Title: **Disparities in accessing mental health services for young people in contact with children's social work: a retrospective analysis of over 71,700 clinical records.**

Short title: Mental health access for children with social work involvement

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Abstract

Aims: Many children and young people with social work involvement (CYPwSW) experience a higher prevalence of mental health difficulties with an increased likelihood of referral to mental health services than their peers. Yet little is known about their likelihood of accessing mental health support following referral. This observational study aims to address this gap, examining how social work status is associated with service access.

Methods: Data were extracted from young people's first referral to mental health services in South London and Maudsley NHS Foundation Trust between 2007 to 2023 and included social work and sociodemographic characteristics. Multilevel logistic regression modelling was used to calculate adjusted odds ratios (OR) and to estimate the associations between social work status (no involvement; other current social work involvement without a formal recorded intervention; past social work involvement; child protection plan; being looked after) and service access.

Results: A total of *N*=71,740 referrals were extracted. Children with current or past social work involvement had significantly higher adjusted odds of not accessing mental health services compared to their peers. The highest adjusted odds were observed among children with other current social work involvement (OR=2.65 [95% CI=2.43, 2.88]) and on child protection plans (OR=2.03, [95% CI=1.88, 2.20]). Past social work involvement (OR=1.14 [95% CI=1.07, 1.23]) and being looked after (OR=1.13 [95% CI=1.04, 1.22]) were also associated with higher adjusted odds, though to a lesser extent.

Conclusions: Findings from this study suggest that children with current and past social work involvement experience disparities in accessing mental health services. The underlying reasons for this are yet to be confirmed, but overall, mental health inequities in social work experienced populations may be amplified at the point of access to mental health support.

Children and young people with social work involvement (CYPwSW) report higher rates of mental health (MH) difficulties compared to non-social work experienced peers (Bronsard et al., 2016). Recent epidemiological work in the UK and Australia has identified that CYPwSW are more likely to be in contact with MH services (e.g., Coughlan et al., 2024a; Green et al., 2019; McKenna et al., 2023). However, a referral to MH support does not necessarily mean that children will access a service. For example, The Children's Commissioner in England reported that 39% of young people had their referral closed before accessing support in 2022-23 (Children's Commissioner, 2024).

CYPwSW may experience unique barriers to accessing MH support. For example, children in out-of-home care experience frequent placement changes or lack consistent advocates (Beck, 2006; Crenna-Jennings & Hutchinson, 2018). There have been growing calls for further research addressing access to MH services for this population. The Independent Review of Children's Social Care in England highlighted MH support as a serious issue (MacAlister, 2022). CYPwSW themselves identified access to MH support as a research priority and advocated for epidemiological research using administrative records to address this question (Devaney et al., 2023). There is emerging evidence that children in out-of-home care are more likely to not get access to MH services (Hansen et al., 2021; Phillips et al., 2023). However, there has been no research on whether this is the case for young people with other forms of social work involvement (e.g., subject to protection plans) or indeed previous social work involvement.

The present exploratory study aims to address this gap by examining the association between social work status and accessing MH services at a large NHS Trust in England.

Methods

Overview

We analysed data from pseudonymised electronic health records (EHRs) routinely collected by South London and Maudsley NHS Foundation Trust (SLaM) MH services using the Clinical Record Interactive Search (CRIS) tool. SLaM is one of the largest MH providers in Europe, serving a geographic catchment of 1.3 million residents. In SLaM, EHRs went service-wide in 2006 and CRIS went service-wide in 2007. Further details, including a cohort profile of CRIS, are provided by Perera et al. (2016).

The sample comprised *N*=71,740 patients, under the age of 18, referred to SLaM MH services between 2007 and 2023 (0.12% referred prior to this). Extracted referrals included referral and discharge dates.

To protect anonymity due to small sample sizes, young people with gender "other" were excluded. To avoid duplicate records from the same young people and focus on initial service access rates, analyses were restricted to first referrals. Records in which the date of birth followed the referral date were excluded, as these likely indicated administrative errors or referrals concerning a parent (e.g., during pregnancy).

Exposure variables

Social Work Status. Five categories were created based on available indicators of social work involvement within patient information forms and risk assessments (see Supplementary Note 1). Children and young people were grouped into the following categories in order of level of intervention (See Supplementary Note 2 for a definition of social work interventions):

1. **No social work involvement:** Children with no indicators of social work involvement.
2. **Other current social work involvement (OCSW):** A residual category for children who had indicators of social work involvement and were referred to MH services by social work services, but who were not identified as having a formal social work intervention.
3. **Past social work involvement:** Children identified as having had social work involvement in the past, such as those who were on child protection plans previously or who were adopted.
4. **Children on protection plans (CPP):** Children identified as being on child protection plans.
5. **Children who are looked after (CLA):** Children who were 'looked after' by a local authority, the majority of whom were in out-of-home care.

Sociodemographic Characteristics. Age at referral was estimated using the birth month/year and referral date. Gender is a structured field within the data, categorised as either "Male" or

"Female". Ethnicity was categorised based on Census categories white/Black/Mixed/Asian/other (Office for National Statistics, 2011). Socioeconomic deprivation was measured at Census 2011 Lower Super Output Area level (LSOA; a standard UK residence unit). LSOAs were linked to their national Index of Multiple Deprivation (IMD) quintiles; IMD is a measure of relative deprivation in small local areas in England ranging from 1 (most deprived) to 5 (least deprived). Based on Public Health England (2024) guidance, referral dates were matched to the relevant IMD quintile that most closely aligned with the time period of the data. Some (*n*=114) referrals were from outside of England (e.g., Channel Islands) and were therefore treated as missing IMD values.

Local Authority. Truncated postcodes were extracted to identify whether referrals originated from local authorities within SLaM (Lambeth, Croydon, Lewisham, or Southwark). Referrals from outside SLaM's catchment area were categorised as "Non SLaM," while missing data were coded as "Unknown".

Outcome Variables

Service access. Service access is the focus of this study and was operationalised into two categories (accessed a service/did not access a service). We used counts for service contacts and events (e.g. appointments) as a proxy for children and young people accessing MH services (see Supplementary Note 3), which aligns with England's NHS primary metric for indicating whether a child has accessed treatment (NHS England, 2024). To ensure the validity of this method, clinicians within SLaM MH services were consulted to verify that the selected service contacts and events are routinely recorded and appropriately indicate service access.

- **'Accessed a service'**: Represented children and young people who had at least one contact or event during their episode of care.
- **'Did not access a service'**: Represented children and young people who had no contact or service event between referral date and discharge date.

The reason for services not being accessed could be multifaceted (e.g., referral issues, young people or families moving outside the area). Further reflections on defining the outcome measure are provided in the Discussion.

Ethical Approval

CRIS was approved for secondary research by the National Research Ethics Service Committee South Central Oxford (ref. 23/SC/0257). The current project (reference 23-048) was approved by the CRIS Oversight Committee.

Experts by Experience

Four groups of experts by experience, convened by the National Children's Bureau and Care Leavers' Association, were consulted at multiple time points to shape research aims, analyses, recommendations and interpreting findings. These groups consisted of: adults and young people with experience of being in care, disabled young people with experience of social work involvement, and parents of CYPwSW.

Practitioner Consultations

This research received iterative feedback from a multidisciplinary group of mental health practitioners and social workers with expertise in the mental health of CYPwSW working across England and convened by the British Association of Social Workers. Consultations helped with shaping research aims, recommendations and interpreting findings.

Analysis

Analyses were completed in RStudio V4.4.0. Descriptive statistics were reported for accessing services across the whole sample. These were reported as frequencies and percentages for categorical variables and mean and median for age. All counts are rounded to the nearest ten, and percentages are calculated based on rounded values to prevent disclosure.

Missingness in variables are a limitation of using electronic health data (e.g. Mathur et al., 2014). Missingness was 19% for ethnicity, 0.08% for gender, 7% for IMD, and 6.9% for local authority. It was decided that missing local authority data was treated as a separate "Unknown" category: consultation with a clinical lead from SLaM indicated that these referrals typically came from other NHS Trusts rather than being 'true' missing data. A Little's test confirmed data were not missing completely at random (Little, 1988). We therefore used multiple imputation equation (MICE) leveraging existing values from other variables including gender, age, IMD, and ethnicity (Pereira et al., 2024). A random forest approach was applied, with 10 multiple imputations.

Accessing services may be influenced by contextual factors, such as the distribution of services or funding, across different local authorities. Experts by experience urged for this to be considered in the methodology. Thus, multilevel logistic regression models were used to estimate the associations of sociodemographic and social work characteristics with accessing services, nested within local authorities.

A stepwise approach to evaluate changes in model fit was conducted (Merlo et al., 2016; see Table S1). First, a null model was fitted to estimate the variance in accessing services accounted for by differences between local authorities. Next, Model 1 introduced individual-level social work characteristics while controlling for local authority-level differences. Finally, Model 2 was adjusted to include social work and sociodemographic characteristics at the 'individual' level, as well as local authority influences at the 'area' level.

Model fit was assessed using the Akaike information criterion (AIC), whereby the model with the lowest AIC is the best fitting model (Akaike et al., 1987). The area under the receiver operating characteristic curve (AUC) was used to assess discriminatory accuracy. The higher the AUC, the better the model was at distinguishing between access and no access. Odds ratios, confidence intervals and model diagnostics were completed using the imputed dataset, while descriptive statistics were analysed using the non-imputed (i.e. original) dataset.

Results

Overview

N=71,740 young people's referrals were included in the study. The cohort had a median age of 12.5 (IQR 8.3-15.3) and a mean age of 11.7 (standard deviation [SD] 4.3). Of these referrals, 51.0% (*n*=36,600) did not access the service and 49.0% (*n*=35,140) did access the service. 12,170 (17.0%) referrals were identified as having social work involvement. Access rates by social work status were as follows: 50.9% CLA (*n*=1,450), 36.7% CPP (*n*=1,120), 50.4% SW past (*n*=1,710), 28.2% OCSW (*n*=810), and 52.9% with no SW involvement (*n*=31,500) accessed a service.

Further details of the social work, sociodemographic, and referral decisions for the full cohort are presented in Table 1.

Table 1. Characteristics of the cohort

	Access		No access	
	n	*%*	*n*	*%*
N	36,600	-	35,140	-
SW status				
CLA	1,450	50.9	1,400	49.1
CPP present	1,120	36.7	1,930	63.3
SW past	1,710	50.4	1,680	49.6
OCSW	810	28.2	2,060	71.8
No SW	31,500	52.9	28,060	47.1
Age (Mean, *SD*)	12.2	4.1	11.1	4.5
Gender				
Female	19,020	55.2	15,440	44.8
Male	17,530	47.1	19,690	52.9
Missing	50	83.3	10	16.7
Ethnicity				
White	15,740	52.1	14,490	47.9
Black	7,320	46.1	8,560	53.9
Asian	1,830	56.5	1,410	43.5
Mixed	3,620	59.6	2,450	40.4
Other	1,440	53.1	1,270	46.9
Missing	6,660	48.9	6,960	51.1
IMD Quintile				
1 (most deprived)	8,790	43.5	11,420	56.5
2	12,680	52.2	11,620	47.8
3	7,310	60.9	4,700	39.1
4	3,940	65.1	2,110	34.9
5 (least deprived)	2,730	65.5	1,440	34.5
Missing	1,150	23.0	3,850	77.0
Local Authority				
Croydon	7,910	54.7	6,550	45.3
Lambeth	6,080	51.9	5,640	48.1
Lewisham	6,250	45.4	7,510	54.6
Non SLaM	8,820	62.6	5,260	37.4
Southwark	6,430	50.2	6,380	49.8
Unknown	1,120	22.7	3,810	77.3

Note. Values have been rounded to the nearest ten, and percentages are based on rounded counts to protect against disclosure. IMD = Index of Multiple Deprivation; CLA = Children looked after by a local authority; CPP = Children on a child protection plan; OCSW = Children with other current social work involvement; SW past = Children with past social work involvement; No SW = Children with no social work involvement

Correlates of accessing services

Multilevel logistic regression assessed associations between predictors and not accessing services across three models: a null model; Model 1, adjusted for social work status; and Model 2, additionally adjusted for age, gender, ethnicity, and IMD quintile.

The intraclass correlation coefficient (ICC) indicated that 8% of the variance in not accessing services was attributable to differences between local authorities (ICC = 0.082). A likelihood ratio (LR) test comparing the multilevel model with a fixed logistic regression showed that the multilevel modelling significantly improved model fit ($p < 0.001$).

Model 2 showed the best fit (AIC = 93527.17; AUC = 0.659) and was therefore selected for interpretation (Table 2; null model in Table S1).

In Model 2, young people with any form of social work involvement had significantly higher adjusted odds of not accessing services. Specifically, referrals for CPP (OR=2.03 [95% confidence interval 1.88, 2.20]) and young people with OCSW (OR=2.65 [95% CI=2.43, 2.88]) were considerably more likely to not access services compared to their peers, while CLA (OR=1.13 [95% CI=1.04, 1.22]) and SW past (OR=1.14 [95% CI=1.07, 1.23]) had more modestly elevated odds.

There was also some evidence for direct associations between sociodemographic factors, including age, gender, ethnicity and deprivation and service access (see Table 2).

Table 2. Multilevel logistic regression models: Factors associated with not accessing MH services

	Model 1[a]			Model 2[b]		
	OR	LL CI	UL CI	OR	LL CI	UL CI
Intercept	1.02	0.68	1.54	1.21	0.79	1.85
Social work status						
CLA	1.11†	1.03	1.20	1.13†	1.04	1.22
CPP present	2.11†	1.96	2.28	2.03†	1.88	2.20
SW past	1.21†	1.12	1.29	1.14†	1.07	1.23
OCSW	2.74†	2.52	2.98	2.65†	2.43	2.88
No current or past SW (ref)	-	-	-	-	-	-
Age (years)				0.95‡	0.95	0.96
Gender						
Female (ref)				-	-	-
Male				1.23†	1.20	1.27
Ethnicity						
White (ref)				-	-	-
Black				1.01§	0.97	1.05
Asian				0.86‡	0.80	0.92
Mixed				0.66‡	0.63	0.70
Other				0.89‡	0.83	0.96
IMD Quintile						
1 (most deprived)				1.91†	1.77	2.05
2				1.41†	1.31	1.51
3				1.04§	0.97	1.13
4				0.96§	0.89	1.04
5 (least deprived) (ref)				-	-	-
Model Performance Metrics						
Adj ICC	0.084			0.076		
AUC	0.615			0.659		
AIC	95829.16			93527.17		

Note. CLA = children looked after by a local authority; CPP = children on a child protection plan; SW past = children with past social work involvement; OCSW = children with other current social work involvement; No SW = children with no social work involvement; OR = odds ratio; LL CI = lower limit of the 95% confidence interval; UL CI = upper limit of the 95% confidence interval; Adj ICC = adjusted intraclass correlation coefficient; AUC = area under the receiver operating characteristic curve; AIC = Akaike information criterion; † = OR significantly greater than 1; ‡ = OR significantly less than 1; § = non-significant odds ratio.

[a]Model 1: Social work status

[b]Model 2: Social work status + sociodemographic variables

Discussion

CYPwSW have been consistently shown to experience higher rates of MH difficulties compared to their peers without social work involvement (Bronsard et al., 2016). This is the largest study to investigate whether CYPwSW have higher or lower odds of accessing MH services following referral compared to peers. One striking finding was that CPP [Children on protection plans] had double the odds [95% CI=1.88, 2.20] of not accessing services compared to non-social work experienced peers. Likewise, young people with other current social work involvement had 2.65 [95%CI=2.43, 2.88] times higher odds of not accessing services compared to non-social work experienced peers.

These disparities resonated with the accounts of experts by experience, who reported that young people with current safeguarding concerns experience challenges accessing MH support. Previous work has found provision of MH services often depends on whether a young person's difficulties are framed as "psychological in origin", leaving those identified as "social in origin" (e.g. bullying or sexual and domestic violence) excluded from MH support (Morgan et al., 2024; 2025). Our consultations with practitioners highlighted that some children would have, on top of environmental circumstances, genetic vulnerabilities to neurodevelopmental and mental health problems that are therefore missed early. The distinction between "social" and "psychological" is both misleading and concerning, as these factors may be difficult to resolve (Briheim-Crookall et al., 2020; Morgan et al., 2025). In fact, experiences such as domestic violence can be potent triggers for mental health conditions. For example, CLA have been found to have 4.92 [95% CI=4.13, 5.85] higher odds of having at least one mental health condition and a 11.76 [95% CI=4.98, 27.76] higher likelihood of post-traumatic stress disorder (Ford et al., 2007).

Consultations with practitioners suggested that this divide between "social work" and "mental health" needs reflects wider service and funding structures. The recent independent review of children's social care in England also emphasises that chronic underfunding of services and siloed working has left families and CYPwSW struggling to have their MH needs met (MacAlister, 2022). Previous research has highlighted constructed divisions between "physical" and "mental" needs as a rationing and exclusion strategy (Beale, 2022). Our consultations suggested that this separation extends to "social" difficulties as well. Experts by experience emphasised that siloed social and MH care systems can leave

CYPwSWs' needs unattended. At the same time, MH practitioners raised the concern that if MH services stepped in, it may mean that social work services would disengage from these families leaving other needs unmet. Future work is needed using linkages with local authority children's social work data to examine this potential multifaceted unmet need of CYPwSW whose difficulties cross service boundaries.

Our practitioner group suggested that young people with current social work concerns can be considered "too unstable" by MH services to be provided therapeutic support. This requirement for stability and safety has been documented in several studies as a condition for accessing MH services (Crenna-Jennings & Hutchinson, 2018, 2020; Morgan et al., 2024, 2025; McGuire et al., 2024). Interview research with clinicians suggests that this is based on the rationale that "family stability" is needed for therapeutic input to be viable, although there was dissensus on what "level of stability" is required (O'Connor et al., 2024). In case notes, the concept of "stability" appeared to be both important and slippery (Morgan et al., 2025). Stability here refers variously to a young person's living situation such as changes or breakdown in placement, legal aspects such as proceedings around custody or domestic abuse, or parental MH. We regard this as an urgent area for further empirical work.

Children with past social work involvement had slightly higher odds of accessing services (OR=1.14 [95% CI=1.07, 1.23]), suggesting that a reduction in assumed safeguarding risks may result in a higher likelihood of accessing support. It is also possible that this association was influenced by the inclusion of adopted children within this group. Practitioner consultations noted that adopters may be more engaged and attend sessions which may contribute to higher rates of service access.

An alternative interpretation is that referral behaviour differed for these groups. Our and other research has found that the likelihood of accessing services can vary depending on referral source (Rengasamy et al., 2024; Hinrichs et al., 2012), and some services may be more common referral pathways for certain conditions (e.g. educational services for neurodevelopmental conditions; Hansen et al., 2021). It might be that different professionals referring, or triggering referrals, for CYPwSW respond to different forms of psychological distress (Coughlan et al., 2024a), or apply different thresholds, compared to professionals referring children/young people without social work involvement. If the latter group's referral

practices are more aligned to the expectations of MH services, this could partly explain the disparity in service access. Further research needs to investigate this possibility.

Notably, CLA had only moderately increased odds of not accessing services (OR=1.13 [95% CI=1.04, 1.22]), which contrasts with previous research reporting substantially higher odds (e.g., Hansen et al., 2021). However, given the markedly high prevalence rates of mental health disorders for CLA our findings still indicate high unmet need (e.g. Ford et al., 2007). Similar to other Trusts nationally, SLaM has dedicated services for CLA which may have increased the likelihood accessing support in this instance (Hiller et al., 2025). This highlights the potential value of dedicated pathways in improving MH service access and raises important equity concerns for other CYPwSW whose needs may remain unmet due to an absence of equivalent support. It is also the possible that dedicated services 'teach' referrers who is more likely to be offered support, leading to successful referrals. Given evidence that CLA may be less likely to be offered certain types of evidence-based therapies (e.g. McGuire et al., 2024), further research is needed to examine the nature and quality of MH support provided. Such work could also inform the development and evaluation of dedicated MH services for children with other forms of social work involvement.

There was some evidence that sociodemographic factors were also associated with the likelihood of accessing services (see Table 3). For example, there was some evidence of a direct association between deprivation and service access. Support for this association can also be found in existing evidence of MH service inequities, including waiting times for deprived communities (The Strategy Unit, 2021; Mahase, 2021). Structural barriers such as transport costs and caregiving burdens may further contribute to inequities in service access (Bidemead et al., 2024). Additionally, our case note analysis suggests "family instability" often encompassed not only social work needs but also economic hardship (Morgan et al., 2025). Further, hypothesis-testing work is required to understand the direct and indirect effects of these sociodemographic characteristics on service access.

In our consultations, MH practitioners lamented barriers that CYPwSW face. We hope that these findings can offer solidarity and bolster practitioners in their conversations with health and social work systems leaders to ensure equitable access to support for CYPwSW. To address inequitable access of MH support, policy changes should focus on providing funding for strained systems. Our findings suggest the following recommendations:

1) One way to redress current inequities is to revise statutory guidelines and legislation. For example, the Independent Review of Social Care (MacAlister, 2022) has advocated that care experience be recognised as a legally protected characteristic. Similarly, Hiller and colleagues (2025) recommended that local authorities should have a statutory responsibility to develop joint service-delivery plans between MH and social work support to ensure access to high-quality MH assessment and support for CLA. We recommend that this legislation should extend to other forms of social work involvement as well.
2) A lack of advocates to navigate complex MH systems has been identified as a key barrier for CYPwSW accessing MH support (Bazalgette et al., 2015). Within clinical case notes, other adults and professionals' perspectives of young people's lives are often given priority (Morgan et al., in press). Experts by experience emphasised that young people should be provided an independent advocate to ensure that they have a voice in the decisions that impact them. They also suggested that an advocate would make young people feel more supported, especially if they were less verbal or less confident. Although some advocacy services for CYPwSW exist, the majority have been identified as targeting or being exclusively available for CLA (Oliver et al., 2006). In line with previous policy recommendations, advocates should truly be independent from local authorities to help navigate complex systems and support access (MacAlister, 2022; Hiller et al., 2025).
3) There is a paucity in research of whether "stability" is necessary for effective support for children and young people. Commissioners should therefore invest in research that examines which therapies are best suited to the needs of young people experiencing social work concerns or other forms of "instability".

Strengths and Limitations

Internationally, this is the largest study to date to look at rates of MH service access for children and young people, which has a focus on CYPwSW. A strength of this study was that it looked at how different types of social work involvement were associated with accessing MH services.

The study also has limitations. While we considered different types of social work involvement, these categories were still not exhaustive and were constricted by the type of

information the service collected. For example, we were unable to explore differences between kinship care or foster placements. Additionally, since only the first episode of care to MH services was used, we could not identify young people with past social work involvement, unless this was identified within risk assessments, and were unable to explore how re-referrals influenced access. Further analysis should examine whether CYPwSW with re-referrals have different likelihoods of accessing MH support.

The study was also undertaken within one MH Trust. While findings were sense checked with an advisory group including practitioners across England, it may still be limited by a geographical focus on South London and could present service structures unique to the Trust. Work is underway to replicate this research in another, more rural Trust.

Furthermore, using EHRs comes with limitations. Information extracted from administrative data may have limited validity and reliability since researchers cannot ensure that clinicians are filling out these forms for the same reasons and the same way consistently (Coughlan et al., 2024a; 2024b; Wickersham et al., 2024). Various factors such as the informant (e.g. relationship to the family), assessor (e.g. professional experience and background), and service contexts (e.g. availability of services and staff resource) could also influence referral outcomes and service access. However, meta-data on this information is unavailable for the service events and contacts that were used as proxies for "accessing services". Additionally, information about the quality of referrals, the reasons given for (no) service access, the clinical complaints of those being referred, or the level of MH difficulties at the point of access are not available in structured data from EHRs. Our interpretation that higher odds of not accessing a service may stem from 1) assumptions about "stability" and 2) division between "mental health" and "social work" needs was informed by the wider literature and by conversations with experts by experience and practitioners, rather than by firm conclusions from complete referral information. Some instances of not accessing a service may be justifiable, as children's needs do not meet service thresholds or have difficulties that are better met elsewhere. Future research should examine the level of MH outcomes during referral, and where children are signposted when services are not accessed.

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Competing Interests

TF's research group receives funds for research methods consultation from Place2Be, a third sector organisation that provides mental health training and interventions in UK schools.

Availability of Data and Materials

Data are owned by a third party, Maudsley Biomedical Research Centre (BRC) Clinical Records Interactive Search (CRIS), which provides access to anonymised data derived from SLaM electronic medical records. These data can only be accessed by permitted individuals from within a secure firewall (i.e. the data cannot be sent elsewhere), in the same manner as the authors. For more information please contact: cris.administrator@slam.nhs.uk.

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