

Mental health contacts and referrals of children and young people in England, 2016–2021: An epidemiological study and comparison of young people who have received protective and care interventions and their peers

Barry Coughlan^{1,2} , Julia Mannes¹, Nicole Marshall¹ , Tessa Morgan¹ ,
Tamsin J. Ford³ , Francesca Crozier-Roche¹, David Graham⁴, Taliah Drayak¹,
Jack Smith¹, Luke Geoghegan⁵, Matt Woolgar⁶ , Rick Hood⁷ & Robbie Duschinsky¹

¹Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK

²School of Business and Social Science, National College of Ireland, Dublin, Ireland

³Department of Psychiatry, University of Cambridge, Cambridge, UK

⁴The Care Leavers Association, Manchester, UK

⁵The British Association of Social Workers, Birmingham, UK

⁶Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

⁷Department of Social Work and Social Care, Kingston University, Surrey, UK

Background: In England, 18% of children and young people (CYP) experience clinical levels of mental health difficulties. CYP who are involved in children's social care, either receiving in-home care (i.e. child protection plans; CPP) or out-of-home care (i.e. children looked after; CLA), may experience higher prevalence than peers. Less is known about actual contacts with mental health services. This study aimed to provide an account of the contacts with mental health services for children with and without CPP and CLA, and reasons for referral. **Methods:** Data were extracted from NHS Digital for all CYP in England in contact (e.g. through referral, appointment, support) with mental health services between April 2016 and March 2021, and included sociodemographic information, CPP or CLA status and referral reason. **Results:** In total, 1,984,827 CYP were in contact with mental health services. The most common referral reasons were anxiety (13%), 'in crisis' (10%) and depression (7%). Contacts tended to increase each year for all groups. Overall, CPP and CLA were between 2 and 3 times more likely to be in contact with mental health services compared to peers. However, this represented between 9% and 18% of CPP and CLA. **Conclusion:** The findings suggest that there are wide discrepancies between mental health needs and contacts with services. CPP and CLA have particularly high levels of unmet need. While these data indicate escalating demand, service contacts have not increased significantly, suggesting an increased threshold for access in a stretched clinical service.

Key Practitioner Message

What is currently known?

Despite having high rates of mental health difficulties, little is known about contacts with services for young people who are involved in social care services, particularly those subject to protective (i.e. in-home care) and care (i.e. out-of-home care) interventions

What has been shown?

Only 9–18% of these young people are in contact with mental health services. Common reasons for referral included anxiety (13%), crisis (10%), depression (7%) and self-harm (6%)

What is the significance of this for clinical practice?

For practitioners and policymakers alike, the finding that mental health needs are high and varied amongst these young people, yet only a portion are in contact with mental health services, may have relevance for the configuration of services

Keywords: Child; adolescent; mental health; social work

Introduction

Approximately 18% of children and young people (CYP)¹ in England have a probable mental health (MH) disorder (Newlove-Delgado et al., 2022). With a third of MH problems starting before 14 years (Solmi et al., 2022), timely contact with MH services for CYP is regarded as a key priority (Deighton et al., 2015). Yet, despite consistent increases in referrals, fewer than half of CYP with a probable MH disorder are referred to MH services (Office of the Children's Commissioner; CC, 2023). The COVID-19 pandemic and the associated public health measures are one factor connected to an upsurge in MH difficulties amongst CYP, with concerns raised about the capacity of existing MH services to respond to this increased need (Ball et al., 2022).

Equitable service provision requires determination of the needs of populations who may be at increased risk of experiencing MH difficulties and service disparities, such as CYP receiving protective or care interventions from children's social care (CSC; Devaney et al., 2023; MacAlister, 2022). The recent landmark review of CSC in England highlighted access to MH services as a particular issue (MacAlister, 2022). Access issues have also been identified by CYP themselves, who have called for further epidemiological research using administrative records (Devaney et al., 2023).

In England, two of the key legislative categories used by CSC are child protection plan (CPP) and child looked after (CLA). Concerns about harm to a child are investigated through a 'Section 47 enquiry', which could lead to a child protection conference. These conferences decide whether a CPP is required to keep a child safe. Children who require out-of-home care are known as children looked after (CLA). Abuse and neglect, common reasons for CYP to become a CPP or CLA (Department for Education; DfE, 2025), are well-known risk factors for later MH difficulties (Sahle et al., 2022).

Data from several sources suggest that CYP with CSC involvement are more likely to experience MH difficulties. For instance, a meta-analysis of international studies reported that 49% of CLA met diagnostic criteria for any MH disorder (Bronsard et al., 2016). These findings are consistent with recent epidemiological work in Australia, which reported that CYP in contact with CSC had nearly three times the odds of having a MH disorder compared to peers (Green et al., 2020). Evidence also suggests that looked-after status is an independent predictor of all self-reported MH difficulties (Ford, Vostanis, Meltzer, & Goodman, 2007).

Although there is strong evidence to suggest that CYP with CSC involvement are more likely to experience MH difficulties, much less is known about their contacts with MH services. In one study, McKenna, O'Reilly, and Maguire (2023) reported that CYP in Northern Ireland who were identified as 'children in need', including those on a CPP and CLA, were considerably more likely to be admitted to a psychiatric hospital and to present to emergency departments with suicide and self-harm.

To our knowledge, no large epidemiological studies in England have addressed the MH contacts and referrals for CYP with different types of CSC involvement using routinely collected administrative data. The current study addresses this gap by attending to the following aims: (1) provide an account of MH contacts and referral reasons for all CYP in England, (2) examine trends over time using administrative data, including pre- and during the COVID-19 pandemic and (3) compare MH contacts and referral reasons for CLA and CPP to peers (i.e. CYP not involved with).

The following research questions guided the analysis:

- 1 What are the characteristics of CYP in England who are in contact with MH services, and for what MH difficulties are they referred?
- 2 Are CPP and CLA more likely to be in contact with MH services compared to peers?
- 3 What are the sociodemographic characteristics of CPP and CLA who are in contact with MH services, and how do these compare to CYP with no CPP/CLA?
- 4 Do CPP and CLA have higher odds of being referred to MH services for certain difficulties compared to other CYP?

Methods

Context

Since 2016, MH services (including community services, child and adolescent mental health services and inpatient units) in England have provided aggregate data to NHS Digital regarding contacts and referrals. These data include sociodemographic characteristics (i.e. gender, ethnicity, age), whether the CYP is a CPP or CLA, and the reason for referral. More information about these data can be found on the Mental Health Services Data Set (MHSDS) website (<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>). We reported our findings in accordance with the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) checklist (see Table S1; von Elm et al., 2007).

Sample

We used count data of CYP in contact with MH services (e.g. including referrals or appointments, assessments) between April 2016 and March 2021, where the CYP was aged between 0 and 18 at the time of referral ($n = 1,984,827$). Data were extracted for six periods: (1) April 2016–March 2021 (aggregate of the entire period); (2) April 2016–March 2017; (3) April 2017–March 2018; (4) April 2018–March 2019; (5) April 2019–March 2020; (6) April 2020–March 2021 (COVID-19).

Data were extracted for each distinct CYP in a given observation period. This means that if a CYP was referred in 2016–2017 and again in 2017–2018, they would appear in both periods. However, this CYP would appear only once in the 2016–2021 aggregate period. Sociodemographic characteristics (i.e. gender, age, ethnicity), referral reasons and CPP/CLA indicators were based on the last available data in a given reporting period.

No young person appeared in more than one gender category, with the total number of young people (1,984,827) matching the total number of young people identified in the gender categories. Only 73 CYP appeared in more than one ethnic category, with the total number of young people, when summed by ethnicity across the different time periods, exceeding the total number of young people (i.e. 1,984,900 vs. 1,984,827). To note, ethnicities

¹Throughout this article the terms child, children and young people, and CYP will be used broadly to describe individuals 18 years and younger. CYP will be used for both children and young people or child or young person.

were grouped according to higher-level categories taken from the 2021 UK census (Office for National Statistics, 2023).

Age was less consistent because some CYP had contact with MH services at different ages. In those cases, CYP appeared in more than one age band ($n = 2,404,750/1,984,827$). Similarly, there were 2,793,079 primary referral reasons (including unknown and not recorded) for 1,984,827 CYP. To note, some of the primary reasons for referral were not available throughout the observation (e.g. codes for suspected and diagnosed autism were introduced in 2018–2019). Further details are available in the MHSDS Technical Output Specification (NHS Digital, 2023).

Governance approvals

This project was approved by the NHS Data Access Request Service (DARS; Approval number: DARS-NIC-440811-F7R7K) on 18 March 2021.

Ethical considerations

Our request did not include participant-level data and, therefore, ethical approval was not required. Still, to safeguard against small cell sizes, we do not present any cell sizes smaller than $n = 10$.

Analysis

To examine whether CPP and CLA were more likely to be in contact with MH services, population estimates were needed for (a) the total number of CPP, (b) the total number of CLA and (c) the total number of CYP aged 18 and under in England. Yearly CPP and CLA figures were obtained from the DfE (2016, 2017a, 2017b, 2022a, 2022b), which is a separate dataset. General population estimates for all CYP were obtained from the ONS (2017, 2018, 2019, 2020, 2021a), which is also a separate dataset. Using these figures, we calculated the percentage of CYP in each group (i.e. CPP, CLA and CYP not CPP/CLA) who had been referred to MH services each year. Then, using odds ratios (ORs), we estimated the association between these groups and referrals to MH services. ORs were calculated using two-by-two tables. As the data were aggregated in Tables, it was not possible to conduct adjusted models.

For the number of CPP and CLA, the DfE provides two main prevalence rates: CPP/CLA at any point in the year and those on a CPP/CLA on 31 March. Because our analysis uses CPP/CLA status from the latest available date in each reporting period (i.e. not at any point in the year), our analysis is based on CPP/CLA figures on 31 March in each period.

Comparisons between the groups are based on children with a documented referral reason. In most years, NHS Digital did not receive a primary referral reason for most children, with missing rates of 66% ($n = 12,546$) for CPP, 74% ($n = 17,481$) for CLA, and 67% ($n = 1,304,451$) for CYP not CPP/CLA. As these data were effectively missing, we excluded these counts.

Experts-by-experience

This work is co-produced and co-authored with experts-by-experience (i.e. adults with lived experience of CSC in England). These colleagues were recruited through existing links with partners, including the Care Leaver's Association. They were involved in the conceptualisation of the study, interpretation of the findings and writing up the manuscript. Their contributions included focusing attention on young people who are subject to protective interventions and support with interpretation around the potential role of demographic characteristics such as age.

Results

Overview

Between April 2016 and March 2021, 1,984,827 CYP in England had at least one contact with MH services, of whom 18,984 (1%) were CPP, and 23,583 (1.2%) were

CLA. Analyses using CPP/CLA figures at any point in the year are presented in Tables 1 and 2.

Across the dataset, 974,132 (49%) CYP were identified as female, 959,504 (48%) as male, 9176 (0.5%) as other and 42,015 (2%) were unknown. CYP appeared in 1.2 different age categories on average. The age breakdown for contact with services was as follows: 757,783 (38%) between 0–10, 719,669 (36%) between 11 and 14, 483,990 (24%) between 15 and 16, 242,851 (12%) at 17 and 200,457 (10%) at 18 years. Concerning ethnicity, 1,155,702 (58%) were identified as white, 79,970 (4%) as mixed race, 81,577 (4%) as Asian, 59,520 (3%) as black, 40,754 (2%) as other and 567,377 (29%) as unknown. Sociodemographic characteristics for each group (i.e. CPP, CLA and CYP not CPP/CLA) and group comparisons are presented in Table 3.

CYP had an average of 1.4 referral reasons. Over two-thirds of CYP ($n = 1,337,023$; 67%) had a referral where a primary referral reason was not provided to NHS Digital. Of those instances where a referral reason was provided, the most common reasons were: anxiety ($n = 264,270$; 13%), in crisis ($n = 204,955$; 10%), depression ($n = 136,779$; 7%), neurodevelopmental conditions, excluding autism ($n = 116,181$; 6%), self-harm ($n = 112,025$; 6%) and conduct disorder ($n = 99,667$; 5%). Referral reasons and group comparisons are presented in Table 4.

Comparing contact rates of CPP and CLA with CYP, not CPP/CLA

Compared to CYP, not CPP/CLA, CPP had consistently higher odds of contact with services, with ORs ranging between 2.42 [2.35, 2.48] and 3.21 [3.13, 3.29] during the period. Similarly, compared to CYP, not CPP/CLA, CLA also had higher odds of contact with services, with ORs ranging between 1.46 [1.42, 1.50] and 2.75 [2.70, 2.81]. See Table S2 for further details. Even when using figures for the entire year (all CPP and CLA), which may yield a low estimate, CPP and CLA still tended to have higher odds for MH contacts (see Tables 1 and 2).

Contacts pre-pandemic and during the COVID-19 pandemic

For CPP and CLA, the odds of being in contact with MH services were higher in 2020–2021 (i.e. during the pandemic) than in 2019–2020 (i.e. pre-pandemic), with ORs of 1.09 [1.06, 1.13] and 1.10 [1.07, 1.13] respectively. This trend was not identified for CYP with no CPP/CLA (OR = 1.00 [1.00, 1.01]). However, stronger differences were observed between other periods. For instance, comparing the pre-pandemic years of 2018–2019 with 2019–2020, although the contact rates were lower for CLA (OR = 0.95 [0.93, 0.98]), the odds of contact with services for CPP were higher than during the pandemic (OR = 1.26 [1.22, 1.30]).

Year-by-year analyses of referral reasons

Further perspective on referral patterns can be gained through year-to-year analyses, as seen in Tables 5 and 6. For instance, although analysis of the aggregate data suggests that CPP and CLA were more likely to be referred for anxiety overall (i.e. between 2016 and 2021), Tables 5 and 6 show that this was only the case in 2016–2017. In fact, in all other periods, CPP and CLA

Table 1. Comparison of contacts for children on a child protection plan at any point in the year with peers who were not subject to protective or care interventions

Period	CPP			No CPP/CLA			CPP vs. No CPP/CLA	
	Contacts (n)	Total	%	Contacts (n)	Total	%	OR	95% CI
2016–2017	5929	116,500	5.09	645,056	12,202,485	5.29	0.96	0.94, 0.99
2017–2018	7230	119,720	6.04	605,991	12,273,890	4.94	1.24	1.21, 1.27
2018–2019	7778	120,190	6.47	716,038	12,345,924	5.80	1.12	1.10, 1.15
2019–2020	9176	118,480	7.74	852,328	12,406,931	6.87	1.14	1.11, 1.16
2020–2021	9731	115,210	8.45	860,141	12,470,789	6.90	1.25	1.22, 1.27

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children with a child protection plan; No CPP/CLA, children and young people who were identified as not being subject to protective or care interventions; OR, odds ratios.

Table 2. Comparison of contacts for children looked after at any point in the year with peers who were not subject to protective or care interventions

Period	CLA			No CPP/CLA			CLA vs. no CPP/CLA	
	Contacts (n)	Total	%	Contacts (n)	Total	%	OR	95% CI
2016–2017	5457	115,210	4.74	645,056	12,203,775	5.29	0.89	0.87, 0.92
2017–2018	7440	118,480	6.28	605,991	12,275,130	4.94	1.29	1.26, 1.32
2018–2019	11,329	118,740	9.54	716,038	12,347,374	5.80	1.71	1.68, 1.75
2019–2020	11,149	117,030	9.53	852,328	12,408,381	6.87	1.43	1.40, 1.46
2020–2021	12,180	113,900	10.69	860,141	12,472,099	6.90	1.62	1.59, 1.65

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children with a child protection plan; No CPP/CLA, children and young people who were identified as not being subject to protective or care interventions; OR, odds ratios.

Table 3. Sociodemographic characteristics for mental health contacts 2016–2021

	CPP		CLA		No CPP/CLA		CPP vs. no CPP/CLA		CLA vs. no CPP/CLA	
	n	%	n	%	n	%	OR	95% CI	OR	95% CI
Gender										
Male	9654	50.85	12,427	52.69	936,134	48.29	1.11	1.08, 1.14	1.19	1.16, 1.22
Female	8892	46.84	11,059	46.89	951,814	49.10	0.91	0.89, 0.94	0.92	0.89, 0.94
Other	29	0.15	53	0.22	9073	0.47	0.33	0.23, 0.47	0.48	0.37, 0.63
Unknown	409	2.15	44	0.19	41,522	2.14	1.01	0.91, 1.11	0.09	0.06, 0.11
Age										
0–10 years	8774	46.22	10,077	42.73	738,212	38.08	1.40	1.36, 1.44	1.21	1.18, 1.25
11–14 years	9313	49.06	11,808	50.07	696,757	35.94	1.72	1.67, 1.77	1.79	1.74, 1.83
15–16 years	5416	28.53	8281	35.11	469,043	24.20	1.25	1.21, 1.29	1.70	1.65, 1.74
17 years	2078	10.95	4166	17.67	236,085	12.18	0.89	0.85, 0.93	1.55	1.50, 1.60
18 years	1178	6.21	2465	10.45	196,485	10.14	0.59	0.55, 0.62	1.03	0.99, 1.08
Ethnicity										
White	13,327	70.20	16,285	69.05	1,123,817	57.97	1.71	1.66, 1.76	1.62	1.57, 1.66
Mixed	1269	6.68	1265	5.36	77,260	3.99	1.73	1.63, 1.83	1.37	1.29, 1.45
Asian	526	2.77	681	2.89	80,245	4.14	0.66	0.60, 0.72	0.69	0.64, 0.74
Black	893	4.70	775	3.29	57,755	2.98	1.61	1.50, 1.72	1.11	1.03, 1.19
Other ethnic group	292	1.54	463	1.96	39,929	2.06	0.74	0.66, 0.83	0.95	0.87, 1.04
Unknown	2678	14.11	4115	17.45	559,607	28.87	0.40	0.39, 0.42	0.52	0.50, 0.54

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children who are receiving a child protection plan; No CPP/CLA, children and young people who were not identified as not being subject to protective or care interventions; OR, odds ratio.

were less likely to be referred for anxiety. Similarly, although the odds of having a referral for attachment difficulties were increased for CPP and CLA overall, these odds tended to be considerably higher when examined on a year-by-year basis. For full details, see Tables S3–S12.

Discussion

We aimed to describe MH contacts and referral reasons for CYP in England between 2016 and 2021. A key finding from this study was that CPP and CLA were about two to three times more likely to be in contact with MH

Table 4. Referral reasons 2016–2021

	CPP		CLA		No CPP/CLA		CPP vs. no CPP/CLA		CLA vs. no CPP/CLA	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	OR	95% CI	OR	95% CI
(Suspected) First episode psychosis	303	1.60	484	2.05	24,000	1.24	1.29	1.15, 1.45	1.67	1.53, 1.83
Ongoing or recurrent psychosis	63	0.33	137	0.58	5471	0.28	1.18	0.92, 1.51	2.06	1.74, 2.45
Bipolar disorder	21	0.11	35	0.15	1457	0.08	1.47	0.96, 2.27	1.98	1.41, 2.76
Depression	2048	10.79	2202	9.34	131,982	6.81	1.66	1.58, 1.73	1.41	1.35, 1.47
Anxiety	2818	14.84	3385	14.35	256,991	13.26	1.14	1.10, 1.19	1.10	1.06, 1.14
Obsessive-compulsive disorder	84	0.44	65	0.28	10,142	0.52	0.85	0.68, 1.05	0.53	0.41, 0.67
Phobias	20	0.11	18	0.08	2181	0.11	0.94	0.60, 1.45	0.68	0.43, 1.08
Organic brain disorder	28	0.15	34	0.14	1341	0.07	2.13	1.47, 3.10	2.09	1.48, 2.93
Drug and alcohol difficulties	170	0.90	238	1.01	5461	0.28	3.20	2.74, 3.73	3.61	3.17, 4.11
Unexplained physical symptoms	106	0.56	628	2.66	18,765	0.97	0.57	0.47, 0.70	2.80	2.58, 3.03
Post-traumatic stress disorder	1011	5.33	1674	7.10	15,093	0.78	7.17	6.72, 7.65	9.74	9.24, 10.26
Eating disorders	440	2.32	396	1.68	48,087	2.48	0.93	0.85, 1.03	0.67	0.61, 0.74
Perinatal mental health issues	163	0.86	168	0.71	5345	0.28	3.13	2.68, 3.66	2.60	2.22, 3.03
Personality disorders	492	2.59	489	2.07	12,922	0.67	3.96	3.62, 4.34	3.16	2.88, 3.46
Self-harm behaviours	2525	13.30	3099	13.14	106,084	5.47	2.65	2.54, 2.76	2.61	2.52, 2.72
Conduct disorders	2661	14.02	3357	14.23	93,569	4.83	3.21	3.08, 3.35	3.27	3.15, 3.40
Neurodevelopmental conditions	518	2.73	772	3.27	38,637	1.99	1.38	1.26, 1.51	1.66	1.55, 1.79
In crisis	3073	16.19	3606	15.29	197,873	10.21	1.70	1.63, 1.77	1.59	1.53, 1.65
Relationship difficulties	1090	5.74	1140	4.83	32,092	1.66	3.62	3.40, 3.85	3.02	2.84, 3.21
Gender discomfort issues	102	0.54	131	0.56	17,190	0.89	0.60	0.50, 0.73	0.62	0.53, 0.74
Attachment difficulties	933	4.91	3031	12.85	16,032	0.83	6.20	5.79, 6.63	17.69	16.97, 18.43
Self-care issues	219	1.15	350	1.48	15,835	0.82	1.42	1.24, 1.62	1.83	1.64, 2.04
Adjustment to health issues	419	2.21	1087	4.61	85,435	4.41	0.49	0.44, 0.54	1.05	0.99, 1.11
Neurodevelopmental conditions, excluding autism	1453	7.65	1901	8.06	112,839	5.82	1.34	1.27, 1.42	1.42	1.35, 1.49
Suspected autism	874	4.60	748	3.17	86,652	4.47	1.03	0.96, 1.10	0.70	0.65, 0.75
Diagnosed autism	339	1.79	322	1.37	27,166	1.40	1.28	1.15, 1.43	0.97	0.87, 1.09
Preconception perinatal mental health concern	–	–	–	–	81	0.00	–	–	–	–
Gambling disorder	26	0.14	175	0.74	13,589	0.70	0.19	0.13, 0.29	1.06	0.91, 1.23
Community perinatal mental health	–	–	–	–	–	–	–	–	–	–
Partner assessment	–	–	–	–	–	–	–	–	–	–
Behaviours that challenge due to a learning disability	–	–	–	–	–	–	–	–	–	–
Unknown	36	0.19	68	0.29	19,073	0.98	0.19	0.14, 0.27	0.29	0.23, 0.37
Not recorded	12,546	66.09	17,481	74.13	1,304,451	67.29	0.95	0.92, 0.98	1.39	1.35, 1.43

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children who are receiving a child protection plan; No CPP/CLA, children and young people who were not identified as not being subject to protective or care interventions; OR, odds ratios.

services compared to peers. These findings are broadly consistent with epidemiological work in other contexts, such as Northern Ireland and Denmark (e.g. Hansen, Christoffersen, Tell  s, & Lauritsen, 2021; McKenna et al., 2023). Still, the results also indicate that, in a given year, fewer than 20% of CPP and CLA are in contact with MH services. This is despite the fact that data from the DfE in England (2022a, 2022b) and international meta-analytic work (Bronsard et al., 2016) suggest

that up to half of these CYP experience MH difficulties in the clinical range. It follows, therefore, that a sizeable number of CPP and CLA with MH difficulties have not even had one contact with MH services.

Furthermore, the recent CC report (2023) suggests that 32% of CYP who are referred to MH services never receive treatment. The current study is not methodologically positioned to identify multiple contacts and treatment activity. However, recent qualitative work

Table 5. Year-by-year comparisons of referral reasons for CPP and No CPP/CLA

Reason	CPP vs. no CPP/CLA									
	2016–2017		2017–2018		2018–2019		2019–2020		2020–2021	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
(Suspected) First episode psychosis	0.80	0.59, 1.10	0.92	0.74, 1.15	0.89	0.71, 1.12	1.27	1.05, 1.53	1.37	1.14, 1.64
Ongoing or Recurrent psychosis	3.00	1.85, 4.87	1.14	0.72, 1.79	0.71	0.43, 1.16	0.70	0.43, 1.15	0.92	0.63, 1.36
Bipolar disorder	–	–	–	–	–	–	–	–	–	–
Depression	1.71	1.51, 1.94	0.90	0.81, 1.01	1.22	1.12, 1.34	1.46	1.36, 1.58	1.63	1.53, 1.75
Anxiety	2.86	2.62, 3.13	0.89	0.81, 0.97	0.74	0.68, 0.81	0.85	0.80, 0.91	0.9	0.85, 0.96
Obsessive-compulsive disorder	3.04	2.10, 4.40	1.27	0.90, 1.79	0.86	0.60, 1.25	0.65	0.45, 0.93	0.66	0.48, 0.91
Phobias	–	–	–	–	–	–	–	–	1.09	0.59, 2.04
Organic brain disorder	–	–	2.05	1.09, 3.84	1.88	1.00, 3.52	1.87	1.00, 3.50	–	–
Drug and alcohol difficulties	–	–	2.11	1.41, 3.17	1.58	1.05, 2.39	3.26	2.54, 4.19	2.67	2.05, 3.48
Unexplained physical symptoms	–	–	0.13	0.08, 0.22	0.21	0.13, 0.32	0.49	0.35, 0.69	0.36	0.26, 0.51
Post-traumatic stress disorder	–	–	4.39	3.72, 5.17	6.79	6.01, 7.67	6.45	5.83, 7.13	7.37	6.74, 8.06
Eating disorders	1.33	1.04, 1.69	0.75	0.61, 0.92	0.69	0.57, 0.83	0.71	0.60, 0.84	0.65	0.56, 0.75
Perinatal mental health issues	–	–	0.92	0.52, 1.63	1.29	0.81, 2.06	2.2	1.63, 2.98	3.43	2.74, 4.29
Personality disorders	0.24	0.14, 0.40	0.32	0.22, 0.48	1.33	0.97, 1.81	2.58	2.09, 3.18	1.83	1.40, 2.38
Self-harm behaviours	3.42	3.07, 3.81	2.16	1.98, 2.35	2.31	2.14, 2.50	2.35	2.20, 2.52	2.23	2.09, 2.38
Conduct disorders	3.51	3.16, 3.89	1.87	1.71, 2.06	2.16	1.98, 2.35	2.76	2.59, 2.95	3.50	3.30, 3.72
Neurodevelopmental conditions	2.25	2.01, 2.52	1.12	1.01, 1.23	0.31	0.24, 0.41	0.65	0.48, 0.87	–	–
In crisis	2.54	2.35, 2.74	1.93	1.79, 2.07	0.67	0.61, 0.74	0.89	0.83, 0.96	1.10	1.03, 1.17
Relationship difficulties	2.98	2.36, 3.76	1.95	1.59, 2.38	1.78	1.52, 2.09	3.09	2.80, 3.40	3.88	3.56, 4.21
Gender discomfort issues	0.74	0.49, 1.12	0.64	0.46, 0.89	0.41	0.30, 0.56	0.28	0.20, 0.39	0.43	0.34, 0.55
Attachment difficulties	6.18	4.97, 7.68	4.06	3.47, 4.76	4.19	3.62, 4.86	4.79	4.32, 5.31	5.64	5.11, 6.22
Self-care issues	–	–	0.65	0.36, 1.17	1.06	0.77, 1.46	0.67	0.53, 0.85	1.50	1.25, 1.80
Adjustment to health issues	0.14	0.08, 0.24	0.08	0.05, 0.13	0.13	0.09, 0.18	0.38	0.33, 0.44	0.47	0.41, 0.53
Neurodevelopmental conditions, excluding autism	–	–	–	–	1.09	0.98, 1.22	0.73	0.67, 0.80	1.07	1.00, 1.14
Suspected autism	–	–	–	–	0.37	0.30, 0.46	0.97	0.88, 1.07	0.61	0.56, 0.67
Diagnosed autism	–	–	–	–	0.21	0.12, 0.36	1.17	1.02, 1.34	1.00	0.88, 1.14
Preconception perinatal mental health concern	–	–	–	–	–	–	–	–	–	–
Gambling disorder	–	–	–	–	–	–	–	–	–	–
Community perinatal mental health	–	–	–	–	–	–	–	–	–	–
Partner assessment	–	–	–	–	–	–	–	–	–	–
Behaviours that challenge due to a learning disability	–	–	–	–	–	–	–	–	–	–
Unknown	0.10	0.06, 0.18	0.10	0.06, 0.16	–	–	–	–	–	–
Not recorded	0.41	0.39, 0.43	0.93	0.88, 0.98	1.48	1.41, 1.56	1.12	1.07, 1.16	0.81	0.78, 0.85

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children who are receiving a child protection plan; No CPP/CLA, children who were not subject to protective or care interventions; OR, odds ratio.

with clinical psychologists (O'Connor, Wilson, Coughlan, Duschinsky, & Foster, 2024) identified that MH services are sometimes hesitant to accept referrals for children with CSC involvement, in part due to resource limitations and pressures on services. Therefore, CSC services and families may be bearing the

brunt of shortcomings in MH provision for CPP and CLA. The findings from the current study add further empirical weight to the call from CYP (Devaney et al., 2023) and policymakers (CC, 2023; MacAlister, 2022) who have identified access to MH services as an important issue for CSC.

Table 6. Year-by-year comparisons of referral reasons for CLA and no CPP/CLA

Reason	CLA vs. No CPP/CLA									
	2016–2017		2017–2018		2018–2019		2019–2020		2020–2021	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
(Suspected) First episode psychosis	1.56	1.23, 1.98	1.13	0.93, 1.37	0.97	0.81, 1.17	1.18	0.98, 1.41	1.59	1.36, 1.85
Ongoing or recurrent psychosis	–	–	1.99	1.41, 2.79	0.94	0.66, 1.35	1.09	0.76, 1.56	1.68	1.29, 2.17
Bipolar disorder	–	–	–	–	–	–	–	–	1.47	0.83, 2.60
Depression	1.48	1.29, 1.70	0.91	0.81, 1.01	0.95	0.87, 1.03	1.03	0.96, 1.12	1.10	1.02, 1.18
Anxiety	2.07	1.86, 2.31	0.75	0.68, 0.82	0.72	0.67, 0.77	0.67	0.63, 0.72	0.88	0.83, 0.93
Obsessive-compulsive disorder	–	–	–	–	0.47	0.31, 0.71	0.34	0.22, 0.53	0.43	0.31, 0.61
Phobias	–	–	–	–	–	–	–	–	–	–
Organic brain disorder	–	–	2.79	1.64, 4.76	2.45	1.55, 3.88	–	–	1.66	0.93, 2.94
Drug and alcohol difficulties	3.62	2.23, 5.86	2.66	1.86, 3.80	2.51	1.91, 3.31	3.23	2.57, 4.06	2.96	2.36, 3.71
Unexplained physical symptoms	1.83	0.98, 3.43	4.68	4.24, 5.16	3.30	3.00, 3.64	1.62	1.36, 1.93	1.26	1.07, 1.49
Post-traumatic stress disorder	10.03	8.03, 12.53	9.24	8.22, 10.38	8.30	7.55, 9.12	8.19	7.53, 8.90	9.39	8.72, 10.1
Eating disorders	0.72	0.51, 1.01	0.56	0.44, 0.70	0.51	0.43, 0.61	0.44	0.36, 0.53	0.39	0.33, 0.46
Perinatal mental health issues	–	–	1.27	0.79, 2.05	1.67	1.19, 2.35	2.15	1.63, 2.84	2.39	1.88, 3.04
Personality disorders	0.96	0.73, 1.25	1.04	0.83, 1.29	2.33	1.91, 2.84	1.63	1.28, 2.06	2.67	2.19, 3.25
Self-harm behaviours	4.19	3.78, 4.64	2.16	1.98, 2.36	1.93	1.80, 2.07	2.12	1.99, 2.26	2.12	2.00, 2.25
Conduct disorders	3.33	2.98, 3.72	2.20	2.02, 2.40	2.34	2.18, 2.50	2.38	2.24, 2.54	3.08	2.91, 3.25
Neurodevelopmental conditions	1.59	1.39, 1.82	0.99	0.90, 1.10	0.68	0.59, 0.79	0.81	0.64, 1.03	1.39	1.10, 1.74
In crisis	1.23	1.10, 1.37	1.14	1.04, 1.25	0.86	0.81, 0.93	1.10	1.03, 1.17	1.41	1.33, 1.48
Relationship difficulties	3.42	2.72, 4.29	2.04	1.69, 2.48	1.72	1.50, 1.96	2.12	1.91, 2.36	2.65	2.43, 2.90
Gender discomfort issues	0.66	0.42, 1.04	0.83	0.62, 1.11	0.31	0.23, 0.42	0.31	0.23, 0.41	0.41	0.33, 0.52
Attachment difficulties	42.62	38.4, 47.29	17.09	15.68, 18.62	14.03	13.01, 15.13	11.65	10.9, 12.45	13.29	12.47, 14.16
Self-care issues	3.63	1.93, 6.82	1.26	0.82, 1.92	1.29	1.02, 1.64	1.21	1.03, 1.43	1.76	1.51, 2.05
Adjustment to health issues	2.56	2.24, 2.93	0.83	0.72, 0.97	0.63	0.56, 0.71	0.78	0.71, 0.86	0.95	0.87, 1.04
Neurodevelopmental conditions, excluding autism	–	–	1.51	1.01, 2.26	0.99	0.90, 1.09	0.97	0.91, 1.04	1.03	0.97, 1.09
Suspected autism	–	–	–	–	0.35	0.30, 0.42	0.57	0.51, 0.63	0.44	0.40, 0.48
Diagnosed autism	–	–	–	–	0.41	0.30, 0.57	0.56	0.47, 0.67	0.81	0.71, 0.92
Preconception perinatal mental health concern	–	–	–	–	–	–	–	–	–	–
Gambling disorder	–	–	–	–	0.50	0.40, 0.61	0.20	0.14, 0.29	6.11	3.54, 10.55
Community perinatal mental health partner assessment	–	–	–	–	–	–	–	–	–	–
Behaviours that challenge due to a learning disability	–	–	–	–	–	–	–	–	–	–
Unknown	0.14	0.08, 0.24	0.21	0.15, 0.29	–	–	–	–	–	–
Not recorded	0.64	0.60, 0.68	0.95	0.90, 1.00	1.40	1.35, 1.46	1.33	1.28, 1.39	0.98	0.94, 1.01

ORs in bold are significant ($p < .05$). CI, confidence interval; CLA, children who are looked after; CPP, children who are receiving a child protection plan; No CPP/CLA, children who were not subject to protective or care interventions; OR = odds ratio.

Another noteworthy finding was the plateauing of contacts for CPP when they reached 17 and 18 years. Notably, it is at this time that the incidence of common MH difficulties increases worldwide (Solmi et al., 2022). Experts-by-experience collaborators highlighted concerns about the winding down of services for CPP aged

17/18. In particular, experts-by-experience questioned whether the levelling off of contacts with services was related to a lack of advocacy for these CYP. They also suggested that CPP or CLA may be reluctant to engage with MH services, but may only have these wishes respected after the age of 16. A further possibility is that

referrers tend to refer to adult MH services in anticipation of long waiting lists. We are not aware of any empirical studies on this issue for CPP specifically. This is a consequential gap and requires more robust evidence than is currently available.

There was some evidence of potential disparities. For instance, the proportion of CYP identified as Asian and Black in contact with MH services is somewhat lower than might be expected based on population estimates (ONS, 2021b, 2023). These findings align with recent work in England and the United States, highlighting inequalities in access to MH services for ethnic minorities (Barnardos, 2023; National Collaborating Centre for Mental Health, 2023; Rodgers, Flores, Bassey, Augenblick, & Cook, 2022). Rationing strategies during periods of scarce resources may disproportionately affect some groups more than others. This highlights the need for innovative approaches to configuring services to ease demands and address unmet needs (e.g. Abel et al., 2021; Wolpert et al., 2019).

CPP and CLA contacts

Pre-pandemic and during the COVID-19 pandemic. There was some evidence that CPP and CLA were more likely to be in contact with MH services in 2020–2021 in comparison to the previous period (2019–2020). This may suggest that the impact of COVID-19 and the associated public health measures was felt more sharply by CPP and CLA. Caution is required, however, because stronger associations were observed during other periods. Year-on-year comparisons may be volatile, and our reporting period only runs until April 2021. Further work using time-series analysis examining the pre- and post-pandemic period (2022–present) would yield valuable insights into these trends.

Referral reasons. The patterns of referral reasons identified in this study are broadly in line with findings from international meta-analytic and epidemiological work (e.g. Bronsard et al., 2016; Green et al., 2020), especially concerning anxiety, depression and conduct problems. Findings regarding referral rates for attachment difficulties are also in line with observations by Woolgar and Baldock (2015), in that CPP and especially CLA were considerably more likely to be referred to MH services for ‘attachment difficulties’. As various commentators have noted (Duschinsky et al., 2021), attachment concepts are used in different ways by MH and CSC communities. Therefore, it would be useful for further work to explore how many CYP consequently receive an attachment-related conceptualisation. Relatedly, further epidemiological work is required to establish the prevalence and typology of ‘attachment difficulties’ in CYP involved with CSC.

Consistent with international epidemiological work (e.g. McKenna et al., 2023; Vinnerljung, Hjern, & Lindblad, 2006), our findings suggest that CPP and CLA are more likely to present to services for issues relating to self-harm than peers. Theoretically, CPP and CLA experience higher levels of MH difficulties and suicidal distress (e.g. suicidal ideation, self-harm, attempted suicide) specifically due to experiences of adversity (e.g. Green et al., 2020; McKenna et al., 2023). However, experts-by-experience also emphasised that self-harm, particularly in the context of residential care, can have a

range of different causes. Qualitative work on this topic is strongly lacking. Therefore, further qualitative work is underway exploring self-harm and suicidal ideation in adults with a history of CSC services.

Strengths and limitations

A strength of this epidemiological study is that it includes the population of children in contact with MH services in England between 2016 and 2021. Still, the findings from this paper should be interpreted in the context of several limitations. First, given the nature of the data (i.e. large administrative data, completed by a high number of people without a tight protocol), we lack information about the context for contacts or referral decisions. Referrer characteristics likely contribute to the way a child’s difficulties are conceptualised. Second, we do not know how CAMHS responded to the referral, and we are making no claims about the validity of the referral reasons. Third, regarding referral reasons, a strong note of caution is due because in two-thirds of cases, a referral reason was missing, and, given the structure of the data, it was not possible to assess whether patterns of missingness were random. It may be the case, for instance, that some groups of young people or young people attending certain services are less likely to have a referral reason reported (see Shoari et al., 2025). To facilitate future epidemiological studies, it would be beneficial for data holders to require certain information to be provided (e.g. as a required field), including referral reasons and diagnoses. Fourth, data were not available for CYP described as children in need (CIN) by CSC. This means that some CYP in the no CPP/CLA category might have been CIN. The group with no CPP or CLA might have a higher level of need than it would if CIN were excluded. Fifth, data were provided in an aggregated form, and thus it was not possible to adjust the ORs to account for potentially relevant sociodemographic factors. Relatedly, because of the data structure, our analysis could not account for issues arising from multiple comparison testing. A further limitation is the lack of information regarding economic disadvantage. Data from epidemiological work in Scotland have identified socio-economic gradients regarding referrals, with only a minority of referrals for CYP from the most deprived areas (Ball et al., 2022). Further work examining the contribution of economic disadvantage to service contact seems necessary to achieve the aim of providing fair and equitable services as outlined in the NHS constitution (Department of Health and Social Care, 2023). Sixth, the study uses three distinct data sets: MHSDS, DfE, and Census data. For further validation, a data linkage between these sources would be useful, in particular to assess alignment between CPP and CLA in DfE data and MHSDS. Further, the number of mental health services providing data has increased considerably since 2016, from 96 to over 400 by 2023 (Shoari et al., 2025). It is not clear whether these reporting practices impacted the number of CPPs and CLAs. Nevertheless, contacts and referrals broken down by year are presented in Table S2. Finally, we extracted data for each year to support comparisons with CPP and CLA data from the Department for Education. However, we acknowledge that this approach does not account for possible seasonal variations. Further work exploring more granular variation in contacts and referrals would be useful.

Conclusions

Since 2016, there has been a fairly consistent rise in the demand for MH services in England, yet many CYP who are experiencing MH difficulties will not come to the attention of services. Whilst CPP and CLA are more likely to be in contact with services than their peers, fewer than 20% of CPP and CLA are in contact with services, signalling a high level of unmet MH needs. However, research into referral practices is strongly constrained by poor data recording practices, an issue that requires urgent attention.

Acknowledgements

B.C. had access to and analysed the original data and confirms responsibility for the integrity and accuracy of the analysis. All authors contributed to and share responsibility for the final version of the submitted article. The authors extend their warmest thanks to Prof Paul Bywaters, Prof Andy Bilson and Prof Marinus van IJzendoorn for their valuable reflections on the study design and analysis.

Conflict of interest statement

T.F. is paid for research advice to Place2Be, a third sector organisation that provides mental health information, training and interventions in schools. All other authors are declaring no conflicts. The remaining authors have declared that they have no competing or potential conflicts of interest.

Funding information

This work was supported by Wellcome Trust (218025/A/19/Z) and the British Academy. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. For the purpose of open access, the author has applied a CC BY public copyright licence to any Author Accepted Manuscript version arising from this submission.

Ethical Considerations

This project was approved by the NHS Data Access Request Service (DARS; Approval number: DARS-NIC-440811-F7R7K) on 18 March 2021. Data were provided by the DARS team on 12 April 2022. The authors' request did not include participant-level data and, therefore, ethical approval was not required. Still, to safeguard against small cell sizes, the authors do not present any cell sizes smaller than $n = 10$.

Data availability statement

The data are not publicly available due to privacy or ethical restrictions. The data that support the findings of this study can be requested from NHS Digital through the NHS Data Access Request Service.

Correspondence

Robbie Duschinsky, Department of Public Health & Primary Care, Forvie Site, Cambridge Biomedical Campus, Cambridge CB2 0SR, UK; Email: rd522@medschl.cam.ac.uk

Supporting information

Additional Supporting Information may be found in the online version of this article:

Table S1. STROBE Statement—checklist of items that should be included in reports of observational studies.

Table S2. Mental health contacts and comparisons.

Table S3. Sociodemographic characteristics for mental health contacts 2016–2017.

Table S4. Sociodemographic characteristics for mental health contacts 2017–2018.

Table S5. Sociodemographic characteristics for mental health contacts 2018–2019.

Table S6. Sociodemographic characteristics for mental health contacts 2019–2020.

Table S7. Sociodemographic characteristics for mental health contacts 2020–2021 (COVID-19).

Table S8. Referral reasons 2016–2017.

Table S9. Referral reasons 2017–2018.

Table S10. Referral reasons 2018–2019.

Table S11. Referral reasons 2019–2020.

Table S12. Referral reasons 2020–21 (COVID-19).

References

- Abel, K., Whelan, P., Edbrooke-Childs, J., Elvins, R., Guttridge, K., Green, R., ... & Bernard, Z. (2021). *Enhancing CAMHS referrals (En-CAMHS) protocol*. Greater Manchester Mental Health NHS Foundation Trust. Available from: <https://njl-admin.nihr.ac.uk/document/download/2038232> [last accessed 18 October 2023].
- Ball, W.P., Black, C., Gordon, S., Ostrovska, B., Paranjothy, S., Rasalam, A., ... & Butler, J.E. (2022). Inequalities in children's mental health care: Analysis of routinely collected data on prescribing and referrals to secondary care. *BMC Psychiatry*, 23, 22.
- Barnardos. (2023). *Double discrimination: Black care-experienced young adults navigating the criminal justice system*. Available from: <https://www.nhs.uk/wp-content/uploads/2023/10/Ethnic-Inequalities-in-Improving-Access-to-Psychological-Therapies-IAPT-Appendices.pdf> [last accessed 28 February 2024].
- Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system: A systematic review and meta-analysis. *Medicine*, 95, e2622.
- Deighton, J., Argent, R., De Francesco, D., Edbrooke-Childs, J., Jacob, J., Fleming, I., ... & Wolpert, M. (2015). Associations between evidence-based practice and mental health outcomes in child and adolescent mental health services. *Clinical Child Psychology and Psychiatry*, 21, 287–296.
- Department for Education. (2016). *Characteristics of children in need: 2015 to 2016*. HM Government. Available from: <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016> [last accessed 24 October 2023].
- Department for Education. (2017a). *Characteristics of children in need: 2016 to 2017*. HM Government. Available from: <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2016-to-2017a> [last accessed 24 October 2023].
- Department for Education. (2017b). *Children looked after in England including adoption: 2016 to 2017*. HM Government. Available from: <https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2016-to-2017b> [last accessed 24 October 2023].
- Department for Education. (2022a). *Characteristics of children in need*. HM Government. Available from: <https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need> [last accessed 18 October 2023].

- Department for Education. (2022b). *Children looked after in England including adoptions*. HM Government. Available from: <https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions> [last accessed 18 October 2023]
- Department for Education. (2025). Characteristics of children in need. HM Government. Available from: <https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2025#9dc9-child-protection-plans-at-31-march-by-initial-category-of-abuse> [last accessed 23 July 2026].
- Department of Health and Social Care. (2023). *NHS constitution for England*. HM Government. Available from: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england> [last accessed 26 October 2023].
- Devaney, J., Power, L., Jacobs, P., Davidson, G., Hiller, R., Martin, J., ... & Thapar, A. (2023). An agenda for future research regarding the mental health of young people with care experience. *Child & Family Social Work*, 28, 960–970.
- Duschinsky, R., Bakkum, L., Mannes, J.M.M., Skinner, G.C.M., Turner, M., Mann, A., ... & Beckwith, H. (2021). Six attachment discourses: Convergence, divergence and relay. *Attachment & Human Development*, 23, 355–374.
- Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *British Journal of Psychiatry*, 190, 319–325.
- Green, M.J., Hindmarsh, G., Kariuki, M., Laurens, K.R., Neil, A.L., Katz, I., ... & Carr, V.J. (2020). Mental disorders in children known to child protection services during early childhood. *Medical Journal of Australia*, 212, 22–28.
- Hansen, A.S., Christoffersen, C.H., Telléus, G.K., & Lauritsen, M.B. (2021). Referral patterns to outpatient child and adolescent mental health services and factors associated with referrals being rejected. A cross-sectional observational study. *BMC Health Services Research*, 21, 1063.
- MacAlister, J. (2022). *The independent review of children's social care: Final report*. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20230308122535mp_/https://childrensocialcare.independent-review.uk/wp-content/uploads/2022/05/The-independent-review-of-childrens-social-care-Final-report.pdf [last accessed 18 October 2023].
- McKenna, S., O'Reilly, D., & Maguire, A. (2023). The mental health of all children in contact with social services: A population-wide record-linkage study in Northern Ireland. *Epidemiology and Psychiatric Sciences*, 32, e35.
- National Collaborating Centre for Mental Health. (2023). *Ethnic inequalities in Improving Access to Psychological Therapies (IAPT): Appendices*. London: National Collaborating Centre for Mental Health. Available from: <https://www.nhs.uk/wp-content/uploads/2023/10/Ethnic-Inequalities-in-Improving-Access-to-Psychological-Therapies-IAPT-Appendices.pdf> [last accessed 28 February 2024]
- Newlove-Delgado, T., Marcheselli, F., Williams, T., Mandalia, D., Davis, J., McManus, S., ... & Ford, T. (2022). *Mental health of children and young people in England 2022 - wave 3 follow up to the 2017 survey*. NHS Digital. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey> [last accessed 18 October 2023]
- NHS Digital. (2023). *MHSDS v5.0 technical output specification*. Available from: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance> [last accessed 24 October 2023]
- O'Connor, M., Wilson, C., Coughlan, B., Duschinsky, R., & Foster, S. (2024). How clinical psychologists respond to child safeguarding dilemmas: A qualitative study. *Child Abuse Review*, 33, e2850. <https://doi.org/10.1002/car.2850>
- Office for National Statistics. (2017). *Population Estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2016*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2016> [last accessed 24 October 2023].
- Office for National Statistics. (2018). *Population Estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2017*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017#links-to-related-statistics-and-how-to-find-data> [last accessed 24 October 2023]
- Office for National Statistics. (2019). *Population Estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2018, using April 2019 local authority district codes*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland> [last accessed 24 October 2023].
- Office for National Statistics. (2020). *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019, using April 2020 local authority district codes*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland> [last accessed 24 October 2023].
- Office for National Statistics. (2021a). *Population estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2020*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland> [last accessed 24 October 2023]
- Office for National Statistics. (2021b). *Population estimates by ethnic group and religion, England and Wales: 2019*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019> [last accessed 25 October 2023].
- Office for National Statistics. (2023). *Ethnic group by age and sex, England and Wales: Census 2021*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicgroupbyageandsexenglandandwales/latest> [last accessed 25 October 2023].
- Office of the Children's Commissioner. (2023). *Children's Mental Health Services 2021–22*. Available from: <https://assets.childrenscommissioner.gov.uk/wp-content/uploads/2023/03/Childrens-Mental-Health-Services-2021-2022-2.pdf> [last accessed 18 October 2023].
- Rodgers, C.R.R., Flores, M.W., Bassey, O., Augenblick, J.M., & Cook, B.L. (2022). Racial/ethnic disparity trends in Children's mental health care access and expenditures from 2010–2017: Disparities remain despite sweeping policy reform. *Journal of the American Academy of Child and Adolescent Psychiatry*, 61, 915–925.
- Sahle, B.W., Reavley, N.J., Li, W.J., Morgan, A.J., Yap, M.B.H., Reupert, A., & Jorm, A.F. (2022). The association between adverse childhood experiences and common mental disorders and suicidality: An umbrella review of systematic reviews and meta-analyses. *European Child & Adolescent Psychiatry*, 31, 1489–1499.
- Shoari, N., Lewis, K., Blackburn, R., Ritchie, B., Cummins, S., Rogers, N.T., ... & Hardeid, P. (2025). Using the English national health service dataset for research into mental health service use among children and young people. *medRxiv*. <https://doi.org/10.1101/2025.11.03.25339389>
- Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar De Pablo, G., ... & Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, 27, 281–295.
- Vinnerljung, B., Hjern, A., & Lindblad, F. (2006). Suicide attempts and severe psychiatric morbidity among former child welfare clients – A national cohort study. *Journal of Child Psychology and Psychiatry*, 47, 723–733.
- von Elm, E., Altman, D.G., Egger, M., Pocock, S.J., Gøtzsche, P.C., & Vandenbroucke, J.P. (2007). The Strengthening the reporting of observational studies in epidemiology (STROBE)

- statement: Guidelines for reporting observational studies. *The Lancet*, 370, 1453–1457.
- Wolpert, M.H.R., Hodges, S., Fuggle, P., James, R., Wiener, A., McKenna, C., ... & Munk, S. (2019). *THRIVE framework for system change*. London: CAMHS Press. Available from: <https://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf> [last accessed 18 October 2023]
- Woolgar, M., & Baldock, E. (2015). Attachment disorders versus more common problems in looked after and adopted children: Comparing community and expert assessments. *Child and Adolescent Mental Health*, 20, 34–40.

Accepted for publication: 5 June 2026