PRUDENCE TRUST

YOUTH ACCESS

EDUCATION POLICY INSTITUTE

Non-specialist mental health support for young people in England

Whitney Crenna-Jennings, Jenna Fowler, Allen Joseph & Jo Hutchinson

September 2024

About the Education Policy Institute

The Education Policy Institute is an independent, impartial, and evidence-based research institute that promotes high quality education outcomes, regardless of social background. We achieve this through data-led analysis, innovative research and high-profile events.

About the Prudence Trust

The Prudence Trust is a grant-maker investing in the advancement of young people's mental health services and research in the UK. The charity's interests are in prevention and early intervention in anxiety and depression among 11- to 25-year-olds. They make grants to both frontline services, building evidence of what works and the translation of evidence into practice. In the past four years, the Trust has given funding in a range of different areas including academic research, digital technology, supporting parents and youth workers and projects that use creative and nature-based approaches to support wellbeing.

About Youth Access

Youth Access is a UK-based charity that exists to ensure that all young people have access to the support they need to thrive on their journey into adulthood. Alongside their member network of 133 local youth advice and counselling services, they champion young people's right to access high quality services proving a range of support from mental health and wellbeing to housing and employment, all under one roof, in their community.

Acknowledgements

This report is funded by Prudence Trust. We particularly wish to thank Lin Richardson and Tara Leathers for their support and feedback throughout the project.

We would also like to thank our partners on the project, Youth Access, and particularly Cassi Harrison and Sarah Uncles for their feedback throughout the project, along with Jake Mills and Justyna Lisiecka at Chasing the Stigma for sharing their data and helping us to understand the landscape of voluntary sector services supporting young people's mental health.

We would like to thank our workshop attendees for helping us to shape the research questions and data collection: Allison Penny, Andy Richardson, Angel Strachan, Anne Kent-Taylor, Bea Stephenson, Becky Rice, Bella Relph, Ben McGregor, Chris Martin, Claire Heald, Dame Clare Gerada, Prof Daisy Fancourt, David Lugo Palacio, Dominic Carter, Dr Nicole Evans, Ellie Wagg, Fergus Crow, Hugh Miller, Ian Macdonald, Jacob Diggle, Jacob Lawton, Jamie Luck, Jodian Dunkley, Jonathan Kelly, Lorraine Coady, Megan Cletheroe, Nadine Bernard, Noah Hudson, Roisin McEvoy, Ruth Glover, Suzi Godson, Theresa Pass, Tom Rebair, Yvonne White, and Zoe Pitt.

In addition, we would like to thank Anne Longfield and Lorraine Khan for sharing their expertise at key points during the project.

Finally, we would like to thank colleagues Dr Tammy Campbell for her guidance throughout the project, Zahra Grieve for administrative support, Natalie Perera for editorial advice, and Sam Tuckett and Eva Jiménez for their support with proofreading.

This publication includes analysis of the National Pupil Database (NPD): https://www.gov.uk/government/collections/national-pupil-database

The Department for Education is responsible for the collation and management of the NPD and is the Data Controller of NPD data. Any inferences or conclusions derived from the NPD in this publication are the responsibility of the Education Policy Institute and not the Department for Education.

This work contains statistical data from ONS which is Crown Copyright. The use of the ONS statistical data in this work does not imply the endorsement of the ONS in relation to the interpretation or analysis of the statistical data. This work uses research datasets which may not exactly reproduce National Statistics aggregates.

About the authors

Whitney Crenna-Jennings is Associate Director for Mental Health, Wellbeing and Inclusion at EPI.

Jenna Fowler is a Research Intern at EPI. Jenna is completing her MPA in Data Science for Public Policy at LSE.

Allen Joseph is a Researcher in the Early Years, Inequalities and Wellbeing team at EPI.

Jo Hutchinson is Director for SEND and Additional Needs at EPI.

Contents

Executive summary

In this report, we investigate the availability of non-specialist mental health services – services delivered outside of NHS community mental health settings (formerly Tier 3) and inpatient settings (formerly Tier 4) – for children and young people up to age 25. These will include early intervention services and services which may be used in conjunction with other, specialist services at different points in a young person's help-seeking trajectory.

According to NHS surveys, one in five young people in England are likely to have a mental illness; many are not accessing NHS mental healthcare, and amongst those accepted into treatment many wait months or years to begin. Given this, there is a clear need to know more about the existence of alternative, non-specialist services and the role they play in meeting need.

To address this, we collected data on a range of publicly commissioned non-specialist service types from integrated care boards (ICBs), which bring together local services with a role in improving health and wellbeing in entities called integrated care systems (ICS), and local authorities (LAs), as well as NHS trusts providing mental health services for young people. Integrated care systems, introduced under the 2022 Health and Care Act, have assumed responsibility for promoting integration across different parts of the health and care systems to improve outcomes and tackle inequalities in local areas. By bringing together local authorities, NHS trusts, and voluntary sector providers on ICBs and Integrated Care Partnerships (ICPs), ICSs aim to enhance partnership working among all stakeholders involved in improving local health and wellbeing. However, we remain far from understanding the extent to which the full range of local mental health services are satisfying different levels of demand – for those with early difficulties and those who need more help.

Given that voluntary, charity and social enterprise (VCSE) services are a big part of the non-specialist service landscape, we explored their availability using supplementary data from a national database on mental health services, the Hub of Hope, and data on open-access hubs provided by our project partners, Youth Access.

To begin to explore how these services may be related to local levels of need, we investigated associations between their presence and local demographic and socioeconomic characteristics. We also explored if the availability of a wider range of services is related to specific local indicators of mental healthcare need, including waiting times for NHS services and A&E attendances for mental health reasons. We find that:

The range of non-specialist mental health services varies across the country, and according to the commissioner or provider consulted.

- We collected data on a range of non-specialist services, including open-access and drop-in services, wellbeing cafes, peer support, and youth groups, as well as services provided through schools, and targeted support for certain at-risk groups of young people.
- **We see significant geographical variation in the range of non-specialist services available to young people – as well as in the levels of awareness around which service types exist amongst the commissioners and providers of these services.** We created an online tool showing the reported availability of different non-specialist service types, in ICSs and local authority areas, according to ICBs and LAs respectively.

- For example, there are notable data, and potentially service, gaps in the north of England: ICBs and LAs in these areas did not hold data on the services asked about, and there appear to only be a small handful of open-access hubs available. Additionally, both the ICB and LAs around Birmingham did not hold data on these services. These areas represent some of the most socio-economically deprived in the country.
- Meanwhile, according to data from LAs, ICBs and on VCSE services, areas in the East of England had a relatively wide range of service availability, despite some pockets of higher deprivation in these areas. Some more affluent areas, including those around London such as Hertfordshire and Cambridgeshire, appeared to have a good range of known non-specialist services and a high density of recorded VCSE services, despite levels of need potentially being lower in these areas.
- Nationally, of the service types we asked about, advice lines and online support were most reported by ICBs, while targeted services for underserved groups, along with targeted services for those on waiting lists to receive NHS treatment, were the least likely to be reported.
- Overall, there does not appear to be a clear relationship between the number of young people in an area or the level of deprivation and the availability of different service types: we find a wider range of services in both rural and urban areas, as well as in more and less deprived areas.
- **Whilst integrated care boards and partnerships bring together both local authorities and NHS trusts to plan effective provision, we find many instances of conflicting information in the responses we received, indicating varying levels of awareness of the service landscape**.
- In general, NHS trusts were much less likely to be aware of these services in their area. **This finding raises concerns that many trusts may not be able to effectively signpost young people who do not meet their thresholds for access to specialist treatment.** The most recent data shows that 40 per cent of young people referred to trusts have their referrals closed before beginning treatment.
- **Overall, these findings suggest a lack of transparency, even across the commissioners and providers of these services, around the existence of non-specialist mental health support for young people.**

There is uneven availability of targeted non-specialist support services for under-served groups of young people – who are less likely to access specialist healthcare services.

- **Some groups of young people, including those with LGBTQ+ and/or minority ethnic identities, are at increased risk of mental health struggles, and face particular barriers to accessing healthcare**. We explored the availability of targeted services for these groups.
- We find that there are more services, both publicly commissioned and VCSE services, for LGBTQ+ young people in London and the South as well as southern areas of the North West. There are significant 'cold spots' – particularly in the North and East Midlands, especially outside of urban areas. **Depending on where young people live, there may not be any targeted support accessible to them.** While some services will offer online support, for young people in these areas, this may be the only option.
- We find even fewer targeted services for young people from ethnic minority groups. Once again, we see a higher density of these services in urban, and more ethnically diverse areas. For this group, as for LGBTQ+ young people, we see a clear lack of services in the North,

outside of urban areas, the East Midlands, and, additionally, in the South West. Whilst there are fewer young people from ethnic minority groups in these areas, these findings indicate that **young people from ethnic minority groups in areas far from urban centres may struggle to access any in-person targeted support.**

- We found that VCSE services supporting these groups exist in areas in which the relevant LAs did not report their existence to us, perhaps because they lacked knowledge of these services. Again, **this raises concerns about a lack of joined-up working to ensure at-risk young people are supported, especially as the VCSE sector may be particularly key in providing support to these groups. It may also be the case that access to these services does not fully depend on top-down referrals; grassroots and peer information sharing may play a role.**
- In only a small handful of ICS areas, there was evidence of additional targeted services for other underserved groups, including care-experienced young people, those who have experienced abuse, refugee and asylum-seeking young people, and neurodiverse young people.

New data confirms that more young people are reaching a crisis point.

- New data from NHS England shows that, **between 2017 and 2023, the number of young people attending A&E for mental health reasons increased by 20 per cent to about 150,000, or just over 1 per cent, of young people aged 11 to 25, whilst admission episodes rose by a third**, indicating that more young people are reaching a crisis point and experiencing multiple visits to A&E.
- We find that in areas with higher mean waiting times for NHS treatment, we also see a higher number of young people attending A&E for mental health reasons. This relationship is mostly accounted for by the number of young people, and therefore the level of need, in an area.

We did not observe a relationship between markers of local need or pressure on the mental healthcare system and the range of local non-specialist services – but this is likely related to how we measured service availability and the quality of our response data.

- Tests of correlation did not suggest that the range of local services was significantly related to the number of young people in the area, or the level of income deprivation, special educational need or ethnic diversity.
- Whilst A&E attendances were more likely in areas with higher waiting times for NHS treatment, we did not observe this relationship being affected by the range of non-specialist services available to young people.
- These findings are likely to be at least partially related to our measure of services, which focuses on the range of available services rather than the number of services. We are not able to explore the relationship between area characteristics and service volume or accessibility, as this would require additional data on the location of all services along with the type of the support they offer – a dataset which does not currently exist, and would likely not be possible to generate through Freedom of Information requests.
- **It is highly possible that the volume and accessibility of services, assuming they are effective and meet young people's needs, is more important than the range of services.**

We also found significant geographical variation in commissioners' awareness of needs and monitoring of service quality – suggesting that in many areas services may not be optimally meeting need.

- **There continues to be significant variation in approaches to joined-up working across commissioners and providers of services following the introduction of integrated care systems.** Some of these – including a lack of standardised data collection and sharing, or comprehensive measurement of outcomes following engagement with services – are likely to be barriers to effective service provision.
- **It remains the case that in some areas, the experiences of young service users are not being fed into service improvement efforts.**
- Measures of young people's outcomes following engagement with services have only recently been included in published national data, covering only a minority of young people. **At both the national and local levels, this appears to be a significant weakness.**

Recommendations

1. This research and wider evidence confirm that a better understanding of what exists and what works in the non-specialist and early intervention space is needed. **The Department for Health and Social care should commission research exploring the existence of non-specialist services supporting young people's mental health**. This research should explore the scope, quality, and accessibility of these services, aiming to help integrated care systems and local authorities better understand service availability in practice.

2. **The government should commission further research to investigate how all existing mental health services, including non-specialist and specialist services, delivered in all relevant settings including schools, are meeting demand for young people's mental health at all levels.** To improve understanding of need and demands for services, additional research should examine incidence patterns in more depth, with a particular focus on specific groups such as girls and young women, ethnic minority groups, and LGBTQ+ youth.

3. **The Office for Health Improvement Disparities (OHID) should work with the Department of Health and Social Care (DHSC) to develop guidance laying out what the local early intervention service offer should look like.** This guidance should highlight that services should be responsive to the different needs and help-seeking behaviours of diverse groups of young people and therefore may look different in different areas. It should be promoted and disseminated to relevant local stakeholders and support should be provided for its implementation.

4. **NHS England should develop guidance on effective governance to address persistent weaknesses in provision**, identified by this research and that of others. This guidance should outline best practices for stakeholder collaboration, addressing fragmentation across different commissioners and providers, embedding children and families in governance structures, and harmonising data collection approaches

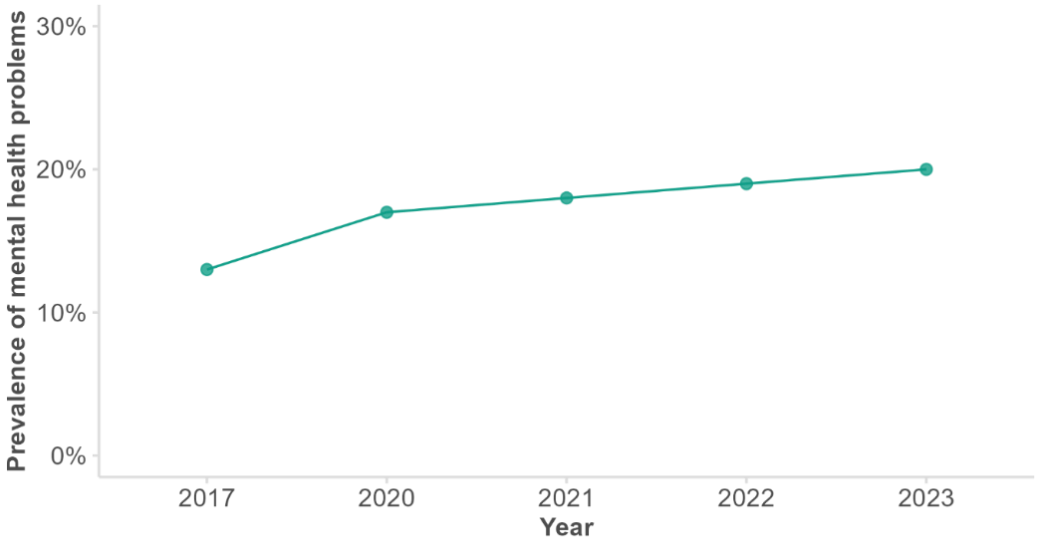
5. **The rollout of Young Futures Hubs, a key pillar of the new government's youth mental health support programme, should address provision gaps and integrate with existing open access services identified through existing research, including this report.** The

government should facilitate knowledge sharing and continuous improvement amongst hubs, particularly in areas of potential weakness identified by this research, such as data use, addressing inequalities, and consistent youth engagement and outcome measurement.

Introduction

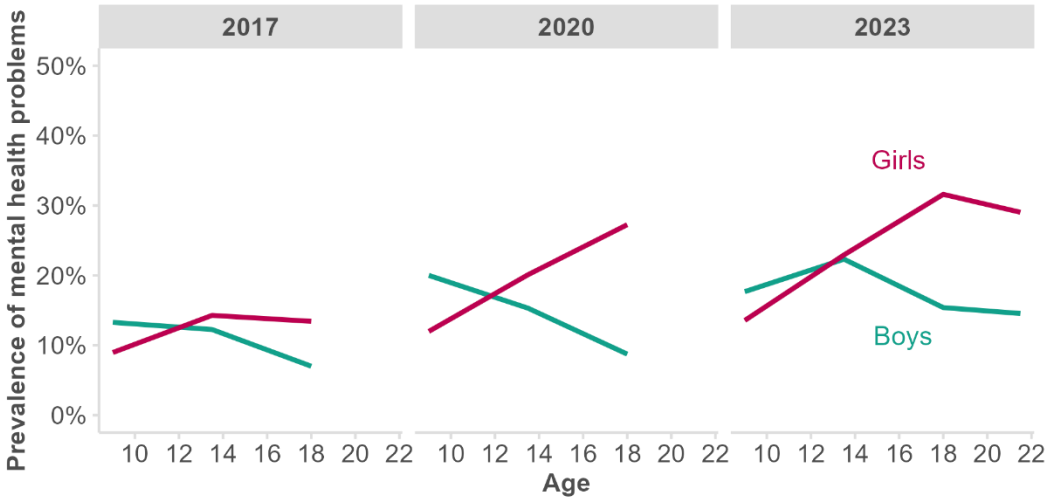
There is clear evidence of a rise in mental health issues amongst young people in England, and other Western countries, in recent years.[1,2] According to NHS data, one in five children aged 8 to 16 have a 'probable' mental disorder, up from one in nine in 2017 (see Figure 1). For older age groups, this approaches a third of adolescent girls and young women (see Figure 2).

Figure 1: Prevalence of mental health problems in 8- to 16-year-olds



Source: Mental Health of Children and Young People in England, 2023, NHSDigital

Figure 2: Prevalence of mental health problems by age and sex



Source: Mental Health of Children and Young People in England, 2023, NHSDigital
Notes: Mid point of age bands used; the 2017 and 2020 sample did not include a comparable age group of 20-23 year olds

[1] NHS England, 'Mental health of children and young people surveys.'
[2] Holt-White et al., 'Briefing No. 4-Mental Health and Wellbeing.'

This increase has emerged as a pressing concern amongst researchers, practitioners, and governments, even as the factors driving it remain contested.[3] Given evidence suggesting most lifelong mental health problems develop in childhood and adolescence, there is a strong case for research and intervention to focus on the early periods of life.[4]

There is a long-standing treatment gap in England – meaning there are more young people with mental health needs than there are accessible services available to them. Since the pandemic, referrals to NHS services have risen dramatically.[5] Tens of thousands wait more than two years to be seen without being directed to any form of interim support.[6] According to the National Audit Office, less than half of young people with a diagnosable condition are accessing specialist NHS mental healthcare.[7] **We know little about alternative services available to these young people, along with services for the larger number with needs which fall below diagnostic thresholds. Given the high prevalence rate, the long-standing treatment gap, and long waiting times to begin NHS treatment in many areas, there is a clear need to know more about the existence of these services, as well as the role they play in meeting mental health need.**

In this report, we investigate the availability of a range of non-specialist mental health services – services delivered outside of NHS community child and adolescent mental health settings (formerly Tier 3) and inpatient settings (formerly Tier 4) – for children and young people up to age 25.

We collected data through Freedom of Information requests to integrated care boards, which bring together local services with a role in improving health and wellbeing, and local authorities, as well as to NHS trusts which provide children and young people's mental healthcare services, about the non-specialist publicly-funded services which exist (either commissioned or provided) in their area. Through a series of additional questions, we also explored integrated care boards' approaches to planning and ensuring services are accessible to young people.

We used two supplementary datasets – a download from the Hub of Hope, a free and publicly available national mental health service database hosted by the charity Chasing the Stigma, and data from our project partners, Youth Access, a national membership organisation of open access hubs using the Youth Information, Advice and Counselling (YIACS) model – to investigate the availability of voluntary, community and social enterprise (VCSE) services including open access hubs across the country. VCSE services are an important part of the early intervention / alternative service landscape, yet we know little about how provision varies by area or the extent to which they are filling gaps in public provision. Private services are outside the scope of this project as we are focused on services accessible to all young people.

---

[3] See Haidt, *The Anxious Generation: How the Great Rewiring of Childhood Is Causing an Epidemic of Mental Illness*; Twenge et al., 'Underestimating Digital Media Harm'; Orben and Przybylski, 'Reply to: Underestimating Digital Media Harm.' Foulkes and Andrews, 'Are Mental Health Awareness Efforts Contributing to the Rise in Reported Mental Health Problems? A Call to Test the Prevalence Inflation Hypothesis.'

[4] Mulraney et al., 'A Systematic Review of the Persistence of Childhood Mental Health Problems into Adulthood.'

[5] NHS England, 'Children and young people accessing mental health services, Mental Health Services Monthly Statistics Dashboard.'

[6] Wadman et al., 'Improving Mental Health and Wellbeing with and through Educational Settings,'

[7] National Audit Office, 'Progress in improving mental health services in England.'

Finally, we explored whether non-specialist service availability is related to local characteristics, including measures of disadvantage, special educational needs and disabilities, and ethnic diversity, given that young people from disadvantaged backgrounds, those with additional needs and those from certain minority ethnic groups are at higher risk of mental health issues and may face barriers to accessing support.[8,9] We also explored the relationship between waiting times for access to NHS treatment and the rate of A&E visits for mental health related reasons in areas with more v fewer types of non-specialist services.

[8] NHS England, 'Mental health of children and young people surveys.'
[9] Nwokoroku et al., 'A Systematic Review of the Role of Culture in the Mental Health Service Utilisation among Ethnic Minority Groups in the United Kingdom.'

Background

Government policy on children and young people's mental health

In response to the rising incidence of mental health issues in young people, successive governments since 2015 have introduced a series of policies accompanied by over £1.5bn in funding. However recent EPI research has found that just over a third of all commitments in the last decade have been fully met.[10]

Focusing on the three pillars of the pre-pandemic response, NHS data shows that some progress has been made but many young people are still missing out on accessible and timely support:

- **Mental health support teams (MHSTs)** working with groups of schools and colleges have been rolled out to 6,800 settings in the country, serving slightly more than a third of all pupils. An evaluation is currently underway to assess the impact of these teams on young people's mental health and wellbeing.[11] Some findings from an early qualitative evaluation of pilot areas suggest that school and college staff feel more confident talking to pupils about mental health issues, but concerns remain about the 'mild to moderate' remit of MHSTs resulting in some children with more complex needs continuing to fall through gaps in provision.[12]
- Approximately 16,700 schools and colleges, representing 70 per cent of eligible settings, have successfully claimed a government grant to train **a mental health lead**. It is not known what impact this initiative has had.
- First announced in 2021, the **four-week waiting time standard** has not yet been mandated across the NHS. According to recent data, many children wait months or years to begin treatment.[13] Currently at least one NHS Foundation Trust providing mental health services for young people have set their own target of a maximum of 52 weeks to be assessed.[14] There has been a particular focus on waiting time standards for eating disorders, with government setting a 2020 target of 95 per cent of young people referred for assessment or treatment for an eating disorder receiving evidence-based treatment within one week for urgent cases and four weeks for routine/non-urgent cases. Initially, there was significant progress towards this target, with urgent cases starting treatment within one week increasing from 65 to 88 per cent, and routine cases within four weeks rising from 65 to 90 per cent between 2016-17 and 2020-21. However, since the pandemic, performance has declined. By the end of the 2022-23, only 79 per cent of urgent cases and 83 per cent of routine cases met these targets. The latest data from Q3 2023/24 shows further declines, with only 64 per cent of urgent cases and 79 per cent of routine cases meeting the targets.

[10] Joseph and Crenna-Jennings, 'Children and young people's mental health services: Targets, progress and barriers to improvement.'
[11] Department for Education, 'Transforming Children and Young People's Mental Health Implementation Programme Data release.'
[12] Ellins et al., 'Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report.'
[13] Children's Commissioner, 'Children's mental health services 2022-23.'
[14] See Oxleas NHS Foundation Trust website.

The overall impact of previous governments' policies is unclear given the paucity of comprehensive published after accessing services. This is further muddied by the significant increase in need in recent years, since the programme was launched. Gaps in data on services and outcomes are also a major barrier to holding government to account.

The newly elected Labour government has committed to placing a mental health specialist in all schools, amongst other commitments to build up the workforce and establish local Young Futures mental health hubs. Questions remain about how and when these will be implemented, how their impact will be measured, and, ultimately, the extent to which they will effectively address the high and growing level of need. Additionally, significant questions remain about action the new government will take to address social and environmental drivers of poor mental health, including poverty and adversity in early life.

Additional weaknesses in mental health provision for young people

The whole system of mental healthcare for young people includes specialist services, GPs, hospitals, social care, youth services, VCSE services, and a range of commissioners. A lack of continuity of care across these services, and coordination across the different commissioners and providers, were cited as barriers to high-quality care by the Care Quality Commission in 2018. Since then, Integrated Care Systems (ICSs), introduced under the 2022 Health and Care Act, have assumed responsibility for promoting integration across different parts of the health and care systems to improve outcomes and tackle inequalities in local areas. By bringing together local authorities, NHS trusts, and voluntary sector providers on Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), ICSs aim to enhance partnership working among all stakeholders involved in improving local health and wellbeing – in theory, helping to address the fragmentation issue identified by the Care Quality Commission (CQC). **However, we remain far from understanding the extent to which the full range of local services are satisfying different levels of demand – for those with early difficulties and those who need more help.** Limited published data on outcomes for young people following engagement with different services means we have a limited understanding of their impact.

Looking beyond service provision, there are stark disparities in mental health outcomes along lines of gender, gender identity, and sexual orientation; race and ethnicity; and socioeconomic position. Growing evidence shows that LGBTQ+ young people and those from certain minority ethnic groups are also at increased risk, and face particular barriers to accessing healthcare.[15,16] Moreover, there is a social gradient in mental health outcomes, meaning young people from more disadvantaged backgrounds fare worse than their more affluent peers.[17] **That mental health issues do not all young people equally has, so far, failed to substantively shape the policy response.** More focus on the specific experiences and needs of these groups is required to inform a government response that is more than just reactive. This could include, for example, targeted preventative programmes for high-risk groups, or efforts to tackle early life adversities which drive poor mental health.

[15] Alam, O'Halloran, and Fowke, 'What Are the Barriers to Mental Health Support for Racially-Minoritised People within the UK? A Systematic Review and Thematic Synthesis.'
[16] Williams et al., 'A Systematic Review and Meta-Analysis of Victimisation and Mental Health Prevalence among LGBTQ+ Young People with Experiences of Self-Harm and Suicide.'
[17] Hazell et al., 'Socio-Economic Inequalities in Adolescent Mental Health in the UK: Multiple Socio-Economic Indicators and Reporter Effects.'

To sum up, we do not have a full picture of the mental health service landscape, we do not know to what extent needs the needs of young people are being met, and government policy to date has not reflected the unequal distribution of mental health issues in the population of young people.

Young people with mental health needs who are not accessing NHS treatment

This report concerns young people with mental health needs outside of those accessing specialist NHS services. There is little to no data collected on this group, and no consensus on which services are responsible for supporting them. Prevalence figures and gaps in provision laid out above suggest this is likely a substantial number. We provide a rough estimate below.

Young people with mental health needs who are not accessing, or have issues accessing, NHS services can be divided into four groups, as seen in Figure 3:

- Group 1: The proportion of **young people with a mental health condition** who are not receiving NHS treatment – more than half of those aged 0-17, according to the NAO. Using the NHS mental illness prevalence rate for 8- to 16-year-olds (20 per cent) and ONS population estimates for this age group (6.1 million), this could amount to over a million young people.[18]
- Group 2: **The 40 per cent of young people referred for NHS treatment who had their referral closed before accessing treatment** (some of these will overlap with Group 1). According to a report by the Office for the Children's Commissioner, this could be up to 400,000 young people, given that one million young people were referred over the same period.[11]
- Group 3: **Young people who are accepted into NHS treatment but wait months or years** to begin treatment. According to a CFYL report, 32,000 young people had waited at least two years to begin treatment at the end of 2023, providing a lower bound estimate for this group.
- Group 4: The larger, but undefined, group **with lower-level mental health needs** (some of these will overlap with Group 2). According to a 2023 NHS survey, 12 per cent of young people have a 'possible' MH disorder – meaning they may not (yet) require specialist intervention, but may still benefit from early support.[1] According to the latest ONS population estimates, this is approximately 700,000 people, providing a lower bound estimate for this group.

Taken together, these groups could add up to roughly two million children and young people.

[18] Office for National Statistics, 'Population estimates.'

Figure 3: The different groups of young people with mental health needs

In a 2018 report, EPI investigated next steps for young people referred to specialist services but not accepted for treatment – currently about 40 per cent of all referrals.[11] Our research showed some of the difficulties young people face in accessing support:

- Overwhelmingly, NHS providers reported no or limited follow-up after a referral was deemed inappropriate.
- A minority of providers reported that they would not accept young people without evidence showing they had engaged with other services first.
- Many providers specified that certain young people's mental health needs should be met by other services, for example, young people who are:
    - Engaging in mild to moderate self-harm as a coping strategy for strong emotions and difficult experiences and not associated with an underlying mental health condition.
    - Homeless, or those who have parents with problems including domestic violence, illness, dependency or addiction, as their needs will be met by children's social care. In previous reports and data collections, we found that difficulties faced by children and young people often do not fit into clear diagnostic boxes and therefore do not meet criteria for access to services.
- Data collected from LAs indicated that there are not always alternative services in place for young people not accessing specialist treatment. A quarter of local authorities who responded to our FOI request in 2019 (27 of 111) reported decommissioning or no longer providing services related to young people's mental and emotional well-being: these included sixteen community-based universal or early intervention services, thirteen school-

based programmes to support children with mild to moderate mental health difficulties, and services providing family counselling and mental health support for looked-after children, those living with domestic abuse and other vulnerable or at-risk young people.

There is consensus amongst public and VCSE organisations supporting children and young people that a mix of open access and targeted services are needed to meet diverse needs.[19] Evidence suggests that targeted services can be more effective in reaching and supporting populations at higher risk, including young people with LGBTQ+ identities and from ethnic minority groups, by addressing the unique needs and experiences of these groups, employing culturally competent care, and implementing tailored interventions.[20] At the same time, ensuring open access services are inclusive and culturally competent is key. In addition, different approaches to delivery, for example, in-person and online support, are important to widening access and ensuring that young people can find support in a way that works best for them. In recognition of this, the NHS and most mental health charities supporting children either offer or advocate for a combination of in-person and online services, including YoungMinds, Mind, Barnardo's, NSPCC, The Mix, and Samaritans.

[19] See National Youth Agency, 'Youth Work Inquiry - Final Report'; YoungMinds, 'Beyond the Waiting List: Five Steps to Improve Young People's Mental Health'; The Children's Society, 'Briefing: Open Access Mental Health Drop-Ins for Young People'; Youth Access and British Association for Counselling and Psychotherapy, 'Young People in Mind: Making Counselling Work for Young People'; House of Commons Education Committee, 'Services for Young People: Third Report of Session 2010–12'.

[20] Coehlo et al., 'Experiences of Children and Young People from Ethnic Minorities in Accessing Mental Health Care and Support: Rapid Scoping Review'; McDermott et al., 'Explaining Effective Mental Health Support for LGBTQ+ Youth: A Meta-Narrative Review'; Williams et al., 'A Systematic Review and Meta-Analysis of Victimisation and Mental Health Prevalence among LGBTQ+ Young People with Experiences of Self-Harm and Suicide'; McDermott et al., '"What Works" to Support LGBTQ+ Young People's Mental Health: An Intersectional Youth Rights Approach.'

Methods

This report aims to address the following research questions:

1. What publicly-funded 'non-specialist' services exist for young people up to age 25 with mental health needs? What is the geographical spread of these services?
2. How is the range of non-specialist services available to young people related to local levels of need?
3. How are non-specialist services related to both waiting times for access to NHS services and the rate of A&E attendances for young people for mental health reasons?
4. How do approaches to young people's mental health service planning and delivery vary across integrated care systems in England?

Developing a definition of non-specialist mental health services

To inform our approach, we held two workshops in November 2023 with representatives of integrated care boards and voluntary sector providers, healthcare and education professionals, researchers, and two representatives from Prudence Trust's young persons' advisory group.

We sought feedback to help us develop a definition and list of non-specialist mental health services to take to public service commissioners and providers. We wanted this definition and list to encompass services outside of standard specialist NHS provision or settings – including services for young people with needs which do not meet diagnostic thresholds, for those not accessing specialist (formerly Tier 3 and Tier 4) mental healthcare, and accessible to those on waiting lists to begin specialist treatment.

Our definition covers services which have the **intention** of addressing mental health issues or supporting young people with their mental health up to age 25. We acknowledge that some readers may not agree with this conceptualisation – it could be argued, for example, that most if not all local services supporting children, parents, and families are relevant to young people's mental health.

Using feedback from attendees, we then pulled together a list of services to query with local commissioners and providers.

We asked about open access mental health and wellbeing support services, including:

- **Youth groups**
- **Youth information, advice and counselling services (YIACS) or early support hubs**
- **Wellbeing cafes or mental health drop-in services**
- **Peer support**

We asked a series of questions about support provided through schools. While some of these services are specialist, they are delivered through schools and are in theory accessible to all young people in education:

- **Mental Health Support Teams**: According to publicly available data, these are operating in all ICB areas (although not in all schools in these areas).
- **School counsellors, mentors, or pastoral or key support workers**
- **Educational psychologists** who provide specialist support through schools.

We asked about help delivered over the phone or online given the low barriers to accessing this type of support:

- **Advice line**
- **Online support service or app**

We also asked about alternatives to NHS talking therapy which were highlighted during our workshop as potentially important alternative support services for young people's mental health:

- **Social prescribing,** an approach which connects people with non-medical support and resources in the community to improve their mental health and wellbeing. This is increasingly an approach used in adults but according to ICBs we consulted is becoming more common a practice for young people.
- **Art or music therapy.** While this qualifies as a specialist service, we included it as an alternative to NHS talking therapy (for example, cognitive behavioural therapy), which is the standard treatment for mental health issues, and because it was suggested by a number of workshop attendees. Arts therapies have some recognition in NICE guidelines for certain mental health conditions, but the evidence base needs strengthening.

We asked about targeted services for young people at increased risk of mental health issues, including:

- **Bereavement services**
- **Targeted service(s) for LGBTQ+ young people**
- **Targeted service(s) for young people from minority ethnic / racialised communities**
- **Targeted service(s) for other underserved groups**
- **Targeted service(s) for young people on waiting lists** for access to NHS mental health services

Finally, we gave respondents the option to list additional services in their area which fall under our definition.

Additional exploration of how services are planned and delivered

Off the back of stakeholder feedback, we decided to ask an additional series of questions exploring the prevalence of 'best practices' for delivering mental health services, across early intervention through to specialist healthcare, for young people.

We asked ICBs about the following approaches to partnership working:

- Whether they had a **young people's mental health partnership board** (these were mandated as part of the £1.5bn in central government funding) or a **designated individual or team who coordinates partnership working**
- Had **cross-service data-sharing infrastructure** to, for example, enable the collection of shared outcome measures
- Had an up-to-date **directory of VCSE services** which was publicly available
- Involved the **VCSE sector in service planning and delivery**
- Had a **young person's advisory group** or mechanism for young people / service users to feed back

We also asked a series of questions about approaches to ensuring services are accessible for young people, including:

- If there was a **'single point of access'** for young people with mental health needs

- If they used a **'no wrong door' approach** meaning young people can access the support they need in one place and/or have a key worker to maintain continuity of care
- Whether young people could **self-refer** to a mental health support service
- If the ICB offered **targeted approaches to groups who are less likely to come into contact with healthcare services can access support** e.g. young people from minority ethnic / racialised backgrounds, LGBTQ+ young people, or any other group identified by the ICB

Data sources

We sent Freedom of Information requests to the 42 integrated care boards (who respond to FOIs on behalf of ICSs and ICPs), 153 local authorities, and 66 NHS trusts providing child and adolescent mental health services asking about the list of services above. We included NHS trusts on our request because, in many cases, they will be signposting young people who are referred to them but not accepted for treatment, and we wished to explore their awareness of alternative services. The full list of questions we asked is available in Appendix A.

We supplemented our data collection on services with data from the Hub of Hope, an online directory for mental health support services hosted by the charity Chasing the Stigma, to explore the availability of voluntary sector services. We also use data on Youth Information, Advice and Counselling Services (YIACS) shared by our project partners, Youth Access.

For our correlation analyses, we used the following data sources:

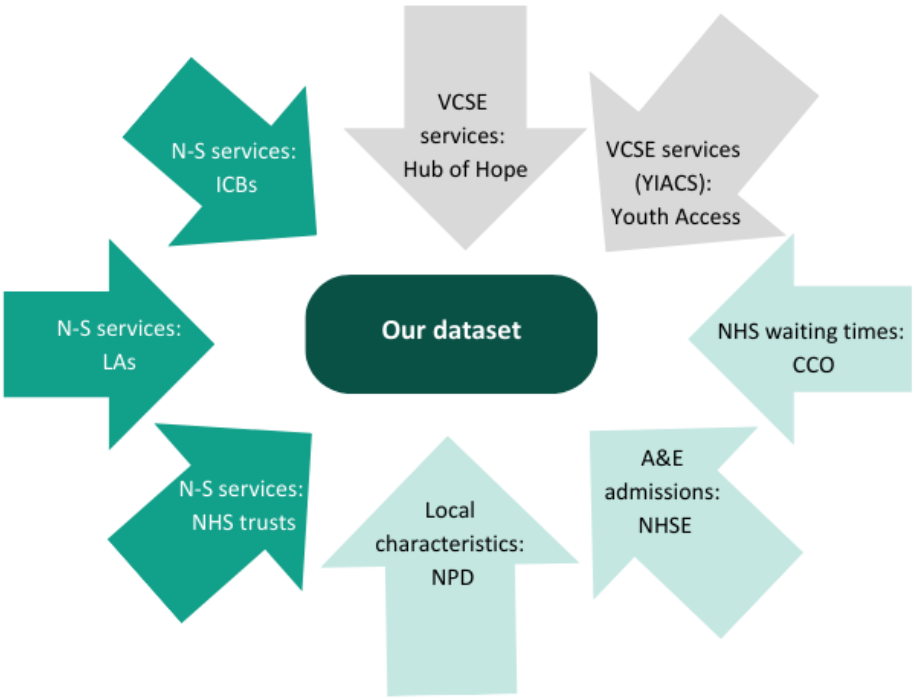
- Data we collected from NHS England (NHSE) on the number of young people aged 11 to 18 and 19 to 25 presenting at A&E departments for a mental health related reason in 2017, 2019, 2021 and 2023, covered by the following ICD-10 codes, in each ICB and sub-ICB area:
    - F20-29: Schizophrenia, schizotypal and delusional disorders
    - F30-39: Mood disorders
    - F40-49: Neurotic, stress-related and somatoform disorders
    - F50-59: Behavioural syndromes associated with physiological disturbances and physical factors
    - F60-69: Disorders of adult personality and behaviour
    - F90-98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
    - F99: Unspecified mental disorder
    - G47: Disorders of initiating and maintaining sleep [insomnias]
    - Z91.5: Personal history of self-harm
- Data on waiting times in 2021 and 2022 collected by the Office of the Children's Commissioner (CCO)
- Data on all pupils attending a state school in England from the National Pupil Database (NPD) in 2020. We generated local authority-level measures of:
    - Disadvantage:
        - The proportion of pupils eligible for free school meals
        - The proportion of pupils eligible for free school meals at least once in the past six years of their school career
        - The proportion of all children aged 0-15 living in income deprived families
    - Additional needs

- The proportion of pupils with a special education need or disability (SEND) statement, including those with social, emotional or mental health problems as identified by their school
- The proportion of pupils with an Education, Health and Care Plan (EHCP)

- Ethnic diversity
  - The proportion of pupils with English as an additional language (EAL)

All sources of data are presented in Figure 4.

Figure 4: Sources of data used in this report



Analysis and outputs

Service availability

We used data collected from ICBs and LAs to generate choropleth (heat) maps showing the average number of non-specialist service types available across ICB areas and local authorities respectively, according to information provided by either respondent. We also created an interactive tool showing the availability of different service types across LA and ICB areas, according to data collected from each. It is important to note that we are looking at the types of available non-specialist service, rather than the number of services available to young people. It is highly possible that the volume of services, assuming these services are effective and meet young people's needs, plays a more important role.

To account for mental health services delivered by the voluntary, charity and social enterprise (VCSE) sector, we include choropleth maps using data from the Hub of Hope indicating a 'high', 'medium' or 'low' number of VCSE services in each local authority. In these maps, we also show the availability of hub services using the Youth Information, Advice and Counselling (YIACS) model across the country. There is likely to be some overlap with the data we received in response to our FOI requests, as some ICBs and LAs provided data covering all services in their area regardless of provider, while

others only specified services that they commissioned or provided. We used the `ggmap` package in R to verify the addresses of the VCSE services in this dataset based on the service names.[21] We were able to confirm the locations of two-thirds of the services. The remaining third proved more challenging to geocode for several reasons: some services had names that returned multiple potential locations when geocoded making it difficult to determine the correct one, some services had ambiguous operating areas whilst some did not appear on Google Maps at all.

We explored using data from the Charity Commission to validate the Hub of Hope data, but we are only able to narrow services down to those supporting children and young people, either exclusively or along with other groups. We cannot identify services related to mental health. The Hub of Hope is one of the only national online directories for mental health and wellbeing support services, to our knowledge, as the Anna Freud Centre have retired their Youth Wellbeing Directory.

Testing associations

We ran correlation analyses to test the relationship between:

- Local area characteristics, including measures of young people's disadvantage; recorded special educational need; and ethnic diversity, and the availability of different non-specialist services
- NHS waiting times and A&E attendances for mental health reasons

We then explored the role played by the availability of different non-specialist services in the relationship between waiting times for access to specialist treatment and A&E attendances for mental health reasons. We first looked at the range of non-specialist services overall, then separately at services specifically for young people on waiting lists, and the open-access services we asked about:

- Youth groups
- Youth information, advice and counselling services
- Peer support services
- Drop-in services / wellbeing cafes

[21] Kahle and Wickham, 'Ggmap: Spatial Visualization with Ggplot2.'

Part 1: Non-specialist services available in local areas

Below we present data collected from ICBs about the range of non-specialist mental health services on offer in their area (see **Error! Reference source not found.**): darker shades of green indicate a wider variety of non-specialist services. ICS areas that are grey either provided unclear information or reported they did not hold the data.

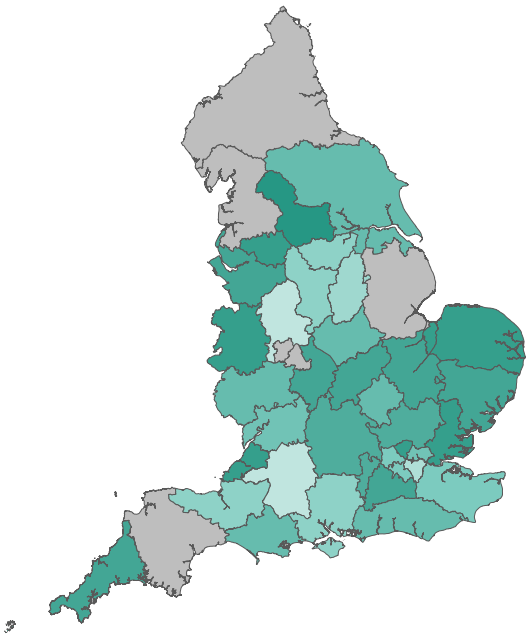
We see a wider range of services available in the South East and East of England as well as southern areas of the North East. The range of services on offer does not directly align with population density, indicating that the availability of a wide range of services is not highly determined by the number of young people in an area.

Given that the purpose of ICSs is to enhance partnership working among all stakeholders involved in improving local health and wellbeing, and that they play a key role in understanding local need and planning effective provision, the fact that a handful did not hold the data we requested is notable. This could indicate:

- A lack of transparency or accountability in these areas.
- A lack of effective joined-up working and shared information on services.
- Poor data or administrative issues that prevented these areas from reporting.

Two ICBs, one in London and one in the Midlands, provided us with a complete list of services in their area at all levels of provision, along with clear information on which organisation commissioned and provided them, including data on the VCSE sector. However, this level of clarity in response data was not the norm.

Figure 5: The range of non-specialist service types in ICS areas (ICB response data)



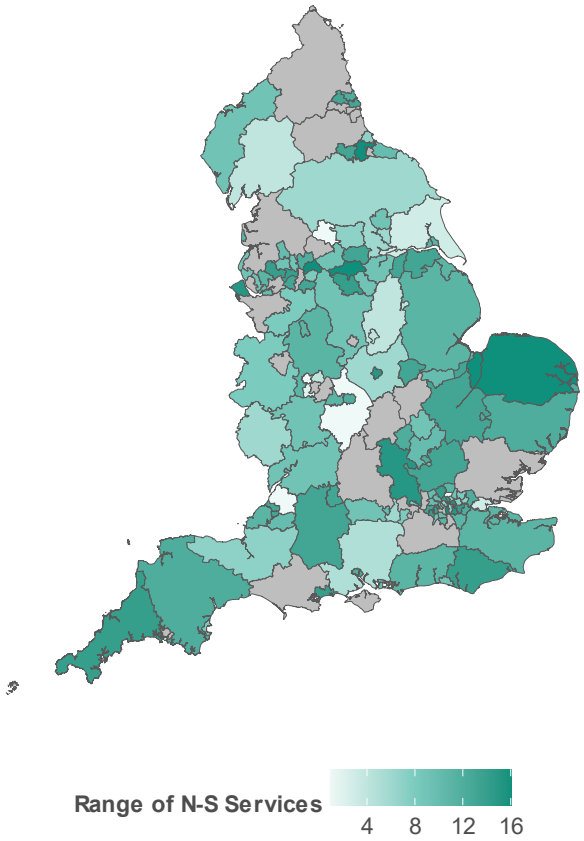
Grey indicates response was refused

We asked local authorities about the same non-specialist mental health services (see Figure 6).

Some LAs within ICS areas for which ICBs provided data did not hold the data we requested, for example, LAs around London including Surrey, Kent and Essex.

To note, both the ICB and LAs in the northernmost areas of the country and those around Birmingham did not hold the data we requested. According to ICBs, areas in the Midlands have better coverage than the LA data tells us.

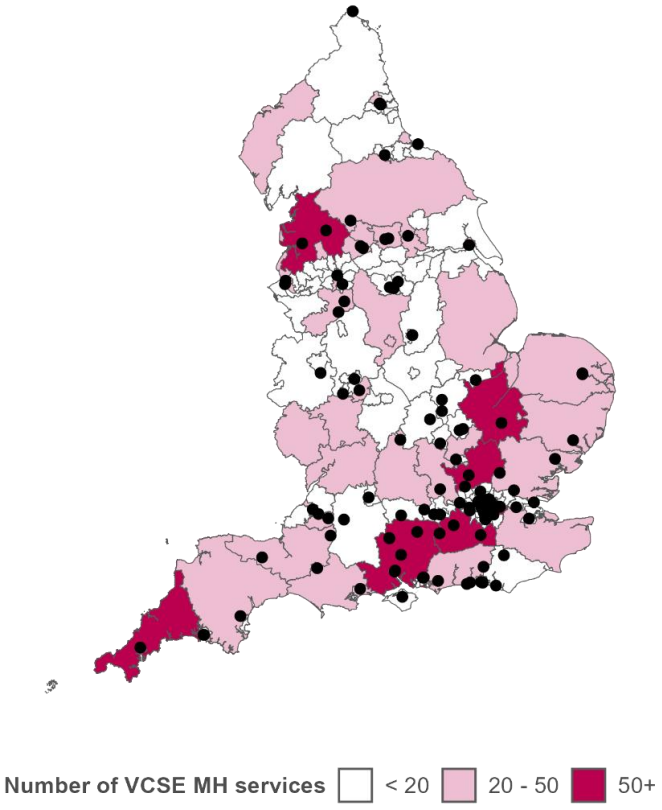
Figure 6: The range of non-specialist service types in local authority areas (LA response data)



While we asked ICBs and LAs about types of non-specialist services which existed in their area, regardless of whether they are provided by public or VCSE services, workshop attendees emphasised that there are varying levels of awareness amongst ICBs around VCSE provision. Therefore, as detailed earlier, we have used data on VCSE services from the Hub of Hope and data on youth information, advice and counselling services from Youth Access to supplement the data we collected (see Figure 7).

Figure 7: Density of VCSE mental health service availability by local authority

YIACS (data provided by Youth Access) indicated by dots and VCSE services (Hub of Hope data) indicated by pink



Youth Information, Advice, and Counselling Services (YIACS) – open access hubs – are primarily concentrated around London and to the west, with a smaller concentration found in cities in the North West. Additionally, there is a higher density of VCSE services in certain areas surrounding London, including Surrey, Hampshire, Hertfordshire, and Cambridgeshire, as well as in Cornwall and Lancashire. There are notable gaps in voluntary and community sector (VCSE) services in the central and northern parts of the country.

Overall, these maps reveal several key takeaways:

- Firstly, there is a noticeable lack of awareness amongst ICBs and LAs regarding the availability of services in northern areas, with only a handful of Youth Information, Advice, and Counselling Services (YIACS) present. Additionally both the ICB and LAs around Birmingham did not hold the data we requested, while there are several YIACS services in the area. These areas represent some of the most deprived in the country.
- In contrast, some more affluent areas, including Hertfordshire and Cambridgeshire have a wider range of service types and a high density of VCSE services, despite levels of need potentially being lower in these areas.
- Areas in the middle of the country generally have a lower range of non-specialist services according to LAs and a lower density of VCSE services, which could be related to lower population density in these areas. According to ICB data, however, there is a good range of services on offer. This could be related to the fact that the ICS covers a larger area, and services may be concentrated in certain LAs. It could also be the case that level of

involvement of ICBs v LAs in the non-specialist space varies across areas. We delve more into the contradictory information we received from ICBs and LAs in the following sections.

- Areas surrounding London, including Kent, Surrey, and Essex, show a lighter presence of both local authority (LA) services and VCSE services.

Next, we explore the availability of specific non-specialist services.

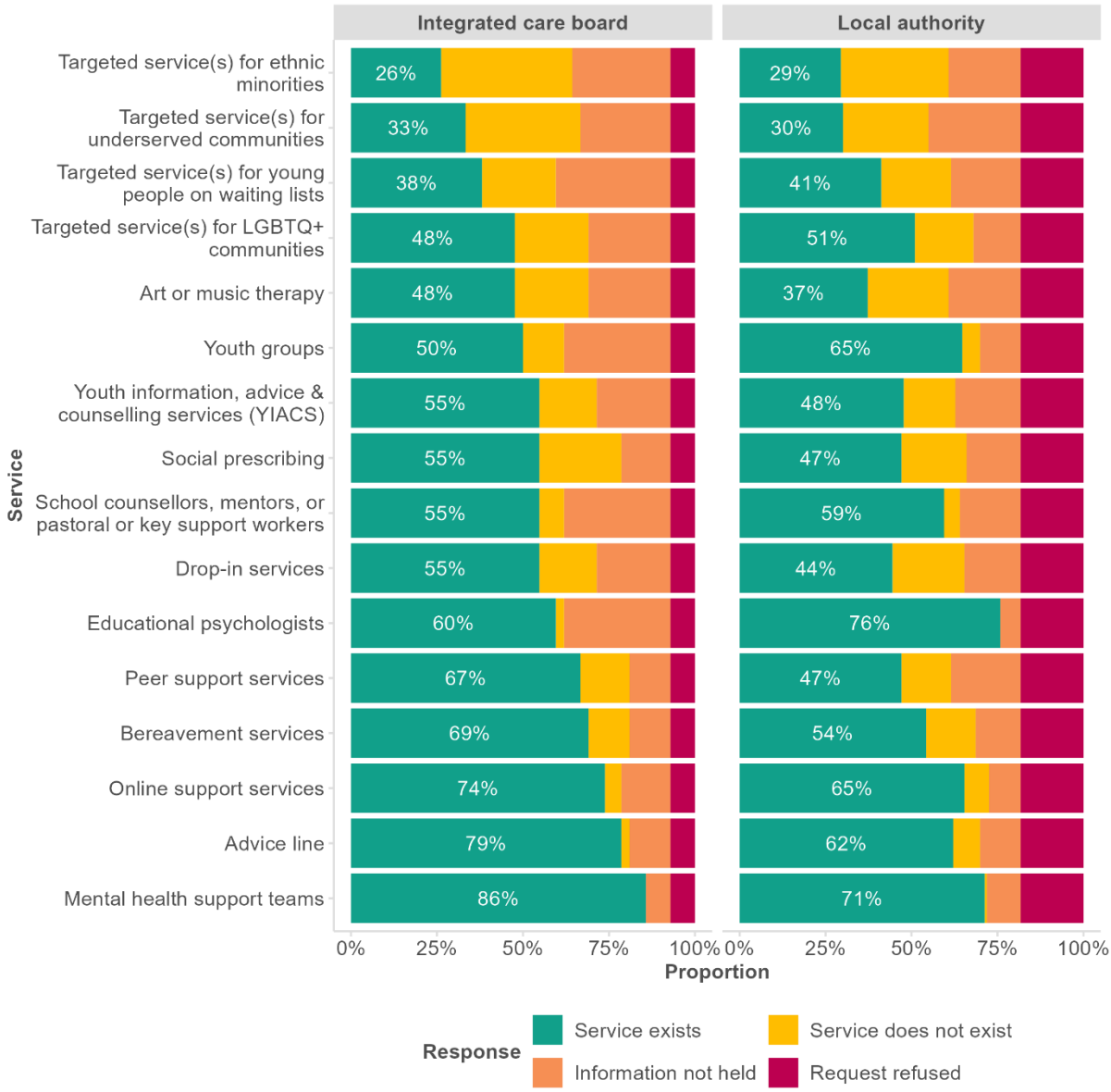
Different types of non-specialist services according to ICB and LA responses

The availability of the different types of non-specialist services we asked about is available in our interactive tool: we present the data provided to us by ICBs for ICS areas, as well as the data from LAs for local authority areas.

We also present the proportion of ICBs and LAs that reported on the different services types we asked about (see Figure 8).

There are notable differences in the availability of different non-specialist services according to ICBs and LAs. ICBs generally demonstrate better awareness of available services compared to LAs. Both ICBs and LAs showed a high level of awareness of mental health support teams (which we know from publicly available data exist in all ICS areas, but not all LAs) and online support. However, there are significant disparities in reported data regarding other service types. For instance, both ICBs and LAs are least likely to report or be aware of targeted support services for ethnic minority groups and other underserved communities. ICBs, concerningly, sometimes lack awareness of services available for those on waiting lists, while LAs are often unaware of art or music therapy offerings in their areas (perhaps unsurprising as they are unlikely to be commissioning these services). Additionally, LAs are more likely to refuse the requested data whilst ICBs are more likely to not hold the requested data, further highlighting the disparities in service awareness and potentially affecting service accessibility for those in need.

Figure 8: Proportions of ICBs and local authorities reporting non-specialist services in their area



Targeted services for LGBTQ+ young people and young people from ethnic minority groups

Here we present the availability of targeted services for two groups of young people who may be at higher risk of mental health issues, while also less likely to access healthcare due to experiences of stigma or discrimination. Figures 10 and 11 present data we collected from local authorities along with data on VCSE services from the Hub of Hope. According to data we received from LAs (and ICBs), targeted services were less likely to exist, relative to some other non-specialist services – and we wished to investigate if the VCSE sector was filling this gap.

Local authorities which stated they did provide a targeted service are shown in green, while those who reported a service did not exist, provided unclear information, did not hold the data, or referred us to a different organisation are in white.

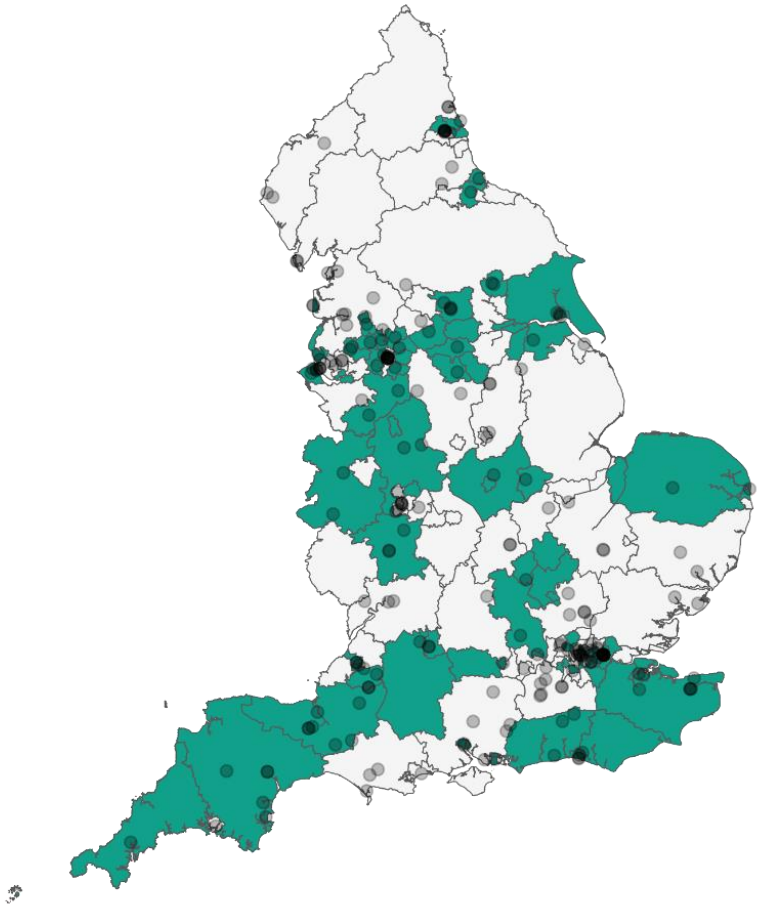
As seen in the maps below, VCSE services supporting LGBTQ+ young people and those from minority ethnic groups exist in more areas than those commissioned or provided by local

authorities. We do see some overlap, likely in part because local authorities reported the VCSE services the commission.

We see better coverage of targeted services for LGBTQ+ young people in London and the South as well as southern areas of the North West, fewer services in the West Midlands, and few outside of urban centres in the North East (see). That more of these services exist in urban areas with dense populations is unsurprising. However, this map makes clear there are significant 'cold spots' – particularly in the North and East Midlands. **Depending on where young people live in these areas, there may not be any targeted support accessible to them. While some services will over online support, for young people in these areas, this may be the only option.**

Figure 9: Targeted services for LGBTQ+ young people (Hub of Hope data and LA response data)

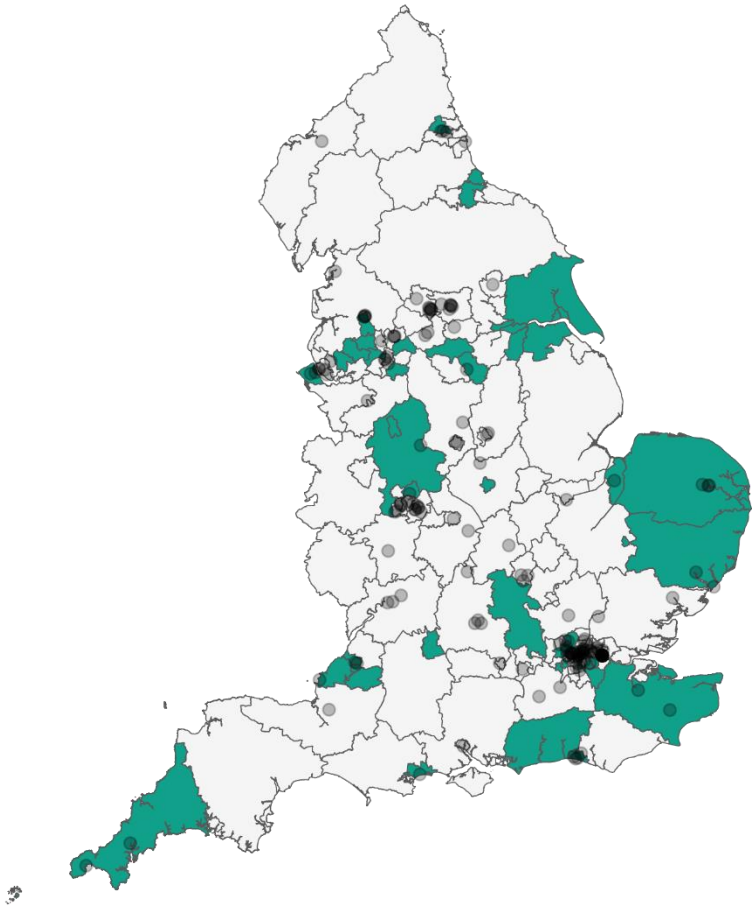
VCSE services (Hub of Hope data) indicated by dots and LA response data in green



Turning to targeted services for young people from ethnic minority groups, we find even less coverage – see Figure 10. Once again, we see that VCSE services exist in LA areas, which the relevant LAs did not report to us, and a higher density of these services in urban, and more ethnically diverse, areas. Similar to services for LGBTQ+ young people, we see a clear lack of these services in the North, outside of urban areas, the East Midlands, and, additionally, in the South West. **Whilst there are fewer young people from ethnic minority groups in these areas, these findings indicate that young people in areas far from urban centres may struggle to access any in-person targeted support.**

Figure 10: Targeted services for young people from ethnic minority groups (Hub of Hope data and LA response data)

VCSE services (Hub of Hope data) indicated by dots and LA response data in green



We asked ICBs about additional targeted services for under-served groups and these included:

- Pathways for care-experienced children and young people (seven ICS areas). Both ICBs and local authorities have statutory duties regarding support for care-experienced young people, so it follows that some would have specific non-specialist services for this group.
- Support for children who have experienced abuse and neglect (five ICS areas).
- Early support for young people with eating disorders (three ICS areas). Given lengthening waiting times for access to eating disorder services, it follows that more non-specialist services are focusing on this issue.
- Gender identity support (three ICS areas).
- Sleep support services (three ICS areas).
- Autism or neurodiversity pathways (two ICS areas).
- Refugee and asylum seeker support (two ICS areas).
- Boys and young men (one ICS area)

However, most ICBs did not report the existence of additional targeted services.

Response variation across ICBs, local authorities and NHS trusts

Comparing data from ICBs, local authorities, and NHS providers, we found substantial variation in the information provided for the same geographic areas. Figure 11 shows variation in responses across ICBs, LAs and NHS trusts, for each local authority area. To compare information received for the same local authority area, we assigned response data from the relevant ICBs and NHS trusts offering CYP mental health services to the corresponding local authority area.

While Integrated Care Boards bring together both local authorities and NHS trusts, we find many instances of conflicting information regarding the availability of non-specialist services across the three respondents, indicating varying levels of awareness around service availability. Perhaps unsurprisingly, respondents seemed more likely to report the existence of services which they were either commissioning or providing, despite the existence of integrated care boards and partnerships, which bring stakeholders together to ensure effective knowledge and data sharing, and service planning and delivery.

Local authorities, for example, as providers of some school-based and open-access support (e.g. youth groups), were more likely to report they existed than either ICBs or NHS trusts. In general, NHS trusts were the least likely to report that there were open-access or targeted services in their area. While we might expect them to have less awareness than the ICB as the local coordinator of health and social care provision, **this finding raises concerns that many trusts may not be aware of services for signposting the young people who do not meet their thresholds for access to specialist treatment.**

Despite the local coordination role of ICBs, two in the Midlands reported they did not hold the data we requested and referred us onto the trusts offering CYP mental health services. Virtually all ICBs reported they did not hold data on services which existed in the last decade, perhaps indicating a lack of institutional knowledge of how the service landscape has changed over time.

Figure 11: Variation in responses from ICBs, LAs and NHS trusts by local authority area

Part 2: Local characteristics and non-specialist services

We tested the relationship between availability of a wide range of different non-specialist services, according to LA data, and a number of local socio-demographic characteristics, including known predictors of mental health need, such as:

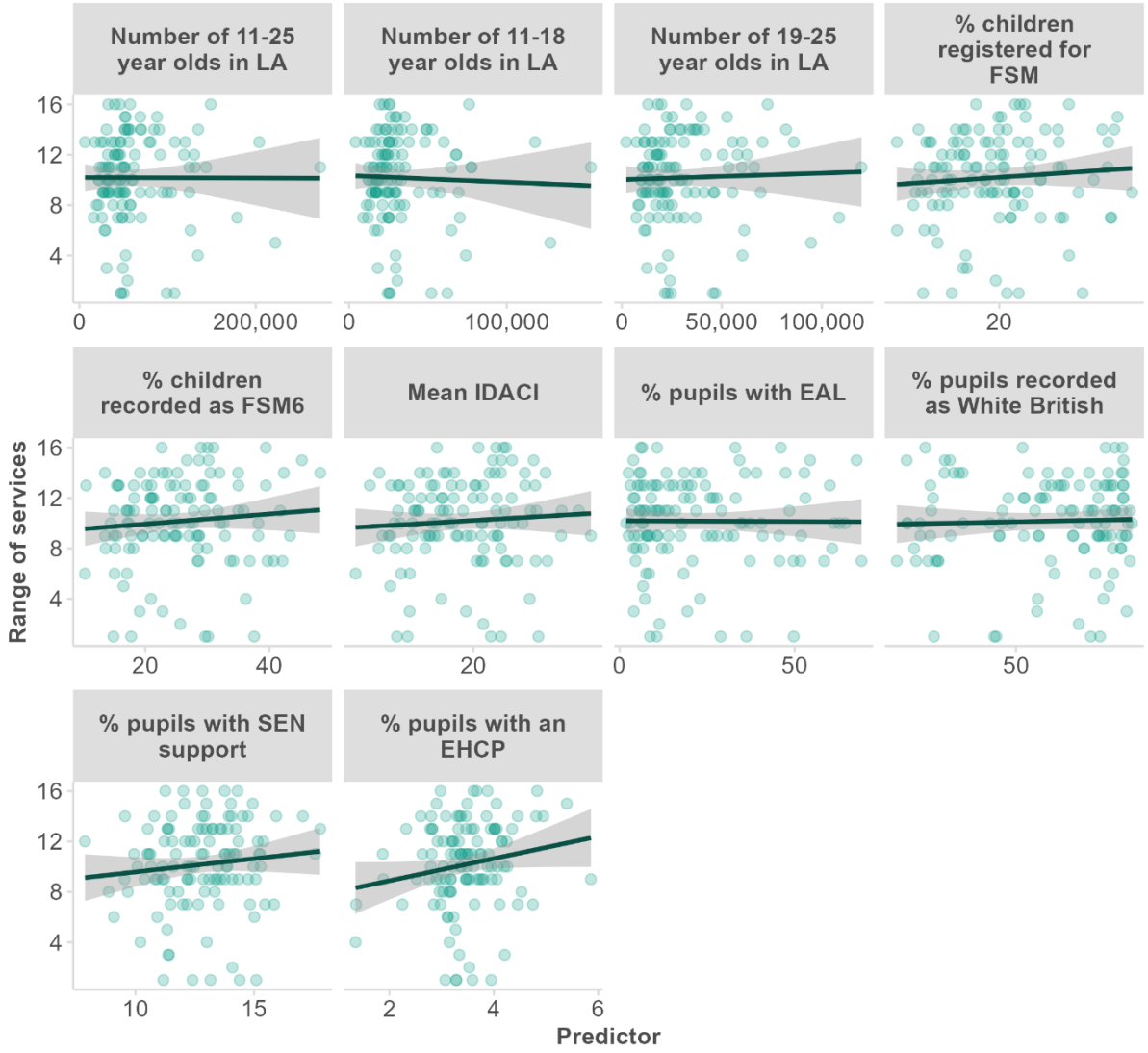
- The level of disadvantage, measured by the per cent of children registered for free school meals; the proportion of children registered for free school meals at some point in the last six years, and an area-level measure of the proportion of families with children living in income deprivation (IDACI)
- The recorded level of support for children with special educational needs and disabilities, recorded at the 'school support' level, and the proportion with an education, health and care plan
- The proportion of children recorded as living in families speaking English as an additional language (EAL)

Results are presented in Figure 12.

Most of the local characteristic measures show a weak correlation with the availability of a range of different non-specialist services, as reported by LAs. The scatter plots in Figure 13 reinforce this; the regression lines are almost flat, and the data points are widely scattered. For example, we find that the range of services is not associated with the number of young people, as seen in our heat maps in Part 1. The wide confidence intervals indicate a high level of uncertainty around the relationships, further suggesting that these predictors do not explain much of the variance in the range of services available.

Turning to the effect of specific factors, we find a weak relationship between levels of additional need and the range of non-specialist services on offer, suggesting that in areas with more need, there may be a greater range of services, or that in areas with capacity to provide more for children with additional needs there is also capacity to provide more mental health support. This relationship is not statistically significant so care should be taken in drawing conclusions from this finding.

Figure 12: The relationship between local characteristics and the availability of non-specialist services



Notes: Each dot represents a local authority. FSM = Free school meals; FSM6 = Registered as FSM-eligible at some point in the past 6 years; IDACI = Income Deprivation Affecting Children Index; SEN = Special educational needs; EHCP = Education, Health and Care Plan

The weak relationships may reflect the fact that the availability of a wider range of different non-specialist services, according to LAs, is more uniform across local authorities, regardless of these demographic and socioeconomic factors. We measured the strength of these correlations and conducted sensitivity analysis to study how this relationship varied by the measure used; we specifically investigated whether it differed in urban v rural areas to account for service accessibility, assuming that services are easier to access in more urban LAs (see Appendix B). This showed a similar pattern of results, likely related to our small sample size of areas. It is important to note that these measures of association are only as good as the data underlying them, and given the data issues previously noted, we should be careful in drawing conclusions from this analysis.

Part 3: NHS waiting times, A&E mental health attendances, and non-specialist services

We explored the relationship between two key local indicators of need amongst young people – waiting times for access to NHS services and A&E visits for mental health reasons – along with the role played in this relationship by different non-specialist services. We wished to investigate:

- First, if in areas with high waiting times for access to NHS services, we also see higher numbers of young people reaching a crisis point and presenting at A&E
- Second, if, in these areas, we also see a lower range of non-specialist services.

We used ICB response data to allow us to compare our data with waiting times and A&E data. We collected data from NHS England on A&E attendances for mental health reasons and used data on NHS waiting times collected by the Children's Commissioner.

NHSE data shows that individual A&E attendances, and admission episodes in particular, for mental health reasons, have risen substantially since 2017 (see Figure 13). Specifically, between 2017 and 2023, the number of young people attending A&E increased by 19.7 per cent, whilst admission episodes rose by 33.8 per cent, indicating that more young people are reaching a crisis point and experiencing multiple visits to A&E.

Following a rise between 2017 and 2019, mostly accounted for by 19- to 25-year-olds, the number of young people attending A&E for mental health reasons levelled off, whilst the number of admission episodes continued to increase, particularly amongst the older age group. This indicates that the number of individuals with multiple visits to A&E for mental health reasons has increased – a finding which chimes with wider evidence showing significant and mounting pressure on the mental healthcare system in recent years.

Adjusting for population growth reveals a similar pattern, though the trend appears less pronounced. Between 2017 and 2019, the proportion of young people attending A&E with a mental health diagnosis increased, but, as with previous trends, it levelled off during the pandemic and has very marginally decreased since. Figure 14 illustrates this shift, with almost all of the increase being driven by 19- to 25-year-olds.

Figure 13: Number of individuals aged 11-25 presenting at A&E and admissions episodes for mental health reasons

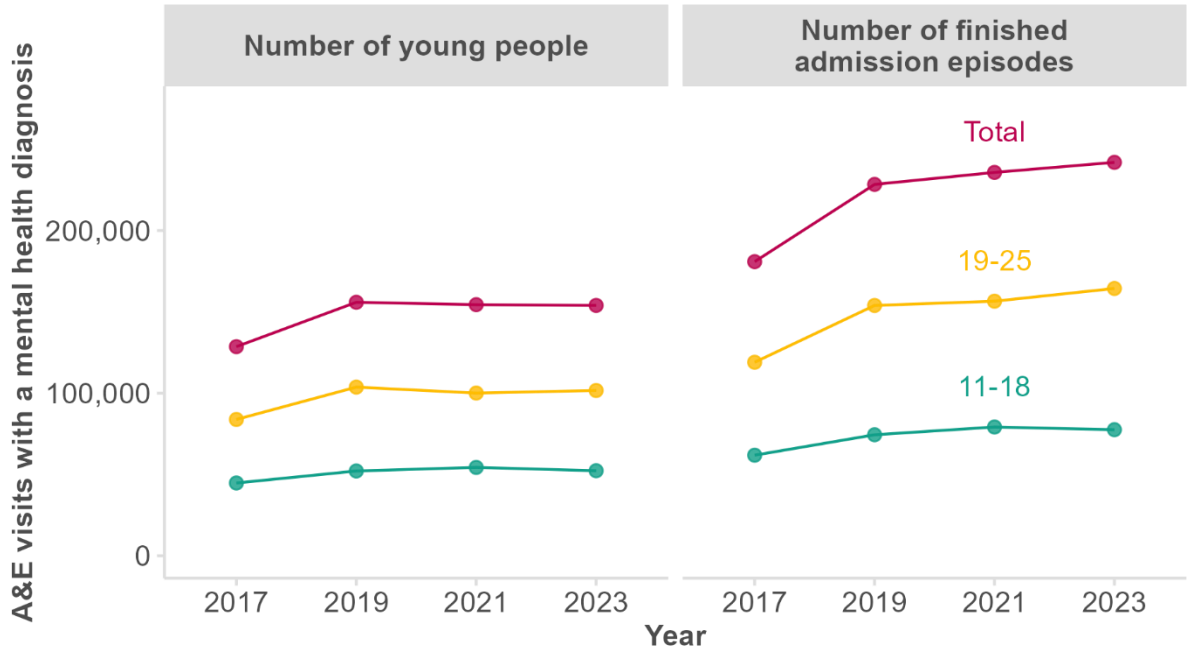
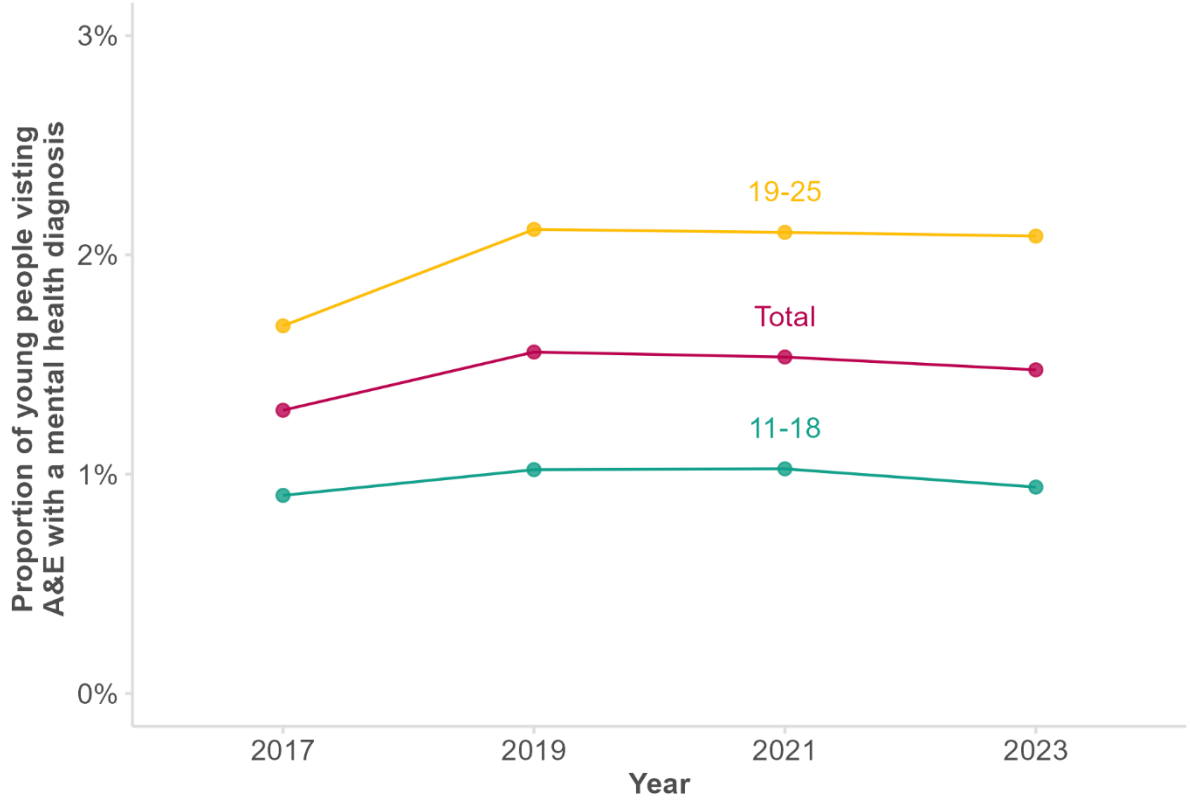


Figure 14: Proportion of young people presenting at A&E for mental health reasons

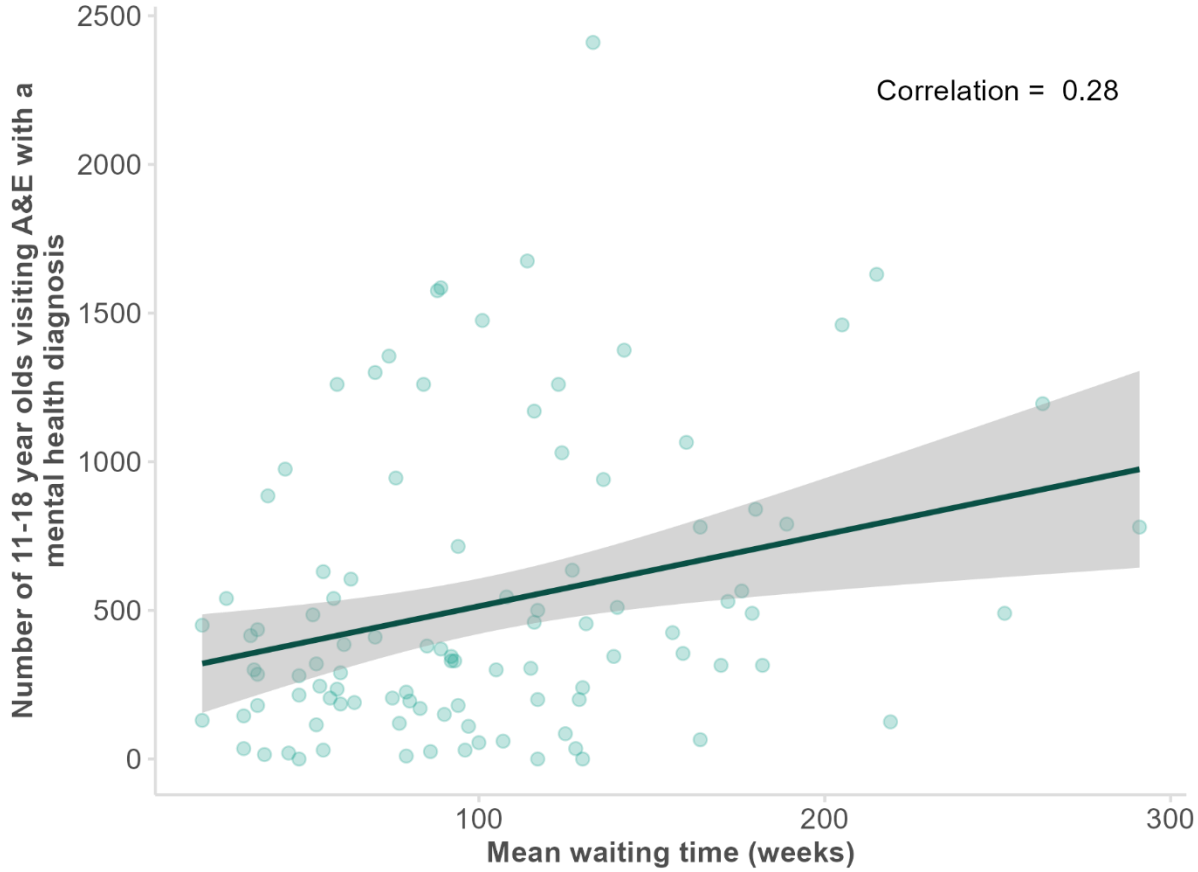


As seen in Figure 15, higher mean waiting times in 'sub-ICB locations', or smaller areas which make up the ICS, are associated with more young people attending A&E for mental health reasons.[22] This is represented by the upward-sloping regression line. We conducted sensitivity analysis to study how

[22] A sub-ICB is a sub-division of an Integrated Care Board's operating area.

this relationship varied by the measure used (see Appendix C); they showed varying levels of agreement based on the measure used.

Figure 15: The relationship between NHS waiting times and A&E mental health attendances



Source: CCo's waiting times data and NHSDigital A&E data. Notes: Each dot represents a Sub-ICB. Waiting times data from FY 22/23 and A&E attendance data from CY 2023.

This suggests that longer waiting times for NHS mental health services are associated with increased pressure on emergency services at area level: in sub-ICB areas, where access to mental health care is delayed, young people may experience higher rates of A&E visits. This effect disappears however when we account for the number of people in a sub-ICB (see Appendix B). This therefore suggests that this effect may be driven by a high overall level of demand for mental health services. Although we cannot directly capture 'need' due to our lack of access to more granular mental health prevalence data, sub-ICB areas with more young people experiencing mental health issues may face increased pressure on both planned and emergency services. It follows therefore that higher demand for mental health services could lead to longer waiting times and simultaneously more A&E presentations.

Although we could not measure these factors directly, unlike the number of people in a sub-ICB, it is possible that other factors may explain or play a role in this relationship, including:

- Systemic capacity issues: If a sub-ICB area has limited resources, such as fewer mental health professionals or insufficient mental health facilities, both waiting times and A&E presentations could increase – meaning that the observed relationship is a symptom of broader capacity constraints. It is also possible that these capacity issues extend beyond mental health services and all services in the area have long waiting times.

- Funding and resource allocation: The proportion of funding and resources allocated by ICSs to young people's mental healthcare could influence both waiting times and the use of emergency services.
- Socioeconomic factors: Sub-ICBs serving more socioeconomically disadvantaged areas might face greater mental health challenges, leading to higher demand and longer waiting times for services. In these areas, individuals may also be more likely to seek emergency care due to barriers in accessing community mental healthcare services, such as transportation issues, stigma, or lack of awareness.
- Psychological factors: Help-seeking behaviours may vary across sub-ICB areas. Cultural factors or community norms regarding how and when people seek help for mental health issues could play a role. In some areas, there might be a tendency to delay seeking help until a crisis point, leading to both longer waits for services and more frequent A&E visits.

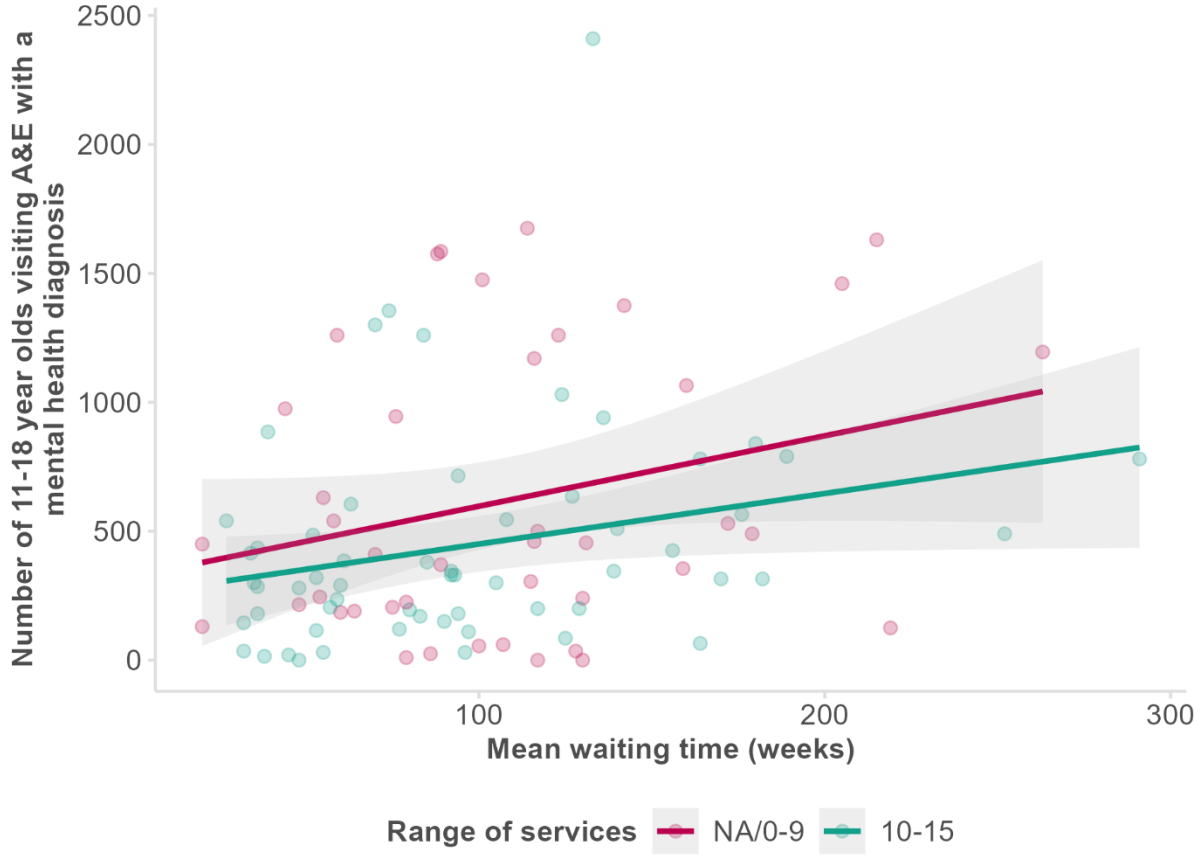
Importantly, this is an area-level relationship, and we cannot conclude that the relationship holds for individual young people. For example, while sub-ICBs with longer waiting times tend to have more A&E presentations, this does not mean that individuals who wait longer are necessarily the ones showing up at A&E.

It is also worth noting the wide confidence intervals indicated by the grey shaded areas around the regression lines. These intervals are relatively wide, suggesting a high degree of uncertainty around the exact relationship. While there seems to be a positive trend, the variability implies that the association is not strongly consistent across all sub-ICBs.

Despite this, this finding is significant from a health system perspective. It indicates that longer waiting times at the sub-ICB level are correlated with more acute or emergency presentations for mental health issues among young people. This could point to the need for policy interventions to reduce waiting times and improve access to mental health care to potentially alleviate the burden on emergency services.

Next, we sought to understand the role played by the availability of different non-specialist services in this relationship (see Figure 16).

Figure 16: The relationship between waiting times and A&E attendances in areas with low v high number of non-specialist service types

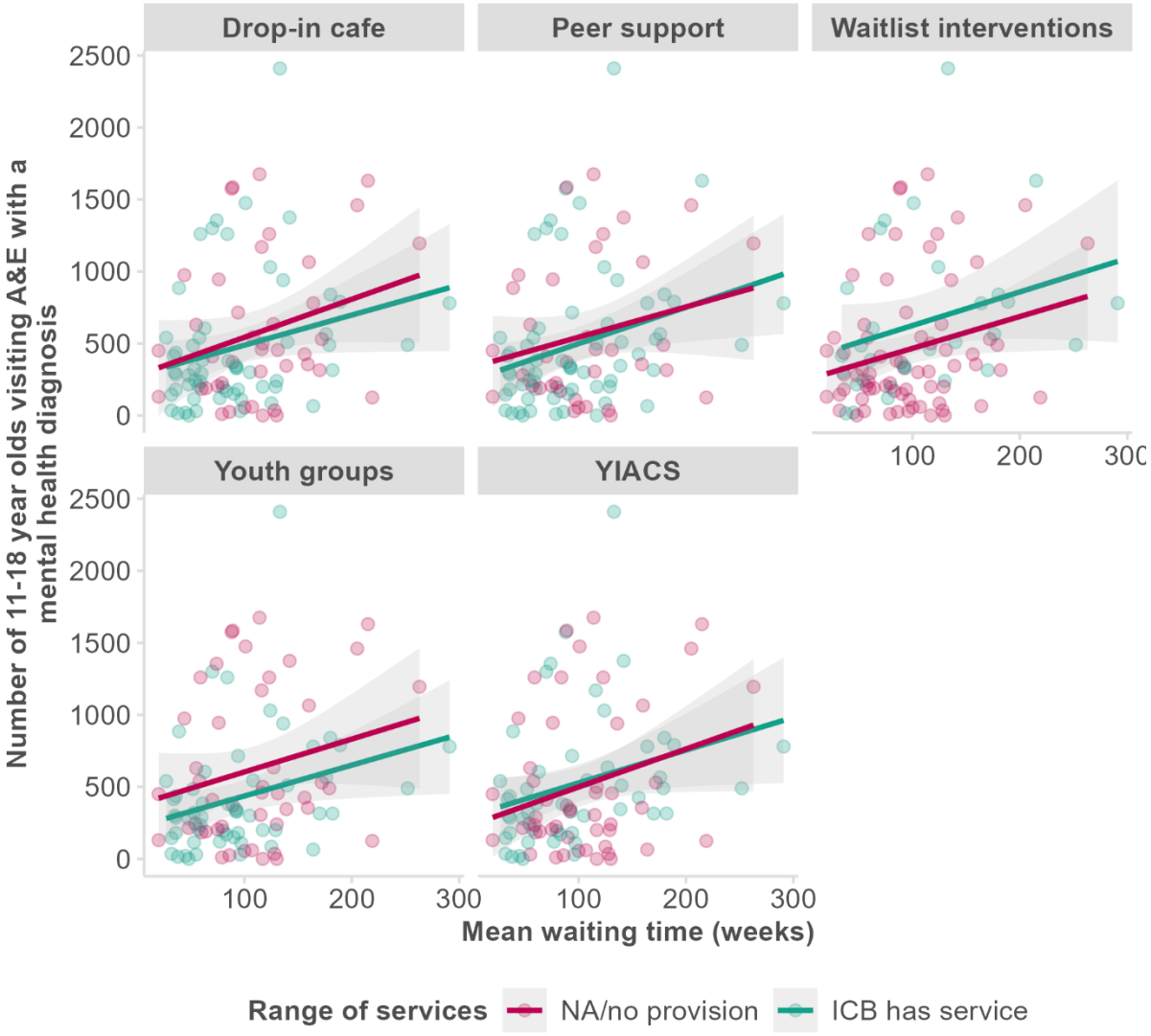


Source: CCo's waiting times data and NHSDigital A&E data. Notes: Each dot represents a Sub-ICB. Range of services based on EPI FOI request to ICBs. Waiting times data from FY 22/23 and A&E attendance data from CY 2023.

Figure 16 shows the relationship between waiting times and A&E attendances in both areas with fewer (red line) and more (green line) types of non-specialist services. The diverging lines on the chart suggest a slightly stronger relationship between waiting times and A&E attendances in areas with fewer services. However, shown by the grey shaded areas, the confidence intervals overlap indicating this is not a statistically significant difference. It is likely that we were statistically underpowered to detect this interaction effect.

Next, we looked specifically at the role played by open access services, including drop-in services such as wellbeing cafes, peer support services, youth groups, YIACS, and specific interventions for young people on waiting lists (Figure 17).

Figure 17: The relationship between waiting times and A&E visits depending on the availability of open-access services and services for waitlisted young people



Source: CCo's waiting times data and NHSDigital A&E data. Notes: Each dot represents a Sub-ICB. Range of services based on EPI FOI request to ICBs. Waiting times data from FY 22/23 and A&E attendance data from CY 2023.

We find a slightly weakened relationship between waiting times and A&E visits in areas with drop-in services and areas with peer support services, with no clear impact of waiting list interventions, youth groups and YIACS. However, the overlapping confidence internals indicate that none of these relationships are statistically significant. Again, it is likely that our study was simply statistically underpowered to detect this interaction effect.

Overall, these findings collectively suggest that even in areas with a wider range of service types, the relationship between waiting times and A&E attendances is still strong, possibly because these areas might still face high demand, with varying issues driving this demand, or that single services, or the list of services we asked about, are not enough on their own. **It is important to note that we are looking at the range of available non-specialist services, rather than the number of services available to young people. It is highly possible that the volume of services, assuming these services are effective and meet young people's needs, plays a more important role.**

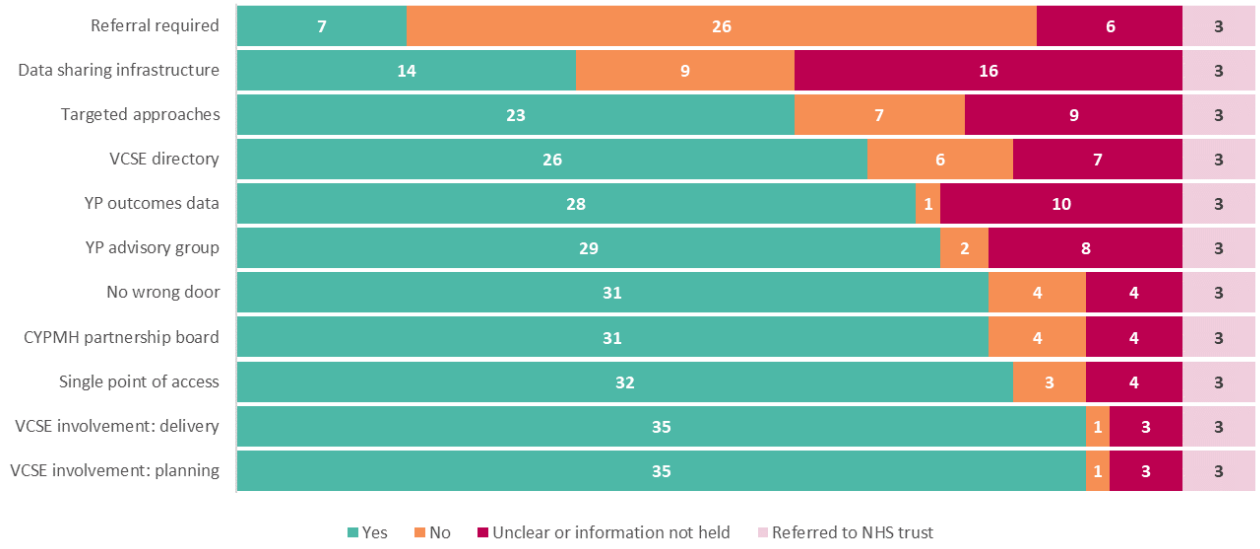
In addition to this, some ICBs provided details about the targeted interventions for young people on waiting lists they said were available in their area: these were signposting to other services and apps, so arguably do not meet our definition. For the ICBs which reported they did have a waiting list intervention but did not provide additional detail, we cannot know if this is a specific service provided for young people on waiting lists or simply that they, in theory, have access to the suite of non-specialist or open-access services in the area.

Part 4: ICS approaches to service planning and delivery

We asked an additional series of questions to ICBs about their approaches to partnership working, involving young people in improving provision, and ensuring services are accessible to those who need them (see Figure 20). These were areas identified by our workshop attendees as key to effective provision of services from non-specialist through to specialist healthcare.

Most ICBs provided one response for their area, while nine provided a breakdown by sub-ICB or local authority area they cover. Here we present the data at ICS level, taking the most common responses across more granular geographic units as the response for the whole ICS. Two ICBs reported they did not hold the information we were requesting.

Figure 18: Approaches to service planning and delivery for young people's mental health (number of ICBs in each response category)



Most ICBs reported they had a partnership board, responsible for overseeing and enhancing the mental health outcomes and experiences of young people within a specific area. One area which did not have a partnership board reported that they did have an individual or team charged with overseeing partnership working. Partnership boards grew out of Local Transformation Plans which were introduced in 2015 to improve services for young people and tied to funding from central government. They are collaborative boards which typically include LAs, NHS organisations, the education sector, VCSE services, youth services, along with service users and their families. **Given the very similar role played by ICSs across local health and social care, it is notable that a handful of areas either did not hold data on these boards or reported they did not exist.**

Only a third of areas reported they had data sharing infrastructure, and of those who did, there was evidence that they had interpreted the question as being about sharing data on young service users across services, which is a common practice. In other areas, there was clear evidence of shared data dashboards used by all providers including the VCSE sector.

Two ICBs additionally reported that they were collecting data on inequalities in mental health outcomes and barriers to access for certain groups of young people. One ICB in the South East

specified that: 'All commissions specifications need to track ethnicity and 'Children Looked After' activity, provide support to overcome barriers of inequality or inequity, pro-actively identify why young people do not attend or are not supported to attend and assist themselves or others to overcome this.' A London ICB reported that 'data is being reviewed regionally and at [the local] level to understand under-served groups at service / team level in terms of access, waiting times, experience and outcomes'. While it is possible similar activities are occurring in other areas, this was only evidenced in two – raising questions about the extent to which commissioners and providers are proactively addressing known barriers to accessing help for young people.

A large majority of ICBs reported they worked with VCSE providers, but fewer reported they had a publicly available up-to-date directory of VCSE services; it is unclear how young people or families in these areas would be aware of the different VCSE services on offer. Two reported they were working on developing these directories.

A majority reported they had a young person's advisory groups, or official mechanism for young services users to feed into service improvement efforts; however, in a third of areas the ICB could not confirm this was the case. Two thirds of ICB areas reported that outcomes following service engagement were measured, but in many they stated this was the case for only some services. One ICB in the South East reported: 'We also use 'goal based outcomes' - a tool to set goals with all young people and their families, to ensure support is needs led and [helps] us to identify progress they feel they have made during and at the end of formal support. We also have an annual survey for children and young people who finish support during a particular period, which explores their whole journey of accessing support from start to finish.' Another in the South East reported: 'It is best practice that all services are required to provide information regarding the impact of delivered interventions. This outcome data forms part of the evaluation reports. Methods and tools for ascertaining this information varies between providers,' suggesting that it may or may not be happening.

Regarding access to services for young people, most areas reported they had a 'single point of access' and a 'no wrong door' approach, however in some cases, it was specified that this meant the young person would be signposted to a more appropriate service. Most ICBs reported that there was at least one mental health service to which young people could self-refer; according to responses, this was not the case in seven ICS areas.

These findings highlight variability in approaches to delivering support for young people with mental health needs across different ICB areas, with some good practice emerging but also areas for improvement in terms of using data, addressing inequalities, and ensuring consistent youth engagement and outcome measurement. While some partnership working is the norm, how this is done and the extent to which it is effective is less clear. It remains the case that in some areas the experiences of young service users are not being fed into service improvement efforts, and it is unclear whether data on the impact of services for mental health outcomes is being comprehensively collected and used for service improvement. Outcomes measures have only recently been included in published national NHSE data, covering only a minority of young people.[23] At both the national and local levels, this appears to be a significant weakness.

[23] NHS England, 'Mental Health Dashboard.'

Conclusion

In this report, we have investigated the availability of non-specialist mental health services for children and young people up to age 25 – given the numerous data points suggesting that many young people with mental health needs cannot currently access specialist NHS services.

Unsurprisingly, we find that the availability of different types of non-specialist services, which may stand in for specialist healthcare for those unable to access it, varies significantly across the country. There does not appear to be a clear relationship between level of need and the availability of different service types: we find a wider range of services in both rural and urban areas, as well as in more and less deprived areas. A notable exception is the north of the country: here, commissioners and providers of these services did not hold the data we requested, while there also appears to be very few voluntary sector services available to young people. This region also includes many areas with high levels of deprivation. We find that in many areas, there are not targeted services for or approaches to boosting engagement for young people with LGBTQ+ or ethnic minority identities.

Overall, NHS providers of specialist services have less awareness of non-specialist services in their area – which is significant, given that they are turning away close to half of young people referred to them, and raises questions about their capacity to signpost young people to relevant alternative services.

Meanwhile, more young people are reaching a crisis point – with the number of A&E episodes for mental health reasons rising substantially in recent years. In areas with high waiting times for access to specialist treatment, we also see more A&E visits. A wider range of non-specialist services does not appear to reduce the pressure on A&E – however, future research should explore the volume of services and the role they play. Unfortunately, given the fragmentation which characterises the system supporting young people with their mental health, getting a handle on the full range of services delivered outside of specialist settings remains difficult.

Weaknesses in service provision previously identified – including fragmentation, poor partnership working, and lack of incorporation of feedback from services users – remain, despite the push toward better integration and joined-up working with the creation of integrated care systems. In this post-pandemic period, with many problems plaguing the healthcare system including long waiting lists for access to treatment generally and workforce weaknesses, it is perhaps the case that ICBs and ICSs are focused elsewhere. Data remains a significant weakness when it comes to young people's mental health provision: we found little evidence of comprehensive data collection on outcomes following service engagement.

For this report, we asked about a list of non-specialist services, including open access and targeted services, as well as alternatives to NHS talking therapies, informed by consultation with a range of stakeholders. There will likely be services which fall into the 'non-specialist' or early intervention category that we have not accounted for. Moreover, we explored the range of service types available, not the numbers of these services. Using this report as a jumping off point, future research could explore additional types of services or the number of different types of services available.

We also note that our findings are only as good as the data provided to us. Collecting data from ICBs, LAs and NHS trusts meant we were validating data provided by each respondent against that provided by the others. Given the existence of ICSs and closer partnership working under this new

model, we would expect good alignment of the data from these three different sources; however, in many instances, this was not the case, meaning we cannot say with absolute certainty that a service does or does not exist in a given area.

Off the back of our findings, we have developed the following list of recommendations, in partnership with Youth Access, a national membership organisation for open access services following the Youth Information, Advice and Counselling model (YIACS):

Recommendations

1. This research and wider evidence confirm that a better understanding of what exists and what works in the non-specialist, including early intervention, space is needed. **The Department for Health and Social care should commission research exploring the existence of these services for young people's mental health; this research should also explore the scope and quality of existing services, where possible, to help integrated care systems and local authorities to have a better understanding of what service availability means in practice.** While standardised data collection may be unlikely to improve the experiences of young people on its own, it would help to fill knowledge gaps, allow investigation of supply of and demand for services in more depth, and could be an important first step toward improving the offer for young people.

2. **In addition, the government should commission research to explore the extent to which existing non-specialist services, along with the full suite of local services supporting young people's mental health, delivered in all settings including schools, are satisfying demand at all levels from early needs to more significant difficulties.** For this to be possible, a better understanding of the different levels of need and patterns of occurrence is required. Whilst more frequent NHS prevalence surveys in recent years have improved our awareness somewhat, **additional research is required into the needs of specific groups of young people, including girls and young women, young people from minority ethnic backgrounds, those with LGBTQ+ identities and those with needs below diagnostic thresholds**.

3. **Given that the availability of different non-specialist service types varies substantially by geographic area and does not appear to be related to markers of local need, the Office for Health Improvement Disparities (OHID) which has prevention, addressing health inequalities, and a focus on mental health as part of its remit, should work with the Department of Health and Social Care (DHSC) to develop guidance laying out what the local early intervention service offer should look like.** Building on DHSC guidance 'Improving the mental health of babies, children and young people: a framework of modifiable factors' this could include a summary of the evidence on the effectiveness of different service types, highlight any gaps in the evidence base, and explore ways of working to best deliver them. This guidance should reflect that services should be responsive to the different needs and help-seeking behaviours of diverse groups of young people and therefore may look different in different areas. It should address how to tailor services for specific communities and their needs, deliver culturally competent support, meaningfully involve young people from diverse groups in service improvement efforts, and communicate

the inclusiveness of open access services to reduce barriers to access for underserved groups – and include examples of best practice. This guidance should be promoted and disseminated to relevant local stakeholders and support should be provided for its implementation. Importantly, accountability mechanisms should be attached to this guidance to ensure its effective implementation across different stakeholders and service areas.

4. **NHS England should develop guidance on effective governance to address persistent weaknesses in provision, identified by this research and that of others.** This guidance should outline best practices for stakeholder collaboration, addressing fragmentation across different commissioners and providers, embedding children and families in governance structures, and harmonising data collection approaches. It should include examples of best practice which have been shown to have a quantifiable impact on relevant outcomes. As above, accountability mechanisms should be attached to this guidance.

5. **The rollout of Young Futures Hubs, a pillar of the new government's youth mental health support programme, should address provision gaps and integrate with existing open access services identified through existing research, including this report.** The government should facilitate knowledge sharing and continuous improvement amongst hubs, particularly in areas of potential weakness identified by this research, such as data use, addressing inequalities, and consistent youth engagement and outcome measurement. National guidance should support local flexibility to meet diverse community needs while ensuring some degree of standardisation.

References

Alam, Shah, Sophie O'Halloran, and Alex Fowke. 'What Are the Barriers to Mental Health Support for Racially-Minoritised People within the UK? A Systematic Review and Thematic Synthesis'. *The Cognitive Behaviour Therapist* 17 (2024): e10.

Children's Society, "Briefing: Open Access Mental Health Drop-Ins for Young People," Children's Society, 2021.

Coehlo, H, Anna Price, Fraizer Kiff, Laura Trigg, Sophie Robinson, Jo Thompson Coon, and Rob Anderson. 'Experiences of Children and Young People from Ethnic Minorities in Accessing Mental Health Care and Support: Rapid Scoping Review', 2022.

Ellins, Jo, Kelly Singh, Mustafa Al-Haboubi, Jenny Newbould, Lucy Hocking, Jenny Bousfield, Gemma McKenna, Sarah-Jane Fenton, and Nicholas Mays. 'Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report', 2021.

Foulkes, Lucy, and Jack L Andrews. 'Are Mental Health Awareness Efforts Contributing to the Rise in Reported Mental Health Problems? A Call to Test the Prevalence Inflation Hypothesis'. *New Ideas in Psychology* 69 (2023): 101010.

Frith, Emily. 'Progress and Challenges in the Transformation of Children and Young People's Mental Health Care'. *Education Policy Institute, London*, 2016.

GOV.UK. '2011 Rural Urban Classification Lookup Tables for All Geographies', 17 October 2023. https://www.gov.uk/government/statistics/2011-rural-urban-classification-lookup-tables-for-all-geographies.

Haidt, Jonathan. *The Anxious Generation: How the Great Rewiring of Childhood Is Causing an Epidemic of Mental Illness*. Random House, 2024.

Hazell, Matthew, Emma Thornton, Hassan Haghparast-Bidgoli, and Praveetha Patalay. 'Socio-Economic Inequalities in Adolescent Mental Health in the UK: Multiple Socio-Economic Indicators and Reporter Effects'. SSM-Mental Health 2 (2022): 100176.

Holt-White, Erica, Alice De Gennaro, Jake Anders, Carl Cullinane, Erin Early, Rebecca Montacute, Xin Shao, and James Yarde. 'Briefing No. 4-Mental Health and Wellbeing', 2022.

House of Commons Education Committee, "Services for Young People: Third Report of Session 2010–12," The Stationery Office Limited, 2011.

Kahle, David, and Hadley Wickham. 'Ggmap: Spatial Visualization with Ggplot2'. *The R Journal* 5, no. 1 (2013): 144–61.

Masur, Philipp K., and Michael Scharkow. 'Specr: Conducting and Visualizing Specification Curve Analyses (Version 1.0.1)', 2020. https://CRAN.R-project.org/package=specr.

McDermott, Elizabeth, Rachael Eastham, Elizabeth Hughes, Katherine Johnson, Stephanie Davis, Steven Pryjmachuk, Ceu Mateus, Felix McNulty, and Olu Jenzen. '"What Works" to Support LGBTQ+ Young People's Mental Health: An Intersectional Youth Rights Approach'. *International Journal of Social Determinants of Health and Health Services* 54, no. 2 (2024): 108–20.

McDermott, Elizabeth, Rachael Eastham, Elizabeth Hughes, Emily Pattinson, Katherine Johnson, Stephanie Davis, Steven Pryjmachuk, Ceu Mateus, and Olu Jenzen. 'Explaining Effective Mental Health Support for LGBTQ+ Youth: A Meta-Narrative Review'. SSM-Mental Health 1 (2021): 100004.

Mulraney, Melissa, David Coghill, Caitlin Bishop, Yasemin Mehmed, Emma Sciberras, Michael Sawyer, Daryl Efron, and Harriet Hiscock. 'A Systematic Review of the Persistence of Childhood Mental Health Problems into Adulthood'. Neuroscience & Biobehavioral Reviews 129 (2021): 182–205.

National Audit Office, 'Progress in improving mental health services in England.' https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/

National Youth Agency, 'Youth Work Inquiry - Final Report,' National Youth Agency, 2019.

Nwokoroku, Sandra Chidimma, Barbara Neil, Chris Dlamini, and Vivian Chinonso Osuchukwu. 'A Systematic Review of the Role of Culture in the Mental Health Service Utilisation among Ethnic Minority Groups in the United Kingdom'. Global Mental Health 9 (2022): 84–93. https://doi.org/10.1017/gmh.2022.2.

NHS England, 'Mental Health Dashboard,' https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

Office for National Statistics, 'Population estimates.' https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates'

Orben, Amy, and Andrew K Przybylski. 'Reply to: Underestimating Digital Media Harm'. Nature Human *Behaviour* 4, no. 4 (2020): 349–51.

Twenge, Jean M, Jonathan Haidt, Thomas E Joiner, and W Keith Campbell. 'Underestimating Digital Media Harm'. *Nature Human Behaviour* 4, no. 4 (2020): 346–48.

Wadman, Ruth, Olivia Taylor, Pamela Qualter, Neil Humphrey, Megan Wood, Mark Mon-Williams, and Nikki Rutter. 'Improving Mental Health and Wellbeing with and through Educational Settings', 2024.

Williams, A Jess, Christopher Jones, Jon Arcelus, Ellen Townsend, Aikaterini Lazaridou, and Maria Michail. 'A Systematic Review and Meta-Analysis of Victimisation and Mental Health Prevalence among LGBTQ+ Young People with Experiences of Self-Harm and Suicide'. *PloS One* 16, no. 1 (2021): e0245268.

YoungMinds. "Beyond the Waiting List: Five Steps to Improve Young People's Mental Health." YoungMinds, 2020.

Youth Access and British Association for Counselling and Psychotherapy. "Young People in Mind: Making Counselling Work for Young People." Youth Access, 2018.

Appendix A: Freedom of Information requests to ICBs, LAs and NHS trusts providing CYPMHS

I would like to request the following information about mental health support for children and young people aged 11 to 25 in [your area] under the Freedom of Information Act.

1. Which of the following **non-specialist publicly funded** services for young people's mental health (a) currently exist and/or (b) used to exist within the last decade *(please indicate if they currently exist, and if they used to exist if you hold this data*):
    a. Social prescribing
    b. Bereavement services
    c. Peer support
    d. Mental Health Support Teams
    e. School counsellors, mentors, or pastoral or key support workers
    a. Educational psychologists
    b. Youth groups
    c. Wellbeing cafes or mental health drop-in services
    d. Youth information, advice and counselling services (YIACS) / early support hubs
    e. Advice line for mental health issues
    f. Targeted service(s) for LGBTQ+ young people
    g. Targeted service(s) for young people from minority ethnic / racialised communities
    h. Targeted service(s) for other underserved groups *(please list here)*
    i. Targeted service(s) for young people on waiting lists for access to NHS mental health services (formerly tier 3)
    j. Art or music therapy
    k. Online support service / app
    l. Occupational therapy
    m. Any other service *(please list here)*

2. Do any of the following exist *(please answer yes or no and elaborate if necessary)*?
    a. A CAMHS or young people's mental health partnership board?
    b. A designated individual or team who coordinates partnership working across services for children and families / settings?
    c. Data-sharing infrastructure to share data across services, for example, schools, social care, youth justice, special educational needs teams, etc.?
    d. Evaluation of young people's outcomes following engagement with services?
    e. A young people's advisory group or official mechanism for young people to feed into service design and improvement?

3. Is there a single point of access for young people with a mental health concern? Please answer yes or no and elaborate if necessary.

4. Do you operate a 'no wrong door' approach? Please answer yes or no and elaborate if necessary.

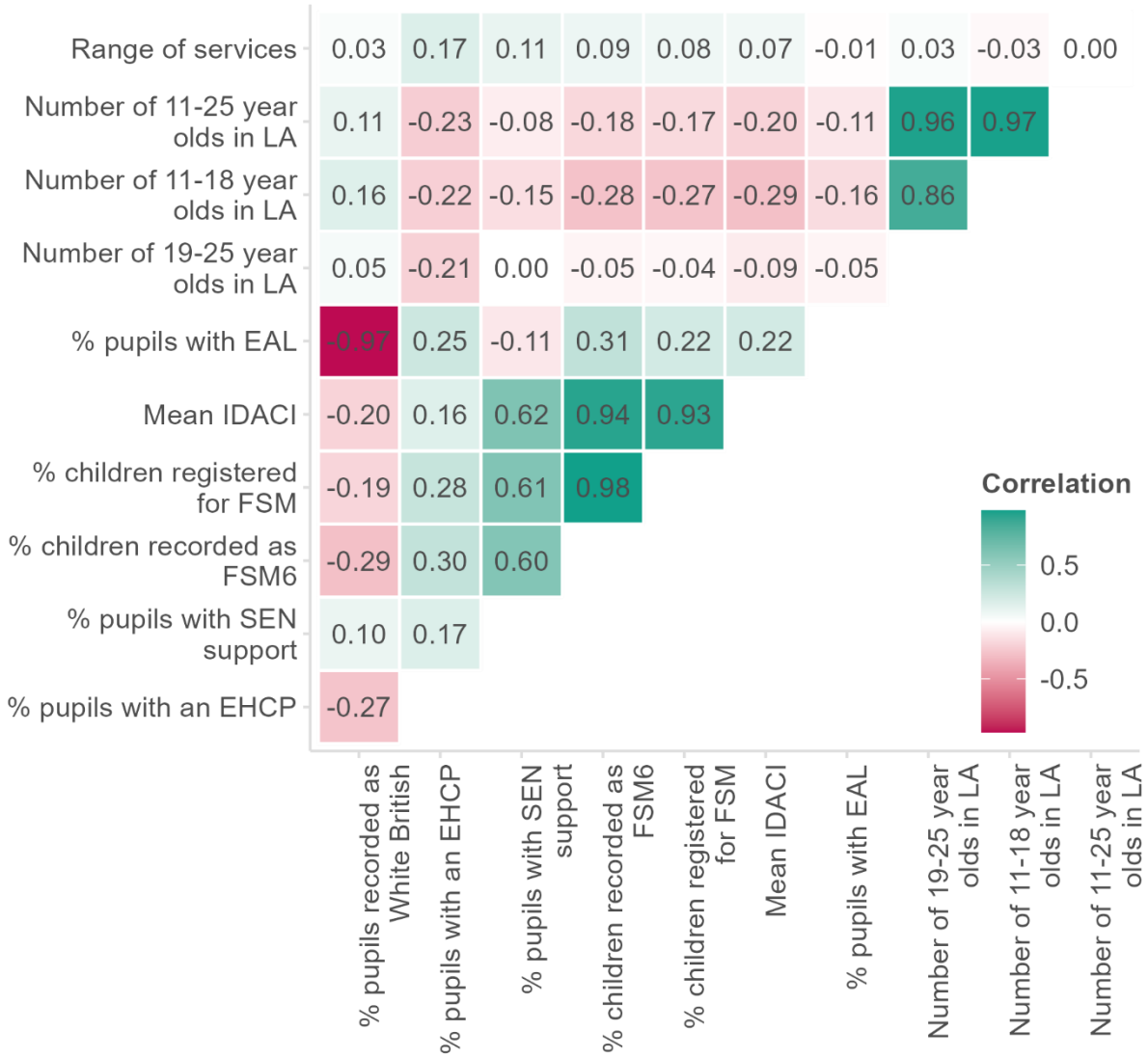
5. Do young people have to be referred to access a mental health support service? Please answer yes or no and elaborate if necessary.

6. Are there specific services or approaches to ensure under-served groups of young people can access support e.g. young people from minority ethnic / racialised backgrounds, LGBTQ+ young people, etc.? Please answer yes or no and elaborate if necessary.

Appendix B: Sensitivity analysis of LA characteristics

We find a weak relationship between the characteristics of the local authority and the range of non-specialist services on offer – see Figure 19

Figure 19: Strength of the relationship between local characteristics and non-specialist services



Notes: FSM = Free school meals; FSM6 = Registered as FSM-eligible at some point in the past 6 years; IDACI = Income Deprivation Affecting Children Index; SEN = Special educational needs; EHCP = Education, Health and Care Plan

We also considered that a young person's ability to access services might vary due to local factors (e.g. distance, public transport availability) even if those services are offered. To account for potential differences, we analysed all local authorities collectively and also separated them based on their rural or urban classification, as defined by the Department for Environment, Food & Rural Affairs.[24]

[24] '2011 Rural Urban Classification Lookup Tables for All Geographies', GOV.UK, 17 October 2023, https://www.gov.uk/government/statistics/2011-rural-urban-classification-lookup-tables-for-all-geographies.

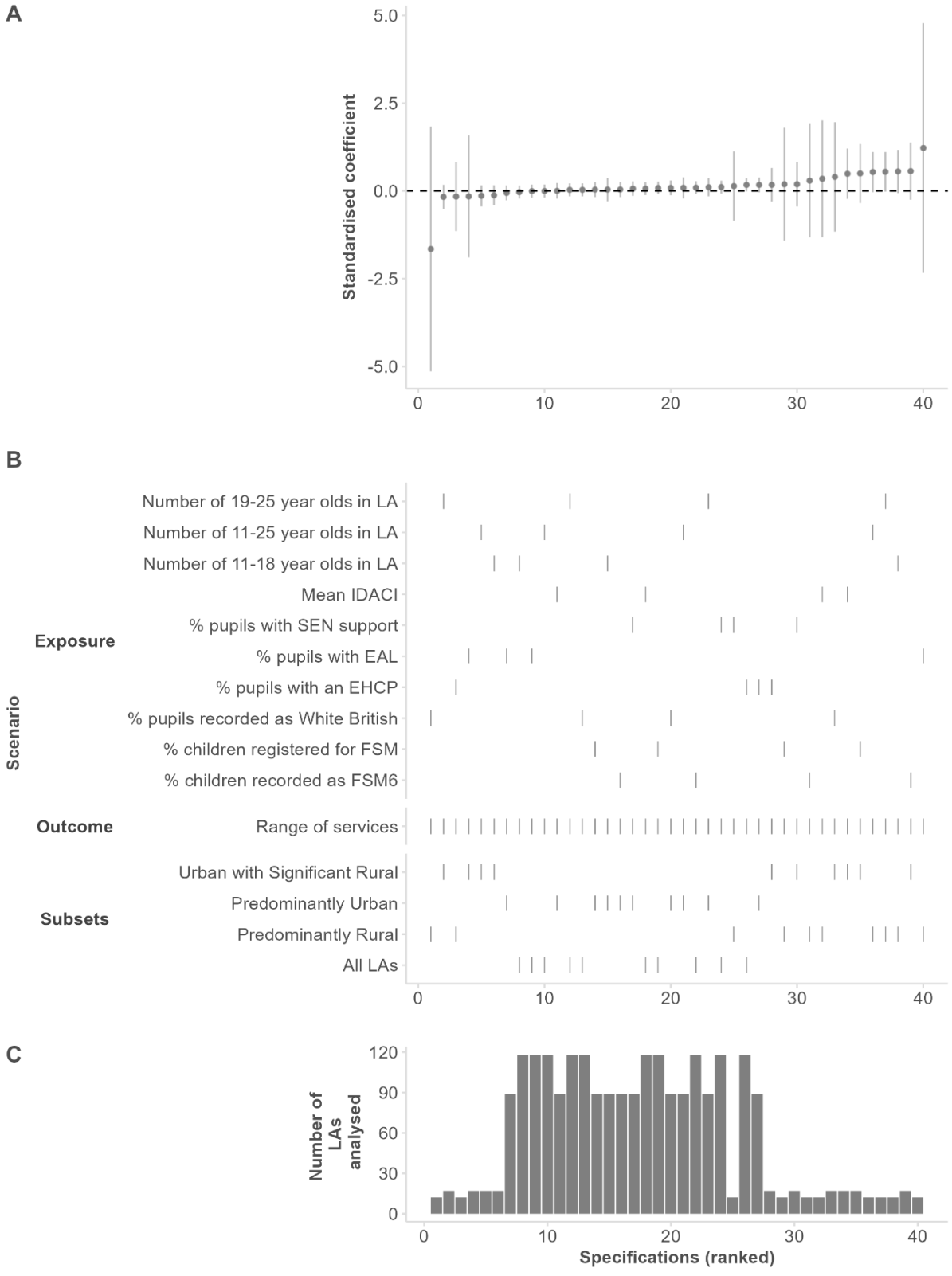
We employed Specification Curve Analysis, using the `specr` package in R, to examine the relationship between local authority characteristics and the range of services offered.[25] The outputs of the Specification Curve Analysis are presented in three panels in Figure 22. Panel A displays the standardised beta coefficients, sorted by the effect size, across different model specifications, with the thick dot representing the estimate and error bars indicating uncertainty. Panel B breaks down the various analytical choices or 'scenarios' used in each specification, including different exposure measures, outcome variables, and subsets of data analysed. Each row represents a specific analytical choice, with marks indicating which choices were used in each specification. Finally, Panel C shows the sample size for each specification, revealing how the number of local authorities analysed varies across different model configurations. Together, these panels provide a picture of how analytical decisions impact the estimated effects and the robustness of findings across multiple specifications.

We consistently found no significant effects across these different analytical approaches. This suggests that the relationship between LA characteristics and service range remains relatively stable, regardless of how we specified our analysis or whether we focused on rural or urban areas or both.

The absence of significant effects in our analysis may be a result of two factors. Firstly, the range of services might not be as important as the number/density or quality/effectiveness of services in determining outcomes for young people. For example, a diverse range of services may be less impactful than a concentrated set of high-quality, accessible interventions. Alternatively, our research may have been constrained by limited statistical power. Detecting subtle effects, particularly when analysing subgroups such as rural versus urban areas, typically requires a larger sample size than what was available in our dataset. Future research could therefore focus on more comprehensive measures of non-specialist service provision and use more granular data (e.g. lower-tier local authorities) to uncover additional potential relationships.

[25] Masur and Scharkow, 'Specr: Conducting and Visualizing Specification Curve Analyses (Version 1.0.1).'

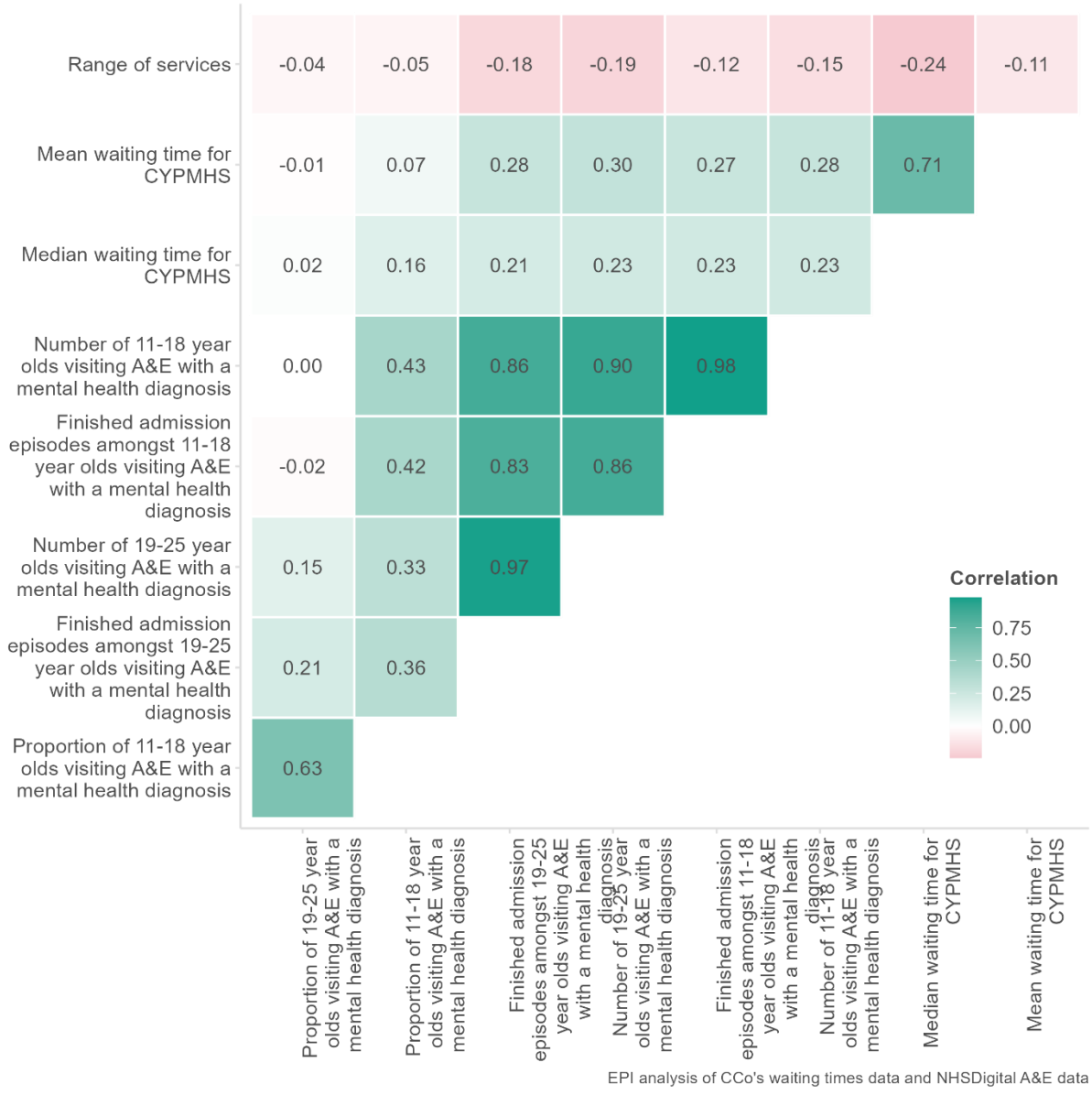
Figure 20: Regression coefficients predicting the range of services under various specifications



Appendix C: Sensitivity analysis of sub-ICB outcomes

We tested the relationship between range of services, waiting times and A&E attendance figures with alternate measures including the median waiting times and for A&E data for young adults – as shown in Figure 21**Error! Reference source not found.**. Across the measures, the effect size varied.

Figure 21: Correlations between the range of services, waiting times and A&E presentations



To supplement this, again using the `specr` package in R, we conducted specification curve analysis to study these associations under various specifications. As

Figure 22 shows, we found that although there was a relationship between waiting times and A&E visits, the magnitudes varied depending on the measure and whether outliers – defined as values falling outside 1.5 times the interquartile range – were included or excluded. It also disappeared when we accounted for the number of young people in the sub-ICB. Lastly, when we subset our

analyses by rurality of the sub-ICB, we found inconsistent findings although we were, of note, limited by statistical power.

Figure 22: Regression coefficients predicting A&E attendance under various specifications