Children and young people's mental health and wellbeing

A needs assessment for Bedford Borough, Central Bedfordshire and Milton Keynes Councils, focussing on prevention, early intervention and access to services

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BEDFORD BOROUGH COUNCIL

milton keynes council

Central Bedfordshire

Public Health

Working together to improve the health and wellbeing of our communities

Contents

Scope of the health needs assessment:

In Scope –

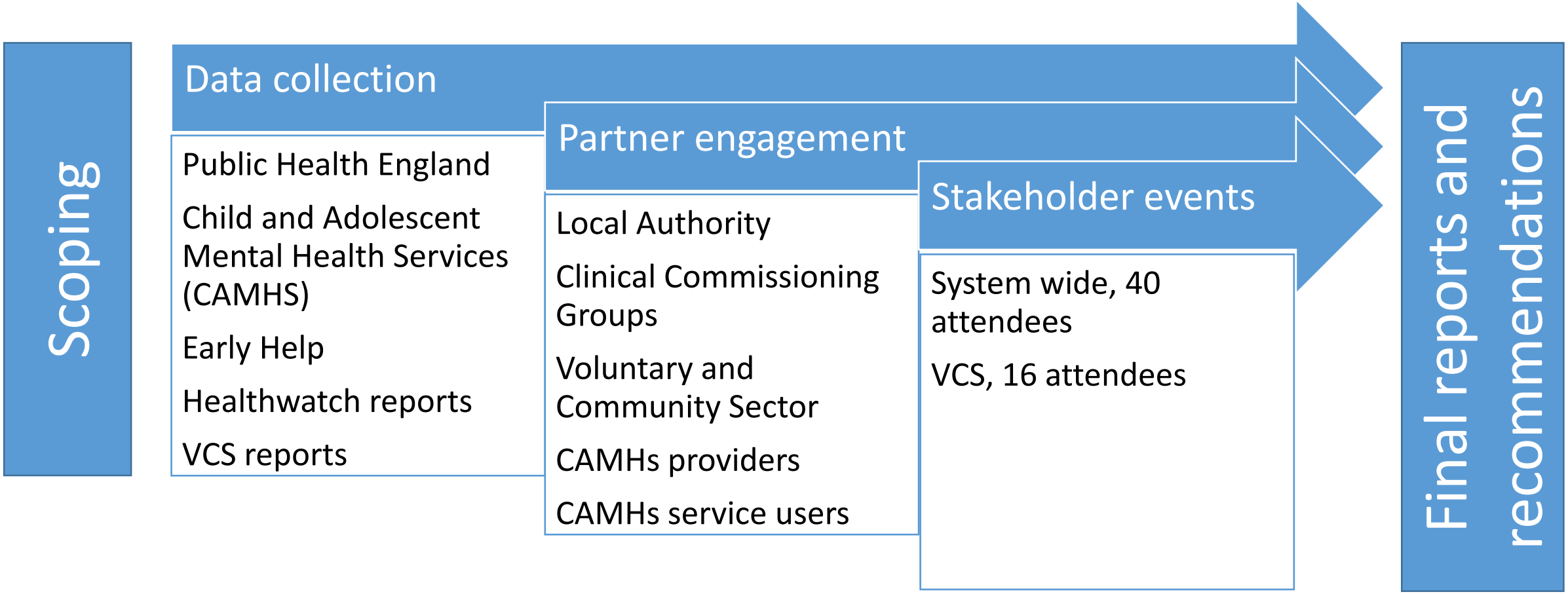
- Prevention and early intervention
- Approach to risk and protective factors
- Access to services, from universal to specialist services
- Transitions
- Evidence base for achieving good mental health and wellbeing in children and young people

Out of Scope –

Work going on elsewhere in the system

- Neurodevelopment disorders including autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)
- Learning Disabilities
  - Separate needs assessments being undertaken for learning disabilities
- Perinatal mental health
- Review of specialist services
- Suicide

Process and engagement



Improving the mental health of children and young people: there is a strong case for prevention and early intervention

Half of all mental health problems manifest by the **age of 14**, with **75 per cent by age 24**[3, 4]

There is on average a **ten-year delay** between young people experiencing their first symptoms and receiving help[7]

Children and adults with **high resilience resources** are **half as likely** to have a diagnosable mental health condition[1]

3 IN 4 CHILDREN

with a diagnosable mental health condition **do not get** access to the **support** that they need[9]

Mental health is used to describe a spectrum

Mental wellbeing / positive mental health

Mental health conditions/ illnesses and disorder

What is mental wellbeing:

'a state of wellbeing in which every individual realises 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' (World Health Organisation, 2014).

Measuring wellbeing:

There are a number of tools that are used to measure mental wellbeing in children and young people, which measure how they perceive their own situation and experience

Resilience: ability to mobilise personal, relational, and socio-economic resources or 'capital' to deal with specific challenges and to thrive or flourish more generally

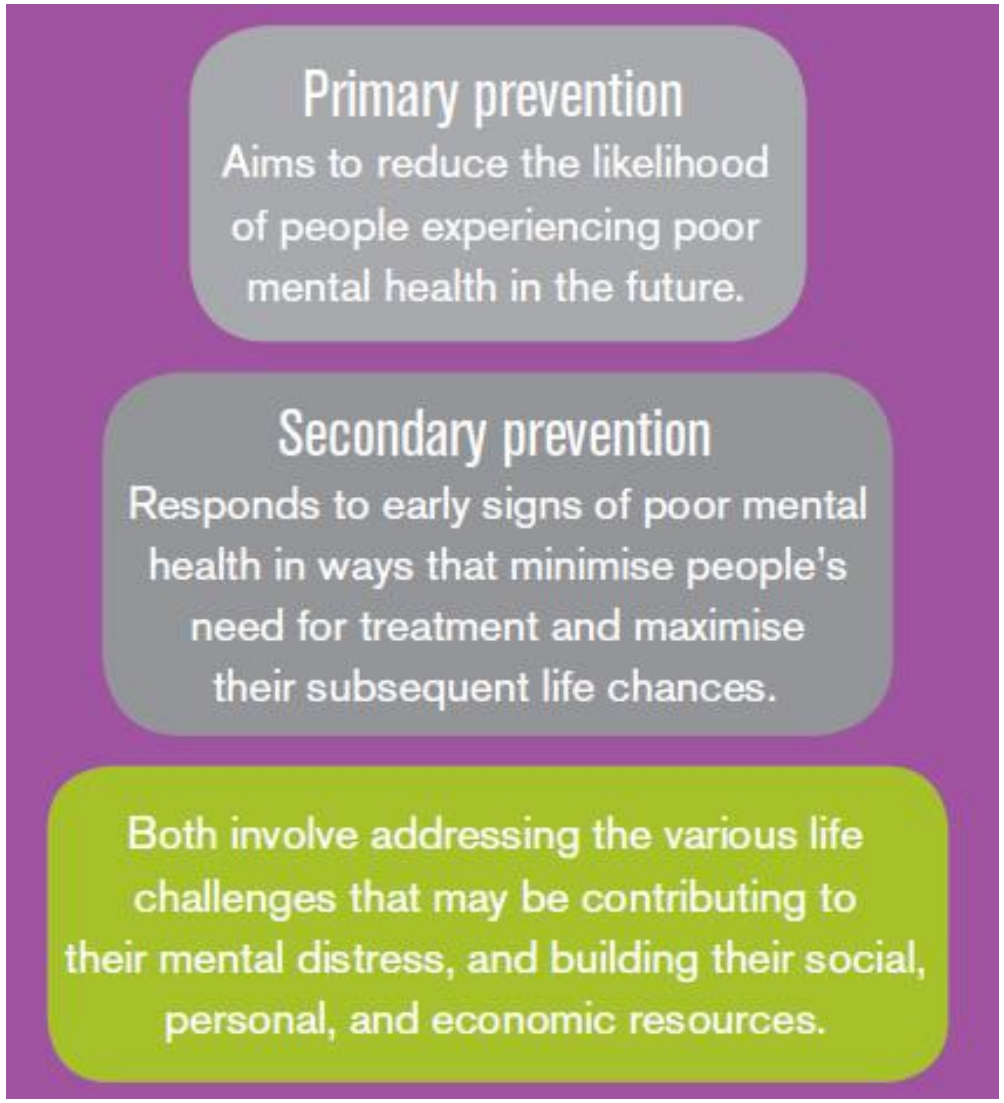
Mental health conditions:

- **Emotional**
  - Anxiety, depressive, mania, bipolar
- **Behavioural (conduct)**
  - Repetitive and persistent patterns of disruptive or violent behaviour
- **Hyperkinetic**
  - Inattention, impulsivity, hyperactivity
- **Less common**
  - Autistic spectrum disorders (ASD), eating disorders, tic disorders, and a number of others

Source: PHE, 2017

Reducing the prevention and treatment gaps

- The ‘treatment gap’ is the difference between those who may need treatment and those who actually receive it.
- *The ‘prevention gap’* refers to those who would derive benefit from preventative activity and the current extent of that activity.



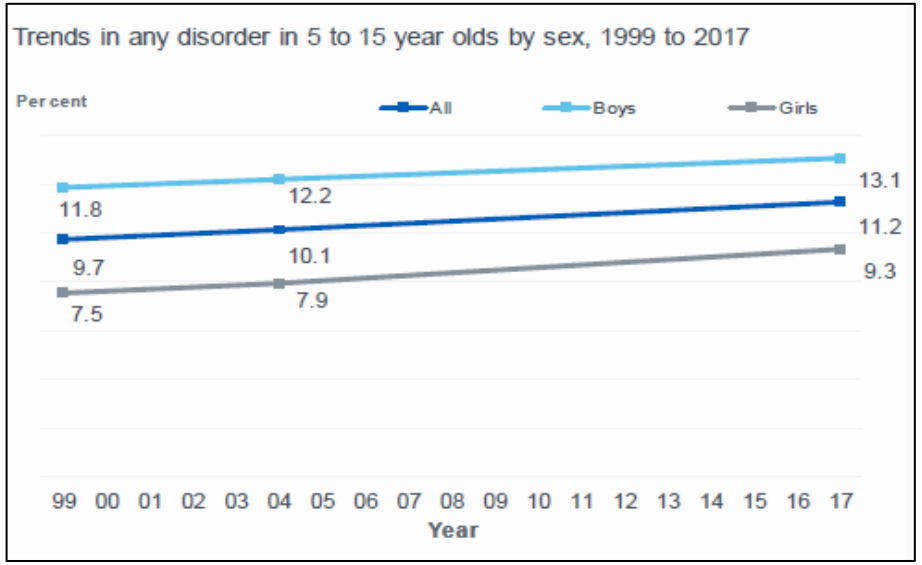
Slight increase in rates of diagnosable poor mental health since 1999 nationally

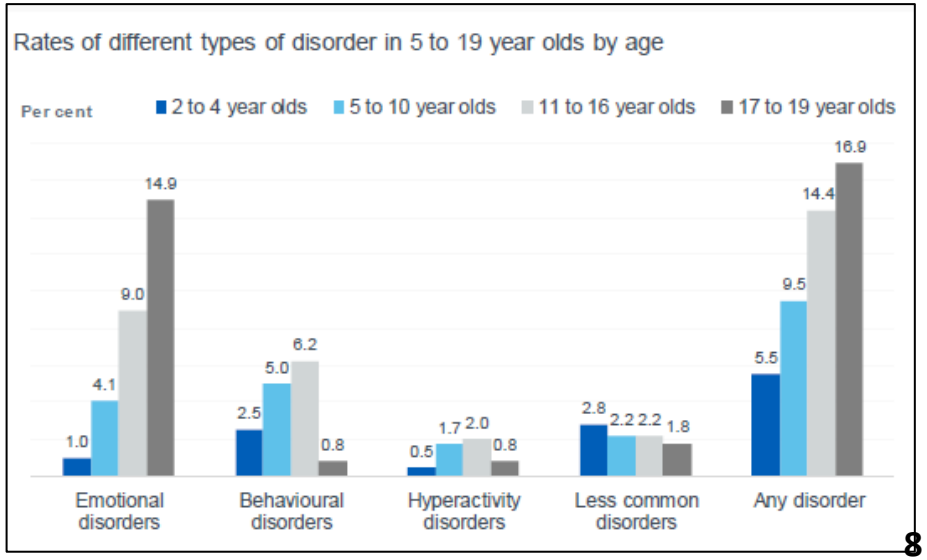
National prevalence by age group (2017):

- **5.5%** in 2-4 year olds
- **10.1%** in 5-15 year olds
- **16.9%** in 17-19 year olds
- **Emotional disorders** are the most common

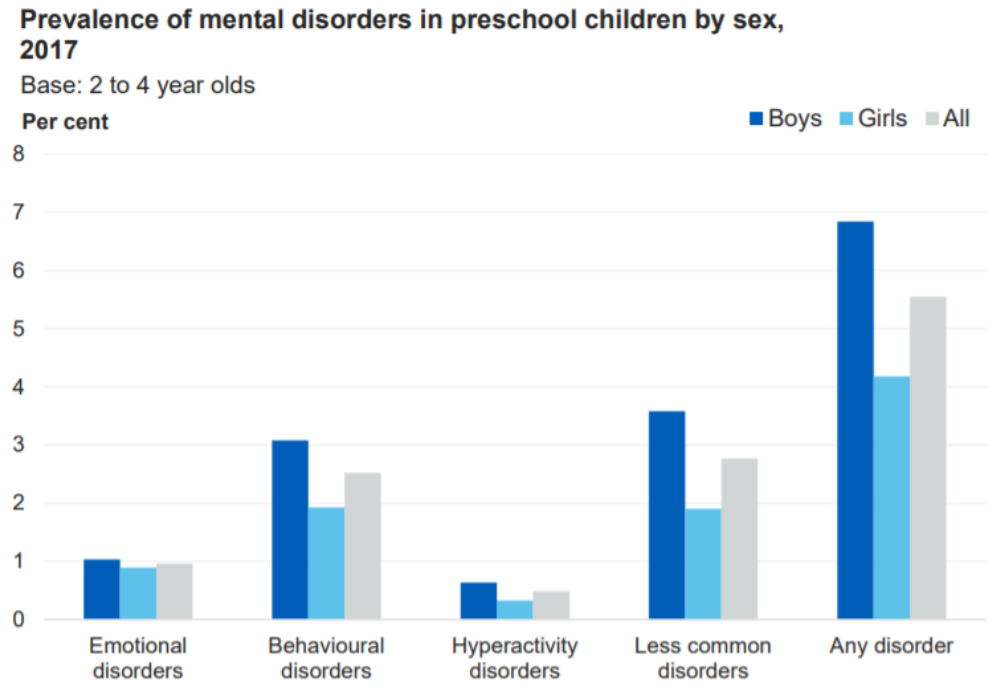
Those who are more likely to have poor mental health:

- **Boys** more likely in younger age groups; **girls** more likely in older aged groups
- **Girls aged 17 to 19** were more than twice as likely than boys that age (23.9% compared with 10.3%)
- Those from **low income** families, living in families experiencing difficulties or with **parents** with poor mental health, and those with **poor general health**.
- **LGBT** or other sexual identity (34.9%) compared with those who identified as heterosexual (13.2%).





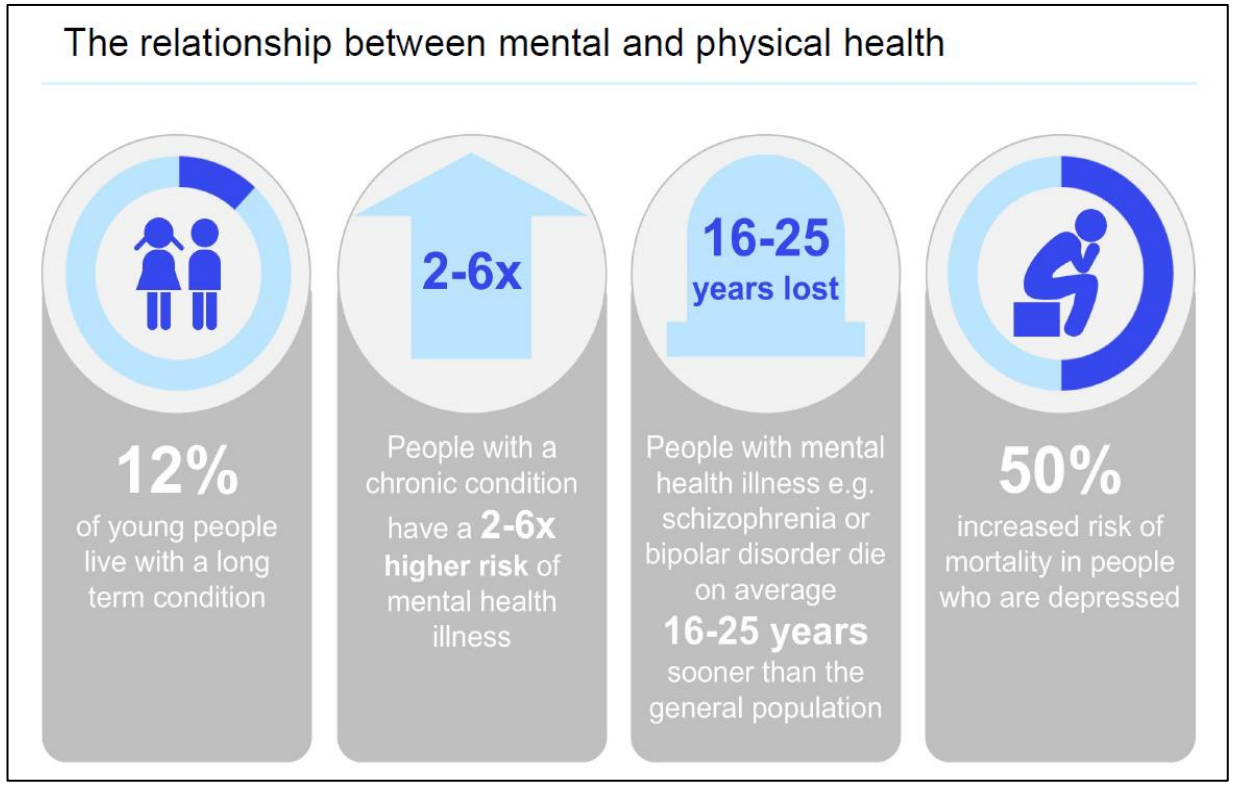
Key factors associated with diagnosable mental health in preschool children include having poor general health, having parents with a poor mental health, living in families experiencing difficulties, and in families with low income



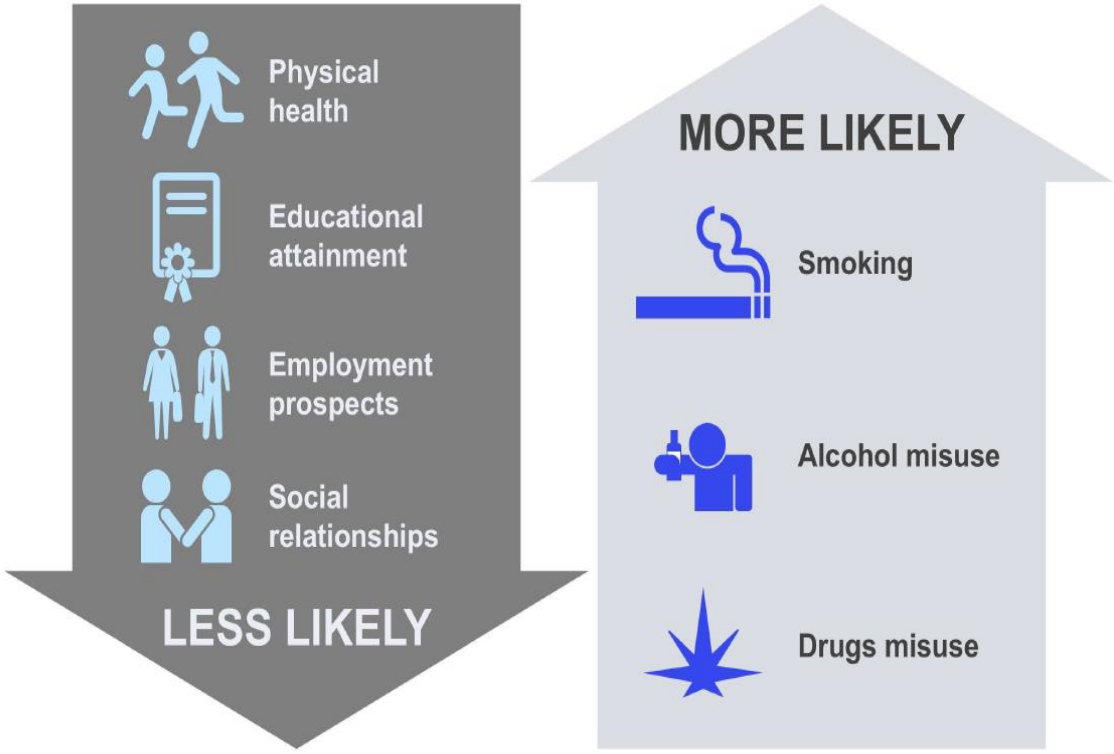
Characteristics of children aged 2-4 who were more likely to have a diagnosable mental health (MH) condition:

- **Demographics:** Preschool boys from white ethnic backgrounds, and preschool children in the North of England
- Health: Children with fair, bad or very bad health compared to those with good health
- **Family:** Children who's parents showed signs of a common mental health disorder, and those living in families experiencing difficulties
- **Socioeconomics:** Children living in the third of households with the lowest income; preschool children who lived with a parent in receipt of benefits related to low income and disability
- **Neurodevelopment disorders** (e.g. autism) and behavioural disorders are most prevalent MH conditions in 2-4 year olds for which there is a ***separate needs assessment*** being undertaken.

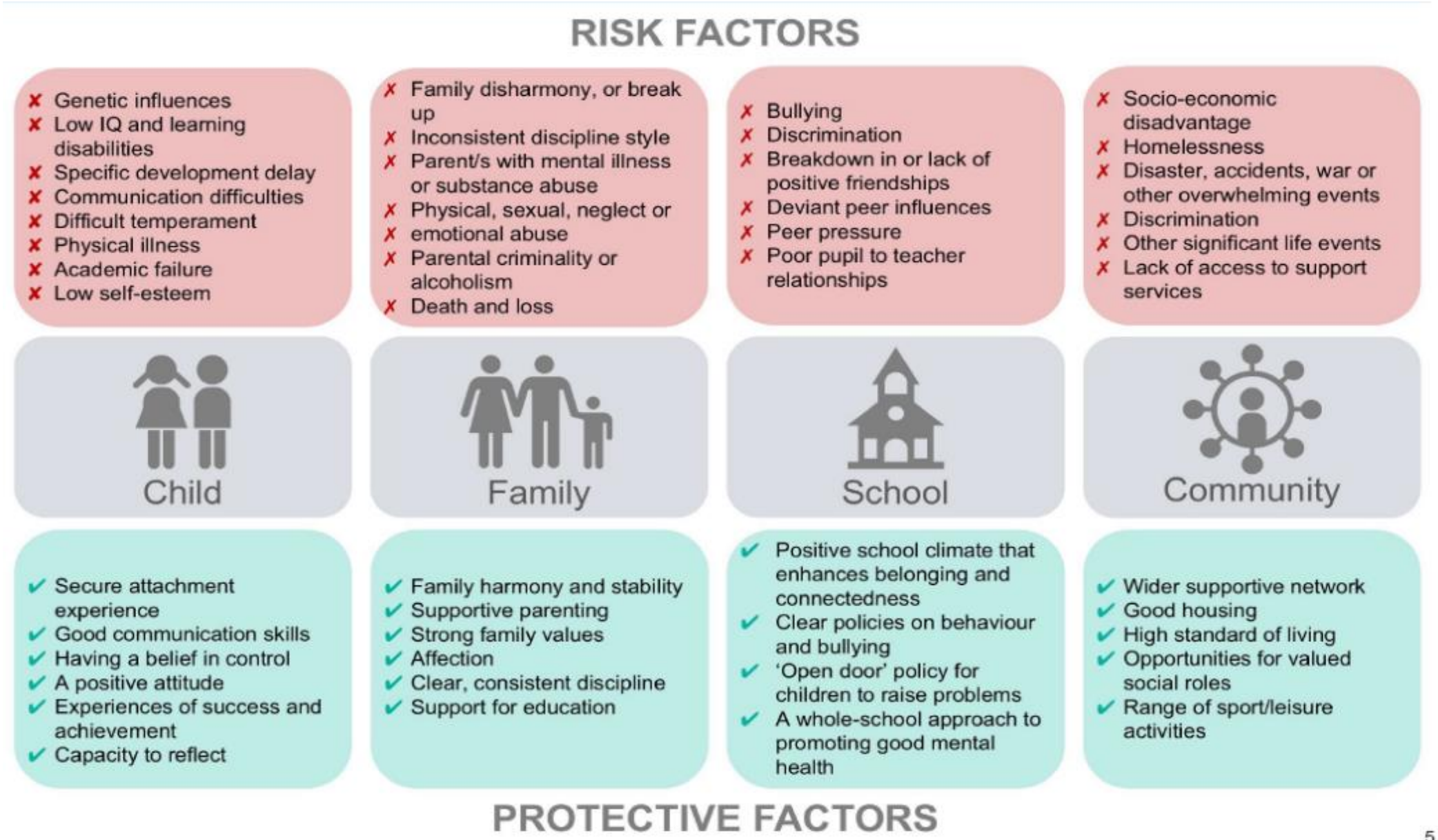
People with poor physical health have a 2-6 × higher chance of mental illness



Those with poor mental health have poorer life outcomes



Risk and protective factors for mental health



Adverse childhood experiences are a significant determinant of poor mental health

Adverse Childhood Experience	Increased likelihood of developing serious mental health difficulties
Physical, sexual, or psychological abuse[101] □ Moderate □ Severe	 11x 48x
Taken into care[102]	11x
Bullying[103]	3x
Violence in the home[104]	9x
Deprived economic backgrounds as children[105]	7x

What children and young people said

Young people don't always feel involved in decision making *"they decided" ; "they didn't believe me"*

A young person had been identified as needing counselling services; however, they indicated that this had never happened.

Young people felt they needed to know more about the care, diagnosis and recovery options available to them. It is clear that access to the right information and advice in a format that is user-friendly to young people, is essential.

Talking to someone about mental health issues or concerns, whether it be a friend, family member or a professional, is the best advice to give young people.

Sandy Youth Mental Wellbeing Project: Youth Action and Health Watch, 2018

Points from discussion with Bedfordshire CAMHs service users

It would be helpful if schools know what support is out there. And listen, even if they don't have the answers

Majority of feedback from CAMHs service users, needing specialist support, on support from GP was negative

Could have more information about MH in GP surgeries – screens, eye catching posters

Internet and social media means CYP are exposed to things sooner. Can get abuse through social media

School doesn't want younger pupils exposed to information about LGBTQ

Adults with MH are taken more seriously than CYP – CYP are said to be over-exaggerating.

Parents vary – not all want to attend parent sessions to find out more about mental health

Not going to get a big social change without tackling the stigma. Language is important

I was bullied for 4 years at school – the one being bullied is isolated if they report it

School "spaces" for support are not always appropriate

CYP with physical conditions are treated better that those with poor mental health

Parents had to travel 4 hours to visit me. Some of the nicest people worked on inpatient ward

Key themes from discussions with partners

Access to services	Waiting times for services (counselling, CAMHs, MIND)	If need identified at aged 17, nearly 18 – difficult to access services	Lots going on in the system – but is it evidence based?	Variable counselling provision across the system
Lack of Tier 4 provision locally – children placed out of area	Variable GP response to CYP presenting with poor MH	Environmental challenges	Cases becoming more complex – unstable families, gangs, exploitation	Impact of internet and social media
Supporting the most vulnerable	Need outreach for most vulnerable who do not attend appointments	CYP living with parents waiting for MH services	Lack of understanding of what its like for Children in Care	Challenges with transitions were identified across all three areas
System or place specific challenges	Schools help to identify the need. Academies – no accountability.	Families with no recourse to public funds	Instability of funding for some programmes	Need to address bullying in schools and colleges

What young people and local partners say - MK

Children and Young People

What are CYP looking for in a CAMH service?

- Choice and flexibility in how they get their care
- To know they're not being judged
- Help early…when they start having problems
- To be involved in shaping services

Overview of CAMHs Tier 2 contract 2015- 16

Look at whole picture

Support for low level mental health needs

More support groups in schools for

More environments for CYP to talk about self-esteem/ confidence concerns

More support for parents

Support for bullying

Positive relationship guidance & support

MySayMK Conference, 2016

Voluntary Sector

Frustration from not knowing how or where to find out what is available to support CYP

Pressure to deliver more for less

Lack of early intervention and low level support

Thresholds for those seeking help are rising

Private and social enterprises delivering services previously delivered by public and voluntary sector

Appears to be less stigma, at least in some communities, to discuss mental health

Need MH awareness training for workers, support for families, strategic investment in play, arts and culture, capacity building in voluntary sector and support for new providers

Emphasis from funders on results, targets and 'hard evidence' rather than preventative, user-led initiatives

Voluntary sector - challenges

Short timescales to work client groups with complex needs don't work

FUNDING – Local authority funding has been cut, increased demand on all funds

VCS need to be more prominent in **whole systems** approach, and role better understood

MH support being provided by **unqualified** / untrained individuals

Increasing **demand**

Long **waiting** lists and waiting times

Pressure on **schools** to deliver too much

Need more **outreach**, disaffected YP aren't used to having support

Pathways for support are not clear

Crisis management trumps early intervention

Staffing / volunteer levels – too much reliance on good will

Voluntary sector - opportunities

Attract a large amount of **FUNDING** to the local area

Bring **skills and resources** to the table

Peer mentors; referral pathways to services

Innovation

VS agencies who deliver **specialist services** e.g. LGBTQ / Gangs/ CSE can support **delivery of training**

Collaboration

VS are more **approachable** / **community based** so **see the issues first hand.** This enables them to be responsive to meet the gaps

Young Unaccompanied Asylum Seekers Forum Partnership between housing, health, children's services and VCS

BUILD TRUST with young people through activities

Peer support

Provide support through transitions periods – work with YP up to age 25

What works in the early years?

- **Enhanced perinatal support** with a specific focus on the mental health of mother and infants e.g. Health visiting, home and family-based support
- **Intensive support for families facing difficulties**: Strengthening Families, Incredible Years; Inter-parent relationship; Video Interaction Guidance
- **Preschool programmes** supporting school readiness, communication and development of social and emotional skills
- **Pathways** complying with NICE guidance

A whole school approach to mental health within in all aspects of school life is key to building resilience in children and young people

Building resilience – what works?

- **Whole school** social and emotional learning programmes that are universal, but can offer support for more vulnerable children
- Addressing **harmful behaviour** – bullying, substance misuse and reducing exclusions
- Supporting successful **transitions** in education and into employment
- **Schools and colleges** to support mental wellbeing of their workforce

Approaches to improve the mental health of the population

- **Whole population approaches**
  - strengthening individuals and communities, addressing wider determinants
- **Life course approaches**
- **Targeted prevention**
  - groups at higher risk
  - individuals showing signs and symptoms
  - people with mental health problems

Groups at increased risk:

- Children and young people from low income families
- Looked after children, children in need
- Black and minority ethnic groups
- Homeless / at risk of homelessness
- Lesbian, gay, bisexual, transgender and queer
- Those seeking asylum
- Young offenders, or at risk of offending
- CYP going through transitions: child to adult/ community services; between education; education to employment; change in life circumstances
- Excluded or at risk of exclusion from education

Going digital: e-headspace, successful Australian national digital delivery service

Population approaches evidenced to improve MH

Improving MH literacy

- Improving MH literacy of public service workforce
- Making Every Contact Count, Health visiting, schools, housing and social care
- Workforce able to identify and act on impact of MH inequalities e.g. Black, Asian and Minority Ethnic groups, LGBT
- Enable self management within communities, peer support, adapt for those with long term conditions

Mentally healthy communities and places

- Secure base for vulnerable families (income, housing, access to health, education and employment
- Universal and targeted approaches eg. Housing First
- Asset based community development – actively involve individuals and communities
- MH is measured as an outcome in investment/ regeneration
- Create and protect green spaces

Reduce stigma and discrimination

- Evidence based activities focused on sustained behavior change
- Awareness raising and education, reduce social distance
- Approaches targeted to where there is most need, and were the greatest impact can be achieved in improving health, employment and education
- Consistent, recovery focused messages, challenge stereo types

Integrated health and social care approaches

- Integrate mental and physical health care – improve quality and efficiency, and outcomes
- Joint planning of health, mental health and social care interventions (Local Authorities, primary care, voluntary and community sector)
- Workforce development, support for those with poor MH to navigate the system
- Access to psychological support

Summarised from the EIF's Mental Health and Prevention: Taking local action for better mental health (2016)

Evidence for savings from investing in prevention

Target	Intervention
Families	Debt and welfare services – every £1 invested results in an estimated saving to society of £2.60 (over five years)
Mothers	£400 investment per birth in universal and specialist provision for perinatal mental health problems would lead to savings to society in the region of £10,000 per birth, including £2,100 to the public sector
Children	Whole-school anti-bullying programmes – every £1 invested results in an estimated saving to society of £1.58 (over four years)
Children	Social and emotional learning – every £1 invested results in an estimated saving to society of £5.08 (over three years)
Children	Parenting programmes addressing conduct disorder – every £1 invested results in an estimated saving to society of £7.89 (over six years)
Young people and adults	Well-being programmes in the workplace – every £1 invested results in an estimated saving to society of £2.37 (over one year)
Young people and adults	Stress prevention in the workplace – every £1 invested results in an estimated saving to society of £2.00 (over two years)
Young people and adults	Suicide prevention – every £1 invested results in an estimated saving to society of £2.93 (over ten years)

Burstow *et al* 2018. *Investing in a Resilient Generation: Keys to a Mentally Prosperous Nation.* Birmingham: University of Birmingham.

Government School's Green paper proposals

Core proposals 20-25% of schools by '22/23:

1. Incentivise and support all schools and colleges to **identify and train a Designated Senior Lead for mental health**.
2. Fund new **Mental Health Support Teams**, which will be supervised by NHS children and young people's mental health staff
3. To pilot a **four week waiting time** for access to specialist NHS children and young people's mental health services.

In addition:

- Department for Education supporting a **Whole School Approach** to mental health
- Focus on **physical health:** sporting future; child obesity plan
- **Online Safety**

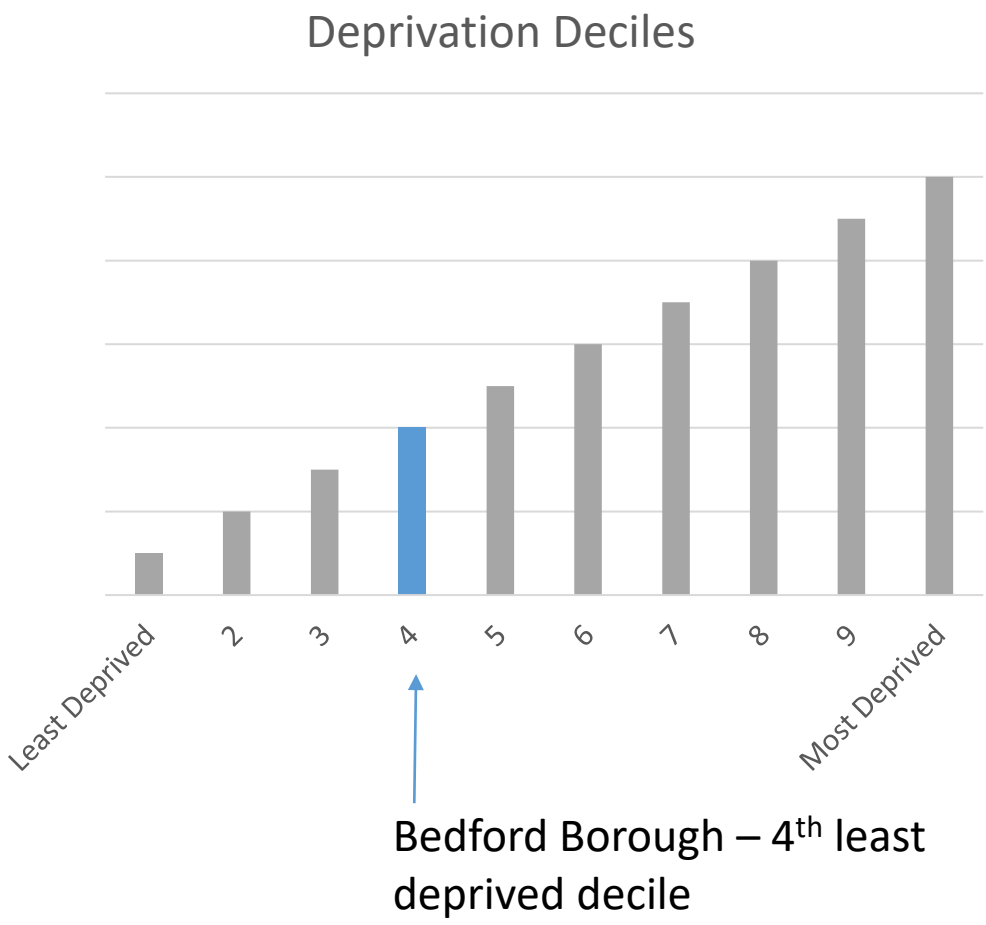
What are the implications locally of NHS Long Term Plan

- Increasing emphasis on **self-care & management** including common mental health problems
- Increase **physical health checks** for those with severe mental illness
- Support for **young carers**, who are are risk of poor MH
- **Expanding MH services** for children and young people – to improve access to services, including those aged 18-25 years.
- **NHS 111** to be single point of access and source of community MH support 24/7

Bedford Borough Slides

Presenting the data and making comparisons

- The following performance data is presented for a number or relevant indicators:
  - Bedford Borough
  - England
  - Data for local authorities in the 4th least deprived decile in England, which includes Bedford Borough
  - Data for Local Authorities with the best performance for each indicator (95th centile)
- Bedford Borough data is compared (RAG) to the average of other areas in England within the **same deprivation decile** (4th least deprived) where available.
- Where unavailable, comparisons are made to with England

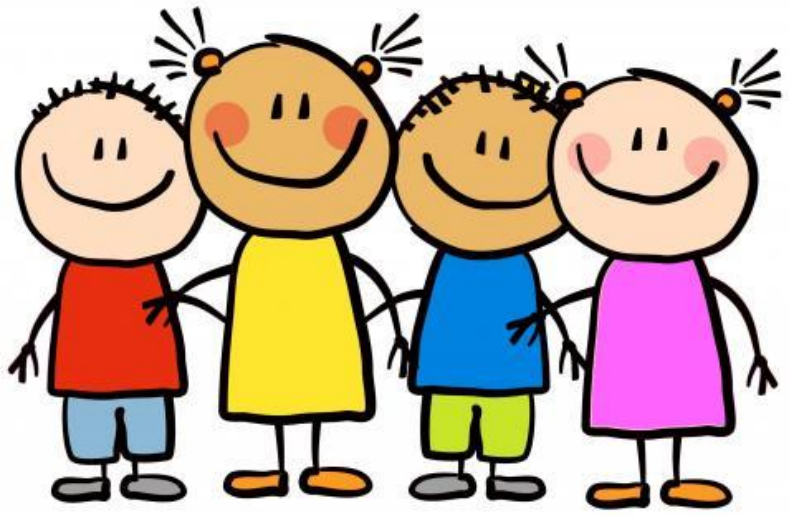


Do we understand the picture of mental wellbeing in our 0-5 year olds?

- Nationally **5.5%** of 2 to 4 year olds have a diagnosable MH condition (PHE, 2017).
- The most common are neurodevelopment conditions, including ASD
- Applied to the local population, that is

377 children in Bedford Borough

- Are we identifying under 5s who need support and referring appropriately?
- Are we picking this up early enough, e.g. through development checks, home visits, contact with other services?
- What about those with low level needs?



The picture of mental wellbeing in school-aged children and young people

Key Points:

- Current pupil resilience and wellbeing data is lacking – the school surveys are going to be repeated in 2019
- School pupils in have similar rates of ***identified*** social, emotional and mental health needs compared to other local authorities in the same deprivation decile.
- Prevalence of poor mental health is estimated and based on a national survey carried out in 2004.
- Rates of hospital admissions in Bedford Borough are similar to comparators

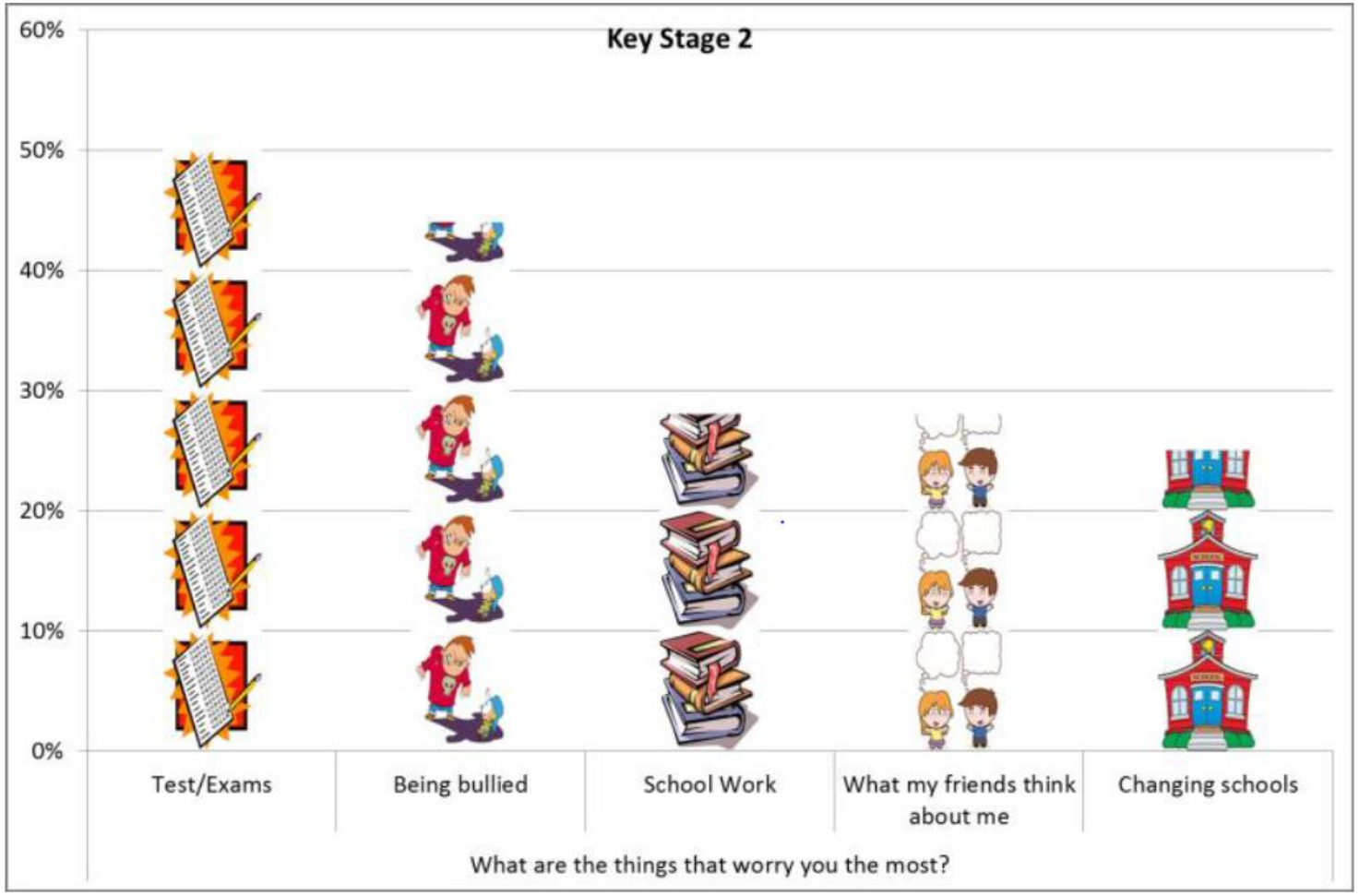
Indicator	England	4th least deprived decile	Bedford Borough	95th Centile
Mental Wellbeing in 15 year olds: Mean wellbeing (WEMWBS-14) score (2014/15)[2]	47.6	-	47.2	-
% of 15 year olds reporting positive satisfaction with life (2014/15)[3]	63.8	-	62.8	68.7
*% school pupils with identified social, emotional and MH needs (2018)[4]	2.39		2.18	1.65
Estimated % of MH disorders in CYP aged 5 to 16 (2015)[5]	9.2	9.0	9.1	8.0
**Hospital admissions for MH disorders per 100,000 population aged 0-17 years 2017/18[5a]	84.7	83.6	91.8	-

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Bedford Borough – Emotional Wellbeing Survey (2014)

Our Worries



How we feel

94 % of pupils reported they were OK, Mostly or Very Happy most of the time.

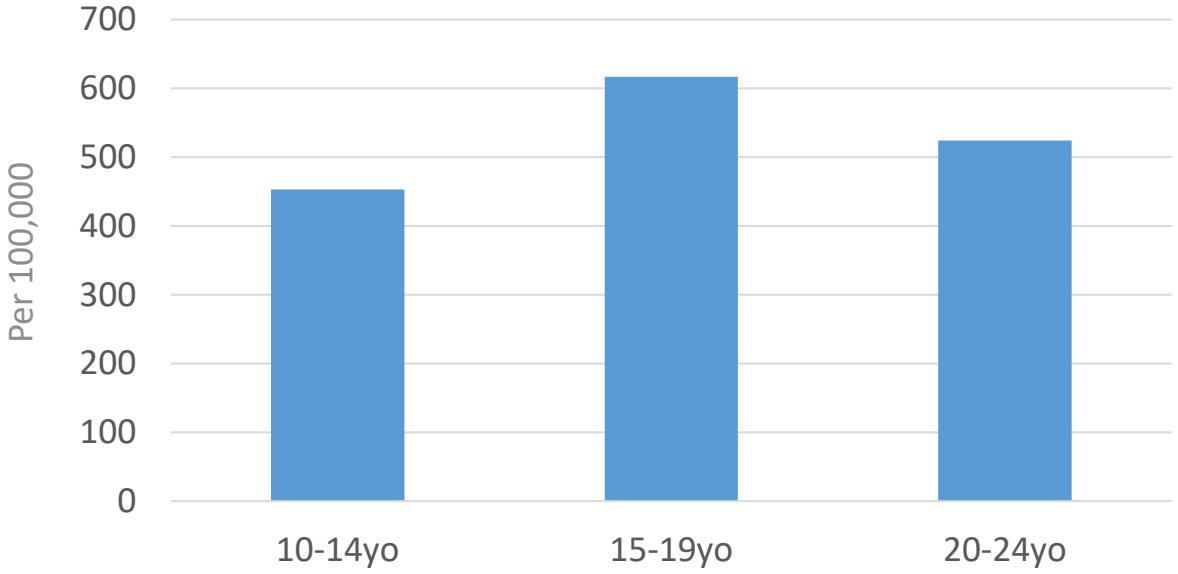
7 to 11 year olds (Key Stage 2, KS2) were most likely to say they were Very or Mostly Happy (**75%**) compared to **68%** of 11 to 14 year olds (KS3) and **55%** of 14+ year olds (KS4).

Overall just under **6%** of all pupils said they felt Sad or Very Sad most of the time.

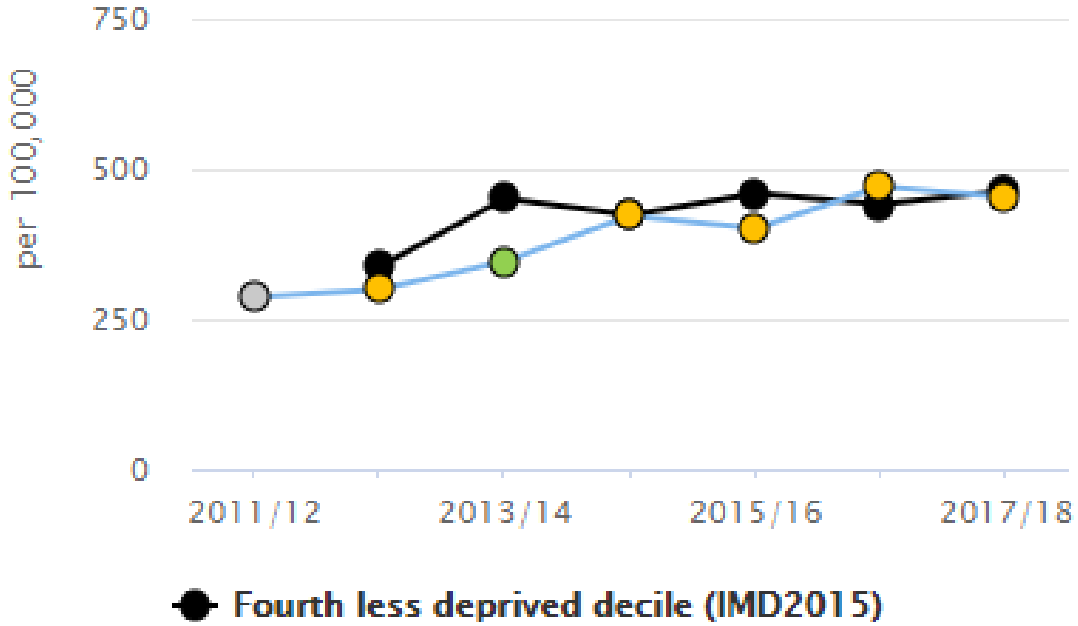
5% of under 14 year olds (KS2 & KS3) reported they felt Sad or Very Sad most of the time, increasing to 10% of over 14 year olds (KS4).

Hospital admissions for self-harm:

Hospital admissions for self-harm (2017-2018) by age group (per 100,000 population)



Trend in hospital admissions for self-harm (2011/12 to 2017/18 (10-24 year olds)



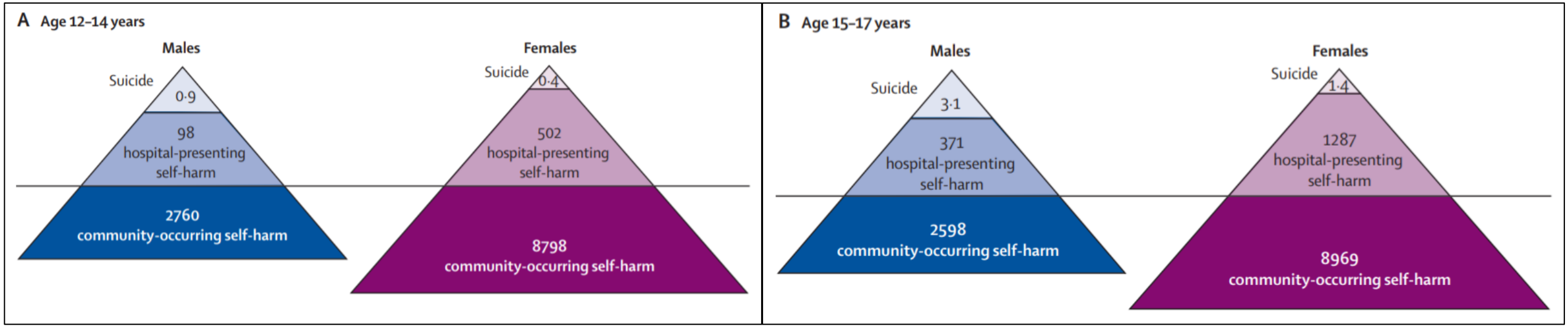
Rates of self-harm are **higher in the 15-19 age group** – indicating the need for primary prevention in the younger age groups and secondary prevention in the older age groups

Admission rates have increased since 2011/12. Admissions rates are statistically **similar** to comparator local authorities for all age groups

But this is just the tip of the iceberg given the hidden nature of self-harm

Estimating “hidden” community self harm

Figures A and B: Incidence of fatal and non-fatal self-harm per 100,000 person-years by age group and sex



Projected annual number of suicides and self-harm in children and young people aged 12 to 17 years in Bedford Borough based on national estimates

	Bedford Borough		
	Males	Females	Total
Suicides	0.13	0.05	<1
Hospital-presenting self-harm	15	52	67
Community self-harm (not to hospital)	170	521	**691**

Protective factors: how are we performing?

Key Points:

- **School readiness** is a key indicator in ensuring children are developing well. In Bedford Borough the level of development is lower than comparators
- The proportion of **healthy weight** in reception children is similar compared with the England average. 22.4% of children are not a healthy weight
- Educational attainment at Key Stage 4 is comparatively lower

Indicator	England	4th least deprived decile	Bedford Borough	95th Centile or Best in England
% of children achieving a **good level of development at the end of reception (17/18)[6]	71.5	72.6	69.6	77.0
% of CYP with **free school meal status achieving a **good level of development** at the end of reception (17/18)[7]	56.6	56.3	54.4	66.7
***Healthy weight** in Reception children (%) (2017/18) [8]	76.6	-	77.6	81.1
*Average **Attainment 8 score** for all pupils in state-funded schools (2017/18)[9]	46.7		45.5	-

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Addressing adversity – how are we performing?

Key Points:

- Poverty indicators mask variation within areas
- Adverse childhood experiences are a predictor of MH problems in children and young people and in adults.
- In Bedford Borough family homelessness is an issue of concern with rates higher than similarly deprived areas.
- BBC also has relatively high rates of CIN due to abuse or neglect compared with statistical neighbours

Indicator	England	4th least deprived decile	Bedford Borough	95th Centile or Best in England
% CYP aged under 20 living in **low income families (2016)[10]	17	15.1	14.8	9.2
% of **LAC 5-16yo where there is cause for concern (SDQ score >17) (16/17) [11]	38.1	40.1	45	21.6
****Children in need** due to abuse or neglect (rate per 10,000 CYP <18) (2018) [12]	181	136.6	163	85.9
CYP who started to be **LAC due to abuse or neglect (rate per 10,000 <18) (2018) [13]	16.4	13.5	15.6	6.5
Family **homelessness: rate per 1,000 households (2017/18) [14]	1.7	1.8	2.5	0.3
Number of unaccompanied **Asylum Seeking Children** Looked After (2018) [15]	600	-	19	6

** RAG rated against local authorities in same deprivation decile

Vulnerability

Key Points:

- These vulnerable groups are at **increased risk** of poor mental health
- **Exclusions:** are there variations in how local data is recorded? How many children have partial timetables?
- **Bullying** data available is old, data is held by individual schools, monitored by Ofsted.

Indicator	England	4th least deprived decile	Bedford	95th Centile or Best in England
****Children in Care**, rate per 10,000 <18 (2018)[16]	64	56	61	33
******Primary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[17]	1.37	1.51	1.39	0.39
******Secondary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[18]	9.4	8.4	5.5	4.5
******% of school aged pupils with a **Learning Disability** (2017)[19]	5.6	4.5	6.5	3.6
*****% of 15 year olds who were **bullied** in last couple of months (14/15)[21]	55	-	52.3	48.3
******% 16-17 year olds not in education, employment or training, **NEET** (2017)[22]	6.0	5.2	5.1	2.3
******First time entrants into **youth justice system**,[23] rate per 100,000 population aged 10-17 (2018)	293	196	194	152.3

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Access to services

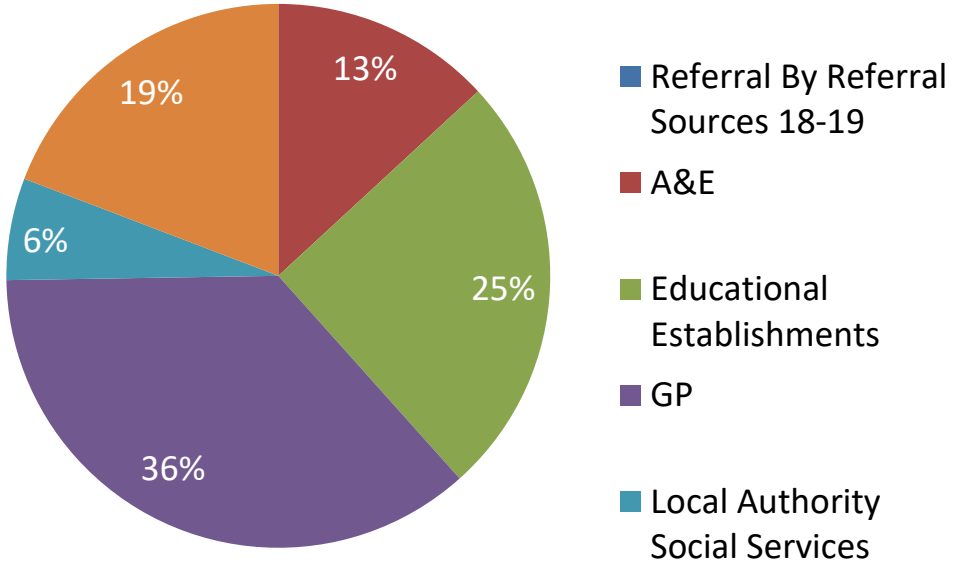
Bedford Borough

Examples of support for children and young people's mental wellbeing include, but are not limited to:

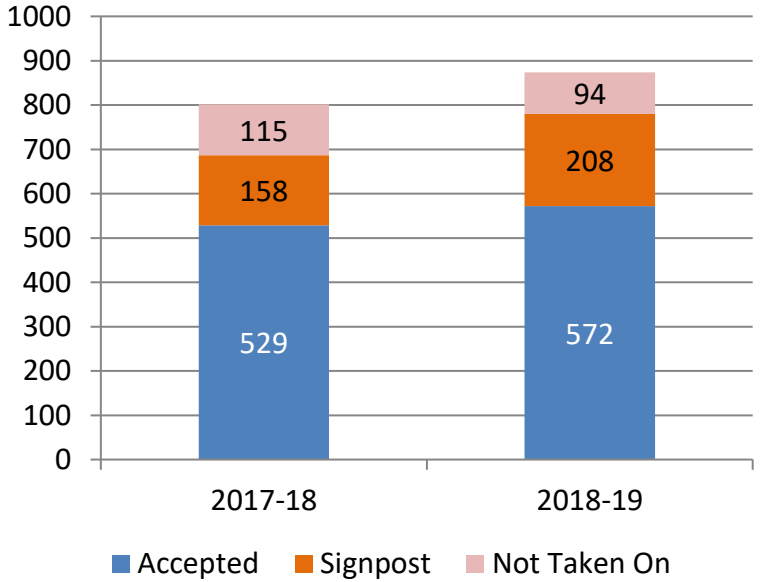
Level of need	Examples of support available for children include, but are not limited to:	
Universal	• Primary Care universal support • Voluntary sector providers • Targeted Early Help team • Universal Parenting Offer - Triple P • Universal Children's Centre Offer • FACES – volunteer parent support	• Child and Adolescent Mental Health (CAMH) School Programme in upper schools and colleges • CHUMs programme in middle, lower and primary schools • Whole school approach to mental health and wellbeing • 0-19 services (School Nursing, Health Visiting) • Peer mentoring pilot in schools • Groundworks mentoring service
Additional Needs	• 1:1 Solution Focus Brief Therapy • Protective Behaviour 1:1 Support • Enhanced Evidenced Based Practice Improving Access to Psychological Therapies (IAPT) CBT Intervention • Targeted Parenting Offer	• CAMH secondary school programme • Families First Bedfordshire Play Therapy • CHUMS • Bedford Open Door • 0-5 Infant Mental Health (IAPT) Trainees
Considerable Need	Child and Adolescent Mental Health Services (CAMHS) – commissioned by Bedfordshire Clinical Commissioning Group (CCG), provided by East London Foundation Trust (ELFT):	
Specialist Need	Inpatient services; CAMHS Crisis Service and 16 plus Street Triage Service; Eating Disorder Service; Care, Education and Treatment Reviews (CETR)	

Access to CAMHS – Bedford Borough (ELFT)

Referral By Referral Sources 18-19



Referral Outcome



Ethnicity	%
White British	49%
Ethnicity other than White British	24%
Not known (missing)	27%

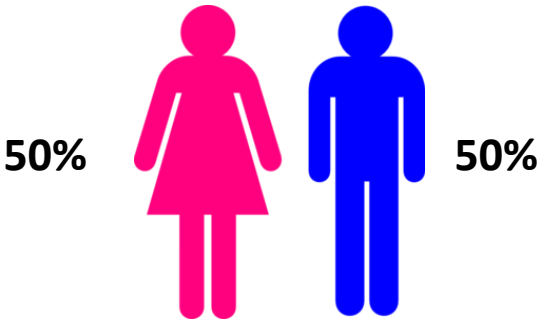
Age (years)	% of referrals
0-4	4%
5-11	14%
12-18	81%

Key discussion points:

- Slight **increase** in referrals 2017-18 (802)to 2018-19 (874)
- Highest proportion of referrals from **GPs** in 18-19 (36%) followed by education establishments (25%), A&E (13%)
- 81% of children and young people referred were aged 12-18 years, 14% aged 5-11 years
- 98% of referrals were seen in 12 weeks or less

Children and Young People's MH Access Target: 32% (ELFT contribution: 27%)

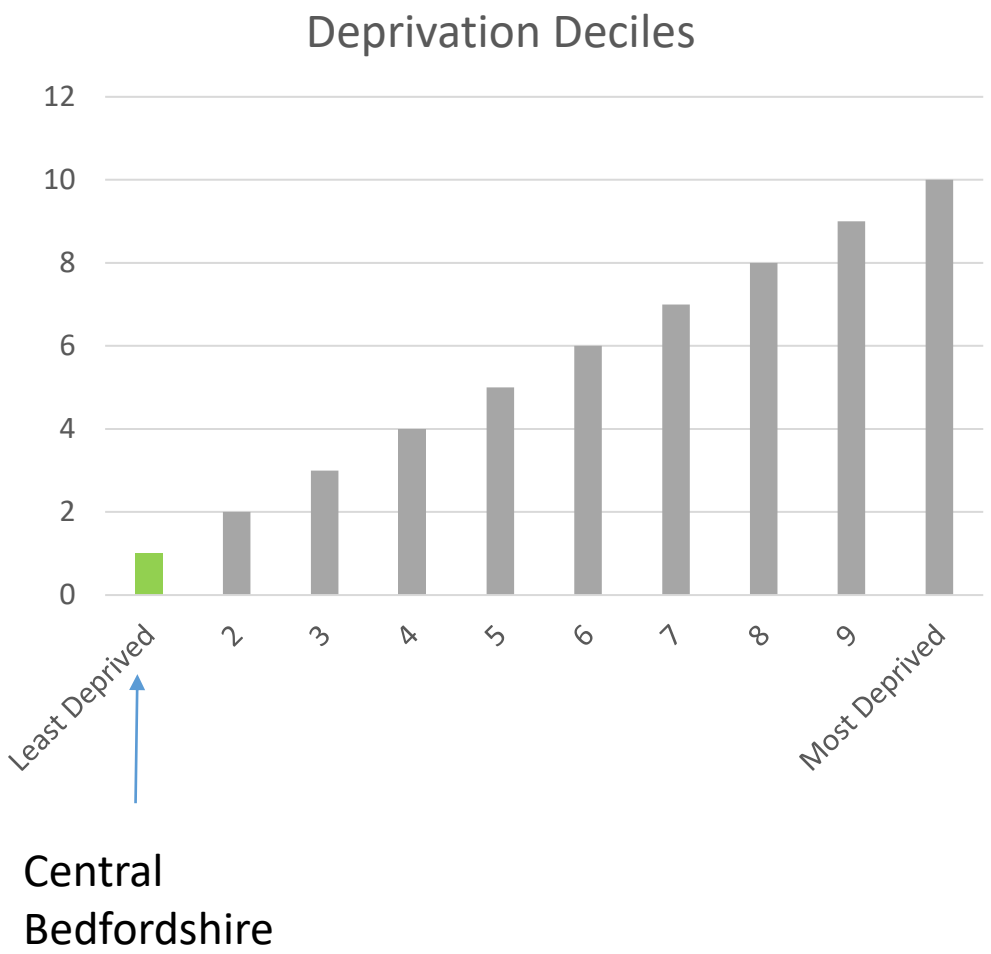
CCG	Prevalence Rate	CCG Trajectory for 2018-19	Bedford Borough (ELFT)	Central Bedfordshire (ELFT	ELFT Total Contribution
Bedfordshire	7,065	2,261	758	1,138	1,896



Central Bedfordshire Slides

Presenting the data and making comparisons

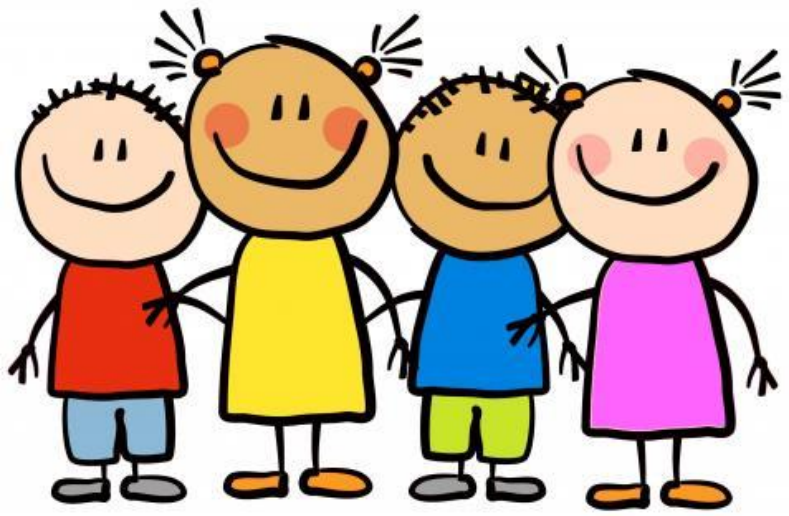
- The performance of Central Bedfordshire is compared (RAG rated) with other areas in England within the **same deprivation decile** (10%) where available
  - Central Bedfordshire is in the **least** deprived decile
- Note: overall deprivation rating **masks pockets of deprivation** within areas
- Different challenges arise in **rural** and **urban** areas
- **England** data and **95th centile** (best) data are also presented



Do we understand the picture of mental wellbeing in our 0-5 year olds?

- Nationally **5.5%** of 2 – 4 year olds have a diagnosable MH condition (PHE, 2017).
- The most common are neurodevelopment conditions, including ASD (out of scope)
- Applied to local populations, that is

600 children in Central Bedfordshire



- Are we identifying under 5s who need support and referring appropriately?
- Are we picking this up early enough, e.g. through development checks, home visits, contact with other services?
- What about those with low level needs?

The picture of mental wellbeing in school-aged children and young people

Key Points:

- Self reported levels of resilience were lower in CBC compared to the wider SHEU survey results
- Prevalence of poor mental health is estimated and based on a national survey carried out in 2004.
- Rates of hospital admissions for mental health related disorders similar to comparators

Indicator	England	Least deprived Decile	Central Bedfordshire	95th Centile
% of Year 8, 10 and 12+ pupils with a low level of resilience (SHEU survey, 2017)[1]		-	37%	-
Mental Wellbeing in 15 year olds: Mean wellbeing (WEMWBS-14) score (14/15)[2]	47.6	-	47.1	
% of 15 year olds reporting positive satisfaction with life (14/15)[3]	63.8	-	65.5	68.7
*% school pupils with identified social, emotional and MH needs (2018)[4]	2.39		2.47	1.65
Estimated % of MH disorders in CYP aged 5-16 (2015)[5]	9.2	8.1	8.4	8
**Hospital admissions for MH disorders per 100,000 population aged 0-17 yrs 17/18[5a]	84.7	90.4	87.9	

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Results from the SHEU Health and Wellbeing Survey, CBC (2017)

Bullying:

- 28% of primary and 19% of secondary school pupils reported having been bullied at or near school in the last 12 months
- **40 % of primary school pupils were sometimes afraid to go to school because of bullying**, and 11% were often or very often afraid
- 27% of secondary school pupils were sometimes afraid to go to school because of bullying, and 5% were often or very often afraid

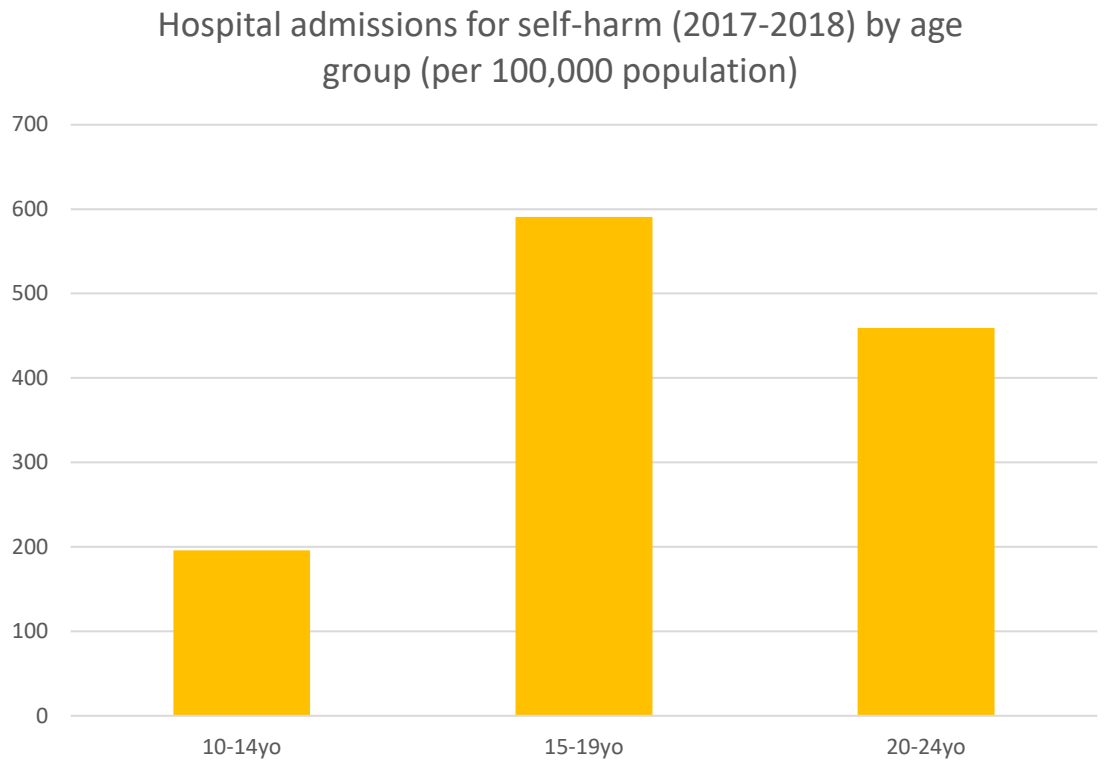
Headlines – good news

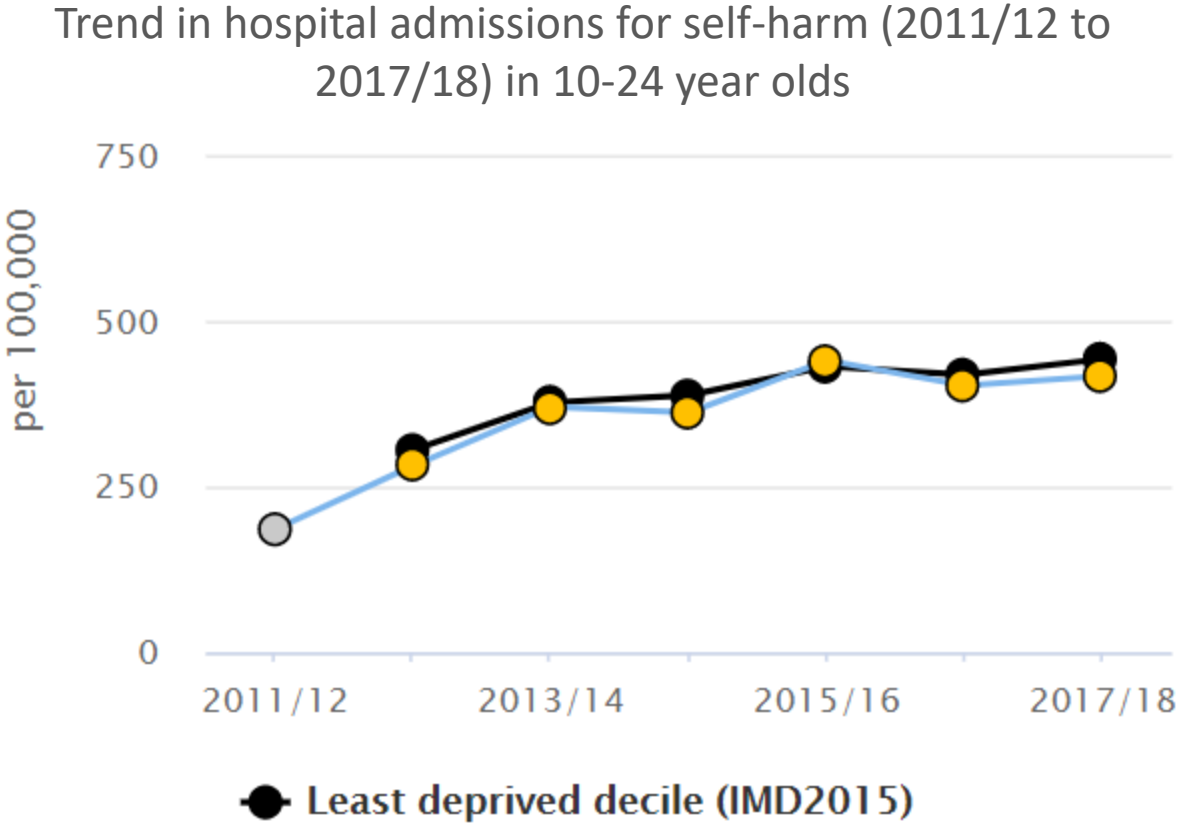
- **Self-esteem scores higher** in CBC than in the wider SHEU sample.
- **Happiness with life** has increased for Yr6 pupils (2014 to 2017).

Headlines - not such good news

- Lower measure of resilience in females than males across all year groups and worse than wider SHEU data for Year 6 to Year 10.
- 1/3 of older students not getting sufficient sleep to feel awake all day.
- **Pupils more likely to report a fear of bullying in 2017 than in 2014**.
- The proportion of pupils saying 'school encourages me to be physically active' is lower in 2017 than in 2014.
- Over 40% of Year 10 pupils said they would go to no one/nowhere if they wanted help or information about their sexuality or gender.

Self-harm:





- Admissions as a result of self-harm are **similar** comparators for all age group. Admission rates have increased between 2011/12 to 2017/18
- Rates of self harm are ***higher in the 15-19 age group*** – indicating the need for primary prevention in the younger age groups and secondary prevention in the older age groups

But this is just the tip of the iceberg given the hidden nature of self-harm

Protective factors: how are we performing?

Key Points:

- ***School readiness*** is a key indicator in ensuring children are developing well. In CBC, the proportion achieving a good level of development at the end of reception (73.2%) is lower than comparators, and for those who are eligible for FSM which is only 44.2%.
- This proportion of ***healthy weight*** in reception children is better than comparators in CBC (80%) compared with the England average. However there is still at lease 20% of children who are not a healthy weight.
- Education attainment at Key Stage 4 is comparatively lower (46.2)

Indicator	England	Least deprived decile	Central Bedfordshire	95th Centile or Best in England
% of children achieving a **good level of development at the end of reception (17/18)[6]	71.5	75.4	73.2	77
% of CYP with **FSM status achieving a **good level of development** at the end of reception (17/18)[7]	56.6	52.8	44.2	66.7
***Healthy weight** in Reception children (%) (17/18) [8]	76.6	-	80	81.1
*Average **Attainment 8 score** for all pupils in state-funded schools (17/18)[9]	57.8	-	46.2	-

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Addressing adversity – how are we performing?

Key Points:

- Poverty indicators mask variation within areas
- Adverse childhood experiences are a predictor of MH problems in CYP and in adults.
- CBC has relatively high rates of CIN due to abuse or neglect

Indicator	England	Least deprived decile	Central Bedfordshire	95th Centile or Best in England
% CYP aged under 20 living in **low income families (2016)[10]	17	9.9	11	9.2
% of **LAC 5-16yo where there is cause for concern (SDQ score >17) (16/17) [11]	38.1		34.8	21.6
****Children in need** due to abuse or neglect (rate per 10,000 CYP <18) (2018) [12]	181	95.6	119	85.9
CYP who started to be **LAC due to abuse or neglect (rate per 10,000 <18) (2018) [13]	16.4	8.3	10.4	6.5
Family **homelessness: rate per 1,000 households (2017/18) [14]	1.7	1.1	1.0	0.3
Number of unaccompanied **Asylum Seeking Children** Looked After (2018) [15]	4480	550	39	6

** RAG rated against local authorities in same deprivation decile

Vulnerability

Key Points:

- These vulnerable groups are at **increased risk** of poor mental health
- **Exclusions:** are there variations in how local data is recorded? How many children have partial timetables?
- **Bullying** data is old, data is held by individual schools, monitored by Ofsted. CBC have more current data, from SHEU survey

Indicator	England	Least Deprived Decile	Central Bedfordshire	95th Centile or Best in England
Children in Care, rate per 10,000 <18 (2018)[16]	64	41	51	33
Primary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[17]	1.37	1.54	1.93	0.39
Secondary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[18]	9.4	7.1	6.1	4.5
% of school aged pupils with a **Learning Disability** (2017)[19]	5.6	5.6	5.4	3.6
% of 15 year olds who were **bullied** in last couple of months (14/15)[21]	55	-	52.1	48.3
% 16-17 year olds not in education, employment or training, **NEET** (2017)[22]	6.0	5.5	6.6	2.3
First time entrants into **youth justice system**,[23] rate per 100,000 population aged 10-17 (2018)	293	158.4	98.1	152.3

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Access to services

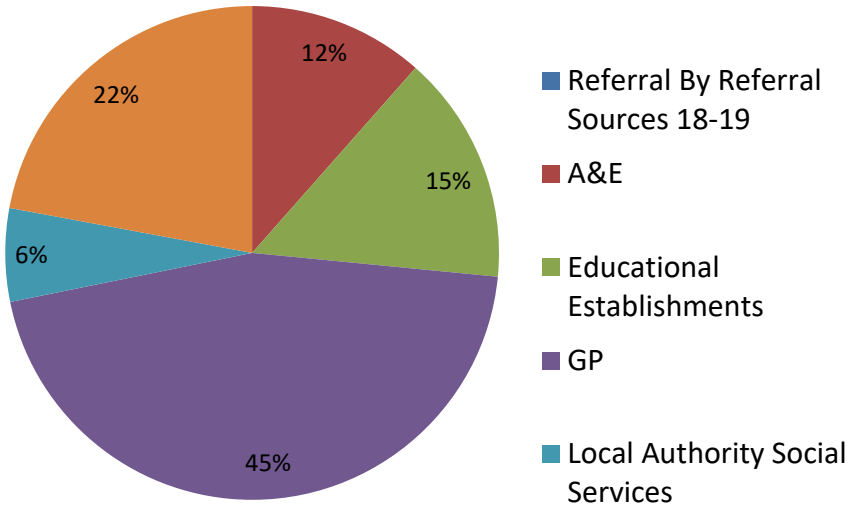
Central Bedfordshire

Examples of support for children and young people's mental wellbeing include, but are not limited to:

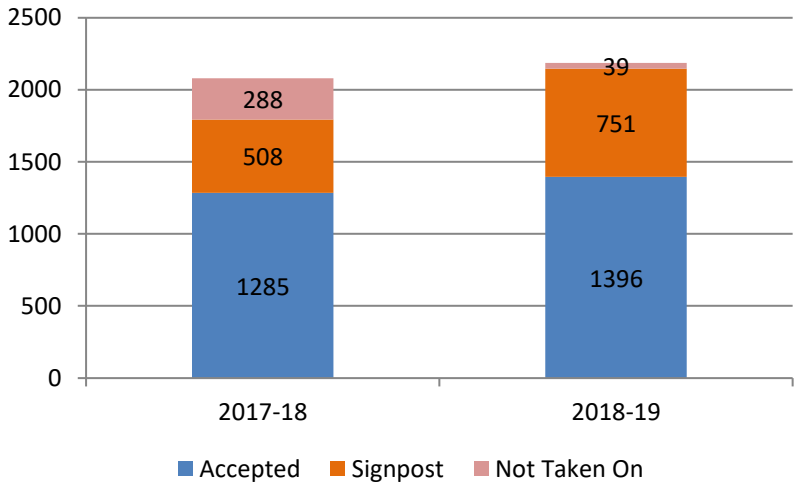
Level of need	Examples of support available for children include, but are not limited to:	
Universal	• Primary Care universal support • Voluntary sector providers • Targeted Early Help team • Universal Parenting Offer - Triple P • Universal Children's Centre Offer • FACES – volunteer parent support	• Child and Adolescent Mental Health (CAMH) School Programme in upper schools and colleges • CHUMs programme in middle, lower and primary schools • Whole school approach to mental health and wellbeing • 0-19 services (School Nursing, Health Visiting) • Peer mentoring pilot in schools • Groundworks mentoring service
Additional Needs	• 1:1 Solution Focus Brief Therapy • Protective Behaviour 1:1 Support • Enhanced Evidenced Based Practice Improving Access to Psychological Therapies (IAPT) CBT Intervention • Targeted Parenting Offer	• CAMH secondary school programme • Families First Bedfordshire Play Therapy • CHUMS • Bedford Open Door • 0-5 Infant Mental Health (IAPT) Trainees
Considerable Need	Child and Adolescent Mental Health Services (CAMHS) – commissioned by Bedfordshire Clinical Commissioning Group (CCG), provided by East London Foundation Trust (ELFT):	
Specialist Need	Inpatient services; CAMHS Crisis Service and 16 plus Street Triage Service; Eating Disorder Service; Care, Education and Treatment Reviews (CETR)	

Access to CAMHs – Central Bedfordshire (ELFT)

Referral By Referral Sources 18-19



Central Bedfordshire Referral Outcome

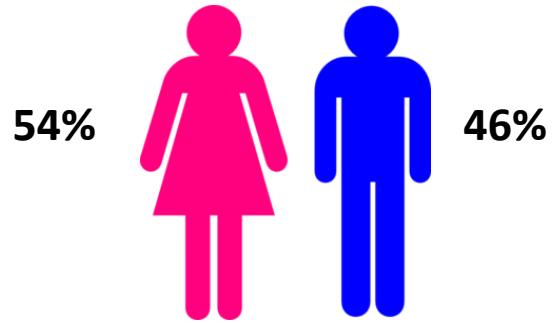


Ethnicity	%
White British	62%
Ethnicity other than White British	7%
Not known (not asked)	31%

Age (years)	% of referrals
0-4	1%
5-11	19%
12-18	80%

Key discussion points:

- Similar number of referrals in 17-18 (2,081) and 18-19 (2,186)
- Highest proportion of referrals from **GPs** in 18-19 (45%) followed by education establishments (15%), A&E (12%)
- 80% of CYP referred were aged 12-18 years, 19% aged 5-11 years
- 98% of referrals were seen 12 weeks or less



CYPMH Access Rate: 32% (ELF contribution: 27%)

CCG	Prevalence Rate	CCG Trajectory for 2018-19	Bedford Borough (ELFT)	Central Bedfordshire (ELFT	ELFT Total Contribution
Bedfordshire	**7065**	**2261**	758	1138	1896

Recommendations: Bedford Borough and Central Bedfordshire

	RECOMMENDATIONS FOR THE SYSTEM
SY1	**Mental health literacy needs to continue to be improved** across the system, including raising awareness and breaking the stigma. Professionals from across the system including front line staff should be encouraged to access training and professional development opportunities, with a particular **focus on those working with vulnerable children and young people**.
SY2 B	Targeted **prevention and early intervention** for individuals at increased risk of poor mental health should remain a priority for the system, and this support should include a **focus on early years and lower/primary schools**.
SY3	There needs to be **up to date and easily accessible information** for children, young people and their families as well as health, education and care professionals on how to promote mental wellbeing and **how to access support if needed**.
SY4	Opportunities for **peer support for children, young people and their families** should be expanded in schools and community settings.

RECOMMENDATIONS FOR THE SYSTEM CONTINUED

SY5	Ensure the forthcoming **Mental Health School Team** is fully aligned to the existing CAMHS School Teams, and compliments the existing pathways and relationships, including with the school nursing teams.
SY6 B	Ensuring **those nearing their 18th birthday receive the appropriate support** and achieve good outcomes should continue to be a shared priority. Actions to support this include: • working towards a flexible 0-25 pathway for mental health support • sharing learning from transition evaluations, including outcomes and the experiences of young people and involving them in decision making • strengthening flexible, multi-agency working through joint commissioning and improved use of the “all about me” document.
SY7	We need to get better at demonstrating that the **voice of CYP** is heard and that action has been taken to improve access to support for mental health and wellbeing

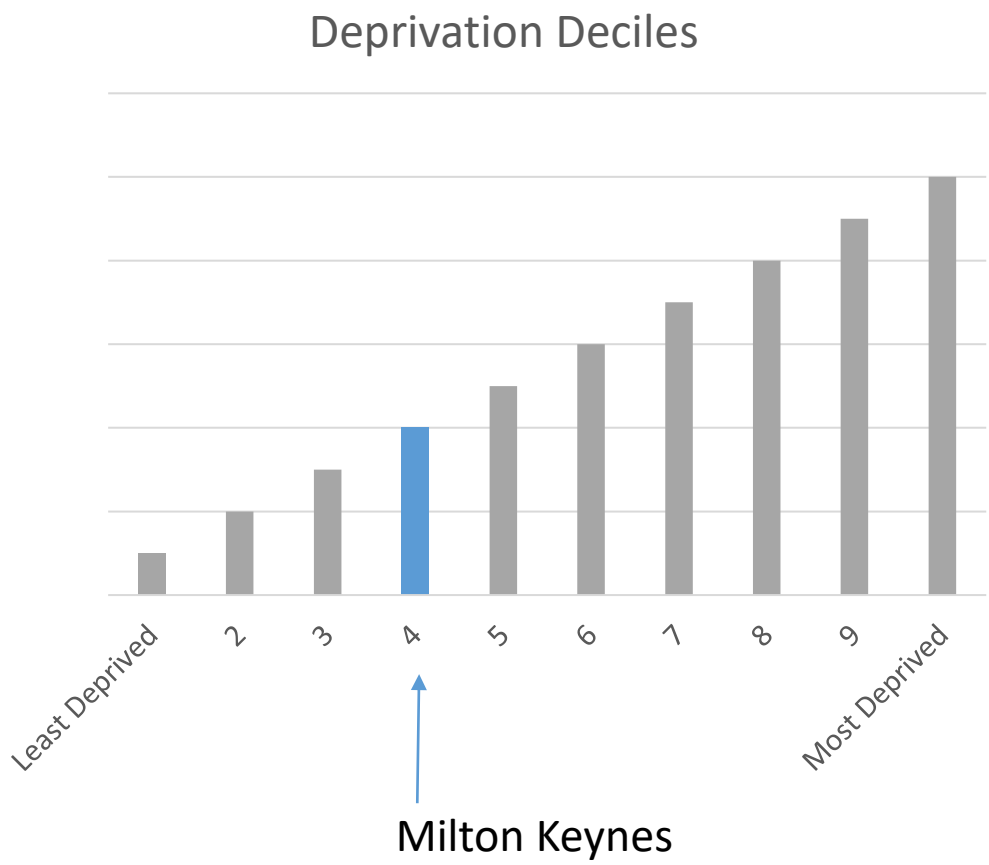
	RECOMMENDATIONS FOR SCHOOLS AND COLLEGES
SC1	Schools and colleges should continue to **build pupil resilience through whole school approaches to mental wellbeing**, including promoting teaching staff wellbeing. Where schools and colleges are not engaging with the local support and services that are available, this should be **identified and addressed**.
SC2	Schools and colleges should **evaluate whether current anti-bullying policies and approaches** (including measures to address online bullying) **are effective and in line with evidence based practice**.

RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH SERVICES	
CA1	There should be an **audit of referrals** to Child and Adolescent Mental Health Services (CAMHS) that are **not seen by CAMHS but are signposted to alternative support**. The audit should assess the effectiveness of signposting. The results of the audit should form the basis of agreed actions and processes to ensure that **those not meeting CAMHS thresholds have timely access to appropriate support**.
CA2 B	The **impact of targeted training** delivered by ELFT aimed at improving quality of referrals **should be reviewed**. Referral sources and rates of inappropriate and signposted referrals should be reported to BCCG to monitor and assess improvement.
CA3 B	The **data reported** by East London NHS Foundation Trust (ELFT, the CAMHS provider) to Bedfordshire Clinical Commissioning Group (BCCG) **should be developed** to include reporting of referral reasons, and confirmed diagnosis / nature of caseloads. More transparent reporting of waiting times is needed, including internal waiting times.

Milton Keynes Data Only Slides

Presenting the data and making comparisons

- The following performance data is presented for a number or relevant indicators:
  - Milton Keynes
  - England
  - Data for local authorities in the 4th least deprived decile in England, which includes Milton Keynes
  - Data for local authorities with the best performance for each indicator (95th centile)
- Milton Keynes data is compared (RAG) to the average of other areas in England within the **same deprivation decile** (4th least deprived) where available.
- Where unavailable, comparisons are made to England data



The picture of mental wellbeing in school-aged children and young people

Key Points:

- Current data on the wellbeing if young people in Milton Keynes is lacking – data from 2014/15 indicates low wellbeing and positive satisfaction with life scores in CYP in MK
- School pupils in MK have significantly lower rates of ***identified*** social, emotional and mental health needs than comparator local authorities.
- Prevalence of poor mental health is estimated and based on a national survey carried out in 2004.
- Rates of hospital admissions for MH are lower in MK than comparator LAs. Potentially due to Liaison and Intensive Support Team based at MK hospital

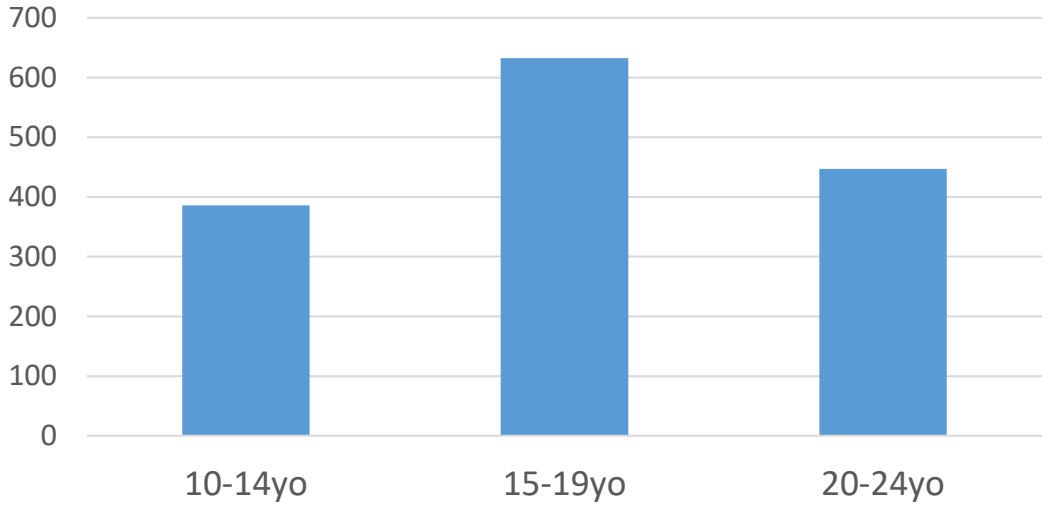
Indicator	England	4th least deprived decile	Milton Keynes	95th Centile
Mental Wellbeing in 15 year olds: Mean wellbeing (WEMWBS-14) score (14/15)[2]	47.6	-	45.4	
% of 15 year olds reporting positive satisfaction with life (14/15)[3]	63.8	-	59.7	68.7
*% school pupils with identified social, emotional and MH needs (2018)[4]	2.39		2.06	1.65
Estimated % of MH disorders in CYP aged 5-16 (2015)[5]	9.2	9.0	9.0	8
**Hospital admissions for MH disorders per 100,000 population aged 0-17 yrs 17/18[5a]	84.7	83.6	42.9	

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

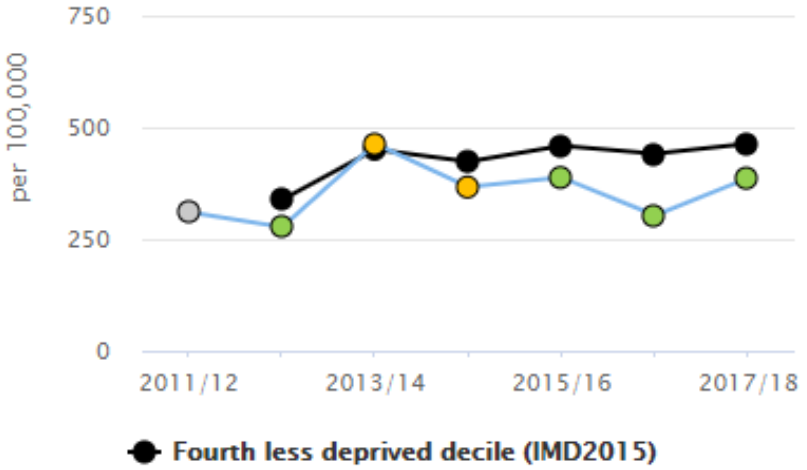
Hospital admissions for self-harm:

Hospital admissions for self-harm (2017-2018) by age group (per 100,000 population)



Rates of self harm are ***higher in the 15-19 age group*** – indicating the need for primary prevention in the younger age groups and secondary prevention in the older age groups

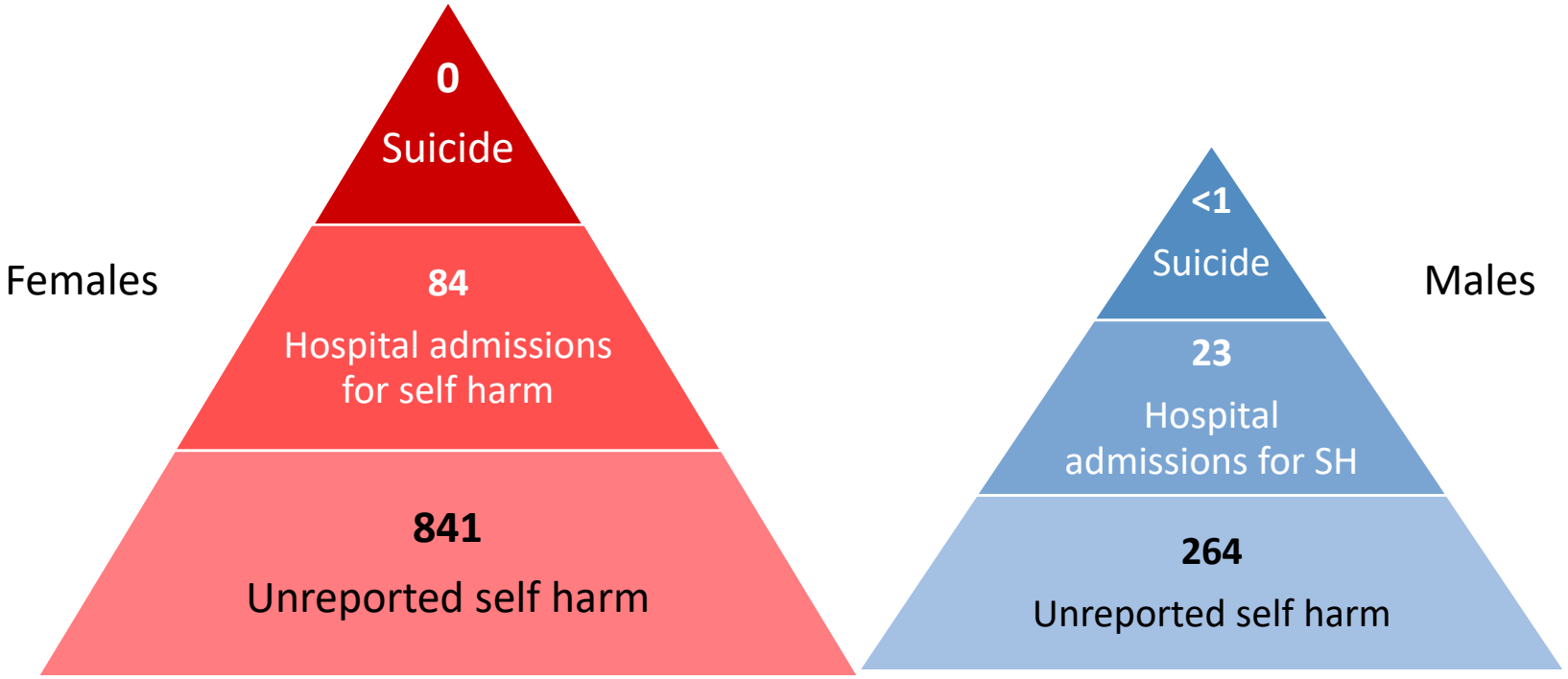
Trend in hospital admissions for self-harm (2011/12 to 2017/18) in 10-24 year olds



Hospital admissions as a result of self-harm in **Milton Keynes are lower than comparator LAs**. Local rates may be as a result of a 24hr Liaison and Intensive Support Team (LIST) based at MK hospital which saw over 400 patients in 18-19, which supported YP without the need for admission

But this is just the tip of the iceberg given the hidden nature of self-harm

Estimating “hidden” community self harm



Projection of study figures for suicide and self-harm in MK (approximate annual number of individuals aged 12-17)

Ages 12-17	Milton Keynes		
Numbers	Males	Females	Total
Suicides	<1	<1	<1
Hospital-presenting SH	23	84	107
Community SH (not to hospital)	264	841	**1105**

Protective factors: how are we performing?

Key Points:

- Protective factors for mental wellbeing include school readiness, healthy weight and education attainment.
- Milton Keynes are performing at a similar level to comparator LAs for these indicators.
- However there is still room for improvement, and efforts should continue to improve outcomes particularly for the most vulnerable groups

Indicator	England	4th least deprived decile	Milton Keynes	95th Centile or Best in England
% of children achieving a **good level of development at the end of reception (17/18)[6]	71.5	72.6	73.3	77
% of CYP with **FSM status achieving a **good level of development** at the end of reception (17/18)[7]	56.6	56.3	60.2	66.7
***Healthy weight** in Reception children (%) (17/18) [8]	76.6	-	76.2	81.1
*Average **Attainment 8 score** for all pupils in state-funded schools (17/18)[9]	57.8		46.2	-

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Addressing adversity – how are we performing?

Key Points:

- Poverty indicators mask variation within areas
- Adverse childhood experiences are a predictor of MH problems in CYP and in adults.
- In Milton Keynes, family homelessness is an issue of concern with rates higher than similarly deprived areas.

Indicator	England	4th least deprived decile	Milton Keynes	95th Centile or Best in England
% CYP aged under 20 living in **poverty (2016)[10]	17	15.1	14.9	9.2
% of **LAC 5-16yo where there is cause for concern (SDQ score >17) (16/17) [11]	38.1	40.1	39.1	21.6
****Children in need** due to abuse or neglect (rate per 10,000 CYP <18) (2018) [12]	181	136.6	100 ↓	85.9
CYP who started to be **LAC due to abuse or neglect (rate per 10,000 <18) (2018) [13]	16.4	13.5	10.6 ↓	6.5
Family **homelessness: rate per 1,000 households (2017/18) [14]	1.7	1.8	5.0	0.3
Number of unaccompanied **Asylum Seeking Children** Looked After (2018) [15]	600	-	26	6

** RAG rated against local authorities in same deprivation decile

↓ Indicates that performance is better than comparators

Vulnerability

Key Points:

- These vulnerable groups are at **increased risk** of poor mental health
- **Exclusions:** are there variations in how local data is recorded? How many children have partial timetables?
- **Bullying** data is old, data is held by individual schools, monitored by Ofsted.

Indicator	England	4th least deprived decile	Milton Keynes	95th Centile or Best in England
Children in Care, rate per 10,000 <18 (2018)[16]	64	56	58	33
Primary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[17]	1.37	1.51	1.55	0.39
Secondary fixed period **exclusions**, rate per 100 pupils, state-funded schools (16/17)[18]	9.4	8.4	9.0	4.5
% of school aged pupils with a **Learning Disability** (2017)[19]	5.6	4.5	5.9	3.6
% of 15 year olds who were **bullied** in last couple of months (14/15)[21]	55	-	59.4	48.3
% 16-17 year olds not in education, employment or training, **NEET** (2017)[22]	6.0	5.2	4.6	2.3
First time entrants into **youth justice system**,[23] rate per 100,000 population aged 10-17 (2018)	293	196	255	152.3

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Access to services

Milton Keynes

Examples of approaches in Milton Keynes to promoting protective factors

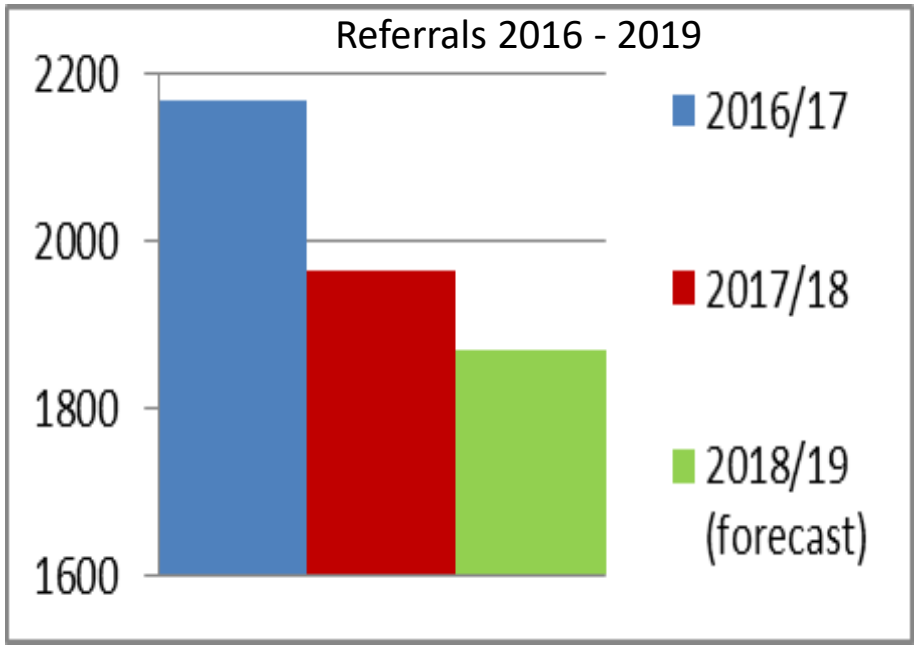
Level	Example approaches					Potential gaps/ risks			
Child	Breastfeeding initiatives	0-19 services (Health Visiting and School Nursing	Family Centre Offer	MH Practitioner in teams working with vulnerable groups e.g. Early Help; Youth Offending	Voluntary Sector Providers Ranges from counselling to family support, support for victims of crime, wellbeing, housing, Drug and Alcohol, and many more	Early Identification of need	High thresholds for services	Targeted support for high risk	Unstable funding for a number of initiatives including voluntary sector initiatives; Early help services
Family	Parenting programmes					Limited capacity in 0-19 service for low level MH support	Support for CYP with parental MH		
School	MH in schools and colleges program		Supporting mental health of school staff	MH training for school staff and governors			Variable School based support	Home schooled CYP	
Community	Healthy Young Peoples Network	CCG-led self-care groups	Lakes Estate Community led programme	Sport and leisure provision		Potential for more asset based/ community led initiatives			

Example approaches in Milton Keynes to addressing risk factors

Level	Example approaches	Potential gaps/ risks
Child Family School Community	Development Checks – HV ad SN Co-location of MH workers with vulnerable groups e.g. YOT, LAC, MASH Domestic Abuse Strategy / Needs Assessments and support services Safeguarding procedures and policies Drug and alcohol services Anti-bullying policies Safeguarding and MH audit Peer support programmes	**Times of transition e.g.** Primary-secondary school Secondary to higher education School to employment CAMHs to Adult MH services **Support for vulnerable groups:** CYP with family in prison young carers – identification, funding for support CYP affected by or at risk of homelessness Potential to improve identification of ACEs for early intervention and targeted support No commissioned trauma / emotional wellbeing support. Rely on over-stretched voluntary provision e.g. Samaritans

Access to Child and Adolescent Mental Health Services (CAMHs) – Provided by Central and North West London NHS Foundation Trust (CNWL)

Referral sources (Oct17-Sep17)	% of total referrals	% not accepted
GPs	58	66
Education establishments	8	No data
Acute trust	7	No data
Carer	7	No data
Total referrals not accepted: 39%		

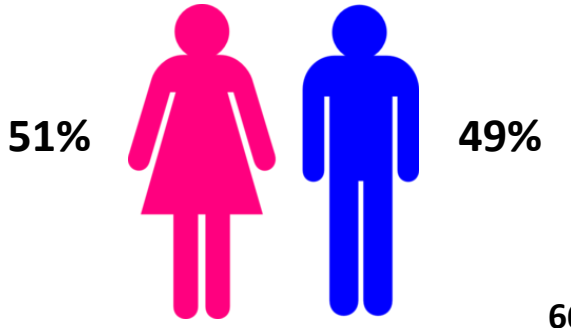


Ethnicity MK	%
British	38%
Ethnicity other than British	16%
Not known/ not stated	45%

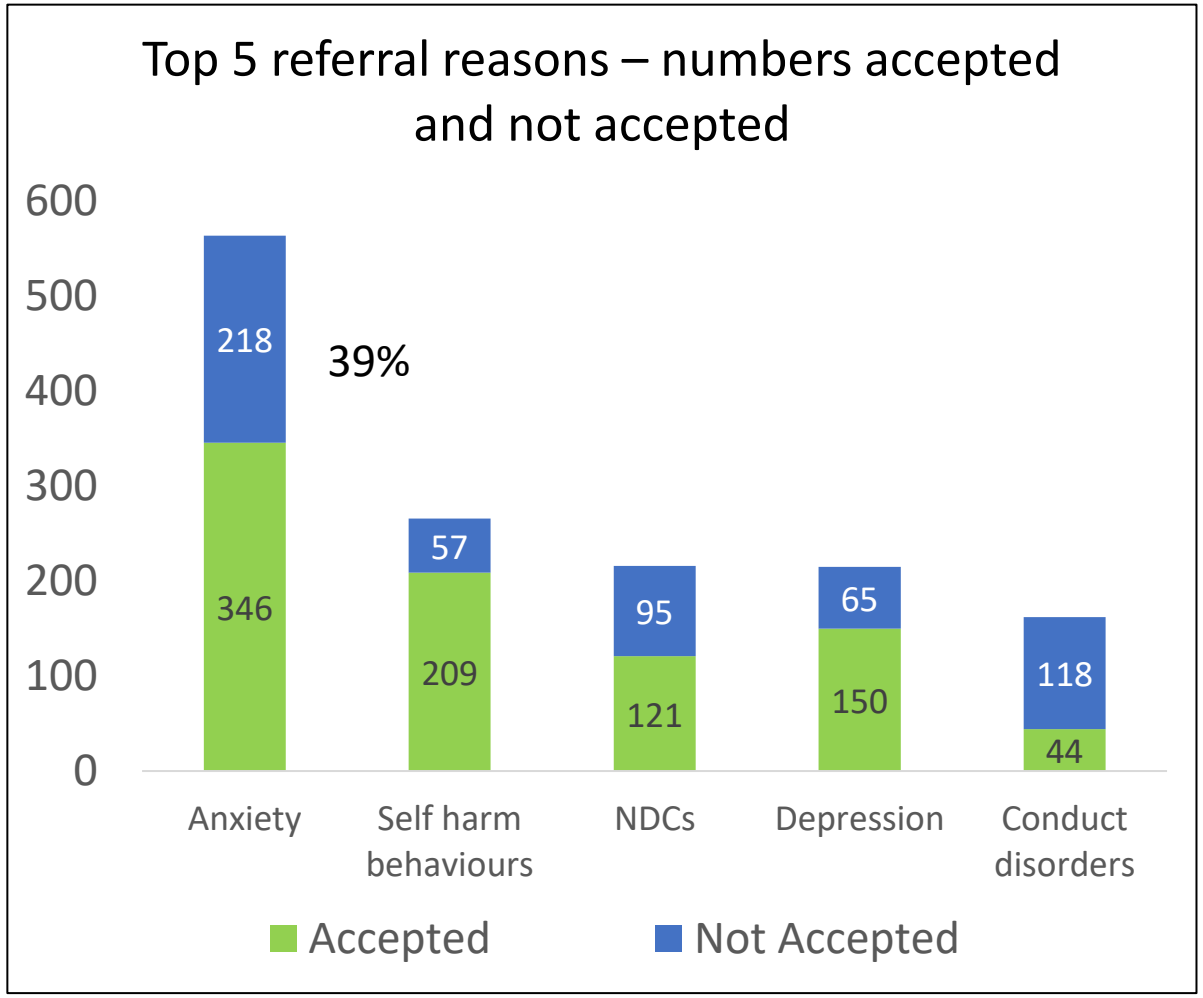
Age (years)	% of referrals
0-4	2%
5-10	33%
11-16	58%
17-19	8%

Key points:

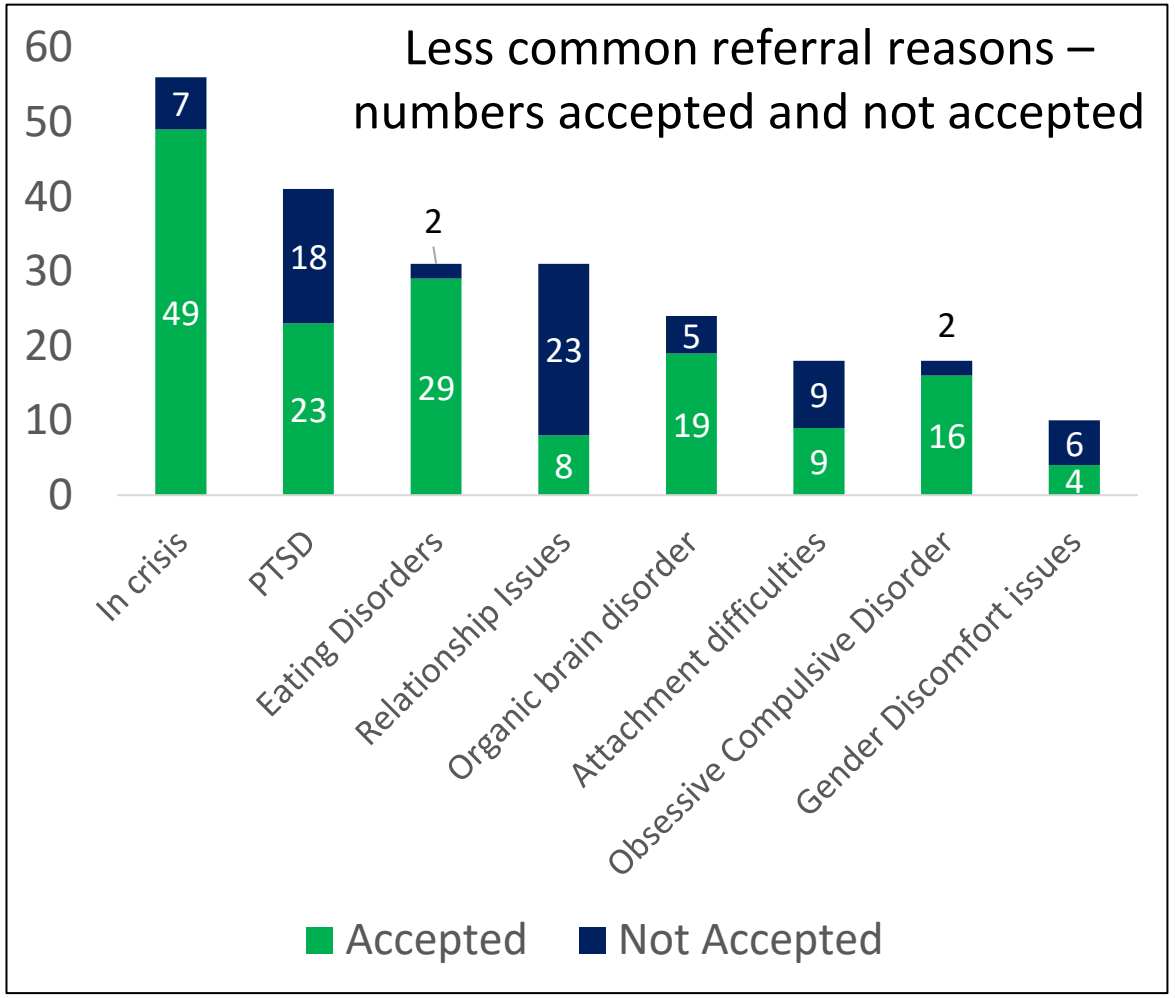
- Number of referrals **decreasing** since 2016/17 – but rates of poor mental health are increasing nationally
- Majority of referrals from **GPs** (58%) followed by education (8%), acute trust 1 hr response (7%) & carer (7%)
- **39% referrals not accepted** (Oct17-Sep18)
- 58% of referrals were aged 11 – 16 years, 33% aged 5 – 10 years



CAMHs referral reasons - data from Milton Keynes CAMHs only (Oct17-Sep18), data not available from ELFT



NDCs = Neurodevelopment conditions



PTSD = Post Traumatic Stress Disorder

Key points for discussion – CAMHs access

- ***GPs*** providing majority of referrals in all three areas, however there is a high proportion of referrals ***not accepted***
- Lack of ethnicity data for CAMHs referrals (often not provided), but it appears that ethnic minorities are under represented in CAMHs
- Average waiting time targets (referral to assessment) are being met
- Waiting time from ***referral to treatment*** is unclear – this is a national challenge
- Referrals not accepted are signposted by CAMHs to alternative support – do we have the right support available? The data on referral reasons not accepted may help to inform the support needed.

Recommendations: Milton Keynes

	RECOMMENDATIONS FOR THE SYSTEM
SY1	**Mental health literacy needs to continue to be improved** across the system, including raising awareness and breaking the stigma. Professionals from across the system including front line staff should be encouraged to access training and professional development opportunities, with a particular **focus on those working with vulnerable children and young people**.
SY2 MK	Further work is needed to **understand and address the gaps in low level support**, including how to **better manage low level need** to prevent needs escalating and **reduce demand on specialist services**. This includes identifying how we better align Universal services, Early Help and the Primary Care Front Door.
SY3	There needs to be **up to date and easily accessible information** for children, young people and their families as well as health, education and care professionals on how to promote mental wellbeing and **how to access support if needed**.
SY4	Opportunities for **peer support for children, young people and their families** should be expanded in schools and community settings.

	RECOMMENDATIONS FOR THE SYSTEM CONTINUED
SY5 MK	Ensure the forthcoming Mental Health School Team compliments the existing pathways and relationships, including with the school nursing teams.
SY6 MK	Ensuring **those nearing their 18th birthday receive the appropriate support** and achieve good outcomes should continue to be a shared priority. We need to: • work towards a **flexible 0-25 pathway** for mental health support • Ensure care and support provided to YP is **appropriate to their level of understanding and life circumstances** and that **commissioned service contracts have the flexibility** to enable this • **strengthening flexible, multi-agency working** through joint commissioning and improved use of the "all about me" document. • **Review changes that have been made based on the voice of young people** who have transitions from children's to adult services, and where action still needs to be taken.
SY7	We need to get better at demonstrating that the **voice of CYP** is heard and that action has been taken to improve access to support for mental health and wellbeing
SY8 MK	A whole systems framework (e.g. i-Thrive) should be developed which clearly identifies where system partners fit into the support pathway.

	RECOMMENDATIONS FOR SCHOOLS AND COLLEGES
SC1	Schools and colleges should continue to **build pupil resilience through whole school approaches to mental wellbeing**, including promoting teaching staff wellbeing. Where **schools and colleges are not engaging** with the local support and services that are available, this should be **identified and addressed**.
SC2	Bullying is a risk factor for poor mental health. Schools and colleges should **evaluate whether current anti-bullying policies and approaches** (including measures to address online bullying) **are effective and in line with evidence based practice**.
SC3 MK	Options should be identified and agreed to provide robust **data** on prevalence and trends of **bullying, resilience and wellbeing** in children and young people

RECOMMENDATIONS FOR CHILD & ADOLESCENT MENTAL HEALTH SERVICES

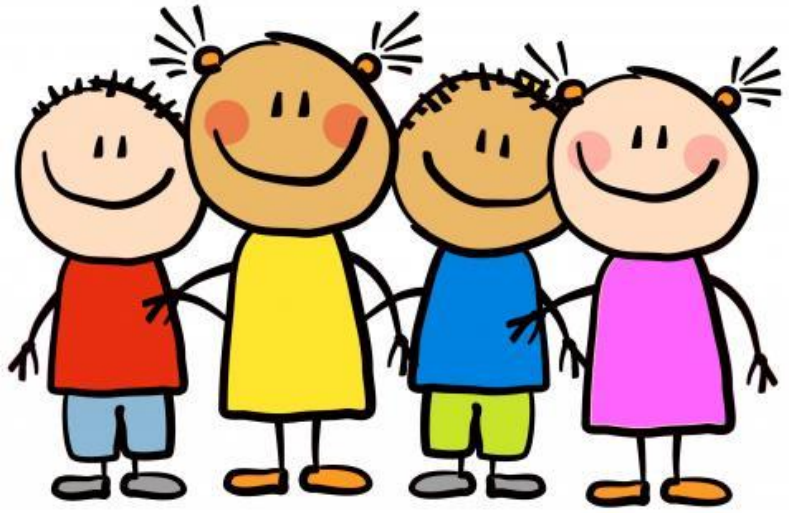
CA1	There should be an **audit of referrals** to Child and Adolescent Mental Health Services (CAMHS) that are **not seen by CAMHS but are not accepted and/ or signposted to alternative support**. The audit should assess the effectiveness of signposting. The results of the audit should form the basis of agreed actions and processes to ensure that **those not meeting CAMHS thresholds have timely access to appropriate support**.
CA2 MK	**Improving quality of referrals: engage with primary care** to understand what they need to manage mild to moderate mental health conditions in children and young people, as well as when and how to make an effective referral to CAMHs. **Work with schools** to understand what they need to improve effectiveness of referrals.
CA3 MK	The CCG needs to request more **transparent reporting of waiting times from referral to assessment and referral to treatment** – including the range in addition to average waiting time.
CA4 MK	**CAMHs service user engagement should be strengthened**, to improve how we listen to and respond to the voice of young people in relation to service design and delivery.

Bedford Borough, Central Bedfordshire and Milton Keynes Data

Do we understand the picture of mental wellbeing in our 0-5 year olds?

- Nationally **5.5%** of 2 – 4 year olds have a diagnosable MH condition (PHE, 2017).
- The most common are neurodevelopment conditions, including ASD
- Applied to local populations, that is

377 children in Bedford BC	**600** children in Central Beds	**655** children in Milton Keynes



- Are we identifying under 5s who need support and referring appropriately?
- Are we picking this up early enough, e.g. through development checks, home visits, contact with other services?
- What about those with low level needs?

The picture of mental wellbeing in school-aged children and young people

Key Points:

- Self reported levels of resilience were lower in CBC compared to the wider SHEU survey results
- Current WB data lacking for BBC & MK
- School pupils in BBC and MK have lower rates of ***identified*** social, emotional and mental health needs.
- Prevalence of poor mental health is estimated and based on a national survey carried out in 2004.
- Rates of hospital admissions similar to comparators in Bedford and Central Bedfordshire, lower in MK. Potentially due to LIST service

Indicator	England	Bedford Borough	Central Bedfordshire	Milton Keynes	95th Centile
% of Year 8, 10 and 12+ pupils with a low level of resilience (SHEU survey, 2017)[1]		No data	37%	No data	-
*Mental Wellbeing in 15 year olds: Mean wellbeing (WEMWBS-14) score (14/15)[2]	47.6	47.2	47.1	45.4	
*% of 15 year olds reporting positive satisfaction with life (14/15)[3]	63.8	62.8	65.5	59.7	68.7
*% school pupils with identified social, emotional and MH needs (2018)[4]	2.39	2.18	2.47	2.06	1.65
Estimated % of MH disorders in CYP aged 5-16 (2015)[5]	9.2	9.1	8.4	9.0	8
**Hospital admissions for MH disorders per 100,000 population aged 0-17 yrs 17/18[5a]	84.7	91.8	87.9	42.9	

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Protective factors: how are we performing?

Key Points:

- ***School readiness*** is a key indicator in ensuring children are developing well. In BBC and CBC, the level of development is lower than comparators, and in CBC this includes those who are eligible for FSM.
- This proportion of ***healthy weight*** in reception children is similar in BBC and MK and better in CBC compared with the England average. However there is still at lease 20% of children who are not a healthy weight.
- Education attainment at Key Stage 4 is comparatively lower for BBC and CBC. In MK it is similar to comparators.

Indicator	England	Bedford Borough	Central Bedfordshire	Milton Keynes	95th Centile or Best in England
% of children achieving a **good level of development at the end of reception (17/18)[6]	71.5	69.6	73.2	73.3	77
% of CYP with **FSM status achieving a **good level of development** at the end of reception (17/18)[7]	56.6	54.4	44.2	60.2	66.7
***Healthy weight** in Reception children (%) (17/18) [8]	76.6	77.6	80	76.2	81.1
*Average **Attainment 8 score** for all pupils in state-funded schools (17/18)[9]	57.8	45.5	46.2	46.2	-

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Addressing adversity – how are we performing?

Key Points:

- Poverty indicators mask variation within areas
- Adverse childhood experiences are a predictor of MH problems in CYP and in adults.
- In Bedford and Milton Keynes, family homelessness is an issue of concern with rates higher than similarly deprived areas. Particularly MK.
- BBC and CBC also have relatively high rates of CIN due to abuse or neglect

Indicator	England	Bedford Borough	Central Bedfordshire	Milton Keynes	95th Centile or Best in England
% CYP aged under 20 living in **poverty (2016)[10]	17	14.8	11	14.9	9.2
% of **LAC 5-16yo where there is cause for concern (SDQ score >17) (16/17) [11]	38.1	46.3	34.8	39.4	21.6
****Children in need** due to abuse or neglect (rate per 10,000 CYP <18) (2018) [12]	181	163	119	100 ↓	85.9
CYP who started to be **LAC due to abuse or neglect (rate per 10,000 <18) (2018) [13]	16.4	15.6	10.4	10.6 ↓	6.5
Family **homelessness: rate per 1,000 households (2017/18) [14]	1.7	2.5	1.0	5.0	0.3
Number of unaccompanied **Asylum Seeking Children** Looked After (2018) [15]	600	19	39	26	6

** RAG rated against local authorities in same deprivation decile

↓ Indicates that performance is better than comparators

Vulnerability

Key Points:

- These vulnerable groups are at **increased risk** of poor mental health
- **Exclusions:** are there variations in how local data is recorded? How many children have partial timetables?
- **Bullying** data is old, data is held by individual schools, monitored by Ofsted. CBC have more current data, from SHEU survey

Indicator	England	Bedford Borough	Central Bedfordshire	Milton Keynes	95th Centile or Best in England
**Children in Care, rate per 10,000 <18 (2018)[16]	64	61	51	58	33
Primary fixed period **exclusions, rate per 100 pupils, state-funded schools (16/17)[17]	1.37	1.39	1.93	1.55	0.39
Secondary fixed period **exclusions, rate per 100 pupils, state-funded schools (16/17)[18]	9.4	5.5	6.1	9.0	4.5
% of school aged pupils with a **Learning Disability (2017)[19]	5.6	6.5	5.4	5.9	3.6
*% of 15 year olds who were **bullied** in last couple of months (14/15)[21]	55	52.3	52.1	59.4	48.3
% 16-17 year olds not in education, employment or training, **NEET (2017)[22]	6.0	5.1	6.6	4.6	2.3
First time entrants into **youth justice system,[23] rate per 100,000 population aged 10-17 (2018)	238	194	98.1	255	152.3

* RAG rated against England

** RAG rated against local authorities in same deprivation decile

Recommendations: BBC, CBC and MK

Recommendations

A high proportion of referrals into CAMHs are not accepted. Progress needs to made to **improve quality of referrals**.

Addressing risk factors and promoting protective factors for good mental health and wellbeing in CYP needs to be a priority

There needs to be **a whole systems approach to early identification** of the signs of poor mental health

Robust data that enables us to understand **local need and access to support** is needed to plan services and improve outcomes

There needs to be more **targeted prevention and access to low level support** particularly for vulnerable groups at risk of poor mental health

The focus for transitions needs to be **on preparing young people for adult services** and **enabling self-management**

There should be an **audit of referrals not seen by CAMHs** to identify what the outcomes are for these individuals