Children and young people

The term ‘children and young people’ in this report relates to the phase of life which starts with a child’s entry into formal education at around age 3 and ends at age 19, when the majority of young people have left secondary education and occupy the role of an adult in society.

Children and young people need health, education, equality and protection in order to thrive. Children are growing and developing. This makes them vulnerable. They require the support of adults to help them articulate their needs and protect their rights. Adult problems with mental health or low wellbeing often have their origins in childhood. If issues are not identified and addressed in childhood, they set the course for prolonged mental health problems and poorer outcomes across the adult phase of a person’s life. This results in increased risk of suicide, lower educational and employment outcomes and increased risk of substance misuse. Similarly, mental health needs or problems with low wellbeing in adults who are parents or carers can in turn, have a negative affect on the health and wellbeing of their children.

Socioeconomic deprivation is a major cause of mental health needs and low levels of wellbeing. Tackling the consequences of socioeconomic deprivation will require action by everyone: the welfare of children must become everyone’s business.

Section 1: Determinants of mental health

1.1 The population of children aged 5-19 is falling**.** In 2010, there were 199,414 children and young people in the board area, making up 16.6% of the population. It is estimated that the number of 5-19 year olds will fall by 4.2% to 190,993 in 2020 (15.9% of the population).[40]

1.2 The Scottish Public Health Observatory’s Children and Young People’s health Profiles from 2010 provide a detailed snapshot of the health, wellbeing and life circumstances of children and young people.[41]

1.3 For the entire Health Board population, the proportion of children living in households reliant on out of work benefits was significantly higher than the Scottish average. A significantly higher number of children were living in areas classified as income deprived (33% versus 16.5% nationally), although levels in East Dunbartonshire and East Renfrewshire were below the Scottish average.

1.4 Children and young people in NHSGGC were significantly more likely to be admitted to hospital as the result of being assaulted than their Scottish counterparts. More children were living in areas with the highest levels of crime in Scotland. Children and young people in NHSGGC were also more likely to be referred to the Scottish Children's Reporter Administration on suspicion of having committed violent offences.

1.5 We have a higher rate of looked after and accommodated children than the Scottish average. Child protection concerns are known to be higher in areas of socioeconomic deprivation, although it is not understood why this is the case.

1.6 The rate of children referred by professionals or members of the public to social work services because of concerns around their general care was significantly lower than the Scottish average – 10.9 per thousand compared to 13.9 per 1000 for Scotland as a whole. This referral rate varied greatly by area; from a high of 22.9 per 1000 children aged 0-15 in Inverclyde, to a low of 9.7 and 9.6 per 1000 in Glasgow City and West Dunbartonshire respectively. Some of the variation may be due to different definitions used across different council areas.

1.7 For our population overall, children and young people's health behaviours were not significantly worse than the Scottish average. The indicators used included active travel to school (physical activity); young people admitted to hospital through alcohol use; and smoking, alcohol and drug use at age 15.

1.8 Active travel to school varied from a high of 54% in East Dunbartonshire to a low of 45% in West Dunbartonshire.

1.9 Admissions of young people associated with alcohol were significantly above the Scottish level in North East and South Glasgow and in Inverclyde, and significantly below the Scottish average in East Renfrewshire, East Dunbartonshire and Renfrewshire. The highest prevalence of alcohol use in 15 year olds was 33.3% in West Dunbartonshire, with the lowest being 23.8% in East Renfrewshire.

1.10 Admissions of young people associated with drug misuse varied from a high of 68 per 100,000 persons aged 0-24 per year in Inverclyde, through to a low of 15.3 in East Dunbartonshire. The percentage of 15 year olds who admitted using drugs varied from a high of 10.7% in West Dunbartonshire to a low of 5.0% Glasgow City.

1.11 Local teenage pregnancy rates were not statistically different from the Scottish average, although the Scottish teenage pregnancy rate is relatively high. The highest rate was 59.3 per 1000 females aged 15-17 per year in North East Glasgow, with the lowest level being in East Renfrewshire where the rate was 17.4 per 1000.

1.12 Scores from the Strengths and Difficulties Questionnaire, which is used to identify behavioural problems in children, were s better in NHSGGC than the Scottish average, although this difference was small. Within our area, the highest problem score (worse) was in West Dunbartonshire (12.3) and the lowest (best) was in East Dunbartonshire (11.3).

1.13 Educational indicators were significantly worse than for Scotland as a whole in terms of school attendance rates for primary and secondary school pupils. Similarly, young people were more likely than the Scottish average to not be in education, employment or training (aged 16-19), although school leavers overall

had a similar proportion entering further or higher education, or employment or training.

1.14 The influence of socioeconomic disadvantage is seen across all indices, characterising health and wellbeing challenges for this age group. Tackling the social determinants of children's health therefore requires action with partners to reduce child poverty, the leading cause of lower levels of health and wellbeing in NHSGGC.

Section 2: What determines the wellbeing of children and young people?

2.1 The recent national consultation with children[42] has identified their priorities as:

- safety and security at home, on public transport and on the streets
- alcohol and drug misuse
- gang fighting
- the state of the environment, e.g. litter and graffiti
- a desire for equal life chances, and
- respect and inclusion

2.2 The United Nations Children's Fund (UNICEF) Report Card 7: an overview of child wellbeing in rich countries demonstrated that the challenge to improve the wellbeing of children in the UK is not limited to addressing those who are living in disadvantage.[43] The UK as a whole was in the bottom third of rankings for five out of six dimensions used to assess health and wellbeing. The lowest rankings were for children's behaviours and risks; family and peer relationships; subjective wellbeing; material wellbeing; and educational wellbeing.

2.3 Recent work sponsored by UNICEF attempts to understand the reasons for low child wellbeing.[44] This research has identified that UK parents struggle to provide children with the time they need in comparison with other European families. UK parents and children were also more likely than their international counterparts to be influenced by a culture of materialism. Parents felt pressure to give children

things when in fact children wanted more family time with their parents.

2.4 A strong, stable and nurturing relationship with a parent or main carer is an important precondition for mental health and wellbeing in children. This is true in the early years and it is equally important for older children and young people.

2.5 There is evidence that parenting support can help parents to become more effective. The National Institute for Public Health and Clinical Excellence (NICE) has recommended parenting support for the treatment of conduct problems and conduct disorder in children.[45] There is some evidence to suggest that parenting support aimed at whole communities may reduce the numbers of children involved in the child protection system.[46]

2.6 As described in the previous chapter on early years, the NHSGGC and Glasgow City Parenting Support Framework provides a basis for helping children through improving parenting. The framework has been designed to ensure all the agencies around children and families can provide appropriate parenting support wherever necessary. An evaluation of the framework will seek to understand how best to engage with families and support them with parenting.

Section 3: A vision of positive mental health and wellbeing in children and young people

3.1 All public services need to work together across the whole population of children and families in order to address the factors associated with low levels of mental health and wellbeing. We also need to provide additional support for children and families identified as having mental health problems, or for those at high risk of such problems because of risk factors such as socioeconomic disadvantage.

3.2 The elements needed to bring about this change are set out in Children and Young People's Mental Health:

A Framework for Promotion, Prevention and Care.[47] These include:

- Developing universal services in the early years in order to provide supports for all children, and tailored support for those at greatest risk in order to improve social, cognitive and emotional development and act to support self-esteem, and promote confidence and independence
- Promoting a positive view of mental health and wellbeing in schools and provide supports by working in partnership with children, parents and other agencies
- Actions with the community: work with groups to support self-esteem of children and young people in their community
- Actions for specific groups or for agencies including the needs of looked after children and young people, and work around addictions in order to provide accessible, quality services which make mental health and wellbeing a priority
- Building capacity within the entire workforce who work with children and young people to build on their strengths in order to support mental health and wellbeing

Section 4: Improving mental health and wellbeing in children and young people

4.1 The WHO's report Promoting Mental Health recognises the central importance of socioeconomic disadvantage in its widest sense as a determinant of mental health and wellbeing.[48] It cites low standard housing, low educational opportunity, substance misuse and violence as specific risk factors.

4.2 School is a central setting to influence the mental health and wellbeing of children and young people. Health Scotland has worked in partnership with Her Majesty's Inspectorate of Education (HMIE) and with Education Scotland in order to develop resources for schools. The principles for effective action: promoting children and young people's social and emotional

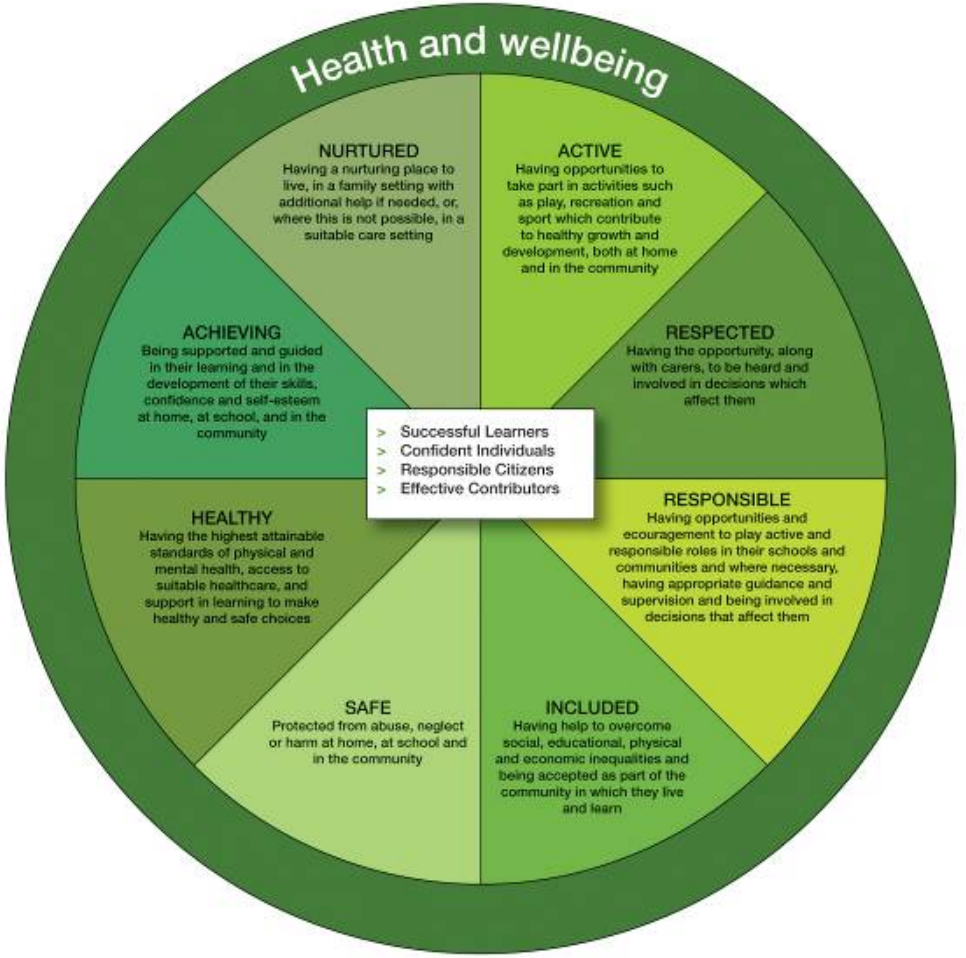
wellbeing in educational establishments for both primary[49] and secondary schools[50] reports build on the work of NICE and set out in a Scottish planning and policy context the ways in which schools should promote wellbeing.

4.3 The central task is to develop a whole-school approach to wellbeing, building on the work of health promoting schools. This approach will use the Curriculum for Excellence's Health and Wellbeing Theme to see wellbeing embedded across learning, so that children achieve learning outcomes against social, emotional, mental and physical wellbeing (Figure 4.1).

4.4 The Health and Wellbeing strand in the Curriculum for Excellence (CfE) seeks to ensure that children[51]:

- make informed decisions in order to improve their mental, emotional, social and physical wellbeing
- experience challenge and enjoyment
- experience positive aspects of healthy living and activity for themselves
- apply their mental, emotional, social and physical skills to pursue a healthy lifestyle
- make a successful move to the next stage of education or work
- establish a pattern of health and wellbeing which will be sustained into adult life, and which will help to promote the health and wellbeing of the next generation of Scottish children

Figure 4.1: The outcomes for health and wellbeing within the curriculum for excellence. From Education Scotland's Curriculum for Excellence Health and Wellbeing: principles and practice



4.5 The current financial challenges have given an impetus to cross agency working, which is focused on outcomes rather than structures. The WHO guidance, CfE and the Framework for Promotion, Prevention and Care, all rely upon partnership working as a central element of their action. The importance of preventative work and better outcomes has also been emphasised for the Scottish public sector by the recent Christie report.[21]

4.6 The UNICEF Child-Friendly City Initiative framework for place-based services helps agencies to articulate a rights-based approach through their decision making and planning for services.[52] It places the needs of children and their views at the centre of decision-making.

Section 5: Specific action to support mental health and wellbeing

5.1 Recent guidance has clarified the role for school-based work around alcohol.[53] Health improvement approaches across NHSGGC include the development of training for people who work with young people, in schools or in community settings. The aim is to raise awareness and knowledge about alcohol and the most popular drugs in current youth culture. The CfE will need to make use of this training as part of the whole school approach to health and wellbeing.

5.2 Further population work involves ensuring that parenting programmes equip parents of teenage children to address issues around drinking and drug use. Work across police, education, social work and health is underway to ensure that young people with harmful drinking are referred on for further interventions. The GCPH research on young people and alcohol provides important insights that can inform health improvement strategies.[54]

5.3 Scottish Government estimate there are between 12,000 and 100,000 young carers in Scotland.[55] Young carers are children who look after someone in their family who has an illness, a disability, a mental health problem or a substance misuse problem. They take on

the practical and/or emotional caring responsibilities that would normally be expected of an adult. Twice as many carers are found in families living within the most disadvantaged areas than are found within families within the most affluent areas. Recent evidence from the NHSGGC and Glasgow City Schools Survey found that 15.2% of those surveyed, or 1 in 7 secondary school children, had caring responsibilities for someone with an illness or disability, including problems with alcohol and drugs. Five percent of those responding provided care every day.[56]

5.4 Caring can be an opportunity for young people to show their love and affection for a family member. Young carers, however, often lack information about the conditions of family members for whom they are caring. Many experience their own health problems because their caring responsibilities are an inappropriate burden. There is evidence that children and young people who are carers are more likely than their peers to have educational, social and psychological problems. Child protection concerns relating to this group of children were seven times greater than amongst their peers.

5.5 Carers saw their role as a positive one, which developed their skills and made them feel good. For a small number of children, the role affected their education, contributed to tiredness, and had a negative impact on relationships at school.

5.6 The Glasgow Association for Mental Health (GAMH) Young Carers Project is aimed at young people between the ages of 12-18 who live with an adult who has a mental health problem. The project provides opportunities for young carers to participate in social and recreational activities and to develop their self-confidence and self-esteem.[57]

5.7 Getting It Right For Young Carers 2010 – 2015 makes recommendations for local authorities and NHS boards to identify and assess the health of young carers and to provide preventative support in order to reduce the

adverse impact of caring on their health and wellbeing.[58]

5.8 The national Choose Life strategy and action plan for suicide prevention sets out the need for partnership working to bring together strands of work around raising awareness; tackling stigma around mental health needs; improving services, providing training for prevention, and ensuring good care for those bereaved as the result of suicide.[59] One of the approaches taken was the production of a film, 'It's OK to ask', for 16-19 year olds with key suicide prevention messages, encouraging young people to seek help and support peers.[60]

5.9 The prevalence of teenage pregnancy is more than ten-fold higher in the most socioeconomically deprived communities in comparison with more affluent areas.[29] Teenage mums are more likely to have poorer educational and employment outcomes, be reliant on long-term benefits, have more relationship breakdowns and have lower levels of mental health and wellbeing than those who have their children in their 20s. This finding is true for both planned and unplanned teenage pregnancies. In addition, the children of teenage mums are more likely to have poorer educational and employment opportunities and have worse health and higher mortality rates than children of non-teenage mothers.

5.10 Health Scotland have published guidance, in collaboration with HMIE and Learning and Teaching Scotland, to improve sexual health: Reducing teenage pregnancy: guidance and self-assessment tool.[61] The guidance focuses on:

- Improving knowledge and awareness: developing parenting support for discussing adolescent sexuality
- Developing leadership, coordination and performance management: defining roles, communication across and within agencies, and developing the workforce

- Standards and service provision: drop-in provision for teens, needs assessment using data, health improvement activities, and workforce development
- Young people: access to sex and relationships education should be continuous and progressive. Work on aspirations, confidence and self-efficacy requires workforce development

Case Study: The Girl Power programme in Inverclyde works with 13-18 year olds to deliver knowledge around healthy relationships, self-esteem and confidence building. It aims to improve self-efficacy in order to reduce coercion into early sexual activity, and thus improve sexual health and reduce teenage pregnancy.

5.11 Gang culture and violence has been a feature of life within some areas of Greater Glasgow and Clyde for many years. Since 2008, a Strathclyde Police led initiative called CIRV (Community Initiative to Reduce Violence), funded by Scottish Government and partner agencies, has been in place across North and East Glasgow City.

5.12 CIRV uses intelligence from a wide group of agencies to identify gangs and to use this grouping to create behaviour change. The evaluation in 2010 showed that gangs who had signed up to CIRV saw a 46.5% fall in violent offending compared to a 24.7% reduction on violent offending in a control group from Glasgow who were not engaged in CIRV.[62] Since April 2011, the CIRV initiative has become a mainstream part of police action across the whole Strathclyde force.

5.13 Children who are looked after by the state are a particularly vulnerable group. The Mental Health Care Needs Assessment of Looked After Children in Residential Special Schools, Care Homes and Secure Care identified that this subgroup of looked after children have a greater number and greater complexity of mental health needs than their peers.[63] This group

also has particular difficulties in accessing mental health services. The report makes recommendations about clarifying the responsibilities of boards where children are looked after in an area out with their board of usual residence, and encourages the use of the Framework for Promotion, Prevention and Care as the planning framework through which Child and Adolescent Mental Health Services (CAMHS) should develop and audit their provision for this vulnerable group.

Section 6: Recommendations

6.1 Parenting programmes must continue for the parents of school age children, focusing on times of transition in their child's life, such as entry into primary one. We will ensure our approaches to parenting reach those families who could benefit most.

6.2 We must work together to bring about the whole school work on health and wellbeing which is envisaged by policy documents and set out in the Curriculum for Excellence. This will require new ways of working across organisations and will become a focus for improving mental health, sexual health and preventative activity around alcohol, tobacco and drugs. The recession is associated with a reduction in wellbeing and a rise in mental health needs across the population. Many young people are leaving school without positive destinations for employment or training. The health impact of these needs will fall on adult health services and on other agencies. However, we will work with education colleagues to develop whole of school approaches, which improve young people's resilience and skills to face this new reality.

6.3 We will ensure that the work of the School Nursing and Health Review considers how best to work with partners to identify and support the health needs of young carers.

6.4 We must build on our recent multi-agency planning work to create a strengthened range of preventative and early intervention services that supports the mental

health, resilience and wellbeing of children and young people that better respond to distress, self-harm and risk of suicide. Such supports should be equitable, evidence-based and better connect with the existing resources of our partners.

6.5 The health service's (or children's services) CAMHS services should have closer working relationships and liaison with schools to identify children and young people at risk of poor mental health as early as possible and put interventions in place which will improve their outcomes.

6.6 We must build the confidence and skills of key frontline workers across services to support and intervene on mental health related issues, including delivery of focused learning inputs, such as suicide prevention skills.

6.7 We should build a comprehensive communication and engagement strategy for children, young people, their parents and carers on mental health themes. This strategy will include utilising multi-media resources, social media approaches and using young people as partners, to ensure a well-informed population, to challenge stigma and discrimination, and to lower the barriers to seeking help and support.