



Bloom Evaluation Report: Cost Benefit Analysis Strand

December 2021



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About the Authors

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Acknowledgements

We would like to thank the young people of Cornwall and their parents / carers, who have put their trust in the Bloom model and process as a means of getting help. We are also grateful to those organisations and services that participated in this evaluation.

Sincere thanks also go to our colleagues in HeadStart Kernow and CAMHS who provide the foundations of Bloom, and to the professionals across the statutory, non-statutory and voluntary sectors – past and present – who have helped establish Bloom across Cornwall.

The support and guidance provided by the members of the Bloom Evaluation Working Group has been invaluable. The industry and good humour of Dan Robinson, the Senior Bloom Administrator, have both been noteworthy throughout the evaluation.

We would like to thank The National Lottery Community Fund for their vision and financial support through HeadStart Kernow, enabling us all to make a real difference to children and young people in Cornwall who are experiencing emotional, social and mental health difficulties.

Executive Summary

This report is one of a suite, each report noting the findings from one strand of the evaluation of the Bloom model and process. An Executive Report of the full evaluation is also available. This report considers the findings of a cost benefit analysis of the Bloom model and process.

Established as a professional consultation model across Cornwall by 2019 for young people experiencing difficulties with their emotional, social or mental wellbeing, Bloom is a true partnership initiative, primarily between CAMHS and HeadStart Kernow (HSK), with participation from a wide range of statutory, non-statutory and voluntary organisations. To date however, it has not been possible to understand the costs and benefits of the model to the senior partners (CAMHS and Cornwall Council), and more broadly to society; and, perhaps most importantly, to the children and young people whose referrals are discussed within the Bloom Professionals Consultation (Bloom Profs) meetings.

This report reflects on the cost modelling of the Bloom model undertaken by the Bloom Evaluation Project Team (Deborah Clarke, the Bloom Operational Lead, and Derek Thompson, Bloom Project Officer and Data Analyst), the benefits of the model, and the conclusions drawn from a literature review. It also considers the development of that cost modelling and a cost benefit analysis undertaken by the National Children's Bureau (NCB), and the environmental impact of the change from in-person to virtual Bloom Professionals Consultation meetings.

For the first time, cost modelling undertaken by the Bloom Evaluation Project Team allows conclusions to be drawn regarding the cost of the model to each of its senior partners (CAMHS and Cornwall Council (through HeadStart Kernow)). The cost-modelling also enables a financial cost per young person discussed within the Bloom model to be attributed, so allowing direct per capita comparisons to be made with other interventions and services providing support to young people within Cornwall and more widely.

The cost of the Bloom virtual model per annum is £140k¹; the cost of the model per young person is £533 (based on the 263 referrals discussed and closed through the virtual model in 2020).

The national and local context within which Bloom operates is set out in the Appendices, whilst importantly this report also considers the findings of a cost benefit analysis conducted by the NCB (Appendix 1: *The Bloom consultation model: potential costs avoided analysis*). The NCB has noted that there are challenges in undertaking analyses of economic cost since they are unable to capture the full potential impact of issues under consideration and of the failure to intervene early. However, the NCB analysis aims to understand the potential

¹ Modelling calculations include in-kind costs incurred by professionals from other organisations / services through attending Bloom Profs meetings but not office accommodation costs or staffing on-costs for Senior Partners or others

costs to services, society, families and young people themselves associated with the wide-ranging needs² with which young people present within Bloom. These potential financial costs to society averted by Bloom as noted within the NCB Report, are amongst the benefits of the Bloom model to young people, professionals and the wider ecology of children's services within Cornwall.

Beyond any potential financial savings, other benefits of Bloom include the model's enabling of child-centred, asset-focussed holistic discussions of young people, leading to person-centred, timely and appropriate suggestions for support; Bloom's collaborative and collegiate structure; and the opportunities it provides for professional networking, upskilling and information-sharing. These other benefits are recounted in many of the reports which together form the comprehensive Bloom evaluation undertaken during the 2020/21 academic year, of which this Report is part.

This report, together with the other reports within the full evaluation of Bloom, will help to inform the future development of Bloom.

² Focussing on distinct referral datasets

Conclusions

The analysis contained within this report allows the following conclusions to be drawn:

A developing understanding of the costs of non-intervention

Despite the difficulties inherent in attributing costs to non-intervention for young people with mental ill-health and other presentations, acknowledged in the studies and reports consulted for this report, it is clear that these costs are both societal and personal, and can often pertain to life-long difficulties and disadvantage should these not be addressed at the earliest opportunity. As part of this evaluation strand the NCB were asked to deliver a cost benefit analysis based on five prevalent referral factors noted within Bloom referrals: anxiety; self-harm; depression / low mood; families affected by domestic violence and abuse; and not attending school regularly.

The NCB analysis notes that their findings *'could be said to underestimate, even in terms of economic costs, the impact of the issues considered'* and concludes that the *'total potential costs to services society, families and young people amongst the 2019 closed cases resulting from all five referral factors is estimated to be in the region of £4.29 million to £7.23 million. **This equates to an average of £19,881 to £33,472 for each [of] the young people who had at least one of the five referral factors considered by this analysis'*** (our emphasis).

In the local context, in 2019/20 Cornwall Council commissioned 300 places per annum at £20k per place (ie £6m) for young people to attend an Alternative Provision Academy (APA).³

Cost-effectiveness of Bloom

The robust cost- and resource-modelling undertaken for this report allows for the first time an understanding of the costs of the Bloom model, and those for each of the senior partners (CAMHS and Cornwall Council (through HeadStart Kernow)). It also allows direct per capita cost comparisons to be made with other interventions and services.

The cost of the Bloom virtual model per annum is £140k⁴; the cost of the model per young person is £533 (based on the 263 referrals discussed and closed through the virtual model in 2020).

The cost of the Bloom model per annum for CAMHS and Cornwall Council jointly is £104k for the virtual model; £143k for the pre-Covid19 face-to-face model.

³ Source: Cornwall Council

⁴ Modelling calculations include in-kind costs incurred by professionals from other organisations / services through attending Bloom Profs meetings but not office accommodation costs or staffing on-costs for Senior Partners or others

The overall cost of the Bloom model includes in-kind costs incurred by professionals from other organisations / services through attending Bloom Profs meetings. Such additional costs for Bloom per annum equate to £36k for the virtual model; and £35k for the pre-Covid19 face-to-face model.

The robust cost- and resource-modelling undertaken for this report allows for the first time direct per capita cost comparisons to be made with other interventions and services. It is beyond the remit of this report to undertake those comparisons, but other reports in the wider Bloom evaluation contain many comments attesting to the value of Bloom to the wider ecology of children's services within Cornwall, and to its cost-effectiveness.

Benefits of Bloom within the support ecology of Cornwall

The benefits of Bloom are noted within the other reports which together form this Bloom evaluation. They note that the Bloom model provides a 'safe space' valued by professionals able to speak candidly together about the young person's presentation and needs, which may include family and other dynamics. Professional networking, shared learning, peer support, cross-team and cross-organisation working, the sharing of risk, informal supervision, and a deeper understanding of psychological presentations and formulation are other benefits of the Bloom partnership approach to helping support those young people who do not meet the criteria for CAMHS or Primary Mental Health (PMH).

The attendance at every Bloom Professionals Consultation (Bloom Profs) meeting of a CAMHS Clinical Psychologist and a PMH Worker allows psychological formulations to inform suggestions for support made at the meetings, and facilitates the swift movement into CAMHS / PMH should the discussion raise relevant concerns that were not apparent from the referral.

There were 39 cases in 2020 where prima facie the referrals did not meet CAMHS / PMH criteria, but which, following a Bloom discussion, were moved into those services without the need for further referral. Such streamlining of processes is an exemplar of cost and resource savings.

Recommendations

Recommendation 1: that Bloom is recognised as delivering a cost and time efficient and effective service for young people and professionals

Recommendation 2: that Bloom is placed on a sustainable footing, with adequate resourcing to ensure it is able to continue to deliver the Bloom model in a timely and robust manner to the benefit of young people and professionals

Recommendation 3: that Bloom is fully funded as a service across Cornwall, taking into account the evidenced impact on young people's and their families' lives, as well as the evidenced financial costs to young people, their families, and wider society when young people are not able to thrive and reach their full potential

Introduction

The Bloom Cornwall-wide Steering Group (CWSG) agreed in September 2020 that a comprehensive evaluation of the Bloom model and process should be undertaken. A sub-group of the CWSG, the Evaluation Working Group (EWG), was established and met regularly to provide advice, support, sense-check, and ensure that evaluation timescales remained on track.

Strands within the overarching Bloom evaluation included consideration of:

- An analysis of the original Bloom Penwith pilot business cases
- Cost Benefit Analysis of Bloom
- Senior Stakeholders
- Core Bloom Professionals Consultation meeting attendees
- Bloom Professionals Consultation meeting - other attendees
- Bloom 'service providers' (organisations suggested at a Bloom Professionals Consultation meeting which might provide appropriate support for the young person being discussed)
- Parents / Carers
- Children and Young People
- Bloom Leadership Group
- Bloom Steering Group members
- Bloom Data and Analysis Comparison Report 2019 and 2020

This report is therefore one of a suite, each report noting the findings from one strand of the evaluation of the Bloom model and process. An Executive Report of the full evaluation is also available.

This report considers the findings of the Cost Benefit Analysis (CBA) evaluation strand, including not only reflections upon the work commissioned from the NCB and contained within their report at Appendix 1, but also the research and detailed cost-modelling work undertaken by the Bloom Evaluation Project Team.

Methodology

It was agreed by the Evaluation Working Group (EWG) that a cost benefit analysis of the Bloom process and model should form part of the comprehensive evaluation of Bloom conducted during 2020/21.

The focus of this strand of the Bloom evaluation was to determine the costs of the Bloom model as delivered through face-to-face or online 'virtual' Bloom Profs meetings; and to understand the societal costs and those to an individual were Bloom not to be available within the wider ecology of children's and young people's services within Cornwall.

The Evaluation Project Team built a cost and time resource model to provide for the first time a means of calculating the cost of the Bloom model to each of its senior partners (CAMHS and HeadStart Kernow). Work was also undertaken to understand the carbon footprint of the Bloom model and process. This is included within this report, as is a consideration of the findings of research undertaken by the NCB at the behest of the Evaluation Project Team. This report therefore provides some context for a consideration of continuing and future investment in Bloom, post the involvement of HeadStart Kernow.

The NCB were also separately supporting HeadStart Kernow as they were funded by The National Lottery Community Fund as Support and Development Provider, providing bespoke support to the six HeadStart partnerships across England. The Bloom Evaluation Project Team proposed that the NCB should undertake a structured cost benefit analysis focussing on gaining an understanding of the potential costs to services, society, and families and young people themselves, which are associated with some of the documented referral factors considered by Bloom. The NCB would provide a report of their findings, so giving the Bloom evaluation a measure of externality. This approach was agreed by the EWG, and so the NCB was asked to conduct such research, which was to be based on referral factors previously identified by the Bloom Evaluation Project Team.

During 2020, the Bloom CWSG agreed that it would be helpful to capture the underlying reasons for referrals sent to Bloom (ie the referral factors), in order to facilitate a more complete understanding of the support needs of children and young people in each of the six localities within Cornwall, and across Cornwall as a whole. As an integral part of the data collection and analytical work of the Bloom Project Team, a number of datasets for all Bloom cases, including those for referrals closed in 2019, were collected.

In order to fulfil the requirement from the CWSG, the Bloom Evaluation Project Team reviewed and determined a range of referral factors for analysis, the majority of which (10 of 12) were drawn from both CAMHS and Together for Families (Troubled Families – now known as Supporting Families) identifiers.

The Bloom Project Officer reviewed the Bloom referral document and the Bloom Consultation Plan for each young person whose case was closed in 2019, and recorded instances of the 12 referral factors which had been agreed. Both the referral and the Consultation Plan were considered since

- Bloom referrals can be completed by anyone, whether a professional with knowledge of the young person, or the family / young person themselves, so perceptions of factors can vary
- the Bloom Consultation Plan is drafted in the Bloom Professionals Consultation meeting, as part of the professionals' discussion, and notes the psychological formulation agreed in the meeting

In preliminary scoping discussions with the NCB, all 12 recorded referral factors were considered for their cost benefit analysis; a final list of five factors was determined the Bloom Project Evaluation Team and agreed by the EWG as the basis for the analysis by the NCB.

The five factors were agreed based upon the following determinants

- **The availability or assumed availability of relevant data from previous studies**

Prior to the opportunity to work with the NCB arising, the Bloom Evaluation Project Team had previously undertaken a partial literature review and contacted a number of organisations (including Public Health England, the Anna Freud Centre, the Early Intervention Foundation, the Mental Health Foundation and the London School of Economics) to source the latest information regarding costing models. Following the NCB's engagement with this strand of the Bloom evaluation, their significant experience in research and analysis of this kind also informed decision-making regarding the referral factors to include within their cost benefit analysis.

- **Referral factors that were not life-long conditions**

It was agreed that those referral factors which were life-long conditions would be excluded from the NCB analysis. While Bloom is recognised as helping young people with life-long conditions, as well as their families, Bloom's focus is young people's emotional, social and mental wellbeing.

- **Referral factors seen in sufficient frequency within the 257 Bloom cases closed in 2019**

It was agreed that the referral factors chosen for the NCB's cost benefit analysis should be noted in sufficient numbers of referrals within the 257 cases closed in Bloom in 2019. The metric agreed was that at least 20% of the population of closed Bloom cases should reference each referral

factor selected for NCB analysis. 217 out of 257 (84% of all closed cases in 2019) contained one or more of the five referral factors agreed.

Referral Factor	Source	Chosen for Cost Benefit Analysis?	Rationale
Children who have not been attending school regularly	Together for Families	YES	Referenced in the preliminary document review, prior to NCB's involvement, and recorded in 21.8% of all cases closed in 2019
Families affected by domestic violence and abuse	Together for Families	YES	Assumed to be referenced in other studies, and recorded in 26.5% of all cases closed in 2019
Parents or children with a range of health problems	CAMHS / Together for Families	NO	This referral factor incorporates a number of sub-factors, e.g. the child referred also has a physical and/or cognitive health issue, a parent or sibling may have a physical and/or cognitive health issue, or a parent may be impacted by substance misuse. As such, it would be difficult to disaggregate this referral meaningfully for the cost benefit analysis. Recorded in 52.9% of all cases closed in 2019
ADHD	CAMHS	NO	Life-long condition. Recorded in 7.4% of all cases closed in 2019
ASD/ASC	CAMHS	NO	Life-long condition. Recorded in 21.8% of all cases closed in 2019
Depression/Low Mood	CAMHS	YES	Referenced in the preliminary document review, prior to NCB's involvement, and recorded in 22.8% of all cases closed in 2019
OCD	CAMHS	NO	Low population. Recorded in 3.5% of all cases closed in 2019
Trauma	CAMHS	NO	Low population. Recorded in 15.6% of all cases closed in 2019
Self harm	CAMHS	YES	Assumed to be referenced in other studies, and recorded in 27.2% of all cases closed in 2019
Anxiety	CAMHS	YES	Assumed to be referenced in other studies, and recorded in 49.8% of all cases closed in 2019
Grief	Bloom Project Team	NO	Low population. Only 6.2% of all cases closed in 2019
Gender Issues	Bloom Project Team	NO	Low population. Only 1.9% of all cases closed in 2019

The Bloom Evaluation Project Team agreed a timeframe for the delivery of the report for this evaluation strand with the NCB, having previously undertaken

further desk research to deepen the understanding of the potential societal cost-savings of Bloom.

Appendix 2 gives information about the Bloom model and process, its genesis and development, and its operation.

As with all Bloom evaluation reports, this Bloom report has been circulated to all members of the EWG including Dr Lisa Gilmour (Bloom Clinical Lead) and Charlotte Hill (Head of Partnerships, Innovation & Wellbeing, Children's Health & Wellbeing, Cornwall Council; Chair CWSG), as well as to the HeadStart Kernow Learning Lead for final approval prior to publication. It has also been circulated to CAMHS senior management.

Analysis

Bloom is a model and a process rather than a service, and with additional resource provided by HeadStart Kernow the Bloom model was rolled out, from an initial pilot in Penwith, across Cornwall from 2018. This roll-out was completed in 2019, with the Bloom model established in each of the six localities within Cornwall, supported by a formal governance architecture and administrative and management functions.

Established as a professional consultation model across Cornwall by 2019 for young people experiencing difficulties with their emotional, social and mental wellbeing, Bloom is a true partnership initiative, primarily between CAMHS and HeadStart Kernow (HSK), with participation from a wide range of statutory, non-statutory and voluntary organisations. To date however, it has not been possible to understand the costs and benefits of the model to the senior partners, and more broadly, to society.

This report considers the wider context of costs and benefits of interventions and non-interventions for children and young people's social, emotional and mental wellbeing. Additional sections reflect upon the operational cost modelling, literature review, and Bloom's carbon footprint, all undertaken by the Bloom Evaluation Project Team.

This report also reflects upon the findings of the NCB cost benefit analysis of five identified referral factors as related in their report at Appendix 1: *The Bloom consultation model: potential costs avoided analysis*.

The wider Cornish context

There are a number of national and local organisations with a focus on mental health promotion and prevention which provide reports and datasets giving insights into the local demographic profile and variances within Cornwall. Some indicative evidence from these reports is noted here.

The Index of Multiple Deprivation (IMD) data published by the Ministry of Housing, Communities & Local Government in September 2019 shows that Cornwall is ranked 83 of 317 local authority areas for deprivation.

The following table is contained within Cornwall Council's Index of Multiple Deprivation 2019 (Appendix 3):

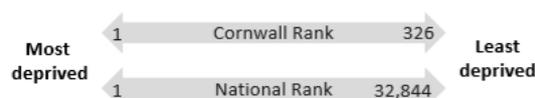


Cornwall's Neighbourhoods: High Deprivation

This table shows the 17 neighbourhoods (LSOAs) in Cornwall with the highest levels of deprivation. These neighbourhoods are in the top 10% most deprived areas in England. There are 326 neighbourhoods in Cornwall and a total of 32,844 across England.

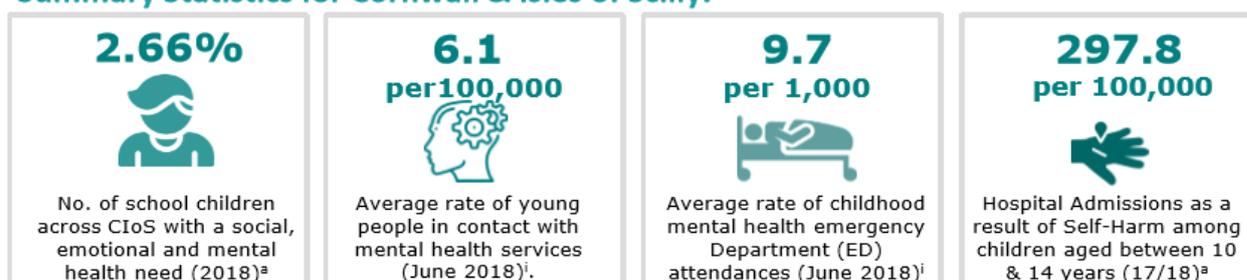
Cornwall Rank		National Rank		LSOA Name	Community Network Area
2019	2015	2019	2015		
1	4	577	1133	Camborne Pengegon	Camborne and Redruth
2	1	884	414	Penzance Treneere	Penzance, Marazion and St Just
3	2	1072	606	Redruth North, Close Hill, Strawberry Fields and Treleigh	Camborne and Redruth
4	3	1119	964	Camborne College Street and the Glebe	Camborne and Redruth
5	6	1661	1512	Camborne Town Centre	Camborne and Redruth
6	7	1712	1733	St Austell Penwinnick and Town Centre	St Austell and Mevagissey
7	11	1821	2415	Kinsman Estate and Monument Way	Bodmin
8	5	2134	1350	Illogan East Pool Park	Camborne and Redruth
9	8	2447	2147	Penzance St Clare and Town	Penzance, Marazion and St Just
10	17	2579	2939	Bodmin Town Centre and Berryfields	Bodmin
11	14	2675	2755	St Austell Alexandra Road and East Hill	St Austell and Mevagissey
12	10	2688	2378	Newquay Town Centre	Newquay
13	12	2985	2497	St Blazey West	St Blazey, Fowey and Lostwithiel
14	22	3199	3816	Camborne North Parade and Rosewarne Gardens	Camborne and Redruth
15	15	3218	2797	Newquay Narrowcliff	Newquay
16	16	3228	2938	Newlyn Harbour and Gwavas	Penzance, Marazion and St Just
17	9	3275	2375	Liskeard St Cleer Road and Bodgara Way	Liskeard and Looe

 www.cornwall.gov.uk



The Joint Strategic Needs Assessment (JSNA) 2019 (Appendix 4) notes that the number of school age pupils (all ages) with social, emotional and mental health needs is higher across Cornwall and the Isles of Scilly (CIoS) (2.66%) than in England (2.39%). Summary key statistics from this report are given below:

Summary Statistics for Cornwall & Isles of Scilly:



Experiences during childhood have a long-lasting impact on a child's mental and physical health and wellbeing. According to Health Visiting Early Help assessments as noted within the JSNA report:

- 4.3% of children aged under 5 in CIoS have been affected by 4 or more adverse childhood experiences (ACEs)
- 15.6% of under 5s in CIoS have a parent affected by mental illness or depression

The Wellbeing Measurement Framework (WMF) survey, introduced by Headstart Kernow, assesses children's general wellbeing, their resilience and mental health. The JSNA report notes that in 2017/18 the survey was completed by 8807 year 8 and 9 students from 37 schools across Cornwall. From that year's study those more likely to have a low mental wellbeing score are girls, year 9 pupils and the most deprived children as well as

- young carers who had a 68% increased chance of having a low mental well-being score;
- those children receiving SEN support who were 46% more likely to have low mental well-being; and
- pupils receiving free school meals who had an 84% increased risk of having a low mental wellbeing score.

The Schools Health Education Unit (SHEU) related behaviour survey was conducted in 2019 to assess the wellbeing of primary and secondary pupils in Cornwall aged 7 - 15 during the summer term 2019. 4759 pupils participated. The key messages from this data as reported within the JSNA include:

- 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.
- 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. This is a similar finding to a comparative study in 2017.

In the local context, in 2019/20 Cornwall Council commissioned 300 places per annum for young people to attend an Alternative Provision Academy (APA). The split between secondary and primary pupils was roughly 80% / 20%; the highest use of APA placements tends to be for Key Stage 4 pupils (ie years 10 and 11). However, there has been an increase in the numbers of very young pupils (Reception and Y1) being referred for provision⁵.

Reflections on the NCB Report

The NCB report *The Bloom consultation model: potential costs avoided analysis* (Appendix 1) notes that they have taken a pragmatic approach to the cost benefit analysis they were charged with producing. Their findings are based on an analysis of five referral factors amongst young people whose cases were considered through Bloom, together with evidence from existing studies, which looked at costs associated with those factors in the wider population. The criteria underpinning the selection of the referral factors is rehearsed within the preceding Methodology section of this report.

⁵ Source: Cornwall Council

Importantly, the NCB report stresses that analyses based on economic cost cannot capture the full potential impact of the issues under consideration and, consequently, of any failure to intervene early.

The selection of the five referral factors which the NCB considered in relation to societal and individual costs is detailed within the Methodology section of this report. The five referral factors were:

- **Anxiety** [recorded in 49.8% of all cases closed in Bloom in 2019]
- **Self-harm** [recorded in 27.2% of all cases closed in Bloom in 2019]
- **Depression / low mood** [recorded in 22.8% of all cases closed in Bloom in 2019]
- **Families affected by domestic violence and abuse** [recorded in 26.5% of all cases closed in Bloom in 2019]
- **Not attending school regularly** [recorded in 21.8% of all cases closed in Bloom in 2019]

The NCB analysis notes that their findings *'could be said to underestimate, even in terms of economic costs, the impact of the issues considered'* but concludes that the *'total potential costs to services society, families and young people amongst the 2019 closed cases resulting from all five referral factors is estimated to be in the region of £4.29 million to £7.23 million. **This equates to an average of £19,881 to £33,472 for each [of] the young people who had at least one of the five referral factors considered by this analysis.** The highest total costs are in relation to family income/productivity, in the region of £870,632 to £1.8 million. The smallest are in relation to Education (£385,154- £532,136)'* [our emphasis].

Bloom Operational Cost Model

As part of this evaluation strand, the Bloom Evaluation Project Team set out to determine for the first time since Bloom was piloted in 2014/15 the resource cost of Bloom per young person, through building a cost and time resource model of Bloom.

Bloom has evolved from a pilot within one locality (Penwith) to an established model with an overarching governance architecture, functioning in each of the six localities in Cornwall. It remains, however, a model and process rather than a service: in collaborative, multi-agency Bloom Profs meetings, it brings together CAMHS Clinical Psychologists, Primary Mental Health Workers, HeadStart Locality Coordinators, Locality Early Help team members, school / college staff, and a variety of other professionals including those from the voluntary and community

sector, to consider carefully and as holistically as possible each young person's referral, their presentation and needs, and to discuss how they might best be supported. Referrals are screened and allocated to Bloom by the CAMHS Access Team, which is co-located within the Early Help Hub.

With the advent of the Covid-19 pandemic, Bloom's pragmatic test-and-learn approach, which has been evident from its inception, enabled flexibility and agility in continuing to ensure that referrals for children and young people continued to be discussed in an holistic and timely manner. Through re-engineering the Bloom model such that Bloom Profs meetings were held virtually, during 2020 and notwithstanding the pandemic, Bloom was able to assist 263 young people to receive appropriate and timely support, an increase over the number in 2019 (257).

In order to determine the costs of Bloom, the Bloom Evaluation Project Team built a cost and time resource model. This was underpinned by detailed calculations based on an in-depth analysis of:

- the return travel time required per attendee (for attending Bloom Profs meetings in-person)
- sampled and averaged distances from bases to Bloom Profs meeting locations, calculated at a standard mileage rate
- an assumed average hourly rate for every participating role in Bloom Profs meetings (including nominated and other professionals as well as the core attendees⁶) based on extant salary scales
- the administrative cost of supporting Bloom processes and data analysis, including the setting up of Bloom Profs meetings
- the number of hours otherwise required to support Bloom by CAMHS and HeadStart Kernow throughout the year

Broadly then, two different models through which Bloom's resource costs could be understood were developed:

- the organisational cost for the main partners (based upon staffing resource currently contributed by HeadStart Kernow and CAMHS)
- the cost per young person's referral discussed and closed with support suggestions (based on typical duration and professional attendance)

Further, given that the Bloom model had had to be re-engineered at pace during 2020 to meet the exigencies of the Covid-19 pandemic, the cost and time resource modelling took note of the variations of mode for the Bloom Profs

⁶ Core attendees are the Clinical Psychologist, a Primary Mental Health Worker, and a HeadStart Locality Coordinator (chair)

meeting, leading to separate figures for costs for the pre-Covid face-to-face Bloom model and the current virtual model.

From the cost and time resource model developed, the following table gives the high-level operational and clinical participation tasks for Bloom⁷.

Bloom Partnership	Tasks
Operational (HeadStart Kernow)	<p>Operational management</p> <ul style="list-style-type: none"> Strategy Process design and development Communications Chairing of Bloom Profs Troubleshooting <p>Governance</p> <ul style="list-style-type: none"> Authoring / distribution of papers to CWSG and Locality-based Steering Groups Attendance at CWSG and Locality SGs <p>Administration</p> <ul style="list-style-type: none"> Updating caseload spreadsheets Responding to all Bloom queries Liaison with Parents / Nominated Professionals / others Nominated Professional feedback survey processing Processing of Consultation Plans Updating RiO All other Bloom administration <p>Management Information and Data analysis</p> <ul style="list-style-type: none"> Data capture Evaluation Reporting Data analysis Research
Clinical (CAMHS)	<p>Clinical management</p> <ul style="list-style-type: none"> Strategy Resource management (clinical input into Bloom) Troubleshooting Attendance at CWSG and Locality SGs Participation in Bloom Profs meetings Psychological formulation input to Consultation Plans Writing of Consultation Plans Updating RiO as necessary

The cost of the Bloom model per annum for CAMHS and Cornwall Council jointly is £104k for the virtual model; £143k for the pre-Covid19 face-to-face model.

The cost per young person in 2019 in the virtual model to the senior partners (ie CAMHS and Cornwall Council) would have been £405 (£104 000/257⁸), whilst in the face-to-face model it would have been £557 (£143 000/257).

⁷ Modelling did not include office accommodation costs or staff on-costs

⁸ 257 = the number of closed cases in Bloom in 2019

The cost per young person in 2020 in the virtual model to the senior partners would have been £396 (£104 000/263⁹), whilst in the face-to-face model it would have been £544 (£143 000/263).

The average cost per young person of the Bloom model to the senior partners for 2019 and 2020, irrespective of meeting mode (virtual / face-to-face) is therefore £475.50.

These are specific costs: within HeadStart there is allocated resource to support Bloom (including a HeadStart Locality Coordinator who acts as the Bloom Operational Lead; other HeadStart Locality Coordinators who act as Chairs for Bloom Profs meetings; a Bloom Senior Administrator and a part-time Bloom Project Officer / Data Analyst). The CAMHS involvement in Bloom is part of a commissioned function *'to provide expert consultation and advice to partners in the localities to support the management of emerging, mild and moderate need of children and young people – as part of the iTHRIVE specification (i.e. an element of total CAMHS spend not a discrete commissioned service)*¹⁰.

The overall cost of the Bloom model includes not only those costs which focus on the senior partners' clinical and professional participation and management, but also those incurred by other professionals by attending Bloom Profs meetings. Such additional costs have been calculated through the modelling undertaken¹¹ by the Bloom Evaluation Project Team. The high-level figures are noted in the following table

Virtual model		Face-to face model	
Per annum	Per young person (263 in 2020)	Per annum	Per young person (257 in 2019)
£36 000	£137	£34 800	£136

These costs are subsumed within each professional's service; it is assumed that they are 'in-kind' costs, and form part of each attendee's service / organisation's recognition of the benefit of inter-professional collaboration towards improving outcomes for young people. It is interesting to note that the costs of the virtual and face-to-face models are similar although there are notable environmental advantages that accrue to the virtual mode through a lower carbon impact.

⁹ 263 = the number of closed cases in Bloom in 2020

¹⁰ Email from NHS Kernow Clinical Commissioning Group August 2020

¹¹ Based upon typical non-senior partner attendance at previous face-to-face and virtual meetings, with an assumed £20 standard hourly rate for calculation purposes

The identified cost of the Bloom virtual model per annum is £140k¹²; the cost of the model per young person is £533 (based on the 263 referrals discussed and closed through the virtual model in 2020).

The robust cost- and resource-modelling undertaken for this report allows for the first time direct per capita cost comparisons to be made with other interventions and services. It is beyond the remit of this report to undertake such comparisons, but other reports in the wider Bloom evaluation contain many comments attesting to the value of Bloom to the wider ecology of children's services within Cornwall and its cost effectiveness. Two examples of such comments are:

- *'Young people who don't meet particular thresholds, or are getting bounced around, can have access to a group of professionals that can really unpick their presentation. Think about the needs, and then put a plan in place for them, or recommendations around a plan, that they might not have had, otherwise... It's thinking a little bit more preventatively. So it's getting that level of understanding of children's presentations in there, right at the start, rather than waiting for children's distress to build.'*¹³
- *'One professional explained that with Bloom "one Primary Mental Health Worker takes... half an hour to an hour to do an assessment, a consultation plan, send it off and it's gone then, it's not on your radar." However if Bloom did not exist "you would have a child, parent, coming into a base to see two primary mental health workers for an hour-and-a-half assessment, Rio to be completed, screening questionnaires, all these other things that are sent off in compliance, that needed to be done when actually I'd say you get similar answers from Bloom".'*¹⁴

It is also notable that respondents to the survey of professionals carried out as part of the comprehensive Bloom evaluation suite mentioned that they would struggle to find the right service should Bloom not be available¹⁵.

Bloom vs costs of non-intervention

The cost of Bloom in Cornwall, delivered virtually in 2020 as noted in the previous section of this report, has been calculated as £140k and at an individual cost of £533 per young person, regardless of which emotional, social and mental well-being concern(s) prompted the referral.

¹² Modelling calculations include in-kind costs incurred by professionals from other organisations / services through attending Bloom Profs meetings but not office accommodation costs or staffing on-costs for Senior Partners or others

¹³ Quote from NCB respondent *Bloom Evaluation Report: Bloom Leadership Team Strand*

¹⁴ Quote from NCB respondent *Bloom Evaluation Report: Bloom Core Attendees Strand*

¹⁵ See *Bloom Evaluation Report: Bloom Professionals Strand (responses to survey question 11)*

In contrast, with specific reference to the five prevalent referral factors, headline costs¹⁶ are noted within the NCB's cost benefit analysis undertaken for this report (it should be remembered that 217 out of 257 (84% of all closed cases in Bloom in 2019) contained one or more of the five prevalent referral factors). The NCB's calculations and literature review were predicated upon the premise that the prevalent referral factors were not addressed at an early stage.

The findings below derive from the NCB Report at Appendix 1 where more information can be found.

Anxiety Bodden, Dirkson and Boegels (2006) note costs of €2,748 / £2,338¹⁷ per family of a clinically referred anxious child per annum.

- Within the closed cases in Bloom in 2019 there were 128 referrals that cited anxiety, equating to a potential financial impact of £299k.

Self-harm Tsiachristas et al (2020) note a cost per presentation in 2020 prices of £632 where it has been assumed that those with a self-harm referral factor would have a 20% chance of presenting at hospital with self-harm in any given year. This gives a total estimated cost up to age 25 of £1,895.

- Within the closed cases in Bloom in 2019 there were 70 referrals that cited self-harm, equating to a potential financial impact of £44k if each young person presented at hospital once.

Depression/low mood Barret et al (2006) note annual costs of £610 for Outpatient/community health care and £17,159 for Social Care (among other costs). From these figures the NCB has estimated a cost per young person in Bloom of £3,146 for Outpatient/community health care and £1,193 for Social Care.

- Within the closed cases in Bloom in 2019 there were 58 referrals that cited depression/low mood, equating to a potential financial impact of £182k for Outpatient / community health care and £69k for Social Care.

Families affected by domestic violence and abuse The Office for National Statistics (2017) notes that childhood witnesses of domestic abuse were significantly more likely to have lower household incomes as adults. A total cost per young person of £503 has been estimated and allocated to the reduced family income category. Also Walby (2004) noted that a total cost per young person of £8,685 has been estimated and allocated to the social care category.

- Within the closed cases in Bloom in 2019 there were 68 referrals that cited families affected by domestic violence and abuse, equating to a potential financial impact of £590k.

¹⁶ See NCB Report *The Bloom consultation model: potential costs avoided analysis* in the Appendices for comprehensive cost breakdowns

¹⁷ Bank of England rate 02/11/2021: <https://www.bankofengland.co.uk/boeapps/database/Rates.asp>

Not attending school regularly Bryant et al (2018) notes that excluded young people typically spend six months to a year in alternative provision but that older young people tend to stay longer.

- Within the closed cases in Bloom in 2019 there were 56 referrals that cited not attending school regularly; Cornwall Council has previously commissioned APA places at a cost of £20,000 each, equating to a potential financial impact of £1,120,000.

The NCB report found that the total potential costs to services, society, families and young people amongst the 2019 closed cases resulting from all five referral factors is estimated to be in the region of £4.29 million to £7.23 million. This equates to an average of £19,881 to £33,472 for each the young people who had at least one of the five referral factors considered by this analysis.

	Very conservative	Conservative	Less conservative
Average per Young Person with at least one of the five selected referral factors	£19,881	£28,417	£33,472

The highest total costs are in relation to family income/productivity, in the region of £870,632 to £1.8 million. The smallest are in relation to Education (£385,154 - £532,136). The NCB notes that this may be partly due to it being harder to draw conclusions on costs to education as a universal and routinely differentiated service, and that studies in relation to just two out of five referral factors identified costs to education. For this reason, caution is advised in any comparison between the cost categories.

Recommendation 1: that Bloom is recognised as delivering a cost and time efficient and effective service for young people and professionals

Recommendation 2: that Bloom is placed on a sustainable footing, with adequate resourcing to ensure it is able to continue to deliver the Bloom model in a timely and robust manner to the benefit of young people and professionals

Recommendation 3: that Bloom is fully funded as a service across Cornwall, taking into account the evidenced impact on young people's and their families' lives, as well as the evidenced financial costs to young people, their families, and wider society when young people are not able to thrive and reach their full potential

Bloom's Carbon Footprint

As part of the comprehensive evaluation of Bloom, of which this report forms part, it was agreed by the Bloom CWSG that the environmental impact of Bloom should also be considered.

A review was undertaken of the following websites

- <https://intranet.cornwallft.nhs.uk/waste-and-carbon-reduction>
- <http://cornwallcouncilintranet.cc.cornwallonline.net/need-to-know/carbon-neutral-cornwall>
- <https://www.ethicalconsumer.org/energy/short-guide-carbon-offsets>

The Analysis Specialist – Carbon Neutral Cornwall at Cornwall Council provided an Emissions Quick Calculator (which has been used to provide a nominal CO² figure within this report) and advised that *'In terms of carbon emissions, by car, you should multiply the mileage by the average car emission factor of 0.28502 – this is based on unknown fuel type of the vehicle. If you do know the vehicle emissions or the fuel type then there are more detailed factors available, which you could then apply and these would generally be lower too.'*¹⁸

In discussion it became apparent that there are multiple challenges and complexities in calculating other environmental impacts including the

- CO² impact of computers, as Bloom moved to virtual Bloom Professionals Consultation meetings rather than face-to-face meetings, in response to the Covid-19 pandemic
- CO² impact of heating individual homes, whilst homeworking is in place, in response to the Covid-19 pandemic
- use of paper documents, whilst acknowledging that the change to virtual meetings has significantly reduced a reliance on paper

As there appear to be no viable calculation models available for such considerations, and for the purposes of this report, the Bloom Evaluation Project Team has focused purely on 'known saved' CO² emissions from the switch from face-to-face to virtual Bloom Professionals Consultation meetings.

The Restormel locality was selected for the carbon footprint calculations since it is neither as compact as Penwith in the far west nor as expansive as North Cornwall in the east. It therefore represents a median area among the six localities within Cornwall. In Restormel, three meeting locations were used on a rotational basis for Bloom so facilitating a robust calculation of the carbon

¹⁸ Email 18 November 2020

footprint for return journeys from office bases to meeting locations, from which an understanding of the Cornwall-wide carbon impact of Bloom could be extrapolated.

To calculate the vehicular CO² impact of a typical face-to-face Bloom Professionals Consultation meeting, the Bloom Evaluation Project Team

- reviewed the attendance of Bloom Professionals Consultation meetings in Restormel and selection of four key members (Clinical Psychologist, HeadStart Kernow Locality Coordinator, Primary Mental Health Worker, and Locality Early Help team member) plus six other attendees
- used Google Directions to calculate the distance from each professional's office base to each of the three Restormel meeting locations (which were used on a rota basis):
 - St Dennis Family Hub
 - Newquay Treviglas Academy
 - St Austell Family Hub
- calculated an average mileage from the three round trips each professional would have, travelling from their office base to the meeting venue and return
- totalled those average miles and the application of the carbon footprint calculation for an average car (unknown fuel) of 0.28502 kg CO²e per mile as indicated by the Analysis Specialist – Carbon Neutral Cornwall.

ROUND TRIPS IN MILES

Core Team and other attendees	BASE	ST DENNIS FAMILY HUB PL26 8AY	NEWQUAY TREVIGLAS SCHOOL TR7 3JA	ST AUSTELL FAMILY HUB PL25 4RA	Average mileage
Clinical Psychologist	PL26	18	36	2	19
Primary Mental Health Worker	PL26	18	36	2	19
HeadStart Locality Coordinator	TR1	32	28	32	31
Early Help Locality Team Member	PL25	14	30	2	15
Professional	PL25	7	30	3	13
Professional	TR1	32	30	32	31
Professional	TR14	49	38	60	49
Professional	TR7	20	2.5	34	19
Professional	PL26	8	21	13	14
Community Facilitator	TR1	32	28	32	31
TOTAL					241

Based upon the above assumptions and calculations, it is possible to infer that, through the use of the virtual Bloom Professionals Consultation meetings, the following CO² emissions have been saved over a typical in-person meeting in Restormel:

CARBON FOOTPRINT (0.28502 kg CO ² e per mile)	Miles	kg of CO ² e	Tonnes of CO ² e
	241	68.68982	0.06868982

Over one year therefore, it is possible to extrapolate that the virtual Bloom Profs meetings have saved at least the following CO² emissions over the in-person Bloom Profs meeting model (based on the supposition that the full capacity of 150 in-person meetings were held per annum):

CARBON FOOTPRINT (0.28502 kg CO ² e per mile)	Miles	kg of CO ² e	Tonnes of CO ² e
	36150	10303.473	10.303473

Literature Review and references

The Bloom Evaluation Project Team consulted and read widely to inform this report and the cost-modelling of Bloom which they have undertaken. Challenges included identifying current or reasonably current literature which explores or references young people's emotional and mental well-being with a focus on outcomes and / or costs, and which is either UK specific, or is comparable to the UK. In seeking to understand the costed impact of the non-availability of Bloom for a young person over their life where no other model / service exists to provide support or an intervention¹⁹, it became apparent that this was an extremely complex evaluation requirement. Despite liaison with several organisations, no pre-existing mode was found to be fully relevant and applicable, and as the NCB has noted in their report at Appendix 1, there are challenges in undertaking analyses of economic cost since they are unable to capture the full potential impact of issues under consideration and of the failure to intervene early.

Of the literature surveyed, the following comments are of note:

'23% of ill health is attributable to mental health problems, 5.5% of research funding is on mental health.' They assert that the *'economic cost of mental illness to the UK is £105 billion, similar to the entire NHS Budget'* (Mental Health Foundation: <https://www.mentalhealth.org.uk/get-involved/faqs>)

The Early Intervention Foundation's report *'Adolescent mental health: A systemic review on the effectiveness of school-based interventions'* states that *'Prevalence data from the Mental Health of Children and Young People (MHCYP) survey suggests that young people's mental health has been deteriorating over the past two decades. In 2017, approximately one in seven young people were identified as having experienced at least one mental disorder (NHS Digital, 2018). The most recent data, which was collected during the first national lockdown (July 2020), suggests that in comparison to previous waves, young people's mental health has deteriorated further. Probable mental health conditions among 11–16-year-olds increased from 12.6% in 2017 to 17.6% in July 2020 (NHS Digital, 2020).'*

The report from the Children's Commissioner: *The state of children's mental health services 2020/21* (Lennon 2021) notes that *'Access to children's mental health services is still not adequate....Spending on children's mental health is slowly increasing but highly variable and still inadequate. The biggest constraint on improvements appears to be spending decisions made locally and nationally. On average, local CCG areas spend less than 1% of their overall budget on children's mental health and 14 times more on adult mental health services than*

¹⁹ Expectation was that this 'life cost of non-intervention' could be defined for a range of separate emotional, social or mental health difficulties and / or age ranges

on services for children... Improving NHS specialist services is only part of the answer. We also need a broader system response to children's mental health, incorporating schools and the voluntary sector...'

Amongst the organisations contacted and reports considered for this report were

- Anna Freud Centre <https://www.annafreud.org/>
- National Children's Bureau <https://www.ncb.org.uk/>
- Early Intervention Foundation (<https://www.mentalhealth.org.uk/our-work/research>)
- Mental Health Foundation [Mental Health Foundation](#)
- Children's Commissioner *The state of children's mental health services 2020/21* Lennon January 2021
- Early Intervention Foundation *Adolescent mental health – a systematic review on the effectiveness of school-based interventions* Clarke, Sorgenfrei, Mulcahy, Daie, Friedrich, McBride July 2021
- London School of Economics *Mental health promotion and mental illness prevention: The economic case* ed Knapp, McDaid and Parsonage April 2011
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
- Northern Ireland Association for Mental Health *Mental Health Promotion: building an economic case* Friedli and Parsonage November 2007
- Public Health England *Commissioning cost-effective services for the promotion of mental health and wellbeing and prevention of mental ill-health* August 2017
<https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning>
- Royal Foundation Centre for Early Childhood: *Big Change Starts Small* June 2021
- HM Treasury *Supporting public service transformation: cost benefit analysis guidance for local partnerships* April 2014
[Supporting public service transformation: cost benefit analysis guidance for local partnerships \(publishing.service.gov.uk\)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf)

Websites:

Overview of NHS approach and symptoms:

<https://www.nhs.uk/mental-health/children-and-young-adults/advice-for-parents/anxiety-disorders-in-children/>

<https://www.nhs.uk/mental-health/children-and-young-adults/advice-for-parents/anxiety-in-children/>

Carbon footprint

<https://intranet.cornwallft.nhs.uk/waste-and-carbon-reduction>

<http://cornwallcouncilintranet.cc.cornwallonline.net/need-to-know/carbon-neutral-cornwall>

<https://www.ethicalconsumer.org/energy/short-guide-carbon-offsets>

Next Steps

This is one of a suite of reports, reviewing all aspects of the Bloom model and process, operability, efficacy and resilience. Taken together, they will inform decision-making about the sustainability of Bloom post-HeadStart and any future development and enhancement of the model.

Glossary

Bloom	Bloom is an innovative partnership approach with CAMHS and Cornwall Council, HeadStart Kernow and other services and organisations, and is an early intervention consultation model for professionals working with young people experiencing difficulties with their emotional, social or mental wellbeing
Bloom Covid 19 East Mid West (C-19EMW) Model	Bloom Profs meetings held with area-specific core attendees (CAMHS Clinical Psychologist; Primary Mental Health Worker; HeadStart Locality Coordinator) during the Covid-19 pandemic in 2020 and 2021
Bloom Pilot Project	The Bloom Pilot Project incorporates the first two phases of Bloom: the first phase initiating Bloom from November 2014 in Penwith, and the second phase running from June 2015 as the model became more established within Penwith
Bloom Professionals Consultation meeting (Bloom Profs)	A Bloom Professionals Consultation meeting can be requested for any child/young person struggling with emotional, social or mental wellbeing difficulties, as long as they are aged 0-18 years and they live or are educated in Cornwall. Referrals are made via the Early Help Hub on a CAMHS referral form and are screened and allocated to Bloom by the CAMHS Access Team
CAMHS	Children and Young People Specialist Mental Health Services sits within Cornwall Partnership NHS Foundation Trust and provides assessment, advice and treatment for children and young people with severe and complex mental health problems. CAMHS also provides support and advice to their families or carers
CWSG	Bloom Cornwall-wide Steering Group
Early Help Hub	Professional triage and processing hub for all service requests for Children's Early Help Services led by Cornwall Council and the Cornwall NHS Partnership Foundation Trust (CFT)
EWG	Evaluation Working Group – a sub-group of the Bloom CWSG established to advise, support, sense-check, and ensure progress on the evaluation suite
HeadStart Kernow	HeadStart is a six-year, £67.4 million National Lottery funded programme set up by The National Lottery Community Fund, the largest funder of community activity in the UK. HeadStart aims to explore and test new ways to improve the mental health and wellbeing of young people aged 10 to 16 and prevent serious mental health issues from developing. HeadStart Kernow is led by Cornwall Council
HeadStart Kernow Community	The HeadStart Community Facilitator contract delivers services to support young people aged between 10 -16 years old, supporting them with their emotional health and wellbeing and preventing the onset of mental ill health, through the delivery of one-to-one and group support for young people, low

Facilitator Contract	level support for parents and families, and support for community groups. Interventions are delivered by six locality-based Youth Facilitators (who mainly deliver one-to-one and group work), and three Community Facilitators (who broadly deliver work with parents, families and community-based groups). The contract is managed by the Learning Partnership for Cornwall and the Isles of Scilly
Nominated Professional	Once a referral is allocated to Bloom, parents / carers are asked to nominate a professional - who knows the child / young person referred in a professional capacity - to attend the Bloom Profs meeting to bring their voice and that of the family to the discussion
Point of Contact	A 'Point of Contact' is agreed at the Bloom Professionals Consultation meeting. They take responsibility for discussing the Consultation Plan with the parent / carer and young person, taking forward any actions and suggestions for support that the parent / carer and young person wish to pursue
VCSE	Voluntary, Community and Social Enterprise

Appendix 1: NCB Report



Bloom Evaluation 2020/21

The Bloom consultation model: potential costs

avoided analysis



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Introduction

About the evaluation of Bloom

Bloom is an innovative partnership approach between Cornwall Partnership NHS Foundation Trust, Cornwall Council, HeadStart Kernow and other services and organisations. Bloom is an early intervention consultation model for professionals offering an holistic approach, across services, to support children's emotional, social and mental wellbeing. Bloom is designed as a rapid and responsive model for children and young people from 0 -18, working within the Tavistock i-Thrive model. Its core purpose is to support young people to thrive. Bloom was piloted in the Penwith locality from November 2014, and, with additional resource provided by HeadStart Kernow, the model was rolled out across Cornwall from 2018.

This report is one of a suite, each report noting the findings from one strand of a comprehensive evaluation of the Bloom model and process undertaken during 2020/21. A comprehensive report of the full evaluation will be available by the end of the academic year 2020/21.

The strands considered within the Bloom evaluation were:

- Original Bloom Penwith pilot business case
- Cost Benefit Analysis
- Senior stakeholders
- Core Bloom Professionals Consultation meeting attendees
- Professionals
- Bloom 'service providers'
- Parents / Carers
- Children and young people
- Bloom Leadership Group
- Bloom Steering Group members

This report addresses the Cost Benefit Analysis strand of the evaluations.

Aims and general approach

In designing this evaluation strand, a pragmatic approach has been taken, taking account of resource available. A full and robust cost benefit analysis can involve many steps, each requiring different data and analyses. Any cost benefit analysis of Bloom is further complicated by the nature of the initiative. As a referral model, it is used in relation to a wide range of young people with varying needs, who may then be referred for a range of further support. A true understanding of cost-benefit would require a complex analysis covering:

- A. Evidence of the potential costs associated with the (wide ranging) needs with which young people are presenting
- B. Evidence on the extent to which those costs can be avoided through better targeted and earlier intervention
- C. The extent to which Bloom facilitates such better targeted and earlier intervention
- D. The cost of Bloom itself
- E. The costs of the (several) services and support on to which young people are referred following consideration of their case through Bloom

The findings in this report relate to point A above. They set out the potential costs to services society, families and young people themselves associated with the needs of young people considered by Bloom. These potential costs provide context for consideration of investment in Bloom and a basis for a full cost benefit analysis that considers the other questions listed above. Other evaluation strands will provide some insight into these other questions, as well as the section of this report 'Overview of the evidence base' below.

The findings are based on an analysis of 'referral factors' amongst young people whose cases were considered through Bloom, combined with evidence from existing studies, which looked at costs associated with those factors in the wider population. The analysis focuses on five such referral factors (see 'selecting referral factors' below).

Selecting referral factors

During 2020, the Bloom Cornwall-wide Steering Group (BCWSG) decided it would be helpful to capture the underlying reasons for referrals sent to Bloom (referral factors), to facilitate a more complete understanding of the support needs in each of the six localities within Cornwall, and across Cornwall as a whole. As an integral part of the data collection and analytical work of the Bloom Project Team, a number of datasets for all Bloom cases, including those for referrals closed in 2019, were collected.

In order to fulfil the requirement from the BCWSG, the Bloom Project Team reviewed and determined a range of referral factors, drawn from both CAMHS and Together for Families (Troubled Families) identifiers. Two additional factors were agreed and included based on their specificity. The Bloom Project Officer reviewed the Bloom referral document and the Bloom Consultation Plan for each young person whose case was closed in 2019, and recorded instances of the 12 referral factors noted. Both documents were considered because:

- a) Bloom referrals can be completed by anyone, be they a professional with knowledge of the young person or the family / young person themselves, so perceptions of factors can vary.
- b) The Bloom Consultation Plan is drafted in the Bloom Professionals Consultation meeting, as part of the professionals' discussion, and notes the psychological formulation agreed in the meeting.

In preliminary scoping discussions all 12 recorded referral factors were considered for this Cost Benefit Analysis, and a final list of five factors was determined the Bloom Project Team and agreed as the basis for the analysis.

The five factors were agreed based upon the availability or assumed availability of relevant data from previous studies, amenability to early intervention (in this case, not life-long conditions) and sufficient frequency within the 257 Bloom cases closed in 2019.

The five referral factors selected are:

- Anxiety
- Self-harm
- Depression/low mood
- Families affected by domestic violence and abuse
- Not attending school regularly

A table listing all 12 referral factors with notes on their suitability for inclusion is included as an appendix to this report.

Overview of the evidence base

In order to inform this analysis of potential costs avoided a rapid review of existing evidence was undertaken. Key points highlighted by the evidence base should be borne in mind alongside the more specific findings that have been drawn out in relation to Bloom and the five selected referral factors.

Studies have looked at the potential costs of conditions and experiences, over varying time periods, and including a range of different types of costs. Typically these include both costs in terms of the services required and reduced income for families and for young people. For example:

- Suhrcke, Puillas and Selai (2008) estimated that mental health problems as whole cost between £11,030 and £59,130 per child annually in England.
- Bodden, Dirkson and Boegels (2006) estimated that societal costs of families with clinically anxious children were almost 21 times as high compared to families from the general population.²⁰
- Tsiachristas et al (2020) estimated the hospital cost of self-harm in England to be approximately £128.6 million, and 19% of these admissions were children and young people under 19.
- Brookes, Goodall, and Heady (2007) estimated that the average cost of a persistent truant to be £44,468 per child and of an exclusion to be £63,851 per child.
- Walby (2004) estimated the annual cost of domestic violence is nearly a £.25 billion. This is overwhelmingly for children rather than for adults, especially those caught up in the co-occurrence of domestic violence and child abuse.²¹

Studies have also stressed the importance of early intervention and how this can reduce, if not avoid, some of these potential costs. The Centre for Mental Health (2015) found, for example, that every £1 spent on CBT for a child with depression returns £2. Brookes, Goodall, and Heady (2007), meanwhile, estimated that the total cost of exclusions could be cut by a quarter or more through prompt referral to appropriate voluntary sector initiatives.

It is important to underline the fact that such analyses based on economic cost cannot capture the full potential impact of the issues under consideration and, consequently, of the failure to intervene early. When considering the findings set out in this report, it is important to do this within the context of evidence base on the wider impact on children and families. Mental health problems in children and young people cause distress and can have wide-ranging effects, including impacts on educational attainment and social relationships, as well as affecting life chances and physical health (Murphy and Fonagy, 2013). Whilst these may all have economic costs attached, these effects are damaging in themselves. The most extreme cases can be devastating for families and communities. Young people who self-harm, for example, are 100 times more likely to commit suicide than their peers (National Workforce Programme, 2011).

The findings set out in this report could be said to underestimate, even in terms of economic costs, the impact of the issues considered. The studies cited, taken together, did not cover all potential costs across all referral factors considered. Some studies were limited in scope. We found, for example, evidence of costs to education in relation to just two out of five referral factors. Costs

²⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2277450/>

²¹ https://paladinservice.co.uk/wp-content/uploads/2013/07/cost_of_dv_research_summary-Walby-2004.pdf

would, arguably, be expected in relation to all five owing to the similarity in needs between the young people affected. Furthermore, the costs calculated are only those applicable up to age 25, so will not represent costs across the full lifetime of the young people affected (see more detail on methodology below).

Methodology for the potential costs avoided analysis

Potential costs identified by existing studies have been applied to the 257 Bloom cases closed during 2019 through the following steps

1. The cost cited by the study is allocated to the most appropriate of the seven cost categories:
 - Inpatient/acute health care
 - Outpatient/community health care
 - Reduced family income/productivity
 - Education
 - Social Care
 - Criminal Justice
 - Other
2. If not already presented in this form, the cost cited by the study is converted, where possible, into an annual, per young person figure.
3. Costs are converted to 2020 prices using the Bank of England inflation calculator.
4. Where the cost cited by the study may only be partly applicable, or there is not complete equivalence between the referral factor and the need considered by the cited study, a weighting is applied.
5. The annual costs are multiplied by the number of years these costs are likely to be applicable – this is generally the mean age of referral to Bloom for the referral factor in question (which is between 10 and 12 depending on the referral factor) up to a maximum of age 25. This maximum age of 25 is chosen as several of studies focus on children and young people’s needs which are not likely to be fully generalisable across the whole life course. In some cases the age range to which costs are applied starts later (for example if in relation to young person’s income) or finish earlier (for those relating social care and education).
6. The resulting figure is multiplied by the number of young people amongst Bloom cases closed during 2019 who were identified as having the relevant referral factor.

As with any such analysis, whilst based on sound evidence and employing robust calculation techniques, a number of assumptions have had to be made in order to develop these findings. The key assumptions are set out in the body of the report below. The assumptions relate primarily to steps 3 and 5, above. The analysis methodology has been designed such that these assumptions can be easily adjusted in light of any new evidence emerging.

Furthermore, total costs can be calculated on a conservative or less conservative basis, depending on the evidence used and overarching assumptions about how it is most appropriately combined. Three sets of figures are therefore provided based on three variations of the analysis methodology. The most relevant figure will depend on how it is being used in any further analysis or decision making and the audience in question.

The ‘**very conservative**’ figures include a maximum of one set of costs for each of the seven cost categories for each young person and where there are two or more possible sets of costs (in relation

to several co-occurring referral factors), the lowest figure is taken. For example, the estimated cost of inpatient/acute health care in relation to anxiety is £7,192 whereas in relation to depression/low mood it is £4,972. In instances where a young person has both the anxiety and depression/low mood referral factors only the lower figure of 4,972 is included in their total.

The '**conservative**' figures are calculated in the same way as the 'very conservative' figures except that where there are two or more possible sets of costs for cost category, the highest figure is taken.

The 'very conservative' and 'conservative' methodologies have been devised in response to the fact that there may be an overlap in costs arising from the different referral factors considered in this analysis. The extent to which the studies cited control for these specific comorbidities and co-occurring experiences as potential confounding factors is mixed and/or unclear, creating the risk of double counting.

The '**less conservative**' figures simply add all the estimated potential costs identified including where there are multiple costs for each category.

The caveats noted above, the various limitations and assumptions discussed throughout this report, and the presentation of a range of potential cost figures within this analysis should all be borne in mind when interpreting the findings set out below.

Potential costs associated with each of the five referral factors

Anxiety

Bodden, Dirkson and Boegels (2006) compared costs to families in the Netherlands with and without a child (aged 8-18) with an anxiety disorder. Bottom-up acquired costs measured by means of cost diaries amounted to €2,748 per family of a clinically referred anxious child per annum. Societal costs of families with clinically anxious children were almost 21 times as high compared to families from the general population.

The study highlighted four categories that make up most of the costs. The remainder of costs making up the total have also been included in this analysis. The table below sets out Bodden, Dirkson and Boegels' categories, how they have been categorised for the purposes of this analysis and the relevant annual costs in 2020 prices.

Table 2: Costs in relation to anxiety drawn from Bodden, Dirkson and Boegels (2006)

Categories for this analysis	Cost name from study	Annual cost from study (£, 2020 prices) ²²	Estimated total cost to age 25 per Bloom YP with anxiety ²³
Inpatient/acute health care	Institutionalised care	£734	£7,192
Outpatient/community health care	Day Care	£643	£6,298
Reduced family income/productivity	Parent lost productivity	£645	£6,318
Education	School absence	£462	£2,266
Other	Other	£302	£2,958

In applying these costs to the young people with a Bloom case closed in 2019, the following assumptions have been made:

- 70 per cent of those with an anxiety referral factor were clinically anxious (analysis step 4).
- With the exception of school absence, which has been taken to be applicable up to age 18, the costs identified by this study are applicable up to age 25 (analysis step 5).

²² Steps 1 to 3 of the analysis (described on pages 3-4) have been applied

²³ Steps 4 and 5 of the analysis have been applied

Self-harm

Tsiachristas et al (2020) considered the hospital cost of patients presenting with self-harm in England. The study estimated there to be 225,172 hospital presentations of self-harm in England in 2013 at a cost of £121.6 million. This gives a cost per presentation in 2020 prices of £632. In applying this cost to the Bloom cases closed in 2019 it has been assumed that those with a self-harm referral factor would have a 20 per cent chance of presenting at hospital with self-harm in any given year (analysis step 4). This gives a total estimated cost up to age 25 of £1,895 which has been allocated to the inpatient/acute health care category.

Depression/low mood

Barret et al (2006) considered the annual costs to society of adolescents (aged 13 to 18 in the UK) who committed criminal offences and included an analysis of the costs associated with those who had significant depressive symptoms. The table below sets out Barret et al's categories of costs, how they have been categorised for the purposes of this analysis and the relevant annual costs in 2020 prices.

Table 3: Costs in relation to depression/low mood drawn from Barret et al (2006)

Categories for this analysis	Cost name from study	Annual costs from study (£, 2020 prices) ²⁴	Estimated total cost to age 25 per Bloom YP with Depression/low mood ²⁵
Inpatient/acute health care	Health care system costs	£687	£3,552
Outpatient/community health care		£610	£3,146
Social Care	Social services	£17,159	£1,193
Criminal Justice	Criminal justice	£71,156	£9,892
Other	Voluntary services	£654	£3,376

Using data from Barret et al (2006) together with data from the Youth Justice Board (2020) and the 2017 mental health prevalence study (NHS Digital, 2018), it has been estimated that 2.2 per cent of young people aged 10 to 18 with depressive symptoms enter the youth justice system for the first time in any given year. Annual costs applied to the Bloom cases closed during 2019 have used this percentage of the costs for social care and criminal justice listed above (analysis step 4). Additionally it has been assumed:

²⁴ Steps 1 to 3 of the analysis (described on pages 3-4) have been applied

²⁵ Steps 4 and 5 of the analysis have been applied

- Costs to the health service are split between inpatient/acute and outpatient community at the same ratio as that found by Bodden, Dirkson and Boegels (2006) – 53%/47% (analysis step 1).
- 50 per cent of those referred with a depression/low mood referral factor had depressed mood²⁶ (analysis step 4).
- 80 percent of the costs to health services for those with depressive symptoms who committed a criminal offence also arise for those did not commit a criminal offence (analysis step 4).
- All costs, with the exception of social services, which is applied up to age 18, are applicable up to age 25 (analysis step 5).

Families affected by domestic violence and abuse

In their report for the Home Office, *The Economic and Social Costs of Domestic Abuse*, Oliver et al (2019) include a review of the impact on children. The evidence base across the wide range of factors considered, focusing on studies able to isolate the impact of domestic abuse from confounding factors such as other child abuse, is limited. However, they report that, according to the Crime Survey for England and Wales for the year ending March 2016 (Office for National Statistics, 2017) childhood witnesses of domestic abuse were significantly more likely to have lower household incomes as adults. Specifically, 7% earn less than £20,000 per annum, compared with 5% of those who were not witnesses. In light of this increased risk of low income and taking account of the average earnings of 20-25 year olds, a total cost per young person of £503 has been estimated and allocated to the reduced family income category.

Walby (2004) estimates a cost of £228 million of social care support for 376,000 children in need in relation to domestic abuse. From this a total cost per young person of £8,685 has been estimated and allocated to the social care category.

The estimated costs in relation to domestic violence and abuse assume:

- 50 per cent of those with a 'family affected by domestic violence and abuse' referral factor would reach the threshold of being children in need under S17 of the Children Act 1989 (analysis step 4)
- Young people would be largely financially independent from age 20 (analysis step 5)
- Social care costs are applicable up to age 18 (analysis step 5).

²⁶ The cited study defined this as young people who met the threshold for a mental health need in relation to depression under the Salford Needs Assessment Schedule for Adolescent. Includes unmet need, suspended need and needs persistent despite intervention

Not attending school regularly

Brookes, Goodall and Heady (2007) estimate (using data from Scott and Knapp, 2001) the costs of truancy to society and individuals across a range of factors. Unlike other studies cited in this report, lifetime rather than annual figures are estimated. These and the consequent costs estimated per Bloom young person are set out in the table below.

Table 4: Costs in relation to not attending school regularly drawn from Brookes, Goodall and Heady (2007)

Categories for this analysis	Cost name from study	Lifetime costs from study (£, 2020 prices)	Estimated total cost to age 25 per Bloom YP not attending school regularly
Inpatient/acute health care	Cost to the health service	£675	£675
Outpatient/community health care		£598	£598
Reduced family income/productivity	Reduction in average lifetime earnings	13 per cent	£17,052 ²⁷
Social Care	Social care cost for truants aged 10-16	£3,010	£3,4311
Criminal Justice	Lifetime cost of crime	£10,367	£5,184

In addition to the costs set out in table 4, a total cost per young person of £4,323 has been estimated and added to the education cost category. This is based on two further sources of evidence. Firstly, Sodha and Margo (2010) cite the cost of alternative provision (pupil referral units) to be £11,000 per annum (in 2010 prices) more expensive than a mainstream school. Secondly, Bryant et al (2018) indicate that excluded young people typically spend six months to a year in alternative provision but that older young people tend to stay longer.

The estimated costs in relation to young people not attending school regularly assume:

- 30 percent of young people with the 'not attending school regularly' referral factor would be excluded at some point between the ages of 11 and 18. (Analysis step 4).
- The entirety of the lifetime cost to the health service estimated by Scott and Knapp (2001) and described by Brookes, Goodall and Heady (2007) as 'very conservative' would be realised by age 25 (this figure reported by the cited study, uprated to 2020 prices, has therefore been used).
- Young people would be financially independent by age 20 (analysis step 5).

²⁷ 13 per cent of the average earnings of 20-25 year olds multiplied by five.

- Social care costs are applicable up to age 18 -two years more than accounted for in the cited study (analysis step 5).
- Half of the lifetime cost of crime would be realised by age 25 (this proportion of the figure reported by the cited study, updated to 2020 prices, has therefore been used).

Total potential costs

Table 1, below, sets out the total estimated potential costs across all five referral factors. This is based on the detail of the analysis set out in the body of this report above and includes three sets of figures corresponding to three different methodologies (see pages 7-8) for building up costs in relation to individual young people.

Table 1 potential costs from mean age of referral to age 25 by category and three methodologies

	Very conservative	Conservative	Less conservative
Acute/inpatient	£675,814	£1,084,965	£1,297,088
Community/outpatient	£634,865	£896,943	£1,022,129
Family income/productivity	£870,632	£1,563,890	£1,797,816
Education	£385,154	£455,092	£532,136
Social Care	£547,178	£753,173	£851,904
Criminal Justice	£636,510	£744,807	£864,031
Other	£544,202	£639,192	£864,755
Total	£4,294,355	£6,138,061	£7,229,858
Average per Young Person (all young people w case closed in 2019 n=257)	£16,710	£23,884	£28,132
Average per Young Person with at least one of the five selected referral factors (n=216)	£19,881	£28,417	£33,472

The total potential costs to services society, families and young people amongst the 2019 closed cases resulting from all five referral factors is estimated to be in the region of £4.29 million to £7.23 million. This equates to an average of £19,881 to £33,472 for each the young people who had at least one of the five referral factors considered by this analysis. The highest total costs are in relation to family income/productivity, in the region of £870,632 to £1.8 million. The smallest are in relation to Education (£385,154- £532,136). This may be partly due to it being harder to draw conclusions on costs to education as a universal and routinely differentiated service. Indeed, studies in relation to just two out of five referral factors identified costs to education. For this reason, caution is advised in any comparison between the cost categories

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Appendix: Referral factors considered for inclusion

Referral Factor	Source	Chosen for Cost Benefit Analysis?	Rationale
Children who have not been attending school regularly	Together for Families	YES	Referenced in the preliminary document review, prior to NCB's involvement, and recorded in 21.8% of all cases closed in 2019 (56 out of 257).
Families affected by domestic violence and abuse	Together for Families	YES	Assumed to be referenced in other studies, and recorded in 26.5% of all cases closed in 2019 (68 out of 257).
Parents or children with a range of health problems	CAMHS / Together for Families	NO	This referral factor incorporates a number of sub-factors, e.g. the child referred also has a physical and/or cognitive health issue, a parent or sibling may have a physical and/or cognitive health issue, or a parent may be impacted by substance abuse. As such, it would be difficult to disaggregate this referral meaningfully for the CBA. Recorded in 52.9% of all cases closed in 2019 (136 out of 257).
ADHD	CAMHS	NO	Life-long condition. Recorded in 7.4% of all cases closed in 2019 (19 out of 257).
ASD/ASC	CAMHS	NO	Life-long condition. Recorded in 21.8% of all cases closed in 2019 (56 out of 257).
Depression/Low Mood	CAMHS	YES	Referenced in the preliminary document review, prior to NCB's involvement, and recorded in 22.8% of all cases closed in 2019 (58 out of 257).
OCD	CAMHS	NO	Low population. Recorded in 3.5% of all cases closed in 2019 (9 out of 257).
Trauma	CAMHS	NO	Low population. Recorded in 15.6% of all cases closed in 2019 (40 out of 257).
Self harm	CAMHS	YES	Assumed to be referenced in other studies, and recorded in 27.2% of all cases closed in 2019 (70 out of 257).
Anxiety	CAMHS	YES	Assumed to be referenced in other studies, and recorded in 49.8% of all cases closed in 2019 (128 out of 257).
Grief	Bloom Project Team	NO	Low population. Only 6.2% of all cases closed in 2019 (16 out of 257).
Gender Issues	Bloom Project Team	NO	Low population. Only 1.9% of all cases closed in 2019 (5 out of 257).

Appendix 2: Bloom model, process and development

Bloom Overview

An innovative partnership approach between Cornwall Partnership NHS Foundation Trust, Cornwall Council, HeadStart Kernow and other services and organisations, Bloom is an early intervention consultation model for professionals offering an holistic approach, across services, to support children's emotional, social and mental wellbeing. Bloom is designed as a rapid and responsive model for children and young people from 0 -18, working within the Tavistock i-THRIVE model. Its core purpose is to support young people to thrive.



Bloom Pilot

A pilot of the Bloom approach supported by CAMHS, GPs, and Cornwall Council ran from November 2014 in the Penwith locality. It was set up to:

- help fill a gap in provision for children and young people with emotional, behavioural and mental health problems who did not meet the threshold for specialist CAMHS
- address the 40% of all GP referrals to CAMHS that were rejected
- build stronger links between professionals in different services
- look at the needs of the whole family as well as the child
- reduce the pressure on specialist CAMHS

With additional resource provided by HeadStart Kernow, the Bloom model was rolled out across Cornwall from 2018, and, pre-Covid19, Bloom was established in each locality in Cornwall.

Bloom Governance

Bloom is overseen by a Cornwall-wide Steering Group (CWSG) as a county-wide multi-organisational initiative, and by six Locality Steering Groups that oversee and support each locality Bloom model. Each Locality Steering Group determines the frequency, time and location of the Bloom Profs meetings held within each locality.

Bloom encourages a test-and-learn approach so that the Bloom model and process remain agile, always subject to the Bloom Underpinning Principles which have been agreed by the CWSG. In brief, these Underpinning Principles are:

- The needs of the child/young person and family comes first
- Working together to meet the needs of the child/young person ie referrals received by Bloom will be treated as a call for a Bloom Professionals Consultation meeting to consider that particular case. They will not be 'bounced back'
- Timely, clear and concise communications written in plain English
- A 'point of contact' for every child
- Bloom is multi-organisational and every voice is valued

Bloom Referral Route and preliminary processes

Any individual or organisation (eg GP, school / college, family worker, school nursing team, parent / carer, or the young person themselves) can refer a young person aged 0-18 years to Bloom by sending a CAMHS referral form to the Early Help Hub. The young person may be in any of the four i-THRIVE quadrants; the CAMHS Access Team co-located within the Early Help Hub determine which referrals are allocated to Bloom.

Since the Bloom model is one of professional consultation, no family member nor the young person referred attends Bloom Profs meetings. Therefore, once allocated to Bloom, parents / carers are asked to nominate a professional, who knows the child / young person referred in a professional capacity, to attend the meeting. This Nominated Professional is given a number of meeting dates from which they will agree one to attend. Meeting invitations are then sent out to the core Bloom Professional Consultation (Bloom Profs) meeting attendees. These are a CAMHS Clinical Psychologist, a Primary Mental Health Worker, the HeadStart Locality Coordinator (who chairs the meeting), a HeadStart Community Facilitator and the Early Help Locality team. The Nominated Professional and others, including from the VCSE and other agencies, organisations, and services, are also sent the meeting invitation.

Bloom Professionals Consultation meetings

The collaborative, multi-agency Bloom Profs meetings, which always include a Clinical Psychologist, Primary Mental Health Worker and a HeadStart Locality Coordinator as Chair, consider as carefully and holistically as possible each young person's referral, their presentation and needs, and discuss how they

might best be supported. Other attendees at Bloom Profs meetings might include professionals such as teachers, Social Workers, Family Workers, representatives from a variety of other organisations and agencies including the voluntary and community sector, and community workers.

The meeting will agree a psychological formulation for the child / young person, and a plan of suggested positive next steps and actions to help them thrive including, where appropriate and possible, agreed community-based support.

Pre-Covid (that is, prior to March 2020), each locality (bar Penwith²⁸) had an established Locality Steering Group and the frequency, timings and locations of Bloom Profs meetings within each locality had been agreed as follows:

Locality	Penwith	Kerrier	Carrick	Restormel	North Cornwall	Caradon
Frequency	Weekly during term time/ as necessary through summer school holiday	Weekly during term time/ as necessary through summer school holiday	Weekly during term time/ as necessary through summer school holiday	Weekly during term time/ as necessary through summer school holiday	Weekly during term time/ as necessary through summer school holiday	Weekly during term time/ as necessary through summer school holiday
Timings	Thursday 1400-1600	Wednesday 1400-1600	Thursday 1000-1200	Wednesday 1400-1600	Tuesday 1000-1200	Thursday 1400-1600
Location	Penzance	Camborne	Truro	Rotation: Newquay; St Austell; the Clays	Rotation: Bodmin; Launceston	Liskeard

Each Bloom Profs meeting could discuss up to four referrals allowing up to 24 to be discussed weekly.

Bloom and Covid-19

With the advent of the pandemic, it was necessary to amend the Bloom model due to the inability to hold face-to-face meetings and the necessary focussing of CAMHS upon children and young people most at risk, adversely impacting on their ability to support the existing model. It remained an imperative that existing referrals to Bloom should be considered in a timely manner; it was also critical that a switch be made to hold Bloom Profs meetings online via Microsoft Teams. During 2020 there were four different 'cohorts' as noted below:

²⁸ As Penwith had been the location for the Bloom pilot, the Bloom model was well-established with Bloom Profs meetings taking place on a weekly basis. The inaugural Penwith Bloom Locality Steering Group was held in December 2020.

1. Jan – 23 March 2020: Bloom Profs held as usual in each locality
2. 23 March – 27 April 2020: Referrals allocated to Bloom but with no Bloom Profs meeting arranged were triaged by a central team: Dr Lisa Gilmour (CAMHS Clinical Psychologist; Bloom Clinical Lead); Henry Lewis (core Bloom Primary Mental Health worker); Deborah Clarke (HeadStart Locality Coordinator; Bloom Operational Lead)
3. April – November 2020: Centralised Covid-19 (C-19) model: online Bloom Profs meetings held with the central team (Bloom Clinical Lead; core Bloom PMH Worker; Bloom Operational Lead), the Nominated Professional and other professionals
4. November 2020 onwards: Decentralised C-19 East Mid West (C-19EMW) model: online Bloom Profs meetings held with area-specific core attendees (CAMHS Clinical Psychologist; Primary Mental Health Worker; HeadStart Locality Coordinator), the Nominated Professional and other professionals

Learning from the core team's management of cohorts 2 and 3, in the decentralised C-19EMW model (which is area-specific ie East, Mid and West Cornwall), each referral is discussed in an hour-long meeting with breaks scheduled between them. The weekly timetable is noted below:

Area	East	Mid	West
Day	Thursday afternoon	Thursday morning	Wednesday afternoon
Meeting slot	13.00 – 14.00	09.15 – 10.15	13.00 – 14.00
Meeting slot	14.30 – 15.30	10.30 – 11.30	14.30 – 15.30
Meeting slot	16.00 – 17.00	11.45 – 12.45	16.00 – 17.00

It will be noted that the C-19EMW model limits the number of referrals which are able to be discussed weekly to nine, necessitating close management of the Bloom referral caseload to ensure all referrals are discussed within a Bloom Profs meeting in a timely manner.

Management information and data analysis

Various reports are prepared for each Locality Steering Group and the Cornwall-wide Steering Group, including a detailed annual data report.

Appendix 3: Cornwall Council: Index of Multiple Deprivation 2019

Information Classification: CONTROLLED



Index of Multiple Deprivation

2019

 www.cornwall.gov.uk

Information Classification: CONTROLLED



Index of Multiple Deprivation

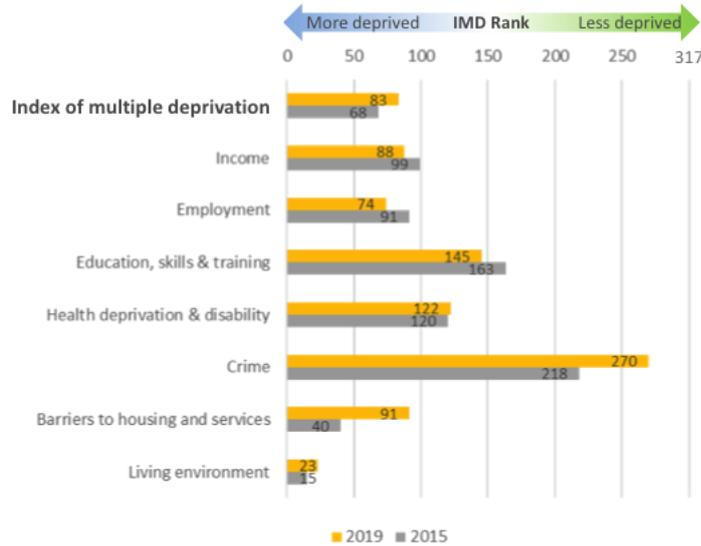
- The Index of Multiple Deprivation (IMD) is a national statistical measure that is published once every four years. The latest data was released in September 2019.
- The Index measures relative deprivation across small geographical areas or neighbourhoods that are called Lower Super Output Areas (LSOAs). There are 32,844 LSOAs across England, with 326 of these in Cornwall.
- Neighbourhoods (LSOAs) are ranked across the following seven categories or domains: income; employment; health and disability; education skills and training; barriers to housing and services; crime; and the living environment.
- Each neighbourhood also receives an overall IMD rank from 1 (the most deprived area) to 32,844 (the least deprived area).
- It is common to describe how relatively deprived an area is by saying whether it falls amongst the most or least deprived 10% of areas in England.

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Cornwall's Overall IMD Rankings

This graph shows a comparison of Cornwall's IMD and domain ranking in 2019 and 2015. There were a total of 317 and 326 local authority areas in England during 2019 and 2015, respectively.

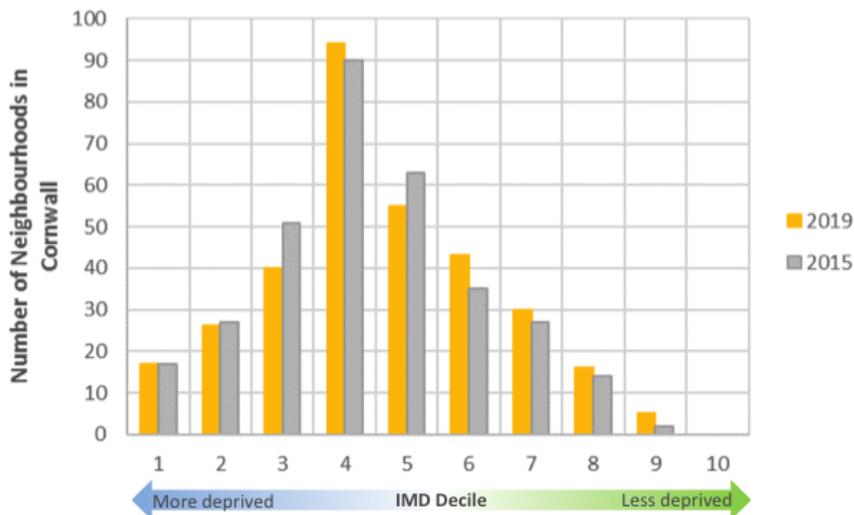


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Cornwall's Neighbourhoods Ranking: Deciles

This table shows how many of Cornwall's 326 neighbourhoods (LSOAs) fall into each IMD decile in 2019 compared with 2015. A decile of 1 means that those neighbourhoods fall within the top 10% most deprived neighbourhoods in England.

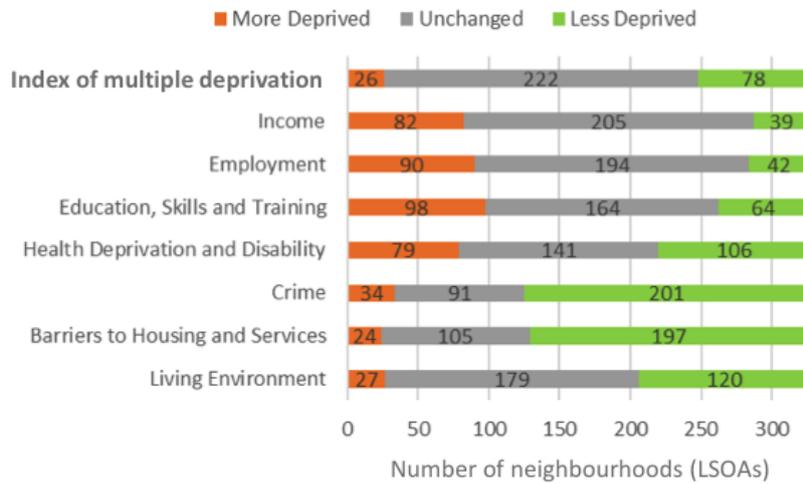


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Cornwall's Neighbourhood Rankings

This graph shows how many of Cornwall's 326 neighbourhoods (LSOAs) have become relatively more or less deprived since IMD was last measured in 2015.



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Cornwall's Neighbourhoods: High Deprivation

This table shows the 17 neighbourhoods (LSOAs) in Cornwall with the highest levels of deprivation. These neighbourhoods are in the top 10% most deprived areas in England. There are 326 neighbourhoods in Cornwall and a total of 32,844 across England.

Cornwall Rank		National Rank		LSOA Name	Community Network Area
2019	2015	2019	2015		
1	4	577	1133	Camborne Pengegon	Camborne and Redruth
2	1	884	414	Penzance Treneere	Penzance, Marazion and St Just
3	2	1072	606	Redruth North, Close Hill, Strawberry Fields and Treleigh	Camborne and Redruth
4	3	1119	964	Camborne College Street and the Glebe	Camborne and Redruth
5	6	1661	1512	Camborne Town Centre	Camborne and Redruth
6	7	1712	1733	St Austell Penwinnick and Town Centre	St Austell and Mevagissey
7	11	1821	2415	Kinsman Estate and Monument Way	Bodmin
8	5	2134	1350	Illogan East Pool Park	Camborne and Redruth
9	8	2447	2147	Penzance St Clare and Town	Penzance, Marazion and St Just
10	17	2579	2939	Bodmin Town Centre and Berryfields	Bodmin
11	14	2675	2755	St Austell Alexandra Road and East Hill	St Austell and Mevagissey
12	10	2688	2378	Newquay Town Centre	Newquay
13	12	2985	2497	St Blazey West	St Blazey, Fowey and Lostwithiel
14	22	3199	3816	Camborne North Parade and Rosewarne Gardens	Camborne and Redruth
15	15	3218	2797	Newquay Narrowcliff	Newquay
16	16	3228	2938	Newlyn Harbour and Gwavas	Penzance, Marazion and St Just
17	9	3275	2375	Liskeard St Cleer Road and Bodgara Way	Liskeard and Looe

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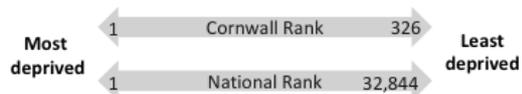




Cornwall's Neighbourhoods: Low Deprivation

This table shows the ten neighbourhoods (LSOAs) in Cornwall with the lowest levels of deprivation. These neighbourhoods rank between the top 20-30% least deprived neighbourhoods in England. There are 326 neighbourhoods in Cornwall and a total of 32,844 across England.

Cornwall Rank		National Rank		Neighbourhood (LSOA) Name	Community Network Area
2019	2015	2019	2015		
326	325	29312	26457	Duporth, Charlestown, Carlyon Bay and Tregrehan	St Austell and Mevagissey
325	326	28717	29230	Latchbrook South	Saltash and Torpoint
324	323	28617	25349	Helston Gwealhellis	Helston and the Lizard
323	321	28183	25077	Probus	Truro and Roseland
322	318	26413	24240	Threemilestone East	Truro and Roseland
321	313	26096	23317	Falmouth Tregenvor and Trescobeas	Falmouth and Penryn
320	306	25575	22102	Carkeel, Notter and Latchbrook North	Saltash and Torpoint
319	322	25473	25342	Helston Gwealdues	Helston and the Lizard
318	320	25327	24678	Falmouth Arwenack Avenue, Melvill & Boscawen Road	Falmouth and Penryn
317	309	25130	22814	Wadebridge Gonvena and St Matthews	Wadebridge and Padstow



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Cornwall's Neighbourhoods: High Deprivation

This figure lists the 17 neighbourhoods (LSOAs) in Cornwall with the highest levels of deprivation and shows their deciles for all seven IMD domains. A decile of 1 means that neighbourhood is in the top 10% most deprived areas nationally for that domain

Neighbourhood (LSOA) Name	IMD Domain							Decile
	Income	Employment	Education, Skills and Training	Health Deprivation and Disability	Crime	Barriers to Housing and Services	Living Environment	
Camborne Pengegon	1	1	1	1	4	2	9	1
Penzance Treneere	1	1	1	1	6	4	6	2
Redruth North, Close Hill, Strawberry Fields and Treleigh	1	1	1	1	6	7	6	3
Camborne College Street and the Glebe	1	1	2	1	2	7	3	4
Camborne Town Centre	1	1	4	1	2	8	1	5
St Austell Penwinnick and Town Centre	1	1	3	1	3	6	6	6
Kinsman Estate and Monument Way	1	1	1	2	6	2	3	7
Illogan East Pool Park	1	1	1	1	6	4	7	8
Penzance St Clare and Town	1	1	3	2	4	7	1	9
Bodmin Town Centre and Berryfields	1	1	2	1	2	8	2	1
St Austell Alexandra Road and East Hill	1	1	2	2	4	6	2	2
Newquay Town Centre	2	1	4	1	1	7	1	3
St Blazey West	2	1	1	2	3	5	5	4
Camborne North Parade and Rosewarne Gardens	2	2	3	2	1	7	1	5
Newquay Narrowcliff	2	1	3	1	3	7	2	6
Truro and Gwavas	1	2	2	3	9	2	1	7
Bodgara Way	1	1	1	2	5	5	7	8





Important to note

- **IMD is a measure of deprivation, not affluence**
Deprivation refers to neighbourhoods that lack the basic necessities they need to thrive. This may refer to income and employment, but also education, health, housing, services, community safety and living environment. Not every person living in a neighbourhood with high levels of deprivation will experience deprivation themselves.
- **Changes in IMD ranking over time is relative to other areas**
Whilst the IMD rank may have improved or worsened over time, this should not be used as a direct measure of whether the level of deprivation itself has changed. A local neighbourhood could have improved in real-terms and may have improved faster than the average, however if other areas with similar levels of deprivation have done slightly better, the neighbourhood will score as more deprived and vice versa.
- **IMD is not a direct measure of deprivation**
A neighbourhood with a score of 50 is not twice as deprived as an area with a score of 25

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Summary

- Compared with 2015, **24% of Cornwall's 326 neighbourhoods are relatively less deprived**, 8% are relatively more deprived and 68% have not changed.
- **Cornwall continues to have 17 neighbourhoods in the top 10% most deprived areas** in England. These are the same neighbourhoods as in 2015, except for Camborne North Parade and Rosewarne Gardens whose rank has increased from 22 in 2015 to 14 in 2019.
- The number of neighbourhoods from Cornwall that are ranked within **the top 30% least deprived areas** in England **was 21 in 2019, up from 16 in 2015**.
- The **primary types of deprivation** in Cornwall's worse affected neighbourhoods relates to **income, employment, education, skills and training and health and disability**.

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Summary

- Cornwall's IMD ranking for 2019 is **83 out of 317 local authorities**. This is a **slightly improved position** compared with 2015, in which Cornwall had an IMD ranking of 68 out of 326 local authorities.
- Cornwall's ranking relative to other local authorities has **improved in four of the seven domains since 2015**:
 - Crime (52 place rise)
 - Barriers to housing and services (51 place rise)
 - Living environment (8 place rise)
 - Health deprivation & disability (2 place rise)
- But has **decreased in three domains** compared with 2015:
 - Income (11 place drop)
 - Employment (17 place drop)
 - Education, skills & training (18 place drop)

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Further Information

- For further information on the Index of Multiple Deprivation, please see the following links:

Cornwall Council Deprivation Webpage

<https://www.cornwall.gov.uk/council-and-democracy/data-and-research/data-by-topic/deprivation/>

Index of Multiple Deprivation 2019 Data Files

<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>

Frequently Asked Questions

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835119/loD2019_FAQ.pdf

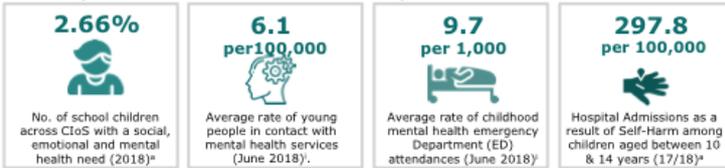
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Appendix 4: Joint Strategic Needs Assessment 2019

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"³¹. 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 years². 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 adulthood².

Summary Statistics for Cornwall & Isles of Scilly:



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 (CloS) 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 years¹¹.

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 CloS. 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 infancy⁴.

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 interventions⁵. This means that mental health problems can persist into adulthood² and affect a range of factors such as employment opportunities in later in life⁶.

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 life².



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

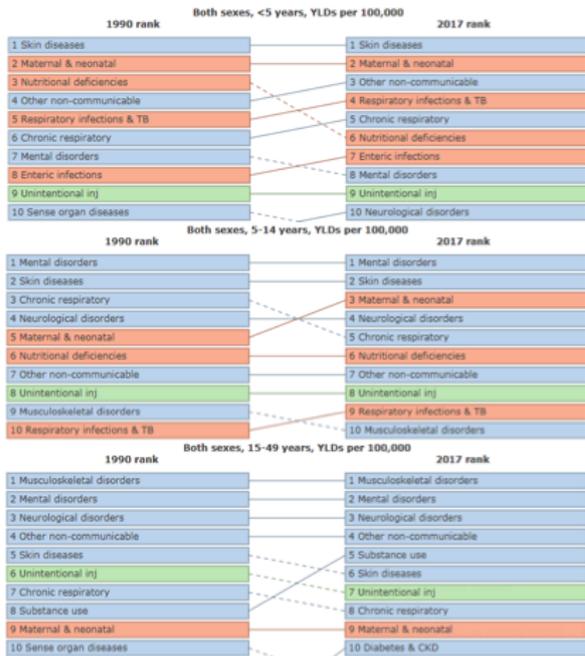
Prevention is about taking action to improve people's quality of life and reduce the chance of getting a mental and physical health condition¹². Many risk factors may be prevented through antenatal, post-natal and later childhood programs. As illustrated below, this can be achieved by targeting a range 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}.



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 Programme¹³.
- 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



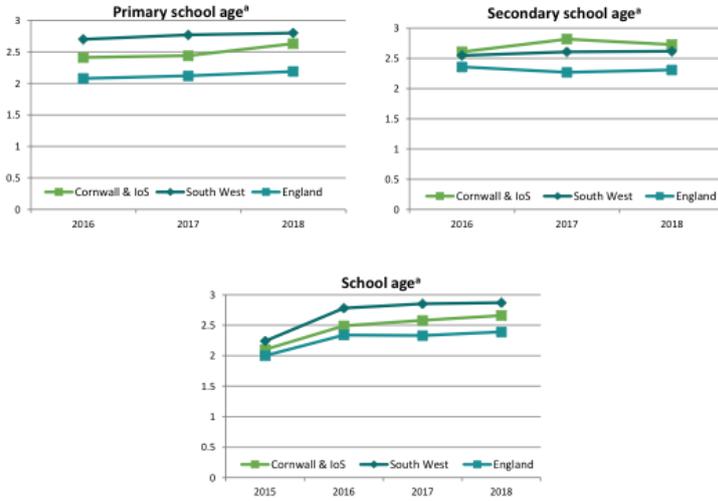
Key Messages

- 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 2016¹¹.
- 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

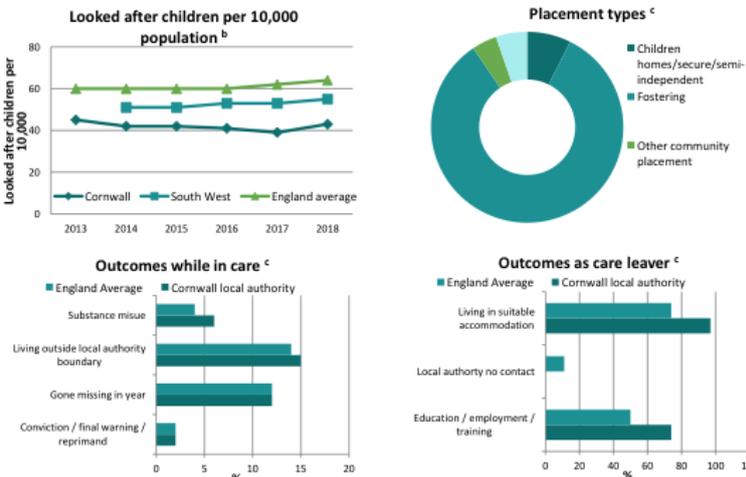


Key Messages

- According to the Education special educational needs statistics, the proportion of primary school pupils with social, emotional and mental health needs was higher in CloS (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 CloS (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 CloS (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 problems². 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 services¹⁴. 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 2018¹⁵.

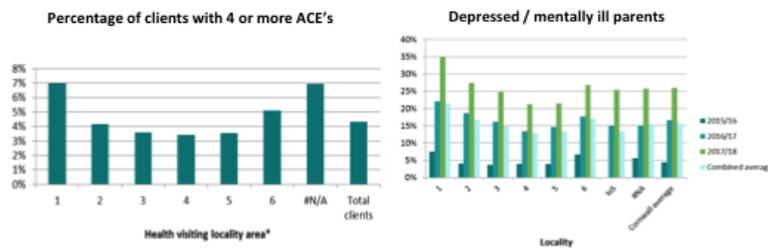


Key Messages

- 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 CloS have higher rates of substance misuse (6%) than the England average.
- There are more LAC children across CloS living in suitable accommodation and accessing suitable education, employment or training when leaving care in 2016 than the England average.

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 wellbeing¹⁶. 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 use¹⁶.



*Not including Isles of Scilly due to small numbers
#N/A 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

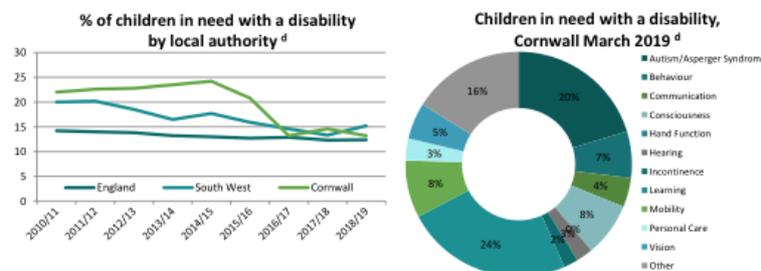
- According to Health Visiting Early Help assessment, around 4.3% of children aged under 5 in CioS have been affected by 4 or more ACEs¹⁶.
- The highest proportion of children with 4 or more ACEs are those living across Camborne, Pool, Redruth, Helston and the Lizard area (Locality 1). These children 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 to¹⁷:

- 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 condition¹⁸. The below graphs illustrates the type and number of disabilities experienced by children in need across CioS.



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}.

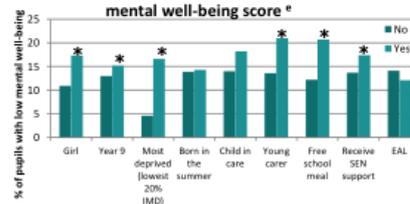
The WMF survey included the seven questions from the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). The SWEMWBS scale asks participants to rate their: feelings of being optimistic about the future; feeling useful; feeling relaxed; dealing with problems; thinking clearly; feeling close to 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 ^a	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).

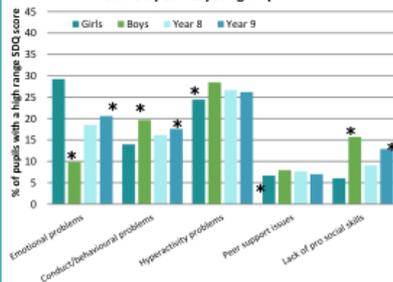
The below graph compares the proportion of pupils with a high versus low range SDQ score for each of the five strengths and difficulties questions.

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).

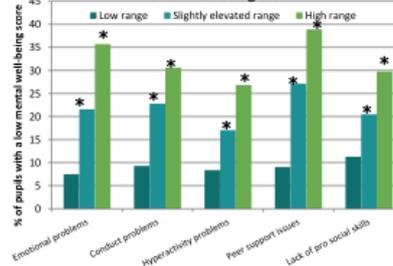
Key Messages

- 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



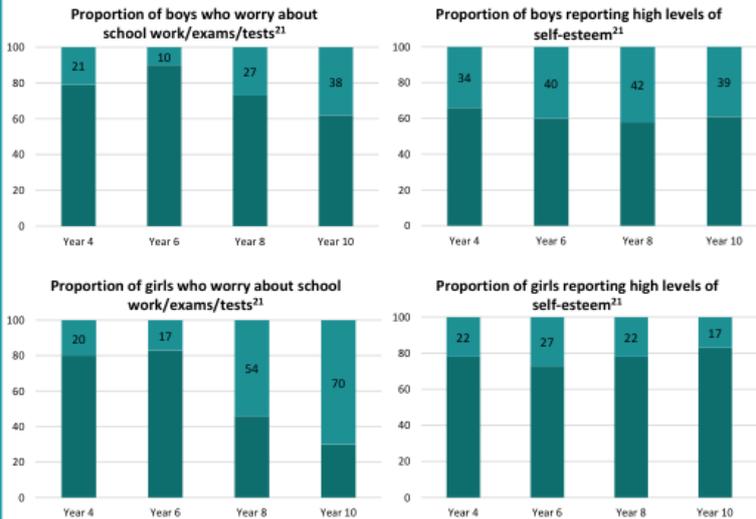
SDQ criteria and proportion of pupils with a low mental well-being score ^e



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 services²¹.

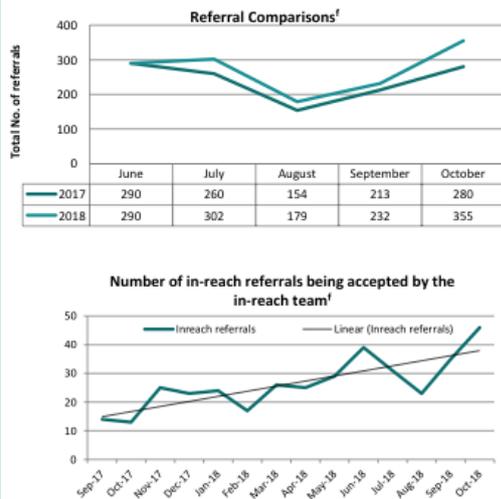


Key Messages

- A higher proportion of year 8/10 girls worry about school work/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 parents²². 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.



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.

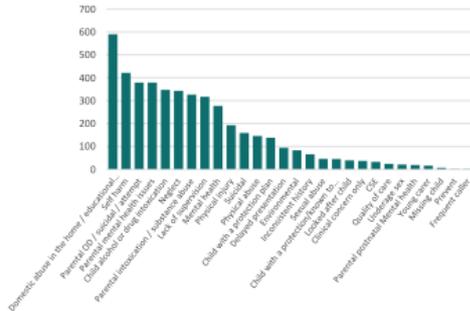
Joint Strategic Needs Assessment Children and Young People's Mental Health 2019: SWAST

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.

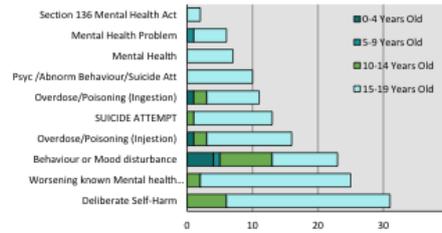
One of the highest child referral themes across the South West region refers to domestic abuse in the home, which can result in emotional impact on the child. However, this frequently involved calls to assess and provide treatment to the adult victim rather than to attend children. A second area of concern is the high impact of mental health illness on children and young people. CloS 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^a



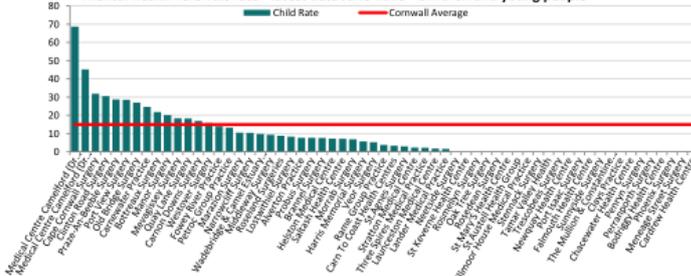
SWAST Calls by Symptom Group: 0-19 Years 2017/18^b



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 treated³. 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 peopleⁱ

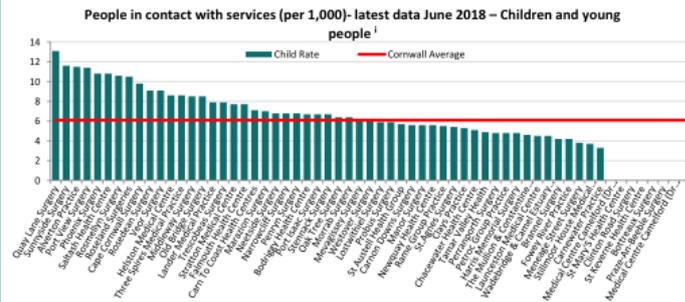
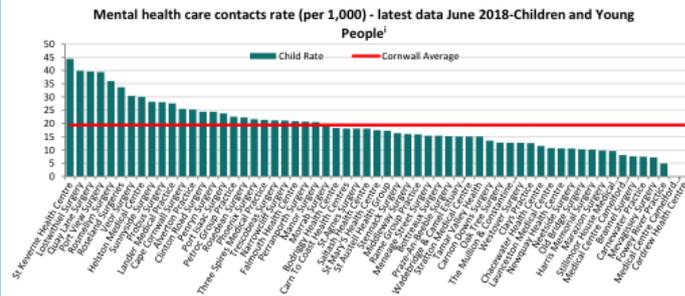


This graph provides information on the rate of mental health referrals received in June 2018 (i.e. referrals compared to the number of children aged 0-18 years and registered with each practice). There were 245 referrals made in June 2018, which varied considerably at the practice level in June 2018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

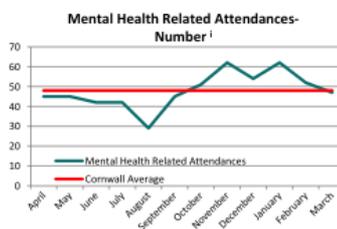
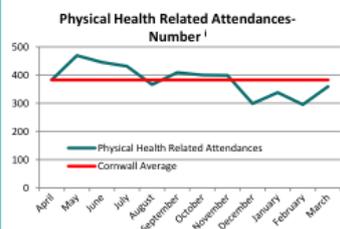
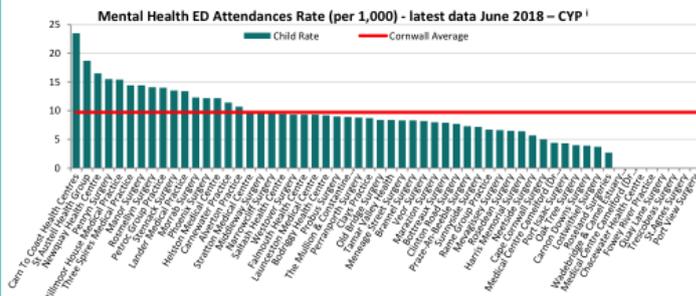
Joint Strategic Needs Assessment Children and Young People's Mental Health 2019: Contact with services



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

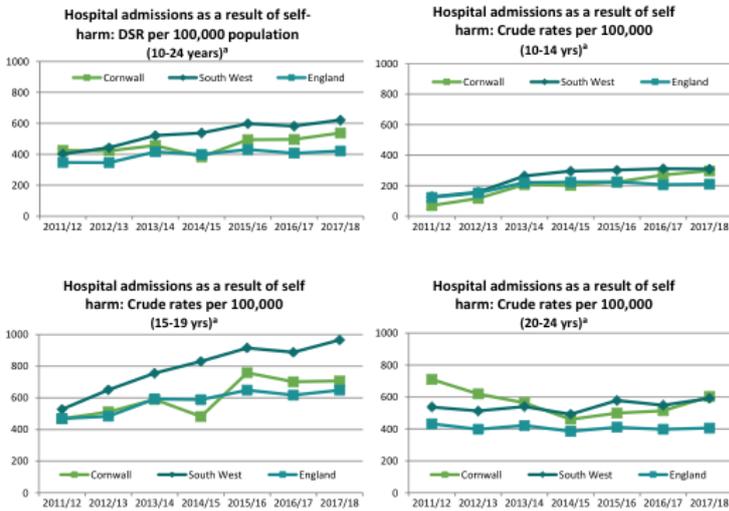


Key Messages

- 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 distress²⁴. 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 underestimate of the true health and well-being burden of self-harm^{25,26}.



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

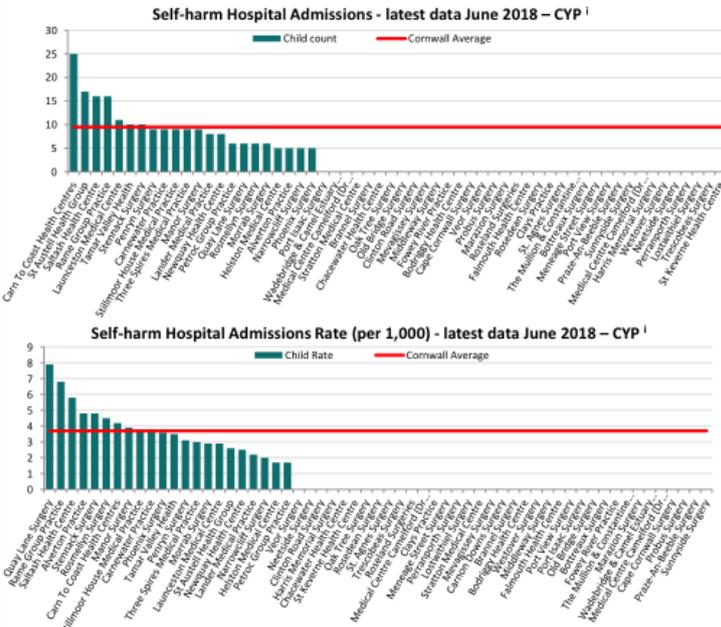
Age-specific rate of self-harm admissions and age-specific rate for patients in the South West region, 2016/17¹

Area name (Region/LA)	Age-specific rate: Admissions					Age-specific rate: Patients					Rate per 100,000 population	
	0-9	10-24	25-44	45-64	65+	0-9	10-24	25-44	45-64	65+	Number of patients	Number of admissions
South West	3.4	590.5	341.6	183.6	50.0	3.2	425.4	240.5	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	31.3	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	198.9	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
Tauntonbridge	0.0	749.3	219.5	121.7	44.7	0.0	467.6	204.3	95.2	38.7	191	260
Tonridge	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
Cherchreach	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	281.1	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	348.4	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	168.4	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 West²⁷.
- 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



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, Rossmellyn surgery and the Manor surgery.

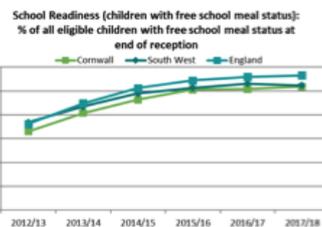
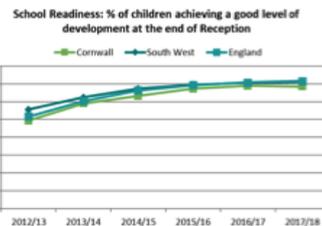
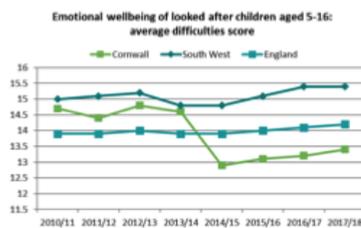
In June 2018, the number of self-harm admissions varied considerably from 0 to a total of 25 patients from the Carn to Coast Health Centre in Camborne. The Quay Lanes Surgery had a lower number of self-harm admissions (6 patients), but the highest rate of admissions during the same month (7.9 per 1,000 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

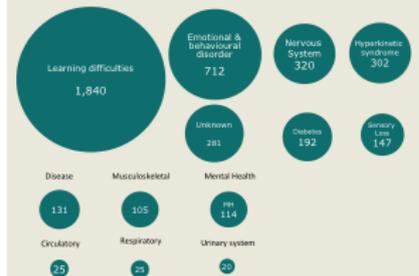
With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is essential. Local authorities have a duty to promote wellbeing among children and young people. As part of this remit, 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 scores²⁶. 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 England²⁶.

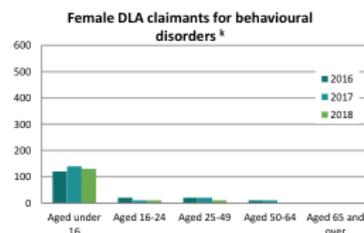
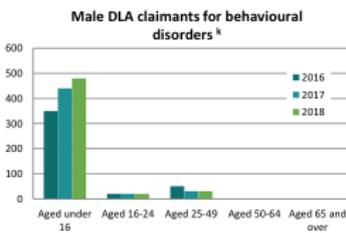


Joint Strategic Needs Assessment Children and Young People's Mental Health 2019: Benefit claimants for a disability

Disability Living Allowance by disabling condition 0-24 Age Group February 2019



Disability Allowance is a benefit paid by the Department for Work and Pensions. The Allowance is paid whether or not the person is in employment.



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

Joint Strategic Needs Assessment Children and Young People's Mental Health 2019

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