Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019

Mental health has been defined as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[1]. In 2017, one in eight (12.8%) 5-19 year old children had at least one mental health disorder (rates of mental health disorders increased with age)[28]. Also, half of all mental health problems are established before the age of 14 years[2]. The increase in prevalence may be due to the inclusion of a wider and older demographic profile. This has a significant impact on a child's well-being and leads to a range of negative experiences early in life and into adulthood[2].

Summary Statistics for Cornwall & Isles of Scilly:

2.66%

No. of school children across CIoS with a social, emotional and mental health need (2018)[a]

6.1 per100,000

Average rate of young people in contact with mental health services (June 2018)[i].

9.7 per 1,000

Average rate of childhood mental health emergency Department (ED) attendances (June 2018)[i]

297.8 per 100,000

Hospital Admissions as a result of Self-Harm among children aged between 10 & 14 years (17/18)[a]

Key Messages

- In 2018, there is a greater proportion of children with a social, emotional and mental health need in Cornwall and the Isles of Scilly (CIoS) than across England, including both primary (2.63%) and secondary (2.73%) school children. There were 2.66% children of school age with a social, emotional and mental health need[a].
- Since 2012/13, rates of self-harm have increased by 321.6% and 50.96% in the 10-14 (from 70.3 to 297.8 per 100,000) and 15 to 19 (from 468.2 to 706.8 per 100,000) year olds, respectively[a].
- In 2017, mental health disorders were ranked first in terms of Years Lived in Disability (YLD) in children aged 5-14 years[11].

Areas for focus:

- **Tackle lifestyle risk factors –** Childhood mental well-being can be improved through a range of prevention activities. These need to take a life course approach, including pre/post natal periods through to adolescence and into adulthood. This includes parental support, healthier life style activities, whole school approaches (e.g. anti-bullying policies and online safety), safe living environments and supportive communities.
- **Vulnerable children –** Early access to mental health interventions are needed to support the mental well-being of more vulnerable children. This includes children who are looked after, children in need and those with a disability and those experiencing adverse childhood experiences. As well as those with emotional needs; living in deprivation (including those receiving free school meals); young carers; and in receipt of special educational needs support for example.
- **Addressing rates of childhood self-harm –** Prevention activities are needed to address the increasing trend of self-harm among children and young people across CIoS. This should be conducted alongside investigations into the number of repeat emergency department attendances because those who self-harm have a 1 in 6 chance of repeat attendances within a year.
- **Healthcare utilisation –** Investigating the long-term trends and potential associations between referrals, care contacts, number of people accessing mental health services and emergency services is needed.
- **Childhood mental health projections –** Understanding changes in the prevalence of childhood mental health conditions would help inform policy and practice. A reliable methodology for predicting future population growth and demand is needed.
- **Future work –** should include an overview of the level of need and demand on inpatient care (i.e. Sowenna in Bodmin and 'out of county' placements) for severe mental illness, and different forms of therapy such as CBT and Functional family therapy for behavioural and conduct disorders.

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Risks

The development of mental health disorders during childhood has been associated with a complex interaction between genetic, biological, psychological and social risk factors during pregnancy and infancy[4].

This is a public health priority because children with mental health problems have unequal chances in society and can experience delays in receiving effective early interventions[5]. This means that mental health problems can persist into adulthood[2] and affect a range of factors such as employment opportunities in later in life[6].

Around 70% of children and adolescents who experience a mental health problem have not had appropriate interventions at a sufficiently early age. This is a public health priority because this causes problems later in life[2].

Early childhood experiences – Risks include post natal depression, attachment problems, bonding difficulties, maltreatment and neglect and migration can impact a child's mental health. [4]

Parental behaviours – Parents with unhealthy behaviours (e.g. smoking or drinking alcohol), a mental illness and/or substance use disorder increases the risk of a child experiencing mental health problems. [4]

Age and sex - Mental health problems are more common in children aged 11-15 years, boys and white children. High risk groups include lesbian, gay bisexual and transgender populations. [2]

Adverse Childhood Experiences (ACEs) - Concerns include trauma (e.g. loss or abuse), negative life events, domestic abuse and childhood adoption (Department of Health, 2017). Looked after children are more likely to experience ACEs and around 45% have a diagnosable mental health disorder. [2]

Community environment - Poor mental illness is found in those involved in gangs (Department of Health, 2017), areas of lower social capital / lack of community support (Inchley and Currie, 2013) poor living and educational settings. [4] [2] [7]

Disability – Those with a physical and/or learning disability, autism and sensory impairment are at increased risk of experiencing a mental health problem. [8] [9]

Poverty - Child poverty and young people not in education, employment, or training (NEETs) are more likely to experience mental health and substance misuse problems. [2]

Social isolation – Affects the mental health of children. Those with problematic behaviours can experience social challenges through the school years. [10]

Substance misuse - Including tobacco, alcohol and drugs have been associated with peer pressure and media influences, and can adversely affect the development of the brain and body. [4]

Bullying – Includes cyberbullying (thought to affect 18% of children), as well as victimisation and discrimination can all affect children's mental health. Can lead to schooling difficulties, violent behaviours, unsafe sex practices and substance misuse. [2]

Poor body image – Is associated with mental health problems. [7]

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Prevention

Prevention is about taking action to improve people's quality of life and reduce the chance of getting a mental and physical health condition[12]. Many risk factors may be prevented through antenatal, post-natal and later childhood programs. As illustrated below, this can be achieved by targeting a range of determinants of health such as promoting healthier lifestyles throughout the life course. Targeting both risk and protective factors provides a number of opportunities to intervene and help avoid potential mental health problems[4,29].

Lifestyle Factors

Routine antenatal & post-natal support

Foster nurturing relationships

Safe & supportive home

Healthier lifestyles of parents

Maintain a healthy weight

Move more

Nutritional diet

Restrict availability of alcohol, tobacco & drugs

Other

School readiness programs

School health visitors/nurses

Improved whole school resilience

Whole school anti-bullying programs

Supportive environments

Support for children who self-harm

Better & safer use of technology

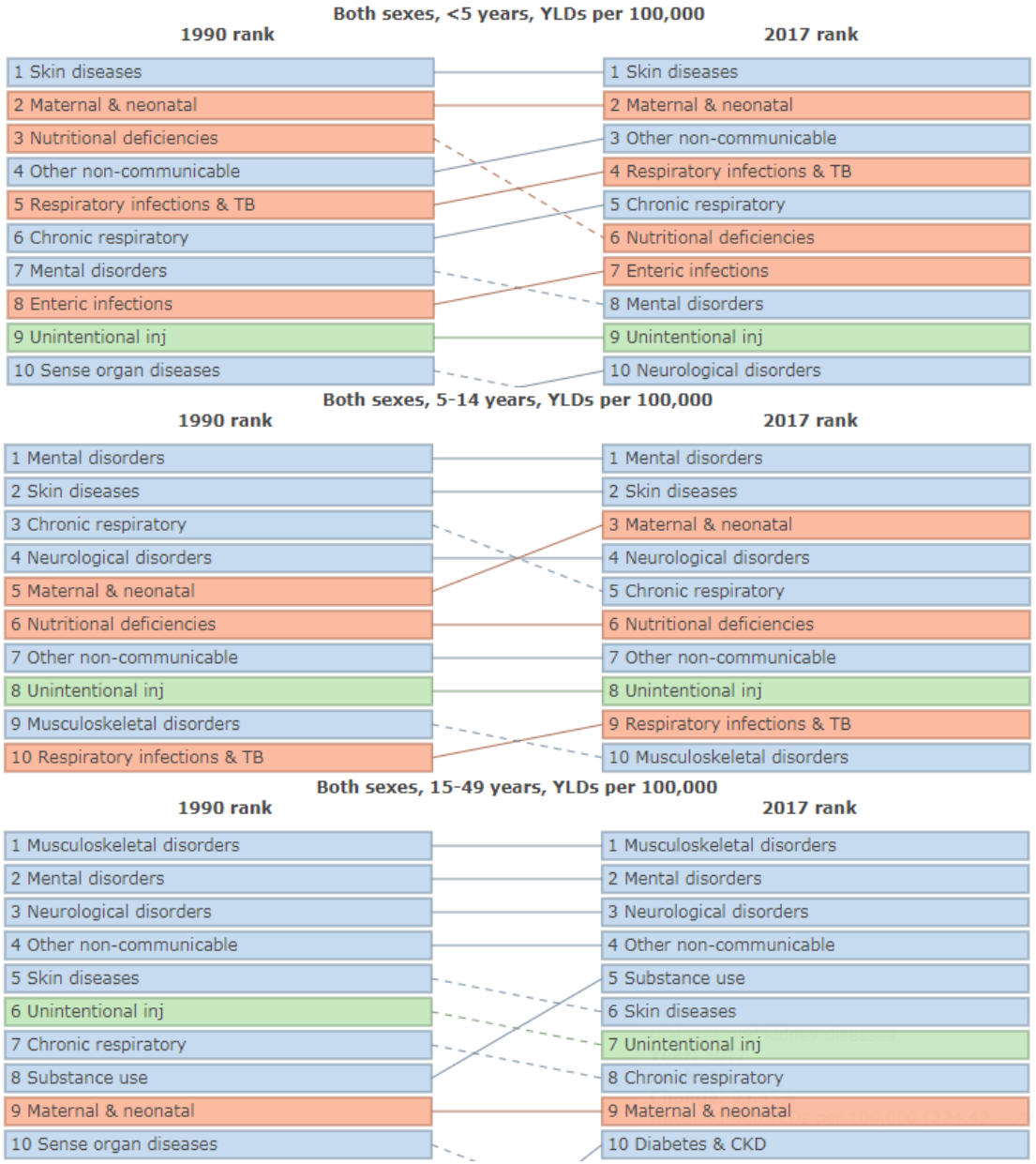
Targeting high risk groups e.g. absenteeism

Key Messages

- Health professionals have an opportunity to intervene and discuss emotional well-being during antenatal and postnatal appointments, as well as in early years and during school through the Healthy Child Programme[13].
- Enabling early attachment and developing safe and nurturing relationships during infancy are essential. This must be combined with a sense of security, safe living environments and supportive communities, nutrition and stimulation during infancy and childhood.
- Improved childhood resilience programmes and anti bullying policies that address culture inside and outside of schools are needed. These are cost effective approaches to improving childhood mental health.
- Whole school approaches are also needed to increase knowledge, reduce stigma, promote resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do.
- The Healthy Child Programme addresses a number of high impact areas (e.g. resilience and emotional well-being), which must be delivered within the existing service model (from Community to Universal Partnership Plus)[13].
- Other key interventions should be targeted at; developing and protecting healthy development (e.g. lifestyle factors such as nutrition), supporting households, schools and communities and supporting vulnerable groups.

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Global Burden of Disease - Cornwall



Key Messages

Most people want to live in good health as long as possible. Whilst life expectancy has increased, health outcomes still vary hugely as a range of inequalities persist. The Global Burden of Disease (GBD) study provides data on mortality, illness and disability, as well as the risk factors linked to burden of ill-health from 1990 to 2016 [11].

These illustrations provide an overview of the top ten causes of Years Lived in Disability (YLD) in 1990 compared to the latest 2017 data. Mental health causes of YLD increases with age, with the condition ranking first in both 1990 and 2017 (1,085.76 YLD/100,000) in the **5-14 year olds**. In this age group the mental health causes of YLD are similar among boys (1,112.51 YLD/100,000) and girls (1,057.91 YLD/100,000).

In the under 5-year olds, mental health causes of YLD changed from a ranking of 7 in 1990 to 8th in 2017. However, mental health causes of YLD differs by gender. In boys, mental health in 2017 was ranked the 6th cause of YLD compared to a the 9th cause of YLD in girls.

For those aged 15-49, the top cause of YLD is musculoskeletal conditions. However, it is not possible to assess the impact among children and young people aged 15-18 years.

Communicable, maternal, neonatal, and nutritional diseases

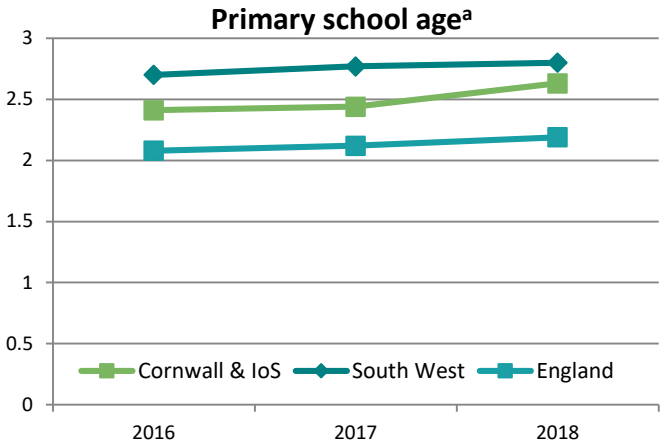
Non-communicable diseases

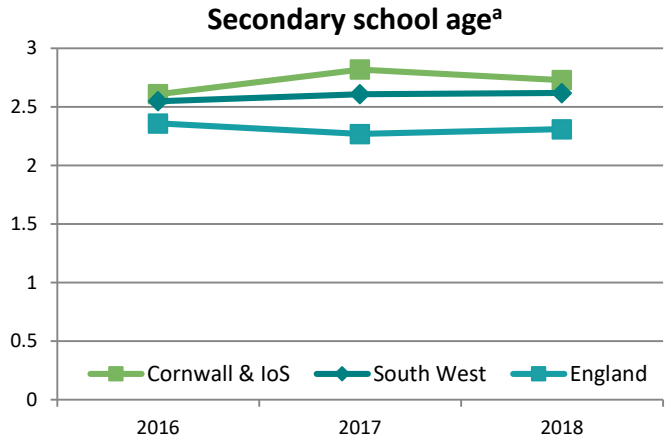
Injuries

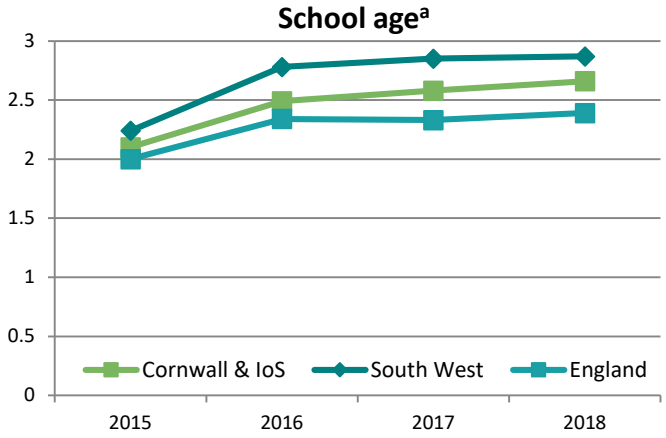
Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Incidence and Prevalence

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs







Key Messages

- According to the Education special educational needs statistics, the proportion of primary school pupils with social, emotional and mental health needs was higher in CIoS (2.63%) than across England (2.19%) in 2018. But the trend over the last three years has remained fairly consistent when compared to 2016 (2.41%).
- Similarly, 2.31% of secondary school pupils had a social, emotional and mental health need in England. Where as, in 2018, there were more pupils with this level of need across CIoS (2.73%). A similar 3-year trend can also be observed in the below graph.
- School age pupils (all ages) with the same social, emotional and mental health needs during the same period was also higher across CIoS (2.66%) than in England (2.39 %). The number of children with these needs at this age also seems fairly consistent at around 2% of this population.

Joint Strategic Needs Assessment

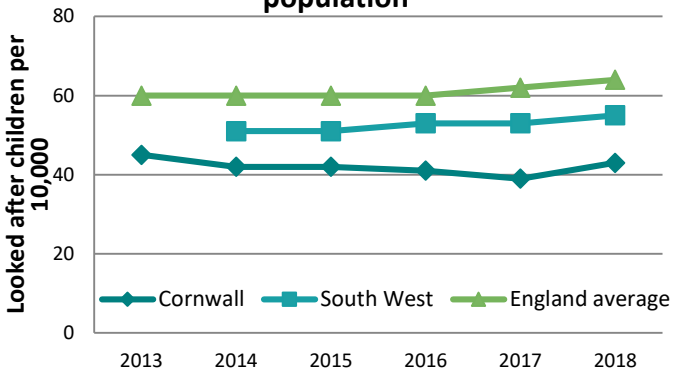
Children and Young People's Mental Health 2019: Looked after children

Vulnerable children and young people such as those being at risk of, or suffering, abuse, neglect, exploitation or youth violence, witnessing domestic abuse, being a young carer, or having a disability are at risk of developing mental health problems[2]. Almost half of children in care have a diagnosable mental health disorder. This raises the need for improved outcomes among 'looked after children' (LAC) and timely access to mental health services[14]. Across England, there are around 73,000 children in care who are significantly more disadvantaged than their peers. This includes lower education attainment, being over represented in the youth justice system and less likely to obtain employment in the future. The following provides an overview of the situation in Cornwall for 465 looked after children in March 2018[15].

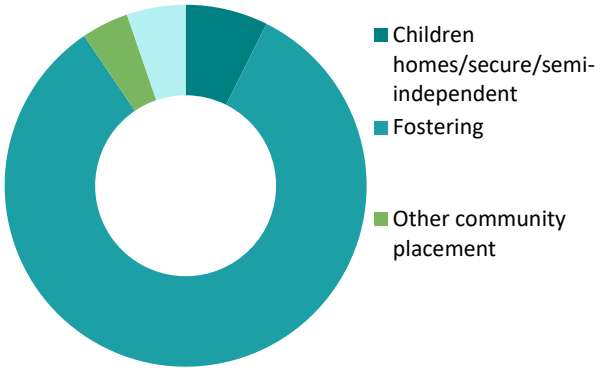
Key Messages

- The number of looked after children (LAC) in Cornwall (43/10,000) is lower than the average across England (64/10,000). The majority of placement types are with in fostering (79%).
- LAC in care across CIoS have higher rates of substance misuse (6%) than the England average.
- There are more LAC children across CIoS living in suitable accommodation and accessing suitable education, employment or training when leaving care in 2016 than the England average.

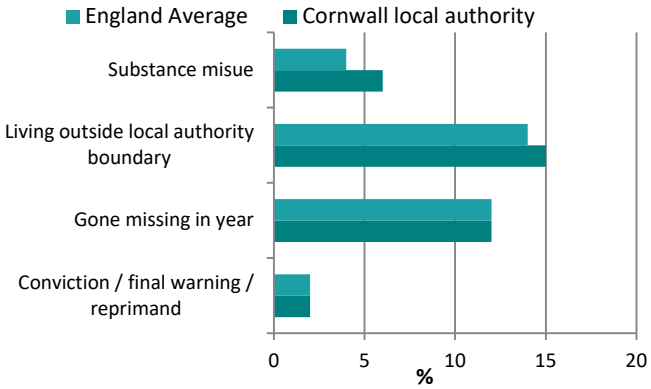
Looked after children per 10,000 population [b]



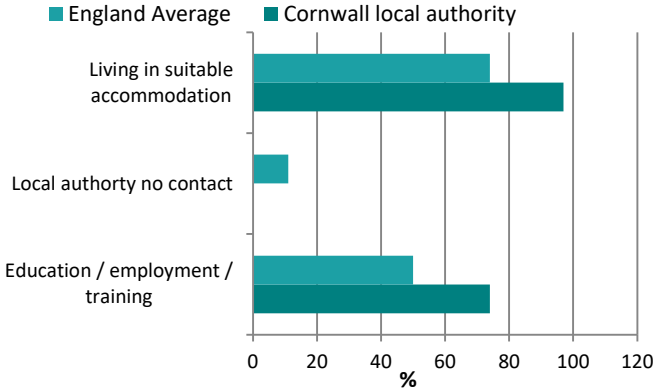
Placement types [c]



Outcomes while in care [c]



Outcomes as care leaver [c]

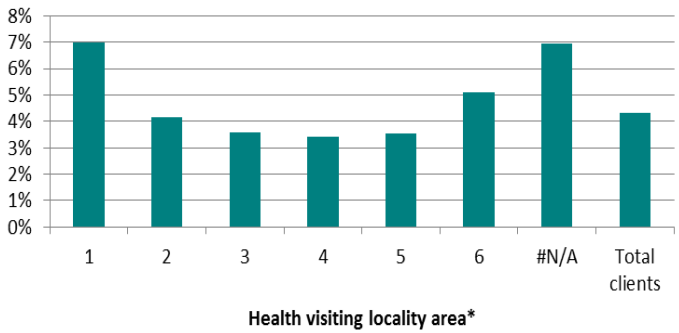


Joint Strategic Needs Assessment

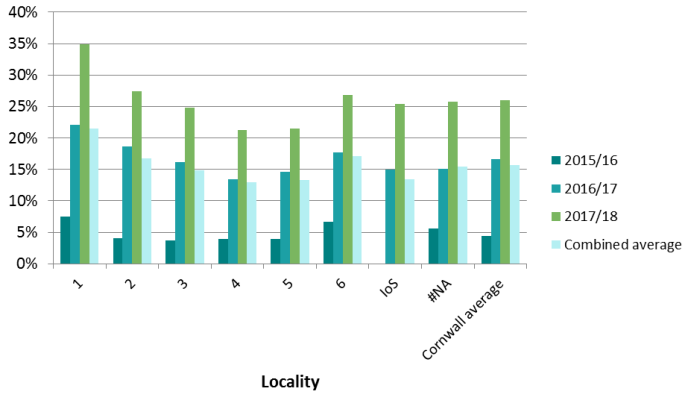
Children and Young People's Mental Health 2019: Adverse childhood experiences (ACEs)

Experiences during childhood have a long-lasting impact on a child's mental and physical health and wellbeing[16]. ACEs impact directly on children's developing brains through exposure to toxic stress and have a strong impact on children developing health impacting behaviours and mental health problems later in life. Children who are impacted by the following ACEs are more likely to develop poor health and wellbeing later in life, which can result from; verbal abuse; physical abuse; sexual abuse; parental separation; domestic violence; incarceration; mental illness; alcohol abuse; and drug use[16].

Percentage of clients with 4 or more ACE's



Depressed / mentally ill parents



**Not including Isles of Scilly due to small numbers*
#NA is clients with postcode out of area.

Key to above figures: Geographic coverage of localities across Cornwall and IoS

Locality Number	Geographic area covered by locality
1	Penzance, St Ives, Hayle and the Isles of Scilly
2	Camborne, Pool, Redruth, Helston and Lizard area
3	Falmouth, Penryn, Truro, Perranporth and Roseland
4	Newquay, St Austell, The Clays, Fowey and Lostwithiel
5	Bodmin, Wadebridge, Camelford and Launceston/Bude
6	Liskeard, Looe, Saltash, Torpoint and Callington

Key Messages

- According to Health Visiting Early Help assessment, around 4.3% of children aged under 5 in CIoS have been affected by 4 or more ACEs[16].
- The highest proportion of children with 4 or more ACEs are those living across Camborne, Pool, Redruth, Helston and the Lizard area (Locality 1). These children will be the most likely to suffer poor health in adulthood.
- 15.6% of under 5s in CIoS have a parent affected by mental illness or depression, which can impact the health of children and young people.
- There is currently no national guidance on tackling ACEs, but current approaches current approaches include:
  - Identification of children affected by ACEs and intervening
  - Supporting parents and care givers to minimise the risk of ACEs
  - Strengthening children's resilience
  - Minimising the effect on children of indirect harm
  - Focusing support and intervention in the early years
  - Focusing on support for individual issues

Joint Strategic Needs Assessment

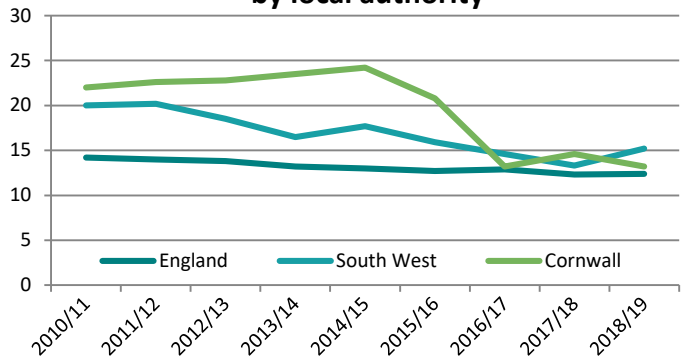
Children and Young People's Mental Health 2019: Children in need

In March 2019, there were a total of 4,177 children in need across CIoS. Of the children in need known to the local authority, 13.2% had a disability (see below graph). A disability includes those with a physical or mental impairment (i.e. which has a substantial and long term adverse effect on a child's ability to carry out normal day to day activities) that has lasted or be likely to last at least 12 months. Children in need and those with a disability may experience a range of health inequalities when compared to their non-disabled peers. For example, those with a learning disability and/or autistic children are more likely to[17]:

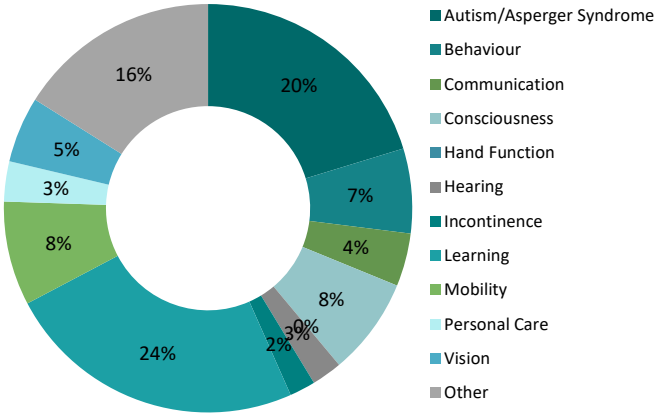
- live in unhealthy housing (e.g. cold and overcrowding)
- experience bullying, physical, sexual, emotional abuse or neglect
- exposed to harsh parenting or chaotic family environments
- more likely to experience adverse life events
- Children living in deprivation are more likely to suffer from mental health problems and increased engagement with more risky health behaviours (e.g. sedentary lifestyle, poorer diet, substance use)

Also, many children will experience a range of health inequalities and may have co-occurring mental health problems. For example, children with autism may experience a range of other physical health conditions and up to 70% of autistic children have at least one co-occurring mental health condition[18]. The below graphs illustrates the type and number of disabilities experienced by children in need across CIoS.

% of children in need with a disability by local authority [d]



Children in need with a disability, Cornwall March 2019 [d]



Key Messages

- Children in need e.g. those with a learning disability and/or autism) are at increased risk of exposure to major categories of social determinants (e.g. poverty, housing and employment opportunities) and consequently experience poorer physical and mental health outcomes.
- The type of disabilities experienced by children are diverse and include a range of physical, sensory and learning difficulties. The most common are having a learning disability or autism, which is followed by mobility.
- The total number of children with disabilities across CIoS has fallen over the last 3-years, although there was a slight increase in 2017/18, which may be due to the new assessment.

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Headstart (1)

HeadStart is a five-year National Lottery funded programme in Cornwall to improve the mental health and wellbeing of young people aged 10-16. The aim is to provide support and increase resilience to help prevent serious mental health issues from developing. Headstart used the 2017/18 Wellbeing Measurement Framework (WMF) survey, which assessed children's general wellbeing, their resilience and mental health. In Cornwall, 8,807 year 8 and 9 students from 37 schools completed the survey (see below table)[19,20].

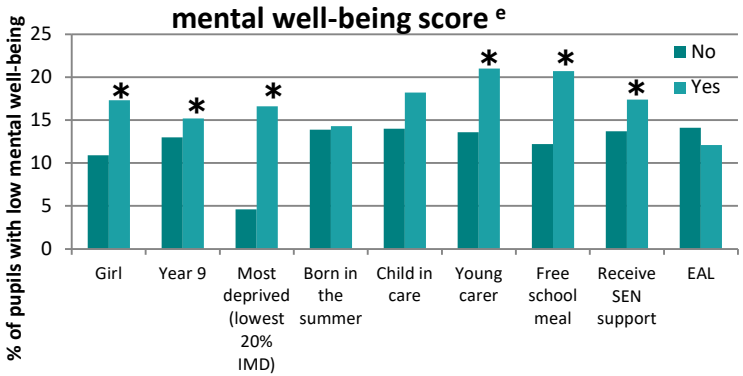
The WMF survey included the seven questions from the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). The SWEMWBS scale asks participants to rate their; feelings of being optimistic about the future; feeling useful; feeling relaxed; dealing with problems; thinking clearly; feeling close to other people; and being able to make up their mind about things. This is on a 5-point scale from 'none of the time' to 'all of the time'.

Pupil demographics for the Headstart study cohort [e]	Year 8 & 9
Girls	49.3%
Proportion of year 8 children	52.3%
Born in the summer	34.0%
Children in care	0.4%
Post looked after children	0.7%
Young carer	14.2%
Free school meals	22.0%
Special educational needs support	9.8%
Children speaking English as an additional language (EAL)	1.9%
Children in lowest deprivation decile (IMD)	5.9%
Low mental well-being score (>1 standard deviation below the SWEMWBS mean score; 23.6 SD 5.3)	14.1%

Key Messages

- A low mental well-being score was influenced by a range of pupil characteristics from age to level of support (below graph). Whilst there was no significant association between a child in care and low mental well-being, being in care has been previously raised as a key risk factor. Findings could be due to a relatively low sample size and number of children self declaring that they are a young carer.
- Girls, year 9 pupils and the most deprived children were more likely to have a low mental well-being score. After adjusting for age, sex and deprivation, being a young carer had a 68% increased chance of having a low mental well-being score.
- Those receiving SEN support were 46% more likely to have low mental well-being. Whereas, pupils receiving free school meals had an 84% increased risk, although this may be a reflection of levels of deprivation.

Pupil characteristics and having a low mental well-being score [e]



Note: *Significant association with a low mental well-being score P< 0.05

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Headstart (2)

The 2017/18 WMF survey also included the strengths and difficulties questionnaire (SDQ), which included questions about emotional difficulties, conduct or behavioral difficulties, hyperactivity problems, difficulties with peers and having a lack of pro-social skills. The scores can be divided into low range (normal for students of the same age), slightly elevated range (having a greater level of difficulty) and high range (high levels of difficulty).

The below graph compares the proportion of pupils with a high versus low range SDQ score for each of the five strengths and difficulties questions.

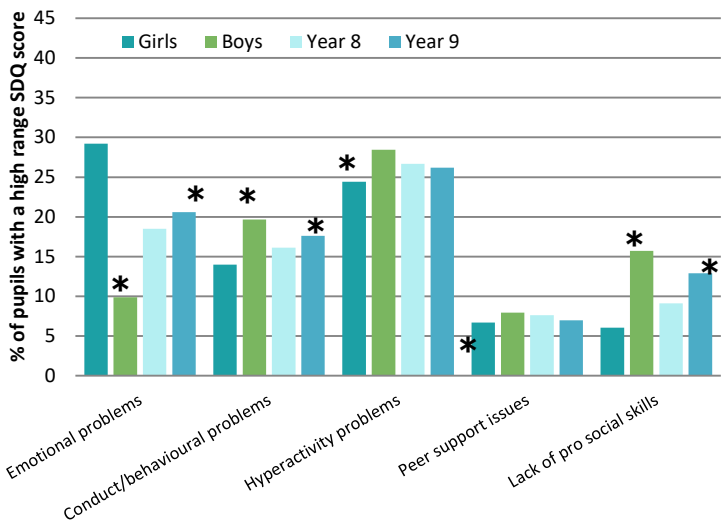
To assess how these strengths and difficulties criteria influences mental well-being outcomes, the second graph compares the low, slightly elevated and high range scores with the proportion of pupils with a low mental well-being score (as determined from the previous SWEMWBS score).

Key Messages

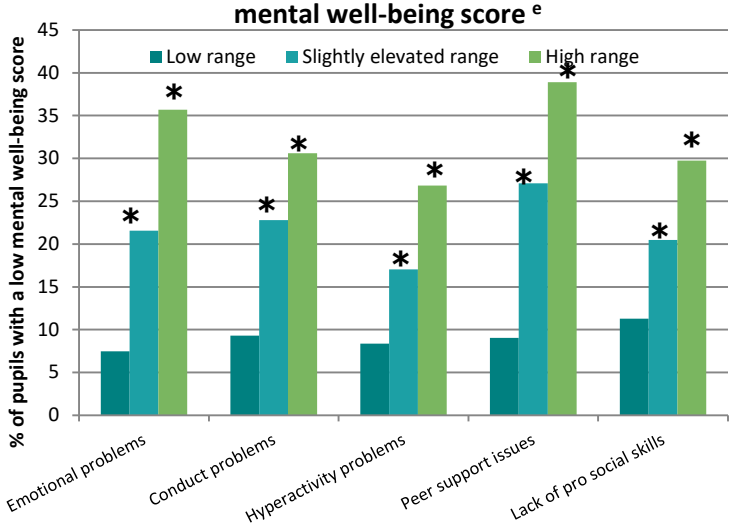
The proportion of pupils with a high SDQ score varied by age (i.e. year group) and sex. More girls and year 9 pupils have a high range score for emotional problems. Behavioural problems are more common in boys and year 9 pupils. More boys had hyperactivity problems and peer support issues (not influenced by year group). More boys and year 9 pupils had a lack of pro social skills.

More pupils with a slightly elevated or high range also had a low mental wellbeing score. Having a slightly elevated range had a two to three-fold increased risk of having a low mental well-being score. Whereas, those with a high range score had a significantly greater risk of having a low mental well-being score (4 to 6 fold increased risk).

Proportion of pupils with a high range SDQ score by sex & year group [e]



SDQ criteria and proportion of pupils with a low mental well-being score [e]



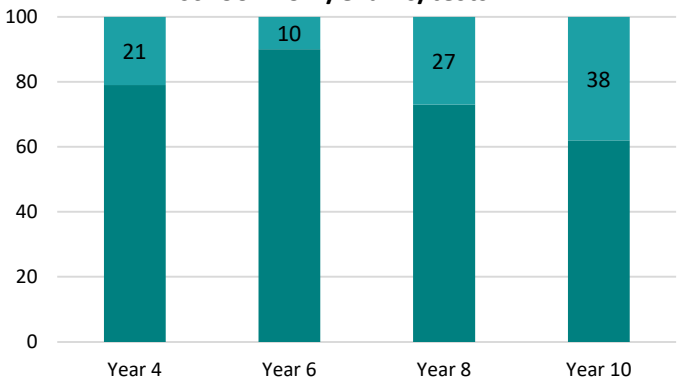
Note: *Significant association with a low mental well-being score P< 0.05

Joint Strategic Needs Assessment

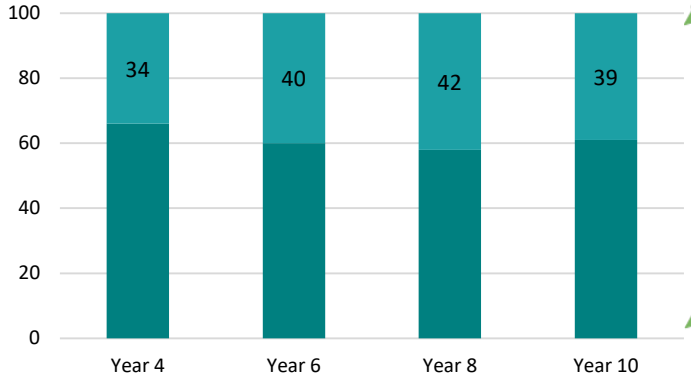
Children and Young People's Mental Health 2019: SHEU Survey 2019

The Schools Health Education Unit (SHEU) enables schools in Cornwall to survey pupils, gather trend data and measure improvement. A SHEU Health Related Behaviour Survey was conducted in 2019 to assess the wellbeing of pupils across Cornwall. These results were collected from a sample of primary and secondary pupils aged 7-15 in Cornwall in the 2019 summer term. This work was commissioned and coordinated by Cornwall Council Public Health through the Cornwall Healthy Schools Team. The data from 4,759 participating pupils will be used to inform planning and support by the schools, the Healthy Schools Programme, Public Health and other services[21].

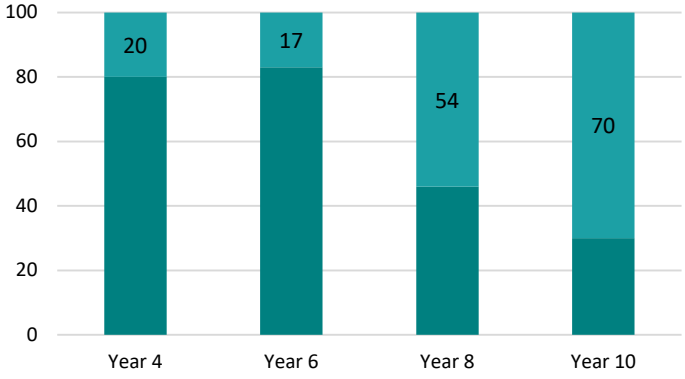
Proportion of boys who worry about school work/exams/tests[21]



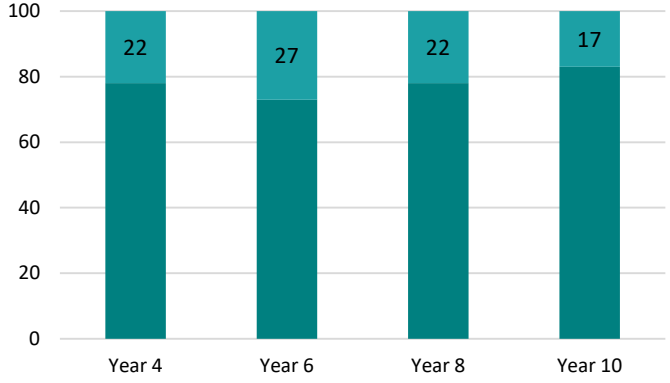
Proportion of boys reporting high levels of self-esteem[21]



Proportion of girls who worry about school work/exams/tests[21]



Proportion of girls reporting high levels of self-esteem[21]



Key Messages

A higher proportion of year 8/10 girls worry about schoolwork/exams/tests than year 8 and 10 boys (left illustration). Compared to Year 8 (50% of girls feel happy about their lives), there is a drop in the proportion of girls who feel happy about their lives (40%) in Year 10.

Self esteem generally improves with age. There is consistently more boys than girls recording high levels of high self esteem (right illustration). In primary school, 40% of Year 6 boys and 27% of year 6 girls recorded high levels of self esteem. By Year 10, 39% of boys and just 17% of girls reported high self esteem. Both similar to the 2017 data.

A total of 56% of Year 6 pupils said that their school taught them to deal with their feelings positively, which is similar to the 2017 survey (57%). A lower proportion of pupils in secondary school said that their school taught them to deal with their feelings positively (31% in 2017 and 30% in 2019).

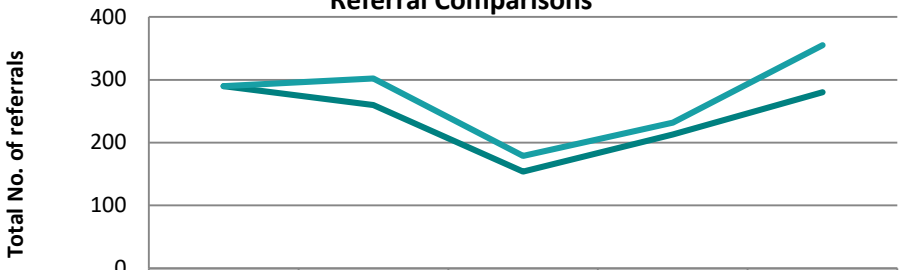
Bullying is a known risk factor influencing the wellbeing of pupils. Nearly a third of pupils across primary and secondary schools said that they had been bullied in the last 12 months. However, this varied slightly across Years 4 (32%), 6 (22%), 8 (29%) and 10 (23%).

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: CAMHS referrals

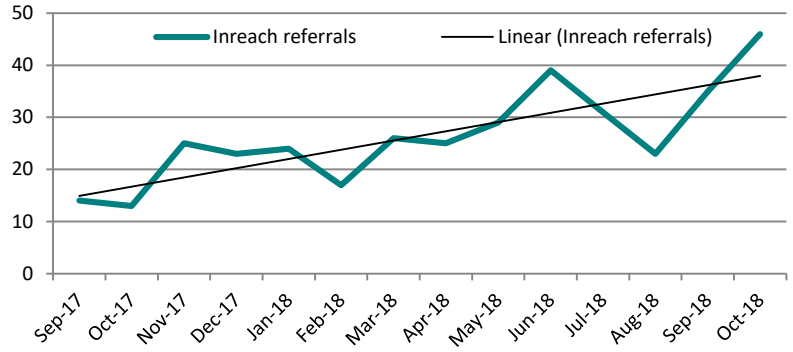
Specialist community child and adolescent mental health services (CAMHS) provide assessment, advice and treatment for children and young people with severe and complex mental health problems. CAMHS also provide support and advice to their families or carers. Referrals can come from any source, including self-referrals and from parents[22]. The CAMHS Access Team from the Early Help Hub provided an overview of referrals into the services in January 2019 (below graphs). It is also important to remember that the Early Help Hub, CAMHS Access Team is just one of two referral routes into CAMHS and that many referrals come into CAMHS via the In-reach urgent assessment clinics.

Referral Comparisons[f]



	June	July	August	September	October
2017	290	260	154	213	280
2018	290	302	179	232	355

Number of in-reach referrals being accepted by the in-reach team[f]



Key Messages

- Referrals to the Early help Hub continue to increase with 1,197 being referred between June and October in 2017 and 1,358 being referred during the same months of 2018, a 13% increase. The number of referrals accepted by the in-reach team suggests an increase over the last 12 months, but longer-term trends are needed to explore this further.
- There is considerable variability of the referrals numbers across the east (677), mid (665) and west (540) localities across Cornwall. The number of referrals is higher in the east (36% of referrals) and mid (35%) than in the west (29%), which may be the variation in number of young people living in each locality. The number of referrals accepted onto CAMHS and primary mental health case loads also varied by locality, with the mid team accepting more referrals (246) when compared to the East (213) and West (192) localities.
- These figures provide an indication of the number of children and young people being referred into CAMHS – specialist services or primary mental health caseloads. The number of referrals appear to vary by month and have increased slightly when compared to 2017.
- Around 40% of referrals to CAMHS and primary mental health worker (PMHW) were declined. This may be due to inconsistencies in referral responses and referral screening, which are reported to have been improved recently.

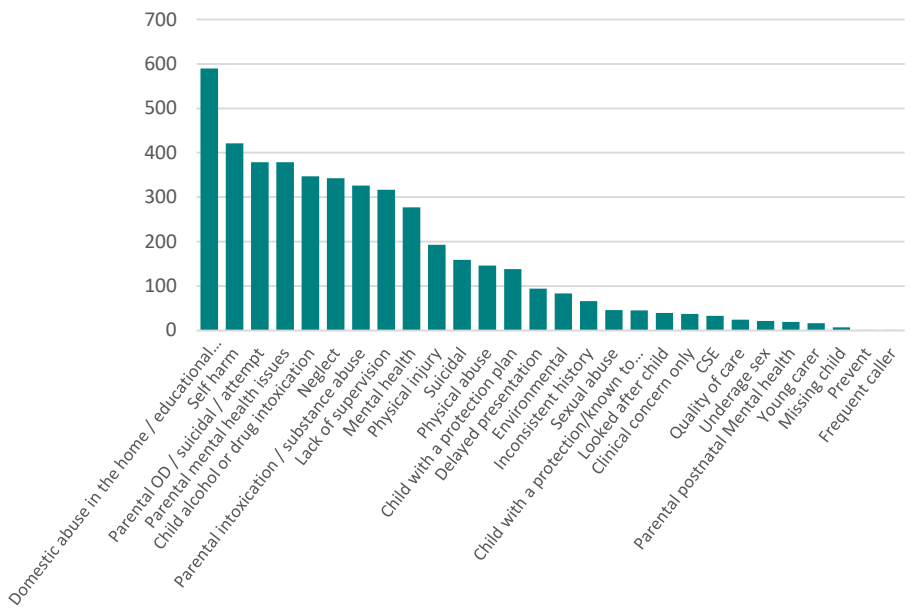
Children and Young People's Mental Health 2019: SWAST

The South Western Ambulance Service NHS Foundation Trust (SWAST) has a statutory duty to safeguard children, vulnerable adults, victims of domestic abuse, and victims of radicalisation from those who would seek to harm them. The Trust operates a number of services including emergency ambulance 999 services (A&E; urgent care services (UCS); and air ambulances. Staff are able to report safeguarding concerns about children via the electronic patient care record system. The referrals are delivered to the Safeguarding Service where safeguarding professionals triage and process the referrals, selecting appropriate partner agencies to escalate the concerns.

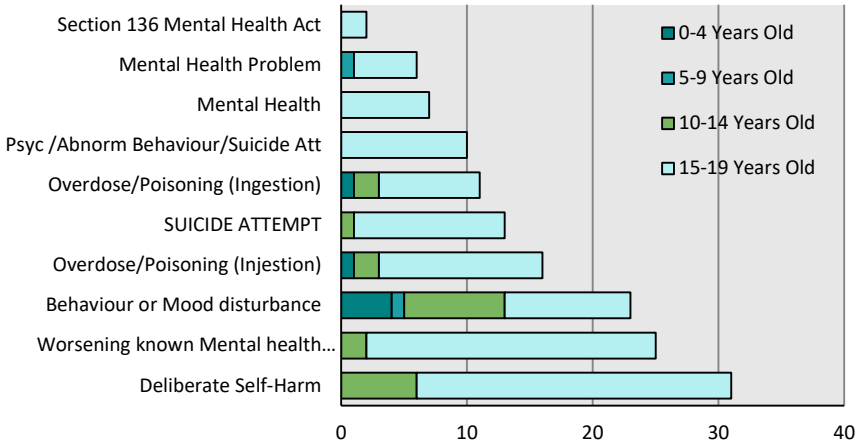
One of the highest child referral themes across the South West region refers to domestic abuse in the home, which can result in emotional impact on the child. However, this frequently involved calls to assess and provide treatment to the adult victim rather than to attend children. A second area of concern is the high impact of mental health illness on children and young people. CIoS have around 8 safeguarding referrals per 1,000 calls in 2017/18, which is lower than the region's average (10 per 1,000 calls)[23].

Majority of the mental health SWAST calls in 2017/18 related to an overdose or poisoning in children aged between 0-19 years, which was followed by psychological and abnormal behavior or suicide attempt. Some of the symptom groups overlap and have changed over the last three years, making it difficult to make direct comparisons. However, it is clear that children and young people aged between 10 and 19 years make up a large proportion of SWAST mental health calls.

Child referral themes April 2017 to March 2018 [g]



SWAST Calls by Symptom Group: 0-19 Years 2017/18 [h]

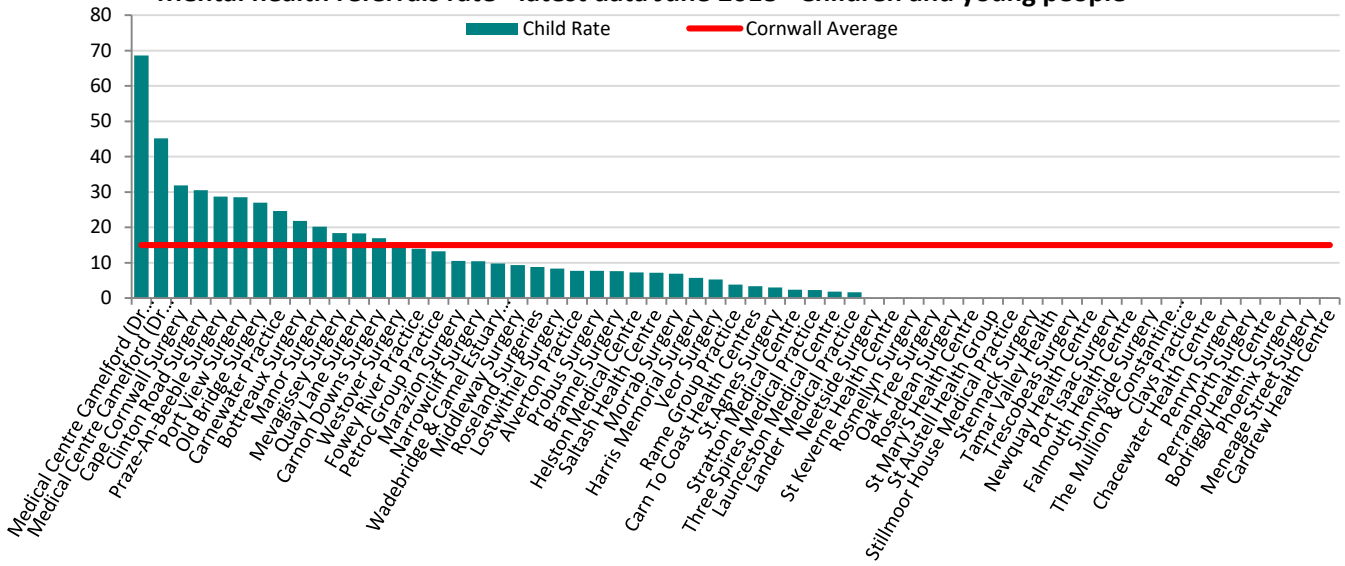


Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Contact with services

The Mental Health Services Data Set (MHSDS) provides the latest record-level data about the care of children and those who are in contact with mental health services. The MHSDS covers not only services provided in hospitals, but also in outpatient clinics and in the community, where the majority of people in contact with these services are treated[3]. The number of children and young people (aged 0-18 years) accessing mental health services can also be broken down to the practice level, which gives an idea of the level of demand. Data at the practice level was provided by Kernow Clinical Commissioning Group (KCCG) in October 2018 and provides a snapshot of those accessing mental health services at the end of June 2018.

Mental health referrals rate - latest data June 2018 - Children and young people[i]



This graph provides information on the rate of mental health referrals received in June 2018 (i.e. referrals compared to the number of children aged 0-18 years and registered with each practice). There were 245 referrals made in June 2018, which varied considerably at the practice level in June 2018 (0-17 referrals with an average of 8.2).

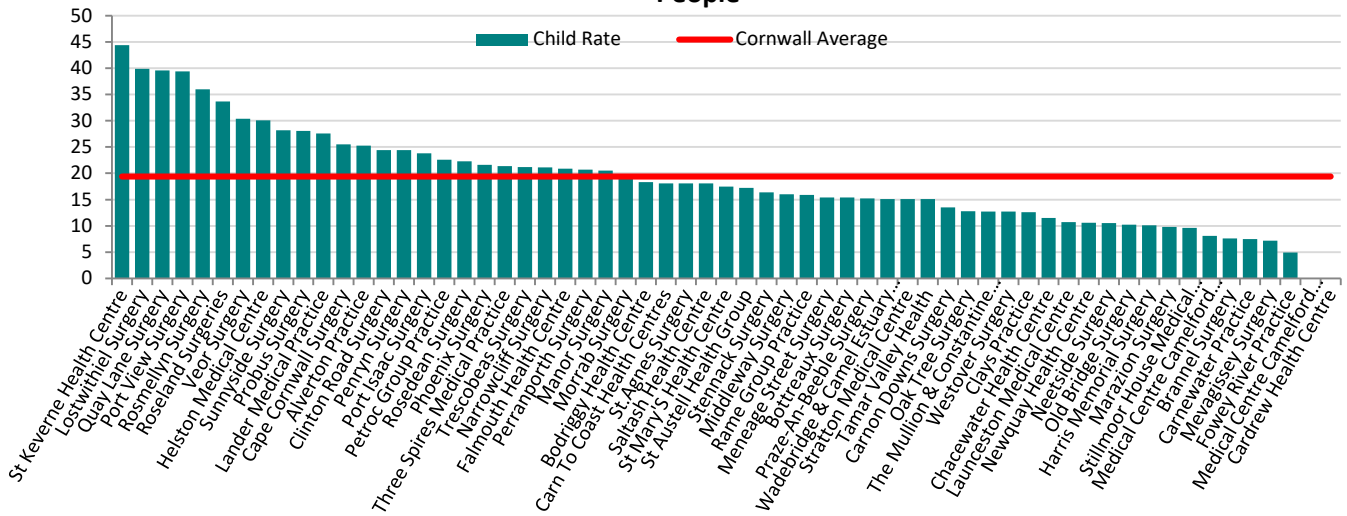
The average rate of referrals was 15 per 1,000 mental health referrals across Cornwall. Targeting practices with high referral rates is needed to understand the potential impact of referral rates on the healthcare system. This should be conducted alongside gaining a better understanding between referral rates and patient outcomes such as care contacts, those accessing services and emergency department attendances, which are described below.

The following two graphs provide information about the type of service use. The first provides a rate for the number of care contacts compared to the number of children at each practice. This is based on a count of how many children had an attendance (contact) with a mental health service in June 2018, based on the recorded care contact date. The third graph provides the rate of children and young people in contact with mental health services in June 2018.

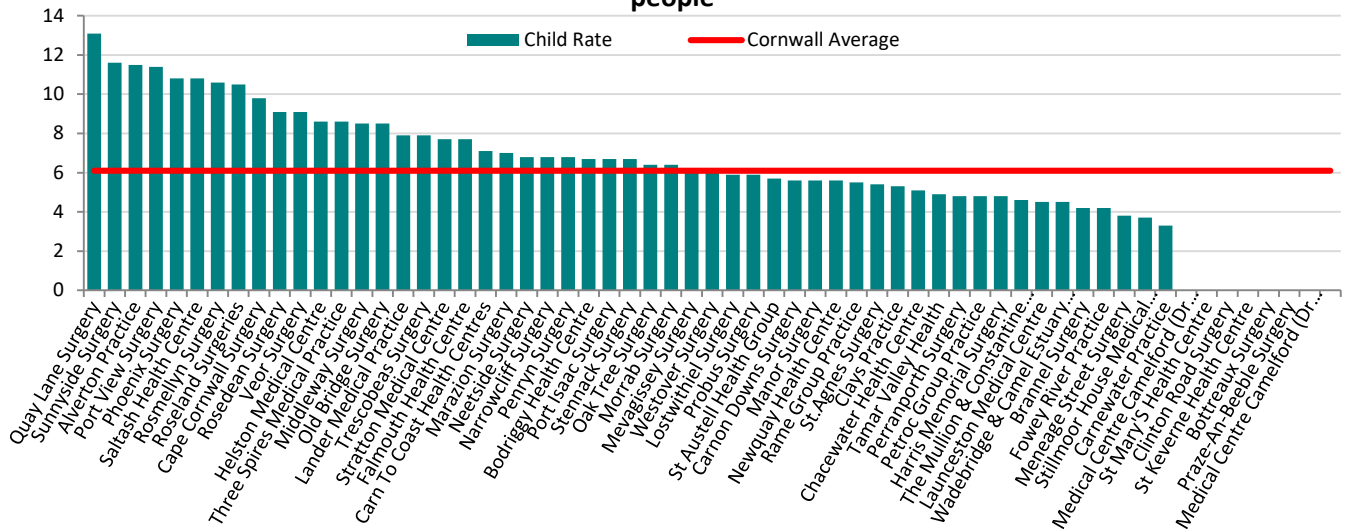
Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Contact with services

Mental health care contacts rate (per 1,000) - latest data June 2018-Children and Young People[i]



People in contact with services (per 1,000)- latest data June 2018 – Children and young people [i]

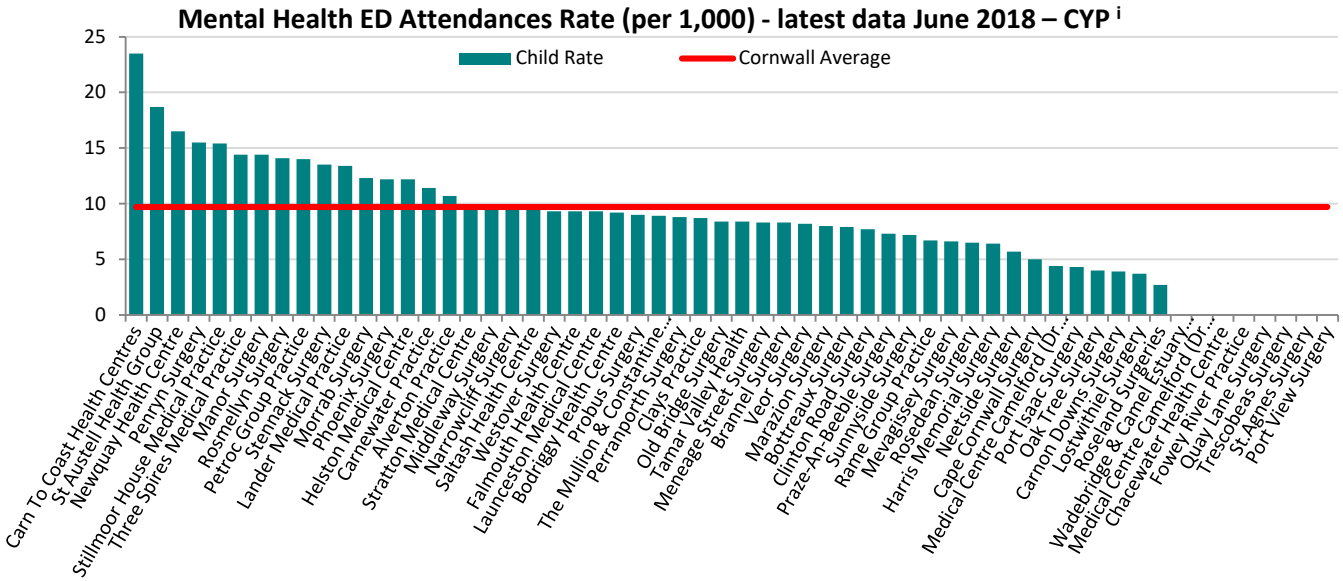


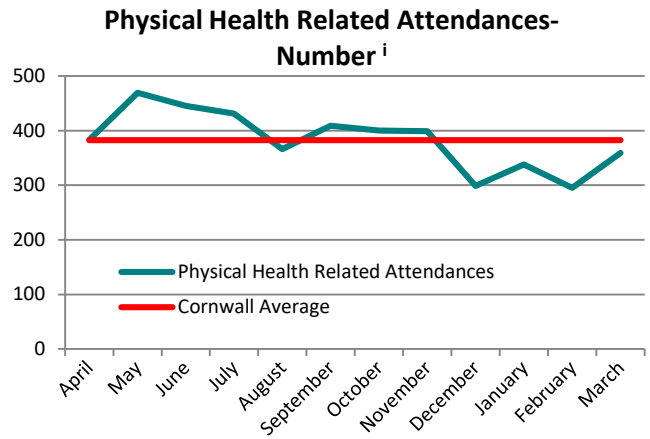
Key Messages

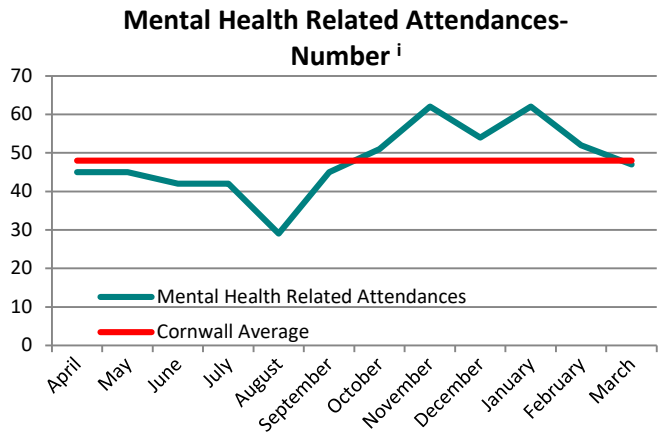
- In June 2018, there were 2,047 care contacts and on average 34.7 care contacts across Cornwall (ranging from 5 to 109 at the practice level). There also seems to be a link between some of the practices with higher or lower rates of care contacts when compared with mental health related A&E referrals (see below and graph in following page).
- A number of practices had a higher rate of care contacts than the average across Cornwall (19.4/1,000 patients). St Austell Health Group and Carn to Coast had the highest number of care contacts, but a slightly lower rate of care contacts when compared to the average rate. These practices had a lower than average rate of care contacts in June 2018, but the highest rate of emergency department attendances.
- There were 710 children in contact with services in June 2018 (13.4 patients a month across Cornwall). The average rate of patients in contact with mental health services was 6.1 per 1,000 patients. Understanding factors influencing the mental well-being of children and young people attending practices with higher than average rates of care contacts or in contact with services would help inform future policy and practice.

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Contact with services







Key Messages

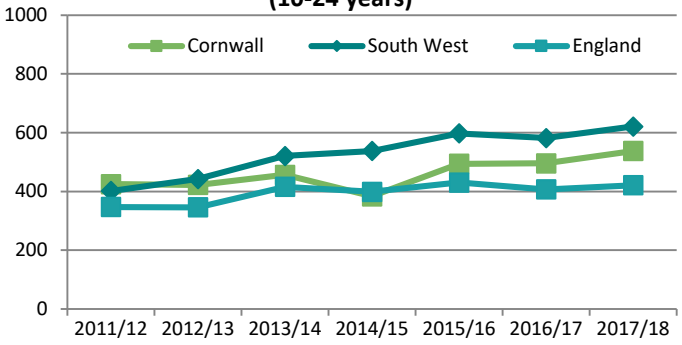
- There were 933 children emergency department attendances in June 2018. The number of attendances varies significantly, with 16 practices having a higher **number** of mental health related emergency department attendances than the average number across Cornwall (average of 18.7 attendances).
- The same 16 practices (i.e. those with highest number of attendances) also had a higher **rate** of mental health emergency department attendances per 1,000 children, with a mental health problem, than the average rate across Cornwall (9.7/1,000 mental health patients). Targeting practices with high rates of attendance may help lower the burden on patients and healthcare services.
- Furthering our understanding into the impact of practices closing/merging is essential. This includes Carn to Coast Health Centre, which has an increasing patient register and the highest rate of attendances.
- The number of mental health patient attendances relating to physical and mental health conditions fluctuates over the 12 month period. The average rate of physical health related emergency department attendances was 48 per 1,000 children in contact with mental health services. This was higher than the rate of mental health related attendances (1.4/1,000).

Joint Strategic Needs Assessment

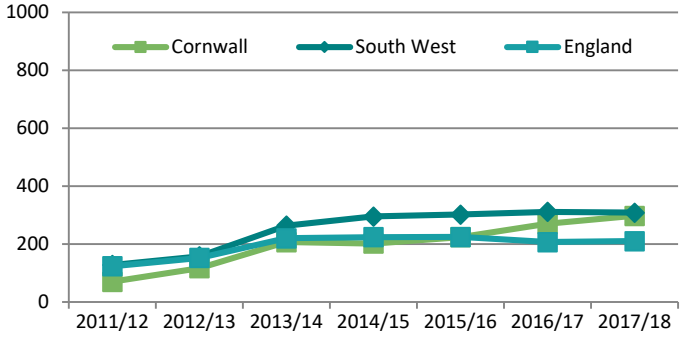
Children and Young People's Mental Health 2019: Self-harm

Self-harm is the intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act; and is an expression of emotional distress[24]. Self-harm may be a presenting feature among some children and young people suffering from depression. Consequently, self-harm is an expression of personal distress and is a significant risk factor of future suicide. Events of self-harm serious enough to warrant hospital admission are used as a proxy for severe self-harm, however, this is a significant under estimate of the true health and well-being burden of self-harm[25,26].

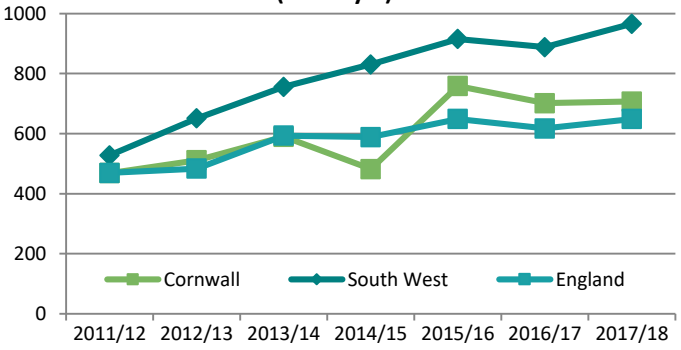
Hospital admissions as a result of self-harm: DSR per 100,000 population (10-24 years)[a]



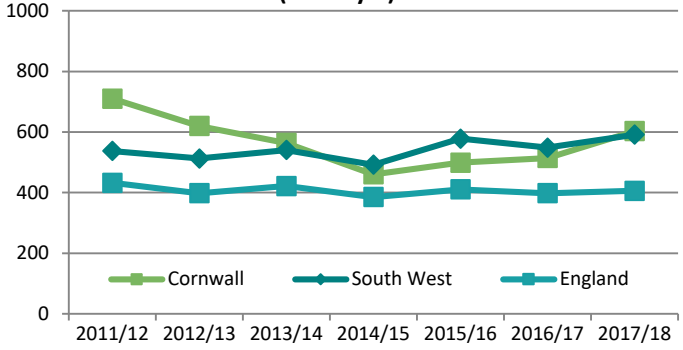
Hospital admissions as a result of self harm: Crude rates per 100,000 (10-14 yrs)[a]



Hospital admissions as a result of self harm: Crude rates per 100,000 (15-19 yrs)[a]



Hospital admissions as a result of self harm: Crude rates per 100,000 (20-24 yrs)[a]



Key Messages

- These graphs present self-harm hospital admissions as a directly standardised rate (DSR). This allows for differences in age structure, and crude rate of finished admission episodes for self-harm per 100,000 population.
- CloS have a higher DSR (537.8 /100,000) than across England (421.2/100,000) in those aged 10 - 24 years, which has increased since 2011/12 (375/100,000).
- Crude rates of self-harm admissions among 10-14 year olds have also increased since 2011/12. Rates of self harm across CloS reached 297.8 per 100,000 in 2017/18, which was greater than across England (210.4/100,000).
- A higher proportion of self-harm admissions occur in the 15-19 year olds, which is also an increasing trend reaching 706.8 per 100,000. In contrast, the number of self-harm admissions in the 20-24 years olds appeared to decrease until 2016/17 (514.3/100,000) i.e. there was a slight increase in 2017/18 (603.0/100,000).
- Hospital admission data is likely to underestimate the true impact of self-harm because they fail to account for cases that do not reach hospital admission status. This unknown impact of self-harm further supports the need for self-harm prevention and support.

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Self-harm admissions

Age-specific rate of self-harm admissions and age-specific rate for patients in the South West region, 2016/17[j]

Rate per 100,000 population

Area name (Region/LA)	Age-specific rate: Admissions					Age-specific rate: Patients					Number of patients	Number of admissons
	0-9	10-24	25-44	45-64	65+	0-9	10-24	25-44	45-64	65+		
South West	3.4	590.5	341.6	183.6	50.0	3.2	425.4	246.5	139.1	43.7	9,779	13,293
Bath and North East Somerset	0.0	517.0	320.5	162.1	56.5	0.0	384.9	202.0	129.2	50.9	333	459
Bristol	1.7	644.3	373.4	295.0	52.0	1.7	394.2	259.8	201.8	43.6	978	1,479
North Somerset	0.0	352.0	230.1	161.1	24.1	0.0	281.0	175.2	114.3	24.1	252	328
South Gloucestershire	0.0	484.3	294.1	163.9	38.9	0.0	404.6	219.2	118.8	31.1	456	585
Plymouth	0.0	628.1	343.5	216.4	61.6	0.0	464.7	282.5	143.2	57.3	562	741
Torbay	6.9	837.8	497.7	255.4	57.4	6.9	513.7	352.8	175.6	43.1	280	419
Bournemouth	0.0	523.1	453.5	346.6	82.2	0.0	411.2	317.1	247.9	73.7	476	644
Poole	0.0	680.0	336.8	159.3	56.8	0.0	419.7	271.7	149.4	50.8	277	369
Swindon	10.1	682.7	482.2	268.8	83.0	6.8	542.2	288.7	199.8	65.2	509	724
Cornwall & Isles of Scilly (combined)	3.4	495.4	366.5	196.9	61.4	3.4	379.6	278.1	147.5	53.2	966	1,260
Wiltshire	1.7	627.6	298.9	188.0	47.2	1.7	466.0	223.9	131.7	42.3	844	1,138
East Devon	7.2	633.2	184.3	75.2	31.0	7.2	500.4	161.3	72.6	31.0	182	215
Exeter	0.0	433.7	349.9	154.8	44.3	0.0	319.9	221.4	121.6	39.4	226	320
Mid Devon	0.0	394.5	226.1	96.5	54.4	0.0	315.6	166.6	87.7	48.9	97	120
North Devon	0.0	778.2	481.7	199.7	55.3	0.0	562.8	306.1	150.7	51.1	194	274
South Hams	0.0	490.9	111.1	81.3	65.0	0.0	407.7	104.6	69.7	47.6	94	112
Teignbridge	0.0	749.3	219.5	121.7	44.7	0.0	467.6	204.3	95.2	38.7	191	260
Torridge	29.2	1073.8	396.0	202.0	62.0	29.2	671.1	310.6	146.4	56.3	146	208
West Devon	0.0	761.2	232.2	90.4	40.9	0.0	538.1	164.4	78.3	40.9	77	103
Christchurch	0.0	663.3	402.1	185.0	70.9	0.0	352.8	250.0	161.9	64.4	79	119
East Dorset	0.0	501.2	294.0	83.7	32.5	0.0	355.7	217.3	83.7	25.3	106	138
North Dorset	0.0	246.5	261.1	106.2	50.9	0.0	211.3	187.5	91.0	45.3	78	97
Purbeck	0.0	407.7	272.4	136.6	55.9	0.0	349.4	207.0	98.6	55.9	63	78
West Dorset	10.8	560.4	374.3	206.5	62.8	10.8	491.2	262.6	149.0	56.2	180	229
Weymouth and Portland	0.0	804.9	586.4	261.1	24.8	0.0	636.0	461.8	213.1	24.8	171	214
Cheltenham	30.3	447.3	371.7	148.0	41.3	30.3	330.8	209.3	120.5	41.3	186	271
Cotswold	0.0	428.6	224.5	115.5	23.3	0.0	285.8	176.0	107.8	23.3	100	129
Forest of Dean	0.0	403.2	213.9	102.0	29.7	0.0	290.0	166.4	70.6	24.7	92	125
Gloucester	0.0	615.4	542.6	257.7	28.8	0.0	449.6	327.9	212.2	24.0	291	419
Stroud	7.7	554.8	240.7	145.1	38.8	7.7	402.5	167.0	110.3	34.9	165	225
Tewkesbury	9.5	437.6	139.6	96.8	30.7	9.5	391.5	120.4	80.7	25.6	102	117
Mendip	8.0	727.0	306.7	137.8	55.4	8.0	502.5	251.3	128.6	43.5	207	268
Sedgemoor	7.2	649.6	275.3	150.5	47.0	7.2	465.4	240.4	138.9	39.7	213	264
South Somerset	5.4	783.8	310.4	174.4	49.1	5.4	533.0	230.7	139.5	44.2	300	410
Taunton Deane	0.0	948.0	439.4	178.4	53.9	0.0	613.8	341.8	140.2	46.2	259	360
West Somerset	0.0	987.5	337.3	69.5	17.5	0.0	548.6	243.6	69.5	17.5	47	72

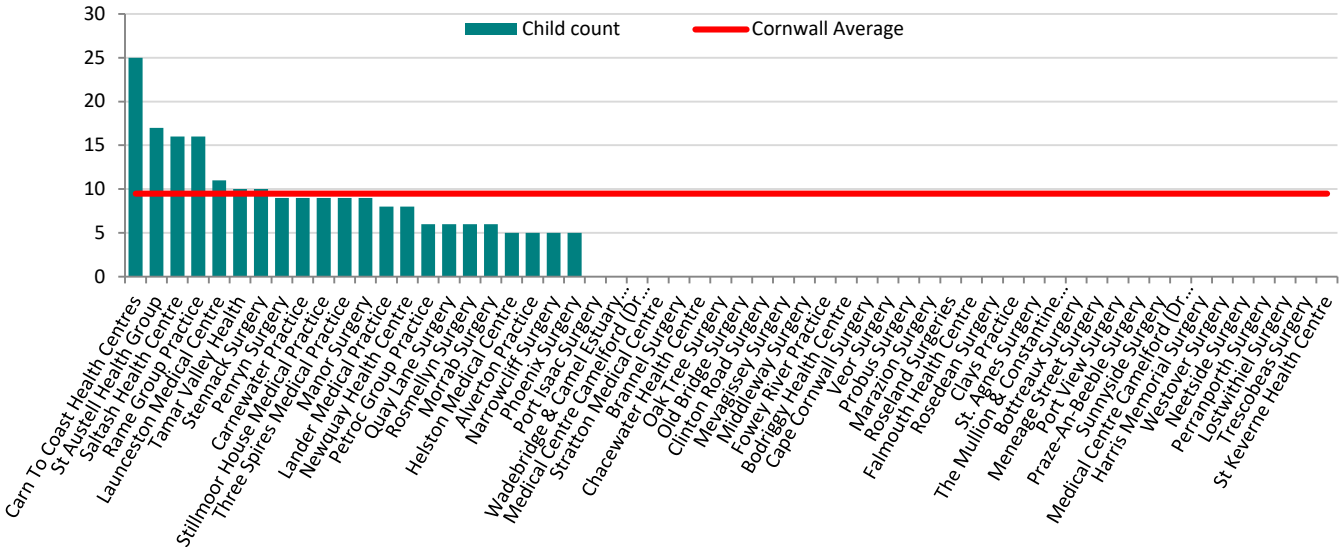
Key Messages

- Self-harm is a public health priority in the South West because the region has the highest rates of emergency hospital admissions for intentional self-harm. In 2016/17, the overall age-standardised admission rate for self-harm ranged from 84.1 per 100,000 in London to 247.6 per 100,000 in the South West[27].
- In the South West, the rate ratio of admissions to patients was lowest among 0-9 year-olds (1.05) and highest among 10-24 year-olds (1.39), indicating higher levels of repeat admissions. The table demonstrates that the 0-9 and 10-24 year olds had the lowest and highest age-specific rates of self-harm admissions, respectively. Furthermore, women aged between 10-24 years had higher levels of repeat admissions than those in other age groups.
- Those who self-harm have a 1 in 6 chance of repeat attendances at Accident and Emergency within a year. It is possible that these repeat admissions may partially explain higher rates of self-harm, and warrants further investigation.

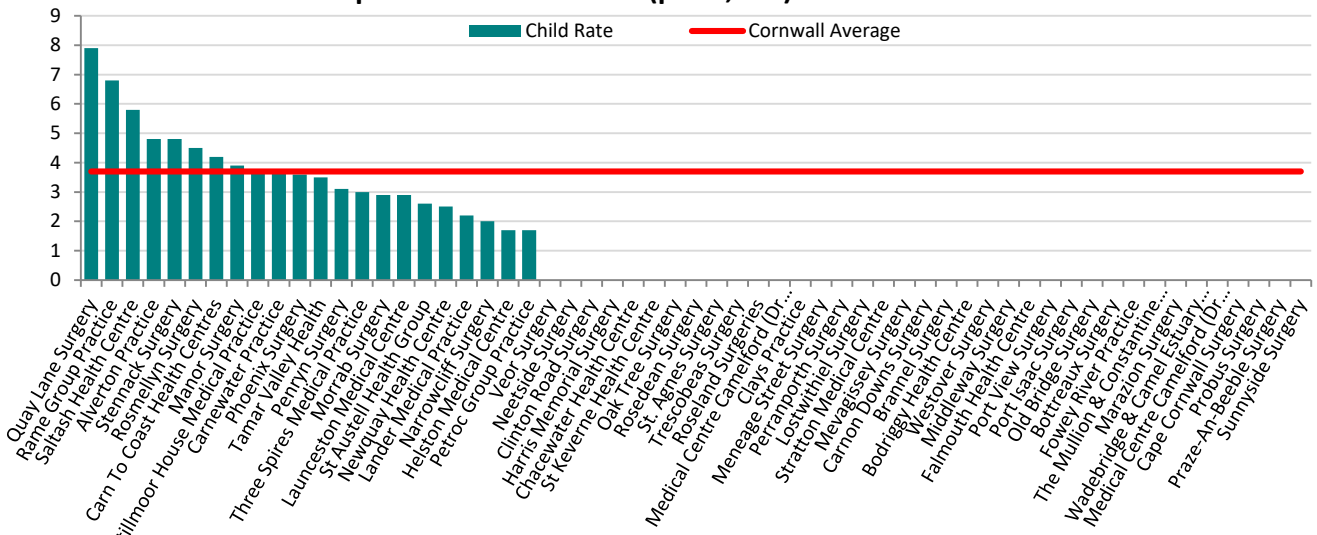
Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Contact with services

Self-harm Hospital Admissions - latest data June 2018 – CYP [i]



Self-harm Hospital Admissions Rate (per 1,000) - latest data June 2018 – CYP [i]



Key Messages

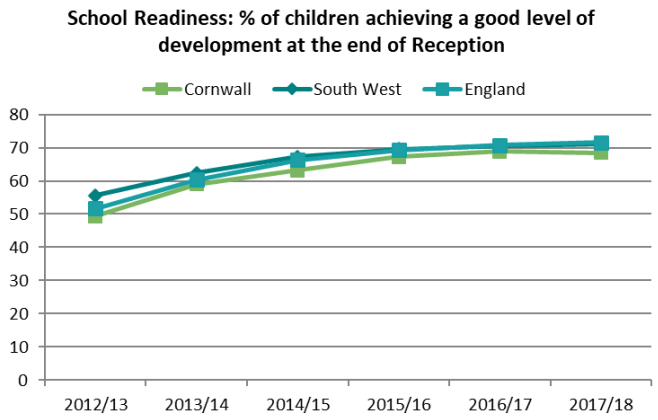
- MHSDS self-harm data from June 2018 provides an overview of the number and rate of self-harm related admissions at the practice level. During this month, there were 210 childhood self-harm attendances (Cornwall average of 9.5 attendances). This is likely to be an under estimate of the true impact of self-harm on children and young people.
- Some of the practices with higher rates of mental health A&E admissions corresponds to higher rates of self-harm attendances. This included Carn to Coast, the Alverton practice, Stennack surgery, Rosmellyn surgery and the Manor surgery.
- In June 2018, the number of self-harm admissions varied considerably from 0 to a total of 25 patients from the Carn to Coast Health Centre in Camborne. The Quay Lanes Surgery had a lower number of self-harm admissions (6 patients), but the highest rate of admissions during the same month (7.9 per 1,000 children) when compared with the average rate (3.7/1,000).
- Eight practices had a higher than average rate for self-harm admissions, which included the Carn to Coast Health centre. Understanding the long-term trends between practices with none versus high admission rates may help inform future self-harm policies. This should be combined with a better understanding of healthcare utilisation (e.g. repeat admissions) among this population.

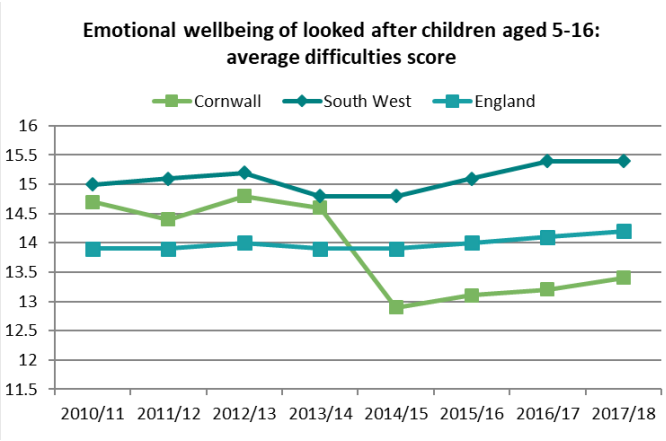
Joint Strategic Needs Assessment

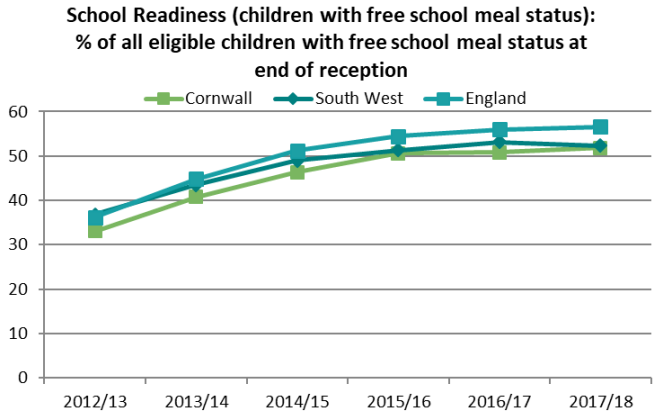
Children and Young People's Mental Health 2019: Protective and Preventive Factors

With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is essential. Local authorities have a duty to promote wellbeing among children and young people. As part of this remit, local authorities collect data from a strengths and difficulties questionnaire (SDQ). This provides a total difficulty score ranging from 0 to 40; a higher score indicates greater difficulties. The below graph presents average difficulty scores for children looked after continuously for at least 12 months and aged 5-16, and for whom an SDQ score was received. Difficulties scores are lower across Cornwall than the South West and appear to be declining ; indicating an improvement until 2014/15 where there appears to be a slight rise in scores[26]. The rapid decline in difficulties score in 2013/14 requires further investigation.

Being ready for school and able to participate in learning is associated with a range of mental health benefits; contributes to the adoption of healthy behaviours; promotes social inclusion; and cohesion within society. Both formal and informal learning have a direct impact on mental wellbeing, protecting against mental illness (e.g. depression) and helps provide resilience to stress and adverse life events. In Cornwall, the percentage of children reaching a good level of development at the end of the Early Years Foundation Stage (EYFS) is increasing. While the percentage of children with free school meals status reaching a good level of development is lower, there is a consistent improvement in school readiness. However, both measures of school readiness is lower than the average across England[26].

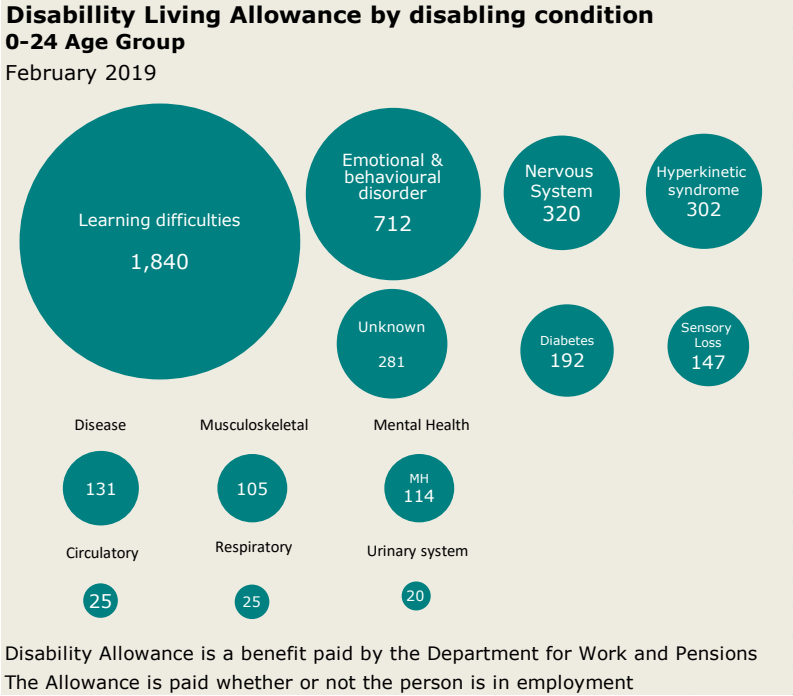


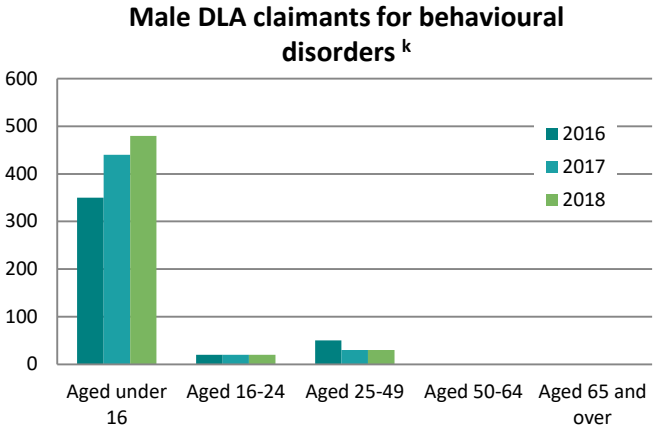


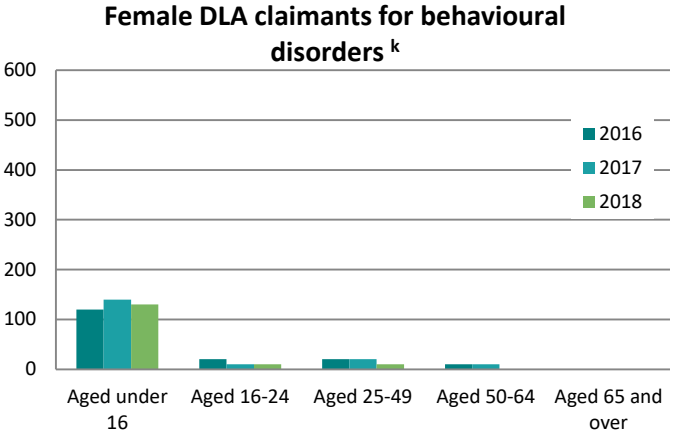


Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019: Benefit claimants for a disability







Key Messages

People with a mental health problem are able to apply for the disability living allowance (DLA). The diagram on the left illustrates the number of people aged between 0-24 years accessing DLA benefit for in February 2019. Those with a learning disability make up majority of the claimants, however, the second largest group are those with an emotional and behavioural disorder. This demonstrates the potential mental health problems experienced by this vulnerable population.

A small number of Disability Living Allowance (DLA) claimants for children and young people are made for psychosis and psychoneurosis (79 in Feb 19). DLA claims for behavioural disorders, are highest in boys where there is an increasing number of claimants. The two graphs below present the DLA claimants across all age groups.

There are also over 1,000 employment and support allowance (ESA) claimants under the age of 24 (graph not shown). 870 (74%) of these claims are made for mental and behavioural disorders (Nov 18).

Joint Strategic Needs Assessment

Children and Young People's Mental Health 2019:

Summary of Performance

(please see detail within the report)

Benchmark (compared with England): Better Similar Worse

Indicator	Year	Cornwall Value	Benchmark
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)	2018	2.63%	Worse
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)	2018	2.73%	Worse
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)	2018	2.66%	Worse
Hospital admissions as a result of self-harm (10-14 yrs)	2017/18	297.8 per 100,000	Worse
Hospital admissions as a result of self-harm (15-19 yrs)	2017/18	706.8 per 100,000	Worse
Hospital admissions as a result of self-harm (20-24 yrs)	2017/18	603.0 per 100,000	Worse
School readiness: percentage of children achieving a good level of development at the end of Reception	2017/18	68.5%	Worse
School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	2017/18	51.8%	Worse
Children who started to be looked after due to abuse or neglect: rate per 10,000 children aged under 18	2018	16.3%	Similar
Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years	2018	131.8 per 10,000	Better
Repeat child protection cases: % of children who became subject of a child protection plan for a second or subsequent time	2018	19.6%	Similar
Children in need due to parent disability or illness: rate per 10,000 children under 18	2018	25.2 per 10,000	Worse
Family homelessness	2017/18	0.9 per 1000	Better

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