The office has shown that children are overall waiting longer, and this has been a growing trend over the past four years. While a slightly smaller proportion of children are having their cases with CYPMHS closed before receiving treatment, proportionally more children are waiting longer for treatment. The end result for a child is that they are still not receiving a service. This means children are in effect not able to access the system, experiencing a de facto 'closed referral', because they are waiting for so long.

Some children have a worse experience of the system than others – often this seems to be related to poorer identification and referral rather than what happens within the service; for example Black and Asian children are underrepresented compared to the overall child population among those referred, and are more likely to be referred when they are in crisis.

The report shows that the system is perhaps working least well for children referred with neurodevelopmental conditions. Referrals for these children are growing fastest in numbers, they are waiting the longest for support, and many children with ongoing neurodevelopmental needs are simply having their referrals closed.

There is a real opportunity with the announcement of the Department of Health and Social Care's (DHSC) mental health strategy.[10] For children, this must be a genuinely ambitious strategy that tackles both the drivers of mental poor health as well understanding their routes through services, providing better pathways for support. Its timing also creates an opportunity for cross government work to ensure that reforms to the Special Educational Needs and Disabilities system are effective and put in place measures that will mean children with all levels of need are receiving the right support in school, regardless of whether they have a diagnosed neurodevelopmental condition, and are being supported when they experience a deterioration in their mental health. It should work to ensure some of the most vulnerable children are receiving the support they need at the earliest possible opportunity.

With increasing referrals to CYPMHS over the past six years, and an evidenced rise in distress among young people, there is not time for further crises in individual children's lives or further demanding services that cannot keep pace. In this context, the Children's Commissioner is recommending a set of changes means children's mental health receives the required ambition it deserves.

8.1 A joint national strategy and outcomes framework for children's mental health and wellbeing

The wide-ranging aims of the DHSC's mental health strategy are welcome but it is imperative that the changing needs of children are addressed. The DHSC should therefore produce a specific strand of the strategy that is focused on children in conjunction with the Department of Education – to ensure it addresses the causes of children's distress, and is done in step with the Department for Education's SEND reforms.

As part of the focus on prevention, the joint strategy needs to:

1. Focus on addressing wider determinants of mental health and wellbeing, including poverty, inequality, insecurity and harms, both online and offline, to prevent needs from occurring or escalating. This must address the inequalities evident in differences between the way children with different characteries are currently accessing CYPMHS.

2. Prioritise joint working on early intervention. This should include:

   i. Joint funding between the Department of Health and Social Care and Department for Education for Early Support Hubs.

   ii. Mental Health Support Teams that provide inclusive mental health support being rolled out rapidly across schools and play a governance role in advising what mental health support is available in schools, as well as assessing its effectiveness.

   iii. Young Futures Hubs rolled out in conjunction with local health services, meaning ICBs must be able to show how they are working to provide outreach, information and advice services.

3. Utilise and seek to identify through investment in research, what support, interventions and treatments in school, the community and in inpatient settings are evidenced as effective. More evidence-based interventions and treatment must be available to children showing signs of distress, who have a mental illness and who have complex social, emotional and mental health needs resulting from trauma.[11] [12] This includes evidence-based therapeutic support and interventions that are provided to children who are looked after, or are on a Deprivation of Liberty order.[13]

4. Create a shared, agreed framework for assessing children who present with neurodevelopmental needs. This framework should be agreed between between health and education, and be utilised in schools, community and mental health services. This in turn should inform a reform of pathways for children with suspected or identified neurodevelopment conditions, who currently may be referred to either community paediatric services or CYMPHS. There should be a pathway for these children consistent across all ICBs that enables access to community health and mental health services. Available therapies also must to work for children with neurodevelopmental conditions.[14] [15]

5. This work must also involve the DHSC tackling the post-code lottery for access to enhanced / intensive support for children with escalating mental health, emotional and behavioural needs. This is vital to ensure the effectiveness of the 2025 reforms to the Mental Health Act.[16]

6. This work must result in improved care for children with trauma: Children who have had adverse life experiences, who may be without family and community experience higher rates of trauma. Despite experiencing huge suffering, and being at a higher risk of self harm and hospital admissions, they are too often are falling through system gaps because they do not meet current criteria for support.[17] There must be clear identification criteria for these children, and clearer pathways of support.

7. A set of outcomes that are tied to how CYPMHS is serving children. These outcomes should show children's journey through mental health services. Overtime, these outcomes should be facilitated by the introduction of a single unique identifier that allows all children's records to be matched across health, social care and education data systems. They should set out:

Community services:

i. The proportion of children receiving treatment, or being referred on to a more appropriate service(s), and the conclusion treatment / service (i.e. improved mental health, non-engagement long-term treatment, referral to inpatient care).

ii. What treatment children received either from CYPMHS or the onward-referred service.

iii. The proportion of children having their referral closed where children were turned away or told to approach a different service, and the reason for the referral closure.

iv. The length of time children wait for treatment, onward referral or referral closure.

v. The journeys of children through CYPMHS by demographic.

Acute services:

vi. Children's attendance at Emergency Departments because of their mental health.

vii. Their onward journey (to place of safety rooms, inpatient services, to general paediatric wards, community services, or no onward support).

viii. What treatment children receive (whether detained under the Mental Health Act, a Deprivation of Liberty order, whether restraint was used).

ix. Their lengths of stay in Emergency Departments and acute wards.

Inpatient services and Mental Health Act detentions:

x. Children's waiting times for a bed in a mental health inpatient unit.

xi. Whether inpatient treatment is provided close to children's homes.

xii. Children's lengths of stay.

xiii. What treatment children received.

xiv. Children's readmission rates.

xv. The conclusion of children's treatment.

4. Ensure children with mental illnesses that may require long-term or life long care are included in its ambitions by:

xvi. Tackling the root causes of children's development of mental illness, or the severity of mental illness. This includes addressing the rising rates of Eating Disorders.

xvii. Investing in research to give mental health parity of esteem with physical health when it comes to research and development of new treatments and interventions.

xviii. Implementing reforms to the Mental Health Act and its code of practice without delay.

8.2 Effective implementation of reforms to the Special Educational Needs and Disabilities system

One possible reason for the rise in children being referred to children's mental health services is that additional support in school is often hinged on a diagnosis of a neurodevelopmental condition. There is also a mutual relationship between children's experience of school, their engagement, attendance and learning outcomes and their wellbeing.

Therefore, alongside improved identification and pathways for children with neurodevelopmental conditions, delivery of the Department for Education's recent SEND reforms must be done in conjunction with the DHSC to ensure that SEND reforms are effective, and that children are not spending months, and often years waiting for additional help from CYPMHs. This means ensuring:

- A clear strategy for how MHSTs, Experts at Hand and Inclusion Bases will work together to oversee and deliver evidence-based interventions
- Joint local commissioning and increased resources for therapists and allied health professionals for children with additional needs, especially in the early years.

- That targeted support provided in mainstream schools for children with additional needs must be evidenced as effective, whether that be training provided to teachers, specific interventions or short-term placements for children.
- Joint working between local services for children with some of the most complex needs who require a package of care because of their medical (physical and mental health) needs and disabilities to attend school.

The Children's Commissioner has been tasked with overseeing the delivery of the SEND reforms. In holding government to account in the roll out of these vital reforms, the office will hold both the Department for Education and Department of Health and Social Care accountable in their delivery of the positive changes needed to ensure children with additional needs are better serviced throughout their education.

Methodology

This report is based on analysis of NHS England data for 2024-25 and comments written by children and young people in response to the Children's Commissioner's survey of children in England, *The Big Future*. Quotes were selected to illustrate some of the themes in this report, and are taken from early responses to *The Big Future*, which launched on 8 May 2026. Written comments were received by 8 June 2026 in answer to the questions 'What should the government do to make your future better?' and 'What would make your local area better?' and have been edited in places for length or clarity.

All quantitative data used in this analysis, except where specified, was sourced from the two datasets described below. Both are extracts provided to the Children's Commissioner's office (CCo) by NHS England. Data on spend is publicly available on the NHS Mental Health Dashboard (see below).

Data sources

NHS Mental Health Dashboard

The NHS Mental Health Dashboard, formerly known as the Five Year Forward View for mental health (FYFVMH) dashboard, aggregates key data across mental health services to monitor performance against targets set in their five-year plan. In 2024-25, the underlying data aggregated in the dashboard was collected via the NHS Mental Health Services Dataset (MHSDS). The dashboard data provides information on:

- The percentage of children accessing mental health services during the year estimated as a percentage of children and young people with a diagnosable mental health condition.
- Levels of spending on children and young people's mental health services and how this compares to overall ICB budgets.
- The percentage of children and young people able to access eating disorder treatment within a 1 week or 4 week time frame.

- Total number of bed days and admissions for children and young people under 18 in Children and Young people's Mental Health Inpatient wards.

NHS Mental Health Services Dataset

The Mental Health Services Data Set (MHSDS) contains pseudonymised record-level data from all ICBs in England about the care of young people and adults who are in contact with mental health, learning disabilities or autism spectrum conditions services.

The dataset provided to the CCo contained information on all children with active referrals to CYPMHS for treatment during 2023-24 including:

- Average waiting time between referral and second contact.
- The number and percentage of children who had referrals that were closed before receiving treatment.
- The number and percentage of children still awaiting their second contact at the end of the year.
- The number and detailed waiting times for children who waited more than 12 weeks to access treatment as well as the number of children who were still waiting (having not received two contacts by the end of the year) for mental health support and how they long they had been waiting for.
- Children's primary referral reasons and waiting times by referral reason.
- The services children are waiting for and waiting times by service type.
- Breakdowns on waiting times by gender, age, ethnicity, geography and the deprivation level of the child's home post code (based on the 2019 Indices of Multiple Deprivation)[18].
- Waiting times and referral data that only includes contacts that directly involve children and their proxies (e.g. family where the child is unable to represent themselves.
- Breakdowns on referral reasons by gender, age and ethnicity.

- Children's referral source and waiting times be referral source.

Limitations of data and analysis

1. Comparability of this report with CCo mental health briefings that covers data from before the 2022-23 financial year is limited. This is because from July 2022, multiple smaller CCGs merged to form new combined ICBs. This gives the impression that performance in some areas has worsened over the past year when this may not be the case (and vice versa when worse performing CCGs are merged with better performing CCGs).

2. The metrics used to calculate overall area scores have changed since 2024. Instead of spend per child in the ICB (previously CCG) reports published after 2024 use spend per child with an active referral to CYPMHS (using totals previously provided by NHS Digital and now provided by NHS England). This aims to capture more directly the link between mental health spend and need, as most children in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated by the percentage of the child population receiving two contacts with CYPMHS, has been dropped from the list of metrics this year. Given these changes, the overall ICB scores are not comparable with the those calculated using data from 2021-22 and earlier.

3. Previous iterations of the referrals and waiting times data (pre-2022-23 financial year) looked only at referrals which started within the financial year. To examine children waiting over a year, the CCo requested data that included any referrals which were active within the financial year. This means that the referrals have potential to have been open much longer and, as a result, the CCo is able to look at children waiting over two years before entering treatment.

4. NHS England data only includes children's mental health services funded by the NHS. As such, this report does not examine figures on mental health provision financed by organisations outside the NHS such as school-based counselling or services provided by local authorities (services which may be supported by the NHS but not considered NHS-funded). ICBs that spend more on external or preventative services at the expense of NHS funded CYPMHS may underperform on indicator scores based solely on CYPMHS.

5. A child is counted as accessing treatment if they have two contacts with CYPMHS. In some cases, a child may have more than one contact before treatment begins, while others may be referred or not need further support from CYPMHS after one contact. Therefore, we cannot confidently state in all cases that a child with fewer than two contacts did not have their needs met or that every child with two contacts has entered treatment. However, this remains the best proxy measure available due to a lack of other reliable data sources estimating the number of children receiving treatment at a single contact.

6. Children whose referrals were closed may not have required specialist treatment with CYPMHS or may have been referred to more appropriate services within the NHS or those funded by local authorities, non-NHS funded charities and other services. Some children may also have chosen not to enter treatment. However, the data provided does not specify why a referral was closed. This is a key gap in evidence about the outcomes and circumstances of those referred.

Annex tables

Table A1: Summary of the total number and percentage of children with active referrals to CYPMHS, by demographics.

Characteristic	Number of children referred	Percentage (%)
Age group		
0 to 6	138,792	13%
7 to 9	200,035	19%
10 to 12	247,329	24%
13 to 15	309,472	30%
16 to 17	153,337	15%
Gender		
Male	503,152	48.0%
Female	530,316	50.6%
Non-binary	3,083	0.3%

Indeterminate	718	0.1%
Other	1,668	0.2%
Ethnic group		
White	661,333	63%
Asian	47,919	4.6%
Black	31,655	3%
Mixed	58,511	5.6%
Other	29,002	2.8%
IMD decile		
Most deprived 10%	149,365	14%
More deprived 10-20%	121,172	12%
More deprived 20-30%	108,323	10%
More deprived 30-40%	98,160	9.4%
More deprived 40-50%	91,338	8.7%
Less deprived 40-50%	88,486	8.4%
Less deprived 30-40%	81,828	7.8%
Less deprived 20-30%	78,846	7.5%
Less deprived 10-20%	77,101	7.4%
Least deprived 10%	73,269	7%

Table A2: Top three known primary referral reasons by age group in 2024-25.

Most common referral reasons by age group	Primary referral reason	Number of children referred	Percentage of children referred (%)
0 to 6			
1st	Suspected Autism	29,149	32%
2nd	Neurodevelopmental Conditions, excluding Autism	22,324	25%
3rd	Anxiety	11,433	13%

4th to 30th	Other reasons combined	27,597	30%
7 to 9			
1st	Neurodevelopmental Conditions, excluding Autism	37,248	28%
2nd	Anxiety	34,446	25%
3rd	Suspected Autism	23,258	17%
4th to 29th	Other reasons combined	40,275	30%
10 to 12			
1st	Anxiety	47,718	30%
2nd	Neurodevelopmental Conditions, excluding Autism	30,909	20%
3rd	Suspected Autism	20,718	13%
4th to 30th	Other reasons combined	58,036	37%
13 to 15			
1st	Anxiety	53,567	27%
2nd	Neurodevelopmental Conditions, excluding Autism	27,724	14%
3rd	In crisis	22,408	11%
4th to 30th	Other reasons combined	93,454	47%
16 to 17			
1st	Anxiety	22,225	22%
2nd	In crisis	16,147	16%
3rd	Neurodevelopmental Conditions, excluding Autism	15,230	15%
4th to 30th	Other reasons combined	47,950	47%

*Note: Some primary referral reasons may not appear in the "Other reasons combined" totals when no children in that group were referred for those conditions.

Table A3: Top five known primary referral reasons by gender in 2024-25.

Most common referral reasons by gender	Primary referral reason	Number of children referred	Percentage of children referred (%)
Male			
1st	Neurodevelopmental Conditions, excluding Autism	84,997	25%
2nd	Anxiety	67,434	20%
3rd	Suspected Autism	55,916	17%
4th	In crisis	26,654	7.9%
5th	Conduct disorders	19,374	5.8%
6th to 30th	Other reasons combined	81,763	24%
Female			
1st	Anxiety	100,454	30%
2nd	Neurodevelopmental Conditions, excluding Autism	47,934	14%
3rd	Suspected Autism	40,076	12%
4th	In crisis	32,994	9.7%
5th	Depression	23,820	7.0%
6th to 30th	Other reasons combined	94,119	28%
Non-binary			
1st	Anxiety	233	25%
2nd	In crisis	136	15%
3rd	Depression	93	10%
4th	Gender Discomfort issues	74	8.1%
5th	Neurodevelopmental Conditions, excluding Autism	70	7.7%
6th to 25th	Other reasons combined	309	34%
Indeterminate			
1st	Self harm behaviours	65	22%

2nd	Anxiety	51	17%
3rd	Depression	50	17%
4th	Neurodevelopmental Conditions, excluding Autism	36	12%
5th	In crisis	27	9.1%
6th to 20th	Other reasons combined	68	23%
Other			
1st	Anxiety	92	23%
2nd	Depression	47	12%
3rd	In crisis	43	11%
4th	Gender Discomfort issues	37	9.4%
5th	Self - care issues	36	9.1%
6th to 24th	Other reasons combined	140	35%

*Note: Some primary referral reasons may not appear in the "Other reasons combined" totals when no children in that group were referred for those conditions.

**Note: NHS England defines gender categories in the following way: Male (including trans man), female (including trans woman), Non-binary, Indeterminate (unable to be classified as either male or female), Other (not listed)[19]

Table A4: Top known primary referral reasons by known ethnic group in 2024-25.

Most common referral reason by ethnic group	Primary referral reason	Number of children referred	Percentage of children referred (%)
White			
1st	Anxiety	113,588	26%
2nd	Neurodevelopmental Conditions, excluding Autism	84,406	19%
3rd	Suspected Autism	62,090	14%
4th	In crisis	32,443	7.4%
5th	Depression	27,180	6.2%
6th to 30th	Other reasons combined	118,088	27%
Asian			
1st	Suspected Autism	6,504	21%

2nd	Anxiety	6,065	19%
3rd	In crisis	4,904	16%
4th	Neurodevelopmental Conditions, excluding Autism	4,729	15%
5th	Depression	1,700	5.4%
6th to 28th	Other reasons combined	7,634	24%
Black			
1st	In crisis	5,193	25%
2nd	Neurodevelopmental Conditions, excluding Autism	3,309	16%
3rd	Anxiety	3,242	15%
4th	Suspected Autism	3,237	15%
5th	Conduct disorders	1,129	5.4%
6th to 29th	Other reasons combined	4,857	23%
Mixed			
1st	Anxiety	9,113	23%
2nd	Neurodevelopmental Conditions, excluding Autism	7,823	19%
3rd	Suspected Autism	5,437	13%
4th	In crisis	5,281	13%
5th	Depression	2,434	6.0%
6th to 30th	Other reasons combined	10,286	25%
Other			
1st	In crisis	4,059	20%
2nd	Anxiety	3,785	19%
3rd	Neurodevelopmental Conditions, excluding Autism	3,406	17%
4th	Suspected Autism	2,183	11%
5th	Depression	1,126	5.5%
6th to 30th	Other reasons combined	5,741	28%

*Note: Data where ethnic group is unknown has been excluded from this table for clarity. Some primary referral reasons may not appear in the "Other reasons combined" totals when no children in that group were referred for those conditions.

Table A5: ICB overall scores and how they have changed from 2023-24 to 2024-25, ordered from best to worst 2024-25 score.

ICB name	Overall score - 2023-24	Overall score - 2024-25	Change in score
NHS Bedfordshire, Luton and Milton Keynes ICB	19	18	-1
NHS Norfolk and Waveney ICB	16	18	2
NHS South East London ICB	14	17	3
NHS Cornwall and the Isles of Scilly ICB	17	16	-1
NHS North West London ICB	15	16	1
NHS Staffordshire and Stoke-on-Trent ICB	13	15	2
NHS Frimley ICB	12	15	3
NHS North East London ICB	17	14	-3
NHS North Central London ICB	15	14	-1
NHS Northamptonshire ICB	15	14	-1
NHS Greater Manchester ICB	13	14	1
NHS Leicester, Leicestershire and Rutland ICB	14	13	-1
NHS Birmingham and Solihull ICB	13	13	0
NHS West Yorkshire ICB	13	13	0
NHS Gloucestershire ICB	12	13	1
NHS North East and North Cumbria ICB	12	13	1
NHS Bristol, North Somerset and South Gloucestershire ICB	11	13	2
NHS Derby and Derbyshire ICB	14	12	-2
NHS Sussex ICB	12	12	0
NHS Hertfordshire and West Essex ICB	12	12	0
NHS Mid and South Essex ICB	12	12	0
NHS Lancashire and South Cumbria ICB	12	12	0
NHS South West London ICB	12	12	0
NHS Dorset ICB	11	11	0
NHS Suffolk and North East Essex ICB	11	11	0
NHS Coventry and Warwickshire ICB	11	11	0
NHS Black Country ICB	10	11	1

NHS Surrey Heartlands ICB	9	11	2
NHS South Yorkshire ICB	10	10	0
NHS Devon ICB	10	10	0
NHS Lincolnshire ICB	8	10	2
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	13	9	-4
NHS Humber and North Yorkshire ICB	7	9	2
NHS Cambridgeshire and Peterborough ICB	6	9	3
NHS Shropshire, Telford and Wrekin ICB	13	8	-5
NHS Somerset ICB	11	8	-3
NHS Cheshire and Merseyside ICB	10	8	-2
NHS Hampshire and Isle of Wight ICB	9	8	-1
NHS Herefordshire and Worcestershire ICB	8	8	0
NHS Kent and Medway ICB	7	7	0
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	6	7	1
NHS Nottingham and Nottinghamshire ICB	7	5	-2

Table A6: 2024-25 ICB performance by indicator, best overall score to worst overall score.

ICB name	Spend per child referred	% budget spent on CYPMHS	Median wait (days)	% referrals closed before treatment	Overal l score
NHS Norfolk and Waveney ICB	£1,424	1.68	29	18	18
NHS Bedfordshire, Luton and Milton Keynes ICB	£1,687	1.28	25	28	18
NHS South East London ICB	£2,013	1.16	31	27	17
NHS Cornwall and the Isles of Scilly ICB	£1,309	1.12	16	28	16
NHS North West London ICB	£2,410	1.16	29	28	16
NHS Staffordshire and Stoke-on-Trent ICB	£1,623	1.35	33	49	15
NHS Frimley ICB	£1,255	1.55	46	26	15

NHS Greater Manchester ICB	£1,188	1.07	13	29	14
NHS North Central London ICB	£1,885	1.57	72	27	14
NHS Northamptonshire ICB	£1,373	0.87	35	17	14
NHS North East London ICB	£1,934	1.18	35	29	14
NHS Birmingham and Solihull ICB	£1,015	1.34	56	24	13
NHS North East and North Cumbria ICB	£1,065	1.04	38	24	13
NHS Leicester, Leicestershire and Rutland ICB	£823	0.85	6	21	13
NHS Gloucestershire ICB	£1,279	1.17	70	26	13
NHS Bristol, North Somerset and South Gloucestershire ICB	£1,578	0.81	22	33	13
NHS West Yorkshire ICB	£1,021	1.01	33	28	13
NHS Lancashire and South Cumbria ICB	£931	0.85	28	26	12
NHS Mid and South Essex ICB	£1,160	0.76	9	27	12
NHS Hertfordshire and West Essex ICB	£1,008	0.98	30	29	12
NHS Sussex ICB	£1,064	0.96	69	15	12
NHS Derby and Derbyshire ICB	£1,491	1.04	48	31	12
NHS South West London ICB	£958	0.9	37	22	12
NHS Suffolk and North East Essex ICB	£968	0.85	19	33	11
NHS Dorset ICB	£1,920	0.93	47	38	11
NHS Surrey Heartlands ICB	£1,181	1.2	43	35	11
NHS Black Country ICB	£1,235	1.21	55	39	11
NHS Coventry and Warwickshire ICB	£599	0.92	51	17	11
NHS South Yorkshire ICB	£1,017	0.81	27	32	10
NHS Devon ICB	£837	0.83	48	18	10
NHS Lincolnshire ICB	£1,261	0.82	35	31	10
NHS Humber and North Yorkshire ICB	£872	0.83	31	29	9

NHS Cambridgeshire and Peterborough ICB	£1,034	0.97	50	39	9
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£1,451	1.02	58	34	9
NHS Hampshire and Isle of Wight ICB	£966	1.1	118	40	8
NHS Somerset ICB	£800	0.81	36	28	8
NHS Cheshire and Merseyside ICB	£899	0.85	35	34	8
NHS Herefordshire and Worcestershire ICB	£767	0.85	77	26	8
NHS Shropshire, Telford and Wrekin ICB	£928	0.82	71	26	8
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£582	0.8	68	24	7
NHS Kent and Medway ICB	£569	0.79	34	33	7
NHS Nottingham and Nottinghamshire ICB	£614	0.8	40	57	5

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