

Health Needs Assessment of the Wellbeing and Mental Health of Children and Young People in Dorset

Developed on behalf of the Children and Young People's Emotional Wellbeing and Mental Health Steering Group

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Executive Summary

This summary outlines key points contained within the report, which are covered in more detail within each relevant section of the Health Needs Assessment (HNA).

Introduction and Background

It is clear, and well-evidenced, that wellbeing and mental health are critical determinants in children and young people's immediate and long-term outcomes.

Mental disorders¹ often occur early and persist throughout the life course; more than half are established by age 14 and three-quarters by age 18-24.

Factors that affect wellbeing and mental health span familial, social, environmental and political spheres. A younger person is more at risk of experiencing poor mental health or mental disorder if they are of a certain ethnicity, have special educational needs, are male in some age groups or female in others, if they are repeatedly absent or excluded from school, if they are living in poverty, amongst others.

Some children and young people can experience multiple risk factors for mental, which can be mutually reinforcing, meaning they compound the effects of one another. A child or young person with a risk factor of special educational needs (SEN), for example, is also more likely to be absent or excluded from school and to live in poverty, other risk factors for mental disorder. Those in contact with the Youth Justice Service are more likely to have been a Child in Need, to live in poverty, to have communication difficulties, amongst other risk factors. Lower attainment and persistent absence are also risk factors for teenage pregnancy, again all of which are risk factors for the individual young person's mental health but also for the children born to younger parents.

The treatment of clinically diagnosed mental disorders is often limited in effectiveness, and there is growing understanding of the individual, familial and societal factors which lead to psychological harm; risk factors. Protective factors which promote positive wellbeing and mental health are also beneficial in preventing, and managing, lower wellbeing and mental disorders also.

National policies, data and research, alongside views of children and young people and their carers, have demonstrated the increasing prevalence and wide reach of lower wellbeing and mental disorders, and opportunities for responding, with support and services across the whole spectrum, including mental health promotion and prevention.

Purpose/Rationale

The HNA will influence future design and commissioning of services in Dorset with findings informing the Children and Young People's Mental Health Strategy and Implementation Plan.

Understanding of the wellbeing and mental health needs of children and young people across Dorset has been derived from national and local indicators, and from evidence around factors that are protective against, or increase risk to, developing or experiencing poorer wellbeing and mental health.

The focus has been on those 0-25 years old, with additional insights gained into the mental health of mothers and fathers during pregnancy, infancy and early years and the impact upon children.

There is the consideration of the range of services which may meet need, information from national and local surveys, service level data, and views of children and younger people, their families and professionals.

¹ The term 'mental disorder' is used within this report as NHS Digital estimates of prevalence determined mental disorder in children and young people by applying rigorous diagnostic criteria for specific disorders set out in the tenth International Classification of Disease (ICD-10)

Impacts of mental health

Living in poor mental health is common, disabling and costly at personal, economical and societal levels.

Mental disorders are linked with suffering, functional impairment, exposure to stigma and discrimination, as well as enhanced risks of morbidity and premature death in adults and in younger people; suicide is one of the leading causes of death among younger people.

Mental ill-health in children and young people causes disability in those who would normally be at their most productive, creating a significant public health challenge but also a huge societal, economic and health and social care burden.

Negative impacts

There are wide-reaching, long-term negative effects of poor mental health in children and young people, with poorer physical health and less healthy behaviours, reduced educational attainment, social development and less healthy relationships. Within adulthood, the effects extend into lower levels of employment and living in poorer quality housing, the continuation of living in deprivation and poverty, increased adverse lifestyle behaviours and an overall increased risk of morbidity and mortality.

Positive impacts

Conversely, positive wellbeing and mental health affords children better physical health, with less health-damaging behaviours and longer lives lived without ill-health. They are less likely to experience social inequalities, have increased educational achievement, increased economic opportunity and reduced mortality.

There has been additional impact observed in recent months during the COVID-19 pandemic, indicating mental health need above usual levels.

Societal and Economic costs

These are numerous, spanning systems, both at the time of experiencing disorders, but also from wider impacts of disengagement with education and poorer educational achievement impeding further life chances. Morbidity and increases in mortality risk are also observed, which can cause significant costs in adulthood.

Three-quarters of the cost of perinatal mental illness relates to adverse impacts upon the child rather than the mother.

Prevalence

Wellbeing

There will always be a fluid spectrum of wellbeing and mental health in children and young people, with the majority experiencing more positive states. However, there are those with lower-level, mild-moderate, need which can be met with information, advice, support or evidence-based lower-level interventions.

While the vast majority of children and young people in the UK are doing well, 'thriving', there are indicators that a significant proportion are not in such a positive position with their wellbeing or mental health, along with a growing body of evidence that this proportion may be increasing in light of the COVID-19 pandemic. Most of the data collected nationally and within this HNA is from prior to the pandemic and so may underestimate current prevalence and reach.

Nationally, measurement of wellbeing has shown decline in children and young people over the last 10 years. 15-year olds in the UK were among the saddest and least satisfied with their lives in Europe, and reported high levels of 'fear of failure' compared with other European countries. In 11-year olds, England was again ranked one of the lowest of 45 countries for overall life satisfaction. Children and young were found to have high levels of emotional complaints such as feeling low and having difficulties sleeping.

The UK also had the second largest gender gap, with nearly a quarter of girls scoring low on at least three out of four measures (life satisfaction, happiness, sadness and purpose) compared to around a tenth of boys.

On a local level, data on these types of measures is available from 2014/15 and indicates across Dorset comparable levels to England for mental wellbeing. Measuring life satisfaction, Bournemouth had lower levels of young people reporting 'positive life satisfaction' than England and South West proportions, while Poole had similar proportions and Dorset CC had higher. In reporting levels of 'low life satisfaction' Bournemouth had more young people with low life satisfaction than Poole and Dorset and bigger proportions than in England.

These confirmed local indicators are not very recent, but there is suggestion that the most recent local position in Dorset may be below that of England.

Mental disorder

Prevalence of mental disorders in those aged 5-19 has increased over the last two decades, to one in eight, one in 20 meeting criteria for two or more. Increases have been seen across genders and through age groups; peaking at nearly one in four in young women having a mental disorder. For the first time, prevalence in younger children of preschool age, 2-4 years old, showed around one in 18 met the criteria for mental disorders.

Across all ages this equates to around 2-5 children per average school class having a mental disorder.

The most common mental disorders amongst children and younger people are emotional disorders, including anxiety and depression and behavioural (conduct disorders). The most common issue for boys are behavioural disorders while for girls they are emotional disorders.

In adolescents and younger adults (16-24 year olds), the prevalence of mental disorders was nearly three times higher in young women than young men, with one in four women and one in seven men showing signs of depression or anxiety. Young women are deemed a high-risk group in the population, significant in both their current and future maternal health.

One in four young women and one in ten young men, aged 16-24, reported having self-harmed at some point in their life, whilst more than a quarter report having had suicidal thoughts in their lifetime, higher than in any other adult age group. Nearly one in ten have attempted suicide in their lifetime.

In Dorset more children and young people are being admitted to hospital with alcohol, substance misuse or self-harm related causes than nationally, and often, regionally. Suicide rates are also higher, both in males and females, than seen nationally and there have been significant increases recently.

Local Population data

There are changes predicted in the next few years, with the number of 0-18 year olds increasing by around 5%; BCP seeing twice the growth rate of Dorset. There is a predicted decline of 19-25 year olds, but overall the population of 0-25 year olds will grow by around 2%, or 4,100 children by 2025.

Treatment gap and effectiveness

Historically, less than 25%-35% of children and young people with a diagnosable mental health condition have accessed support.

However, if all individuals with mental illness received the best available treatment, the total burden of mental disorders would reduce by only 28%. There must therefore be efforts beyond healthcare, aimed at promoting protective factors for wellbeing and mental health and in reducing risk factors for the development of poor mental health.

Factors influencing mental health

There are a number of wide-ranging risk and protective factors which influence children and young people's wellbeing and mental health. These factors operate at individual, family, community and structural levels.

Protective factors

These include organised attachment, positive parenting styles, good physical health, self-esteem and self-regulation, education, and positive school and wider community environments and networks.

Risk factors

These are numerous, including

- individual characteristics (age, sex, ethnicity, physical health, disabilities)
- family and socio-economic characteristics (number of children, employment, income parental physical and mental health, family dysfunction)
- individual circumstances (life events, poor education, social supports including friendships, immigrant status, debt)
- household characteristics (accommodation type, housing tenure)
- geography (urban/rural, region)
- societal factors (discrimination, inequalities, crime, deprivation)

Local position

Historically, Bournemouth, Poole and Dorset have benchmarked similarly or better against regional and national averages for protective factors, for positive elements of wellbeing and GCSE attainment, although there are significant reductions in attainment for children in care and those who have been in a position of poverty.

More recently figures have shown locally there are lower levels of children living in poverty than previously, low levels of those physically active (but similar to England) and a mixed picture of children classed as in need or cared for compared with regional and national pictures.

For many other preventative and risk factors, the picture has been mixed, with variance across local authorities for many indicators, possibly highlighting the existence of inequalities. Sections within the main report highlight these in detail, however, some key categories are discussed below.

Family functioning

Familial factors associated with having a mental disorder in children and young people include parents with poorer physical or mental health, less healthy family functioning and living in lower-income households.

Across Dorset there have been higher rates than seen in England of divorce and separation, with half of households who divorce having at least one child under 16.

There were fewer reported domestic violence incidents than nationally, per 1,000 population, in 2017. Nationally modelled data in 2018 showed between 16-18% of 0-17 year olds across Dorset were living within a household experiencing one risk (of domestic abuse, substance abuse or severe parental mental disorder) translating to around 23,000 children and young people, around 6,000 of whom were predicted to be between 0-4 years of age.

A measure of parental mental health is taken from the prevalence in the general population, at around one in six. More than two-thirds, of the total number of 0-17 year olds living within a household of risk, as above, were estimated to be living with a parent with a severe mental health disorder. This equates to around 16,900 children and young people.

The modelling figures were likely to be underestimates as they only accounted for the status of one adult within a household.

The rate of Children In Need has varied between 2016-2019 in comparison with England rates, sometimes above or below. At 2019, the rate was higher across all three authorities than England. Child Protection Plans have shown a similar mixed picture in the same period, but reporting lower than England rates in 2019.

Parental mental health

Parental mental health is shown to be strongly associated with mental disorder in children and young people. One in four children in the UK aged 0-16 have a mother with a mental disorder, and children of mothers with depression have a five-fold increase in risk of developing mental health illness. In Dorset around 1,000 parents were on a mental health pathway in February 2020.

Data is not readily available on father's mental health throughout their child's life, however research has found around 10% of first-time fathers have post-natal depression and 38% are concerned about their mental health. Fathers are more at risk if their relationship with their partner is strained or if their partner is experiencing postnatal depression and paternal depression is associated with maladaptive parenting behaviours toward children and negative child outcomes.

Attachment

Early child-parent and child-carer relationships are paramount to thriving later in childhood and as an adult, both socially and cognitively. There is a significant amount of evidence demonstrating the value of sensitive and attuned parenting in the development of a baby's brain and the development of a secure attachment. Issues with attachment and parenting styles impact on the physical, mental and socio-economic outcomes of a child later in life.

Around a third of representative populations have poor attachment. Attachment is not one singular measure, but rather a collection of risk factors which can lead to attachment problems. These include prevalence of adult mental disorders, teenage mothers, substance misuse, children in care and child maltreatment, and family homelessness which can indicate whether a population is more at risk of having higher levels of poor attachment.

Across Dorset there is increased prevalence of mental disorders above that of England in Bournemouth, but lower in Dorset and Poole. Rates differ across Dorset in teenage conceptions, higher in BCP than England. Mothers under 18 and 20 years have shown higher percentages in BCP than England for under 18s and higher for both authorities in mothers under 20 years than England.

Children in Need indicators are mixed across Dorset, with higher rates of children in care, and more children both entering and leaving care across Dorset than regionally or nationally, in line with or slightly higher than England. The rate of children under 5 in care in Bournemouth was in line with England, while Poole and Dorset was lower.

Family homelessness in 2017 was lower than in England across Poole and Dorset (no data for Bournemouth).

This does not present obvious conclusions, other than there may be a picture of slightly more disorganised attachment within Bournemouth.

Early years development and all-age Education across Dorset

Development in early years is crucial for long-term growth and opportunity; disparities in child development are recognisable by the second year of life and have an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential, with associated poorer long term outcomes including mental health and general wellbeing.

Communication skills are a protective factor for wellbeing and mental health and there are known associations with poor communication skills and mental disorders. Strong and persistent differences in communication through language are evident, with a child's socio-economic background an important factor.

By age 3 there is already a 17-month income-related language gap, with children from disadvantaged groups twice as likely to experience language delay. Five-year olds with poor vocabulary are three times more likely to have mental health problems as adults and two-thirds of 7 to 14 year olds with serious behavioural problems have language impairments.

Locally, a good level of development at around age 2 is seen, above England and South West levels. There is good quality provision of early years education and high uptake in eligible 2 year olds across Dorset, although slightly lower uptake in Bournemouth. For three and four year olds, less uptake has also been seen in BCP, than regionally and nationally.

An indicator of poverty, Free School Meals uptake pan-Dorset has been lower than England uptake but, within area, highest uptake was seen in Dorset CC.

There is a development and attainment gap associated with being in receipt of free school meals. Around 15% fewer children in BCP and 18% fewer in Dorset achieved good levels of overall development, and 13% fewer children in BCP and 15% fewer in Dorset achieved good development in the phonics check, when in receipt of FSM, compared with those who are not.

Great disparity in levels of attainment by age 19 is also seen between those who had previously taken FSM and those who had not. Between 2015-2019, 20-40% less of those who had taken Free School Meals at age 15/16 achieved Level 2 or 3 qualifications in comparison with those who had not taken FSM.

There are also significant disparities in attainment and educational progression for children in care across Dorset, as there is nationally.

Increased risk of mental disorder for those with increased vulnerability, within marginalised groups, or in particular circumstances

Any child or young person can experience mental health problems, however, some groups of children and young people are at increased risk because of their background, belonging to a marginalised group, social circumstances or life events.

Groups at greater risk covered within this HNA are wide-ranging. Children and young people from different ethnic backgrounds, with minority sexual and gender identities, who are obese, bullied, with poorer physical health states or with physical or learning disabilities, neurodiversity or special educational needs are at increased risk of experiencing mental disorders. Familial contexts known to increase the risk are those households with less healthy family functioning, low-income or with a parent in receipt of income-related benefits, with parents with poorer physical or mental health states, where children and younger people have roles as young carers or are military families. Children and young people who have experienced abuse or neglect or who are involved with social services or in care, absent or excluded from school, in contact with youth justice, homeless, asylum-seeking or not engaged in employment, education or training are also at increased risk of mental disorder.

Community and structural levels factors also include living in poverty, poorer quality or colder housing, poorer quality of education, and wider systems' inequalities and discrimination.

These groups are covered in detail within the report and the increased risk studied for children within some of those groups is as great as five-six times the likelihood of developing mental health disorders over young people in the general population.

Some children and young people experience multiple risk factors, and there is complex interplay between these factors that further increase the risk of mental health disorder. This compounding effect, or mutual reinforcement, can vastly increase the likelihood of experiencing other risk factors and/or mental disorder, and have far-reaching consequences for health, achievement and opportunity, with effects extending into adulthood.

Effects of these inequalities can be seen in reduced and poorer access to, and outcomes from, in the contact some of these children and young people have with services, support. These impacts continue in reduced attainment, employment, income and future opportunity.

Approach to identifying and treating or supporting mental health – THRIVE

Within Dorset, mental health services are working to align with the THRIVE Framework, to replace tier-based systems with a whole system approach, based on the identified needs of children and young people and their families within five groupings:



Support mechanisms

In addition to mental health services, there are a wide range of professionals, groups and settings that can support and improve a child or young person's psychological well-being. Many operate at a universal level such as midwives, health visitors, schools, school nurses and community workers, supporting children and young people in their development and health. There are Voluntary, Community and Social Enterprises that offer excellent support and have strong relationships with communities, particularly those groups most at risk.

Service Data

Nationally CAMHS has seen increased demand with longer waiting times, static DNAs and longer inpatient stays, amongst other indicators. GPs have expressed concerns over access to CAMHS services with perceptions of long waiting lists, high levels of rejected referrals, having to advise patients they may need to wait until severity of complaint matches referral criteria and of not having adequate alternative, lower level support mechanisms, below that which CAMHS offers, for their patients to access.

Local CAMHS data indicates services are under pressure, with increased referrals a trend seen locally over a number of years, often high levels of inappropriate referrals and slightly higher rates of DNAs than other mental health services within the Trust. Although waiting times are somewhat shorter than national averages, they are a continued challenge with many waiting longer than preferable to access treatment, perceptions of which were also evidenced in view-seeking exercises. Increased complexity and severity of presenting problems is also of concern when considering numbers on caseloads and their duration or lengths of stay.

New initiatives to tackle some of these pressures, and better serve local need, have begun such as the pilot 'Gateway' service in the East of the county, which includes self-referral, and the initiation of Mental Health Support Teams in schools. The impact of both of these is anticipated to alleviate some of the delays in access, rejection of referrals, and providing earlier and lower-intervention.

Beyond CAMHS, digital offers through ChatHealth and Kooth have seen continued uptake, and higher usage has been evidenced within Kooth since the COVID pandemic. There is also on-going work to address variation in school counselling offers and the Educational Psychology Service and School Nursing continue to perform their vital role within the mental health service offer.

Service mapping

This has demonstrated there is much provision of support across the different groupings within THRIVE. It has been recorded that service users and referrers often find the landscape of offers confusing and for those referred to CAMHS, the Gateway will alleviate some of that confusion.

It is beyond the scope of this HNA to provide information on access to those services or the appropriateness, quality or effectiveness of them. Reference to systems mapping is made within the Key Findings and Recommendations.

Stakeholder views

Children, young people, parents and carers alongside staff have expressed the need for earlier, lower-level and alternative provision, alongside the offer of specialist services which they value and often regard highly.

They want more flexible approaches which are more appropriate and responsive to their needs, with quicker access.

Interventions

PHE have recently reviewed evidence for approaches to improving children and young people's mental health and wellbeing, more comprehensive than would have been afforded by this needs assessment.

They found eight promising interventions operating at individual, family and community levels and a wider range of interventions from a review of other literature. A large number were also contained within the Early Intervention Foundation's Guidebook (EIF), where strength of evidence of impact and relative costs have been considered.

Children and young people's views were part of the review and they supported taking an assets-based approach to promoting mental wellbeing (recognising and building on the strengths of supportive interpersonal relationships and the characteristics of supportive places, environments and wider influences).

Key findings and recommendations section

The findings and recommendations summarises the outputs of the detailed HNA report and recommendations are provided within nine themes.

The themes focus on parental mental health, early years, family functioning, approaches within schools, particular risks within adolescence and young adulthood.

There is also emphasis on the different groupings of need, of enabling and supporting those who are thriving or indicate lower-level need through to specialist services and beyond to those who may find support or services difficult to comprehend, access or engage with.

Finally there is a move to workforce development, to implement enhanced approaches to training to ensure those who work with children, young people and their families feel able to recognise protective mechanisms, the signs and impacts of risk factors and have avenues through which to support them in the most appropriate way.

Introduction

Purpose/rationale for HNA

The wellbeing and mental health of our children and young people is essential both for their own health and future opportunities but also for the wellbeing of society. It is commonly accepted that if we better address these needs in our children and young people, we reduce the burden of illness for them now and in the future, as adults. We know around half of adults accessing mental health services had a diagnosable condition before the age of 14, and 75% by the age of 18ⁱ. Nationally, the prevalence of mental health conditions is rising, now at one in eight childrenⁱⁱ.

There have been considerable shifts in ambitions, resources and service delivery to address rising demand, need for increased access and effective services. These have been outlined in national publications such as Closing the Gapⁱⁱⁱ, Future in Mind^{iv}, Five Year Forward View^v, NHS Long Term Plan^{vi} and translated locally in our Mental Health and Wellbeing Strategy 2016-20, Dorset's Sustainability and Transformation Plan and Local Transformation Plans. The views shared and plans made are ethically, morally and economically sound^{vii}.

To continue to develop our local ambitions, services and mechanisms of support, further understanding of the need that exists, current provision and the gaps this will highlight is required, to ensure we employ future resources most appropriately and efficiently in supporting our children and young people as fully as we can.

The Health Needs Analysis (HNA) for Dorset has been developed to establish the wellbeing and mental health needs of children and young people across Dorset and understand how our services and support meet those needs, through a systematic process of assessment.

National, local and modelled data has been used, alongside view-seeking work performed with stakeholders, to appreciate current and future populations, who may sit within vulnerable groups, where children and young people may demonstrate need within differing segments of the THRIVE model^{viii} and how we currently meet this need.

This work will inform future design, development, funding and commissioning of the services and support our children and young people need in developing or maintaining their wellbeing and positive mental health, while working to prevent, manage and treat mental disorders. Based on the picture that emerges, we will aim to provide services and support at times and places which enable access that is:

- Early
- Preventative
- Appropriate
- Wider-reaching (increasing access for those with a diagnosable mental health condition)
- More equitable
- Using evidence-based interventions

The HNA will provide that understanding through identifying:

- Characteristics of the current and future populations of children and young people in Dorset
- Prevalence of wellbeing and mental health in children and young people, nationally and locally
- Protective and risk factors which affect our children and young people's wellbeing and mental health, helping to identify those who may require greater support with their wellbeing and mental health
- The extent to which current services and support meets determined need, highlighting gaps in our offer to support children and young people, through both quantitative and qualitative information
- Areas of need indicating a requirement for additional or alternative services/support

This is visualised below in figure 1.



Figure 1: Process of development of the HNA
Source: DHC in-house creation

Reasons for undertaking this HNA include:

- Research shows that, nationally, levels and patterns of mental disorders amongst children and young people are changing, with an increase in many mental health conditions and wider reach than previously known. A HNA is of benefit in providing understanding of the current emotional and mental health needs of children and young people across Dorset.
- Dorset CCG has increased investment in children and young people mental health services both for existing and new approaches and would benefit further from sufficient intelligence to enable targeted funding.
- There is an expectation of increasing access to mental health services; it is of value to develop understanding of current access, challenges and successes within services alongside need across the population, to target services and support appropriately.
- A reorganisation of local authorities in April 2019 has formed two Unitary Authorities. The HNA enables use of data which aligns with those new local authorities, where possible, ensuring accuracy in decision making.

The health needs analysis is a systematic approach to understanding need and potential gaps in provision of services and support. It will, along with the Local Transformation Plan and Dorset's Mental Health Strategy 2020 to 2024^{ix}, inform the future design, funding, commissioning and implementation of services and other support mechanisms for children and young people in supporting their wellbeing and mental health.

Aims and Objectives of the Health Needs Analysis (HNA)

Aims

- To understand the level of current and future need of children and young people in supporting their wellbeing and mental health across Dorset.
- Appreciate current service and support provision, and potential gaps, to target planning for service redesign and resource allocation.

Objectives

1. Review national literature and evidence concerned with wellbeing and mental health in children and young people, including policy, legislation and priorities.
2. Gather epidemiological data to understand local populations, both current and future, and provide information on numbers of children and young people we may have within more vulnerable groups, either generated from local data or modelled from national/international data.
3. Assess quantitative and qualitative data to establish indicators of wellbeing and prevalence of mental health disorders. Current and predicted levels of need will be estimated:
 - i. Within the general population of children and young people
 - ii. Within groups of children and young people at higher risk.
4. To map known current service and support provision within THRIVE segments.
5. To make assessment of possible gaps, or inequity, in provision.
6. Provide summary of key findings.
7. To develop recommendations in light of key findings.

Methodology

This HNA is constructed by way of a 'Health Needs Assessment' approach, constructed of epidemiological, comparative and corporate elements^x:

Epidemiological: This approach considers the epidemiology of the condition, examining demographic data, markers of health need and information on higher risk groups, along with current service provision and effectiveness of interventions and services.

Comparative. Comparing local data of indicators of wellbeing and mental health with regional and national data. Comparing CAMHS service provision data with that of other national organisations.

Corporate. This approach develops the HNA by way of eliciting views of stakeholders on what services are needed. In this HNA this will involve accessing current local engagement work, alongside any previous relevant local or national engagement findings. This local knowledge is vital in understanding local need.

Development of the HNA will utilise, specific to children and young people:

- a. National and local publications to understand the context in which children and young people's wellbeing and mental health sits.
- b. Data and literature on wellbeing and mental health to understand the prevalence of wellbeing and mental health issues in children and young people, and those factors that are either indicators of increased risk, or preventative, in managing or promoting wellbeing and mental health.
- c. Demographic/epidemiological data regarding the younger population of Dorset, including predictions of future population change.
- d. Current service provision understanding, to include the wider landscape of offers.
- e. Data demonstrating current service usage and pressure points.
- f. Stakeholder engagement work, including service users, parents and carers, and staff members, both locally and nationally.

Scope

Inclusions

All children and young people aged between 0-18 years of age.

With additional perspectives on:

- Mental health needs extending into early adulthood, up to age 25 where possible.
- Parental mental health
- Maternal mental health during the Perinatal period (to 24 months following birth), infants and children under 5.

Exclusions

None of note.

Background

Mental Health Definitions

Wellbeing and positive mental health are vital to public and societal health; they are essential to all interactions, taking care of one's self and others, quality of life and having the capacity to sustain life's ups and downs. Wellbeing and positive mental health are protective against physical illness, social inequalities and unhealthy lifestyles^{xi}. It is vital therefore to address the needs of people with defined mental disorders but also to protect and promote the wellbeing and mental health of all people in recognition of its intrinsic value.

The World Health Organisation (WHO)^{xii} defines mental health, as

“...a state of well-being, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”

Mental health and wellbeing are intrinsically linked and are often used interchangeably; it is challenging to find a commonly accepted definition of wellbeing. There is acceptance of it being more than the absence of mental illness; of a state in which someone is comfortable, healthy or happy. Current broader concepts include an individual's sense of life satisfaction, purpose, and degree of control, as well as the ability to adapt to change or misfortune^{xiii,xiv}

Within this report, the definition of wellbeing is aligned with that used in national publications^{xv,xx}. That which encompasses concepts of personal, or emotional, well-being such as happiness, purpose and sense of life satisfaction, but extends to more general factors which influence wellbeing; physical health and positive relationships along with wider determinants of having gainful employment, good quality housing, higher levels of household income and safe, accessible environments and access to support and community networks. Where information is available within these spheres, this report will make reference to them.

Mental disorder is defined by the WHO as:

“disturbances to a person's mental health that are often characterised by some combination of troubled thoughts, emotions, behaviour and relationships with others. Examples of mental disorders include depression, anxiety disorder, conduct disorder, bipolar disorder and psychosis.”

Overview of the prevalence of mental health disorders

Adults

In England, one in four adults will experience mental health issues each year, and at any given time one in six working-age adults are affected^{xvi}. Lifetime risks vary from one in four, to one in two, within different settings^{xix}.

Children and young people

Data on the prevalence of mental health disorders in children and young people is drawn from The NHS Digital survey data held in the report “Mental health of children and young people in Great Britain, 2017^{lix}”.

They found one in eight children (12.8%) in the UK between 5 and 19 years old, and one in 18 preschool children, had at least one mental disorder. They reported 1 in 20 children (5%) in the UK were determined as having two or more mental disorders.

The most common type of mental disorder in children and young people were emotional disorders, which include anxiety and depression, followed by conduct disorders. Conduct disorders were the most prevalent type in the previous survey in 2004^{xvii}.

The prevalence of mental health problems and disorders in children and young people is examined in more detail within the section below titled ‘Prevalence of Mental Disorder in Children and Young People’.

Impact of mental health

Globally, mental disorders are the leading cause of disability and the third leading cause of overall disease burden, following cardiovascular disease and cancers^{xii}. In the UK mental disorders represent the largest single cause of disability^{xviii}. Living in poor mental health is common, disabling and costly at personal, economical and societal levels^{xix}.

Mental disorders have high rates of prevalence, are often of long duration and, although best to diagnose and treat early, many mental health disorders go undiagnosed or are treated at more advanced stages, when impacts are more severe for individuals and their families^{xx}. At least half of mental disorders last more than a year, some persisting for years or over a lifecourse, especially if untreated or inadequately treated^{xxiv}. While three out of four people with physical illness receive treatment, only one in four people with mental health problems do^{xvi}.

Mental illnesses often occur early and persist throughout the life span. It is well documented that of those with lifetime mental health problems, half are established by the age 14, and three quarters by 18 to 24 years of age^{v,vi}. International data suggests around 13-23% of children and adolescents experience mental disorders and recent survey results show one in every nine children in England between the ages of 5 and 15, and one in every eight between 5 and 19 years, has a mental disorderⁱⁱ.

The consequences of mental illness are multi-dimensional. Mental disorders are linked with suffering, functional impairment, poorer physical health and increased adverse lifestyle behaviours, even within younger age groups. These factors lead to an enhanced risk of longer-term morbidity and increased mortality risk in adults and in younger people; suicide is the third leading cause of death among adolescents^{xxi}.

PHE published an infographic in 2016 (figure 2) illustrating key facts about mental health^{xxii}.

Facts about mental health illness in CYP

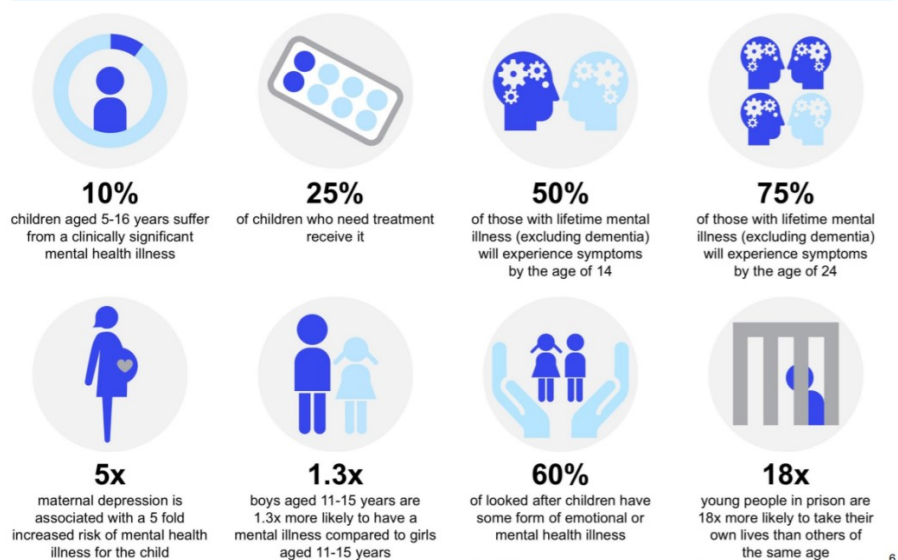


Figure 2: Infographic of facts about mental health in children and young people.

Source: PHE (2016)

Risks associated with poorer mental health which can lead to increased mortality concern the younger age group, including smoking, smoking in pregnancy, sexual health, alcohol consumption, and obesity. Some of these issues are linked to the major causes of death in Dorset in adults of cardiovascular disease (CVD) and cancer.

There are other wide-reaching, long-term negative effects of adverse mental health in children and young people; poorer physical health and less healthy behaviours, reduced educational attainment, social development and less healthy relationships. Within adulthood, the effects extend into reduced chances of employment and good quality housing and the continuation of living in deprivation and poverty.

Conversely, positive wellbeing and mental health affords children better physical health, with less health-damaging behaviours and longer lives lived without ill-health. They are less likely to experience social inequalities, have increased educational achievement, increased economic opportunity and reduced mortality^{xxiii,xxiv}.

No other health condition has the same reach as mental ill-health in its combined extent of prevalence, persistence and breadth; mental ill-health causes in children and young people causes disability in those who would normally be at their most productive^{xxxiii}. This is not only a significant public health challenge but a huge societal, economic and health and social care burden.

It is recognised early prevention of these can reduce all of these impacts, including morbidity risk, avoiding the need for more expensive interventions and the later societal and economic impacts of illness. The promotion of mental and wellbeing is beneficial for all, including those with mental health conditions.

Impact of COVID-19 pandemic on mental health of children and young people

There have been five publications during 2020 on the impact of COVID-19 on children and young people's mental health from the Evidence-based Practice Unit, a partnership between UCL and the Anna Freud Centre, reviewing national and international evidence^{xxv}. Some of their key findings are shown below:

General population

- Extended periods of local lockdowns and home confinement, have led to some children and young people displaying a range of psychological distress.
- Large studies have found increases in the prevalence of anxiety and depression among young people during the pandemic.
- Lack of outdoor activities, poor social support, close family members contracting the virus and gender may all be contributing factors in the development of these mental health challenges.
- Some young people have enjoyed more time at home, with time and flexibility to take part in leisure activities, and have developed new routines at home. This also applies to some young people with Autism Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD).
- Findings regarding the relationship between the pandemic and suicide are mixed. In the US, more than a quarter of those between 18-24 years had contemplated suicide between May-June 2020; a higher proportion than older age groups.
- Studies have shown the pandemic has had some harmful effect on psychological wellbeing and related factors such as worry, happiness, stress, and life satisfaction.

For those with pre-existing mental health conditions

- Young people with eating disorders, obsessive compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD) report worsening symptoms.
- Children and young people receiving mental health care, such as for PTSD and other trauma-related disorders have experienced substantial restructuring of their support in the context of the pandemic.

For those with pre-existing physical health conditions

- Parents and caregivers have expressed concern about the health and wellbeing of children and young people who are living with complex health conditions such as epilepsy and cystic fibrosis.
- Many young people with physical health conditions and disabilities have been affected by social isolation and have experienced negative effects on their wellbeing. However, young people with pre-existing conditions are not affected uniformly, with some experiencing lower levels of mental health difficulties than peers.
- Young people with disabilities had higher anxiety and depression scores than their peers before the pandemic. For many, this did not improve during the lockdown, while for others it notably deteriorated.

Those in more at-risk groups

- The pandemic has amplified many of the existing risk factors for poor mental health in children and young people experiencing socio-economic disadvantage; including poor health, social isolation, uncertainty, financial stability and job loss.
- Children and young people with pre-existing social care needs, such as young people experiencing homelessness, children in care, young carers, and young people experiencing poverty are, on the whole, struggling more due to reduced support systems and further financial impacts of the pandemic.
- Children and young people of colour are disproportionately affected by the coronavirus as they and their parents and carers are both more likely to be key workers, and more likely to work in shut-down sectors. They therefore have greater likelihood of exposure to the virus while also being more likely to experience loss of household income. As a result, the mental health impact for these young people is exacerbated.
- LGBTQI+ youth may be disproportionately affected by mental health challenges associated with the pandemic owing to the loss of safe spaces and difficulties accessing health and psychosocial support services. In a study of secondary school pupils in the South-West of England, LGBTQ+ pupils had higher anxiety and depression scores and lower levels of wellbeing than their peers prior to the pandemic. Whilst during lockdown their peers experienced increases in wellbeing and decreases in anxiety, this was not true for those pupils identifying as LGBTQ+.
- The NSPCC has reported a threefold increase in the number of counselling sessions about child sexual abuse within the family. In some cases, there were more frequent sexual abuses or abuse that had only happened recently (UK).

Data has also been provided by an online provider of mental health support, Kooth^{xxvi}, showing some of the changes in usage since the pandemic began, shown in figure 3 below. They reported an increase in demand for mental health support and large increases in digital conversations across many presenting issues, including sadness, health anxiety, self-harm, suicidal thoughts, abuse and loneliness.

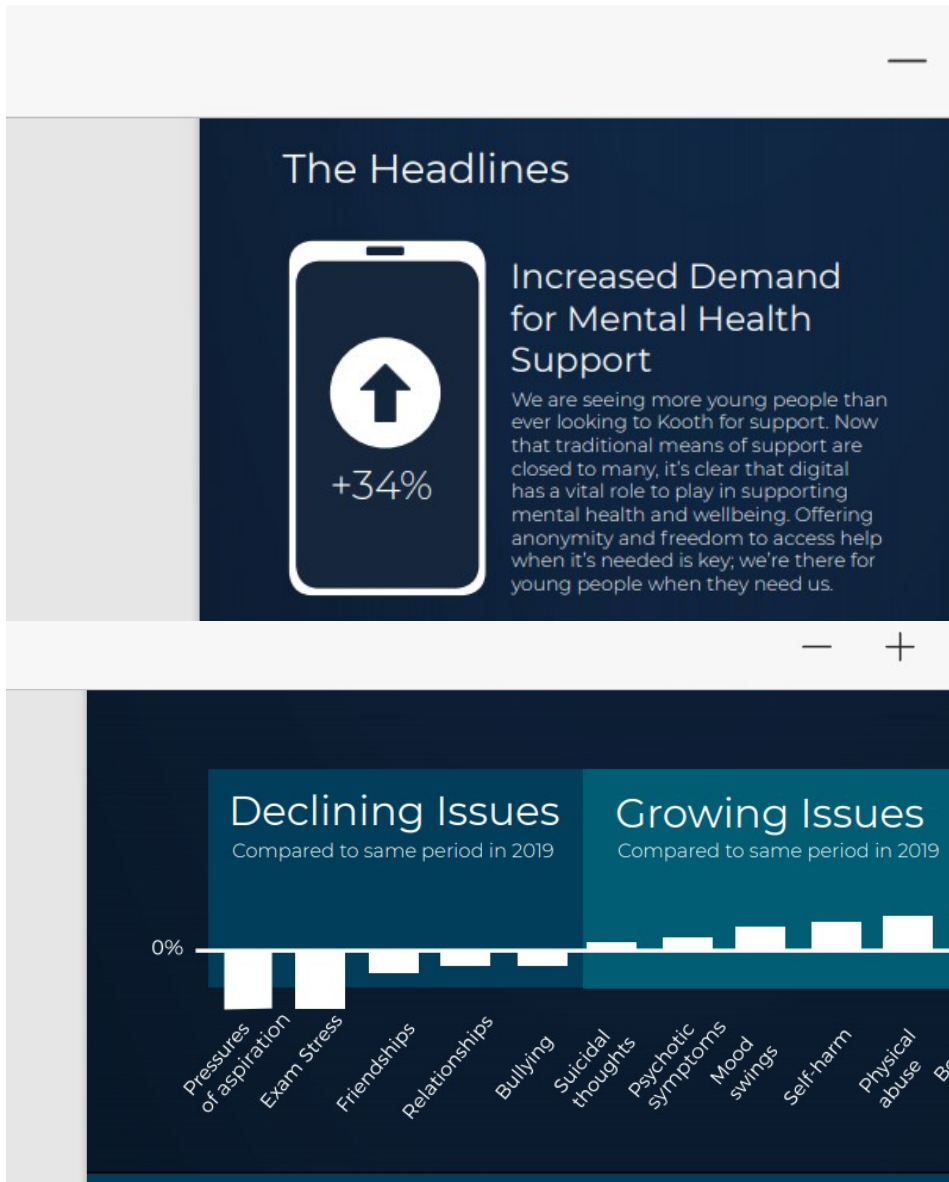


Figure 3: Infographic of impact of COVI-19 on contacts Kooth receive from children and young people. Source: Xenzone (2020)

Burden of disease

In the general population poor mental health is now the commonest single cause of disability adjusted life years (DALYS²) lost in the Western world (23%, compared to 16% each for cardiovascular disease and cancer).^{xix}

A DALY is a measure for understanding the impact of conditions that create ‘disability’, estimates how much a condition or disease affects (‘burdens’) the life of the population^{xxvii}. It is reported in terms of healthy life years lost in states of less than full health; it provides a picture of the burden, for conditions where it is more useful than comparing mortality, such as in mental health. More detail on DALYs is given in appendix 1.

Figure 4 below demonstrates how this is calculated.

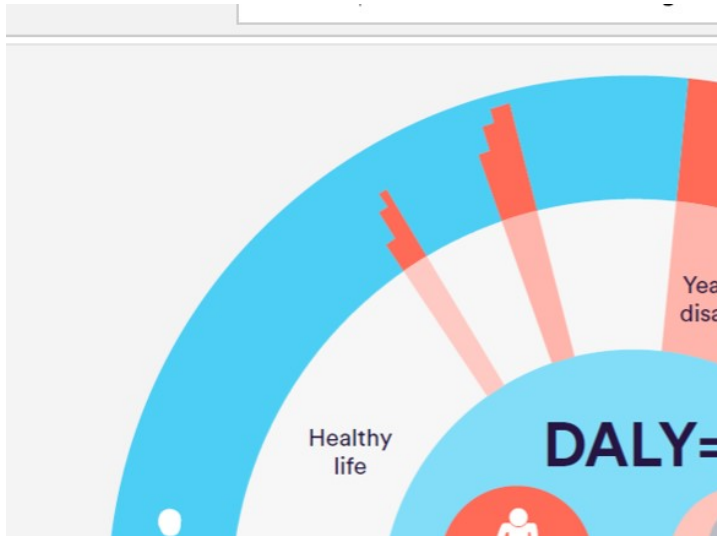


Figure 4: Disability Adjusted Life Years (DALYs)

Source: Public Health England (2015), cited in ‘Using DALYs to understand young people’s health’ Nuffield Trust^{xxvii}

To demonstrate the disease burden on a local level, figure 5 below shows epidemiological findings from the Global Burden of Disease (GBD) study. It showed in both 1990 and 2017 in Dorset, across both sexes aged 5-14 years, ‘Mental Disorders’ had the highest ranking for percentage of DALYS. Bournemouth and Poole showed the same picture:

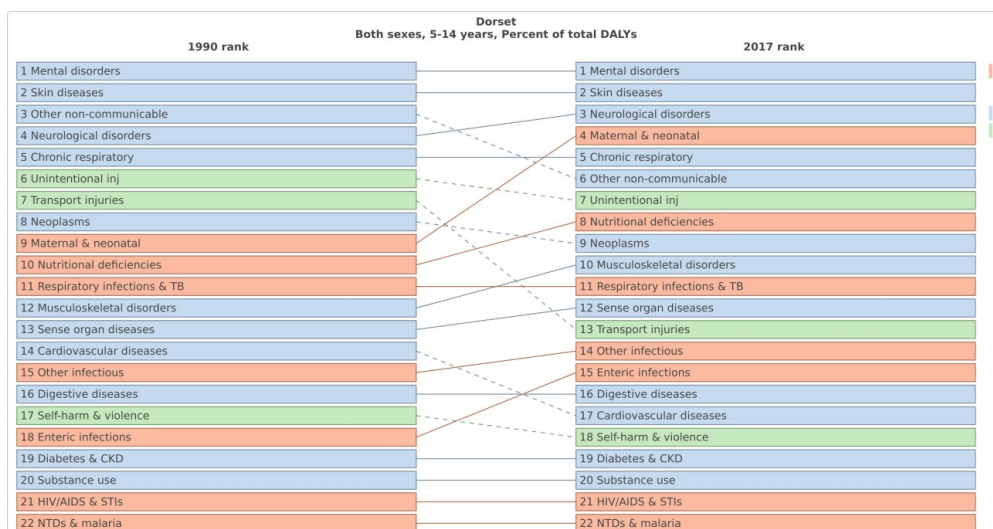


Figure 5: Percentage of DALYs in Dorset, for males and females aged 5-14 years.

Source: GBD^{xxviii}

A crude measure of the number of DALYS within the population of Dorset’s 5-14 year olds, amounts to around 920 lost years of ‘healthy life’ due to mental disorders³.

²One DALY can be thought of as one lost year of “healthy” life. DALYs are a “health gap” measure that represents the gap between the current health status of a population and one in which everyone lives into old age free of disease and injury.

Costs

Many reports over the last decade, including ones from PHE, the Faculty of Public Health and the Foresight report on Mental Capital and Wellbeing^{xx} have highlighted the diverse and long-term effects mental ill-health has on individuals, families and society. 2008 estimates placed costs at around £49 billion for economic costs alone in England, growing to £77 billion per year for when wider impacts on wellbeing were considered.

More recently, mental health problems have been calculated to cost the NHS around £14bn per annum, stated as the largest single cost to the NHS (11% of current spending). Wider societal costs have been estimated at around £100-105bn, once the impact on work, crime and violence has been taken into account.^{xix} Of these costs, it is understood perinatal mental health costs the NHS around £1.2bn, with wider social costs of around £8.1bn for each annual birth cohort^{xxix}.

The Foresight report also estimated, using data from the Kings Fund and the Psychiatric Morbidity Survey, there were 828,000 people with moderate to severe depression in England around 2008. It was reported that extending NICE-recommended treatment to all experiencing depression would result in economic benefits well in excess of £1 billion each year. The additional treatment costs of around £66 million would be vastly outweighed by higher Government revenues and reduced benefit payments, with benefits to individual wellbeing adding very substantially to this figure if costed.

While these figures account for the general population, the impacts of poor mental health upon children and young people and their persistence throughout the lifecourse indicate costs will be generated through loss of educational achievement, decreased economic output and the known impacts of living in poverty, amongst others. There are also costs generated from the impact had on family members and carers alongside the children and young people affected.

There are economic benefits to be realised in promoting and improving positive mental health. It has been reported^{xxxiii} increased subjective well-being increases life expectancy, provides protection from coronary heart disease similar to giving up smoking and improves health outcomes from a range of chronic diseases, such as diabetes. In children and young people it significantly influences alcohol, tobacco and cannabis use. PHE^{xxii} also reports measured benefits in the reduction of use of public services seen with better mental health, alongside improved educational attainment leading to increased earnings.

Positive feeling predicts pro-social behaviour, such as participation and civic engagement, and it is recognised that while the absence of mental illness provides good outcomes, having positive mental health incurs additional benefits. Importantly, this also holds true for people with existing mental health problems.

The challenge often is that departments from where investment is made are not the ones that see a return^{xx}, however in this instance, savings would be predicted for healthcare and Dorset's wider system, albeit some in the medium to longer-term, in reduced need for both general and specialist health services, for social care support and in greater engagement with education and communities.

Although figure 6 below is an example of spend within the wider-system on services related to differing levels of 'overall', rather than just mental health, need it is of note that within the descriptor of each of the groupings are many of the children and young people known to be at higher risk of mental health disorders.

It may provoke thought regarding the financial implications of having not supporting the mental health needs of these children and families at various points, effectively facilitating their movement through to requiring higher levels of support. It is fair to assume there is a role to be had in the reduction of progression up the ladder of wider need, by addressing the mental health needs of children, young people and their families as early as possible

³ Calculated using the approximate measure of 1,100 years lost per 100,000 population across all three areas (pre-reorganisation).

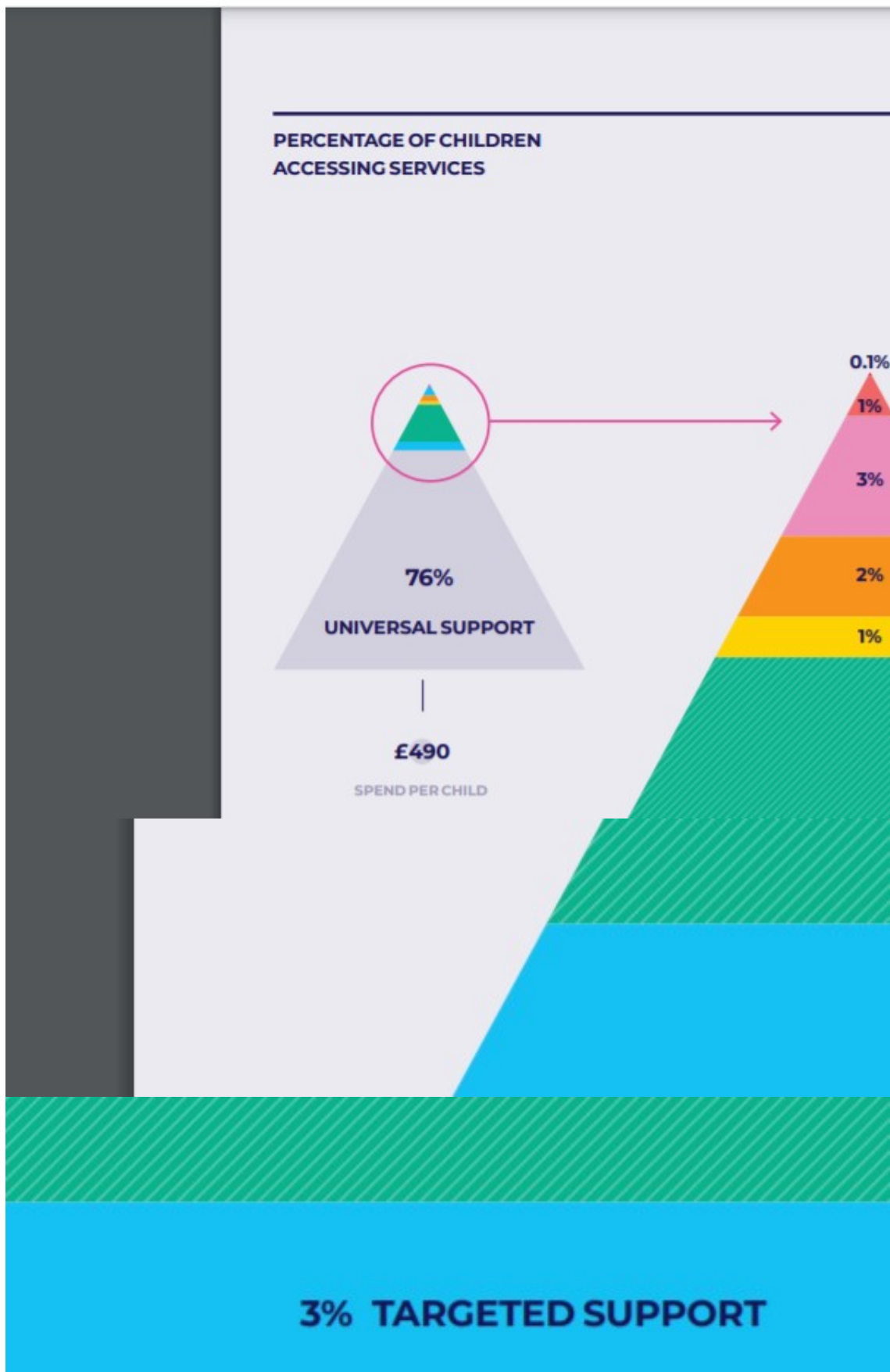


Figure 6: Percentage of children accessing different levels of support
Source: Children's Commissioner

Definition of need – capacity to benefit

Within this HNA, a commonly accepted definition of need used is ‘*the capacity to benefit from services*’. This focuses on interventions and support provision that could produce real benefits, and on individuals who could benefit from receiving them^{xxx}.

Unmet need in healthcare can be thought of as a need that is present but where someone does not, or cannot, access support for it, for example, someone requiring assessment or treatment for a mental health need but is delayed in receiving such due to long waiting lists, or who cannot afford transport to the location where the service is offered. Other reasons why need may not be met include examples such as a distrust of systems through which services are offered, high referral thresholds or services offered at certain times of the day, therefore not accessible to all.

It is important also to consider that needs are not necessarily met simply through contact with services, requiring thought around the significant impact contexts have on need; of social determinants and inequalities^{xxxi}.

Treatment gap and effectiveness

A simple definition of the treatment gap is the number of people with an illness, disease, or disorder who need treatment but do not get it (expressed as a percentage). A global systematic review found the treatment gap for depression in the general population was 56% and Generalised Anxiety Disorder was 57.5%.^{xxxii}

Nationally, the Future in Mind^{iv} publication reported 25–35% of children and young people with a diagnosable mental health condition accessed support. Updates to the NHS Long Term Plan report access is increasing with 30.5% of children and young people with a mental health condition accessed treatment and support in 2017/18.

Additionally, the treatment of some clinically diagnosed mental illness is often limited in effectiveness^{xxxiii}. It has been estimated if all individuals with mental illness received the best available treatment, the total burden of mental illness would reduce by only 28%.^{xix}

Consequently, given treatment gaps and limitations of support and treatment, consideration of efforts beyond healthcare delivery are required.

Promoting protective factors for mental health and reducing risk factors is therefore vital, as treatment is not, or cannot be, accessed by all and when accessed is only partially effective in the presence of other, wider factors^{xxxiii}.

Overview of Protective and Risk factors

There are a number of wide-ranging risk and protective factors which influence children and young people's mental health. These factors operate at individual, family, community and structural levels, presented by PHE in figure 7 below.

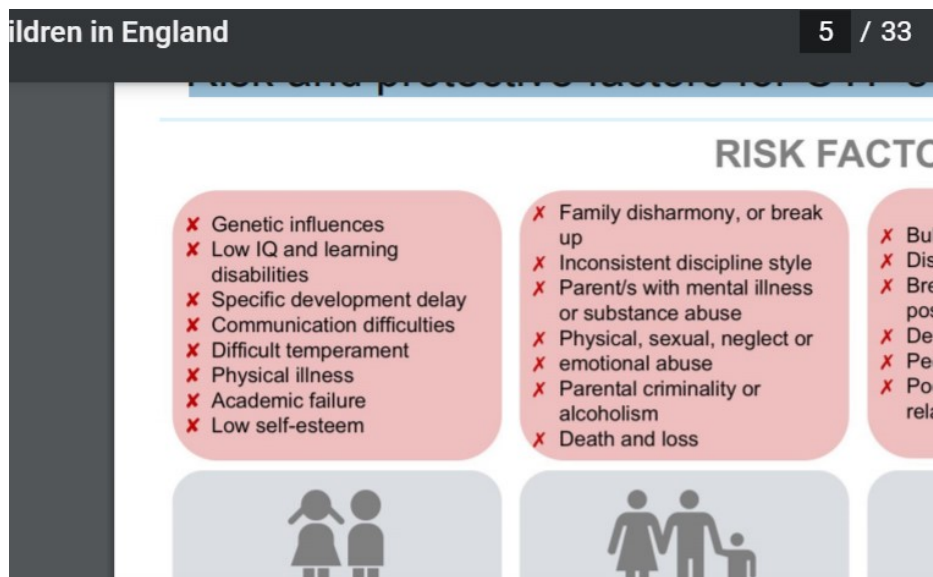


Figure 7: Risk and protective factors for CYP's mental health.

Source: Public Health England (2016) The Mental Health of Children and Young People in England

Mental disorders are influenced by diverse biological and social risk factors, including:

- genetic factors
- biographic characteristics (age, sex)
- family and socio-economic characteristics (number of children, employment, income)
- individual circumstances (life events, social supports, immigrant status, debt)
- household characteristics (accommodation type, housing tenure)
- geography (urban/rural, region)
- and societal factors (crime, deprivation index)^{xxxiv}

The Foresight report on Mental Capital and Wellbeing developed an illustration of the complex, multi-factorial, influences on mental health, their interactions and frequently changing nature over time, shown in figure 8 below.

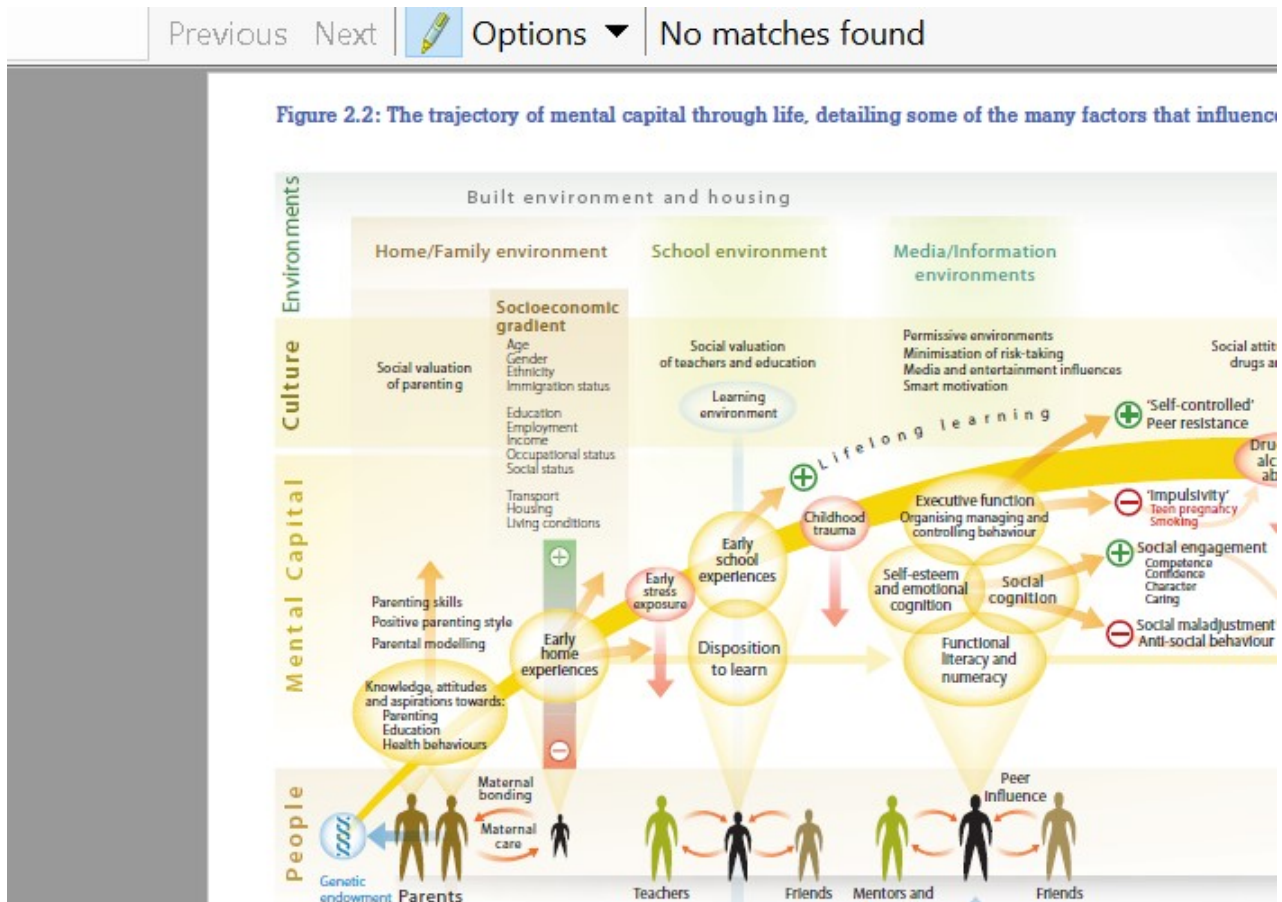


Figure 8: Conceptual overview of Mental Capital throughout life
 Source: Foresight: Mental Capital and Wellbeing Project (2008)^{xxxiv}

Protective factors and resilience

There are known protective factors which decrease vulnerability and aid the promotion, and maintenance, of emotional and mental wellbeing in children and young people, which Public Health England^{xxii,xxxv} summarise within a number of spheres:

- **Individual** factors include positive early attachment, a healthy lifestyle, good physical health, physical activity, communication skills, self-esteem, experiences of achievement and the ability to recognise and regulate own emotions.
- **Family** factors include good family mental wellbeing, affection and styles of parenting which are loving, trusting and supportive.
- **Learning** environment factors such as engagement with education, opportunity to participate, positive relationships with teachers and peers and positive whole-school approaches.
- **Community** factors include participation in the wider community, a supportive network, feeling socially included and valued, good housing, feeling safe from violence and with opportunities to be active.

Resilience is considered key in developing, maintaining and promoting wellbeing and mental health. Multiple definitions of resilience exist, including an individual's 'capacity to bounce back from adversity' or 'the capacity of a dynamic system to adapt successfully to disturbances that threaten the viability, the function, or the development of that system' or something that implies the on-going dynamism of the state 'a process to harness resources to sustain well-being'^{xxxv,xxxvi}.

Negative impacts of risk factors upon a child may be moderated when a child has a greater level of resilience, sometimes through several protective factors, such as the presence of a supportive adult^{xxxv}.

A PHE-led review of evidence^{xxxvii} to identify approaches to improving children and young people's mental health and wellbeing worked with focus groups of children and young people (71 in total). They found the mental wellbeing of young people is greatly affected by, and specific to, their background, place and demographics; including sexuality, gender, ethnicity and poverty.

Wider influences were also discussed, and included:

- | | | |
|--|----------------------------------|---|
| • Stability (home, employment, school) | • Hobbies (art, gaming, reading) | • Self-care and self-regulation (impacting on decisions e.g. removing oneself from unsafe places or building personal resilience) |
| • Sleep | • Physical Activity | |
| • Money | • Music | |
| • Food | • Pets | |
| • Volunteering | • TV/film | |
| • Hugs | • Shopping | |

They also highlighted the differential exposure to both risk and protective influencing factors for different individuals, such as young carers not having much time for hobbies when considering their caring responsibilities.

Risk factors for mental health problems

The relationship between risk factors and mental health problems is complex, and the impact of exposure to risks will vary from child to child, however, all children exposed to potential causes of psychological harm will have an increased chance of developing mental health problems either in childhood or later in life^{xxxviii}.

Importantly, for some children the impact of events is so great they require professional care and treatment. However, despite the distress that children can experience from negative events it is important to consider not working to remove all emotional upset from a person's life, as these experiences, if not overwhelming, can build resilience and help individuals learn to manage other events^{xxxviii}.

Any child or young person can experience mental health problems, however, some factors pose increased risk, related to characteristics, background, social circumstances or life events^{xxxviii,xxxix}. These include:

Individual factors:

- Poor physical health status
- Ethnicity
- Learning difficulties
- Sexual identity, race, religion

Social factors:

- Exposure to abuse such as neglect, domestic abuse or sexual abuse
- Household factors of parental separation and parental mental health
- Poor education
- Deprivation, poverty and unemployment

Environmental factors:

- Injustice
- Discrimination
- Social and gender inequalities
- Exposure to war and natural disaster

Higher-risk groups are examined later, in more detail, in the section titled 'Children and Young People deemed more vulnerable to, or at higher-risk of, developing mental health problems: Risk factors'.

The NHS Digital surveyⁱⁱ and Mentally Healthy Schools^{xl}, overseen by the Anna Freud Centre, also report factors related to the social context, or 'lifestyle' factors. Internet and social media use, sleeping difficulties and body image alongside school-based factors, for example, exam stress, transitions or exclusions are thought to be associated with poorer mental health.

The Centre for Longitudinal Studies also published a report in 2016^{xli}, highlighting factors found to be statistically significant in influencing children’s mental wellbeing and mental illness by the age of 11, seen in figure 9 below.

Figure 4. Children’s mental illness and wellbeing at age 11

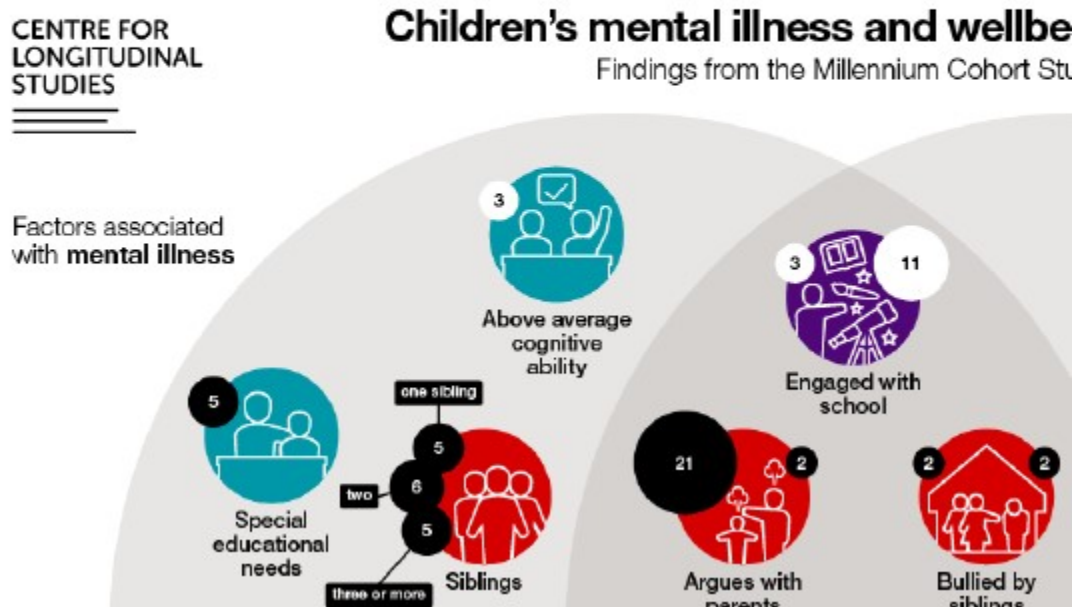


Figure 9: Children’s mental illness and wellbeing at age 11 – findings from the Millennium Cohort Study.
Source: Centre for Longitudinal Studies

It reported, for wellbeing, that wider environment and social relationships were the most salient and explained the most variance in wellbeing measures. They noted school connectedness, being bullied, friendships, and perceptions of safe neighbourhoods were strongly correlated with wellbeing.

In respect of mental illness, they reported strongest associations were seen in arguing with parents, peer problems, chronic illness, communication difficulties, special educational needs, and parental mental health.

Overview of inequalities, risk factors and ‘mutual reinforcement’

As discussed physical and mental health is influenced by complex interactions between many factors, such as individual behaviours, the places and communities in which people live, quality of health and care services and wider determinants such as education, housing and access to green space.

Inequalities arise as a result of avoidable, unjust and systematic variations in these factors across populations. The term can also refer to differences in the care people receive and the opportunities they have to lead healthy lives^{xiii}. Inequalities are both a cause and a consequence of poor mental health^{xiii}.

Individuals can be disadvantaged by a combination of factors, which can be ‘mutually reinforcing’. Within lower socio-economic groups, for example, there is higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives. Those living in deprived areas also have nine times less access to green space, with higher concentrations of fast food outlets, and less access to affordable healthy food^{xiv}.

This is discussed in more detail later in the report.

Approach to identifying, supporting and treating mental health

THRIVE model of need^{xlv}

Within Dorset, mental health services are working to align with the THRIVE Framework, to replace tier-based systems with a whole system approach, based on the identified needs of children and young people and their families^{viii}.

The THRIVE model was designed to shift the way services are conceptualised and potentially delivered, in a different approach to the tiered model, acknowledging that need and support extends beyond healthcare.

THRIVE is a conceptual framework with five needs-based groupings which young people may be in, shown in figure 10 below.



Needs based groupings:

- **Thriving:** prevention and promotion
- **Getting Advice and Signposting:** signposting, self-management and one-off contact
- **Getting Help:** goal focused, evidence-informed and outcomes focused intervention
- **Getting More Help:** extensive, evidence-informed, treatment
- **Getting Risk Support:** risk management and crisis response



Figure 10: THRIVE conceptual framework
Source: Wolpert, M. et al. (2019). THRIVE Framework for system change^{viii}

The authors define the rationale for these groupings as distinct in terms of:

- Needs and/or choices of the individuals within each group
- Skill mix of professionals required to meet these needs
- Resources required to meet the needs and/or choices of people in that group

It advocates for effective use of data to inform delivery and meet those needs, identifying groups of children and young people and the range of support they may benefit from. It is also strongly advised that children and young people and their families are active decision makers.

The five groups, in more detail, are:

- **Thriving** – using prevention and health promotion approaches. Those children and young people and families not currently needing individualised mental health advice or help; assumes not everyone requires or would benefit from mental health interventions, and offering specific mental health interventions undermining individuals' own strength and strategies may sometimes be culturally iatrogenic (undermining ability to manage own health). The need is to maintain or improve mental wellness, wellbeing and resilience through application of active prevention and health promotion strategies⁴.
- **Advice and support** – Within this grouping would be children, young people and families adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support or advice.
- **Getting help** – children, young people and families who would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved.
- **Getting more help** – These children and young people would benefit from extensive long-term treatment which may include inpatient care, but also extensive outpatient provision.
- **Risk Support** – This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children and young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference; who self-harm; or who have emerging personality disorders or on-going issues that have not yet responded to treatment

The THRIVE Elaborated report, by Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust, stated from the 2004 prevalence study there was the view that 10-20% of children and young people have problems with their mental health significant enough to indicate a more specialist help offer; therefore 80 to 90% of young people are anticipated to be within the Thriving grouping. No update to this approach has been noted within the survey of 2017 by NHS Digital. There is a question to be raised about the impact of the current pandemic of COVID-19 and whether those proportions are shifting or liable to shift as we continue through it.

⁴ The Thrive Elaborated document points to **Thriving** as “an area of mental health support that some consider has been neglected by mental health professionals and commissioners over the years, but one where the potential impact could be greatby understanding factors likely to lead to psychological harm, services can apply strategies to tackle these causes and prevent harm to individual children. This requires rigorous understanding of the environmental causes of potential harm to children and young people’s psychological health, and the active application of strategies to try to reduce or remove these as far as possible before they affect a child’s emotional wellbeing: **primary prevention**”

SUMMARY - Introduction and Background

Wellbeing and good mental health in children and young people is paramount to the wellbeing of individuals, families, schools and wider society.

Half of adults accessing mental health services had a diagnosable condition by the age of 14, and three-quarters between the ages of 18 and 24. Nationally, the prevalence of mental health conditions is rising, at one in eight children in 2017.

National and local policies have recognised the need to drive change, to better address and support children and young people in order to reduce the immediate and lifetime burden of illness.

The Health Needs Assessment has been designed to assist in building a local picture of need, current provision in addressing that need and the gaps this will highlight. This will enable future design of services, and allocation of resources, to be most appropriate, efficient and accessible in offering support to our children and young people.

Overview of the prevalence of mental health disorders

Diagnosable mental health problems affect one in four adults each year and one in six working adults have symptoms. Lifetime risks vary from one in four, to one in two, in different settings.

Although three out of four people with physical illness receive treatment, only one in four people with mental health problems do.

In the UK prevalence of mental disorder is at one in eight children (12.8%), and one in 18 preschool children, having at least one mental disorder. 1 in 20 children (5%) were determined as having two or more mental disorders.

The most common type of mental disorder in children and young people were emotional disorders, which include anxiety and depression, followed by conduct disorders.

Impact

Living in poor mental health is common, disabling and costly at personal, economical and societal levels.

Mental, emotional or psychological problems, many of which fall short of diagnosable mental illness, together account for more disability than all physical health problems combined. At least half of mental disorders last for longer than a year, with some persisting for years or over a lifecourse, especially if untreated or inadequately treated. Later diagnosis and treatment often leads to more severe impacts upon individuals and their families.

The impacts of mental disorder are wide-ranging, with extensive reach; upon health and social development and participation, but also current and future life circumstances. Effects upon self-esteem and self-belief, educational engagement and attainment affect future employment and life chances significantly.

These disabling effects are even more profound when considering children and young people affected are at their most physically healthy and productive.

Conversely, emotional and mental wellbeing affords children better physical health, with less health-damaging behaviours and longer lives lived without ill-health. They are less likely to experience social inequalities, while experiencing increased educational achievement, increased economic opportunity and reduced mortality.

Impact of COVID-19 pandemic

Research has shown increases in the prevalence of anxiety and depression among young people during the pandemic, with some harmful effects on psychological wellbeing and related factors such as worry, happiness, stress, and life satisfaction.

There have been increases in anxiety and depression in those with pre-existing mental and physical health conditions, and significant restructuring of support mechanisms.

There has been an amplification of many of the existing risk factors for poor mental health in children and young people experiencing socio-economic disadvantage or increased vulnerability. Children and young people who require social care input such as those homeless, in care, living in poverty or who are young carers are experiencing increased difficulties in accessing support and financial assistance. It is also reported that children and young people from minority ethnic backgrounds are being disproportionately affected with an increased likelihood of being children of key workers, and key workers themselves, and more likely to work in shut-down sectors. This therefore leads to greater exposure to the virus, while being more likely to suffer loss of household income. Similarly those who are LGBT+ are reported to be disproportionately affected, with the loss of safe spaces and difficulty in accessing care and support. Sexual abuse reports to the NSPCC have increased three-fold, reported as events either increasing in frequency or beginning during the pandemic.

Need and the treatment gap

Unmet need in healthcare can be thought of as a need that is present but which does not, or cannot, access support. Additionally, it cannot be assumed needs are met simply through contact with services, as there are wider determinants and inequalities affecting the experience of care received and the outcomes.

In 2015 25%–35% of children and young people with a diagnosable mental health condition accessed support. Updates have shown 30.5% of children and young people with a mental health condition accessed treatment and support in 2017/18.

Consequently, given that treatment gaps exist and there are known limitations of support and treatment, consideration of efforts beyond healthcare delivery are required to support those with poor mental health and develop and maintain positive mental health and wellbeing.

Promoting protective factors for mental health and reducing risk factors is therefore vital.

Protective and Risk factors

There are complex, multi-factorial and wide-ranging protective and risk factors influence children and young people's mental health, operating at individual, family, community and structural levels.

Protective factors

While the absence of mental ill-health enables good outcomes, achievement of positive emotional and mental wellbeing affords children and young people better physical health, with less health-damaging behaviours, longer lives lived without ill-health, increased life expectancy and reduced risk of other diseases and mortality. They are less likely to experience social inequalities and have increased educational achievement and economic opportunity. These positive effects can also be seen in those who have existing mental health conditions, when improvements are achieved.

Protective factors documented at individual, family and community levels include positive early attachment, good physical health, communication skills, family mental wellbeing, engagement with education, good housing and good opportunities to be active.

There are known protective factors which decrease vulnerability and aid the promotion, and maintenance, of emotional and mental wellbeing in children and young people, within a number of spheres:

- **Individual** factors include positive early attachment, a healthy lifestyle, good physical health, physical activity, communication skills, self-esteem, experiences of achievement and the ability to recognise and regulate own emotions.
- **Family** factors include good family mental wellbeing, affection and styles of parenting which are loving, trusting and supportive.
- **Learning environment** factors such as engagement with education, opportunity to participate, positive relationships with teachers and peers and positive whole-school approaches.
- **Community** factors include participation in the wider community, a supportive network, feeling socially included and valued, good housing, feeling safe from violence and with opportunities to be active.

Resilience is considered key in developing, maintaining and promoting wellbeing and mental health. Multiple definitions of resilience exist, including an individual's 'capacity to bounce back from adversity' or 'the capacity of a dynamic system to adapt successfully to disturbances that threaten the viability, the function, or the development of that system' or something that implies the on-going dynamism of the state 'a process to harness resources to sustain well-being'.

Negative impacts of risk factors upon a child may be moderated when a child has a greater level of resilience, sometimes through several protective factors, such as the presence of a supportive adult.

Mental wellbeing of young people is greatly affected by, and specific to, their background, place and demographics; including sexuality, gender, ethnicity and poverty.

Wider influences included:

- | | | |
|--|----------------------------------|---|
| • Stability (home, employment, school) | • Hobbies (art, gaming, reading) | • Self-care and self-regulation (impacting on decisions e.g. removing oneself from unsafe places or building personal resilience) |
| • Sleep | • Physical Activity | |
| • Money | • Music | |
| • Food | • Pets | |
| • Volunteering | • TV/film | |
| • Hugs | • Shopping | |

There is differential exposure to both risk and protective influencing factors for different individuals, such as young carers not having much time for hobbies when considering their caring responsibilities.

Risk factors

Although all children and young people can experience mental ill-health some factors pose increased risk, related to characteristics, background, social circumstances or life events, for example, their gender or ethnicity, those living in poverty, of a different sexual identity or children in need.

The complex interplay between these factors has also been outlined, with the recognition of 'mutual reinforcement' (where multiple risk factors have a compounding effect).

Approach to identifying, supporting and treating mental health

Lastly, there is detail provided on the THRIVE framework used locally, formed of five needs-based groupings operating at a whole-systems level. The rationale for these groupings is that they are distinct in terms of the needs and choices of individuals within each group, the skill mix of professionals and resources required to meet these needs. The approach strongly advocates for supporting the needs of children across all groupings, including those who are considered 'Thriving' and advises children, young people and their families are active decision makers.

General demographic information – Dorset Population

The following section contains general demographic information, such as population structure but also information on characteristics of ethnicity, deprivation and poverty, amongst others, reported particularly in relation to known risk factors for mental health.

Information from a number of national and local datasets, such as PHE Public Health Profiles, ONS Census and surveys and the Department of Education's Local Authority Interactive Tool (LAIT) have been used to create a profile of need for the area looking at indicators aligned to vulnerability and risk and protective factors for mental health. Further information on these data sources is contained in appendix 2.

Dorset

Dorset is a county in South West England, covering an area of 1,024 square miles (2,652km²) and is bordered by Devon to the west, Somerset to the south west, Wiltshire to the north-east and Hampshire to the east. The county town is Dorchester which is in the south-west of Dorset. The largest urban areas are Poole, Bournemouth, Christchurch and Weymouth & Portland. Around half the population lives in the south east area, while the rest of the county is largely rural with a low population density, often within sparsely distributed rural communities and areas and with poor or variable public transport links.

On the 1 April 2019, Dorset's local authorities merged to form two unitary authorities:

- **Bournemouth, Christchurch and Poole (BCP)**, consisting of the old unitary authorities of Bournemouth and Poole as well as the non-metropolitan district of Christchurch
- **Dorset Council**, which merged the five remaining non-metropolitan districts of East Dorset, North Dorset, Purbeck, West Dorset, and Weymouth and Portland, as well as the former county council to become a Unitary Authority (UA).

Further details about the county of Dorset, the geographical area, population density and changes to the local authorities that took place in April 2019 can be found in appendix 3. As a result of this change most datasets available capture data that is prior to, and/or post, the April 2019 re-organisation. Wherever possible the post-reorganisation data has been quoted.

Total Population

Based on Office for National Statistics (ONS)^{xlvi} mid-2019 Population Estimates the population of Dorset was 773,839, split between BCP Council (395,331- 51%) and Dorset Council (378,508 - 49%).

Whilst the population is evenly split between the two unitary authorities, shown in figure 11, geographically BCP UA covers 6% of Dorset's land area (16,132ha*) compared to 94% within the Dorset Council area (249,123ha*).

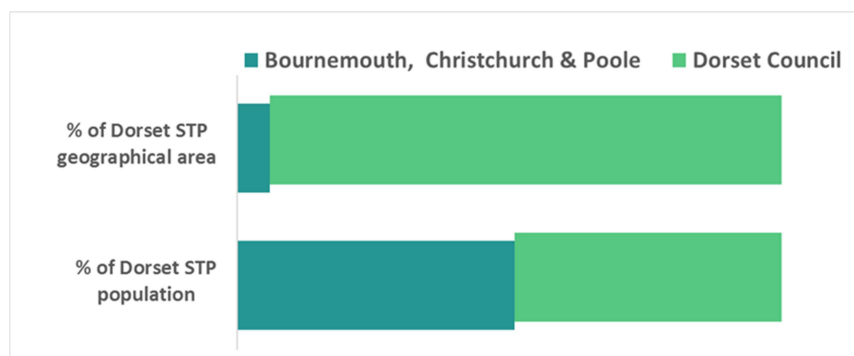


Figure 11: Ratio of % population to % land area for the two unitary authorities in Dorset
Source: ONS - NOMIS.

This creates different challenges in the logistics of service delivery, from the lower population density and wider geography of the more rural areas, to the higher population density and challenges associated with the urban areas.

Age

The numbers of children and young people in Dorset, by age-groups, are shown in Table 1 below, by UA, Pan-Dorset and that of England.

Table 1: Population of Dorset UA, BCP and Pan-Dorset, by gender and age structure, compared with England population.

	BCP Council	Dorset Council	Pan-Dorset	England
All ages				
	Number (% of BCP population)	Number (% of Dorset population)	Number (% of Pan-Dorset population)	
All Persons	395,331 (51%)	378,508 (49%)	773,839	56,286,961
All Males	196,612 (50%)	185,388 (49%)	382,000 (49%)	27,827,831 (49%)
All Females	198,719 (50%)	193,120 (51%)	391,839 (51%)	28,459,130 (51%)
Children and Young People				
Smaller age bandings				
	Number (% of BCP population)	Number (% of Dorset population)	Number (% of Pan-Dorset population)	
0-4 yrs	20,275 (5%)	15,875 (4%)	36,150 (5%)	3,299,637 (6%)
5-10 yrs	27,030 (7%)	23,367 (6%)	50,397 (7%)	4,227,939 (8%)
11-16 yrs	24,616 (6%)	24,639 (7%)	49,255 (6%)	3,896,599 (7%)
17-18 yrs	7,823 (2%)	7,867 (2%)	15,690 (2%)	1,218, 266 (2%)
19-25 yrs	36,566 (9%)	21,037 (6%)	57,603 (7%)	4,868,399 (9%)
Larger bandings				
0-18 yrs (including the year of being 18)	79,744 (20%)	71,748 (19%)	151,492 (20%)	12,642,441 (22%)
0-25 yrs (including the year of being 25)	116,310 (29%)	92,785 (25%)	209,095 (27%)	17,510,840 (31%)

Source: 2019 Mid-Year Estimates (with 2020 LA Codes), Office for National Statistics

The age profiles (ONS mid-2019 population pyramids) for England, BCP and Dorset UA are shown below in figure 12.

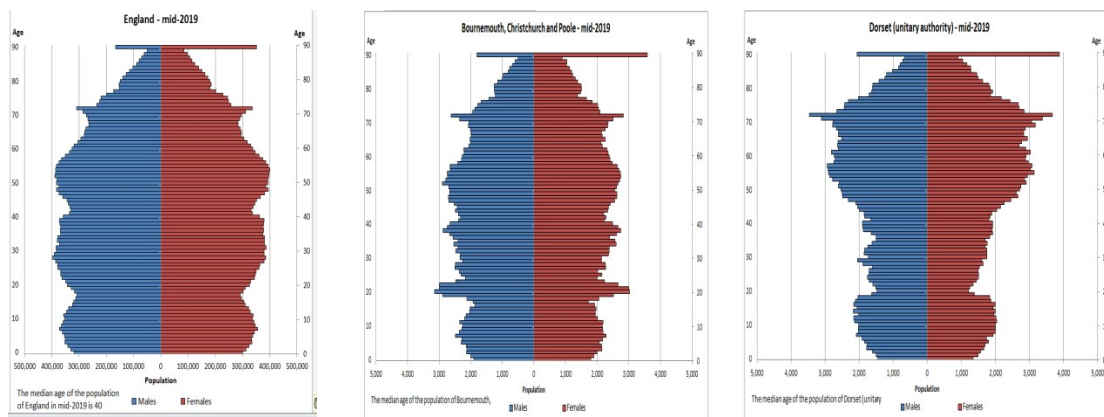


Figure 12: mid-2019 Predicted Population pyramids for England, BCP and Dorset Unitary Authorities.
Source: ONS: The Analysis of Population Estimates Tool 2019

The BCP population age profile is similar to that of England, except for an increased proportion of 19-25 year olds, expected with a significant student presence around the university and language colleges in this area. Compared to the England profile, Dorset has a lower proportion of 0-25 year olds and 25-40 year olds, with a greater proportion of people over 60 years.

Figure 13 below shows the population of children and young people (0-18, 19-25 and 0-15 years) as a percentage of the total area population.

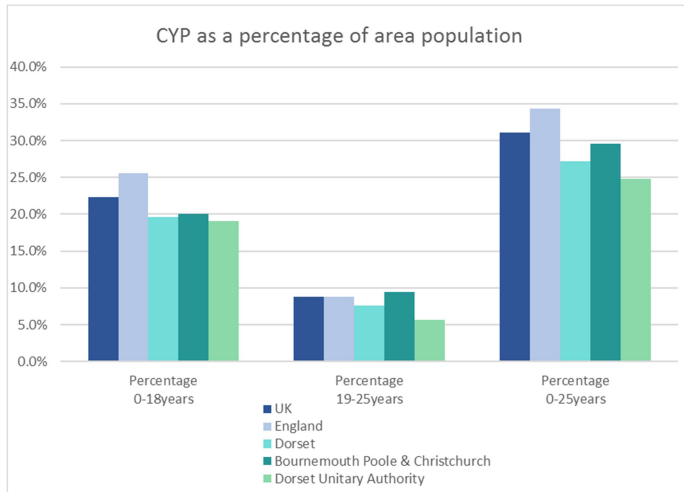


Figure 13: Children and Young People as a percentage of the area population
Source: Dorset CCG

Dorset, BCP and Dorset UA had a lower proportion of 0-18 years in comparison to the UK and England. Dorset UA had a lower proportion of 19-25 year olds compared to the UK and England (6% vs. 9%) and also compared to BCP (9%).

The percentage 0-25 years population for Dorset, BCP and Dorset UA were all below the UK and England, although BCP had a higher proportion (29%) than Dorset UA (25%).

It can be seen in figure 14 in BCP there was a greater proportion of the population of children and young people who were aged between 19-25 at around 32%, again as expected given the higher education institutions in BCP. Dorset UA showed the proportion at around 23%.

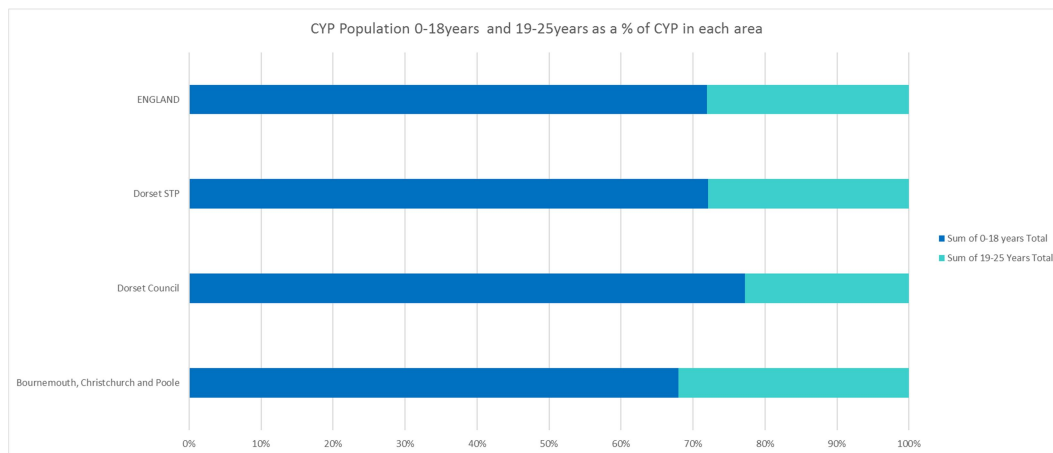


Figure 14: Children and Young People 0-18 and 19-25 years – mid-2018 proportion of the CYP population.
Source: Dorset CCG

Predicted Population Change

The charts below in figure 15 show the predicted population change for 0-18, 19-25 and 0-25 years cohorts in Dorset, BCP and Dorset UA between the years of 2018 and 2025.

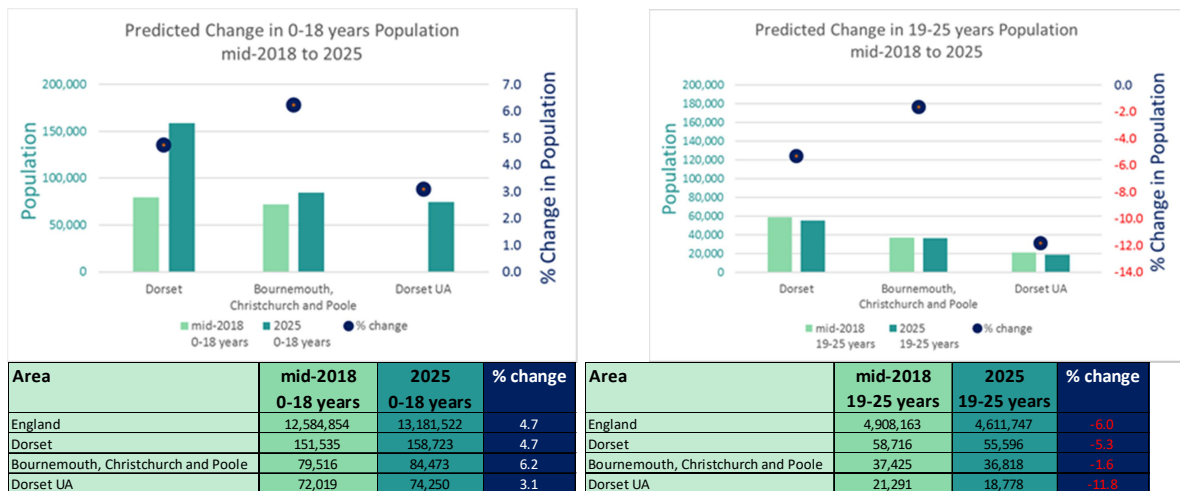


Figure 15: Predicted population change mid-2018 to 2025, 0-18 and 19-25 years for Dorset, BCP and Dorset UAs
Source: Dorset CCG

The 0-18 years population is predicted to grow by approximately 5%, or 7,200, between 2018 and 2025 across Dorset in line with England. It is expected to increase in both Unitary Authority areas, although the growth rate in BCP (6.2%) is twice that of the growth in Dorset UA (3.1%), with around 5,000 additional population of children and young people in BCP and 2,200 in Dorset UA.

The 19-25 years population is predicted to fall by 2025 within England (-6.0%) and across Dorset (-5.3%), but a greater decrease is expected within Dorset UA (-11.8%) and a much smaller decrease than nationally or locally will be seen in BCP (-1.6%).

Overall, the 0-25 years cohort of population shows a predicted increase from mid-2018 to 2025 across Dorset of 1.9%, shown in figure 16 below. This is comprised of a drop of -0.3% in Dorset Unitary Authority, and an increase of 3.7% in BCP. This increase, from the 2018 estimate of 210,251 0-25 year olds, will equate to an increase in population between 0-25 years across Dorset of approximately 4,100.

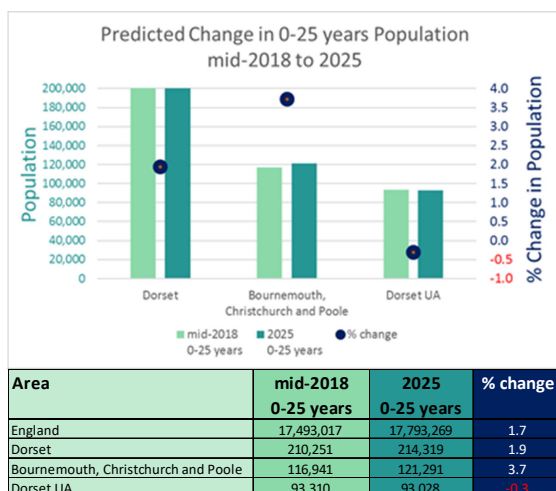


Figure 16: Predicted population change mid-2018 to 2025, 0-25 years – Dorset, BCP and Dorset UAs
Source: Dorset CCG

THRIVE model – Population apportionments

Figure 17 below is a representation of the numbers of children and young people between 0-18 years old within our local population who may require the support offered within each THRIVE grouping. The following diagram and table provide a crude measure of what potential demand may look like within each of the THRIVE clusters, using data from the ONS mid-2019 estimated population, mapped to THRIVE apportionments for the groupings.

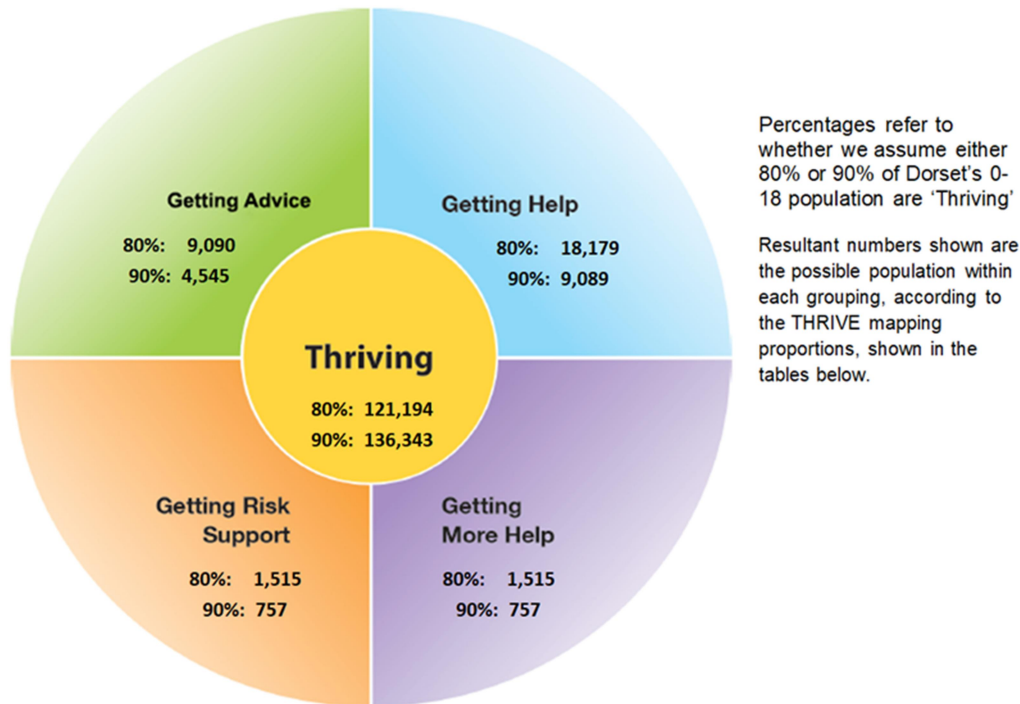


Figure 17: Possible proportions of Dorset population within each THRIVE groupings, 0-18 years of age
Source: DHC in-house modelling

Data has been interpreted to provide an illustration of the number of children and young people that may sit within each of the THRIVE groupings of need, based on population data. While the majority of the population should be within the 'Thriving' Grouping, which still requires input to promote and maintain mental health and wellbeing, the other groupings estimate there may be between 15-30,000 of those aged 0-18 requiring some form of more formal support within the other groupings, and 6-12,000 of those aged 19-25.

Further detail of apportioning is contained in the tables below, the first displaying the apportionings for those aged 0-18 and, the second, for those aged 19-25:

Table 2: 0-18 years, population possibly 'Thriving' and within each other THRIVE grouping, based on THRIVE apportioning applied to ONS mid-2019 populations.

Current Pan-Dorset, BCP and Dorset populations, 0-18 years, mapping to Thrive model groupings

0-18 years							
THRIVE Group	Predicted % in THRIVE Groups, of those 'Not Thriving' (10-20%)*	Pan-Dorset, if 90% Thriving	Pan-Dorset, if 80% Thriving	BCP, if 90% Thriving	BCP if 80% Thriving	Dorset Council, if 90% Thriving	Dorset Council, if 80% Thriving
Total 0-18 Population		151,492	151,492	71,748	71,748	75,568	75,568
Thriving		136,343	121,194	64,753	57,398	68,011	60,454
Total Not Thriving		15,149	30,298	7,175	14,350	7,557	15,114
Getting advice	30	4,545	9,090	2,152	4,305	2,267	4,534
Getting help	60	9,089	18,179	4,305	8,610	4,534	9,068
Getting more help	5	757	1,515	359	718	378	756
Risk Support	5	757	1,515	359	718	378	756

As documented in the author's words, these groupings are hypothetical, based upon algorithms developed, but require understanding gained in the 'real-world' to understand the accuracy and local relevance of these.

Table 3: 19-25 years, population possibly 'Thriving' and within each other THRIVE grouping, based on THRIVE apportioning applied to ONS mid-2019 populations.

Current Pan-Dorset, BCP and Dorset populations, 19-25 years, mapping to Thrive model groupings

19-25 years							
THRIVE Group	Predicted % in THRIVE Groups, of those 'Not Thriving' (10-20%)*	Pan-Dorset, if 90% Thriving	Pan-Dorset, if 80% Thriving	BCP, if 90% Thriving	BCP if 80% Thriving	Dorset Council, if 90% Thriving	Dorset Council, if 80% Thriving
Total 19-25 Population		57,603	57,603	36,566	36,566	21,037	21,037
Thriving		51,843	46,082	32,909	29,253	18,933	16,830
Total Not Thriving		5,760	11,521	3,657	7,313	2,104	4,207
Getting advice	30	1,728	3,456	1,097	2,193	632	1,263
Getting help	60	3,456	6,913	2,194	4,388	1,262	2,524
Getting more help	5	288	576	183	366	105	210
Risk Support	5	288	576	183	366	105	210

Finance Analysis:

Original work performed by Dorset CCG referred to resource allocation apportioning that may be required to support the mental health needs of children and young people across Dorset. Further detail on this can be found in appendix 4. The detail also contains hypothetical apportioning for supporting those within the 'thriving' cohort, and in what manner, which may be useful in building new approaches to support and intervention.

Ethnicity

The diversity of our population is vital in understanding mental health need, as it is recognised people of different ethnic backgrounds can be at greater risk of developing mental health conditions and experience higher prevalence and severity compared with individuals of other ethnicities. There are differences observed in the prevalence of mental health conditions across both adults and children and young people^{lixcliv,cxv}.

The impact of different ethnic backgrounds upon health outcomes has been understood for some time and highlighted once again, during the current COVID-19 pandemic. In addition to genetic or cultural reasons for differences, there are also inequalities related to ethnicity in living circumstances, life chances and access to, and receipt, of services and support.

Ethnicity is often associated with other factors affecting mental health, such as living circumstances and income. It is understood people from minority ethnic backgrounds are more likely to live in poverty. The ONS recently published 'Child poverty and education outcomes by ethnicity', showing children in Bangladeshi and Pakistani households were the most likely to be living in low income and material deprivation, while those in Indian households were the least likely. Children in Asian households were 2.5 times as likely, compared with the national average, to be in persistent low income during the period from 2013 to 2017^{xlvii}.

Ethnicity within this report is written with regard to government guidelines around terminology^{xlviii}.

Ethnicity - All-age

National data on self-reported ethnicity, taken from the 2011 UK census data, reported of the 53 million people living in England, 85.4% identified as White, including White British, Irish, Gypsy and Traveller and other White ethnicities.

The next most common ethnic group was Asian or Asian British, which included Indian, Pakistani, Bangladeshi, Chinese and other Asian ethnicities, which made up 7.8% of the English population. This was followed by Black, African Caribbean or Black British which made up 3.5% of the population, and Mixed or multiple ethnic groups which made up 2.3%. Lastly, other ethnic groups, including Arab and other ethnic groups, made up 1% of the population.

Bournemouth, Poole and Dorset populations showed differing proportions of ethnicities to England, shown in table 4. 92% of people in Bournemouth identified as White compared to the England average of 85%; Poole had a higher percentage of people identifying as White at 96%, and Dorset at 98%. As such, there were lower numbers of individuals from all ethnic backgrounds pan-Dorset, with marginally larger groups of people identifying as Asian/Asian British in Bournemouth (4%) and in Poole (2%), and as Black/African/Caribbean/Black British in Bournemouth (2%). All other ethnicities made up small minorities pan-Dorset at around 1% or less.

Table 4: Breakdown of ethnicity all-age population across Dorset, based on 2011 UK census data

	Bournemouth	Poole	Dorset
Ethnic Group – 2011	%	%	%
White	92.0	95.9	97.9
Asian/Asian British	3.9	2.2	0.9
Black/African/Caribbean/Black British	1.0	0.4	0.2
Mixed/multiple ethnic groups	2.3	1.3	0.8
Other ethnic group	0.9	0.3	0.1

Ethnicity of Children and Young People

Governmental analysis of local data in children and young people between 0-17 years of age was conducted using 2011 Census data, and showed slightly greater diversity of ethnicity, than seen across all ages. This data is shown in table 5.

Locally, the highest proportion of individuals identified as White; Bournemouth with the lowest proportion at 88.1%, increasing in Poole and Dorset at 93.4% and 96.2%, respectively. The next largest proportion represented was Mixed/multiple ethnic groups (2-6% pan-Dorset), followed by Asian/Asian British (1-4% pan-Dorset), and levels at 1% or lower of Black/African/Caribbean/Black British and Other ethnic groups; these patterns showed higher proportions of people of each ethnicity in Bournemouth and the pattern remained similar, but at a lower level, in Poole and Dorset.

Overall, 11.9% were of an minority ethnic identity in Bournemouth, 6.5% in Poole and 3.8% in Dorset.

Table 5: Breakdown of ethnicity in children and young people, 0-17 population, based on 2011 UK census data

Percentage of persons aged 0-17 years by ethnicity from the 2011 Census						
Local Authority (pre-2019)	Asian/ Asian British	Black/African/ Caribbean/ Black British	Mixed/ multiple ethnic group	Other ethnic group	White	Total non-White population
Bournemouth	4.2	0.9	5.8	1.0	88.1	11.9
Poole	2.6	0.4	3.3	0.2	93.4	6.5
Dorset CC	1.3	0.2	2.2	0.1	96.2	3.8
England	10.0	5.0	5.2	1.3	78.5	21.5

Source: ChiMat. Ethnic populations (2011 Census)^{xlix}

Ethnicity – School age

In 2019, BCP had the largest proportion of school children from minority ethnic groups of the three local authority areas at 20.4% equating to around 10,000 children when looking at the school population, excluding 16⁺. This is lower than the proportion in England (33%) but much higher than the South West Region (15.2%). Dorset UA had 7.9% of school children from minority ethnic groups, equating to around 3,700 children.

Index of Multiple Deprivation (IMD) and living in Poverty

There are well-established links between living in areas of deprivation and experiencing poorer outcomes across different aspects of life, educational attainment, employment, social interaction, levels of activity, physical and mental health.

Measures of deprivation are not the same as measures of income; they relate to how people live. Deprivation is the consequence of a lack of income and other resources, which cumulatively can be seen as living in poverty.

The Index of Multiple Deprivation (IMD)¹ is a measure of different themes related to deprivation for small geographical areas across England, using Lower Super Output Areas (LSOAs), with average population sizes of approximately 1,500 residents or 650 households.

These LSOAs are ranked from 1 (most deprived) to 32,844 (least deprived), and these can be viewed as divided into deprivation tenths (deciles) or into deprivation fifths (quintiles).

Broadly, the indicators provide relative measures based upon seven domains, or facets, of deprivation:

- Income
- Employment
- Health and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment.

It is the level of deprivation of the LSOA as a whole which is reported and this cannot be interpreted as the level of deprivation that an individual within that LSOA will be experiencing; some who live in a deprived area will be deprived, and some will not, and some people who are themselves deprived will live in areas determined as less deprived.

To illustrate IMD data, maps of deprivation for BCP and Dorset UA are shown, in figure 18, below. They show 8% of LSOAs in Dorset UA and 19% in BCP are in the most deprived deciles (1-3). 33% of LSOAs in both BCP and Dorset UA are in the least deprived three deciles (8-10).

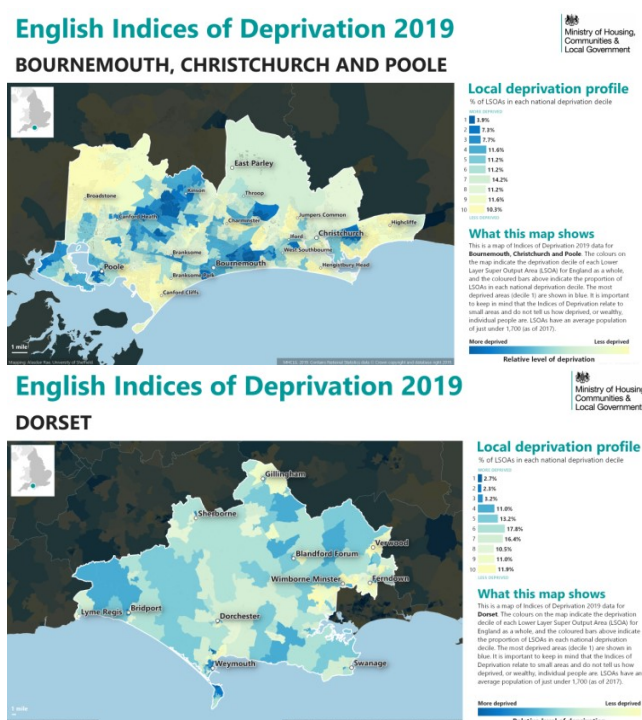


Figure 18: Maps of deprivation for BCP and Dorset UA
Source: Ministry of Housing, Communities and Local Government

Deprivation and Poverty

The links between experience of deprivation and mental health in young people are accepted and well documented. There are recognised links between growing up in poverty and resulting impacts on behaviour, educational attainment, poorer physical and mental health outcomes. The original Marmot Review in 2010, and continued in their follow-on report in 2020ⁱⁱ, highlight evidence of childhood poverty leading to premature mortality, poor physical and mental health outcomes and reduced 'life-chances' as adults.

There is a plethora of evidence to show children living in poverty are exposed to a range of risks which can seriously impact upon their mental health, including debt, poor housing, and low income. Research shows living with low income can cause mental health problems for parents and children alike, and is associated with multiple mental health disorders in children and with the persistence of mental health problems of parentsⁱⁱ.

Underlying reasons for the links between poverty and mental health issues are complex, but factors such as parental stress and school bullying have been shown to contributeⁱⁱⁱ. Income has been shown to adversely impact upon the psychological functioning of mothers, with a strong association between the lack of control perceived by mothers from low income backgrounds and the social and wellbeing of children, which include levels of self-esteem and behavioural issuesⁱⁱⁱⁱ.

Children and young people living in poverty are thought to be three times more likely to have mental health issues compared to their more affluent peers^{iv,iv}. The Kings Fund reported children living in households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those whose household is in the highest fifth, and nine times as likely to have psychotic disorders^{xiii}. This social difference is believed to be steepest for behavioural disorders, such as ADHD, and self-harming behaviour^{iv}.

Children living in poverty are also more likely to have special educational needs, to have a learning disability, be absent or excluded from school, be involved with the criminal justice system and, through generally lower attainment, are more likely to continue to live in lower-income and be exposed to health and social inequalities.

An original analysis performed by The Children's Society in 2016^{vi} found children living in poverty are more likely to feel like a failure, useless and hopeless about their future than their more affluent peers. Yet organisations often don't recognise children in poverty as a vulnerable group; only one in ten mental health trusts saw children in poverty as a priority group for access to mental health services.

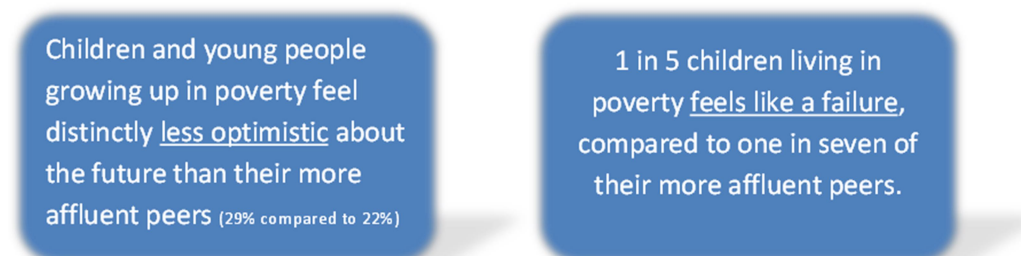


Figure 19: Findings from 'The links between child poverty and mental health problems' report
Source: The Children's Society

Reducing the numbers of children who experience poverty can improve these adult health outcomes and increase healthy life expectancy, as well as enabling future opportunity as they move into adulthood. For more immediate support, it is important that where children and young people are identified as maybe living in poverty, offers of support are made known as early as possible and that offers feel relevant and accessible.

Measures routinely used to demonstrate the level of deprivation within an area and poverty affecting children and young people are shown below:

- Index of Multiple Deprivation (IMD)
- Income Deprivation Affecting Children Index (IDACI)
- Percentage of children under 16 living in low-income families
- Pupils eligible for free school meals

Income Deprivation Affecting Children Index (IDACI) score for local areas

The IDACI score is derived from a combination of subsets from the Income Deprivation domain and indicates the proportion of children, aged 0 to 15, living in income deprived families^{lvii}.

The IDACI score in 2019 for BCP was 0.147, which equated to approximately 15% of children aged 0 to 15 living in income deprived families, and approximately 12% in Dorset UA (IDACI: 0.121), seen in figure 20.

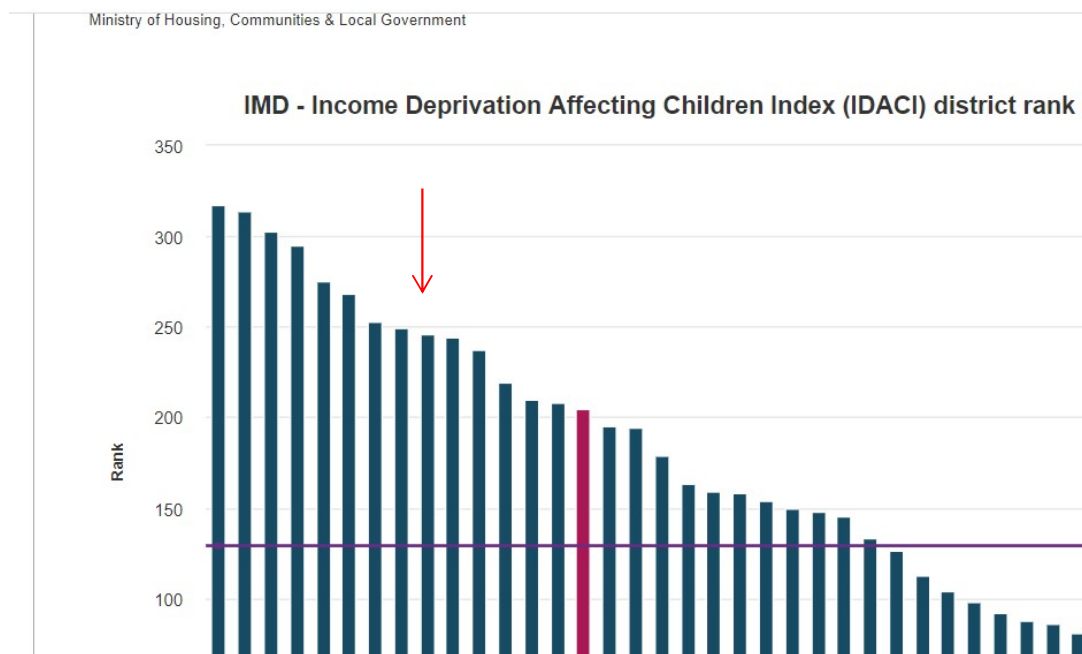


Figure 20: IDACI ranking for English Unitary Authorities, 2019
Source: Ministry of Housing, Communities & Local Government^{lviii}

Ranking of UAs was out of a maximum 317; a rank of 1 being the most deprived (higher ranking is less deprived). BCP was ranked 159th, whilst Dorset UA ranked 205th.

Cross-referencing IMD and IDACI measures – local level:

The following was created by Dorset CCG to show whether any relationship can be seen between the Decile for Index of Multiple Deprivation (IMD) and the Decile for Income Deprivation Affecting Children Index (IDACI) across Dorset.

Areas are split into deprivation tenths, or deciles. Tables 6 and 7 below show the number of LSOAs within Wards ranked in the lowest three deciles for both indicators of deprivation, indicating the most deprived areas across both measures.

Within BCP, there were 38 LSOAs ranked in the lowest three deciles for both indicators; 22 of which were in Bournemouth, 14 in Poole and two in Christchurch. Within Dorset UA, there were 16 LSOAs ranked in the lowest three deciles for both indicators; 13 of which were in Weymouth and Portland.

Tables 6 and 7: Number of LSOAs within each UA ward in the lowest 3 deciles for both IMD and IDACI measures of deprivation (i.e. most deprived).

Ward Name	Number of LSOAs	Ward Name	Number of LSOAs
Kinson South	6	Melcombe Regis	4
East Cliff and Springbourne	5	Littlemoor	2
Alderney	4	Underhill	2
Boscombe West	3	Westham North	2
Kinson North	3	Ferndown Central	1
Poole Town	2	Tophill West	1
Newtown	2	Tophill East	1
Grange	2	Weymouth East	1
Strouden Park	2	Bridport South	1
Hamworthy West	2	Sherborne East	1
Branksome East	1		
West Southbourne	1		
Boscombe East	1		
Hamworthy East	1		
Westbourne and West Cliff	1		
Oakdale	1		
Canford Heath West	1		
Number of LSOAs	38	Number of LSOAs	16

Bournemouth, Christchurch and Poole

Dorset Council

Data from the NHS Digital Prevalence survey in 2017 allowed the opportunity to explore recent data on a possible relationship between prevalence of mental disorder and deprivation in those aged 5-19 years, using the IMD measure of area deprivation, not the IDACI measure. From the survey data at a national level, across both genders, there was not an obvious relationship, seen in figure 21. This was the same when split by boys and girls (not shown).

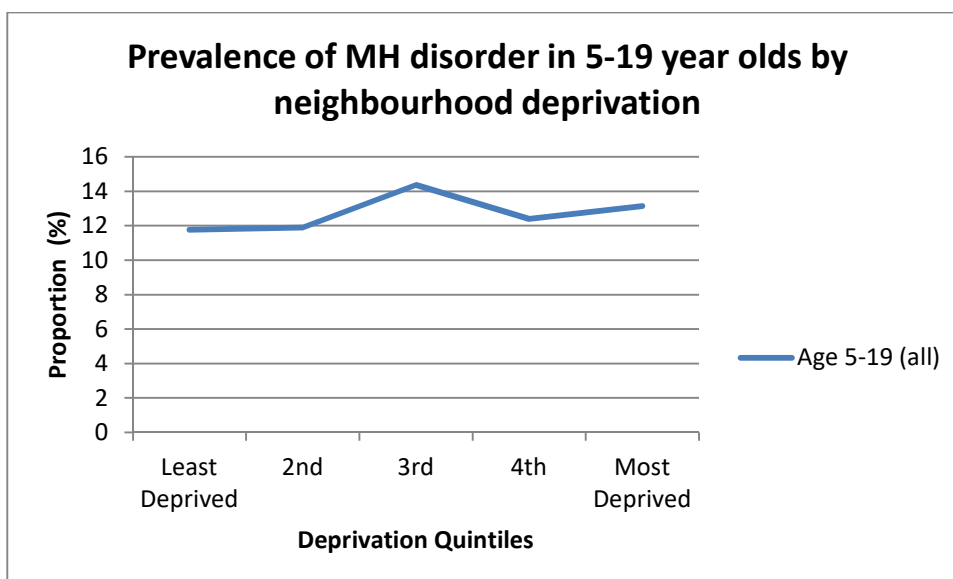


Figure 21: Mental disorder prevalence, 5- 19 year olds by neighbourhood deprivation
 Source: DHC in-house modelling, using 'Mental disorders in 2 to 19 year olds by neighbourhood deprivation, age and sex table' from 2017 NHS Digital survey^{ix}

There was an association, however, reported by authors between prevalence and income, detailed below in section 'Findings from the NHS Digital Prevalence Survey of Mental Health in Children and Young People in England, 2017'. This is in concordance with other research findings of connections between poverty and risk of mental disorder in children and young people.

Free School Meals and Indications of low-income (poverty)

Eligibility for Free School Meals (FSMs) has been determined as a reliable measure of socio-economic disadvantage in school pupils, and has been used consistently by many organisations and institutions for many years^{ix}.

It was shown earlier in the report that there was lower uptake of FSM across Dorset than in England, but within area, Dorset County Council (CC) pupils presented higher uptake than Bournemouth and Poole across both primary and secondary age pupils.

However, it is worth considering that 71% of children living in low income households are within working families, often not eligible for FSMs. FSM figures reflect uptake only and there may be a significant proportion, one study reported 11%^{ix}, of those eligible who do not take up the offer. This may be due to reasons such as being unaware of eligibility or how to apply, for cultural reasons of not wishing to take up welfare offers or risk of stigmatising those children who do.

It has been suggested the use of the 'Percentage of children under 16 living in low-income families' indicator may be a more suitable measure of the number of children living in poverty.

Percentage of children under 16 living in low-income families

The indicator 'Percentage of children in low-income families (under 16)' relates to the percentage of children in low income families⁵. Relative low income measures families in low income where their reported income is less than 60% median income in the reference year, whereas Absolute low income measures families in low income based on what low income looked like in 2010/11.

The calculation of relative low income is illustrated below in figure 22.

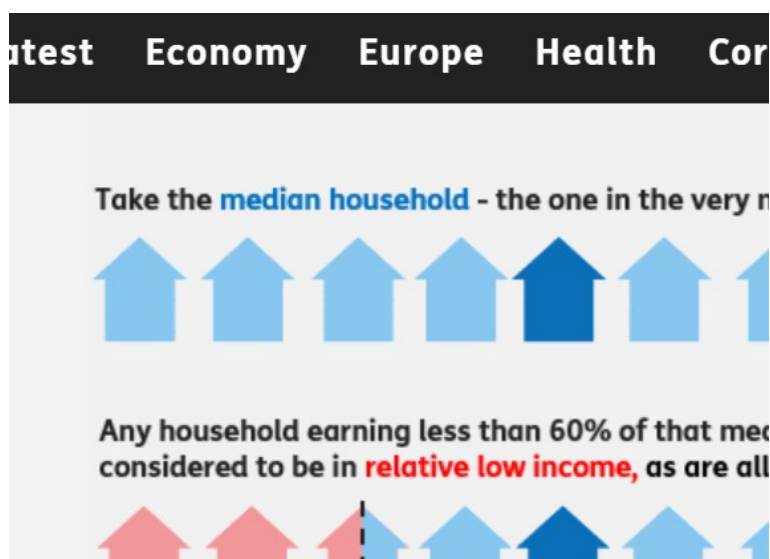


Figure 22: Calculation of relative low income
Source: Full Fact (2019)^{xi}.

⁵ Low income families: those who have claimed one or more of Universal Credit, Tax Credits or Housing Benefit) at any point in the year

Information derived from the Local Authority Information Tool (LAIT) can be seen in figure 23 below, of children under 16 living in relative and absolute low income households. It has incomplete data, but overall a downwards trend was seen in the percentage of 0-16 year olds living in low income families in Dorset, Bournemouth and Poole between 2014 and 2015, with a slight rise in 2016 for Poole and Dorset authorities, followed by a downward movement again until 2018 for Bournemouth and Poole; data between 2016-18 was not available for Dorset CC.

In 2019, BCP and Dorset had similar positions. Around 12% of children under 16 were living in lower-income families, equating to approximately 8,200 in BCP and 7,200 in Dorset UA. The percentages were lower than figures for England, at 17-18% during 2017-19.

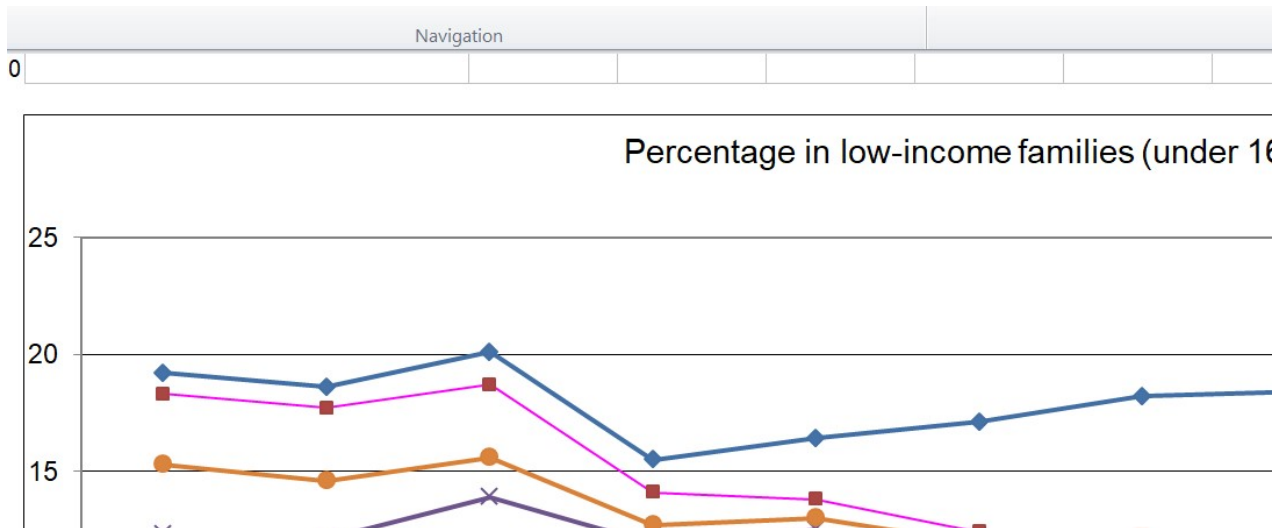


Figure 23: Percentage of under-16s living in relative and absolute low income households
Source: LAIT

There are other indicators reported nationally, by the Children’s Society^{lxii}, which differ from the poverty data from the LAIT above. They indicate that during 2017-18 around 23% of children in Dorset CC were living in poverty, and 23-28% of children across previous Bournemouth and Poole authorities. This is in comparison to 30% nationally. Source methodology does not make clear what ages these measures have covered and therefore it is not possible to model numbers within the population.

Housing

Many children growing up in poverty are living in poorer quality and insecure housing, and forced to move frequently, often leaving behind schools, friends and a sense of belonging in their area each time they move^{lxii}.

Quality of housing has been shown to impact on a number of outcomes for children and young people, and particularly upon their physical and mental health. Children living in poorer-quality housing have been shown to have higher levels of stress hormones and behavioural problems^{xx}.

Impacts on mental and physical health can result from the number of people living in the accommodation, the ability to adequately heat it, and the type of accommodation itself, while some research shows conditions such as dampness and overcrowding, can affect children on both a physiological and psychological basis^{lxiii}. It is also believed housing quality may be a proxy measure for the quality of the home learning environment, for example, a lack of resources or disruptive family circumstances^{xx}.

Research contained in the Marmot Review^{lxiv} outlined how more than one in four adolescents living in cold housing were at risk of multiple mental health problems, compared with 1 in 20 who have always lived in warm housing. Other research by Sheffield Hallam University^{lxv} also found growing up in a cold home is linked to an increased risk of depression and anxiety; while other works^{lxvi} have established associations between the well-being of children and young people and the warmth of the family home, with families outlining how they have to cope with “the emotional and psychological fallout from their experiences of fuel poverty”. It is highlighted this information is not routinely, or often, captured in CAMHS assessments.

Researchers from University College London^{lxvii} recently looked at a range of wealth indicators of the families of 8,500 children within the Millennium Cohort Study, and found ‘housing wealth’ (a measure of home ownership and property value) also influences levels of mental health in children.

Those who live in housing with a greater value had fewer behavioural and emotional difficulties. Children and young people whose houses were worth more than £400,000 had an average 16% lower behavioural and emotional difficulties score than those whose houses were worth around £100,000, even when accounting for other factors that would possibly influence those difficulties, such as income.

They expressed concern over falling home ownership, the subsequent growing number of families renting and the potential effect of widening inequalities in housing wealth impacting upon children and young people’s mental health.

Other published research in 2020^{lxviii}, comparing data over time from the Millennium and British cohort studies, in 2000 and 1970 respectively, reported changes observed in the association between social housing tenure and child outcomes.

Across both cohorts, it was reported children in social housing exhibit worse outcomes across cognitive, mental health and physical health, than children in non-social housing.

Local housing position

Tenure and type of dwelling are shown below for BCP and Dorset UA, using 2011 census data. Detached and Semi-Detached houses may indicate larger spaces to occupy and access to outdoor space, while flats may indicate less space and less access to outdoor space, which are indicators of increased risk. However, housing value may not be straightforward in assuming greater housing value as there are a number of areas within BCP which have higher than national average prices for flats, in affluent areas such as Sandbanks, where current prices of flats are more than twice the national average^{lxix}.

This data does not allow us to investigate in which housing tenure or types children and young people are living in, it is only a general population measure.

The data also shows the percentage of rented properties. Private rental can be a solution for some families to the lack of social housing provision, but it has been shown poor conditions are more prevalent in private rented housing, with a greater proportion of homes being classed as non-decent compared to other tenures^{lxx}.

BCP

It can be seen in figure 24 below that in BCP 65% of housing was owned, leaving 24% private or socially rented, with twice as much privately rented accommodation than public rented. There was 1% of housing of 'other' tenure. It is noted there is a large student population within the authority of BCP, who are more likely to be renting.

maps Spotify - Acoustic... Prevention Concord... Part B Not

Tenure

187,826 Residential Properties



Figure 24: Tenure of residential properties in BCP (percentage)
Source: 2011 Census. Office for National Statistics

Dwelling types are shown in more detail in figure 25; there were more people living in flats within BCP (more than one-third of all residences) compared with Dorset UA.

Dwelling type

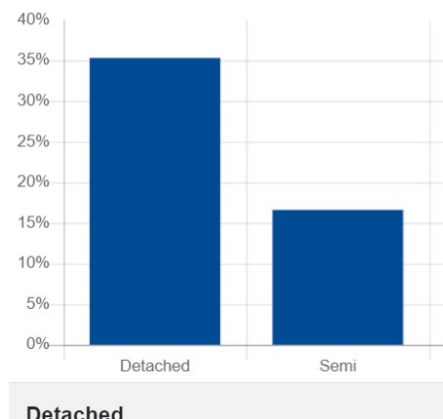


Figure 25: Types of dwellings in BCP (percentage)
Source: 2011 Census. Office for National Statistics

Dorset UA

While in Dorset UA, 72% of housing was owned, leaving 26% private or socially rented, with a fairly even split between private and public rented. There was also 1.7% of ‘other’ housing. Dwelling types are shown in more detail in figure 27. While there are more people living in caravans or mobile homes in Dorset, this is not necessarily indicative of a large Gypsy or Travelling community, as there are around 65 residential parks, pan-Dorset^{lxxi}.

Tenure

182,677 Residential Properties



Figure 26: Tenure of residential properties in Dorset UA (percentage)
Source: 2011 Census. Office for National Statistics

Dwelling type

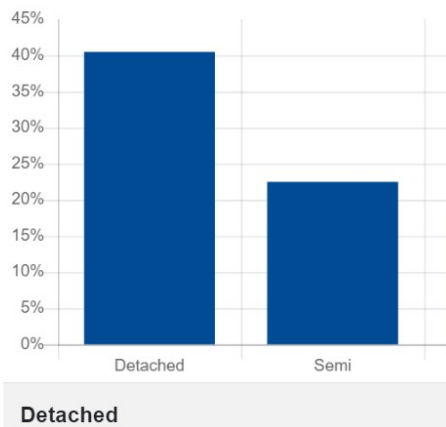


Figure 27: Types of dwellings in Dorset UA (percentage)
Source: 2011 Census. Office for National Statistics

No further data was able to be obtained on indicators of potential differences in housing wealth within and across authorities, or further breakdown of what proportion of housing tenures and dwellings are occupied by families.

Population data related to risk within Perinatal, Infant and Early Years periods

Live Births

Birth data informs on the number of infants entering the population, and the number of new families or families who are expanding. Some risk factors related to adverse mental health in pregnancy, on which quantitative data is available for, such as pregnancy loss or previous complications are detailed below. Further detail on these risk factors is given in the section ‘Early Years: Perinatal and parental mental health, Infancy, Early Childhood and Attachment’.

In 2019 there were 3,508 Live Births in BCP and 2,748 in Dorset UA^{lxxii}, seen in table 9 below. In 2018, there were 3.2% fewer live births from 2017 and the lowest number of live births since 2006. Table 8 shows the split across authorities.

Table 8: Live births by area of usual residence of mother, numbers, 2018.

Area	Geography	Number of live births
ENGLAND	Country	625651
Dorset	County	6655
Bournemouth, Christchurch and Poole	Unitary Authority	3814
Dorset Unitary Authority	Unitary Authority	2841

Source: Office for National Statistics (ONS).

Figure 28 below demonstrates that although the majority of live births in 2018 were to mothers over 25 years of age, there were still around 17% to mothers under 25 years of age. The impact of maternal age below 25 years this upon maternal and child mental health is discussed below.

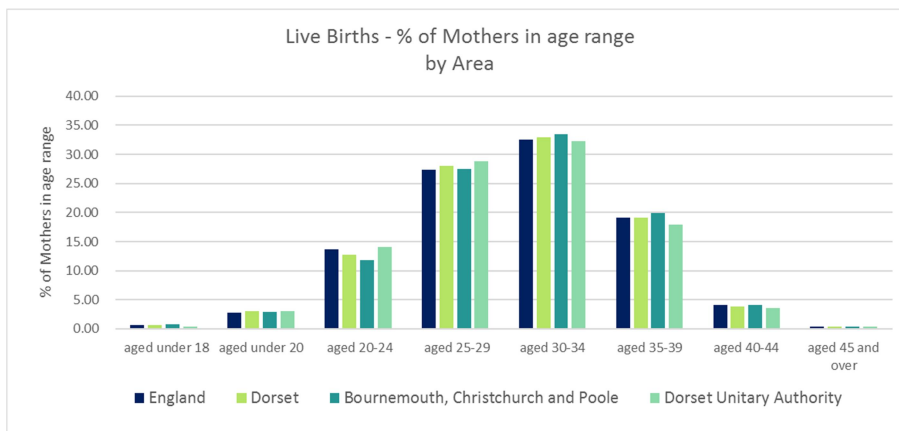


Figure 28: Percentage of Live births to Mothers, by age range and area
Source: Dorset CCG, from ONS data, 2018

Births to teenage and younger parents

Evidence has consistently shown younger mothers, under 20, have increased risks of poorer outcomes for both mothers and children. Newer evidence also demonstrates increased risk of poorer outcomes for children in parents up to 25 years of age^{lxxiii,lxxiv,lxxv}. Data therefore includes numbers of births where the mother is up to the age of 25.

Children born to teenage mothers have an increased risk of low birthweight which can significantly impact upon the child's long-term health. Vitality, teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth.

Children within a family of teenage parents are also at a 63% increased risk of living in poverty, with the effects upon mental health previously discussed.

Most recent data from the ONS shows in 2019 there were around 520 births to younger mothers (below aged 25) in BCP (15% of all births) and 500 (18%) in Dorset UA. While BCP had a lower proportion of births to younger mothers than England and the South West, whose proportions were 17% and 16% respectively, Dorset UA had a higher proportion of births to younger mothers.

Table 9: Live births by age of mother, numbers, 2019.

Age of mother	BCP	Dorset
Total	3,508	2,748
Mother aged under 18	14	9
Mother aged under 20	77	74
Mother aged 20-24	432	415

Source: NOMIS, 2021.

The proportion of births to mothers under 20 was 2.72% for England and 2.49% in the South West. BCP at 2.19% had a lower proportion of births to mothers under 20 while Dorset at 2.69% had more births than the South West, in line with England.

Births to mothers under 18 equated to 0.40% of all births in BCP and 0.33% in Dorset, both below England proportions of 0.60% and the South West at 0.56%.

Dorset CCG data had previously reported the percentage of births to mothers under the age of 18 using 2018 live birth data. The percentage of live births by age range of mother is shown below in figure 29.

Across Dorset there was a comparable percentage of births to mothers under 18 years old to that seen across England (0.63%); this was however made up of a higher proportion of births to mothers under 18 in BCP and a lower proportion in Dorset UA (0.76% and 0.35% respectively). For mothers under 20, there was a higher than England proportion across Dorset (higher in Dorset UA than BCP).

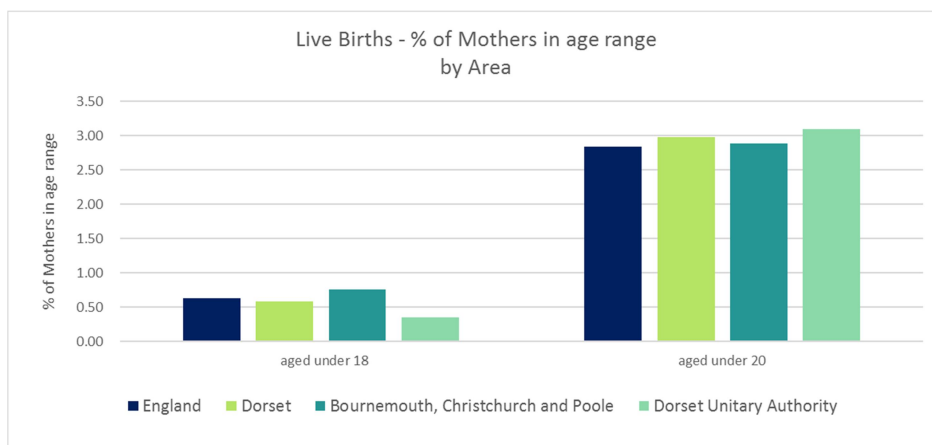


Figure 29: Percentage of Live births by age range of Mothers, <18 years and <20 years, by area
Source: Dorset CCG, from ONS data, 2018

Trauma during pregnancy or birth, or death of a baby.

Mental health problems, particularly post-traumatic stress disorder (PTSD), have been associated with experiencing a traumatic childbirth, stillbirth or death of a baby. Traumas can include stillbirth, infant complications and other forms of traumatic childbirth experiences. NICE defines traumatic births as: “births...which are physically traumatic...and births that are experienced as traumatic, even when the delivery is obstetrically straightforward^{lxxvi}”.

Stillbirths

The Stillbirth Rate⁶ across Dorset has been consistently lower than the England rate since 2015, seen in table 10 below, again reported under new UA organisations.

Table 10: Stillbirth rates 2015-19

	2015-2017	2016-2018	2019 (number)
BCP		3.	2.8 (10)
Dorset	-	3.3	2.9 (8)
South West	3.5	3.5	3.5 (185)
England	4.3	4.2	3.8 (2,346)

Source: PHE Child Health Profile^{lxxvii} and ONS Birth Summary Tables 2019^{lxxii}.

Infant Mortality

Nationally it has been recognised that, although numbers are small, infant mortality is strongly associated with inequalities linked to levels of deprivation, and nationally, increases have been seen in the most deprived decile since 2010^{lxxviii}. The infant mortality rate⁷ has been variable, with Dorset showing similar rates to England, above that of the South West and higher than BCP, seen in table 11 below.

Table 11: Infant mortality rate

	2015-2017	2016-2018
BCP⁸	2.9	3.4
Dorset UA	3.9	3.6
South West	3.3	3.3
England	3.9	3.9

Source: PHE Child Health Profile^{lxxix}.

Caesarean Sections

Caesarean sections are often required for a number of maternal and infant reasons. By their very nature (i.e. they are used when there are complications) they are likely to be associated with an increased risk of problems, and therefore are a possible indicator of births which may be more physically or mentally traumatic.

The England average for Caesarean sections in June 2019 was reported as 28%, 12% elective and 16% emergency^{lxxx}. Caesarean sections accounted for 28% of deliveries in Dorset UA and 30% in BCP in 2019^{lxxxii}; no breakdown of data by elective or emergency was available, but these rates may reflect inequalities in access to maternity services, which would need to be explored further in establishing local provision of services and access to them by different groups of women.

⁶ The rate is the number of stillbirths per 1,000 total (live and still) births

⁷ The infant mortality rate is the number of infant deaths, before their first birthday, per every 1,000 live births

⁸ PHE has reported this data within the post-reorganisations UAs for the time periods specified, not under the previous organisations of Bournemouth and Poole UAs and Dorset County Council.

Births to UK vs Non-UK born mothers

Ethnicity and, in particular, belonging to a minority ethnic group, have been highlighted by some studies as potential risk factors for perinatal mental illness, although evidence is mixed. There will be some non-UK born mothers who are not at a significant disadvantage if they speak English and are established in this country.

However, there will be some women for whom language challenges, knowledge and networks affect the seeking, accessing and receiving of treatment, which may impact upon development of the infant and the physical and mental health of both the infant and mother. If there are women recently arrived in the country they are more at risk of the above challenges such as a lack of social support networks, which are known risk factors for perinatal mental health problems.

Nationally in 2018 births to non-UK-born mothers accounted for 28.2% of all live births, compared with 28.4% in 2017, seen in table 12 below. This was the first drop in the proportion of births to mothers born outside the UK since 1990. Despite the decline, the proportion was still high in comparison to previous years.

Table 12: Percentage of live births born to non-UK-born mothers by local authority district, England and Wales 2007 to 2018

Area	% Live births born to non-UK mothers										
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
England and Wales	24.1	24.7	25.1	25.5	25.9	26.5	27.0	27.5	28.2	28.4	28.2
Bournemouth, Christchurch and Poole	19.2	20.4	21.4	22	23.4	24.1	24.8	24.6	28.1	26.8	26.1
Dorset Unitary Authority	8.4	9.4	10.4	9.8	9.6	10.6	10.1	10.6	9.3	9.9	10.2

Source: ONS Births by parents' country of birth, England and Wales: 2018

Levels of births to non-UK born mothers in BCP have been comparable to that seen in England, while much lower levels have been seen in Dorset UA; around a third of England proportions.

Of note may be the large 6.9% increase in live births for non-UK born women in BCP between 2008 and 2018, which contributes to the projected increase in the 0-19 population to 2025 in Bournemouth.

SUMMARY – Demographic Information

There were an estimated 151,492 children and young people aged 0-18 living across Dorset in 2019, constituting 20% of the whole population. Extending the age range to 0-25 years, they made up 27% of the whole population.

Population structure

While the general and younger pan-Dorset population is fairly evenly split between the two unitary authorities, in BCP there is a higher population density across a significantly smaller area than in Dorset UA. This can create challenges in delivery of support and services across lower density but wider geographical areas of Dorset UA and the higher population within more urban areas seen in BCP.

Detailed breakdown of the younger population is provided in the report, and overall BCP's age profile is similar to that of England, except for an increased proportion of 19-25 year olds, expected with the university and language colleges. Compared to the England profile, Dorset has a lower proportion of 0-25 year olds and 25-40 year olds, with a greater proportion of people over 60 years.

Population projections

Population growth was projected between 2018-2025, by approximately 5%, or 7,200 individuals, in the 0-18 years population across Dorset. The growth rate in BCP is twice that of the growth in Dorset UA, with around 5,000 additional population of children and young people in BCP and 2,200 in Dorset UA by 2025.

The 19-25 years population is predicted to fall by 2025 across Dorset but a greater decrease is expected within Dorset UA and a much smaller decrease than nationally or locally will be seen in BCP.

Overall, the 0-25 years cohort of population shows a predicted increase from mid-2018 to 2025 across Dorset of 1.9%, comprised of a small drop in Dorset UA, and an increase in BCP. This increase, equates to an increase in population between 0-25 years across Dorset of approximately 4,100 between 2018-2025.

Population within THRIVE groupings

Data has been interpreted to provide an illustration of the number of children and young people that may sit within each of the THRIVE groupings of need, based on population data. While the majority of the population should be within the 'Thriving' Grouping, which still requires input to promote and maintain mental health and wellbeing, the other groupings estimate there may be between 15-30,000 of those aged 0-18 requiring some form of more formal support within the other groupings, and 6-12,000 of those aged 19-25.

Ethnicity

Ethnicity is often associated with other factors affecting mental health, such as living circumstances and income. While Dorset County has a lower proportion of individuals from minority ethnic backgrounds, there are larger proportions within the Bournemouth area, at last census date. There was a different picture in the younger population, with larger proportions than in the general Dorset population. Although still below that of England, Bournemouth had a higher proportion, followed by Poole and then Dorset.

Deprivation

There are well-established links between living in areas of deprivation and experiencing poorer outcomes across different aspects of life, educational attainment, employment, social interaction, levels of activity, physical and mental health.

Maps of deprivation for BCP and Dorset UA have shown 8% of areas in Dorset UA and 19% in BCP are in the most deprived deciles. 33% of areas in both BCP and Dorset UA are in the least deprived three deciles.

For deprivation indicators affecting children, in 2019, ranking of UAs (out of a maximum 317, with rank 1 being the most deprived (higher ranking less deprived)), BCP was ranked 159th, whilst Dorset UA ranked 205th.

Cross-referencing indicators of general deprivation and those specifically affecting children demonstrated within BCP, there were 38 areas ranked in the lowest three deciles for both indicators; 22 in Bournemouth, 14 in Poole and two in Christchurch. Within Dorset UA, there were 16 areas ranked in the lowest three deciles for both indicators; 13 of which were in Weymouth and Portland.

Poverty

There is a plethora of evidence to show children living in poverty are exposed to a range of risks which can seriously impact upon their mental health, including debt, poor housing, and low income. Research shows living with low income can cause mental health problems for parents and children alike, and is associated with multiple mental health disorders in children and with the persistence of mental health problems of parents.

Children and young people living in poverty are thought to be three times more likely to have mental health issues compared to their more affluent peers. Children living in the poorest households are over four times more likely to experience severe mental health problems than those whose household has the highest fifth, and nine times as likely to have psychotic disorders.

Around 12% of children under 16 were living in lower-income families within BCP and Dorset In 2019, equating to approximately 8,200 in BCP and 7,200 in Dorset UA. The percentages were lower than figures for England, at 17-18% during 2017-19.

Housing

Many children growing up in poverty are living in poorer quality and insecure housing, and forced to move frequently, often leaving behind schools, friends and a sense of belonging in their area each time they move.

Quality of housing has also been shown to impact on a number of outcomes for children and young people, and particularly upon their physical and mental health. Children living in poorer-quality housing have been shown to have higher levels of stress hormones and behavioural problems and it also believed to serve as an indicator of the quality of the home learning environment.

Association between the well-being and mental health of children and young people and the warmth of the family home have been established. More than one in four adolescents living in cold housing were at risk of multiple mental health problems, compared with one in 20 who have always lived in warm housing.

Measuring home ownership and property value, known as 'housing wealth', also influences levels of mental health in children. Those who live in housing with a greater value had fewer behavioural and emotional difficulties, even when accounting for other factors that would possibly influence those difficulties, such as income.

In BCP 65% of housing was owned, leaving 24% private or socially rented, with twice as much privately rented accommodation than public rented. In Dorset UA, 72% of housing was owned, leaving 26% private or socially rented, with a fairly even split between private and public rented.

Demographic information related to Perinatal Mental Health and Early Years development

There were fewer live births across Dorset than in the previous year, the lowest number of live births since 2006.

There are known increased risks of poorer outcomes in mothers and children, where the mother is under 20 years of age, and risks persist in mothers up to 25 years of age. These families are also at increased risk of living in poverty, with those associated adverse outcomes.

Dorset had a higher proportion of births to younger mothers, under the age of 25, than England and the South West. There were more births to mothers under 20 in Dorset than in BCP, while there were less births to mothers under 18 across Dorset, below that of England and the South West. There have been varying trends over the years previous.

Other indicators of inequalities and potential risks for poor maternal mental health were included. Stillbirth rates across Dorset have been consistently lower than the England rate since 2015, while Dorset showed similar rates of infant mortality to England, above that of the South West and higher than BCP up to 2018.

Caesarean sections accounted for nearly a third of deliveries across Dorset, in line with England in 2019.

Births to non-UK mothers may be both beneficial, with an increased likelihood of breastfeeding, and a risk factor for maternal mental health, and therefore for the outcomes of the child, through lack of social networks and access to support. Levels of births to non-UK born mothers in BCP have been comparable to that in England, while much lower levels have been seen in Dorset UA; around a third of England proportions. There has been a large 6.9% increase in live births for non-UK born women in BCP between 2008 and 2018.

Inequalities, the interplay between risk factors and ‘Mutual reinforcement’

The discussion about inequalities is made at this point to further inform the review of further chapters, where references are made.

Our physical and mental health is influenced by complex interactions between many factors, such as individual behaviours, places and communities in which people live, quality of health and care services and wider determinants such as education, housing and access to green space.

Inequalities are both a cause and consequence of poor mental health^{lxxxii}. Health inequalities are differences in health between different groups of people, arising as a result of avoidable, unjust and systematic variations in these factors across populations. The term can also refer to differences in the care people receive and opportunities they have to lead healthy lives.^{lxxxiii}

They can therefore involve differences in:

- Health status, e.g. life expectancy and prevalence of health conditions
- Access to care
- Quality and experience of care, e.g. patient satisfaction
- Behavioural risks to health, e.g. alcohol consumption or diet
- Wider determinants of health, e.g. employment, housing quality

A recent report from the Commission for Equality in Mental Health^{lxxxiv} highlighted the ‘triple barrier’ of mental health inequality, which affects large numbers of people across differing sections of the population:

1. Some groups of people experience far poorer mental health than others, often reflective of social disadvantage
2. Often those same groups of people have less access to effective and relevant support in dealing with their mental health and
3. Where accessing support, their experiences and outcomes are often poorer, in some circumstances causing harm.

Individuals can be disadvantaged through experiencing multiple risk factors which can compound, or ‘mutually reinforce’, the effects of others,^{xlii}. For individuals within lower socio-economic groups, for example, there is higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives. Those living in deprived areas have nine times less access to green space, higher concentrations of fast food outlets and less access to affordable healthy food^{lxxxv}. An example of the interplay is shown below in figure 30.

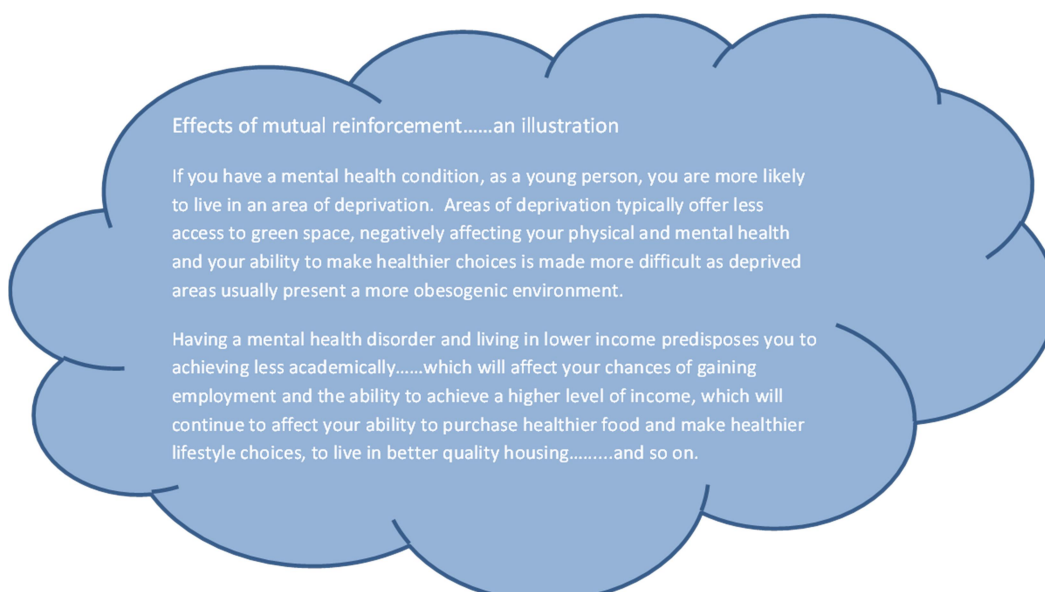


Figure 30: Example of the interplay of multiple risk factors
Source: DHC in-house visual creation

In older adolescents and adults, the AMPS ^{cxv} highlighted inequalities related to gender; younger women experienced higher rates of mental disorder, self-harm and PTSD than men of the same age. Alcohol and drug dependence were twice as likely in men as in women.

Inequalities in mental ill-health have been evidenced across a range of protected characteristics, such as sexual orientation, sex and ethnicity. In those who identify as LGBT, for example, there are higher rates of poor mental health, including emotional disorders, self-harm and suicide attempts, than in those who identify as heterosexual.

The APMS findings also highlighted differences in mental ill-health by ethnicity, such as higher rates of psychotic disorder experienced by Black men (3.2%) and Asian men (1.3%) than among White men (0.3 per cent), and detention under the Mental Health Act was four times higher in those who were Black or Black British than in those who were White. However, in children and younger people, there appears to be trends of increasing mental disorder in those of a White background, although there is no differentiation between those of a White British or White Other background, which could be important as there may be differences in circumstances, cultures and experiences between different backgrounds described as White.

Those from socially excluded groups have also been shown to experience higher rates of mental ill-health than the general population. In those experiencing homelessness, more than 80 per cent reported a mental health difficulty, and are 14 times more likely to die by suicide than those in the general population, while asylum seekers and refugees are known to be at increased risk of experiencing depression, PTSD and other anxiety disorders ^{lxxxiii}.

Access to health services refers to the opportunity to receive services which are timely, appropriate, sensitive and easy to use. Inequitable access can mean particular groups receive less care relative to need, less appropriate or sub-optimal care, the consequences of which are poorer experiences, outcomes and overall health status. Access includes preventive interventions, as well as primary and secondary health care.

Measuring user experience, such as through patient satisfaction gives indications of a person's perceptions of how they have been treated in care episodes; the 2017 British Social Attitudes survey, found respondents who identified as Black had lower levels of satisfaction with the NHS than respondents who identified as White (by 12 percentage points) ^{lxxxiii}. In the Stonewall study ^{cxv}, referred to earlier, a number of respondents reported experiencing unequal treatment from health care staff because of their LGBT identity (13%), rising to 32% of transgender people and 19% for LGBT people of a minority ethnic background.

Differences in care pathways have also been observed, for instance in patients with psychosis of different ethnicities, during contact with the police, the justice system or GPs ^{lxxxiii}.

In receiving treatment, they also demonstrated demographic inequalities; after controlling for level of need, people who were White British, female, or in mid-life (especially aged 35 to 54) were more likely to receive mental health treatment; people of a Black background had particularly low treatment rates. Socioeconomic inequalities in treatment use were less evident, although people living in lower income households were more likely to have requested but not received a particular mental health treatment.

Inequalities within the wider, social, determinants of health are widely accepted. The Kings Fund report that colder, poor-quality and overcrowded housing conditions are associated with increased risk of mental health disorders and lower physical health (another risk factor for mental health); households from minority ethnic groups are more likely than White households to live in overcrowded homes and to experience fuel poverty.

Another example is access to good-quality green space, known to improve physical and mental health while lowering levels of obesity, however, levels of access are likely to be worse for people in deprived areas and areas with higher proportions of minority ethnic groups ^{lxxxiii}.

The risk of experiencing social and emotional behavioural problems is much greater in disadvantaged and vulnerable children and young people, who are often at greater risk of exposure to adverse childhood experiences. Additionally, marginalised groups of children and young people, including young carers, refugee and asylum-seeking families, those disabled, LGBT and children in care, have increased vulnerability to mental health problems^{lxxxiii}, which in part are explained by the inequalities they experience in social and health determinants.

Early years development and all-age Education in Dorset

Early Years Development and Assessment

The Universal Health Visiting Service undertakes universal health reviews with children at age 2-2½ years of age, using the Ages and Stages Questionnaire (ASQ). This has been determined a reliable measure of development to assess child development outcomes, reviewing communication, problem solving and social-emotional and physical development.

PHE reports disparities in child development are recognisable by the second year of life and have an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential, with associated poorer long term outcomes including mental health and general wellbeing. There have been geographical variations in access and uptake of this review, for example, between 2017-18 data at regional levels access ranged from 76-96%^{xxxv}.

Recent evidence sets out a case for language as a primary indicator of child well-being, impacting on children's social, emotional and learning outcomes. Almost all children learn to communicate through language, yet strong and persistent differences in their ability to do so are evident, with a child's socio-economic background an important factor. By age 3 there is already a 17-month income-related language gap, with children from disadvantaged groups twice as likely to experience language delay. Five year olds with poor vocabulary are 3 times more likely to have mental health problems as adults. Two-thirds of 7 to 14 year olds with serious behavioural problems have language impairments.

While the reasons behind the word gap in the early years are complex, exposure to a breadth and depth of vocabulary and a learning-rich home environment, supported by high-quality early years provision, are essential.

Locally, PHE data indicated around 90-92% of children were achieving a good level of development across Dorset, in 2018/19, shown in figure 31



Figure 31: Proportion of children achieving a good level of development at 2-2½ years, in 2018/19
Source: PHE Public Health Profiles

There is no detail available, for previous or new local authorities across Dorset, on the subsets of levels of child development, that of expected levels in communication skills or in personal-social skills at 2-2½ years.

Early Years Education

Early Years education is designed to improve the survival, growth, and development of young children.

The aim of Early Years education is to improve school readiness skills and ameliorate poorer achievement outcomes for disadvantaged students. As shown above, their role is vital, alongside home support, in reducing disparities in language and general development, which increase the likelihood of poorer mental health and other outcomes.

An increase in school readiness leads to improved educational achievement, and later, greater earning potential and productivity. It also provides opportunity for socialisation through interacting with peers and adults, learning social norms and developing social-emotional and problem solving skills. Lastly, it provides an environment in which opportunities present to identify support needs or increased risk in children and families, including mental health needs^{xxxvi}.

Figure 32 below indicates increased likelihoods of poor outcomes if children are not in receipt of good quality early education, all of which are also associated with poorer mental health.



Figure 32: Predicted outcomes of poorer early education

Utilisation of Early Years provision

Data from the Local Authority Interactive Tool (LAIT) shown below in figures 33 and 34 demonstrates the degree of utilisation of early years education for children aged two and those aged three-four years. Two-year old funding is based on supporting 'disadvantaged children', those who meet financial criteria (family in receipt of benefits) or category of need⁹.

⁹ Two-year old funding can also be provided for those looked after by a local authority, those with a statement of special education needs (SEN) or an education, health and care (EHC) plan, those who receive Disability Living Allowance or have left care under an adoption order, special guardianship order or a child arrangements order

Two year old children:

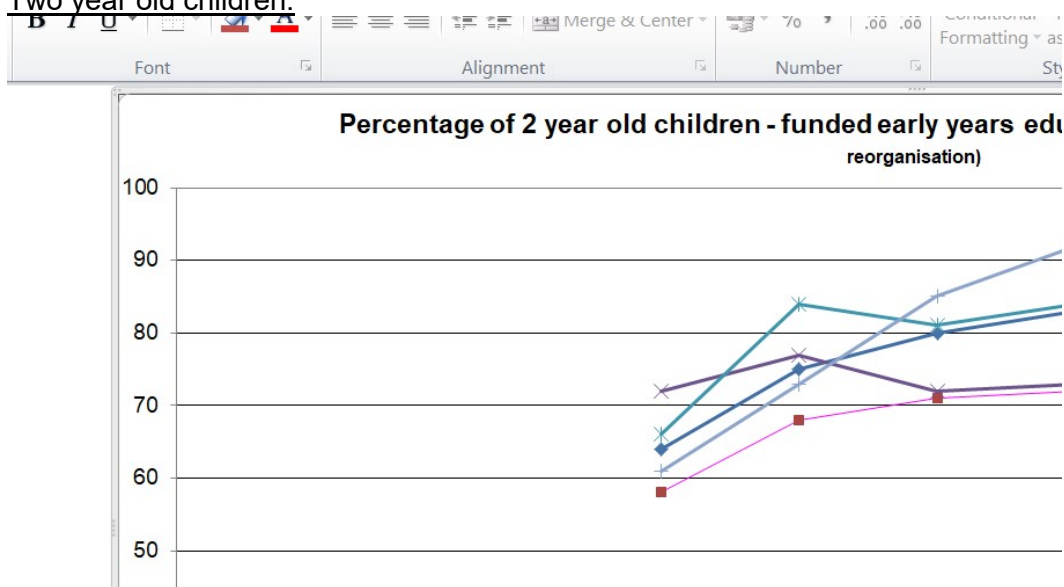


Figure 33: Percentage of 2 year olds partaking of funded Early Years education, of those eligible
Source: LAIT, accessed November 2020.

It can be seen from figure 33 above that, in 2020, there were more eligible children utilising funded places at two years old in Dorset, at 89%, than in BCP at 80%. These were both higher uptake percentages than seen in the South West and England (69%).

Prior to the reorganisation, there had been a rising trend in Poole, and a fairly level trend seen in Dorset. There had been a consistently lower percentage in Bournemouth. This may suggest the current percentage in BCP is reflective of higher uptake in Poole raising the BCP proportion as a whole.

Three-four year old children:

The information in figure 34 below indicates the percentage uptake of funded early education across all three-four year old children.

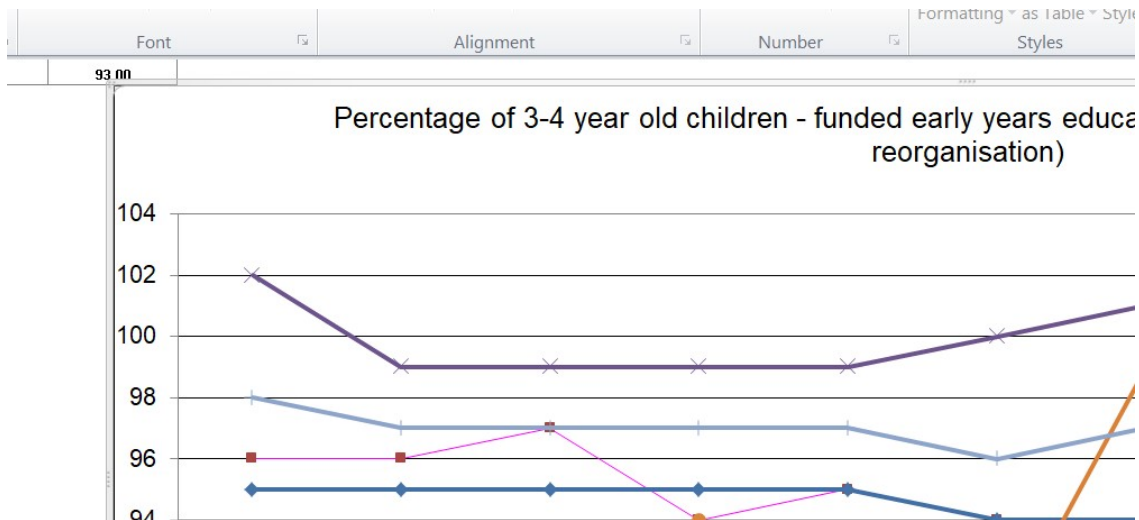


Figure 34: Percentage of 3-4 year olds partaking of funded Early Years education
Source: LAIT, accessed November 2020.

It can be seen from figure 34 above that in 2020 there were more eligible children utilising funded places, at three-four years old, again in Dorset (96%) than in BCP (91%). While both areas were above 90% uptake, Dorset was positioned higher than percentages in the South West and England, while BCP was below both. Previously, Poole had shown a variable trend in the 5 years prior, Bournemouth had seen a declining trend from 97% to 91%, while a fairly steady trend had been seen in Dorset. Bournemouth and Poole areas had been below the South West and England proportions since 2015, bar one year in Poole. This again may suggest opportunities for areas which could benefit from targeting to increase uptake.

Quality of Early Years Education

It is shown within the LAIT that in both Dorset UA and BCP, 99% of two year olds in early years funded education are within an organisation rated as ‘good’ or ‘outstanding’ by Ofsted.

For three-four year olds, 98% within BCP and 91% in Dorset are within an organisation rated as ‘good’ or ‘outstanding’.

School Readiness

School Readiness is a national education standard to measure the development of children at the end of the early years’ reception period, around age 5^{lxxxvii}. If children are prepared and able to effectively participate during their education from an early age, it has been shown to benefit their mental health and other outcomes.

Those who suffer from development difficulties can experience impairment in any of the following areas; physical and motor, social and emotional, and communication and language progression. They are then more likely to display difficulties upon entering school, predisposing them to greater risk of mental health issues.

PHE Public Health Profiles data from 2018/19 is the most current data available but only reports data against post-reorganisation UAs. It can be seen from that there was a higher percentage of children achieving a good level of development in BCP than in Dorset UA. These were in line with, or above, the England percentage at 71.8%, and South West at 72%.



Shown in figure 35 below, development in phonics screening was in line with that of England and the South West in 2018/19. For communication and language skills, there was a higher proportion of children achieving that in BCP and in line with England and South West was Dorset’s proportion.

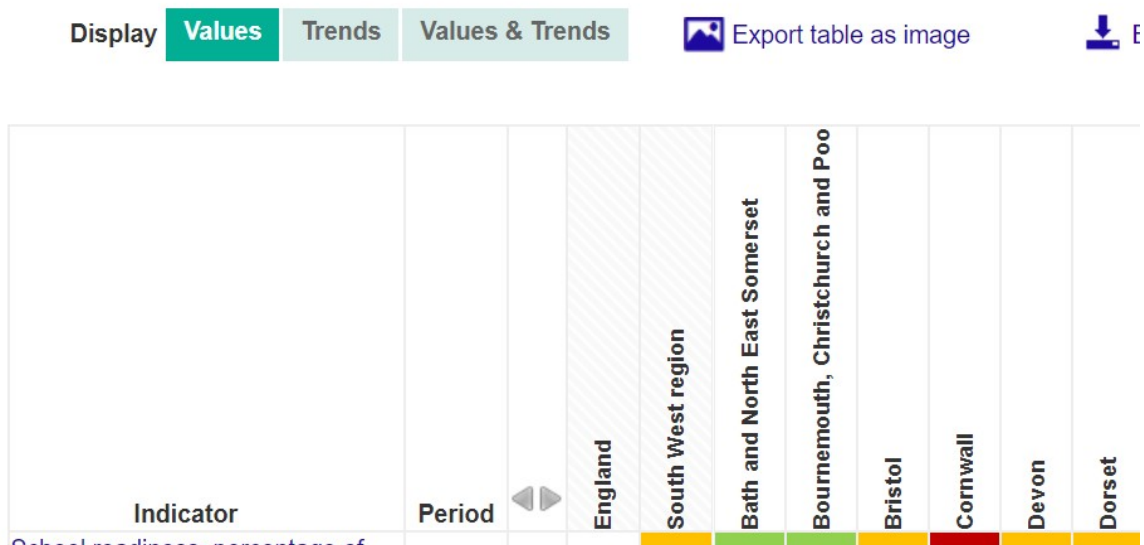


Figure 35: School Readiness Indicators
Source: PHE Public Health Profiles

Primary, Middle and Secondary schools

Data used within this section is from GOV.uk report dated 20th August 2019 and the most recent OFSTED reports for Weymouth and Bournemouth & Poole Colleges.

Number of educational sites

There are significantly more primary and middle schools within Dorset Council than Bournemouth Christchurch and Poole. The number of secondary and 16+ establishments is similar across both authorities, seen in table 13 below.

Table 13: number of educational sites in Dorset (excluding Independent Schools)

	Bournemouth, Christchurch and Poole Council	Dorset Council	Grand Total
Primary	70	122	192
Middle School	1	10	11
Primary and Secondary	15	26	41
Secondary	24	27	51
16 plus	5	5	10
Grand Total	115	190	305

Source: Gov.uk

Total student population

Table 14 below shows the number of pupils within each local authority area by gender. Please note that the 16+ establishments in Dorset UA and Bournemouth and Poole College do not have roll numbers recorded on the GOV.uk website. This data estimates there to be a total population of 128,442 students in Local Authority education.

Table 14: Number of pupils split by gender within each phase of education and Unitary Authority.

	No. of Boys	No. of Girls	College roll	Total
Bournemouth, Christchurch and Poole Council	36079	39181	2896	78156
16 plus	9350	12795	2896	25041
Middle School	240	239		479
Primary	14350	13478		27828
Primary and Secondary	2154	3037		5191
Secondary	9985	9632		19617
Dorset Council	25154	24595	537	50286
16 plus			537	537
Middle School	2557	2498		5055
Primary	11014	10793		21807
Primary and Secondary	2341	2212		4553
Secondary	9242	9092		18334
Grand Total	61233	63776	3433	128442

Sources: Gov.uk report dated 20th August 2019

61% of the percentage of the student population within Dorset is served by BCP, and 39% by Dorset Council, shown below in figure 36.

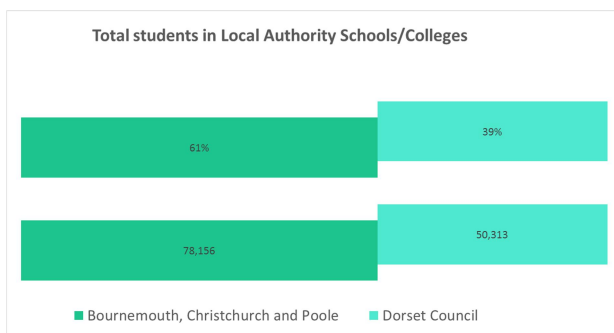


Figure 36: Proportion of student population in BCP and Dorset UA
Source: Dorset CCG

Educated other than mainstream school provision

Elective home education

Nationally there have been increases in the number of children home-schooled; official figures showed around 60,000 children nationwide in 2018-19, up from around 34,000 in 2014-15, which is a 76% increase over the four-year period.

Home-educated children are not automatically 'vulnerable' but some children educated at home do fall into that category, with evidence from many local authorities that the proportion who do is increasing.^{lxxxviii} Concerns have been raised about understanding the quality of education received, monitoring processes, lack of regulatory frameworks, and the visibility of, and regular contact, had with these children.

Locally, there are a number of CYP whose parents have registered them as home educated; this figure obviously fluctuates throughout the year. Within BCP at end of March 2020 there were 502 children and young people in elective home education. In March 2020, within Dorset CC. there were 495 children and young people recorded as being home-educated. Both authorities have guidance available to parents on home education.

Further information was provided for the Dorset area (CC/UA), showing varying levels and a larger increase of late:

	Number registered as being EHE
End of academic year 17/18	487
End of academic year 18/19	516
End of Mar 2020	495
End of academic year 19/20	516
As of 01/02/21	630

Special schools

BCP is reported as providing four, and Dorset Council six, special school sites for those with additional needs not most appropriately met within mainstream school provision.

Learning Centres (Pupil referral units, short stay school, hospital provision)

These make educational provision for children who are not able to attend school, after being permanently excluded from school or for those unable to attend school for medical reasons. Five are available across Dorset.

Children Missing Out On Education

Within national statutory guidance^{lxxxix} it is commented that children and young people missing out on education are at significant risk of underachieving, being victims of harm, exploitation or radicalisation, and are more likely to not be in education, employment or training later in life (NEET).

Reasons considered for not engaging with education include children within refugee and asylum seeking families, families who are highly mobile, those experiencing mental health problems or experiencing abuse and neglect.

Within BCP there were 637 'children missing education'¹⁰, at March 2020. Historical data to match that of BCP was not available for Dorset UA, but at February 2021, there were 116 open cases with 252 referrals that academic year.

¹⁰ 'Children missing education' are children of compulsory school age who are not registered pupils at a school and are not receiving suitable education otherwise than at a school

Post-16 education

The 16+ College roll information below is from college data sources and most recent OFSTED reports for Weymouth College, Bournemouth & Poole College and Kingston Maurward College.

Weymouth college

There are no recorded government figures on numbers of students at Weymouth College. Data from the college site reports over 3,000 students attend. From an Ofsted short inspection in March 2020^{xc}, it was reported the college had just over 400 adult learners and around 380 apprentices, divided fairly equally between 16- to 18-year olds and adults.

That leaves an approximation of around 2,300 16-19 year olds in receipt of full-time college education, which appears reasonable based on previous records (Financial reports from 2017/18 reported around 1,900 funded students and previously there were 1,169 students full-time aged 16–19 in the Ofsted Inspection of 2015^{xcj}). 95 learners were in receipt of high-needs funding.

Bournemouth and Poole College

In March 2019^{xcj}, the colleges had 2,896 students on 16 to 19 study programmes and apprenticeships account for some 25% of provision; the college had 1,997 apprentices on roll; approximately one third are aged 16 to 18. Ofsted rated the colleges as requiring improvement in a number of areas.

Kingston Maurward College

Kingston Maurward is a land-based college and financial reports from 2018/19 report The College's student population as 666 16-to-18 year old students, 539 apprentices, 86 higher education students and over 1,000 adult learners. In the 2017 Ofsted short inspection it was stated there was a very large proportion of learners with learning difficulties and/or disabilities in attendance, compared with other local providers, representing just over half of learners. They were noted to achieve at least as well as other learners.

Bournemouth University

The student population is noted as over 19,000 with around 2,600 international students.

Overall attainment

PHE remark that children with poorer mental health are more likely to have lower educational attainment and evidence suggests that the highest level of educational qualifications is a significant predictor of wellbeing in adult life; educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources.

Previous indicators of attainment, used by PHE, were the percentage of those achieving 5 GCSEs at grades A*-C. This measure has not been in use since 2017; Indicators of attainment now include 'Attainment 8 score' which measures the achievement of a pupil across 8 qualifications at KS4 (age 14-16 years) with each individual grade a pupil achieves being assigned a point score. Other indicators include the 'Percentage of pupils achieving grades 5 or above in English and Mathematics GCSEs', which indicates they have met the threshold of a 'strong pass', equivalent to a 'C' grade.

In BCP state-funded secondary schools, in 2019^{xciii}, the average attainment 8 score was 50 and percentage achieving grades 5 or above in English and Mathematics GCSEs' was 51%. In Dorset UA it was 46.4 and 40.8%, respectively. Placing of BCP and Dorset UA using the percentages, BCP's position is 66th out of 483 schools and Dorset around 286th.

Impact of poverty on educational readiness and achievement

Free School Meals

Free school meals (FSM) are a well-accepted measure of socio-economic disadvantage in school pupils. It can be seen that the percentage uptake of free school meals across Dorset has been historically lower than the England rate, seen in table 15. Dorset County Council (CC) had a higher uptake than Bournemouth and Poole across both primary and secondary age pupils in 2018.

Table 15: Free School meals uptake

Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)	Comment
Free school meals: % uptake among all pupils (school age)	2018	13.5	10.7	9.8	13.1	SW Region: 11.0
Free school meals: % uptake among all pupils (Primary school age)	2018	13.7	11.0	11.4	13.1	SW Region: 11.4
Free school meals: % uptake among all pupils (Secondary school age)	2018	12.4	9.1	6.8	12.1	SW Region: 9.9

Source: Dorset CCG, using PHE Public Health Profiles data

More recent data for 2020 showed in primary schools, both BCP and Dorset UA had 15% of pupils eligible for, and claiming, free school meals. This was in line with the South West at 15% and lower than England at 18%. For secondary school pupils in 2020, BCP had 11%, and Dorset UA 15%, of pupils eligible for, and claiming, free school meals. Dorset UA was above the South West proportion of 13% and nearer the England figure of 16%.

Impact of poverty on educational readiness and achievement

While PHE data from 2018/19 showed school readiness pan-Dorset was generally in line with or above the England average, children in receipt of Free School Meals were less likely to show the expected level of general and phonics development at the end of Reception, shown in figure 37 below.

Compared with all children, percentages of children in receipt of FSM achieving a good level of development were around 15% less in BCP and 18% less in Dorset; in England the difference was 15%. Percentages of children in receipt of FSM achieving the expected level of development in the phonics check were 13% fewer in BCP and 15% fewer in Dorset when compared with all children, while the in England the difference was 12%.

[Gmail](#)
[YouTube](#)
[Maps](#)
[Spotify – Acoustic...](#)
[Prevention concord...](#)

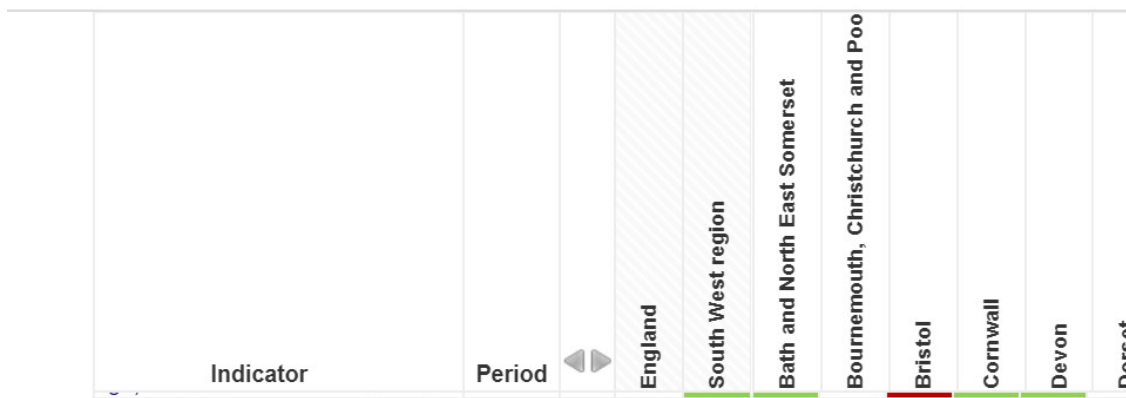


Figure 37: School readiness in those in receipt of Free School Meals (FSM), an indicator of children who are living in poverty
Source: PHE Public Health Profiles

Attainment by age 19, of those in receipt of FSM at age 15/16

Attainment by age 19 is reported at levels 2 and 3; level 2 is 5 (or more) GCSEs at grades 9-4/A*-C or equivalents e.g. Level 2 vocational qualification, while level 3 is 2 (or more) A levels or equivalents e.g. Level 3 vocational qualification^{xciv}.

When looking at attainment of level 2 qualification by age 19, data shows those who were in receipt of FSM at age 15/16 and those who were not. Figures 38 and 39 show data between 2012 and 2019 allowing a view of trends in attainment by those in receipt of FSM and not in receipt; the figures do have differing scales so awareness of this is required in interpretation.

Between 2015-2019, for those previously in receipt of FSM, 20-40% fewer individuals achieved level 2 qualifications than individuals who had not been in receipt. A decline was seen in all authorities between 2018-19, but greater decline was seen in Poole and Bournemouth.

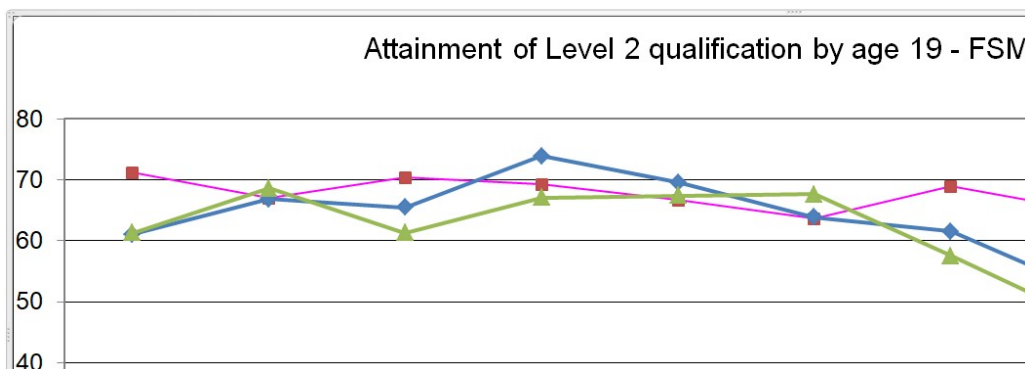


Figure 38: Attainment by age 19 of those in receipt of FSM at age 15/16
Source: LAIT, accessed December 2020.

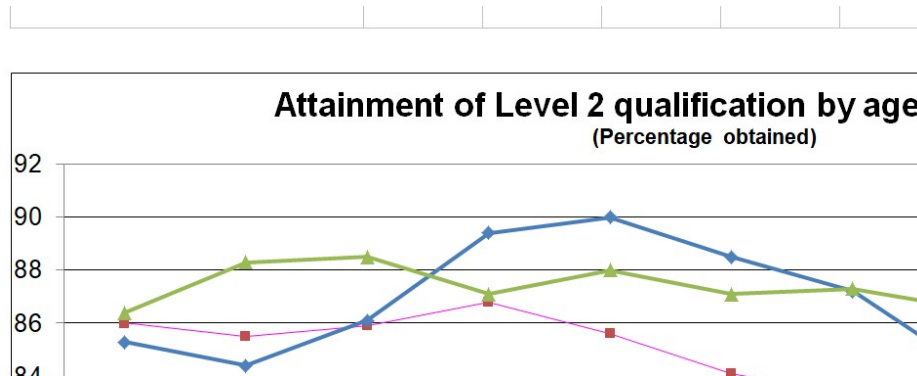


Figure 39: Attainment by age 19 of those not in receipt of FSM at age 15/16
Source: LAIT, accessed December 2020.

While declines in attainment of level 2 qualifications were observed across all authorities for those in receipt and those not in receipt, the percentage point change is much smaller for those not in receipt (not immediately apparent due to the scale of the figure shown). For instance, between 2017-2019, Bournemouth shows a percentage decrease of around 2% for those not in receipt but on the figure for those in receipt of FSM the decrease is around 20% in Bournemouth during the same time period.

Level 3 qualifications

The picture is similar for those obtaining Level 3 qualifications in LAIT data, with the inequality gap reported as between 28-40% across the regions of Bournemouth, Dorset and Poole during 2015-2019; that is 28-40% fewer young people achieved level 3 qualifications if they had previously been in receipt of FSM.

Overall and Persistent Absence, and Exclusion, from School

Evidence has shown educational experience in children up to age 12 provides opportunities for engagement in tasks which promote their mental wellbeing. Disillusion with, absence or exclusion from school are known risk factors for children's wellbeing and mental health and behavioural difficulties, which may indicate underlying mental health disorders, often lead to exclusions^{xcvi,xcvii,xcviii,xcix,ci}.

Authorised absence is absence with permission, including instances of absence where a satisfactory explanation has been provided e.g. illness. Unauthorised absence occurs without school permission, including all unexplained or unjustified absences and arrivals after registration has closed^{xcv}.

Two types of exclusion exist; fixed (suspended) and permanent (expelled)^{xcvi}.

Association between absence, exclusion, mental health and risk factors for mental health

Children with mental health problems are more likely to be absent from school, for a variety of reasons. This results in reduced learning and increased social isolation in the short term and longer-term reduced educational achievement and life chances, leading to further inequalities.

Children are at a higher risk of missing school if they have poor mental health, in particular if they have conduct disorders, anxiety or depression, SEND, a long-term health condition, are female, have caring responsibilities or have been bullied. Detailed analyses performed in 2011, showed there were observed differences in absence levels between children with different ethnic backgrounds, particularly Gypsy Roma or Irish Traveller pupils (8-9 times higher than in White British pupils), and remarked the effects of ethnicity were generally smaller than the odds of absence with levels of poverty and deprivation, which were twice the odds of being absent if in receipt of FSM or in the most deprived IDACI quartile compared with the least deprived. They also commented on the effects of multiple factors, giving an example of an Indian (reduced odds), English speaking (reduced odds), female pupil of increasing age, with FSM eligibility and SEN having a 12 times increased odds of being absent^{xcviii}.

Being excluded from school is also associated with poor physical health, substance abuse, antisocial behaviour, crime, low academic achievement, unemployment and homelessness**Error! Bookmark not defined.**

Research in 2017^{ci} provided evidence suggesting excluding children from school acted as a predictor for longer-term psychiatric problems and psychological distress. They found poor mental health can also lead to school exclusion; a "bi-directional association" between psychological distress and exclusion.

Exclusion occurs disproportionately in children and young people from certain groups. Shared characteristics of those more likely to be persistently absent or excluded were being of an older age, having Special Educational Needs and Disability (SEND), being eligible for Free School Meals (FSM) and having Child in Need (CiN) status. and boys, particularly those from mixed or black ethnic groups, were more likely to be excluded.

Pupils excluded from school consistently had higher levels of behavioural problems, attention difficulties and perceived stress than their peers along with reduced ability in managing emotions, problem solving, goal setting, empathy and helping others.

As regards their support networks, young people excluded from school recorded lower levels of support within families, communities, schools and with peers**Error! Bookmark not defined.**

Local data on unauthorised absence

Table 16 below demonstrates an overall unauthorised absence percentage in all schools across the three authorities, in line with the proportion seen in England, but slightly higher than seen in the South West region.

Within primary schools, Bournemouth has a slightly higher percentage than that of England and local comparators. In Secondary settings, it is Poole and Dorset who showed higher proportions, with Bournemouth in line with the South West and below England.

Table 16 : Percentage of sessions missed with unauthorised absence in state-funded schools, 2019

Unauthorised absence (%)	Bournemouth	Poole	Dorset	South West	England
Primary	1.2	1.1	1.0	1.0	1.1
Secondary	1.5	1.9	1.7	1.5	1.8
Total	1.4	1.4	1.4	1.2	1.4

Source: LAIT data.

Persistent absence

If a child is “persistently absent” it means they have missed 10% or more of available sessions during the school year^{xcvii}. Illness is the most common reason given for persistent absence.

Evidence^{xcviii} suggests that persistent absentees are more likely to be bullied, excluded from school and be involved in risky behaviours (experiment with drugs, alcohol etc.) than those who are not persistent absentees, and there are clear links between absence and attainment. When controlling for other pupil characteristics persistent absentees were likely to achieve the equivalent of one grade less in each GCSE taken over peers who consistently attended. Just under a third of young people who were persistently absent during the final year of their compulsory school education, are not in education, employment or training (NEET) at the age of 18. This compares to just over a tenth of their non-PA peers^{xcviii}.

As detailed in other sections of this report, being persistently absent and the increased likelihood of experiencing risk factors for absence, impacts upon wellbeing and mental health, but also future relationships and opportunity. PHE remark that educational qualifications determine an individual's labour market position, which influences income, housing and other material resources; all of which relate to overall health and health inequalities.

Evidence^{xcviii} found persistent absentees (PAs) were more likely to come from lone parent households or households with no parents, compared to their non-PA peers. Almost a third of persistent absentees came from workless households in comparison to less than one in ten of non-PAs. Children eligible for free school meals are more than twice as likely to be persistently absent than those who are not eligible.

Parental attitudes of persistent absentees and other non-PA pupils differ significantly. Parents of non-PA pupils tend to feel personally engaged with their child's school life and expect them to continue on with full-time education after leaving school. The parents of persistent absentees on the other hand, tend to feel less engaged with their child's school life, with many expecting their child to start some form of trade or apprenticeship scheme, or enter full-time paid employment after leaving school^{xcviii}.

A sizeable proportion of persistent absentees are disengaged with education; they report not being happy at school, feeling it a waste of time, they do not want to go to school and are not inclined to work hard while there. In line with this, a greater proportion of persistent absentees find lessons boring and a waste of time compared to their non-PA peers^{xcviii}.

National data on Absence

Analysis in 2018/19^{xvii} showed around 11% of all enrolments¹¹ were persistent absentees. Levels of absence were similar in male and female pupils, in overall and persistent absences.

Levels of absence were greatest in those pupils from Travellers of Irish and Gypsy/Roma heritage at 18% and 12.6% respectively, and lowest in pupils of Chinese and Black African ethnic backgrounds at 2.3% and 2.9% respectively.

In pupils claiming free school meals (FSM) there was an overall absence rate of 7.5%, in comparison with 4.2% of non-FSM pupils. The persistent absence rate was 22.8% in pupils claiming FSM, more than double the rate of non-FSM pupils at 8.3%.

In pupils with a SEN statement or education healthcare (EHC) plan there was a higher rate of overall absence rate (8.7%) than in those pupils with SEN support (6.5%) and both were higher than in pupils with no identified SEN (4.3%). In pupils with a SEN statement or education healthcare (EHC) plan the persistent absence rate was 24.6%; more than double the rate for pupils with no identified SEN (9.0%).

An analysis performed in 2009^{xcix} examined in more detail absence in those with SEN and those without. In accordance with current figures, they found pupils with special educational needs were more likely to be absent from school than other pupils. In 2008/09, pupils with no special educational needs missed the least amount of school through absence (5.6 per cent of half days missed). Pupils at School Action Plus (9.6 per cent) and with statements (9.4 per cent) missed the most school through absence. Children with profound and multiple learning difficulties and behavioural, emotional and social difficulties were the most likely to be absent from school. Unpicking reasons for absence, with special educational needs were more likely to be absent due to arriving late, being excluded (no alternative provision) and other unauthorised or authorised circumstances. However, pupils with special educational needs were less likely to be absent due to illness and family holidays, compared to those without.

National data on Exclusion

Government data from 2018/19^c established boys have more than three times the number of permanent exclusions than girls. The number and rate of permanent exclusions has decreased for boys, but increased for girls, from 2017/18.

Permanent and fixed period exclusion rates generally increase as age increases, both peaking around age 14 before reducing again. Permanent exclusion rates were shown to be more than four times higher among pupils eligible for FSM, the rate being 0.27, compared to 0.06 for those not eligible. Fixed period exclusion rate followed the same pattern; 13.76 for FSM eligible pupils, compared to 3.83 for those not eligible.

Other studies^{ci} also found exclusion from school was more common among boys, secondary school pupils, and those living in socio-economically deprived circumstances. Poor general health and learning disability among children and poor parental mental health were also associated with exclusion.

Exclusion rates were higher among special educational needs (SEN) pupils, with permanent exclusion rate for SEN pupils with an education, health and care (EHC) plan at 0.15, for pupils with SEN support it was 0.32, compared to 0.06 for those without SEN. The pattern persisted for those with fixed period exclusions; the rate being 16.11 for EHC pupils and 15.59 for SEN support pupils, compared to 3.57 for those not eligible.

Exclusion rates also varied by ethnicity, with a continuation of pupils of Gypsy/Roma ethnic groups having the highest rates of both permanent (0.39) and fixed period exclusions (21.26), followed by those of Traveller of Irish heritage ethnic groups at 0.27 and 14.63 respectively. The fixed period exclusion rate for Travellers of Irish heritage has decreased from 17.42 to 14.63. The fixed period exclusion rate had increased for all other ethnic groups, except Black Caribbean, and Irish.

¹¹ Enrolment – a pupil who is on the educational roll at a school for at least one session during the year

Local data on absence and exclusions

Local data from the Department of Education for 2018/19^{ci}, shown in table 17 below, demonstrated higher rates of persistent absence in Bournemouth than seen in England, across both primary and secondary schools.

In Dorset and Poole there were lower levels in primary school than in England and Bournemouth. Poole was also lower than England for secondary schools, whereas Dorset showed a comparable level at secondary level.

Table 17: Number, and percentage, of persistent absentees in Primary and Secondary schools across Bournemouth, Poole and Dorset., 2018/19

LA	Number of persistent absentees	Percentage of persistent absentees
PRIMARY SCHOOL		
Bournemouth	1,009	8.8
Dorset	1,578	7.0
Poole	648	6.9
<i>England</i>	-	8.2
SECONDARY SCHOOL		
Bournemouth	1,381	14.2
Dorset	3,474	13.8
Poole	962	13.1
<i>England</i>	-	13.7

Source: LAIT data.

Fixed Period Exclusions

The latest data available from 2016/17 from PHE is shown in figure 40 below as a rate per 100 (equivalent to a percentage).

Primary school fixed period exclusions were higher in Dorset (1.85) and Poole (1.67) than England (1.37). Bournemouth had the lowest proportion at 1.16.

The opposite was observed in local Secondary schools, where Bournemouth had the highest rate of fixed period exclusions per 100 pupils (15.5), significantly above the England benchmark (9.4) with Poole (7.3) and Dorset (7.9) below.

Both Bournemouth and Poole had higher rates of fixed period exclusions due to persistent disruptive behaviour than England. Dorset had a lower rate.

Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)	Comment
Primary school fixed period exclusions: rate per 100 pupils	2016/17	1.37	1.16	1.67	1.85	SW Region:1.69
Secondary school fixed period exclusions: rate per 100 pupils	2016/17	9.4	15.5	7.3	7.9	SW Region:9.4
Fixed period exclusion due to persistent disruptive behaviour: rate per 100 school aged pupils	2016/17	1.4	2.4	1.6	1.0	SW Region:1.4

Figure 40: Fixed period exclusions, across local authorities
Source: Dorset CCG, using PHE Public Health Profiles data

A worsening picture is evident from later LAIT data which shows, for 2017/18 and 2018/19, primary schools rates of fixed period exclusions rose to 2.4 and 3.1 in Bournemouth, a stable picture was seen in Poole of 1.8 and 1.7 and in Dorset a rise was also seen to 2.0 and 2.1. This were higher than national trends where England remained at around 1.4. There was no data available for 2020.

Again in 2017/18 and 2018/19 LAIT data shows, in secondary schools, a greater percentage rise in fixed period exclusions was observed across authorities. Bournemouth 15.9 and 18.0, Poole 11.4 and 12.0 and Dorset 9.7 and 9.5. England saw smaller rises to 10.1 and 10.8.

Permanent Exclusions

Local Authority data shows minimal numbers for permanent exclusions within Primary Schools, but for Secondary schools it shows an increasing trend, seen in figure 41. The prevalence in Poole and Bournemouth is twice that seen in Dorset and of England.

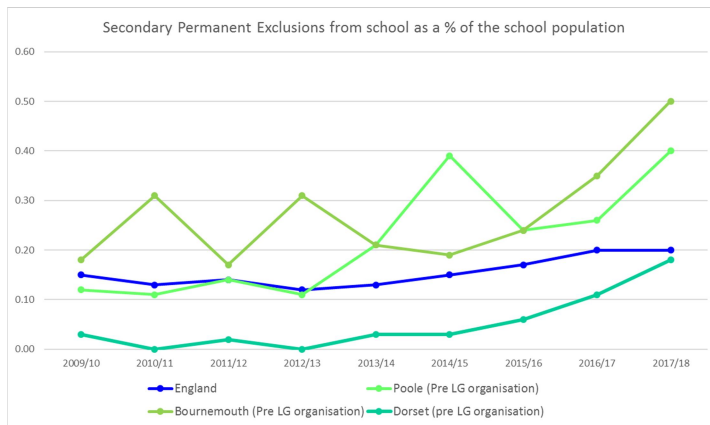


Figure 41: Secondary Permanent Exclusions from school as a % of the school population
Source: LAIT

Benchmarking with other local authorities

The charts below give an indication of the position of permanent exclusions across our three local authorities, when benchmarked against other national unitary or county authorities^{ciii}, seen in figures 42-44. Dorset is presented differently, in comparison with other county, rather than unitary authorities.

Rates of permanent exclusions

It can be seen from figure 42 that in 2018/19 Bournemouth had a higher rate of the school population that were permanently excluded than most, at 0.29 (29 pupils per 10,000). This proportion was only just below the maximum for all unitary authorities at 0.31 in Redcar and Cleveland and in line with Blackpool.

Bournemouth - Permanent exclusions from school (rate):

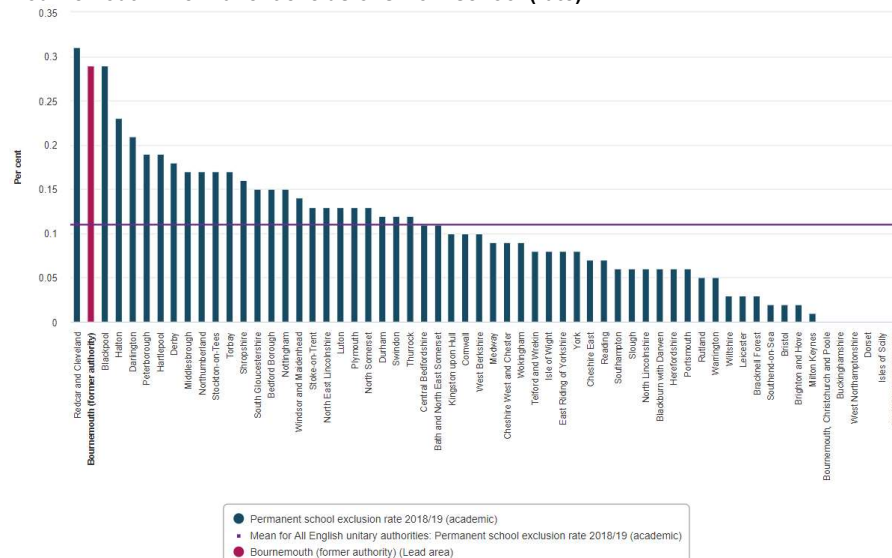


Figure 42: Permanent exclusions from school in Bournemouth, in comparison with other English Unitary Authorities, 2018-19
Source: LG inform

Poole also had a higher proportion of pupils permanently excluded from school (0.17) in comparison with the average proportion for all unitary authorities in England at 0.11 (11 pupils per 10,000).

Poole - Permanent exclusions from school (rate):

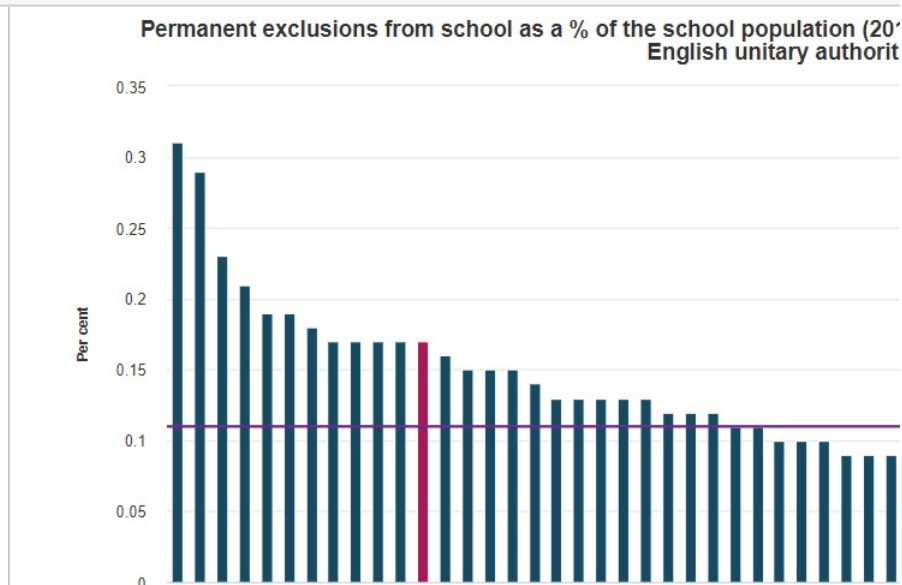


Figure 43: Permanent exclusions from school in Poole, in comparison with other English Unitary Authorities, 2018-19
Source: LG inform

For Dorset CC, there was a fairly high proportion of pupils permanently excluded from school (0.15, or 15 pupils per 10,000) in comparison with the average proportion for all county authorities in England at 0.09 (9 pupils per 10,000).

Dorset - Permanent exclusions from school (rate):

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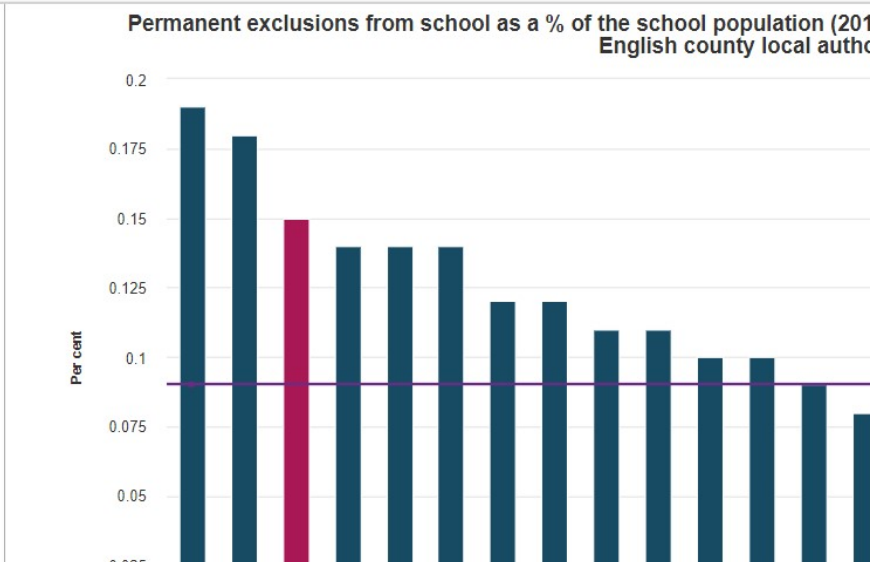


Figure 44: Permanent exclusions from school in Dorset, in comparison with other English County Local Authorities, 2018-19
Source: LG inform

Trends in permanent exclusions

It can be seen in figure 45 below that in Bournemouth and Dorset CC proportions of the school population who have been permanently excluded has steadily grown since 2014/15. In 2018/19 levels were almost three times higher than in 2014/15 in Bournemouth and seven times higher in Dorset CC^{ciii}.

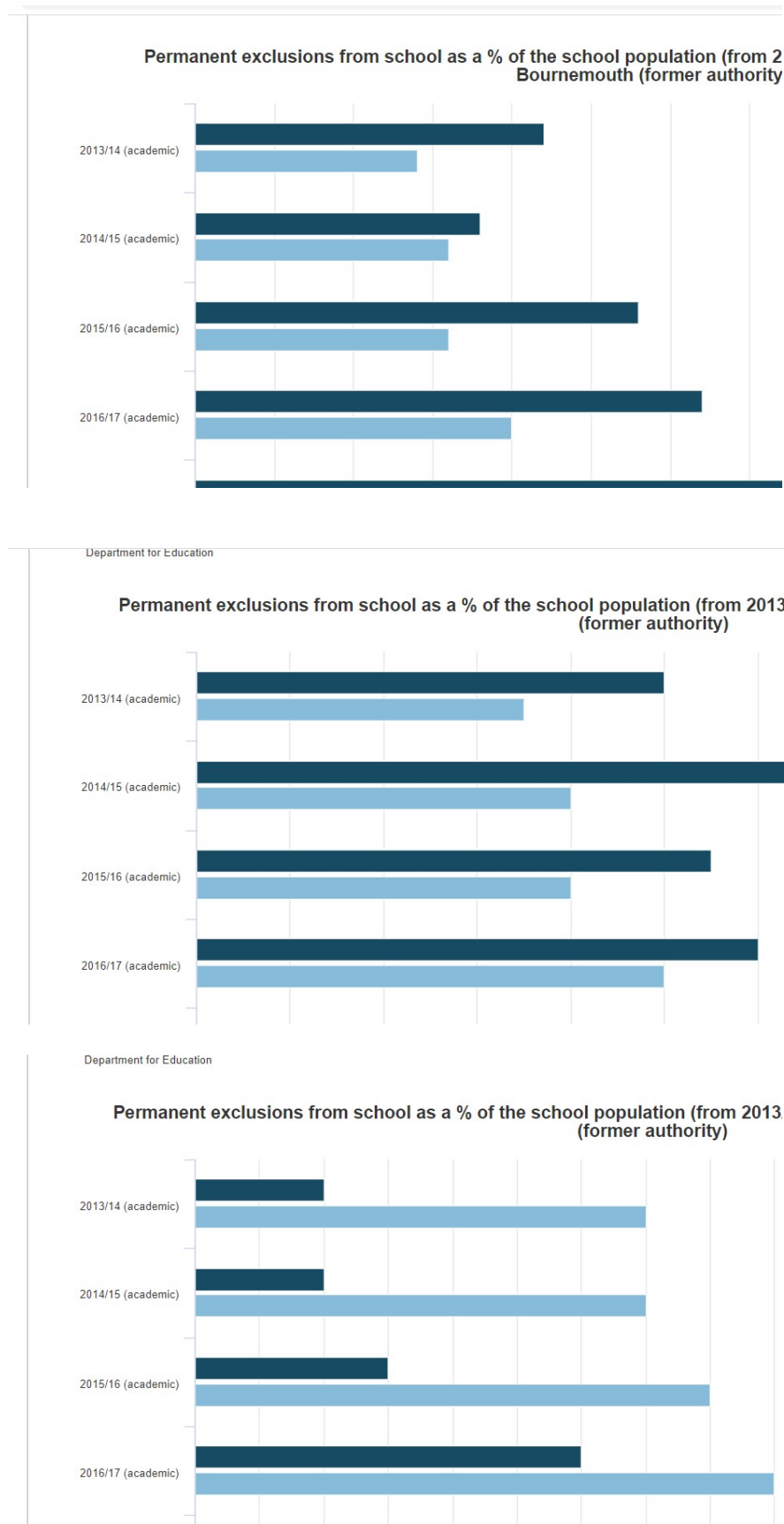


Figure 45: Permanent exclusions from school, as percentage of school population (2013/14-2018/19)
Source: LG Inform

SUMMARY – Education Information

Early Years development and educational provision

The Ages and Stages Questionnaire has been determined a reliable measure of development to assess child development outcomes and disparities in child development have an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential, with associated poorer long term outcomes including mental health and general wellbeing.

90-92% of children were achieving a good level of development across Dorset, in 2018/19.

Early years education is designed to improve the survival, growth, and development of young children. The aim is to improve school readiness skills and ameliorate poorer achievement outcomes for disadvantaged students. An increase in school readiness leads to improved educational achievement, and later, greater earning potential and productivity.

In 2020 there were more eligible children utilising funded places at two years old in Dorset, at 89%, than in BCP at 80%. Both areas had higher uptake than the South West and England. Prior to the reorganisation, there had been a rising trend in Poole, and a fairly level trend seen in Dorset. There had been a consistently lower percentage in Bournemouth. This may suggest the current percentage in BCP is reflective of higher uptake in Poole raising the BCP proportion as a whole.

In 2020 there were again more eligible children utilising funded places, at three-four years old, in Dorset (96%) than in BCP (91%). While both areas show uptake above 90%, Dorset is positioned higher than percentages in the South West and England, while BCP is below both.

The quality of early years education was as 'good' or 'outstanding' in the large majority of provider organisations.

School readiness

School Readiness is a national education standard to measure the development of children at the end of the early years' reception period. If children are prepared and able to effectively participate during their education from an early age, it has been shown to benefit their mental health and other outcomes.

There was a higher percentage of children achieving a good level of development in BCP than in Dorset UA, in line with, or above, England and the South West.

School, Colleges and University

Data on numbers attending and provision has been included, but no data on level of mental health need.

Impact of poverty on educational readiness and achievement

Free school meals (FSM) are a well-accepted measure of socio-economic disadvantage in school pupils. Dorset County Council (CC) had a higher uptake than Bournemouth and Poole across both primary and secondary age pupils in 2018.

Locally, in 2018/19, children in receipt of Free School Meals were less likely to show the expected level of general and phonics development at the end of Reception by 13-18% less across areas and different measures.

Looking at later qualifications at age 19, for those who had previously been in receipt of FSM, 20-40% fewer individuals achieved level 2 qualifications than individuals who had not, between 2015-2019. A decline was seen in all authorities between 2018-19, but with greater decline in Poole and Bournemouth.

The picture was similar for those obtaining Level 3 qualifications, previously in receipt of FSM, with the inequality gap between 28-40% across the regions of Bournemouth, Dorset and Poole between 2015-2019.

Educated other than mainstream school provision

Nationally there have been increases in the number of children home-schooled; official figures showed a 76% increase over the four-year period from 2014-15 to 2018-19.

Home-educated children are not automatically 'vulnerable' but some children educated at home do fall into that category, with evidence from many local authorities that the proportion who do is increasing. Concerns have been raised about understanding the quality of education received, monitoring processes, lack of regulatory frameworks, and the visibility of, and regular contact, had with these children.

Locally, there are a number of CYP whose parents have registered them as home educated; this figure obviously fluctuates throughout the year. Within BCP at end of March 2020 there were 502 children and young people in elective home education. In March 2020, within Dorset CC. there were 495 children and young people recorded as being home-educated. Both authorities have guidance available to parents on home education.

Children Missing Out On Education

Within national statutory guidance it is commented that children and young people missing out on education are at significant risk of underachieving, being victims of harm, exploitation or radicalisation, and are more likely to not be in education, employment or training later in life (NEET).

Reasons considered for not engaging with education include children within refugee and asylum seeking families, families who are highly mobile, those experiencing mental health problems or experiencing abuse and neglect.

Within BCP there were 637 'children missing education', at March 2020. Historical data was not available for Dorset UA, but at February 2021, there were 116 open cases with 252 referrals this academic year.

Absence and Exclusions

Disillusion with, absence or exclusion from school are risk factors for children's wellbeing and mental health. They are equally risk factors for disruptive behaviour, which often leads to exclusion, and may indicate underlying mental health problems.

Children are at a higher risk of missing school if they have poor mental health, in particular if they have conduct disorders, anxiety or depression, SEND, a long-term health condition, caring responsibilities or have been bullied. The ethnic background of a child also influences the odds, as do indicators of poverty generally to a larger extent.

Resultant effects of absence or exclusion from school are reduced opportunities for learning and increased social isolation in the short term and longer-term reduced educational achievement and life chances, leading to further inequalities.

Being excluded from school is associated with poor physical health, substance abuse, antisocial behaviour, crime, low academic achievement, unemployment and homelessness.

Locally, there are comparable or higher rates of absences and exclusions than in England, Permanent exclusions have been shown to be higher in comparison with other local authorities nationally, with trends showing growing rates of permanent exclusions locally over recent years.

Prevalence of Mental Disorder in Children and Young People

It is understood one in four (25%) people will experience mental health problems within their lifetime, and that 50% of mental health problems in adult life (excluding dementia) begin by the age of 14 years and 75% by age of 18-24 years^{iv,vi,xvii}.

Findings from the NHS Digital Prevalence Survey of Mental Health in Children and Young People in England, 2017

Overview

New data obtained in 2017 on the prevalence of mental disorders in children and young people in England were published by NHS Digital^{lix}, collected from 9,117 children and young people, aged 2-19 years old. The term 'mental disorder' was used as they applied operationalised diagnostic criteria for specific disorders using standardised tools, rather than screening for general mental health problems.

They reported one in eight children (12.8%) of 5-19 year olds had at least one mental disorder¹², with one in 20 (5%) meeting the criteria for two or more. They also reported 1 in 18 (5.5%) 2-4 year old children were identified as having a mental disorder.

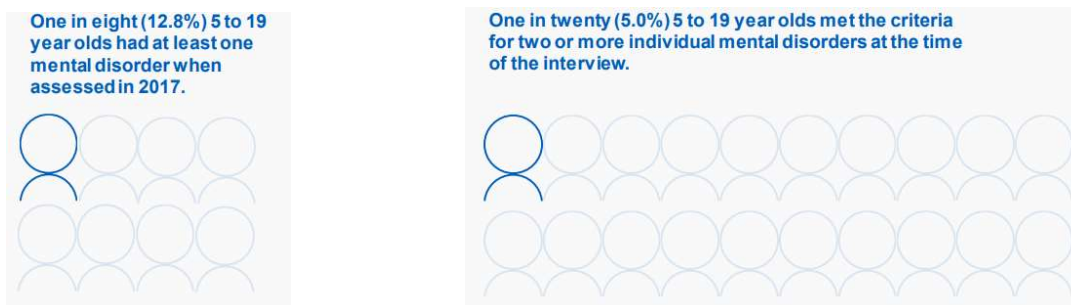


Figure 46: Prevalence of mental disorder in 5-19 year olds, England 2017
Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

Emotional disorder rates had increased over time, while other types were relatively stable, Prevalence was observed to be rising, using comparable data available from previous surveys for those 5-15 years old. Rates were 11.2% (one in nine) in 2017, up from 9.7% in 1999 and 10.1% in 2004 (figure 47 below), overall and in both genders.

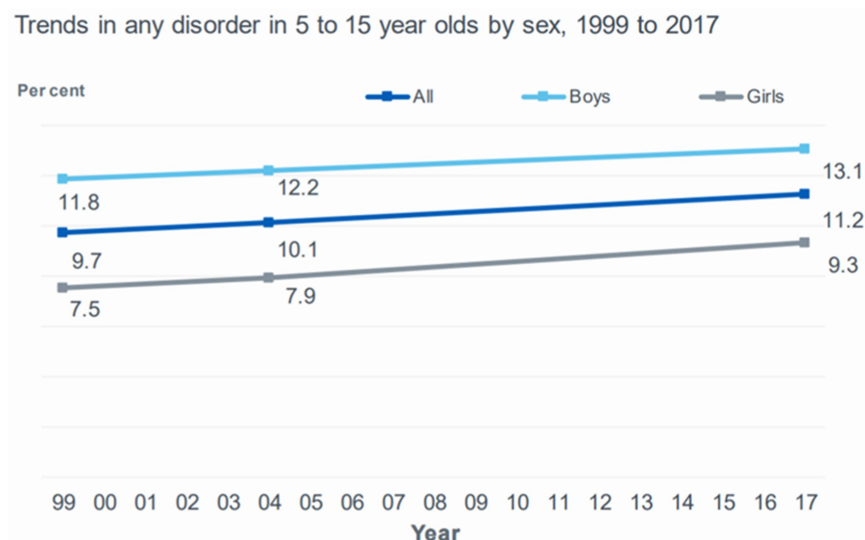
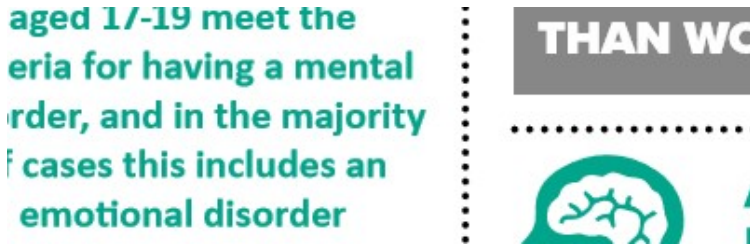


Figure 47: Trends in any disorder in 5 to 15 year olds by sex, 1999 to 2017
Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

¹² Mental disorders were identified according to International Classification of Diseases (ICD-10) standardised diagnostic criteria, using the Development and Well-Being Assessment (DAWBA). To count as a disorder, symptoms had to cause significant distress to the child or impair their functioning. All cases were reviewed by clinically trained raters.

Prevalence by age and type of disorder

For the age group 5-15 year olds comparable data is available from previous surveys, and it was observed there was an increase in prevalence over time, from 9.7% in 1999 to 10.1% in 2004 and 11.2% in 2017. A breakdown within that age group showed, between 1999-2017, proportional increases of 13% in those aged 5-10 years and 19% in those aged 11-15.



Source: 'Key Data on Young People 2019'^{CV}

The most prevalent type of disorder, at one in twelve 5-19 year olds, was of 'Emotional disorders' (8.1%), which include anxiety and depressive disorders. Anxiety disorders (7.2%) were nearly four times more common than depressive disorders (2.1%).

Around one in twenty (4.6%) 5 to 19 year olds had a behavioural disorder, with rates higher in boys (5.8%) than girls (3.4%).

Hyperactivity was observed in around one in sixty children, and other less common disorders, including autism spectrum disorders (ASD), eating disorders and tic disorders were seen in one in fifty. Further detail on types of disorders is contained with appendix 5.

The figure below demonstrates the prevalence of each disorder within each age group sampled (figure 48). It shows one in eleven young people aged between 11-16% (9%) and one in seven of those aged 17-19 years (14.9%) had an emotional disorder.

Different disorders were prominent at different stages; 'any disorder' and 'emotional disorders' saw increases in prevalence with age. The highest prevalence for both were seen in the age group of 17-19, followed by the age group 11-16; young people aged 17 to 19 were three times more likely to have a disorder (16.9%) than preschool children aged 2 to 4 (5.5%).

Rates of behavioural and hyperactivity disorders were, meanwhile, highest in children aged 5 to 16 years and a different picture was present in less common disorders.

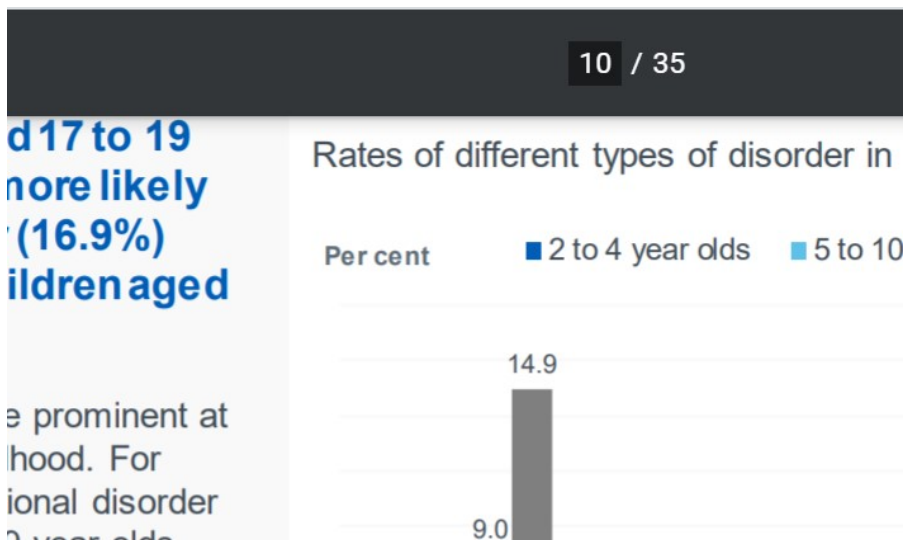


Figure 48: Types of disorders in 5-19 year olds, England 2017
 Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

Prevalence across genders

While overall prevalence was reported of 14.4% of 11-16 year olds and 16.9% of 17-19 year olds meeting the criteria for a mental disorder at the time of the survey, differences could be seen within genders. The below chart in figure 49 shows the variance across age groups showing the developmental trend for disorders to increase throughout teen age years for both genders, and to continue increasing during older adolescence in young women to 23.9%, equating to nearly one in four young women.

Chart 7.6: Prevalence of mental health disorders in children and young people I



Figure 49: Prevalence of 'any disorder' in children and young people by age and gender, England 2017
 Source: AYPH, Key Data on Young People Report, 2019 using data from NHS Digital 2018. Mental Health of Children and Young People in England, 2017

Of note were the differences in gender in relation to types of disorders, such as in emotional disorders, shown in figure 50 below. While fewer females had emotional disorders at age 5-10, there was a marked increase during 11-16 and concerning rates of emotional disorders seen in 17-19 year olds females. While they were at 10.9% between 11 and 16 years old, this had risen to nearly a quarter of females between 17-19 years of age (22.4%).

Focus on young women: one in four 17 to 19 year old girls



Young women have been identified as a high risk group in relation to mental health.

This survey also found rates of emotional mental disorder and self-harm were higher in this group than other demographic groups.

Nearly one in four (23.9%) 17 to 19 girls had a mental disorder. And 22.4% had an emotional disorder.

One in eighteen (5.6%) young women were identified with body dysmorphic disorder (BDD). BDD is an anxiety disorder characterised by the obsessive idea that some aspect of one's body part or appearance is severely flawed and warrants exceptional measures to hide or fix. 1.6% of young women were identified with an eating disorder.

Half (52.7%) of young women with a disorder at the time of the interview also reported having self-harmed or made a suicide attempt.

Emotional disorder in 5 to 19 year olds, by age and sex

Age Group	Boys (%)	Girls (%)
5 to 10	4.6	3.6
11 to 16	7.1	10.9
17 to 19	7.9	22.4

Figure 50: Emotional disorders, 5-19 year olds, by age and sex
 Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

This is concurrent with their findings that around half of the young women with a disorder had self-harmed or attempted suicide (52.7%). Other research and local data has also demonstrated greater prevalence of self-harm and suicide in young women, explored later in this report.

While worthy of consideration for present need, with the consideration that three-quarters of adult mental health problems are established by age 18, this also has significance in relation to maternal and child health in future generations, especially given the impact of maternal mental health on attachment and early years development.

Characteristics of children and young people with a mental disorderⁱⁱ

Demographics: White British 5 to 19 year olds were three times more likely (14.9%) than Black/Black British (5.6%) or Asian/Asian British (5.2%) children to have a disorder. Those 5-19 year olds from a Mixed/Other background also had high prevalence at 12.1% and White Other at 8.3%.

Health: Children with poor general health, special educational needs, or children with a parent with poor mental health or in receipt of a disability-related benefit, were more likely to have a mental disorder than other children. Girls rating their health as 'fair/bad/very bad' were seven times more likely to have a disorder than girls rating health as 'very good'. In the same respect, boys were four times more likely with self-rated poor health.

Family: Rates of mental disorder were higher in children living in households with less healthy family functioning and in those whom have a parent with physical or mental health disorder. It is recognised these particular associations do not confirm causality; it may be that poor family functioning or parental health may contribute to onset of mental disorder but equally it could be the presence of mental disorder which create problems in family functioning and deterioration in parental physical or mental health.

Socioeconomics: Living in a low-income household or with a parent in receipt of income-related benefits was associated with higher rates of mental disorder in children. As noted earlier, while no association was found with neighbourhood deprivation, association between mental disorder and living in poverty has been established.

Predictors of increased risk reported in the national prevalence survey

The survey reported factors associated with mental disorders which were consistent across ages 2-16 as:

- **Ethnicity:** They found children and young people of a White ethnic background to be more likely to have any mental disorder, and similar risks for emotional disorders for those from White and Black or minority ethnic backgrounds, and again more likelihood of being from a White Background in those with behavioural disorders. This is in contrast to some other data around ethnicity and risk, and there have been reports of increased risks and indicators of need highlighted for those from minority ethnic backgrounds since the COVID-19 pandemic, which has taken place after this original survey.
- **Family context:** family functioning, parental mental health (marital status of the parent beyond age 4)
- **Socioeconomic context:** receipt of welfare benefits, region, (household tenure in ages 5-10)

Social context of mental health

The survey also reported 'social' factors associated with mental disorder. They found young people with a mental disorder were more likely to have:

- Spent longer (four hours or more) on social media, compared themselves to others when online, and felt that the number of 'likes' they got affected their mood
- Been bullied and bullied others, both online and offline
- Experienced types of adverse life events, like parental separation and financial crisis
- Low levels of social support and a smaller social network
- Self-harmed or attempted suicide both in the past four weeks and at some time in their life
- Not participated in clubs or organisations, in or out of school
- Tried alcohol, illicit drugs, tobacco and e-cigarettes
- Not identified as heterosexual.

The Royal Society for Public Health estimate 91% of 16 to 24 year olds use the internet for social networking, and suggest that this is linked with increased rates of anxiety, depression and poor sleep^{xxxv}.

Applying prevalence assumptions to local population

A crude prevalence can be indicated through modelling local population estimates from 2019, with 2017 prevalence estimates applied. This indicates around 8,304 children and young people aged 5-19 in BCP, and 7,538 within Dorset, would be considered to have one diagnosable mental disorder, a total of nearly 16,000 children across Dorset. This is shown in table 18.

Around 3,244 children and young people aged 5-19 in BCP, and 2,945 of those within Dorset UA, would be considered to have two or more diagnosable mental disorders.

Table 18: Modelled prevalence of mental disorder, using NHS digital 2017 prevalence proportions

Unitary Authority (post-4/19)	Population (5-19)	At least one mental disorder	Two or more disorders
BCP	64,879	8,304	3,244
Dorset	58,890	7,538	2,945
Total	123,769	15,842	6,189

Prevalence within 2-4 year olds (Preschoolers)

It was found in the 2017 NHS Digital survey that 1 in 18 (5.5%) 2-4 year old children identified as having a mental disorder; with higher rates in boys (6.8%) than girls (4.2%). This would equate to around 700 children in BCP (2-4 year old population of approximately 12,700) and 550 in Dorset UA (population approximately 10,000).

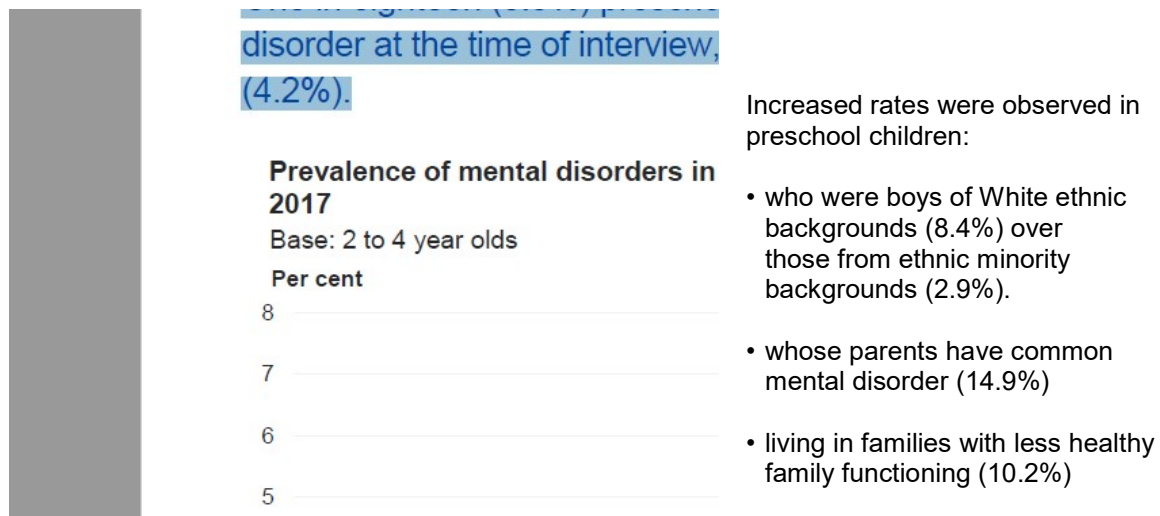


Figure 51: Prevalence of mental disorders in preschool children (aged 2-4 years), England 2017
Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

Whilst again the rates showed no association with the area-level deprivation measure (IMD), there was an association between prevalence and incomeⁱⁱ. Preschool children living in the third of households with lowest income were more than twice as likely to have a mental disorder (8.9%) than those in highest income (4.0%). Also higher rates were seen in those living with a parent in receipt of benefits related to low income and disability (10.4%).

Other characteristics of preschool children with a mental disorder

Demographics: White British 2 to 4 year olds were more likely (6.1%) to have a mental disorder than children from a minority ethnic background (3.9%). By gender, this was the case in boys, however girls were more likely to have a disorder if from a minority ethnic background.

Health: One in five (21.6%) preschool children whose general health was reported as fair, bad or very bad were identified as having a mental disorder, compared to 3.2% of preschool children whose general health was reported as very good. It should be noted that the mental disorder may have been an aspect of the child's general health

Family: Rates of mental disorders were higher in preschool children whose parents showed signs of a common mental disorder (14.9%) and in preschool children living in families with less healthy family functioning (10.2%); again no causality can be assumed

Socioeconomics: Preschool children living in the third of households with the lowest income were more likely to have a mental disorder (8.9%) compared to preschool children in households with higher income (4.0%). Rates of mental disorders were also higher in preschool children who lived with a parent in receipt of benefits related to low income and disability (10.4%)

Household income was also associated with the increased presence of emotional and behavioural disorders. Children living in households with the lowest income had higher rates of emotional disorders (9.0%) behavioural (6.1%), compared to emotional disorder prevalence of 4.1% for children in households with the highest income and 1.7% for behavioural.

Prevalence within the 16-24 age group

The 2014 English Adult Psychiatric Morbidity Survey (APMS)^{civ} gathered data specific to 16-24 year olds, and the prevalence of common mental disorders in this age group was nearly three times higher in women (26.0%) than men (9.1%), shown in figure 52. These findings concur with the latest NHS digital survey results from 2017 showing higher rates in older adolescent females.

Figure 52: Prevalence of common mental disorder symptoms, by age and sex, England 2014.
Source: McManus et al (2016) Adult Psychiatric Morbidity Survey

It can be seen in figure 53 below, there were various rates of common mental health disorders in this age group, but that younger females showed higher proportions of all types of disorder than any other group.

Chart 7.9: Rates of common mental disorders in past week, by age and sex, all a

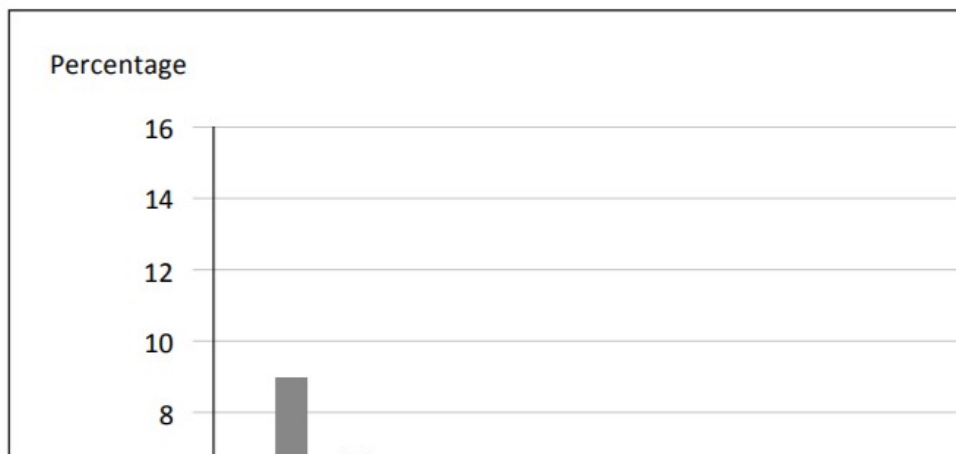


Figure 53: Prevalence of common mental disorder symptoms in past week, by age and sex, all adults, England 2014.
Source: McManus et al (2016) Adult Psychiatric Morbidity Survey

Statistics published by the Association for Young People's Health in 2019 reported anxiety and depression was present in nearly a quarter of young women aged 16-24 (24.6%) and a seventh of young men (14.7%)^{cv}; the authors concluded young women were a high-risk group in the population.

The most recent Scottish Health Survey results for 16-24 year olds on wellbeing and mental health measures also found more than 1 in 5 (22%) had a score indicating a possible psychiatric disorder, the highest proportion amongst all adult age groups in the survey^{cvi}.

Secondary care indicators related to mental health

Hospital admission rates for mental health conditions

Hospital admission rates in 2019/20 for mental health conditions in those aged 0-17 years, per 100,000 population, are shown in figure 54 below. BCP had a rate of 119.1 per 100,000 population, above that seen in England and Dorset. Dorset was similar at 95.8 to that of England at 89.5.

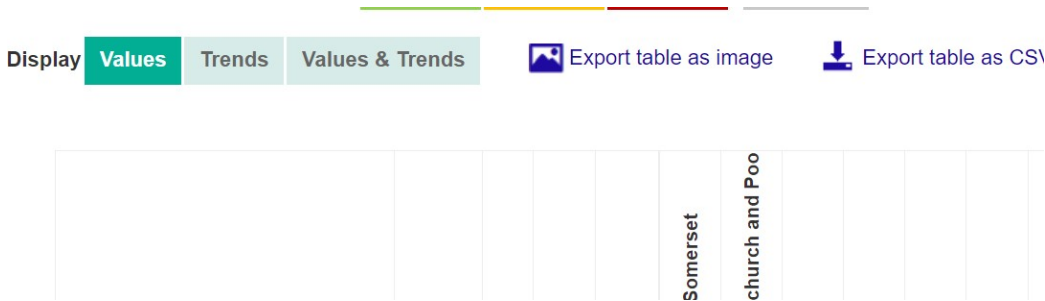


Figure 54: Hospital admissions for mental health conditions, 0-17 years of age in 2019/20
Source: PHE Public Health Profiles

Trend data on hospital admissions for mental health conditions are shown in figure 55, under the previous three local authorities.

Bournemouth and Poole both saw increases from 2014/15, to significantly above that of England in 2016/17 and Bournemouth at 116.7 and Poole at 119.2, in 2018/19, both remained above the England rate which was 84.7. Dorset has shown a relatively stable picture in line with England during the same time periods.

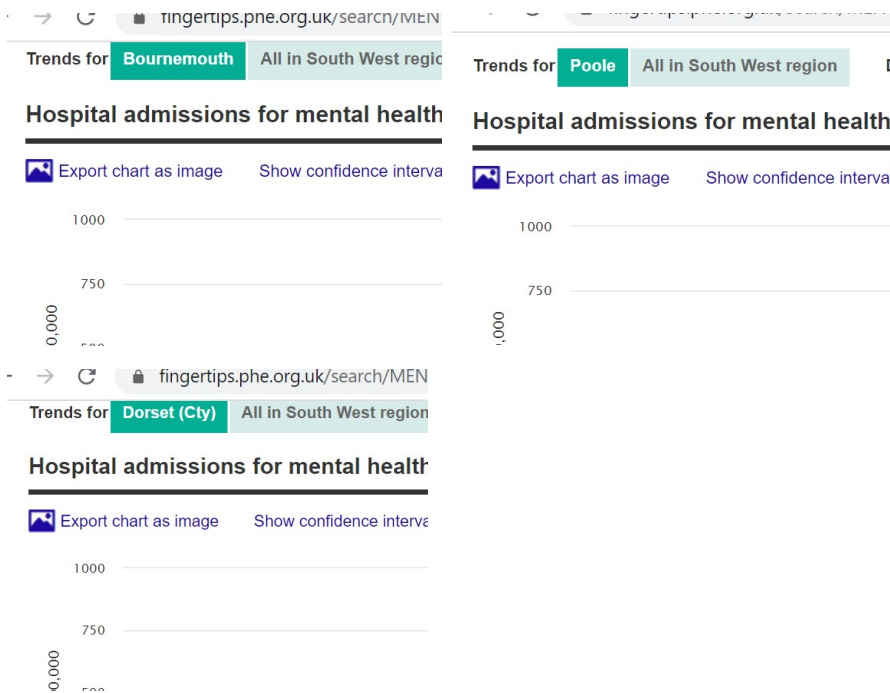


Figure 55: Trends in hospital admissions for mental health conditions, 0-17 years of age, across local authorities
Source: PHE Public Health Profiles

Admissions for self-harm

Hospital admission rates for self-harm

In 2019/20 in BCP the rate of admissions for self-harm (age 10-24) was 814.8 per 100,000, a nearly twice that seen in England. For Dorset the rate was 707.1 per 100,000, significantly above that of England. Both regions had higher rates than seen in the South West.

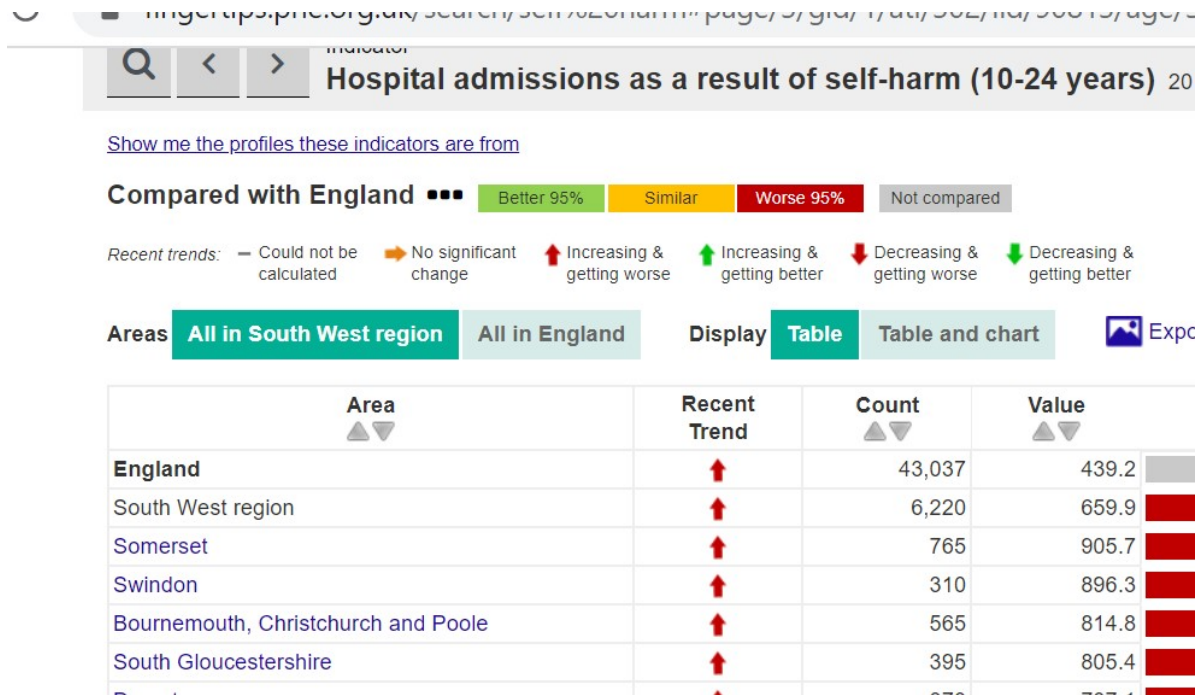


Figure 56: Hospital admissions as a result of self-harm in 10-24 year olds, rate per 100,000 (CYP), 2019/20
Source: PHE Public Health Profiles

Prior to that, in 2018/19, the rate of admissions for self-harm (age 10-24) at 817.7 per 100,000 was nearly twice the rate seen in England, with 575 admissions. The rate of admissions for self-harm at 627.9 per 100,000 was a third above the rate seen in England, with 335 admissions.

Further breakdown of admission data related to self-harm is contained later in this report in section on ‘Self-harm and Suicide’. Essentially, in children and young people aged 10-24, despite the national picture remaining fairly stable, all three previous local authorities across Dorset had rates of self-harm above that of England and all demonstrated a continuing rise in rates since 2016/17. In the new combined authorities, rates in 2020 remain above the national and regional rates.

Hospital admission rates for alcohol and other substances

This information is contained in the section on ‘Those involved with substance abuse’ later in the report.

In summary, in 2018/19 the hospital admission rate in under 18s for alcohol specific conditions was 60.1 per 100,000 in BCP, again twice that of England. This represents 135 admissions per year in BCP. The hospital admission rate for substance misuse was 133.2 per 100,000, worse than England.

The hospital admission rate in under 18s for alcohol specific conditions is 48.9 per 100,000, again a third above the rate seen in England at 32. This represents 100 admissions per year in Dorset. The hospital admission rate for substance misuse (15-24 years) is 91.5 per 100,000, which is worse than England.

Wellbeing and Indicators of lower-level (mild-moderate) need

There will always be a fluid spectrum of wellbeing and mental health in children and young people, with the majority experiencing more positive states. However, in addition to understanding the proportions of those meeting criteria for mental disorders and meeting criteria for mental health services, would be a proportion of the younger population with mild-moderate need, to be supported with preventative action, advice, support or evidence-based lower-level interventions.

Wellbeing has been described as more than the absence of illness, often considered a measure of positive health and it is at the forefront of many national publications and reports^{cv,cvii,cviii,cix,cxxvii}, all emphasising the impact of wellbeing on cognitive development and learning, and mental, physical and social health.

Positive wellbeing builds resilience in young people and, across ages, people with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental. While difficult to define, many methods have been applied to quantify it. This is somewhat harder to quantify, however, some indicators are available which focus on this^{cvii}. Currently, indicators of mental health and wellbeing often used are 'Life satisfaction', 'happiness', 'anxiety' and 'worthwhile' measures.

Research suggests that, while a relationship exists between well-being and mental disorders, they are not simply the opposite of each other; an individual may report lower subjective well-being but have no identifiable mental disorder, and high subjective well-being may be present even with a diagnosed mental disorder. Outcomes, however, can be equally poor for those with low subjective well-being and those with mental disorders.

There have been a number of risk factors established for low well-being, such as difficult family relationships, being bullied, being within a family under financial strain and experiencing a combination of social, familial and material disadvantages.

While wellbeing may not be considered to have the significance attached to it that mental health has gained, wellbeing is associated with important outcomes. For instance, research has established associations between self-harm and significantly lower wellbeing scores than in peers who had not self-harmed^{cccxiii}, and those with lower wellbeing scores are noted to be engaging in activities of risky behaviours, have poorer health, and engage less in behaviours with protective mechanisms, such as exercise and eating healthily.

National Subjective wellbeing

The Children's Society 'Good Childhood Report'^{cvii} in 2020 focused on measuring the wellbeing of children nationally and in comparison with other European countries. Samples of children deemed representative of the diverse make-up of the population were surveyed, providing indicators of wellbeing within 'Life satisfaction' and 'Happiness' measures.

Most children and young people did report they were happy with their life as a whole, however, a small proportion indicated they were unhappy and showed lower levels of overall life satisfaction, as well as lower levels of satisfaction with appearance, school and friendships. They reported fewer friendships, higher levels of sadness and increased expectations of failure than previously seen and in comparison with other European countries.

In 2020 in the measure of 'overall life satisfaction', the majority of children scored on or above the midpoint of the scale (10 out of 20), however, nearly one in five (18%) of children scored below the midpoint, deemed to have low well-being. This was a larger proportion than had been recorded during the previous five years, when the proportion had ranged between 10-13%. It was noted the data was collected during April-June 2020, coinciding with a first period of national lockdown as part of measures to manage COVID-19 pandemic.

Time trends in wellbeing

Children's happiness with life has been in decline for most of the last decade, with worries about relationships with friends, appearance and school key factors.

Recent data from 2020 shows life satisfaction and wellbeing measures in children between 10-15 years old in the UK have decreased over time. Between 2009-10 and 2017-18, children have shown decreases in life satisfaction and happiness overall, as well as with friendships and in their interaction with school. Levels of happiness with family and schoolwork remained stable^{cvi}.

Overall happiness with life, and the change over time, is shown in figure 57 below¹³.

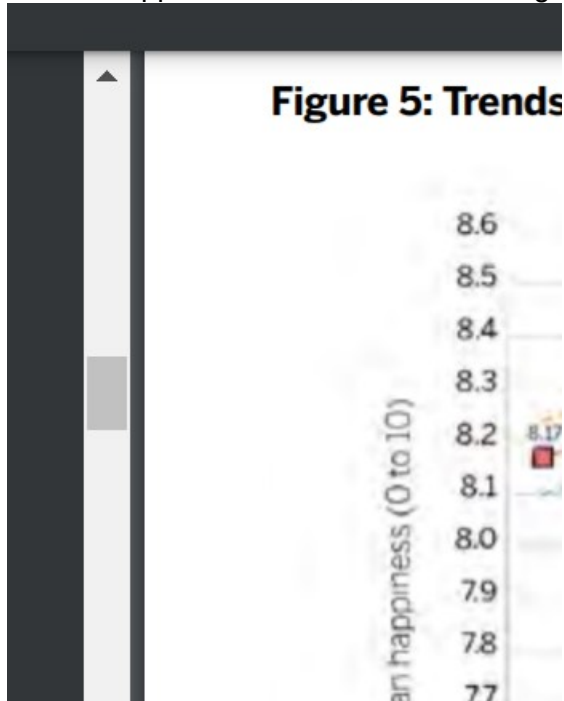


Figure 57: Trends in children's happiness (life as a whole) with different aspects of life by gender, UK, 2009-10 to 2017-18
Source: Good Childhood Report (2020)

The majority of the data was collected prior to the COVID-19 pandemic and it is acknowledged the pandemic response may have further impacted upon figures, not yet seen.

Wellbeing by Gender

In comparison with other European countries, the UK had the second largest gender gap, with nearly a quarter of girls (23%) scoring low on at least three out of four measures (life satisfaction, happiness, sadness and purpose) compared to 14% of boys.

Gender differences in children aged 10 to 15 were consistent with those reported in previous annual surveys^{cvi}. Boys were happier with their appearance than girls, and girls were happier with schoolwork. No consistent differences were observed between boys and girls for happiness with life as a whole, family, friends or school.

There were, however, significant and sustained increases in the proportion of boys who are unhappy with school, and girls who are unhappy with their friends.

¹³ The dotted lines show an estimation of how precise the estimate taken from the sample is; the dotted lines indicate the range of values within which there is 99% certainty that they contain the true mean of the whole population.

Indicators in comparison with other European countries

Prior to the COVID pandemic, 15 year olds in the UK were among the saddest and least satisfied with their lives in Europe, and reported high levels of 'fear of failure' compared with other European countries^{cvi}.

The UK ranked lowest of 24 European countries in 2018 for the proportion of children with high life satisfaction, ranked 23rd for low sadness (i.e. the UK had the second highest proportion with high sadness), and lowest for having a positive sense of purpose in life. While the UK ranking of 9th out of 24 for happiness was more optimistic, the UK fared poorly across measures, with the lowest proportion of children across the 24 countries without a low score on any measure.

The UK also demonstrated the largest decrease in life satisfaction, between 2015 and 2018, of comparable countries.

A recent study of children's health in 45 countries (Europe along with Canada) found children in the UK fared poorly for subjective wellbeing. For children aged 15, England ranked 36th; at the younger age of 11 years old, with England ranked 43rd^{cvi}.

Children in these England also demonstrated high levels of emotional complaints such as feeling low and having difficulties sleeping.

Other sources of wellbeing data

Wellbeing results for 10-15 year olds in Great Britain, reported by the ONS, showed average proportions of those who gave high or very high ratings in response to questions on life satisfaction, life being worthwhile, happiness and anxiety. Generally ratings were positive, ranging from 70.6% to 81% depending on the question and gender, shown in figure 58 below.

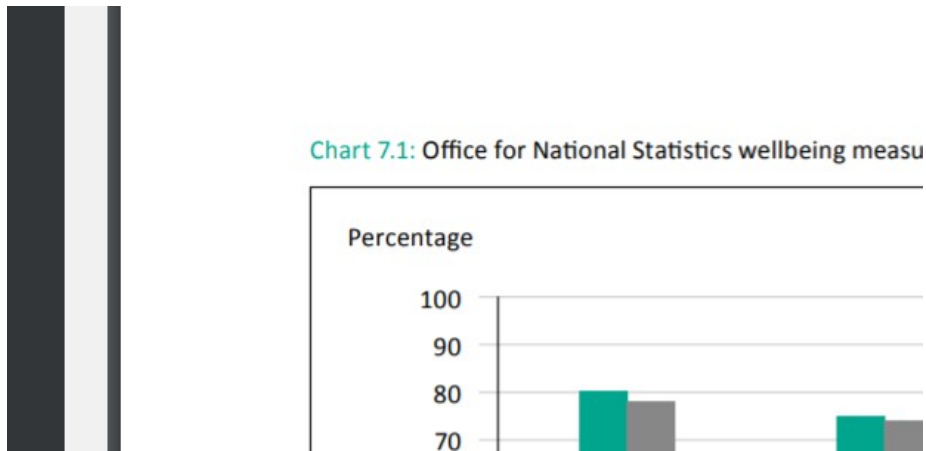


Figure 58: Office for National Statistics wellbeing measures, 10-15 year olds by gender, Great Britain, various years
Source: ONS Children's Wellbeing measures, 2018 contained in AYPH: Key Data on Young People 2019 full report

A similar question on life satisfaction was also included in the 'What About YOUth' (WAY) survey of 15 year olds, where 75% of boys and 55% of girls gave high or very high ratings.

The ONS^{cvi} also reported life satisfaction scores for those aged 16-19 and 20-24 during 2019-20. Approximately 84% had either 'high' or 'very high' scores, with around 13% scoring 'medium' and 3% scoring 'low'. In the 20-24 year old category approximately 83% had either 'high' or 'very high' scores, with around 15% scoring 'medium' and 3% scoring 'low'.

Further analysis of the data contained within the WAY youth survey was performed and showed differences in wellbeing associated with affluence, deprivation, sexual identity and disability or long-term health conditions, described below.

Wellbeing (WEMWBS) and health promoting behaviour

Further analysis of WEMWBS scores and their associations with behaviours and other risk factors, are shown below in figure 59. Wellbeing scores were higher for those not engaging in risky behaviours, not experiencing bullying and in those who report excellent general health. Lower scores were seen among those who did not eat daily recommended portions of fruit and vegetables, those not engaging in physical activity, those who felt their body was not 'about the right size', and those who had been bullied.



The wellbeing of 15 year-olds: further analysis of the 201

Figure 1: health behaviours and attitudes ar

	< Worse
Would you rate your general health as excellent?	N
Do you eat 5 portions of fruit and veg per day?	N

Figure 59: Health behaviours and attitudes and the average WEMWBS score
PHE Report analysing 'What About YOUth (WAY)' survey data from 2014/15Error! Bookmark not defined.

This clearly showed those engaging in activities associated with poorer health (risk factors) also consistently had lower wellbeing scores. However, those engaging in activities considered to give better health (protective factors) had higher average wellbeing scores.

Wellbeing and association with social circumstance

Responses were further analysed within three categorised levels of affluence and in relation to relevant IMD quintiles. There was a clear association between family affluence and reported wellbeing, with those in the higher groups having above average WEMWBS scores. Association was also observed between deprivation and wellbeing, with a higher average score in each quintile than that in the previous quintile, shown in figure 60.



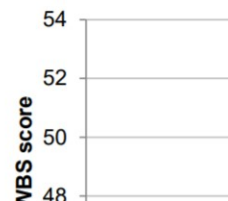
Figure 9: WEMWBS score by depriv



Figure 60: WEMWBS score by deprivation and by family affluence
PHE Report analysing 'What About YOUth (WAY)' survey data from 2014/15Error! Bookmark not defined.

the most affluent. Calculating average following results:

Figure 8: WEMWBS score by fami



Wellbeing and association with health

Average wellbeing scores for those stating they had a disability, long-term illness or medical condition were lower than those who stated they did not. More detailed analysis by type showed those with asthma and diabetes had average wellbeing scores very close to the survey average, while those with epilepsy and conditions relating to vision, hearing, mobility or mental health had lower scores. In particular those reporting conditions related to mental health had significantly lower wellbeing scores with an average of 36.8.

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) - Children and Young People

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a tested scale measure of mental well-being, used in multiple surveys, covering a range of feelings and attitudes towards life. A single score ranging from 14-70 is formed (70 highest and 14 lowest), based on responses to 14 statements. It can be seen below in figure 62 that in 2014/15, 15 year olds in Bournemouth, Poole and Dorset CC had similar average scores to England. Dorset had slightly higher scores than Bournemouth whose scores were slightly higher than in Poole.

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Mean score of the 14 WEMWBS statements at age 15 2014/15

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Area	Recent Trend	Count	Value
England	-	-	47.6
South West region	-	-	47.5
Gloucestershire	-	-	48.1
Bath and North East Somerset	-	-	48.1
Wiltshire	-	-	47.9
Devon	-	-	47.7
Dorset (Cty)	-	-	47.6
Cornwall	-	-	47.4*

Figure 62 Average score Warwick-Edinburgh Mental Well-being Scale (WEMWBS) in 15 year olds. PHE Public Health Profiles utilising 'What About YOUth (WAY)' survey data from 2014/15

Life satisfaction - Children and Young People

'The Good Childhood Report' states that data is available at a local authority level for 'mean well-being' in 2018/19 (shown in appendix 6). While it has been possible to access data tables on a national level, this HNA has been unable to access local data tables to extract a most recent picture^{cx}. Local news^{cx} reported the same data concluding young people aged 11-16 in Dorset had lower than England average scores for well-being (6.2 while England average was 6.5). The information reports the average score across the South West was 6.4, but highlighted more than one in five (21.7%) respondents provided scores of less than five, indicating lower wellbeing, representing an estimated 69,000 children in total.

The last data available locally on 'life satisfaction' from PHE was extracted from the What About YOUth survey in 2014/15. The percentage of 15 year olds who responded to the question "Overall, how satisfied are you with your life nowadays, where 0 was 'not at all satisfied' and 10 was 'completely satisfied'?".

PHE define the indicator shown in figure 63 below as the positive effect of high mental wellbeing on satisfaction with life among 15 year olds, defined by a score of 7-10 to the question "Overall, how satisfied are you with your life nowadays?". Higher proportions of 15 year olds in Dorset CC (68%) than in Bournemouth, Poole and England, who all had similar proportions, reported positive life satisfaction.

Areas **All in South West region** All in England Display **Table** Table and chart

Positive satisfaction with life among 15 year olds: % reporting positiv

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Area	Recent Trend	Count	Value
England	-	-	63.8
South West region	-	-	64.4
Bath and North East Somerset	-	-	70.4
Wiltshire	-	-	68.8
Dorset (Cty)	-	-	67.8
Devon	-	-	66.6
South Gloucestershire	-	-	66.0

Figure 63: Proportion of 15 year olds reporting positive life satisfaction PHE Public Health Profiles utilising 'What About YOUth (WAY)' survey data from 2014/15

Bournemouth had a higher proportion of young people reporting a low score for life satisfaction (classified as a score of 0-4) than locally, regionally and nationally, seen in figure 64 below. Poole had a comparable level to that of England and the South West, while Dorset County had slightly lower levels (less young people recording a low score for life satisfaction) than seen in England and the South West.

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Percentage reporting low life satisfaction at age 15 2014/15

[Export table as image](#) [Export table as CSV file](#)

Area	Recent Trend	Count	Value
England	-	-	13.7
South West region	-	-	13.4
Torbay	-	-	17.4
Bristol	-	-	16.7
Bournemouth	-	-	16.5
Swindon	-	-	14.8
Somerset	-	-	14.0
South Gloucestershire	-	-	13.9
North Somerset	-	-	12.6

Figure 64: Percentage of 15 year olds reporting 'low' life satisfaction, Source: PHE Public Health Profiles, utilising 'What About YOUth (WAY)' survey data from 2014/15

Summary – Prevalence

Half of all mental health problems emerge before the age of 14 and three quarters by age 18-24. Inequality underlies many risk factors for mental health problems, and needs to be addressed through the wider determinants of health.

One in eight children (12.8%) of 5-19 year olds had at least one mental disorder, with one in 20 meeting the criteria for two or more disorders.

One in 18 (5.5%) preschool children, those aged 2-4 years, were identified as having a mental disorder.

Type of disorder

The most prevalent type of disorder, at one in twelve 5-19 year olds, was that of emotional disorders which includes anxiety and depressive disorders. Anxiety disorders were nearly four times more common than depressive disorders.

Behavioural disorders were seen in around one in twenty, higher rates seen in boys than girls. Hyperactivity and other less common disorders were seen in one in sixty children or one in fifty, respectively.

Age

Rates were shown to increase with age; 5.5% of 2 to 4 year old children experienced a mental disorder, compared with 16.9% of 17 to 19 year olds.

Different disorders were prominent at different stages; 'any disorder' and 'emotional disorders' saw increases in prevalence with age. The highest prevalence for both were seen in the age group of 17-19, followed by the age group 11-16; young people aged 17 to 19 were three times more likely to have a disorder than preschool children.

Rates of behavioural and hyperactivity disorders were, meanwhile, highest in children aged 5 to 16 years.

Trends and gender

For the age group with comparable data, 5-15 year olds, an increase in prevalence over time was seen, from 9.7% in 1999 to 10.1% in 2004 and 11.2% in 2017.

Prevalence of 'Any disorder' increased throughout teenage years for both genders, and continued increasing during older adolescence in young women to 23.9%, equating to nearly one in four young women. Concerning rates of emotional disorders seen in 17-19 year olds females. While they were around 10% between 11 and 16 years old, this had risen to nearly a quarter of females between 17-19 years of age (22%).

These findings were consistent with adult surveys with increased proportions of symptoms of mental disorder in young women aged between 16-24 years of age, at more than a quarter. Overall, younger females showed higher proportions of all types of disorder than any other adult group.

This was concurrent with their findings that around half of the young women with a disorder had self-harmed or attempted suicide, and other research and local data demonstrating greater prevalence of self-harm and suicide in young women. The significance of this is not just in relation to immediate morbidity for the young women, but in relation to maternal and child health in future generations.

Characteristics of children and young people with a mental disorder and associated social factors

Mental disorders were associated with ethnicity, more common in White British, Mixed/Other and White Other backgrounds. Associations were also found with poor general health and special educational needs, or parental health and with less healthy family functioning. Socioeconomic factors were also a predictor.

'Social' factors were also associated with having a mental disorder in children and young people, such as increased time on social media, comparisons to others, having been bullied or bullying others and experienced some types of adverse life events, like parental separation, amongst others.

Locally, around 8,300 children and young people aged 5-19 in BCP, and 7,500 within Dorset, would be estimated to have one diagnosable mental disorder, a total of nearly 16,000 children across Dorset.

Around 3,200 children and young people aged 5-19 in BCP, and 3,000 of those within Dorset UA, equating to more than 6,000 children pan-Dorset, would be considered to have two or more diagnosable mental disorders.

Preschool children

One in 18 2-4 year old children met criteria for mental disorder; with higher rates in boys than girls. This would equate to around 700 children in BCP and 550 in Dorset UA.

Increased rates were, again, observed in preschool children related to ethnicity and in those whose parents had a common mental disorder, were living in families with less healthy family functioning, with poorer Health and lower income households.

Indicators of lower-level need

There will always be a fluid spectrum of wellbeing and mental health in children and young people, with the majority experiencing more positive states. However, in addition to understanding the proportions of those meeting criteria for mental disorders and meeting criteria for mental health services, there are proportions of the younger population with mild-moderate need, to be supported with preventative action, advice, support or evidence-based lower-level interventions.

Wellbeing is at the forefront of many national publications and reports, including from PHE and other governmental departments, emphasising the impact of wellbeing on cognitive development and learning, and mental, physical and social health.

'Life satisfaction' and 'happiness' are accepted measures of mental wellbeing. Most children and young people do show higher levels of satisfaction, overall however in the UK, they have lower levels of life satisfaction and with appearance, school, and friendships. They have fewer friendships, higher levels of sadness and increased expectations of failure.

Time trends in wellbeing

Life satisfaction and wellbeing measures in children between 10-15 years old in the UK have decreased over time, 2020 data shows.

Wellbeing by Gender

The UK had the second largest gender gap, with nearly one in four girls scoring low on at least three out of four measures (life satisfaction, happiness, sadness and purpose), in comparison to one in seven boys.

Comparison with other countries

The UK ranked lowest of 24 European countries for the proportion of children with high life satisfaction. UK was 23rd for low sadness (i.e. the second highest proportion with high sadness), and lowest for having a positive sense of purpose in life. While the UK ranking of 9th out of 24 for happiness was more optimistic, the UK fared poorly across measures, with the lowest proportion of children of the 24 countries without a low score on any measure.

Local data

The last data available locally was from 2014/15 and showed Bournemouth had more young people with a low score for life satisfaction than locally, regionally and nationally. Poole had a comparable level to that of England and the South West, while Dorset County had slightly lower levels (less young people recording a low score for life satisfaction) than seen in England and the South West.

Unconfirmed data reports in 2018/19 young people aged 11-16 in Dorset had lower than England average scores for well-being (6.2 while England average was 6.5). It was highlighted more than one in five (21.7%) respondents in the South West provided scores of less than five, indicating lower wellbeing, representing an estimated 69,000 children in total.

Associations with wellbeing and risk/protective factors

Analysis of data contained within the WAY youth survey was performed and showed differences in wellbeing associated with affluence, deprivation, sexual identity and disability or long-term health conditions.

They demonstrated those engaging in protective behaviours, such as increased physical activity, less sedentary behaviours and eating recommended portions of fruit and vegetables, had higher average wellbeing scores than those engaging in activities associated with poorer health (risk factors including drinking and smoking).

Children and Young People deemed more vulnerable to, or at higher-risk of, developing mental health problems: Risk factors

There are children and young people within groups commonly identified^y as having an increased risk of developing mental disorder due to increased vulnerability, being within a marginalised group or living within a particular circumstance. To incorporate the position they are in and past experiences they may have had and the impact that may have on accessing and receiving support needs additional consideration when designing and implementing local provision of wellbeing and mental health services and support.

Each section below reports on the risk factor and the prevalence of mental disorder in children and young people in relation to the presence of that factor. It also details the impact on wider determinants of health and other outcomes, as part of overall wellbeing and mental health.

Those with Adverse Childhood Experiences (ACEs)

ACEs are Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences that can negatively impact children and young people throughout their lives (figure 65). The World Health Organisation (WHO) estimated that, in 21 countries studied, 30 percent of adult mental illness could be attributed to ACEs^{lxviii}. The ten widely recognised ACEs, within three categories, are:

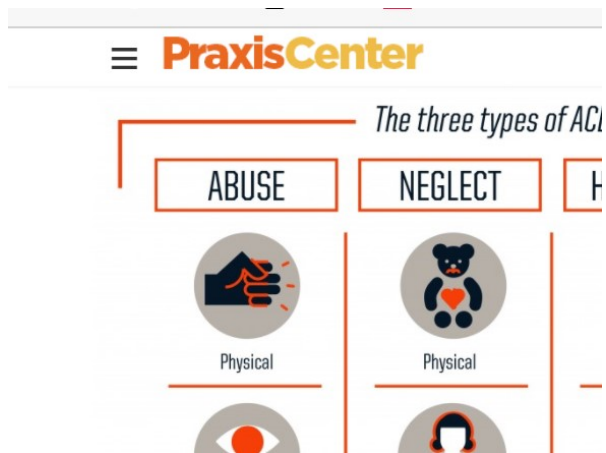


Figure 65: Types of Adverse Childhood Experiences (ACEs)

A nationally representative survey of more than 3,800 English residents (18 to 69) found 47% of the population had at least one adverse childhood experience and 14% up to four. The prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively^{cxii}.

Modelling within that survey suggested some degree of the prevalence of risk-behaviours nationally, independent of socio-economic status, could be attributed to ACEs, for instance, 52.0% of violence perpetration, and 37.6% of unintended teenage pregnancy.

It has been reported around 48% of children and young people have experienced one or more ACEs^{cxiii}, shown in figure 66 below.

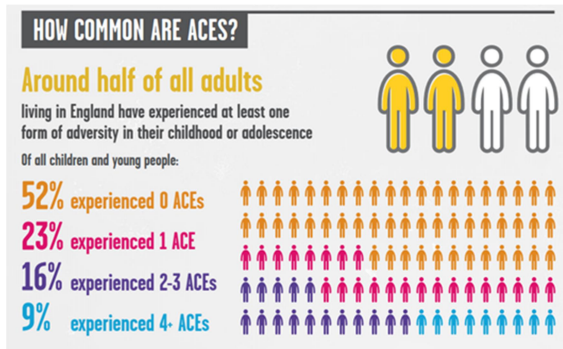


Figure 66: Proportion of children and young people who have experienced an ACE
Source: Health Education England and Young Minds^{cxiii}

Figure 67 below shows impacts of experiencing four or more ACEs in comparison with people who do not. These include increased risks of unhealthy or risky behaviours, lower wellbeing, being involved in violence and of imprisonment.



Figure 67: Impact of ACEs
Source: Health Education England and Young Minds^{cxiii}

However, the Institute of Health Equity^{lxviii}, which houses 'The Marmot Review 10 years on' states the WHO's reporting are estimates, and there are concerns that other adversities in childhood are associated with poor adult outcomes. It is important to note the ACEs approach does not address the full range of vulnerabilities, lacking contextualisation of the role of poverty and other social determinants of health^{xxxv}.

Other types of childhood adversity that can have similar negative long term effects, discussed within this report, including bullying, poverty and community adversities such as living in a deprived area and neighbourhood violence, amongst others.

Ethnicity

As discussed earlier, ethnicity has an effect on the risk of developing mental health in adulthood. People from minority ethnic backgrounds are documented as having greater levels of need for mental health support, with more difficulty in accessing, and less likely to be in receipt of, it^{cxiv}.

Prevalence of common mental health issues (including depression and anxiety disorders) is higher in Black and Black British women than within other ethnic groups. Psychosis is more common among those from minority ethnic groups, substance dependence is more common among Black and Black British men and Black people are more than three times as likely to experience homelessness^{cxv,cxvi}.

The NHS digital survey in 2017^{cxvii} reported greater prevalence of mental health disorders in preschool boys of White British backgrounds (8.4%) than those with a minority ethnic background (2.9%), but prevalence was greater in girls with a minority ethnic background than those who were from White backgrounds.

In older age groups, White British 5 to 19 year olds were about three times more likely (14.9%) than Black/Black British (5.6%) or Asian/Asian British (5.2%) children to have a disorder. However, in young people aged 5-19 with Mixed/Other background prevalence was 12.1% and White Other was 8.3%. The pattern of association with ethnic group was similar for boys and girls.

In children and young people mental health issues are more common in some minority ethnic backgrounds than others, and those from minority ethnic, migrant or refugee backgrounds are more likely to display developmental difficulties associated with psychosis/develop psychotic disorders later in life^{cxv}.

Surveys are beginning to show the impact of COVID-19, detailed earlier in this report; these are felt by many young people across all ethnic groups but disproportionately so by children from minority ethnic communities, with widening inequalities^{cxviii}.

Recent data from XenZone^{cxix} a UK digital mental health provider of the 'Kooth' service has reported depression has increased by 9.2% among children and young people from minority ethnic groups, while decreasing by 16.2% in those who are White.

They also have reported an increase of 26.6% in suicidal thoughts in children and young people from minority ethnic groups compared to the same period last year and an increase in anxiety/stress of 11.4%. For White children and young people, increases were also seen but at lower levels of 18.1% and 3%, respectively.

Sexual and gender minority groups

Lesbian, gay, bisexual and/or transgender, plus other identity groups (LGBT+)

People identifying as lesbian, gay, bisexual or as another gender identity, such as transgender, are at higher risk of experiencing poor mental health, more likely to experience problems of depression, suicidal thoughts, self-harm and alcohol and substance misuse.

Children and young people identifying as LGBT+ are considered one of the most vulnerable groups in society. They are usually in the state of adolescence, which brings many challenges ordinarily; anxiety, depression and suicide are reported as causes of youth morbidity and mortality across the world. In addition, they are at greater risk of experiencing hostile environments at home and in wider society, are subject to direct and indirect discrimination, harassment, disadvantage and inequality with detrimental consequences for mental health.^{cxx,cxxi}

ONS figures show 4.1% of young people aged 16–24 identified as LGB in 2016, higher than the general population proportion of 2%^{cxxii}. The 2017 NHS Digital survey reported amongst 14 to 19 year olds, one in ten identified as lesbian, gay, bisexual or other (Girls (13.2%), boys (7.1%))ⁱⁱ. They found young people 14-19 years old who identified as lesbian, gay, bisexual or other were almost three times as likely to have a mental disorder than those identifying as heterosexual, shown in figure 68 below.



Figure 68: Proportions of young people identifying within different sexual identities and associations with mental disorder. Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

This higher prevalence has been attributed to a range of factors such as inequalities, discrimination, isolation and homophobia. Some members of the LGBT+ community have expressed dissatisfaction with health services; with mental health services being perceived to be discriminatory most often^{cxxiii}.



Figure 69: Proportion of lesbian or bisexual women who had negative health sector experience in the year preceding 2008. Source: Hunt, R. Fish, J. (2008) report: *Prescription for Change. Lesbian and bisexual women's health check 2008*

Research^{cxiv} in 2008 into the experiences of over 6000 lesbian and bisexual women, including teenagers, reported significant findings related to mental health, shown in figure 70 below. The study reported one in five lesbian and bisexual women had self-harmed compared to one in 250 in the general population, and in those under 20, it was one in two, compared with one in 15 teenagers in the general population.

Suicide had been attempted by 5% of those women, which rose to 16% in those under 20, compared with an estimated 0.12% of all those under 18. Recent research has reported between 11% - 32% of young people who identify as LGBT+ have attempted suicide in their lifetime^{xvi}.

The prevalence of an eating disorder was four times higher than in the general population. More recent data on the prevalence of eating disorders also reported prevalence of 16%^{xvi}.

Mental health:

- ¶ **One in five** lesbian and bisexual women have deliberately harmed themselves in the last year, compared to 0.4 per cent of the general population. **Half** of women under the age of 20 have self-harmed compared to one in fifteen of teenagers generally.
- ¶ **Five per cent** have attempted to take their life in the last year and **sixteen per cent** of women under the age of 20 have attempted to take their life. ChildLine estimate that 0.12 per cent of people under 18 have attempted suicide.
- ¶ **One in five** say they have an eating disorder, compared to one in 20 of the general population.



Figure 70: 2008 survey findings regarding prevalence of self-harm and suicide amongst lesbian and bisexual women
Source: Hunt, R. Fish, J. (2008) report: *Prescription for Change. Lesbian and bisexual women's health check 2008*

Surveys conducted in New Zealand^{cxv} reported sexual and gender minority youth were over three times as likely to demonstrate symptoms of depression and more than twice as likely to have self-harmed than their heterosexual peers. One in five had attempted suicide, with almost half of respondents having considered a suicide attempt.

41% of sexual and gender minority youth had sought professional services for emotional support in the last 12 months, compared with 16.6% of their non-LGBT+ peers.

In Scotland, 40% of LGBT youth considered themselves to have a mental health condition in comparison to 25% of non-sexual and gender minority youth, with bullying identified as a key factor in distress.^{cxvi}

Family functioning

For the majority of children the most influential group in their life will be their family. It is understood that caregivers possess tremendous power over the shaping of children's lives. Children who experience clear and consistent parenting that is warm and responsive mainly develop effective emotional self-regulation and pro-social behaviour, and experience academic achievement and positive outcomes later in life.

Conversely, children with caregivers who take drugs, are violent, or experience mental disorders may develop in ways to work with the demands of these hostile early environments; ways likely to be maladaptive for the individual and for society^{xx}.

Parental health behaviours such as smoking and use of substances also impact throughout childhood; for example parental alcoholism is associated with higher risk in children of anxiety and abuse. Indirect consequences of parental behaviour can also arise, such as children and young people taking on caring responsibilities for siblings, emotional abuse or neglect, chaotic family life with poor parent-child bonds, inadequate accommodation, interrupted education and socialisation.

PHE define factors within the family which affect the wellbeing of children and young people:

- family relations
- parental health
- parental healthy living

Family relations

Family relations refers to the quality of family interactions including parenting styles, attachment, interpersonal relationships and family functioning. Where positive feelings about family are present they are highly correlated with feelings of life satisfaction and happiness overall.

Loving, trusting relationships, support and a sense of connection within families are positive influences, whereas poorer family functioning including hostility and family breakdown are understood to be harmful to mental wellbeing^{cxvii}.

The NHS Digital 2017 prevalence survey found levels of family functioning¹⁴ to be associated with the presence of mental disorder. More than one-third (38.2%) of children living in families with the least healthy functioning had a mental disorder, compared with one in ten (8.3%) of those living in households with the healthiest, shown in figure 71 below. It has been acknowledged that while family functioning may contribute to the onset of mental disorder, the presence of mental disorder could also lead to problems in family functioning.

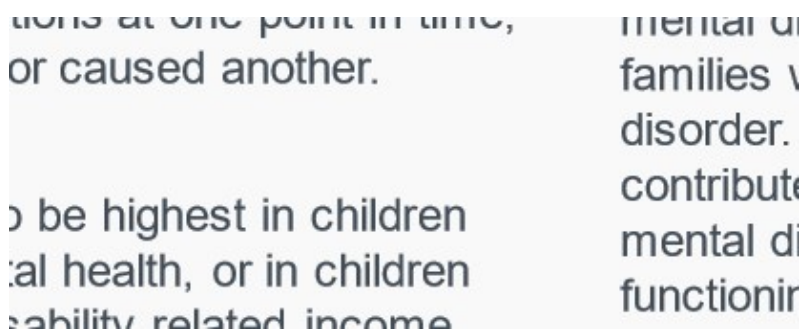


Figure 71: Family functioning and association with mental disorder

Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

¹⁴ Identified using the General Functioning Scale of the McMaster Family Activity Device.

Prevalence of emotional disorders was increased in children whose households recorded less healthy family functioning (13.8% compared with 8.1% in surveyed population). Seen in figure 72 below, behavioural disorders were also more common; at 18.2%, six times more likely in children whose families recorded the least healthy functioning than those with the healthiest functioning (a score of up to 1.50), and four times more likely to have a behavioural disorder than in those surveyed overall.

Figure 6: Any behavioural disorder by 2017

Base: 5 to 19 year olds

Per cent

Figure 72: Percentage with any behavioural disorder, by family functioning score, 2017 (5 to 19 year olds)
Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017

There are many levels of family disharmony or dysfunction, which may affect children’s mental health. Inter-relationship arguing, conflict, separation and divorce are all known to affect children’s mental health.

Some studies on higher levels of family conflict and lower cohesion have found these are associated with anxiety, depression, ADHD, and lower levels of conflict and greater family cohesion tend to be found in families with more typically developing children^{cxxviii}. It is difficult to obtain local data, but a national survey of 1,018 families with children reported 53% experience serious conflict on a regular basis.

National divorce data from the ONS in 2013 showed almost half (48%) of couples divorcing had at least 1 child aged under 16. There were 94,864 children, below 16 years, in families where parents divorced, with over a fifth (21%) of children under 5 and 64% under 11.

Parental health and parental healthy living

Health states, behaviours and the wellbeing of family members impact upon the wellbeing of children and young people. This is discussed in more detail in the section on ‘Parental mental health’ below.

Local family functioning data

2011 census data showed Bournemouth, Dorset and Poole with higher proportions of separation or divorce than in England, with Bournemouth experiencing the highest, followed by Poole and then Dorset; proportions were higher or comparable to the South West region.

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Marital breakup: % of adults 2011

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Area	Recent Trend	Count	Value
England	–	4,998,333	11.6
South West region	–	529,996	12.2
Torbay	–	16,207	14.8
Bournemouth	–	20,426	13.2
Cornwall	–	57,440	13.0
Plymouth	–	27,462	13.0
Swindon	–	21,291	12.7
North Somerset	–	20,950	12.6

Figure 73: Percentage of marital break-up, 2011 in the South West region
Source: PHE Public Health Profiles, taken from census data of 2011

Domestic Violence

Domestic violence is associated with antenatal depression, postnatal depression, anxiety and PTSD; although causality cannot be inferred, a high level of domestic violence in a local area indicates the population is more at risk of mental health problems during the perinatal period. Living in a household where domestic violence is occurring is also a risk factor for poor mental health in babies and toddlers^{lxvii}

Domestic violence incidents in 2018, across Dorset, were recorded at 7,304 incidents across all ages, and within age-groups whose households are more likely to contain children and young people, there were 6,439 incidents (incidents recorded against those aged between 16-60 years)^{cxix}.

Reviewing the rates of overall domestic violence incidents reported to the police in the 2018/19 financial year, there were 18.9 incidents per 1,000 population pan-Dorset, lower than the rate of 27.4 per 1,000 seen nationally. These rates relate to all incidents and are not restricted to those involving households containing children or pregnant women.

In Dorset UA, local data showed there were 1,440 families with one or more child member (currently aged under-18, including those unborn) who triggered the 'Dorset Families Matter' Domestic Abuse criteria at July 2020. Cross-referencing with police data showed there were 1,166 of those in which one or more members of the family were involved in a DA incident in the preceding 12 months. The majority of those (983) had between one and three incidents.

Domestic abuse victims

Dorset CCG reported data showing, during six months of 2017, there were 167 recorded domestic abuse victims, aged 18 and under, seen in figure 74.

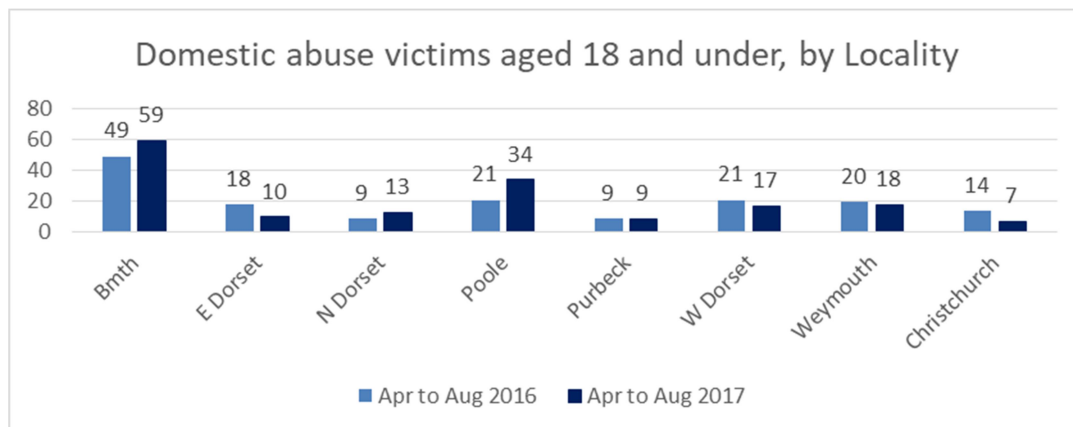


Figure 74: Number of domestic abuse victims aged 18 and under, by Locality
Source: Dorset CCG

Further breakdown reported,

- 72% of recorded victims were female.
- 55% of victims were 17-18 years of age; 31% aged 12-16.
- 7% were aged 5-11 and 0-4 respectively.

Domestic abuse suspects

In the same six months of 2017 there were 155 suspects aged 18 and under; 66% were male, 49% were aged 17-18 and 49% were aged 12-16, seen in figure 75.

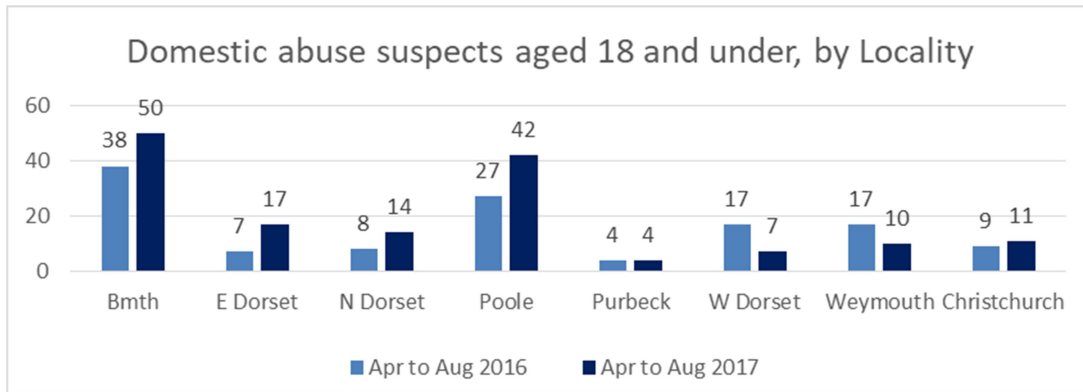


Figure 75: Domestic abuse suspects aged 18 and under, by Locality
Source: Dorset CCG

They show that Bournemouth had the highest number of domestic abuse victims and suspects aged 18 across both periods of time recorded, followed by Poole. There were no rates by population presented.

Sexual abuse (as an indicator of sexual offences in under-18s): local data

Domestic abuse encompasses both non-sexual abuse by a partner or family member but also sexual assault, rape or unwanted touching carried out by a partner or other family member.

Figures 76 and 77 below show the number of victims and suspects of sexual offences outside of those carried out within domestic abuse, which may give a proxy measure of abuse outside of the home but may also contain offences not categorised as abuse. The highest number of victims were in Bournemouth and Poole, however, initial review of the data may suggest higher rates in other local areas, given the smaller populations. A more varied spread of suspects across areas of North and West Dorset and Weymouth, which again may have higher rates, but no rates by population were presented.

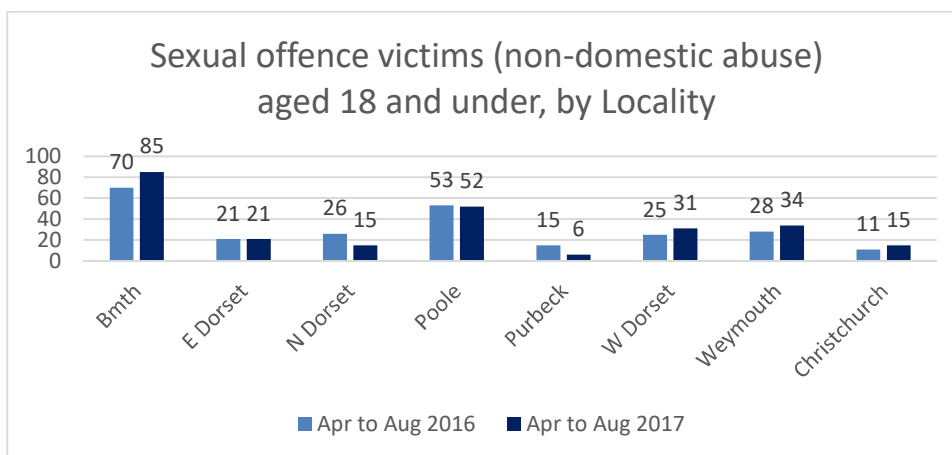


Figure 76: Sexual offence victims (non-domestic abuse) aged 18 and under, by Locality
Source: Dorset CCG

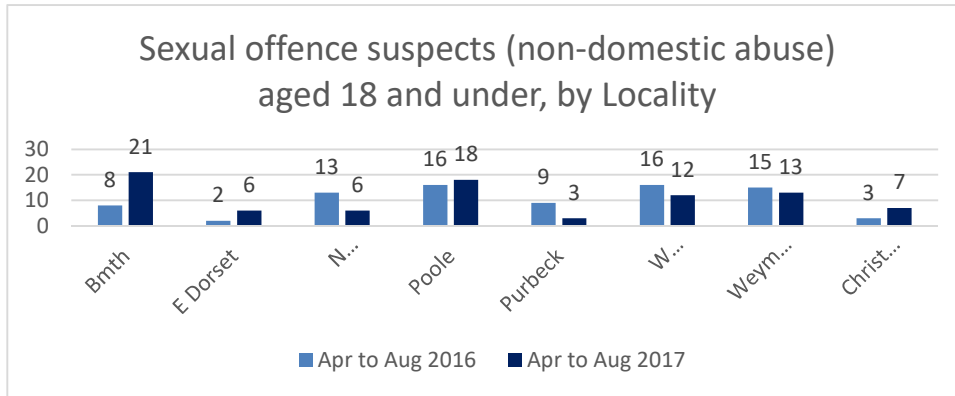


Figure 77: Sexual Offence Suspects (non-domestic abuse) aged 18 and under, by Locality
Source: Dorset CCG

Further breakdown showed there were a total of 259 recorded sexual offence victims in 2017 and 86 suspects, aged 18 and under,

- 81% of victims were female and 90% of suspects were male.
- 61% of victims and 52% of suspects were 12-16 years old.
- 18% of victims were between 5 and 11 years of age.

This data shows reported offences only and it should be noted that domestic and sexual offences are hugely under-reported. An increase in numbers of offences over time is likely to be due to victims having an increased confidence to report these offences and to professionals around children being more aware of the signs of abuse, having a lower tolerance to abuse, knowing how to raise the subject with children and young people and knowing what support is available.

It also cannot be assumed that the victims and suspects in this data are directly related offences. There are far fewer sexual abuse suspects aged 18 and under than victims, suggesting that adults are more likely to sexually abuse those aged 18 and under; there is also growing awareness of the issue of child to parent violence.

Toxic Trio modelling

In 2018 The Children's Commissioner^{CXXX} reported modelled prevalence data for those children living in households with a combination of three possible risk factors for harm; domestic violence, alcohol or drug dependency and parental mental ill-health, and their co-occurrence, using Evidence from the Adult Psychiatric Morbidity Survey.

The authors referred to wide-ranging literature on the damaging consequences of these factors on the wellbeing, mental health and outcomes of children. While the risk factors they report on are related to 'risk of harm' the three risk factors of the 'toxic trio' are also factors which increase the risk of adverse mental health in both parents and their children.

2018 populations from within the pre-reorganisation LA boundaries were used to model local data for Bournemouth, Poole and Dorset.

Below in figure 78 is one example of the modelled data mapping, showing the number at risk of any one of the trio, in age group 0-4:

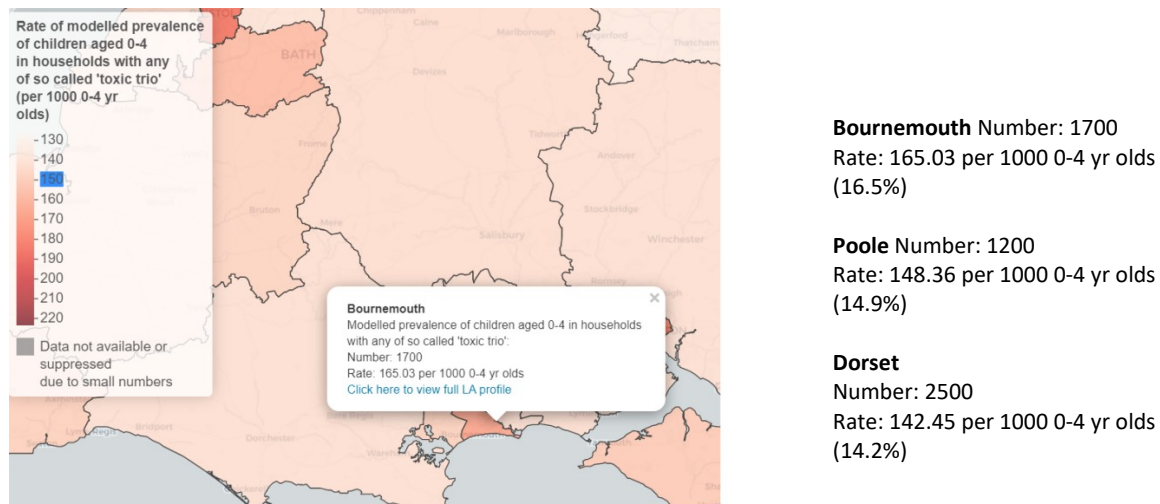


Figure 78: Modelled prevalence within Dorset of projected % of CYP 0-4 yrs, living within a 'family at risk', any of 'the toxic trio' (domestic abuse and/or alcohol/substance abuse and/or parent with a serious mental health condition)
Source: Children's Commissioner^{CXXX}

Within Bournemouth and Poole areas the modelled data suggested between 16-18% of those aged 0-17 (around 10,500-12,000 children combined) were within a household experiencing one of those risks, with around 4-5% (approximately 2,600-3,300 children) within a household experiencing 2 or more of the above risks, and around 1% with all 3 (around 666 children).

For the Dorset CC area, there may have been 16% of 0-17 year olds within a household experiencing one risk, translating to approximately 12,000 children and young people. They estimated around 4% were within a household experiencing 2 or more of the above risks (around 3,000 children), and 1% with all 3 present (around 770 children).

Table 20 below models local numbers based on estimated rates per 1,000 data, held within the Children's Commissioner report. The local estimates show highest numbers in the Dorset CC area but highest rates in Bournemouth, followed by Poole and then Dorset, in both 0-4 and 0-17 age groups.

Table 20: Locally modelled data on estimated populations of 0-17 and 0-4 year olds living within households where there is one of the 'toxic trio' risk factors

Population from ONS: mid-2018 Population Estimates

Age	Bournemouth	Poole	Dorset	Pan-Dorset
0-4	10,832	8,108	18,202	37,142
0-17	36,373	30,188	76,699	143,260

Number of children within possible 'toxic trio' situation – household with any one of 3 risk factors (modelled using rate per 1000)

0-4				
Number	1,788	1,203	2,593	5,584
Rate per 1000 children	165.03	148.36	142.45	-
0-17				
Number	6,540	4,881	11,904	23,327
Rate per 1000 children	179.8	161.7	155.2	-

Number of children, 0-17 years, within possible 'toxic trio' situation – household with parental mental health problem (modelled using rate per 1000)

Number (rate) of 0-17 year olds living with severe parental mental health problem*	4,827 (132.7)	3,542 (117.3)	8,537 (111.3)	16,906 (-)
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*as stated earlier, there may be more than one adult in a household with a mental health problem, but this estimate shows any household with at least one adult with a mental health disorder. As the descriptor is 'severe mental health problem' it will not capture parents who have lower-level mental health disorders¹⁵.
Source: Children's Commissioner^{xxxx}

The authors highlight these are likely to be underestimates as the APMS only recorded the responses of one adult per household, and other adults within these households may have some of these factors also, which would lead to higher numbers and rates if risk factors for all adults were captured.

¹⁵ Further details are available from <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/07/Vulnerability-Technical-Report-2-Estimating-the-prevalence-of-the-toxic-trio.pdf>

Parental mental health

“The best thing we can do to care for a child is to care for their mother”

It has been commented above that parental mental health is associated with increased mental disorder in children and young people, however parental mental health is not routinely recorded, but worldwide, it is believed 15-23% of children live with parent with a mental illness.

It is suggested by PHE that general population prevalence be used as a crude indicator of parental mental health. Prevalence within the general adult population taken from the 2014 English Adult Psychiatric Morbidity Survey (APMS)^{cxxxix} showed 17%, one in six adults (over 16 years), met the criteria for a common mental disorder (CMD). Within the 16-24 age group the prevalence of common mental disorders in this age group were three times higher in women (26.0%) than men (9.1%).

Prevalence data from the GP QOF dataset 2019-2020^{cxxxix} puts national prevalence at 0.93% of the registered population, and the South West region at 0.87%. Dorset STP runs at 0.99%, marginally above that of the national and regional rates. The numbers of those with SMI on GP data^{cxxxix} register across Dorset CCG is 7,880 number of people on the SMI register at the end of the reporting period.

A survey in 2018 of more than 1000 GPs, conducted by MIND^{cxxxix}, reported 40% of GP consultations were in respect of mental health and two-thirds of GPs report the proportion of patients they are seeing for help with their mental health had increased in the preceding 12 months.

In the UK, it is estimated that 68% of women and 57% of men with mental health problems are parents^{cxxxix}. Other estimates suggest 50-66% of parents with a severe and enduring mental illness live with one or more children under 18 (equating to around 17,000 children and young people).

One study^{cxxxix} suggested 20% of parents have a mental illness, and further examined records of children and young people using CAMHS services. Of those CAMHS service users examined they found 79% were living with a parent with mental illness and stated “.....many families had co-occurring risk factors of domestic violence and limited social supports”.

Another UK study^{cxxxix} examining healthcare utilisation of children and young people and associations with differing family factors, from a population of more than 6700 children and young people in South East London, determined 16% (980) had a parent with a diagnosed mental health condition, most commonly depression and/or anxiety.

They also reported parental depression was associated with increased utilisation of ED, outpatient and inpatient services by children and young people, as well as with increased GP consultations among adolescents.

In the 2017 NHS Digital survey, children whose parents had scored highly for a mental disorder were five times more likely to have an emotional or behavioural disorder than those whose parents showed little or no evidence of mental disorder^{lix}.

Maternal mental wellbeing is known to be a key determinant of childhood wellbeing, particularly in early childhood. A recent large-scale UK study reported one in four UK children between the ages of 0 and 16 have a mother with a mental illness, and that over half of UK children, by the age of 16, will have had a mother who has experienced mental illness^{cxxxix}. The South west had the fourth highest proportion of mothers with mental illness (25%), and the authors reported highest prevalence coincided with areas with the highest levels of deprivation and adult mental illness in general. They also reported children born into poverty, or to teenage parents, were more likely to be exposed to poor maternal health.

As shown earlier, locally, the Children's Commissioner's modelled prevalence data estimated 'Children in households where a parent is suffering mental health problems' as higher in Bournemouth, followed by Poole and Dorset, and the ranking for each local authority is shown below in table 21.

Table 21: Modelled prevalence data estimated 'Children in households where a parent is suffering mental health problems'

Local Authority	Number	Rate (per 1000 0-17 year olds)	Percentile amongst LAs (0 = Lowest, 100 = Highest)	rank
Bournemouth	4,827	132.7	47	
Poole	3,542	117.3	22	
Dorset CC	8,537	111.3	10	
Total	16,906			

Source: Children's Commissioner^{xxxx}

Children at increased risk, in need of support and protection (those with Child in Need plans, Child Protection Plans and Children in Care)

Child in Need is a broad definition^{cxix} spanning a wide range of children and adolescents, in need of varying types of support and intervention, for a variety of reasons. A child is defined as 'in need' under section 17 of the Children Act 1989, where

- they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for them of services by a local authority
- their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services; or
- they are disabled

The overall group of Children in Need of help and protection comprises children under a number of different social care classifications: children with a Child in Need Plan or a Child Protection Plan and Children in Care.

A Child in Need Plan may be put in place if felt further support is needed but there is no risk of continuing harm. A Child Protection Plan is used if it is believed there is a risk of continuing harm.

One in ten pupils in 2019/20 had been a child in need in the last 6 years, equivalent to around 3 pupils in every classroom on average; in half of all secondary schools it was 10-20% of pupils^{cl}. The most prevalent factors identified with being a child in need were domestic abuse, mental ill health and substance misuse, with assessment data showing 62% of children needing a social worker experienced one or more of these^{cl}.

It has been demonstrated that children in need have worse outcomes than children as a whole, across England's school population. A national review in 2019^{cl} established that needing help and protection, even briefly, has a profound impact on children's educational outcomes. The disadvantage was additional to other needs, although compounded for many children by also having special educational needs or living in a low-income family.

Children in need are over three times more likely to have special educational needs and three times more likely to be eligible for free school meals (an indicator of poverty)^{cxl,cxli}. They were also more likely to be persistently absent from, or to miss, school, fail to reach expected levels of reading, writing and maths at age 11, and significantly less likely to achieve GCSE's at grade A*-C, including English and Maths.

Given the challenges faced by children in need and the i outcomes for this cohort are significantly lower than that school population, children in need are:

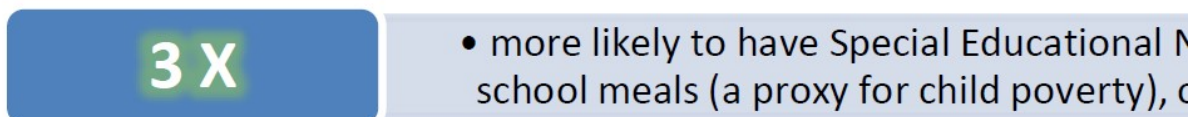


Figure 79: Children in need – educational outcomes
Source: Durham, Insight (2019)

A governmental review^{cl} of outcomes for children who have required social services support found children who have needed a social worker do significantly worse than others at all stages of education, and those who have had a Child in Need or Child Protection Plan are almost as likely to do poorly as children in care. When making statistical consideration of a range of other factors such as special educational needs, low income, ethnicity, English as an additional language, past school moves and where a child lives, children who needed a social worker in the year of GCSEs were half as likely to achieve a strong pass in English and Maths than those who were not.

Poorer educational outcomes persist even after social work involvement ends. Children who needed a social worker in the four years prior to taking GCSEs were between 25-50% less likely to achieve a strong pass in English and Maths.

In continuing their education, young people who needed a social worker in the year of GCSEs, beyond age 18 only 6% were in higher education compared to 27% of those not in need.

Local information regarding Children in Need (CiN)

Levels of referrals to social services

A referral is a request for services to be provided by children’s social care in respect of a child who is not currently in need. Table 22 below, of LAIT data reports for 2019, shows a similar picture across the two new authorities, higher than South West but below England rates.

Table 22: Level of referrals to social services - Rates per 10,000 children

	Level of referrals to social services - Rates per 10,000 children		
	2018	2019	2020
BCP	-	-	452.00
Dorset UA	-	-	462.20
Bournemouth (pre re-organisation)	451.60	562.50	-
Poole (pre re-organisation)	493.50	395.50	-
Dorset (pre re-organisation)	636.70	611.00	-
South West	517.40	495.50	434.20
England	552.50	544.50	534.80

Source: LAIT, accessed January 2021

Whilst there is currently reported a similar position across the new authorities, historical trend data seen above in table 22 and below in figure 80 for the previous three authorities shows a variable picture over time.

Bournemouth had shown rates that declined between 2016-18, often in line with regional and national rates, rising again in 2019 to above South West rates. Poole, although initially above regional and national rates, had seen a decline to below that of the South West and England between 2017-19. From 2015-19, Dorset CC area had shown consistently higher rates than of other authorities, South West and England rates between 2015-2019.

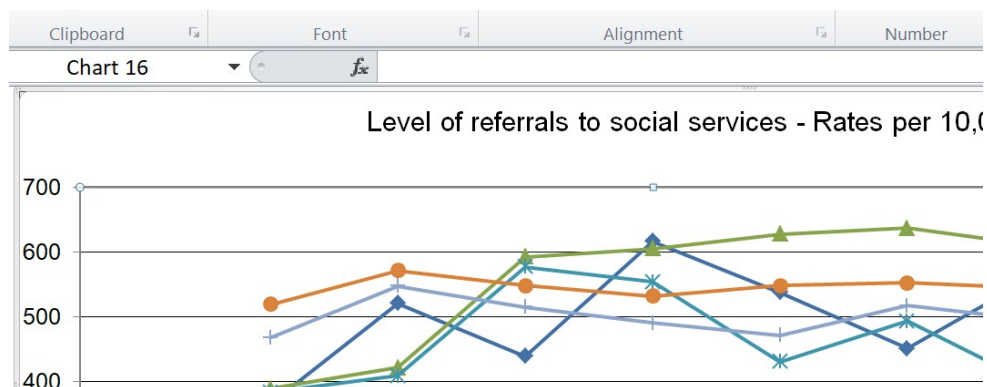


Figure 80: Historic level of referrals to social services 2013-2020
Source: LAIT, accessed January 2021

The percentage of re-referrals to social services within 12 months of the original referral, within Dorset CC area, was around 26-27% between 2016-19, higher than South West percentages of 23-24% and England proportions at 22-23%. Bournemouth was between 19-27% and Poole 17-21%, more in-line with regional and national comparators^{cxlii}.

Numbers of Children in Need

Shown below are snapshots of the number of school-age children in need in 2019 and 2020 and recent rates of children in need across Dorset.

The numbers of children in need at the end of March 2020 are shown below in table 23, with lower numbers in BCP.

Table 23: Number of school age children in need at 31 March 2020

Local Authority (pre-reorganisation)	Number of children in need at 31 March 2020
BCP	2,281
Dorset UA	2,854
Total	2,545

Previous to the Local Authority reorganisations, at end of March 2019, it can be seen in table 24 below, there were lower numbers in Poole, followed by Bournemouth and a larger number seen in Dorset. Referring back to Table 1 showing the population of Dorset County, with age structure, it can be seen that although the overall population of Dorset is higher, there was a larger 5-16 year old population in BCP than Dorset. The higher numbers of children in need seen in Dorset are not therefore related to simply a larger population within that age-group.

Table 24: Number of school age children in need at 31 March 2019

Local Authority (pre-reorganisation)	Number of school age children in need at 31 March 2019
Bournemouth	685
Dorset	1,345
Poole	515
Total	2,545

Source: LAIT, accessed January 2021

It can be seen in table 25 that in 2020, rates of CiN were also highest in Dorset UA, higher than South West and England rates, while rates in BCP were higher than South West rates but lower than those seen in England. No breakdown was available by type of need. Historically there has been variation seen when comparing with regional and national rates, and within County.

Table 25: Children in Need, rate per 10,000

Local Authority	Children in Need rate per 10,000				
	2016	2017	2018	2019	2020
BCP	-	-	-	-	302
Dorset UA	-	-	-	-	421
Bournemouth (pre re-organisation)	401	243	304	371	-
Poole (pre re-organisation)	383	323	373	365	-
Dorset (pre re-organisation)	338	306	314	354	-
South West	321	306	319	323	281
England	337	330	341	334	324

Source: LAIT, accessed January 2021

A Government review of children in need in 2018 showed at least 12% of children had their own mental health recorded as a factor in requiring support^{cl}. Further Government data^{cxliii}, in table 26, shows factors of concern identified at the end of a Child in Need assessment, shown below for the reporting year ending 2020 (data is available from around 10 years earlier).

Table 26: Children in Need factor identified at end of Assessment, by Local Authority, 2020

	Episodes	Alcohol Misuse (child)	Alcohol Misuse (parent)	Alcohol Misuse (person)	Drug Misuse (child)	Drug Misuse (parent)	Drug Misuse (person)	Domestic Violence (child)	Domestic Violence (parent)	Domestic Violence (person)	Mental Health (child)
BCP	1437	26	191	70	68	135	71	155	376	170	133
Dorset UA	2948	76	471	113	135	380	157	386	914	274	273

	Mental Health (child)	Mental Health (parent)	Mental Health (person)	Learning Disability (child)	Learning Disability (parent)	Learning Disability (person)	Physical Disability (child)	Physical Disability (parent)	Physical Disability (person)	Young Carer	Privately fostered
BCP	133	325	62	57	27	7	39	29	8	21	11
Dorset UA	273	857	198	129	59	36	69	119	30	22	8

	Unaccompanied asylum seeker	Going missing	Child sexual exploitation	Trafficking	Gangs	Socially unacceptable behaviour	Self-harm	Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Other
BCP	37	37	28	C	12	49	30	225	151	117	40	585
Dorset UA	c	58	109	C	11	167	72	721	672	469	273	575

Child maltreatment - Child Protection Plans (CPP)

Child maltreatment includes neglect or abuse of a physical, sexual or emotional nature and under those categories a Child Protection Plan can be put in place to address the risk of harm to the child or young person.

Children who are the subject of a child protection plan have been identified as at risk of significant harm in the above categories of abuse and neglect and there is strong evidence of the detrimental effects on mental health and wellbeing in those who experience such harms.

PHE^{cxliiv} define neglect as the persistent failure to meet a child's basic physical and/or psychological needs, for instance inadequate provision of food, shelter or clothing, the failure to protect a child from physical or emotional harm or not accessing appropriate medical treatment.

They further outline that child abuse, in particular sexual abuse, has a particularly powerful negative and far reaching impact and may result in severe mental disorders, high risk lifestyles, physical illness, aggression, self-destructive and violent behaviours, anti-social behaviour, problems with relationships and an impaired capacity for parenting.

Neglected children, not in receipt of the love and care they need, are also more likely to experience mental health problems including depression, post-traumatic stress disorder, and attention deficit and hyperactivity disorder. Poor attachment in early life can create difficulties with developing and maintaining healthy relationships with their peers and other people later in life, including with their own children. In a more physical sense, malnourishment resulting from neglect causes delayed development and impaired cognitive function which can lead to depression in later life as well as dissociative disorders and impaired memory.

Children experiencing the above situations may also be living with violence or the fear of violence, both of which are significant risk factors for poor mental wellbeing. It may include experiencing violence oneself or witnessing violence (especially domestic abuse) against a loved sibling, parent or other relative or adult. There is strong evidence for the relationship between experiencing violence and adverse mental health outcomes such as depression, anxiety, conduct disorder, suicidal behaviour, substance abuse, post-traumatic stress disorder, low self-esteem and poor life satisfaction^{cxliiv}.

National data on from the ONS in 2020^{cxliiv} reported the extent and nature of child abuse seen in England and Wales. Drawn from the Crime Survey for England and Wales (CSEW) they estimated one in five adults aged 18 to 74 years has experienced at least one form of child abuse, whether of an emotional physical or sexual nature, or has witnessed domestic violence or abuse, before the age of 16 years, amounting to around 8.5 million people. More than half of adults (52%) who had experienced abuse by age 16 went on to experienced domestic abuse later in life; this was compared to 13% of adults who did not experience abuse by the age of 16 years.

They reported the hidden nature of child abuse; around one in seven adults who called the National Association for People Abused in Childhood's helpline in the year previous year had not told anyone about their abuse before and in that year, 'Childline' delivered nearly 20,000 counselling sessions to children in the UK where abuse was the primary concern; around 1 in 20 of which resulted in referral to external agencies.

At 31 March 2019, they stated nearly 50,000 children in England were looked after by their local authority because of experience of, or risk of, abuse or neglect.

Childhood maltreatment is believed to affect one in three children globally; the burden of mental ill health associated with childhood maltreatment was considered in a UK retrospective cohort study in 2019^{cxlvi}. The study reviewed GP records between 1995 and 2018 of 217,758 patients aged under 18 who had experienced, or were suspected to have experienced, childhood maltreatment or related concerns, and compared them to the records of 423,410 patients who had not.

They concluded mental disorders arising from child maltreatment have made a substantial contribution to the mental ill health burden in the UK. They found patients who were maltreated were more than twice as likely to develop serious mental disorders such as psychoses, schizophrenia and bipolar disorder, or require a prescription to treat mental ill health, compared to those with no recorded experience of maltreatment. The researchers also found maltreated children were more than twice as likely to develop other mental disorders, such as depression or anxiety.

The researchers commented on clear under-recording of child maltreatment in GP records, with potential opportunities to spot child maltreatment or implement management plans for vulnerable individuals being missed.

Local data on Child Protection Plans (CPP)

Numbers and proportions according to category

LAIT data showed in BCP there were 226 CPPs reported at end of March 2020, with 339 CPPs starting within the year. Additional understanding from in-house reporting showed in June 2020, 60% of the current CPPs had a primary need of neglect, 15% of physical abuse, 3% of sexual abuse and 23% of emotional abuse (although primary need is recorded, a child with a plan may be experiencing more than one type of abuse). Of those who had a plan, 55% were female and 45% male.

At March 2020, in Dorset UA there were 276 CPPs, with 393 CPPs starting within the year. In the year previous, at March 2019, there had been 328 CPPs^{cxlvii}, 73% of which were due to neglect, 8% physical abuse, 8% sexual abuse and 11% emotional abuse. It was remarked upon within the Dorset data that neglect categories include children witnessing or hearing domestic abuse, as they are deemed to be neglected in not being protected from potential emotional harm of being exposed to domestic abuse. It is not clear if the same approach was taken with BCP data.

Rates of CPPs

Rates of Child Protection Plans are shown in table 27 below; in 2019 Bournemouth (37.4) and Dorset (39.8) had a lower rate per 10,000 than England (43.7) of children who are subject to a child protection plan for any reason. Poole (24.5) had a significantly lower rate. All three authorities had shown a variable rate in the preceding three years, sometimes above or below England averages.

Table 27: Rate of Child Protection Plans, per 10,000

836	Poole (Pre LG reorganisation)-CPP rate	-	39.40	45.50	41.40
986	London-CPP rate per 10,000	-	34.60	37.20	40.60
970	England-CPP rate per 10,000	-	37.80	42.00	42.90

Source: LAIT, accessed January 2021

Table 28 below shows the most recent data available on the rate of CPP with an initial category of abuse. In 2018 Bournemouth (22.2) and Poole (22.5) had a slightly higher rate per 10,000 than England (21.2) of children who are subject to a child protection plan with a category of abuse. Dorset (13.1) had a significantly lower rate.

Table 28: Rates of Child Protection Plans, with a category of abuse

Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)
Children subject to a child protection plan with an initial category of abuse: rate per 10,000 children aged under 18	2018	21.2	22.2	22.5	13.1

Source: PHE Public Health Profiles, accessed June 2020

The rate of Child Protection Cases which start within the year (per 10,000), in table 29, shows a higher rate in Dorset UA than in BCP, the South West and England in 2020. Previous years within the three local authorities have shown variability in the rates across Bournemouth, Poole and Dorset, all fluctuating above and below Southwest and England rates between 2017-19.

Table 29: Rate of child protection plans starting during the year (rate per 10,000)

Local Authority	Rate of CPP starting within the year				
	-	2017	2018	-	2020
BCP	-	-	-	-	45
Dorset	-	-	-	-	58
Bournemouth (Pre LG reorganisation)	-	53	76	57	-
Poole (Pre LG reorganisation)	-	36	54	35	-
Dorset (Pre LG reorganisation)	-	76	46	63	-
South West	-	53	55	54	48
England	-	56	58	56	55

Source: LAIT, accessed December 2020

Children in Care (CIC) (sometimes referred to as Looked After Children (LAC))

The vast majority of children who enter care do so as a result of abuse and neglect or from experiencing the impact of trauma and abuse, or additional vulnerabilities, on their emotional and behavioural development. Particular concerns have been raised about the high prevalence of emotional and behavioural difficulties among care populations, with concern that adverse experiences while in care may further compound these difficulties^{xxiii, cxlviii, cxlix, cl, cli}.

Children in care are amongst some of the most vulnerable individuals in society, with heightened risk of poorer wellbeing and mental health than peers, from both the challenges which resulted in care provision but also from continuing challenges of being in care. They are also more likely to have poorer educational and life outcomes^{cxlviii, cl, cli}.

Around two-thirds of children in care during 2017/18 had previously been on a Child in Need Plan in the five years previous and nearly 40% had been on a Child Protection Plan^{cl}.

A number of outcomes are worse for children in care; they are ten times more likely to have a statement of special educational need, with more than a quarter requiring a statement of SEN compared with 3% of all pupils. Educational attainment is considerably lower than that of children who are not in care, for example of those in care, 41% attain 5 GCSEs [A* to G] compared to 91% of all children^{xx, clii}. It has been proposed lower attainment is linked to lower individual and school expectation but also a high prevalence of undiagnosed ADHD, dyslexia and other disorders in children in care^{xx}.

Unemployment on leaving school is four times more likely, and around one-third of prisoners were in care as children^{xx}.

It is hypothesised that inappropriate responses to behaviour perceived as challenging contributes to the breakdown of placements and is linked to a drift into criminal and exploitative sub-cultures across the country. This impacts upon the stability of placements and ability to achieve successful outcomes, but also the future of children in care and care leavers, who are dramatically over-represented in the prison population. Care leavers often remain vulnerable with childhood trauma continuing to affect behaviour and development into early adulthood, including poor emotional regulation and impulse control^{cxviii}.

Children in care, who had been looked after for at least 12 months, are five times more likely to offend than all children and the impact of criminality can be a barrier to successful transition to adulthood and future life prospects^{cli}.

National protocol recommends systems have an awareness of the additional vulnerabilities of Black Asian and Minority Ethnic looked-after children, who find themselves over-represented in both care and youth justice systems^{cli}.

National prevalence of mental health disorder in children in care

A 2010 NICE evidence report reviewed a number of studies working to establish the level of mental health needs of those children who are in care, reviewing findings from around 4,000 children. They reported greater need in children in care than in that of the general population, and no real decline in prevalence over the preceding five decades^{cxlviii}.

There have been varying degrees of mental health need of children in care reported but conclusions are around 45-72% of children in care have a diagnosable mental disorder (compared to just 12 per cent of the general under-19 population), and children in care are 12 times more likely to suffer post-traumatic stress disorder than peers not in care^{cliii}.

Around 40% are understood to have conduct disorder and up to 70-80% having recognisable problems^{xx, cxlviii, cxxxi, cl, cliv, clv}.

Work in 2007 further broke down types of disorders in children in care, showing 37% of children in care had conduct disorders, 12% had emotional disorders (anxiety and depression) and 7% were hyperactive, with some children having more than one type of disorder.

In 2018, nearly 40% of children in care (continuously for at least 12 months) had emotional and behavioural health scores which were a 'cause for concern'^{cl}, comparable with an earlier study's finding where children at point of entry into care showing emotional or behavioural problems was at 37.5%^{cxlviii}.

A NICE evidence report also reviewed need in children under five years old, and concluded a prevalence of around 25% of children in care under five years old demonstrating mental health problems. A further study analysing mental health problems at point of entry into care, also considered children under the age of five. They reported nearly one in five (18.9%) showed signs of emotional or behavioural problems, with 14.7% of children under three years old showing such problems^{cxlviii}.

There have also been observed differences in children within different care settings; studies have shown higher proportions of children in residential care affected by poor mental health, with reports of between 62-72% meeting criteria for a mental disorder or displaying significant emotional or behavioural problems^{cxlviii,clvi}. **Error! Bookmark not defined..** One source reported 60% met the criteria for a conduct disorder and 66% had physical complaints^{xx}. Another reported 50% showed indications of conduct problems and 23% emotional problems. Nationally around 12.5% of those in care were in residential settings in 2019.

Frequent moves of placement can also affect mental health. A study of children and young people's views compared the mental health needs of children in care who had frequent changes of placement, compared to those who did not. They found one-third (30%) of those aged over three years old in care had a 'probable' psychiatric diagnosis utilising the Strengths and Difficulties Questionnaire. Those who had moved placement three times or more in the year previous were three times more likely to have a 'probable' psychiatric diagnosis, and they were significantly more likely to report deliberate self-harm in the previous six months, when compared with those who had moved placement less frequently. The author also reported they although there was greater need in those who had moved placement more frequently, they were much less likely to access mental health services^{clvii}.

Nationally, 78,150 children were in care at March 31st in 2019, and using the 45-72% prevalence would indicate around 35,000-56,000 children nationally would meet diagnostic criteria and 55-63,000 would have recognisable problems (70-80%).

Local prevalence data on children in care

On 31 March 2020 there were 526 children in care within Bournemouth, Christchurch and Poole Council and 247 reported care leavers aged between 17-21 years old^{clviii}. On 31 March 2020 there were 474 children in care within Dorset Council (LAIT) and 255 reported care leavers aged between 17-21 years old.

Rates of children in care during 2020 have been 70 per 10,000 in both BCP and Dorset UA, higher than England at 67 and South West at 57 per 10,000.

Across Dorset, table 30 below outlines numbers of children in care the mental disorder prevalence estimates of 45-72% would equate to.

Table 30: Numbers and rates of CiC, and estimated numbers of those with mental health disorder

As at March 31 2019		Bournemouth	Poole	Dorset CC
Numbers (rates) of children in care aged under 18		251 (69 per 100,000)	194 (64 per 100,000)	416 (54 per 100,000)
	Modelled number of those aged under 18 with mental health disorder (according to prevalence estimates of 45-72%)			
	At 45%	112	87	187
	At 72%	181	140	300

Source: LAIT and Gov.uk: National Statistics. Children looked after in England including adoption: 2018 to 2019

Figure 81 below shows that between 2012-16 Bournemouth had consistently higher rates of children in care than Dorset, Poole, the South West and England, although declining from 2014. Pan-Dorset, rates have fluctuated over time with Poole and Dorset CC seeing steady increases, bringing rates in line with those of England. Dorset has seen an increase from 39 to 59 per 10,000 children between 2012-18.

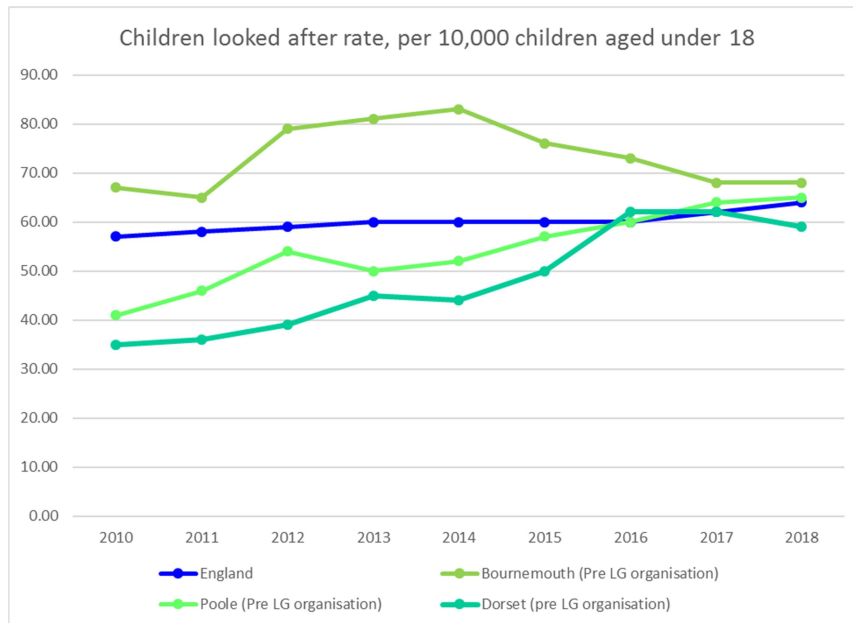


Figure 81: Children Looked After rate per 10,000 population, <18 years, 2010-2018
Source: LAIT data, created by Dorset CCG

Data below in figure 82 shows the gender and ages of children in care in 2016 across the county. It can be seen most children in care were male, reflective of South West and England pictures, except for in Dorset CC where there were slightly more females in care at March 2016.

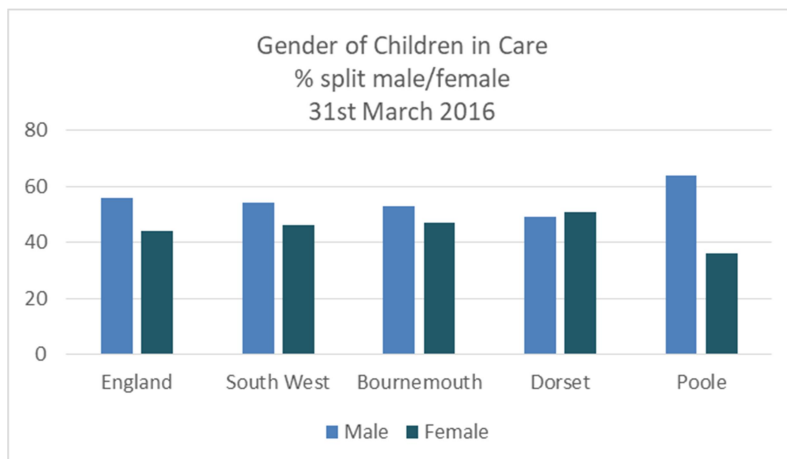


Figure 82: Percentage Children in Care, by gender
Source: Dorset CCG

Figure 83 below showed age ranges of children in care across the county and highlighted 10-15 year old children were most commonly in care, which is reflected regionally and nationally.

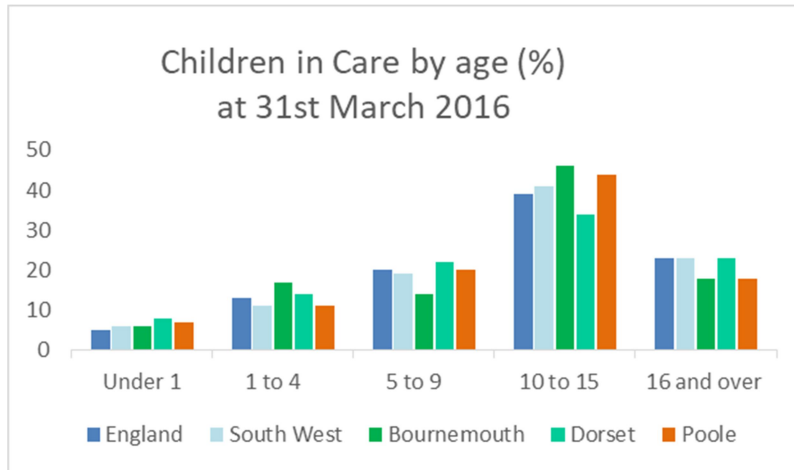


Figure 83: Percentage Children in Care, by age
Source: Dorset CCG

In 2016, it could be seen there was a greater percentage of under-ones in care across Dorset than in England and, between the ages of one to four, there remained a greater percentage in care in Bournemouth and Poole than in England.

Local data from PHE showed in 2017/18, in figure 84 below, rates of children in care under 5 years old were comparable to that of England and the South West in Bournemouth and Dorset, while they were lower in Poole, shown below:

Looked after children aged <5: Rate per 10,000 population aged <5 2017/18 Crude rate - per 10,000

[Export table as image](#) [Export table as CSV file](#)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	11,830	34.9	34.3	35.6
South West region	-	1,060	35.2	33.2	37.4
Torbay	-	75	104.5	82.2	131.0
Plymouth	-	82	53.6	42.6	66.5
Cornwall	-	140	48.6	40.9	57.4
Swindon	-	70	47.4	36.9	59.9
Bournemouth	-	44	39.4	28.6	52.9
North Somerset	-	43	36.7	26.5	49.4
Somerset	-	106	36.3	29.7	43.9
Devon	-	124	32.9	27.3	39.2
Dorset (Cty)	-	57	30.7	23.2	39.7
Bristol	-	85	28.5	22.8	35.3
Wiltshire	-	73	26.4	20.7	33.2
Bath and North East Somerset	-	24	25.3	16.2	37.6
Gloucestershire	-	86	24.7	19.8	30.6
Poole	-	18	22.1	13.1	34.9
South Gloucestershire	-	27	16.6	10.9	24.1
Isles of Scilly	-	-	-	-	-

Figure 84: Children in care, under 5 years old, rate per 10,000
Source: PHE Public Health Profiles, using DfE statistics

Modelling, using the above 2017/18 rates of children in care, would indicate in the 0-4 years population, in 2019, Bournemouth would have approximately 40 children under five in care, while Poole would have 18 children and 31 children in Dorset CC.

Rates of children starting to be looked after

LAIT data for 2020 showed rates of 29 per 10,000 children entering care for both BCP and Dorset UA, a higher rate than South West rates at 23 and England rates at 26 per 10,000.

During 2018-19, Bournemouth had rates above the South West but below England; Poole's rates were in line or above those of England and above the South West. Dorset rates were below England, in line with the South West.

Rates of children ceasing to be looked after

Bournemouth, Poole and Dorset had higher rates of children leaving care, above South West and England rates. Data under the new authority boundaries shows Dorset UA with rate of 20 per 10,000 which is below the South West rate of 22 and England rate of 25. BCP was similar to Dorset UA at 19 per 10,000.

Frequency of placements

It can be seen in figure 85 below, that between 2016 and 2019, Bournemouth showed a fluctuating picture, with between 3-12% of children in care having three or more placements.

In 2020, the BCP area showed 3% of children in care having multiple placements. Poole was similar to Dorset CC in fluctuation, with between 7-12% of children in care having three or more placements in Poole and 7-14% in Dorset CC. In 2020, Dorset UA was showing 10% of children with three or more placements.

All have been in line with the South West and England rates, although not as much fluctuation is observed regionally and nationally. This could be due to larger numbers within the regional and national data sets.

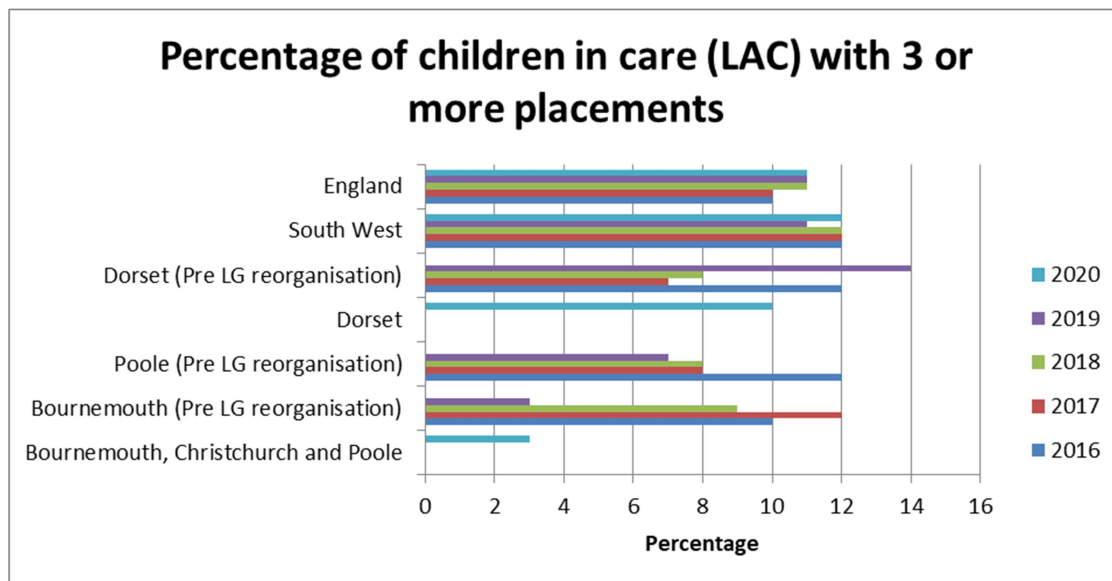


Figure 85: Children in care, with three or more placements (percentage), 2016-2020
Source: LAIT, accessed February 2021

Emotional and Behavioural Health of Children in Care

The indicator ‘emotional health of looked after children’ describes the emotional and behavioural health of children and young people who have been in care for at least 12 months, recorded by their main carer. The LAIT data registers a score of above 13 as cause for concern.

Figure 86 below shows the percentage of children in care with an SDQ score of concern. Between 2017-19, Bournemouth and Poole were either in line with or had a slightly higher percentage of children in care (termed LAC in figure) with an SDQ score of concern than England and South West levels.

Dorset County Council area had higher percentages than both other Unitary Authorities and the South West and England. In 2020, post-reorganisation, Dorset UA has a proportion recorded above that of South West and England, while BCP is in line with the England proportion.

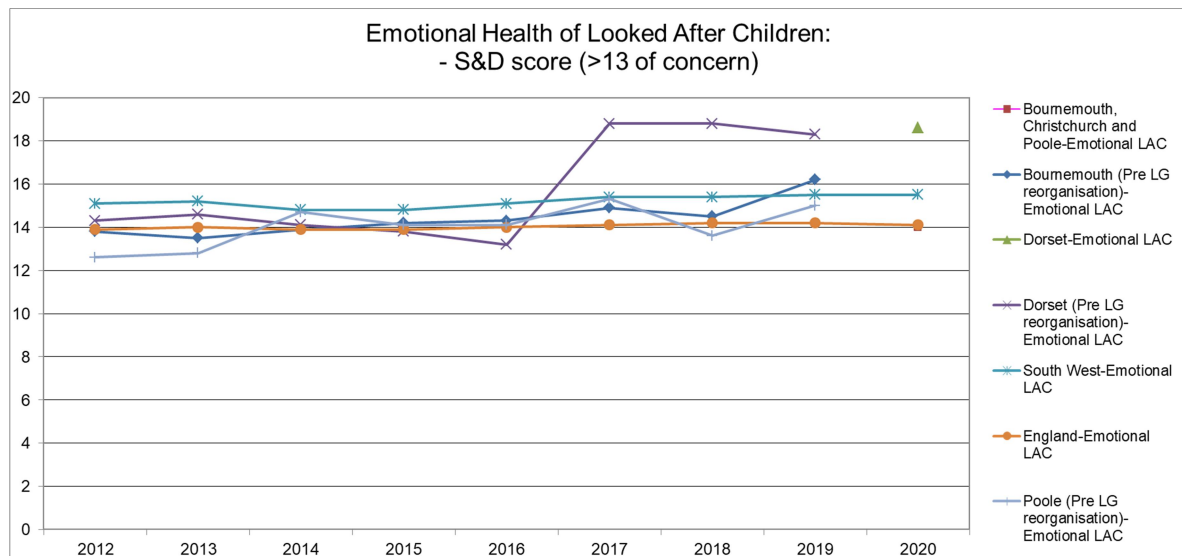


Figure 86: Percentage of Children in Care with a Strengths and Difficulties score of "concern" (>13)
 Source: LAIT, accessed December 2020

Children in Care – Education

As highlighted, for children in care there are great disparities in educational engagement and attainment. They are four times more likely to have a special educational need (SEN) and more than ten times more likely to have a statement of SEN or an Education Health and Care plan (EHC)^{clix}, and significantly less likely to attain GCSEs^{xx}.

The type of primary need for SEN of children in care differs from that of their peers, shown in figure 87 below. Children in care at secondary school age tended to have more social, emotional and mental health problems, while peers were usually experiencing problems more associated with autism and speech and language.

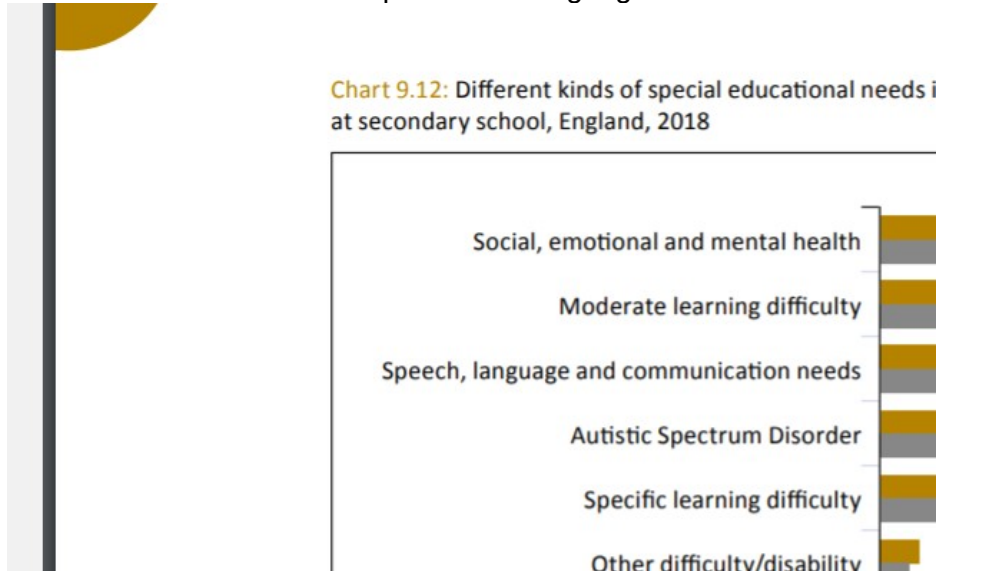


Figure 87: Different kinds of special educational needs in looked after children compared with their peers at secondary school, England, 2018
 Source: AYPH – Key Data on Young People, 2019

Attainment

Children in care progress far less well than children in the general population between primary school and Key Stage 4 (ages 14-16)^{clix}.

Indicators of attainment include ‘Attainment 8 score’ which measures the achievement of a pupil across 8 qualifications at KS4 with each individual grade a pupil achieves being assigned a point score. ‘Progress 8’ is also used, which compares pupils’ KS4 results to those of other pupils nationally with similar prior attainment, at the end of primary school (KS2).

Government data shows in 2019, the average Attainment 8 scores for children in care and children in need were much less than for non-looked after children, at around 19.2% for those in care and ‘in need’, compared with 44.6% in those not in care^{clix}.

It is also possible to review average progress 8 scores, nationally, in 2018 for children with no SEN, with SEN support and SEN statements or EHC plans. Figure 88 below demonstrates the differences seen in children who have been in care and those who have not. There is a worse gradient seen across all categories for those children in care.

Figure 3: Average Progress 8 scores for pupils with no identified SEN Educational Health Care (EHC) plans (looked-after children versus non-looked-after children)

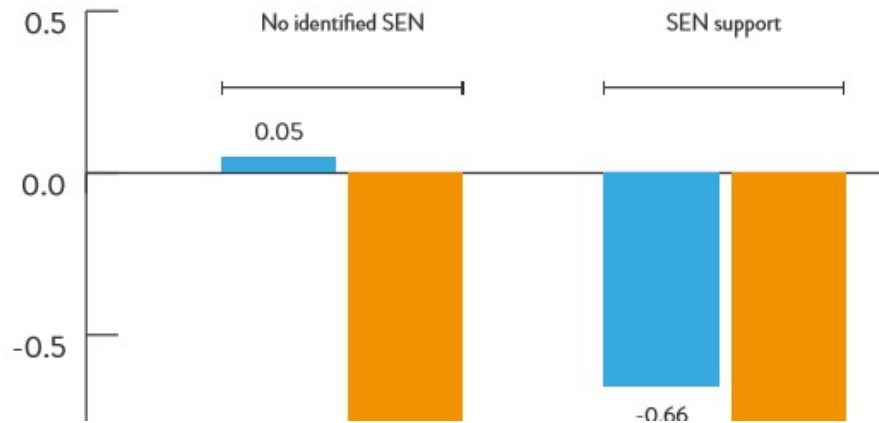


Figure 88: Average Progress 8 scores for pupils with no identified SEN; SEN support; and SEN statements or Educational Health Care (EHC) plans (looked-after children versus non-looked-after children) (2018)
 Source: The Centre for Social Justice: 12 by 24 report^{clix}

Disparity in education continues when moving through to higher education; about 6% of care leavers between 19-21 years go to university, compared with 34% in the general population of the same ageclix.

Local data on attainment for children in care

It can be seen in figure 89 below, that Attainment 8 scores show variability across the county and over time. Scores were above that of England and the South West in 2016 and in 2017, children in care in Dorset had higher scores than England, with Bournemouth and Poole below. Since then, children in care in Bournemouth have showed higher scores in 2018 and 2019, above that of all other areas. Children in care in Poole and Dorset have seen attainment below that of Bournemouth, the South West and England in 2018 and 2019.

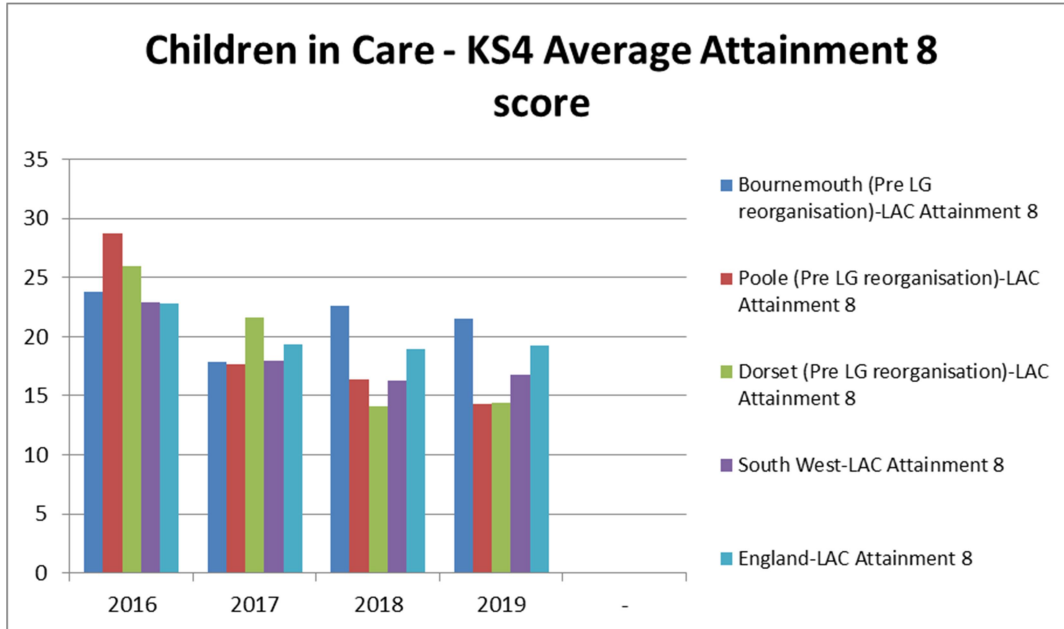


Figure 89: Attainment 8 scores for Children in Care, 2016-2019
Source: LAIT, accessed February 2021

It can be seen in figure 90 below, however, that children in the general school population across Dorset have Attainment 8 scores mostly in ranges of 45-54%, above that of England and the South West, including in the latest data available for BCP and Dorset UA in 2019 and 2020. These are two-three times higher than scores for children in care.

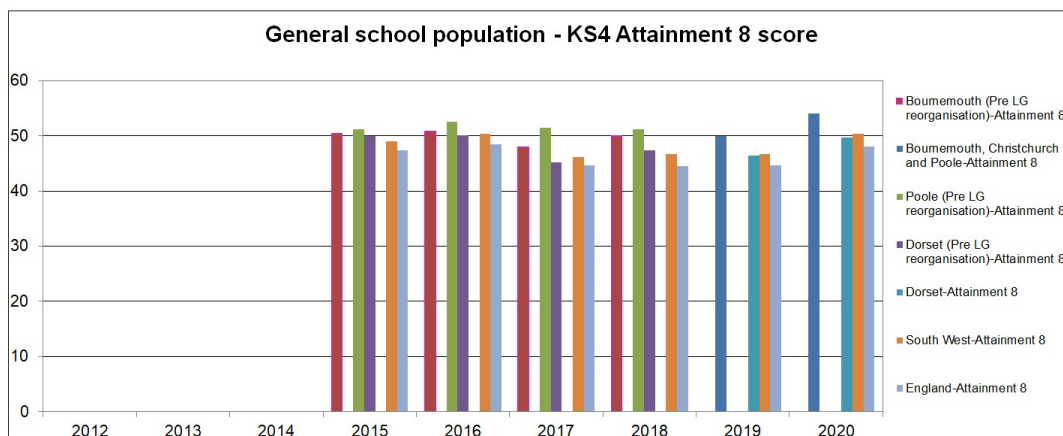


Figure 90: Attainment 8 scores for Children in Care, 2015-2020
Source: LAIT, accessed July 2021

Data shown in figures 91 and 92 below demonstrate that children in care also had lower attainment rates when reviewing Progress 8 scores than children in the general school population, with some variability in the scores, described below. A positive score means pupils on average do better at KS4 than those with similar prior attainment nationally, while negative scores means on average they do worse at KS4 than those with similar prior attainment nationally.

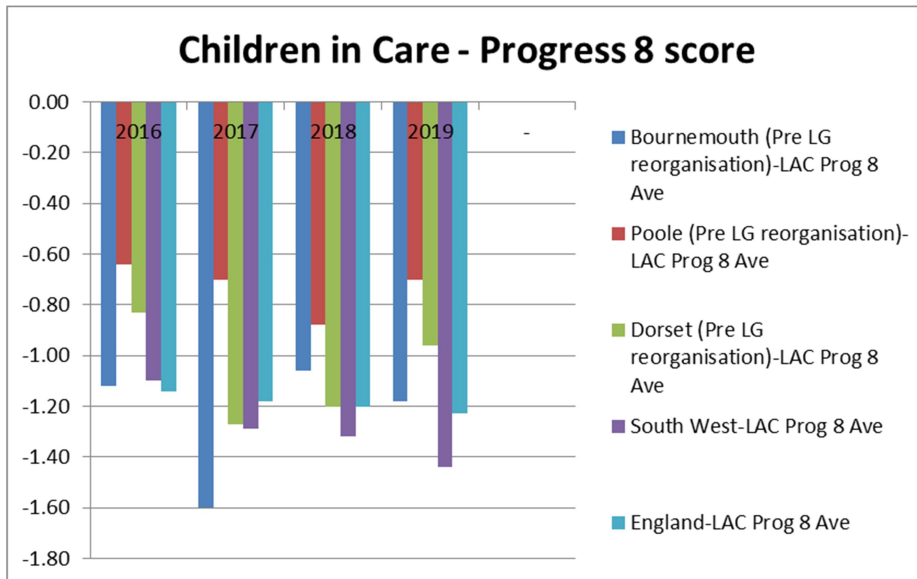


Figure 91: Progress 8 scores for Children in Care, 2016-2019
Source: LAIT, accessed February 2021

It can be seen that in 2016 and 2017, children in care in Bournemouth had worse outcomes between KS2 and KS4 than those children in care in the South West and England, while children in care in Poole and Dorset CC had less worse outcomes. Children in care across all three LAs had less worse outcomes than those children in care in the South West and England in 2018 and 2019.

It can be seen in figure 92 below, however, that children in the general population have Progress 8 scores mostly in the positive range, including in the latest data available for BCP and Dorset UA in 2019.

Where historically local areas have received negative scores, they have not been to the same degree as that seen for children in care. For instance, in Dorset CC in 2017, the score for children in the general population was -0.15. The figure above shows for the same time period, for children in care in Dorset CC the negative value was greater than -1 at -1.25.

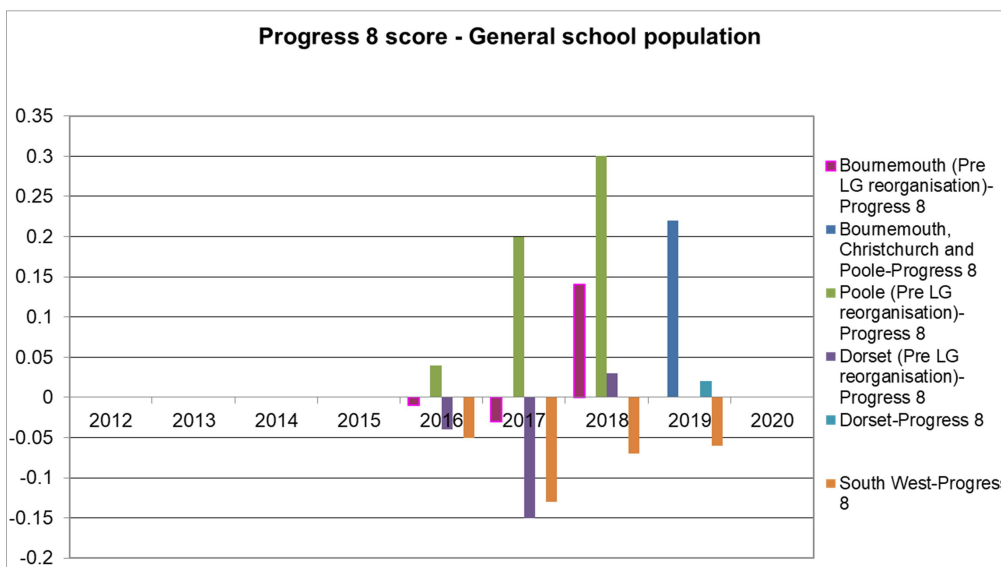


Figure 92: Progress 8 scores for children in the general school population, 2016-2019
Source: LAIT, accessed February 2021

Children in Care – Unauthorised absence

For children in care, in care continuously for at least 12 months, unauthorised absence from school significantly increased between 2016 and 2018 in all local authority areas, shown in figure 93 below. Data for 2019 shows the trajectory continuing for Poole (at 1.9%), remaining level in Dorset (1.7%), and declining in Bournemouth (to 2.3%). The England proportion in 2019 was 1.4%; all areas in Dorset have demonstrated higher absence rates for children in care than seen in England.

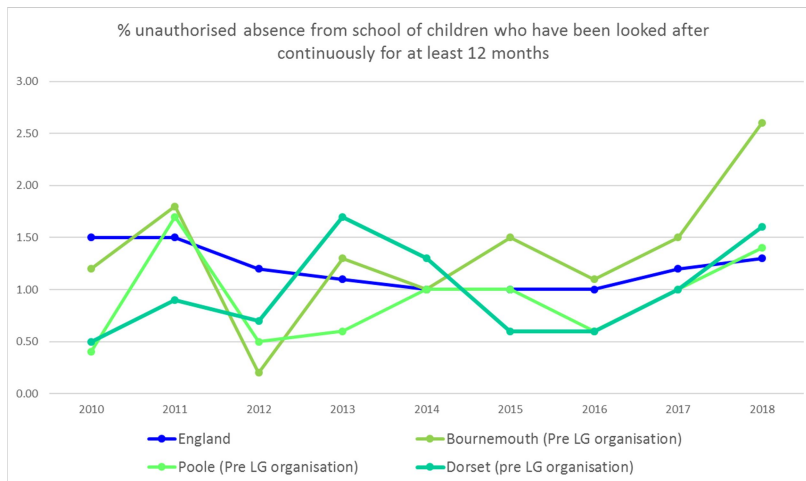


Figure 93: % unauthorised absence from school of children who have been in care for at least 12 months
Source: Dorset CCG

Children in Care – not in education, employment or training (NEET)

LAIT data reports 29% of care leavers are NEET (those aged 19-21 years who were looked after beyond age 14) in BCP. In the previous local authorities, Bournemouth proportions were between 36-47% in 2017-19 and Poole 26-43%. There are 41% of care leavers who are NEET in Dorset UA, in line with previous Dorset CC figures since 2017.

Children in Care – Offending

The vast majority of looked-after children and care leavers do not become involved with the criminal justice system, however, they do remain over-represented in comparison with others in the system; children in care are five times more likely to offend than all children^{clxi}.

Previous local data available shows the percentage of children in care subject to a conviction, final warning or reprimand during the year, in figure 94. The percentage appears to have been increasing across all three LAs between 2016-2018. LAIT data cannot be used to provide a more up to date picture as there are gaps in data between 2016-2020.

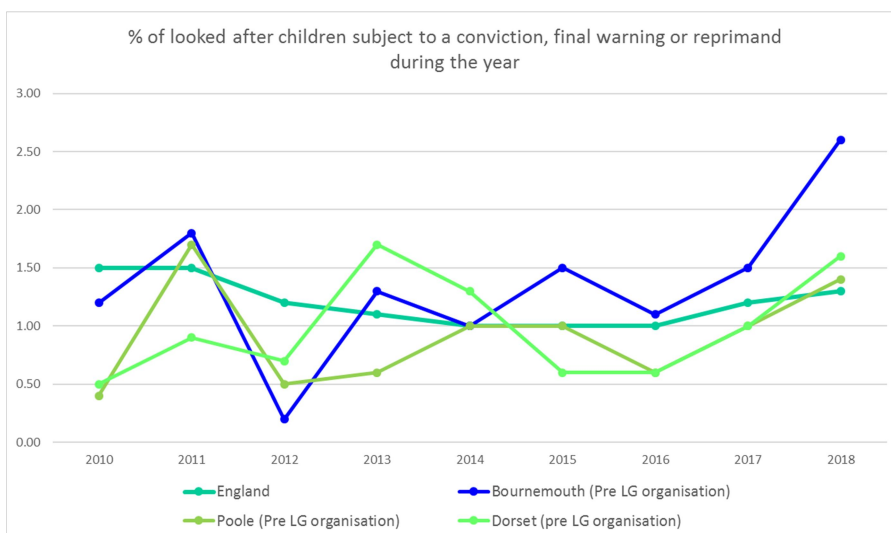


Figure 94: % of children in care who have been subject to a conviction, final warning or reprimand during the year
Source: Dorset CCG

Children in Care – Unaccompanied asylum seekers

Nationally, there has been a rising number of children who are unaccompanied asylum-seekers entering the care system.

At March 2018 there were 4,480 unaccompanied asylum-seeking children in care, around 6% of all children in care, in England. These children are more likely to live in poverty and have specific needs, some of which has been detailed earlier, but which may include mental health difficulties stemming from past experiences, current asylum claim anxieties, challenges and delays in accessing education, barriers in language and cultural awareness, increased stigma and lack of support in schools with resultant absences and exclusions^{clxii,clix}.

They face reduced access to schooling and additional, distinct barriers when navigating their journey to further education and university. Having arrived alone, they have limited or no financial support or networks, dependent on support from children's services or charities, are often not granted status to remain until aged 18 and therefore unable to access support to do so^{clix}.

Local numbers of children in care who were unaccompanied asylum-seeking children (UASC) during the year

Within BCP there were 39 Unaccompanied Asylum Seeking children in care at 31 March 2020 and 9 in Dorset UA. It can be seen in figure 95 below that this has varied across all LAs in the past few years, LAIT data reports.

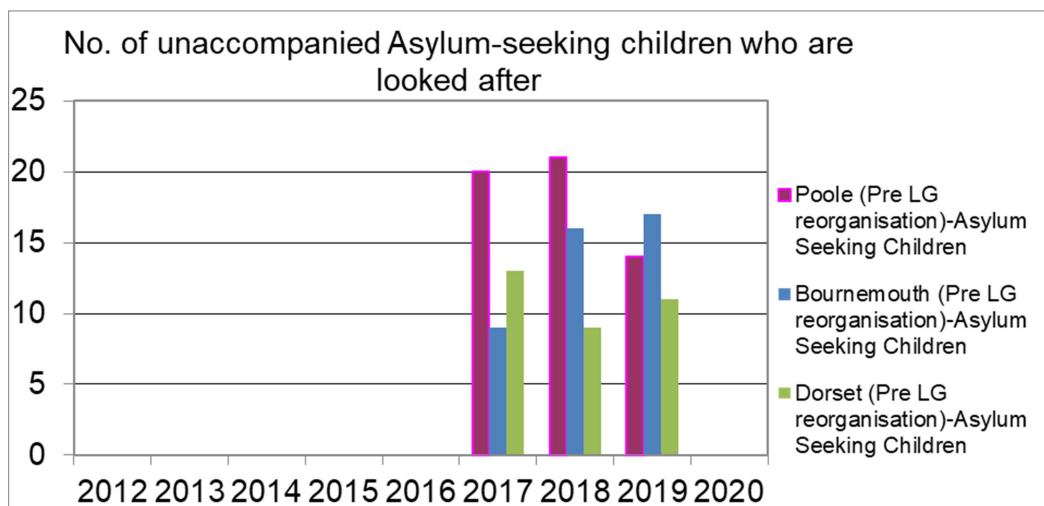


Figure 95: Number of UASC who are in care, 2017-2019
Source: LAIT, accessed December 2020

Children adopted

Adoption does not resolve the issues these children and young people have experienced, and continue to face.

Recent research has identified that children who are adopted in the UK can face enduring mental health and behavioural problems, with evidence showing no improvement in children's mental health four years after they were adopted. Their emotional and behavioural problems increased with the number of adverse childhood experiences they had experienced, which included abuse, neglect and unstable living arrangements^{clxiii}.

Those who are adopted therefore still need access to the same type of support as children in care^{cliii}.

Neurodiversity

The neurodiversity paradigm^{clxiv} is a relatively recent approach to considering Autism and other human neurocognitive variations, such as dyslexia, hyperactivity disorder (ADHD) and dyspraxia (developmental co-ordination disorder). This paradigm frames neurological diversity as being an important and valuable part of human diversity, encouraging people to view such neurological differences as natural and normal variations of the human genome.

The prevalence of some of these conditions and the impact on, or association with, mental health and wellbeing are considered below. In this HNA, Autism Spectrum Disorder is considered initially, followed by separate consideration of learning differences, given there are mixed views on whether to consider ASD alongside other learning differences^{clxv}.

There is a degree of interchangeable language used with regards to learning/intellectual disabilities and learning differences. During this report, learning or intellectual disabilities refers to those which impede cognitive ability, while learning difficulties refer to differences which make learning new skills or tasks more problematic for individuals but that do not affect intellectual capability. Where data terminology is used interchangeably this will be highlighted.

Autistic Spectrum Disorder

Autism spectrum disorders (ASDs) are developmental disorders characterised by impaired social interaction and communication, severely restricted interests, and highly repetitive behaviours^{clv}. While affecting social interaction and relationships in both childhood and adulthood, much research has also shown the presence of ASD has negative impacts on learning, educational achievement, employment, reduced lifetime earnings, the ability to partake in community activities and, at times, on the ability to live independently in adulthood^{clxvi}.

Autism is strongly associated with a number of coexisting conditions not part of the diagnostic criteria but which impact upon the wellbeing of the child or young person and their families or carers^{clxvii}. Approximately 70% of people with autism meet diagnostic criteria for at least one psychiatric disorder and 40% criteria for at least two disorders, mainly anxiety, attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD). These are often unrecognised but further impair a young person's functioning. Intellectual disability is also present in approximately 50% of children and young people with autism^{clxvi,clxviii,clxix}. It is estimated that 20-30% of people with a learning disability also have autism^{clxx}.

Language disorders, specific learning difficulties and developmental coordination disorder, manifesting as general clumsiness or an unusual gait, also commonly coexist with autism. Children and young people can also experience fine motor problems which can affect self-help skills and handwriting, which can lead to frustration and problems at school^{clxvi}.

Functional problems are also common^{clxvii}, with major impacts seen upon the child and family, for instance sleeping problems, eating difficulties and gastrointestinal problems. These, along with other challenges and conditions, can further impair psychosocial functioning and cause or increase behaviour that challenges. Mortality rates are higher in autism than in the general population, in association with comorbid medical health issues^{clxvi}.

National survey data of adults estimated, based on data collected from the APMS in 2007 and 2014, that 0.8% of adults have autism spectrum disorder (ASD), with men believed to have higher rates of ASD (1.5%) than women (0.25%).

Although no obvious differences were found in levels of ASD in relation to ethnicity or age, it was reported this was likely to be due to low sample sizes within the surveys.

Those with ASD were found to experience lower levels of education, with higher rates of ASD recorded in those with no qualifications (1.5%) compared to those with degree-level qualifications (0.2%)^{clxxi}.

Mental health difficulties in those individuals with autism, may arise for a number of reasons, such as difficulties with communication, challenges in navigating educational systems and working environments, and a lack of social inclusion and relationships, amongst others^{clxxii,clxxiii}. It is believed between 40-82% of young people with autism have been bullied at school^{clxxiv} and adults with the condition often experience isolation and adverse experiences such as being bullied and socially excluded^{civ}.

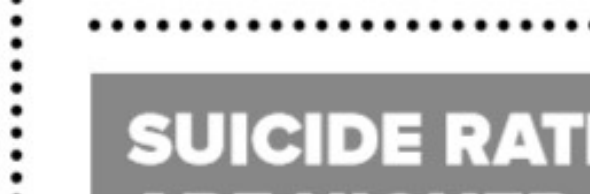
It is understood that autism is a developmental condition and, as such, poor mental health is not an inevitable part of being autistic. However, there are documented experiences of difficulty in diagnosing mental health disorders in individuals with autism^{clxxv,clxxvi,clxxvii}, suggestive of underdiagnoses of mental health conditions in those with autism. Despite suffering greater ill-health, people with a learning disability, autism or both often experience poorer access to healthcare^{clxx,civ}.

Surveys and reports from the National Autistic Society^{clxxviii} found nine out of ten people with autism have been worried about their mental health during the COVID-19 pandemic, and that people with autism were seven times more likely to be chronically lonely than those in the general population. In their 2019 report, prior to the pandemic, they reported 76% of autistic people had tried to access mental health support in the previous five years, but only 14% believed there were sufficient mental health services in their area to support their needs.

An adult mental health charity recently reported, from their text messaging support service, texters they supported were seven times more likely to be autistic, with autism mentioned in around 2% of their 1,000 daily conversations^{clxxviii}.

National prevalence of ASD and mental disorder

Data drawn from both the NHS Digital survey in 2017 and the APMS in 2014 concluded around 0.8% of adults and around 1% of those between 10-24 years of age have ASD^{cv}:



Source: 'Key Data on Young People 2019'^{cv}

As mentioned, NICE have reported prevalence of 70% of people with autism meeting criteria for one mental disorder, and 40% meeting criteria for two disorders. A longitudinal study in 2015 followed 58 adults over four decades, and found mental health disorders in more than half (56%); 28% had experienced mild to moderate difficulties, 23% had severe and 5% very severe problems.

In the NHS Digital survey undertaken in 2017, the proportion of children diagnosed with autism spectrum disorder (ASD) who experience mental health disorder was believed to be around 1.2% nationally, more so in boys (1.9%) than girls (0.4%); around five times as many boys as girls. This corresponds with other national larger-scale and regional survey findings, conducted between 2004-2009, which reported prevalence of around 1% in children and adolescents, again higher in boys than girls^{clxxix,xvii,clxxx}.

Rates appeared higher, in the 2017 survey, in younger age groups than older ones (1.5% of 5 to 10 year olds; 1.2% of 11 to 16 year olds; 0.5% of 17 to 19 year olds), seen in figure 96 below, although the authors note these estimates were only drawn from small numbers.

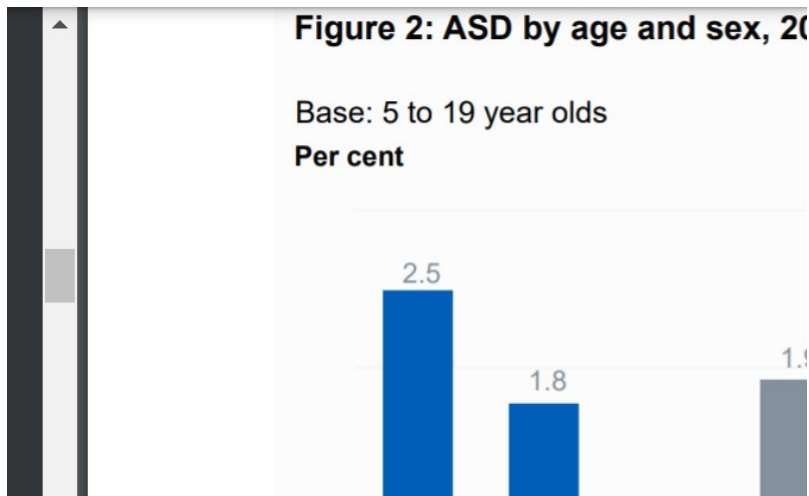


Figure 96: ASD by age and sex, 2017
Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017^{lix}.

Local prevalence of ASD

It is understood that, while diagnoses of ASD may be made from as early as 18-24 months, it is often around school age that diagnoses are provided^{clxxxix, clxxxii}. The below does not give us the full picture of all children with ASD locally, but a picture of school-age children identified as being affected by ASD.

Across Dorset, the number of those identified as having a special educational need (SEN) with a primary need for support due to ASD is shown below in table 31:

Table 31: Headcount by SEN provision with primary need of ASD

LA	SEN No Statement or EHC (across PRU, Primary and secondary schools)	Statement or EHC (as previous, but including special school provision)
BCP	342	528
Dorset UA	472	480

Source: 'Special educational needs in England': Academic Year 2019/20^{clxxxiii}

PHE data, contained in figure 97 below, has provided a rate per thousand of those identified as having a special educational need (SEN) with a primary need for support due to ASD,

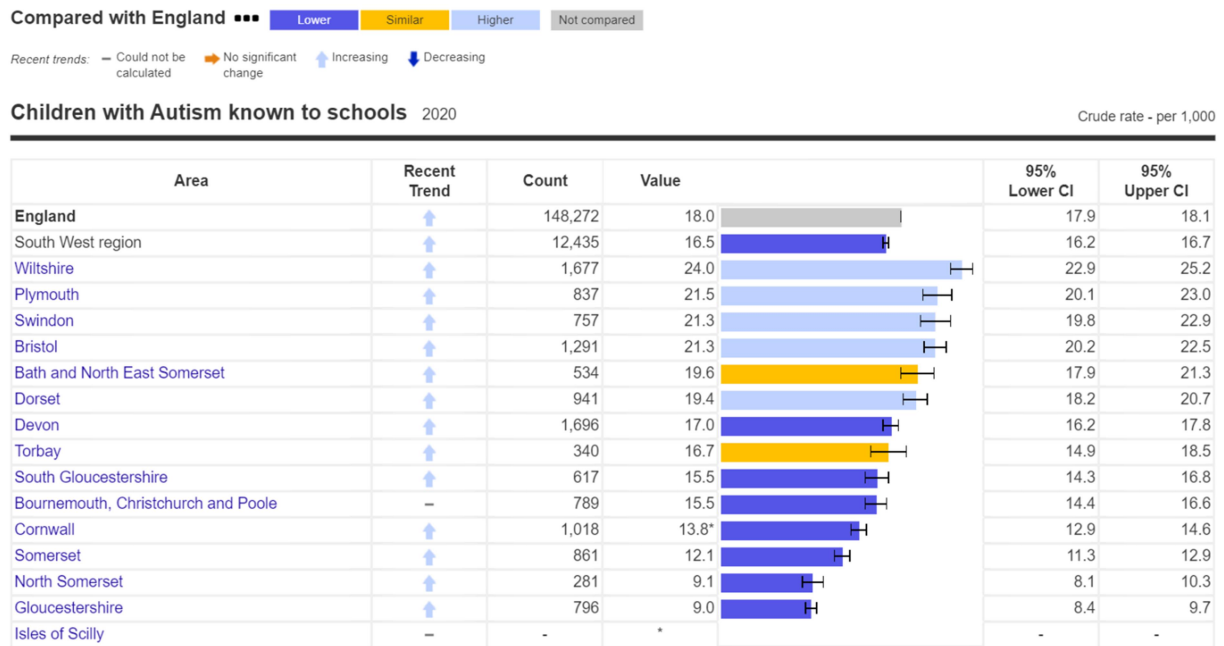


Figure 97: Autism identified as primary need for Special Educational Need support in Schools, 2020
Source: PHE Public Health Profiles

The data above reports, for children with a primary need for SEN support of Autism, rates per 1,000 of 19.4 in Dorset and 15.5 in BCP, compared with 16.5 in the South West and 18.0 in England. The data reports a growing trend^{clxxxiv} but it was not possible to clarify at which points data was related to Dorset CC and to Dorset UA. Trend data was not available for the previous organisations of Bournemouth and Poole in the PHE dataset.

Specific Learning Difficulties or Differences

Specific learning difficulties, or differences, are considered to be those which create barriers to learning and outputs but which do not affect IQ; this is in contrast to learning disabilities in that they are considered to affect overall cognitive function^{clxxxv}.

Across the range of specific learning difficulties, it is estimated between 5-10% of children are affected. Although there are genetic origins, these are combined with environmental interactions affecting developmental trajectories and lifetime learning and outcomes^{xx}.

Characteristic features of some learning difficulties can be difficult to diagnose, with co-occurrence and symptoms aligning with those seen in other psychiatric conditions. This may result in additional or alternative diagnoses, delaying appropriate input.

Specific learning difficulties therefore often remain unidentified, or are identified at later stages, with a continuing lack of recognition and understanding of both the difficulty itself, the common co-occurrence with other learning difficulties and the teaching or technological input required to foster positive outcomes^{clxv}. If learning difficulties persist into adulthood, unrecognised, service provision and treatment can be ineffective^{civ}.

Learning difficulties can result in underachievement in, and disengagement with, school, sometimes leading to a long-term cycle of anti-social behaviour, exclusion and criminality^{xx}. Rates of ADHD have been shown to be up to five times higher in children in care and youth offenders^{clxxxvi}. ADHD has been identified in 26% of prisoners and is associated with increased rates of criminal convictions. ADHD has also been linked to increased mortality^{civ}.

Work undertaken by the Foresight Project^{xx} looked at long-term social and economic consequences in two types of learning difficulties, dyslexia and dyscalculia (challenges related to numeracy). They reported having dyslexia could reduce the probability of achieving five or more GCSEs (A*-C) by 3-12 percentage points and reduce lifetime earnings by £81,000. For developmental dyscalculia, the reduction in GCSE attainment, as above, could be 7-20 percentage points and lifetime earnings reduced by £114,000.

While not every child with a learning difficulty has a mental health problem, there is a greater risk of mental health problems among those children and young people who have a learning difficulty^{clxv}, including anxiety, depression and low self-esteem^{clxxxvii}. Again these are often overlooked, underdiagnosed, treated at later stages or left untreated, as there are challenges in identifying boundaries and overlaps between conditions such as ASD or ADHD and mental health problems such as anxiety and depression^{clxxxviii} with symptoms sometimes mistakenly attributed to the person's learning difference.

Hyperactivity disorders, such as ADHD for instance, can affect children and young people over a lifetime, disrupting relationships and making everyday life difficult. Hyperactivity disorders in adulthood have been linked to being economically inactive, having no qualifications, and having a substance abuse disorder^{clxxxix}. In the APMS survey^{civ} in 2014 found of adults screening positive for ADHD, links were seen with higher unemployment and almost three times as many individuals were claiming out-of-work benefits than those who did not screen positive (one in three as oppose to one in eleven). Symptoms and features of ADHD can overlap with symptoms of other learning difficulties, conditions or disorders. Common coexisting conditions in children include disorders of mood, conduct, learning, motor control, language and communication, and anxiety disorders.

Learning difficulties can extend into adulthood and coexisting conditions seen in adults include personality disorders, bipolar disorder, obsessive-compulsive disorder and substance misuse^{civ}.

National prevalence of learning difficulties and mental disorders

Dyslexia

Dyslexia is thought to affect around 10-15% of the population in the UK and around 10% of school-age children^{cx,cxci}. A recent Parliamentary report estimated, however, more than 80% of pupils with dyslexia are failing to be diagnosed^{cxci}.

Children with dyslexia experience three times more behavioural disorders; one third of children with behavioural problems are affected by dyslexia.

Hyperactivity

NICE reports prevalence rates, with ICD-10 identification of hyperkinetic disorder, of 1 to 2% in childhood. Under the previous, less stringent DSM-IV criteria, childhood prevalence rates were 3 to 9% and it is understood an increase in rates may be seen under the newer DSM-5 criteria.

The NHS digital survey in 2017 considered the prevalence of mental health disorders in those with 'hyperactivity' disorders, which encompasses the ICD-10 classification of 'hyperkinetic' (similar to the DSM-V of ADHD). The majority with a hyperactivity disorder met the criteria for hyperkinetic disorder. They stated children who have a hyperactivity disorder are at greater risk of developing dysfunctional personality traits such as delinquency and antisocial behaviour.

About one in sixty (1.6%) of 5 to 19 year olds were identified as having a hyperactivity disorder, more prevalent in boys (2.6%) than girls (0.6%). Their previous surveys in 2004 and 1999 had shown prevalence of around 2% in those 5-16 years of age^{xvii}.

Rates of hyperactivity disorders were lower in young people aged 17 to 19 (0.8%) compared to adolescents aged 11 to 16 (2.0%), seen in figure 98 below.

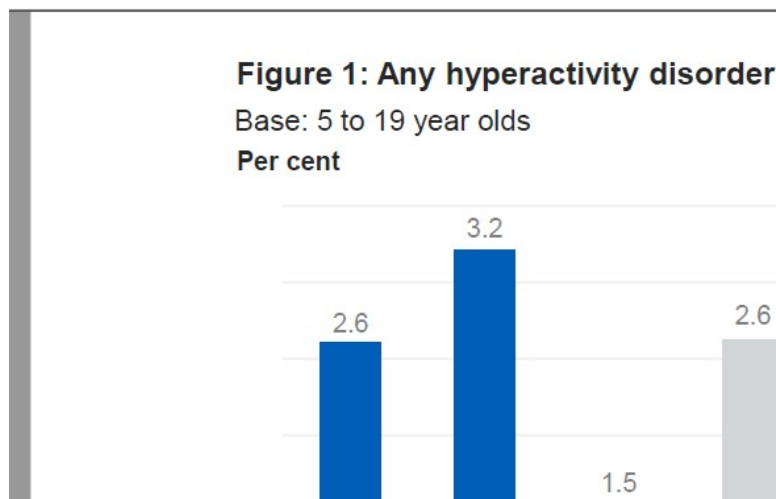


Figure 98: Any hyperactivity disorder by age and sex, 2017

Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017

Those with SEN were much more likely to have a hyperactivity disorder (11.9%), as were children whose general health was poor, rising in prevalence in relation to degree of severity of parent's mental health and the degree of unhealthy family functioning.

In preschool children (2-4 years of age) they reported lower rates of around 0.5% across genders, with higher levels of 0.6% in boys over 0.3% in girls.

The adult APMS^{ci} survey in 2014, referred to previously, also estimated rates of ADHD in the general adult population at 1 in 10 (9.7%) adults screening positively for ADHD, similar in both men and women. Screening positive for ADHD indicates that someone warrants a fuller assessment and therefore the actual prevalence will be lower. However, it does provide key information on the distribution of ADHD characteristics in the general adult population. The proportion of those screened positive for ADHD aged 16–24 was higher at 14.6%, or one in seven.



5-10 ye
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Source: 'Key Data on Young People 2019'cv

A third of the adults who screened positively for ADHD at the time of the survey were receiving treatment for a mental health or emotional problem and nearly a quarter of individuals received treatment for anxiety (23.8%) or depression (22.9%).

Local prevalence of children with learning difficulties

Local prevalence data has not been readily available, and given the complexity in diagnosis and the probable levels of underdiagnoses explored in much of the literature, it would be unclear as to how precise these would be. This is a recognised challenge with co-occurrence often of other learning disabilities and learning difficulties such as ASD, dyslexia, and dyspraxia, amongst others.

PHE data from 2013 estimated local prevalence of ADHD in young people aged 16–24 years, numbers of which were believed to be 3672 in Bournemouth, 1979 Poole and 5250 in Dorset.

Learning disabilities

A learning disability is defined as that which impairs the development of an individual and therefore their functioning, occurring before age 18. It impacts the way individuals develop in all core areas, and ultimately how they live their lives and access support and care^{cxcii}.

A learning disability can occur for various reasons; it can be chromosomal or genetic in origin such as in Down's Syndrome, or a consequence of events occurring prior to, or during, birth or later. Maternal infections and in-utero development sometimes affected by environmental effects (such as foetal alcohol syndrome) can occur. Issues during birth can involve a lack of oxygen, trauma or premature birth. Beyond birth there can be effects on development from the environment, ranging from a lack of stimulation to abuse and neglect. Injury and childhood infections can also result in the development of learning disabilities.

Learning disabilities can be mild, moderate, severe or profound. In all cases a learning disability is lifelong^{cxci}.

Some learning disabilities co-exist with other impairments, which have in themselves been identified as risk factors for mental health. For instance PHE outlines for children with cerebral palsy, one in four also have a severe learning difficulty and between one in three and one in ten also have a physical disability^{cxci}. The Public Health Observatory also reported children and young people with learning disabilities were much more likely to live in poverty, to have few friends and to have additional long term health problems and disabilities such as epilepsy and sensory impairments; risk factors associated with mental health problems.

Research shows that people with learning disabilities have poorer general health, and receive poorer healthcare, than people without learning disabilities^{cxci}.

All of these problems may be exacerbated for those with greater support needs, particularly if they have difficulty in communicating their feelings or distress, and changes in wellbeing in those with high support needs can be overlooked, particularly if they also have high levels of medical or care needs^{cxci}.

There are approximately 1.5 million people with a learning disability in the UK (2.16% of the adult population), 1.2 million of which are within England. Around 351,000 (2.5%) children and young people aged 0-17 are believed to have a learning disability in the UK; 299,000 of which are in England^{cxci,cxvi}.

National prevalence of mental health disorders in those with learning disabilities

Research demonstrates an estimated 20-54% % of people with learning disabilities have mental health problems^{cxvii,cxviii}. People with lower intellectual ability have been shown to have higher rates of common mental health problems (25%) compared to those with average (17.2%) or above-average (13.4%) intellectual functioning.

Prevalence of a diagnosable psychiatric disorder in children and young people with learning disabilities has been reported as 36%, in comparison to 8% in those who do not have a learning disability^{cxix}. Children and young people with learning disabilities are between four and a half and six times more likely to have a diagnosable psychiatric disorder than peers without learning disabilities, and three to four times more likely to have a behavioural disorder^{cc,cxviii}.

One national study reported intellectual disabilities accounted for 14% of all British children with a diagnosable psychiatric disorder; particularly marked for those with autistic-spectrum disorder, hyperkinesis and conduct disorder. Controlling for the effects of social disadvantage significantly reduced the increased risk of psychiatric disorders among children with learning disabilities, again demonstrating the impact of interacting contextual risk factors.

Children and young people with learning disabilities were 33 times more likely to be on the autistic spectrum, and were much more likely to have emotional and conduct disorders^{cxix}.

Local data prevalence estimates

Data on children and younger people with learning disabilities is predominantly gained through information collected by the Department of Education on ‘Special Educational Needs’ (SEN). Children not included are children educated at home and those in independent mainstream and independent special schools. Three types of SEN, when combined, approximate to learning disabilities: moderate learning difficulty (MLD), severe learning difficulty (SLD) and profound multiple learning difficulty (PMLD); this does not refer to learning difficulty as defined earlier within this HNA, but to learning disability. Further data on SEN is detailed in the section below.

Recent data from PHE, shown in figure 99 below, shares a number of indicators within a learning disability profile locally. In comparison with England data, dark blue indicates a lower level, orange a similar level and light blue a higher level.

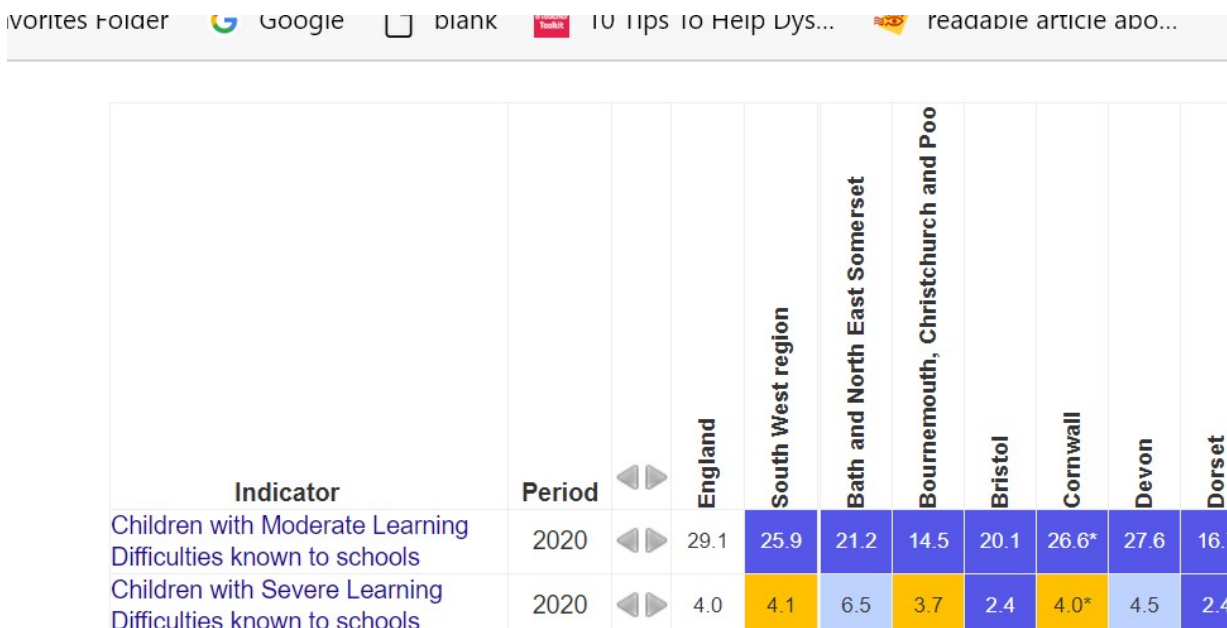


Figure 99: Learning Disability Profiles showing BCP and Dorset information
Source: PHE Public Health Profiles

The indicator shown above in figure 99, termed ‘Children with learning difficulties known to schools’ is, in this instance, a measure of the three types of SEN indicating learning disabilities; that of MLD, SLD and PMLD. Shown in crude rate per 1,000 pupil population, both BCP and Dorset have rates of around 19 per thousand, lower than the South West rate of 31 and the England rate of 34.

This data also shows in 2019/20, within BCP and Dorset, there was an estimated rate of 2.99 and 3.17 per 1000 adults receiving long-term support from the local authority in respect of learning disabilities. This is slightly lower than the rate of 3.46 per 1000 adults seen in England. PHE recommend this is viewed in line with GP QOF prevalence; the Dorset CCG Quality Outcomes Framework (QOF) data showed pan-Dorset prevalence of all registered patients with learning disabilities (all-age) was of 0.6% in 2019/20. Prevalence for England and the South West was at 0.5% for both.

However, figures within the Public Health Observatory for Learning Disabilities^{cci} report outlined around 20 per thousand population had a learning disability. Further reports also suggested only 23% of adults with learning disabilities in England are identified as such on GP registers; the remaining 77% are believed to be the ‘hidden majority’ of adults with learning disabilities who typically remain invisible in data collections.

Those with ‘mild’ learning disabilities, not captured, are still believed to have significant support and health needs. Data from governmental studies has shown they are significantly more likely than their peers to be still living with their parents, be unemployed, have literacy and numeracy problems and to experience high levels of psychological distress^{cxvii}.

Special Educational Needs SEN(D)

The 0-25 SEND Code of Practice (2015) identifies four broad areas of special educational need and support, namely:

- Communication and interaction
- Cognition and learning
- Social, emotional and mental health
- Sensory and/or physical needs.

School census records identify twelve types of needs within the four areas above and, for statistical purposes, children are categorised by their 'most significant' or primary need.

Of the twelve types of need, four relate to cognition and learning, the latter three of which involve at least some limitation of a child's intellectual functioning^{ccii}:

- specific (like dyslexia)
- moderate
- severe
- profound and multiple learning difficulties

SEN support is that provided by the school, in a cycle which assesses the needs of a child or young person, plans and implementation of support, and review, to help them make good progress. A child with more complexity of need may need an education, health and care (EHC) plan if support is required that is beyond usual school provision^{cciii}.

Impact of SEN

SEN has been consistently shown to be a strong predictor of poorer outcomes for children and young people, in particular with education and employment, mental health and social issues.

There is a general increased risk of mental health disorders among children and young people with SEN^{clxxxviii, cciv}. A detailed analysis^{cciv} in 2008 demonstrated children and young people with SEN were:

- 16 times more likely to have a persistent mental disorder and four times more likely to develop a mental disorder
- more likely to have persistent conduct disorder
- more likely to develop emotional and conduct disorder (30% vs 14% and 51 % compared with 12%)
- four times more likely to have persistent emotional disorder and twice as likely to develop emotional disorder

As described earlier, those with SEN are also more likely to be absent and persistently absent from school, while exclusion rates are five times higher for those with SEN support, and two times higher for those with an EHC plan, than for those with no support needs. Children with profound and multiple learning difficulties and behavioural, emotional and social difficulties were the most likely to be absent from school.

While mental health needs for some may be the classification of SEN, some issues experienced by those with SEN may lead to mental health problems such as frustration, difficulty with social interaction, lack of networks, stigmatisation and bullying.

A local youth survey of children in school years 4 to 6, found a strong association between SEN and feeling uninformed, being bullied, feeling unsafe when out and about and of having tried smoking. They also described themselves as significantly less happy than others.

National prevalence of SEN

National statistics for 2020^{ccv} showed 12.1% of all pupils were recorded as having SEN support, without an Education, health and care (EHC) plan, up from 11.9% in 2019. 3.3% of all pupils had an EHC plan, a rise from 3.1% in 2019.

The most common type of need for pupils receiving SEN support was speech, communication and language needs and with an EHC plan it was Autism Spectrum Disorder (ASD). SEN was more prevalent in boys than girls, with boys representing 73.1% of all pupils with an EHC plan and 64.6% of pupils with SEN support.

This concurs with the NHS Digital Prevalence Survey^{lix} findings that around one in ten (9.6%) 5-19 year olds was recognised as having special educational needs, with rates higher in boys (12.5%) than girls (6.4%). SEN was nearly six times more likely in children who had a mental disorder (35.6%) than in those without a disorder (6.1%), however, sometimes, the special educational need could have been related to an aspect of the mental disorder itself.

Half (47.9%) of boys with a mental disorder were recognised as having special educational needs, compared with a fifth (20.9%) of girls with a disorder.

Different types of mental disorders were more likely to be associated with having SEN; nearly two thirds of children with a hyperactivity (62.9%), or other less common disorder (64.8%), were recognised as having special educational needs, compared with around a quarter of children who had an emotional disorder (26.8%).

Local data on school pupils with SEN

Table 32 below outlines the numbers of children and types of SEN support required. Across Dorset in 2019/20 12.5% of all pupils had SEN support, without an EHC plan, in BCP and 14.6% in Dorset UA. Dorset's proportion was above that of England.

3.3% of all pupils in schools in BCP, and 3.7 in Dorset UA, had an Education, health and care (EHC) plan, Dorset being above the England proportion.

Of all BCP pupils in 2019/20, therefore, 6,362 were receiving SEN Support, and 1,714 had an EHC plan. In Dorset UA, 6,693 were receiving SEN Support, and 1,896 had an EHC plan. A further breakdown is shown in table 34 in the subsection 'Primary type of need' below.

Table 32: Number, and percentages, of pupils, by type of SEN provision, in BCP Council and Dorset UA in 2019/20. Those in red are higher than England proportions.

	EHC plans/ Statements of SEN	EHC plans/ Statements of SEN (%)	SEN support	SEN support (%)
BCP Council	1,759	3.3	6,764	12.5
Dorset UA	2,013	3.7	7,891	14.6
England	-	3.3	-	12.1

Source: LAIT data

Reviewing the breakdown by gender, DfE data^{ccvi} shows in BCP 15% of boys, and 9% of girls, of the school population required either SEN support or a SEN statement/EHCP. In Dorset, there were 17% of boys and 10% of girls, while in England these figures were 15% and 9%.

Table 36: Percentages of school pupils with SEN across Dorset, by gender, 2019/20

		SEN No Statement or EHC	Statement or EHC	Total
Bournemouth, Christchurch and Poole Council	Boys	4,003	1,299	26,207
	Boys (%)	62.9	75.8	51.2
	Girls	2,359	415	25,022
	Girls (%)	37.1	24.2	48.8
Dorset	Boys	4,219	1,395	24,544
	Boys (%)	63.0	73.6	50.4
	Girls	2,474	501	24,113
	Girls (%)	37.0	26.4	49.6
England	Boys	645,159	201,544	4,239,466
	Boys (%)	64.6	73.1	51.0
	Girls	354,261	74,060	4,073,085
	Girls (%)	35.4	26.9	49.0

Source: Department for Education^{ccvi}

Historical trend data on SEN

SEN support

Across the three previous local authorities 2019 data, in table 33, showed Bournemouth had fewer children with a need for SEN support at 11.5% than the England proportion of 11.9%. Poole (13.7%) and Dorset (13.2%) had higher proportions of children needing SEN support.

Table 33: Percentage of school pupils with Special Educational Needs SEN, 2019

Bournemouth	Poole	Dorset	England
11.5%	13.7%	13.2%	11.9%

Source: LAIT data.

Figure 100 below reflects the data above and presents the percentage change over time, which has seen the levels in all three authorities beginning to converge between 2017-19.

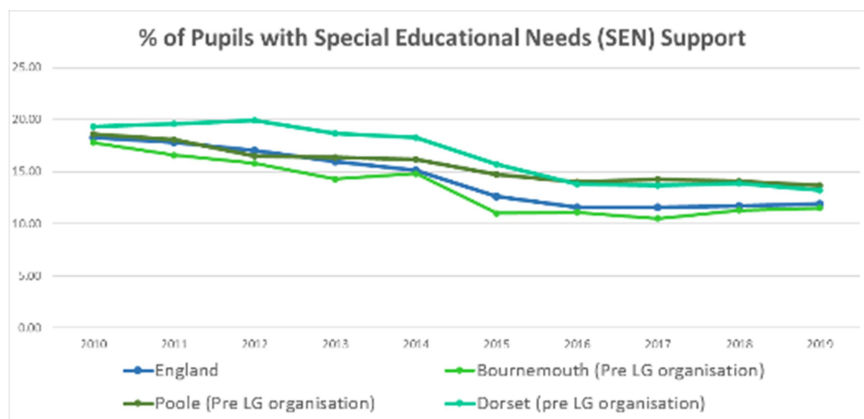


Figure 100: Percentage of pupils with Special Educational Needs Support
Source: LAIT data

In primary schools levels of SEN support, without an statement/EHCP, have declined since 2014, been relatively stable between 2016-19 with a slight increase in Poole in 2017 and in Dorset in 2018, shown in figure 101. Dorset had remained above the national average each year since 2012.

In secondary schools, levels have begun to converge since 2016 to around 11% in 2019 in England, Bournemouth and Dorset. Poole has remained around 5 percentage points higher since 2015, with a slight decrease to around 4% percentage points higher in 2019.

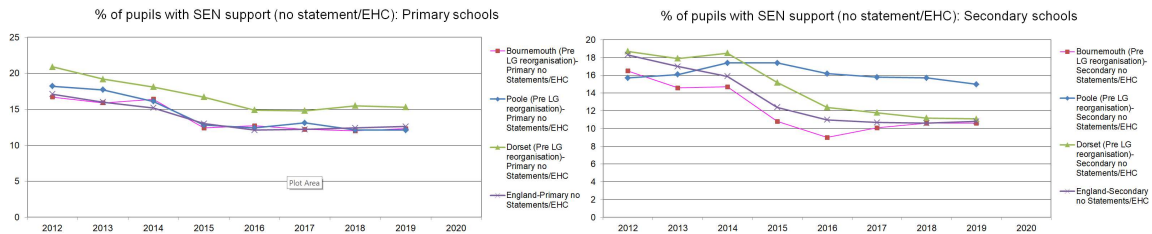


Figure 101: Percentage of pupils who have SEN support, but without a statement or EHCP, primary and secondary schools
Source: LAIT data

EHC plans

The percentage of pupils with a statement of SEN or EHC plan in 2019 across all schools was comparable to the England proportion of 3.1%; Bournemouth and Poole both at 3% and Dorset somewhat higher at 3.4%.

The three previous Local Authority areas (Bournemouth, Poole and Dorset) have generally followed the national trend, with an upward trend seen across both primary and secondary between 2017-19. Dorset has seen an increase in prevalence greater than other local areas, especially in Primary SEN.

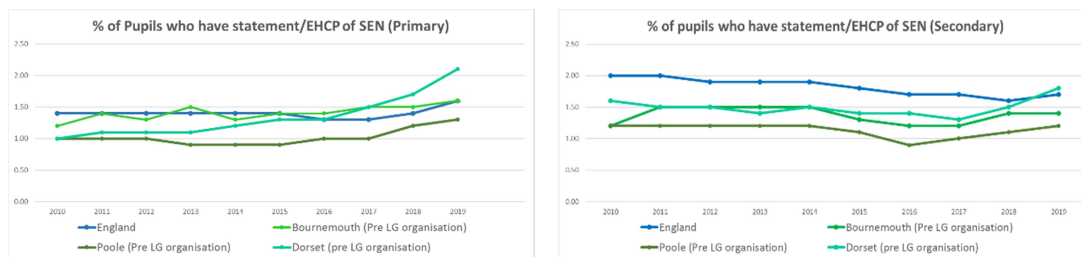


Figure 102: Percentage of pupils who have a SEN statement or EHC, primary and secondary schools
Source: LAIT data

SEN support by primary type of need

The primary type of need for SEN support is detailed below in table 34. Children and young people may have secondary needs for support also, but the primary focus gives an indication around the types of need. Permanent links to the figures used to populate these tables are contained in appendix 7.

Table 34: Headcount for SEN provision, type of need within BCP and Dorset, by SEN support and by Statement/EHC

	SEN No Statement or EHC		Statement or EHC		Total (SEN and statement/EHC)	
	BCP	Dorset	BCP	Dorset	BCP	Dorset
Speech, Language and Communications needs	1,756	1,677	240	316	1,996	1,993
Specific Learning Difficulty	1,298	1,793	77	142	1,375	1,935
Social, Emotional and Mental Health	1,294	1,099	263	224	1,557	1,323
Autistic Spectrum Disorder	342	472	528	480	870	952
Moderate Learning Difficulty	593	504	159	307	752	811
SEN support but no specialist assessment of type of need	423	405	n/a	n/a	423	405
Other Difficulty/Disability	219	385	35	143	254	528
Physical Disability	200	141	97	93	297	234
Severe Learning Difficulty	5	4	201	114	206	118
Total	6,362	6,693	1,714	1,896		51,229

Source : Department for Education^{CCVI}

SEN support by gender and primary need frequency

In both BCP and Dorset UA, nearly two-thirds of SEN support is for male pupils. As seen in table 34 above, within BCP the most frequent needs are for Speech, Language and Communications needs, followed closely by Specific Learning Difficulty and Social, Emotional and Mental Health. In Dorset the top three are the same, with Specific Learning Difficulty the most frequent.

EHCPs by gender and primary need frequency

In both BCP and Dorset UA, three-quarters of EHCPs are for males, and as shown above the most frequent needs are Autistic Spectrum Disorder; Speech, Language and Communication Difficulty; Social, Emotional and Mental Health and both Moderate and Severe Learning Difficulties.

SEN by primary need of social, emotional and mental health emotional disorders

PHE data from 2018 also showed percentages of school-aged children (5-16 years) with Special Education Needs (SEN) where the primary need was social, emotional and mental health emotional disorders (anxiety disorders and depression), seen in table 35 and figure 103. The results showed a picture across Dorset as higher, or in line, with England proportions. Dorset's proportion flagged red, above England, for Primary school pupils, with Bournemouth and Poole flagging red for both whole school and Secondary school proportions.

Table 35: Percentages of school pupils with social, emotional and mental health needs, by all school, primary and secondary, 2018

Indicator	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (school age)	2.39	2.72	3.11	2.48
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)	2.19	1.94	2.10	2.82
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)	2.31	2.93	4.09	2.21

Source: PHE Public Health Profiles, table created by Dorset CCG

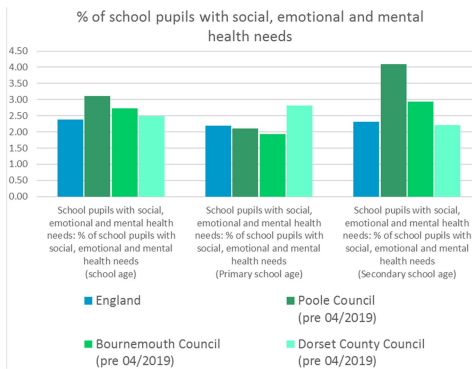


Figure 103: Percentage of school pupils with social, emotional and mental health needs, 2018
Source: PHE Public Health Profiles, chart generated by Dorset CCG

Following the local authority reorganisation 2020 data is available for the above domain, in figure 104, but only for school age; at time of writing there is no data by primary or secondary for 2020. The data shows there is a higher percentage of school pupils in BCP, than in England, who have a primary SEN of social, emotional and mental health. The proportion in Dorset UA is less than that of England.

Indicator	Period	England	South West region	Bath and North East Somerset	Bournemouth, Christchurch and Poole	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	2020	2.70	3.20	3.13	2.89	3.55	3.13*	3.78	2.54	2.94	*	2.71	4.16	3.31	2.70	3.71	3.74	2.58

Figure 104: Percentage of school pupils with social, emotional and mental health needs, 2020
Source: PHE Public Health Profiles

Children and young people with a disability

The UK Equality Act 2010 defines disability as a physical or mental impairment which has a substantial and longer-term negative effect on a person's ability to participate in normal daily activities^{cv}.

Disability incorporates a wide range of conditions, including mental health needs, learning disabilities, sensory conditions, physical disabilities such as mobility, hearing or visual difficulties, and long-term illnesses^{ccvii}.

The national annual Family Resources Survey^{ccviii} in 2020 reported the prevalence of disability. Around one in five working age adults reported having a disability, shown in 105 below. In children (in this survey 'child' is reported as individuals aged below 16, unless they are a dependent 16 to 19 year old), prevalence has risen from 6% to 8% over the last 10 years. Between the ages of 0 and 19 years of age, they found 1.2 million children and young people were recorded as having a disability.

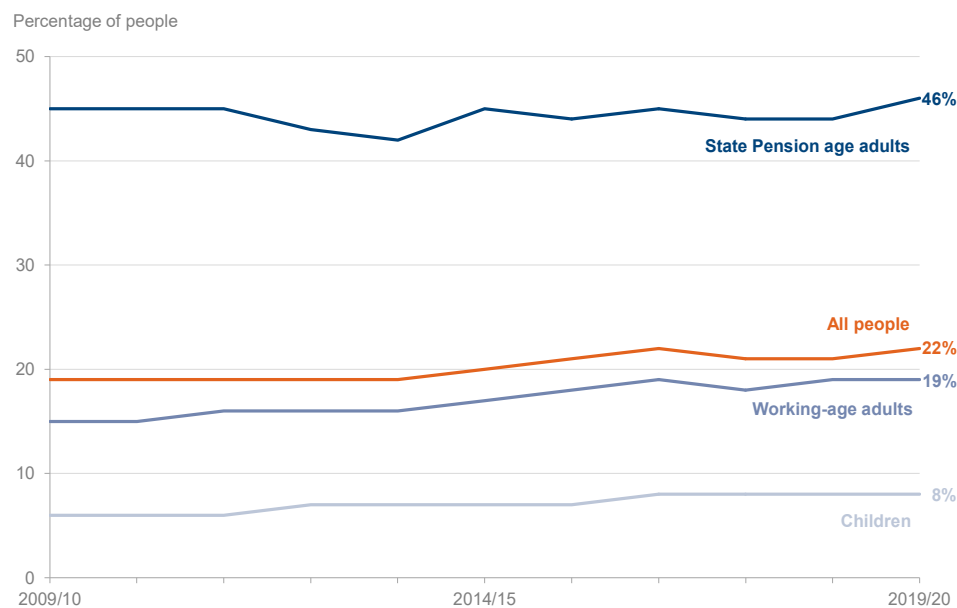


Figure 105: Disability prevalence by age group in UK, 2009/10-2019/20
Source: Family Resources Survey

Within smaller five-year age groups, between ages 10 and 24, consistent levels of 11-12% of children and young people met the definition for having a disability within the Family Resources Survey. The ONS also captured self-reported disability in 2020; of those aged 16-24 years of age, 15.8% reported having a disability^{ccix}.

Previous data reported by the Association for Young People's Health^{cv} had highlighted nearly a quarter of 11-15 year olds reported a long-term illness or disability and one in ten of those aged 10-24 years old had a disability affecting their normal daily activities.

In terms of gender, across ages, most age groups had a higher proportion of females than males reporting that they are disabled, but it was an opposing picture in those aged 15 and younger, shown in figure 106 below.

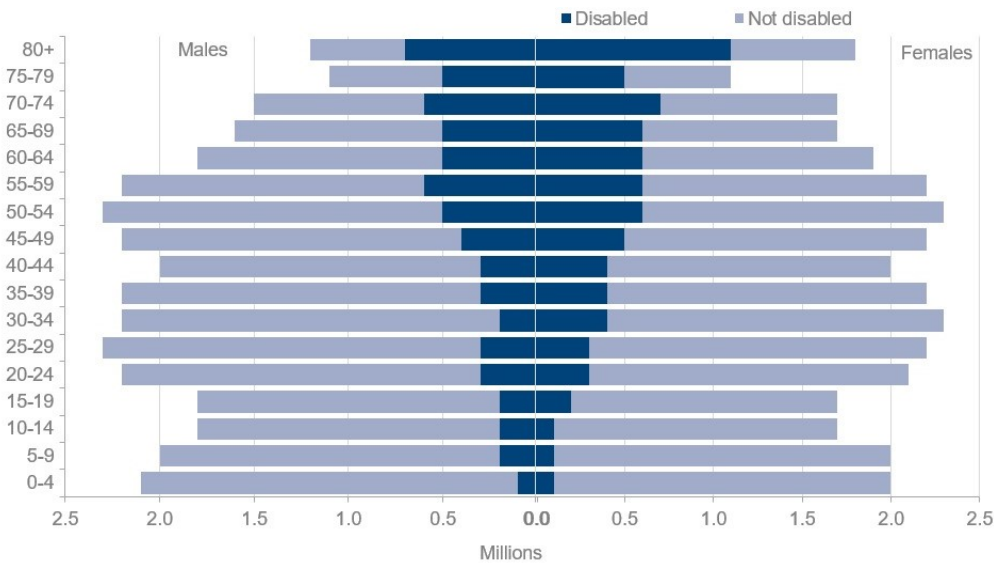


Figure 106: Disability prevalence by age group in UK, -2019/20
Source: Family Resources Survey

Impairment types reported

In the total population, mobility, stamina (or breathing or fatigue), and mental health impairments were the three most reported categories. over the last three years. Mental health was the only category of impairment to have increased, from 25% to 29% between 2017 to 2018. This increase of around 700,000 people put mental health as the third most prevalent impairment.

In children, the most common category of impairment reported was of social or behavioural, applying to 45% of children with a disability, shown in figure 107 below. Learning impairment was next most prevalent for children, at 35%. A mental health impairment was reported for 31% of children with a disability, making it the third most prevalent impairment type reported in younger people.

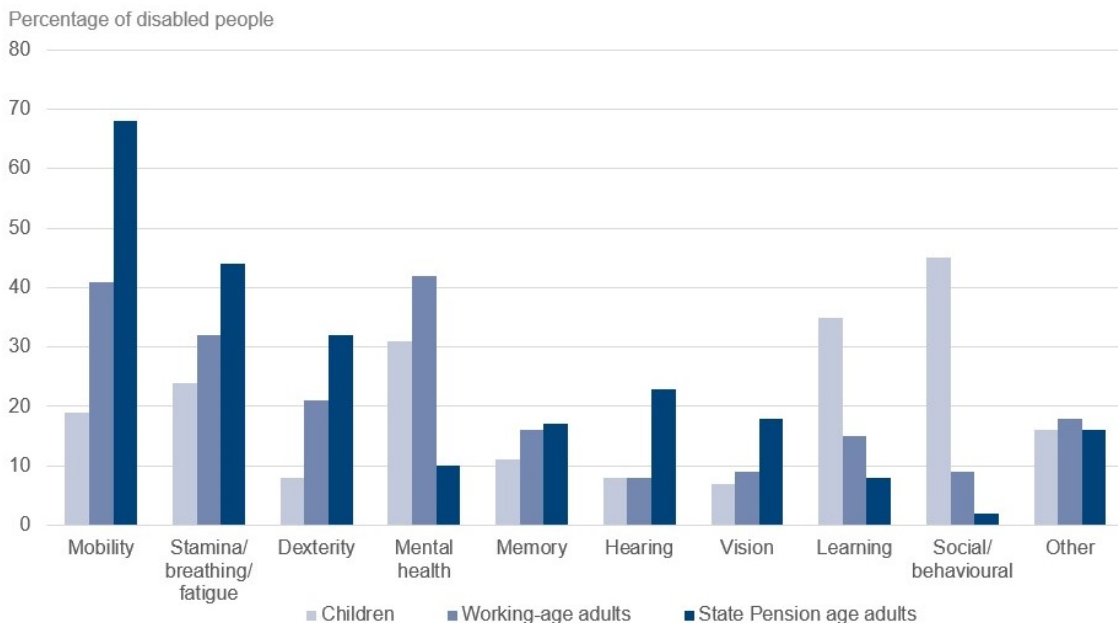


Figure 107: Impairment types reported by disabled people, by age group, 2019 to 2020, United Kingdom
Source: Family Resources Survey

Other associated factors in children and young people with disability

Previous research showed children with a disability (32%) were more likely to live in a lone-parent family than children without a disability (22%). A quarter of children with a disability lived with one or more siblings who also had a disability and almost half lived with a disabled parent. They were also more likely to live in homes in states of substantial disrepair^{ccx}.

Prevalence of mental health disorders in those with a disability

It is reported children with disabilities have a much greater chance of developing mental health problems, and those with a mental health disorder may fall within the definition of disability^{ccxi}.

There appears to be a gap in detailed understanding of the prevalence of mental disorders in the national literature in children and young people with disabilities. This may lie in a challenge around separating data for those whose disability is classified as a mental health impairment over that which develops once someone has a disability.

The 2017 NHS digital prevalence survey in children and young people did not capture data surrounding disability and the association with mental health.

Local prevalence of children and young people with disability

BCP 'Insights'^{ccxii} currently reports data on disability using 2011 census data. They showed there were 1,332 children (2%) aged 0-15 years who had a disability which limited their daily activities 'a little', while 887 (1%) were 'limited a lot'. In those aged 16-24 there were 1,446 children (3%) with a disability limiting their daily activities 'a little', while 702 (2%) were 'limited a lot'. No 2020 data was able to be obtained.

In Dorset UA, the number of children and young people recorded as having a disability, in July 2020, was 464.

Children and young people with a Long-Term Condition (LTC)

In children and young people, asthma is the most common LTC affecting around 1.1 million children and epilepsy the most common neurological LTC, affecting around 112,000 . A LTC can be defined as a disability if the effects are impairing and long-term^{ccxiii}.

Research conducted in 2003, but still referred to, highlighted 37% of children with epilepsy had a mental health condition, higher than that in children with diabetes (11%) and those in a control group (9%)^{ccxiv}.

**Epilepsy | 5-15 y**

Source: RCPCH (2020)

In the NHSD 2017 prevalence study, Sadler et al reported children with a mental disorder had similar levels of non-limiting long-term illness compared to children without a mental disorder (7.7% to 6.6%).

Palliative or End of Life Care (EOL)

Palliative care for children and young people focuses on anticipating, preventing, diagnosing, and treating symptoms for those diagnosed with life-limiting and life-threatening conditions, supporting them and their families to make important decisions. Palliative care should be involved from diagnosis, whether treatment is directed at the condition or not, and can be intensified as a person approaches the end of their life^{ccxv}. Conditions children may have include cancer, organ failure, cystic fibrosis, muscular dystrophy and severe cerebral palsy amongst others^{ccxvi}.

Nationally, NICE^{ccxvii} reported despite decreased mortality rates in years prior, in 2012, more than 2,000 children and young people aged between 1 and 19 died in England and Wales, with approximately 40% of deaths in those less than 15 years old being neonatal deaths (from birth to 28 days). ONS data showed for 2018 showed deaths of those aged 1-19 to be still around 2,000 children and young people.

It is challenging to separate out those related to long-term or life-limiting conditions alone. ONS estimates indicated around 40,000 children and young people aged 19 or under in England were living with a life-limiting condition and may have needed palliative care in 2016.

Pan-Dorset it has been reported there are around 400 infants, children and young people with a life-limiting or life-threatening illness, but the period for this data is uncertain.

The NHSD 2017 prevalence survey reported having a life-limiting long-term illness was associated with having a mental disorder; a quarter of 11-19 year olds with a mental disorder also had a life limiting long-term illness (25.9%), compared to 4.2% of those without a mental disorderⁱⁱ.

Youth offending

There is evidence of the growing multiplicity and complexity of factors surrounding children and young people involved with Youth Justice. The Youth Justice Board reported consensus among practitioners in the youth justice system, of smaller numbers of children creating a greater concentration of those who are the most complex and with the highest need. They are understood to be amongst the most vulnerable in our society, often having experienced neglect and abuse, having care experience and high levels of mental health issues, communication difficulties and/or learning disabilities^{ccxviii}.

They are more likely to have mental health problems than those who are not in contact with the Youth Justice system, and to have more than one mental health problem. High proportions of young people in contact with the Youth Justice system have higher risk of mental health problems as well as learning disability, learning difficulty, speech, language and communication problems, substance misuse, physical ill-health, and sexual health problems, than their non-offending peers^{ccxix}.

While numbers of children and young people in custody have reduced significantly in recent years, reoffending rates are higher nationally in 2019 than a decade ago^{ccxx}.

Reviews of major issues for young people in contact with the youth justice system have showed^{ccxix, ccxxi}:

- Over three quarters have
 - a history of temporary or permanent school exclusion
 - serious difficulties with literacy & numeracy
- Over half have
 - difficulties with speech, language and communication
 - problems with peer and family relationships
- Over a third
 - have a diagnosed mental health disorder
 - of those accessing substance misuse services are from the YJS
 - have been in care

Additionally, they found twice as many young people who commit an offence have been a victim of crime than in non-offenders. They have also commented on the over-representation of younger people from particular ethnic and social class groups. They report working-class boys of Black and White ethnicities or with a Muslim religion are particularly over-represented in custody; over 40% are from minority ethnic backgrounds. Large proportions of young people involved with Youth Justice have previously been in care (38% in Young Offender Institutions, 52% in Secure Training Centres).

A further review of data in 2020, found seven out of ten (71%) children or young people were assessed as having a concern of mental health need^{ccxxii}. They also found concerns around

- Substance Misuse (75%),
- Speech, Language and Communication (71%)
- and more than half were a current or previous Child in Need (56%)

Prevalence of mental health disorders in those involved with Youth Justice

As detailed above, previous research has suggested 71% of children or young people involved with youth justice services were assessed as having a concern of mental health need, more than a third have a diagnosed mental health disorder.

Public Health England report young people in prison are eighteen times more likely to commit suicide than others of the same age^{xxii} and a 2017 report from the University of Manchester^{ccxxiii} on antecedents to suicide in children and young people reported out of 285 deaths in those under 20 years old, 60 had recent contact with youth justice services, equating to one in five (21%). In those aged 20-24 years, it was also one in five (20%).

Local data - First time entrants to the Youth Justice System

First time entrants (FTEs) are those who receive their first youth caution (previously reprimands and warnings) or conviction for an offence^{ccxxiv}. According to LAIT, based on estimated figures, the number of First Time Entrants to the Youth Justice System has shown a decrease in England since 2010.

Shown in figure 108, there has been a more variable picture across Dorset, with strong declines seen between 2012 and 2014, then further variability across authorities. In 2018 and 2019 rates in Bournemouth were at 369 per 100,000 for both years, Poole (344, 392) and Dorset (312, 280) all of which were higher than England rates for the same two years (280, 224). These rates were also above those of the South West, which was in line with England.

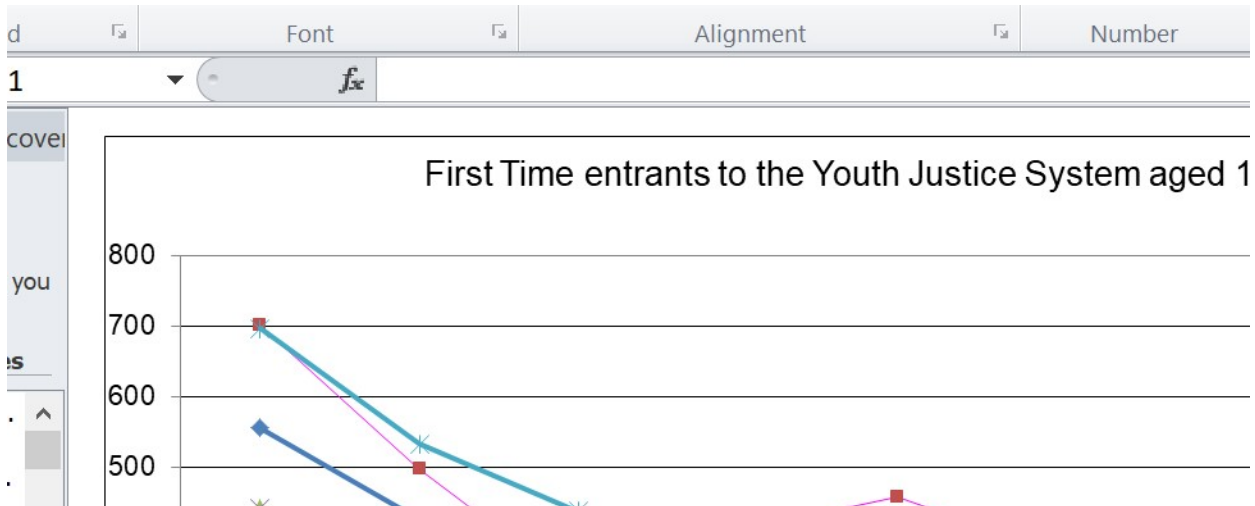


Figure 108: First time entrants to the Youth Justice System aged 10-17, rate per 100,000. Source: LAIT data, 2020

The rate of children cautioned or sentenced across Dorset was 49 per 10,000 in 2019 and 57 per 10,000 in 2018, shown in LAIT data. These rates were higher than both South West and England rates during the same time period; around 6-8 per 10,000 higher than England and 8-13 per 10,000 higher than the South West over the same two years.

Rates of young people aged between 10-17 receiving a conviction were lower locally than regionally or nationally. Bournemouth, Poole and Dorset figures were combined within LAIT data and only available until 2017. The rate in 2017 across all three authorities was 0.11 per 1,000, where England was 0.41.

Examination of source data from 2018/19^{ccxxv} allows breakdown by gender and self-reported ethnicity for those cautioned or sentenced, shown in table 36 below.

Table 36: Numbers of children and young people aged 0-17 cautioned or sentenced in 2018/19, by gender and ethnicity

Age	Gender	Ethnicity	Number
10 to 14	Female	White	22
		Mixed	8
	Male	White	65
15 to 17	Female	Black	1
		Mixed	3
		Unknown	1
		White	60
	Male	Black	5
		Mixed	5
		Unknown	5
		White	138
TOTAL			313

Dorset UA additionally provided information from within the 'Dorset Families Matter' (DFM) system, showing over 12 months a breakdown by age of younger individuals who triggered crime/anti-social behaviour criteria. Figures were indicative, as individuals move both in and out of area and crimes may be committed elsewhere. 565 individuals aged 10-25 triggered DFM crime/ASB criteria in the 12 months prior to July 2020; of those the breakdown by age range is shown in table 37 below.

Table 37: Number of individuals who triggered DFM criteria for crime/ASB July 2019-July 2020

Age (at July 2020)	Number
10-16	222
17-18	123
19-25	220

Source: Dorset UA in-house data

Asylum seeking or refugee children

Refugees are those who are fleeing armed conflicts, serious human rights violations or persecution, and whilst a claim is being assessed they are classed as an asylum-seeker. Therefore not all asylum seekers will be recognised as a refugee, but every refugee has initially been an asylum seeker^{ccxxvi}.

Risk factors for mental health problems in children and young people in such a situation are numerous. Parental mental health may be affected in relation to both their previous situation and current circumstances such as employment and housing. Children and young people themselves may have witnessed or experienced traumatic events, have expressive language difficulties, be in poverty and experience cultural isolation, amongst other risk factors. A framework provided for contextualising these risks is shown in appendix 8^{ccxxvii}

A summary of research conducted over the past two decades^{ccxxviii} suggests asylum seekers and refugees:

- are more likely to experience poor mental health than the local population, with higher rates of depression, PTSD and other anxiety disorders
- are five times more likely to have mental health needs than the general population, with around two-thirds experiencing serious mental distress.

Data shows, however, they are less likely to access or receive support than the general population, and research has shown there are real concerns over deportation if accessing mental health support^{lxxxiv}.

There has been some more detailed examination of mental health effects in migrants (those who 'chose' move to a different country) and it may be worth considering those in the absence of other data. The Foresight report on mental capital and wellbeing^{xxxiv} commented on the elevated risk of psychotic illnesses for immigrant groups and their descendants in the UK; they were five times more likely to have a psychotic illness and effects extended across ethnicities, including those of a non-British White ethnic background. They stated that in spite of extensive research, reasons for these elevated levels of risk remain unclear. Raised rates persisted for those from ethnicity minority and immigrant groups after adjusting for other factors such as socioeconomic status and predisposition to migrate with mental disorder, with some evidence that discrimination and isolation of migrants from their peers contribute. The report concluded there may be a number of factors, associated with psychoses in all groups, but more common in immigrants, such as social disadvantage in childhood e.g. separation from parents.

Locally, complete detail of children and young people within these categories has not been available. Local data collection has identified there were 33 unaccompanied asylum seeking children in care in BCP at March 2020. The number of children with refugee status was reported as unknown.

Within Dorset UA, at August 2020, there were 44 children with refugee status under the Syrian Resettlement programme, residing with their parents. There were also a number of pregnancies at the time of reporting. Detail has not been available within Dorset UA on the number of unaccompanied, asylum-seeker or other refugee children.

Children within Gypsy, Roma, Traveller and Travelling Showpeople's communities

Gypsy, Roma and Traveller communities are well-recognised, distinct populations^{ccxxix}. Dorset Council has previously defined these groups^{ccxxx} as:

"Persons of nomadic habit of life whatever their race or origin, including such persons who on grounds only of their own or their family's dependents' educational or health needs or old age have ceased to travel temporarily or permanently, but excluding members of an organised group of Travelling Showpeople or circus people travelling together as such."

And Travelling Showpeople as:

"Members of a group organised for the purposes of holding fairs, circuses or shows (whether or not travelling together as such). This includes such persons who on the grounds of their family's or dependent's more localised pattern of trading, educational or health needs or old age have ceased to travel temporarily or permanently, but excludes Gypsies and Travellers as defined above"

It is documented that those from Gypsy and Traveller communities experience significant inequalities, with lower life expectancy by 10-25 years, fewer years lived in good health and Traveller communities experiencing higher rates of infant mortality, maternal death and stillbirths than the general population^{ccxxxiii}.

It has been commented that the lack of data capture of the specific Gypsy, Roma and Traveller ethnicities of people, and disaggregated data usage, makes analysis of health and social care usage limited^{ccxxxii, ccxxxiii}.

Across ages previous research has found that poor physical and mental health outcomes are widespread in the Gypsy and Traveller community, linked to accommodation insecurity, living conditions, poverty, social exclusion, discrimination and stigma^{ccxxxv, ccxxxii, ccxxxiii}. Research conducted by the Equality and Human Rights Commission is reported as finding 44% of the British public surveyed openly expressed negative feelings towards Gypsies, Roma and Travellers; higher than for any other protected characteristic group^{ccxxxiii}.

It is understood that Irish Traveller adults are disproportionately burdened by mental ill-health in comparison to their non-Traveller counterparts^{ccxxxii, ccxxxiv, ccxxxii, ccxxxiii}. They experience a higher number of days with poor mental health, a higher prevalence of frequent mental distress and increased levels of anxiety and depression and qualitative research has identified a generally negative view of mental health disorders in those interviewed from Traveller communities. Suicide is the cause of death in 11% of Traveller deaths, they are up to seven times more likely to die by suicide than those in the general population and 82% of the community has been affected by suicide^{ccxxxiv}. All of the above indicate a need for increased mental healthcare and suggest poor mental health may be more prevalent in parents.

There is a shortage of literature on the mental health needs of gypsy or travelling children and young people, and certainly on those from travelling showpeople communities and one study highlighted that discussions around mental health for these young people is 'shameful'^{ccxxxv}.

An cross-sectional analysis performed in Ireland^{ccxxxii} however, reported evidence on Traveller youth, which was not available for review. Their conclusions were that mental health and wellbeing outcomes for Traveller youth within Ireland showed either similar or better outcomes than non-Traveller youth across all mental health items. They suggest further research is needed, including longitudinal studies and conducted outside of Ireland.

There are pieces of research however, that highlight other risk factors for mental health, alongside that of parental mental health mentioned above. Challenges in educational experience and attainment are well-documented and have persisted at least over the past two decades. Government national data has highlighted Gypsy, Roma and Traveller pupils have previously, and remain, the groups with lowest achievement across all Key Stages, and the highest percentage of absences and exclusions^{ccxxxvi, ccxxxvii, ccxxxviii}.

Children and young people from these backgrounds are also more likely to be identified as having special educational needs (SEN), and are four times more likely than any other group to be excluded from school as a result of their behaviour^{ccxxxix}.

A recent, government-supported, qualitative study^{ccxi} examining barriers to education involved 44 Travellers aged 15 to 25. 61% of those surveyed left school while in primary or secondary education, with only 5% going on to University. Despite common conceptions of a frequent lack of parental support for education, 61% reported strong parental support for their education. 45% of girls and 29% of boys reported leaving school due to bullying, and while there were examples of positive teacher support, two-thirds (67 percent) said they had been bullied by teachers because of their ethnicity. This is consistent with other research documenting racism and bullying in general at school and stigmatisation by some teachers^{ccxxiii, ccxxv, ccxli}.

Lack of educational engagement, attendance, continuation and attainment is likely to significantly impact on social inclusion, achievement and mental health of Gypsies, Roma and Traveller children and young people across the life course^{ccxli}.

There is no robust local data regarding the population of Gypsy and Traveller children and young people across Dorset and it is difficult to provide an estimate of local transient populations of children. While this may have been more accessible previously, with continued engagement provided by the Dorset 'Traveller Education' service, this service no longer exists. The number of children within communities who are settled on a site, was reported in August 2020 as 41 children between 0-18 years old, and approximately seven 18-25 year olds, living across four sites within Dorset UA, with two further 0-18 year olds on one site in BCP¹⁶.

¹⁶ Source: Gypsy and Traveller Liaison, Dorset Council.

Homelessness of families or young people and Temporary Accommodation

Children from homeless households are often the most vulnerable in society, with homelessness a social determinant of health, associated with severe poverty, adverse health, education and social outcomes^{lxi}.

Homelessness has a significant impact upon children and young people; young people describe their lives as being 'on hold', and find it much harder to engage with others and with school, achieve goals and protect their own well-being. Many children growing up in poverty are living in insecure housing and forced to move frequently. Often these children are leaving behind schools, friends and a sense of belonging in their area each time they move^{lxii}.

Homeless young people often experience a disrupted education and are much more likely to be not involved with further education, employment or training (NEET).

Homeless young people can easily become involved in crime through poverty and a lack of other options, which further decreases their life chances. However, they are also more likely to be victims of crime, with their situation exposing them to greater risks of exploitation, particularly if homeless at a younger age.

The chaotic and unstable nature of being homeless means that poor physical and mental health in those young people is common, as is substance misuse.

All of the above are associated with, or risk factors for poorer mental health or mental disorders, and the impact of homelessness in young people extends beyond just the young person to wider society^{ccxlii}.

Data on homelessness

The ONS report the number of households living in temporary accommodation is an indicator for homelessness across the UK. Provision of temporary accommodation can be made while assessment decisions are made or while homeless households are waiting for longer-term accommodation and is largely provided for applicants with priority need. Trends of increasing figures in England have been seen in recent years, and households with children in temporary accommodation have also risen. In June 2020 a Government report^{ccxliii} stated 63.8% of households in temporary accommodation had dependent children; a total of 127,240 dependent children living in temporary accommodation.

Recent data from the ONS in 2019^{ccxliv} commented that, in the general population, trends in numbers of people seeking help for homelessness have been reasonably stable between 2013-2018. Although the majority of those seeking support are single people, those aged between 25 and 49 years of age, and males, households with dependent or expected children are categorised as having a priority need. In 2017/18, 72% of priority need accepted in England was for those households with dependent or expected children and 2% for young people.

A recent Shelter survey of teachers^{ccxlv} showed more than half (56%) had children or young people who were homeless in their class in past 3 years, and 47% within the last 12 months. The report commented on the impact of being in temporary accommodation, shelters or other people's houses; that of overcrowding, poor quality housing, tiredness, impact on nutrition and the impact of those factors, with poor attendance, behaviour, educational attainment and relationships with staff and peers.

Housing waiting lists

Locally, data on the rate of households on the housing waiting list have seen higher rates than England in Bournemouth during 2017/18 and 2018/19. Poole has had significantly lower rates than England and Bournemouth. Dorset has had slightly lower rates than England since 2015/16, however rates are rising year on year and converging with those of England, as they reduce.

In temporary accommodation (indicator of homelessness)

PHE data from 2017/18 (figure 109) shows the rates of households in temporary accommodation as below that of England, but above those of the South West region, in Bournemouth and Poole. Dorset is in line with the South West.

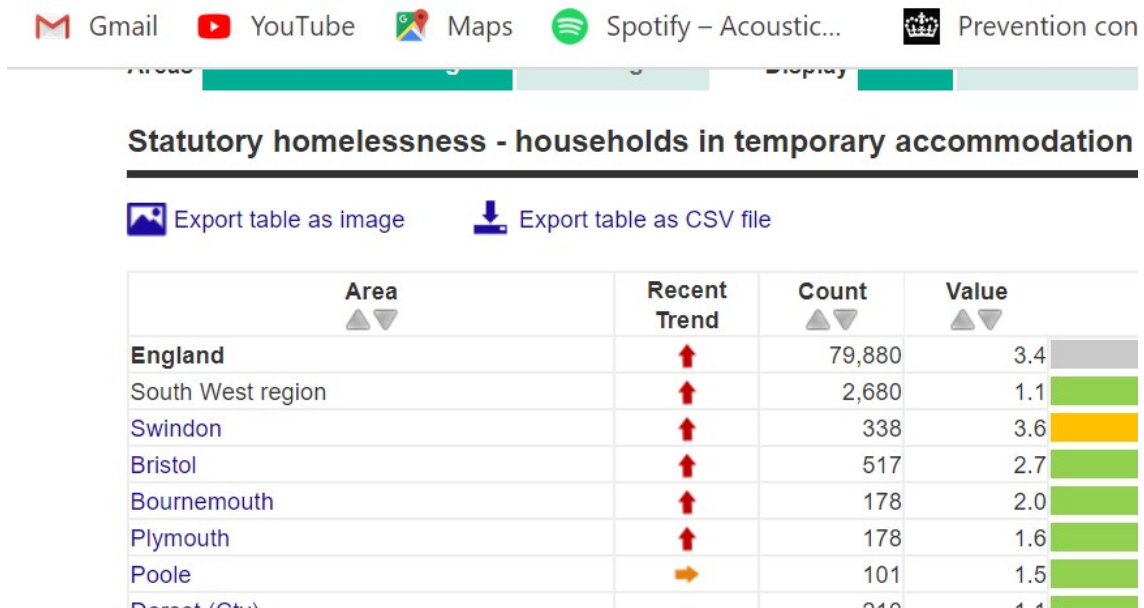


Figure 109: Statutory homelessness - households in temporary accommodation in 2017/18. Source: PHE Public Health Profiles

It can be seen in figure 110 below that trends in the rates in temporary accommodation have been rising since 2015/16 across areas of Dorset (no data for North Dorset was available). Bournemouth shows the largest rise in rates, with more than double in 2017/18 compared with 2015/16. Poole and East Dorset areas have also shown increases in the last three years of reporting, while in West Dorset levels have remained fairly stable.



Figure 110: Households in temporary accommodation, per 1,000 households, 2010/11-2017/18. Source: House of Commons Library: Local Authority Homelessness Statistics (England)

Homeless and in priority need

Local Government data^{ccxlvii} shows rates per 1,000 households of those accepted as ‘Homeless and in priority need’ (nationally, 72% of which were households with dependent or expected children). The England rate in 2017/18 was 0.6 per 1,000 households; Bournemouth had a higher rate of 0.9, Poole of 0.4 and Dorset of 0.5.

Homeless young people aged 16-24

PHE reported 2017/18 data on the rate of ‘Accepted homeless households headed by applicant aged 16-24’, shown in figure 111 below. It highlighted rates in Poole were higher than those in the South West, while Dorset had lower rates, and both were below that of England. There was no data available for Bournemouth.

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Homeless young people aged 16-24 2017/18

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Area 	Recent Trend	Count 	Value 
England		12,010	0.52 
South West region		880	0.37* 
Bristol		156	0.81 
Torbay		45	0.74 
Plymouth		81	0.73 
Poole		31	0.48 
Cornwall		105	0.44 

Figure 111: Rates of homeless young people in 2017/18.
Source: PHE, Public Health Profiles.

In conclusion, although there may be small numbers of homeless children reported within Dorset, it may be worth consideration of the significant impacts had upon children and young people who are homeless or in temporary accommodation and in children who are potentially ‘hidden homeless’¹⁷.

¹⁷ Hidden homelessness is a broad term that is used to refer to people who are not recorded by official statistics. This means that they have not approached their local authority for homelessness assistance. This includes people who become homeless but find a temporary solution by staying with friends or family or living in other insecure accommodation – Shelter 2018^{lxviii}.

Individuals with excess weight or who are underweight

It is understood being overweight or obese is complex, with societal and environmental influence, alongside emotional origins and impacts. Obesity has a bi-directional association with mental health in adults, children and young people; it is evident from as early as seven years of age that mental health and obesity are entwined and exacerbate each other^{ccxlvii}. There is also complexity in understanding associations with those underweight, as the majority of individuals with eating disorders (80-85%) are not underweight^{ccxlviii}. Eating disorders will be covered separately below.

A review of studies in 2017^{ccxlix} concluded strong evidence for the association between obesity and depression, with odds of developing depression between 1.2 and 5.8 times greater than in peers of a healthy weight, and also odds of developing obesity, when experiencing depression were between 1.18 and 3.76 times greater. Evidence was modest for associations between obesity and anxiety disorders and inadequate for other psychiatric conditions.

In younger people, researchers in a large UK study^{ccxlvii} of over 17,000 children found close links between obesity and mental health. Their study suggested seven-year olds who were obese were at greater risk of suffering emotional problems, such as anxiety and low mood by the time they reached 11 years, and the association gradually increased throughout childhood. Links were not apparent in younger children.

They also found girls tended to have higher BMIs and more emotional problems than boys and that poverty increased the risk of developing both obesity and mental health disorders.

Evidence has suggested increased risks of between 1.4 and 2.8 greater odds of developing psychosocial problems if obese, with this increasing to 11 times greater if obese and being bullied^{ccl, ccli}.

Other cohort research^{cclii}, in Finnish children, concluded conduct problems at 8 years old were prospectively associated with being overweight and obese in young adulthood.

Reviews of evidence^{ccliii, ccliv} have established relationships between obesity and psychological comorbidities such as anxiety and depression, poorer perceived lower scores on health-related quality of life, emotional and behavioural disorders, and self-esteem during childhood. Children with excess weight were more likely to experience multiple associated psychosocial problems than healthy-weight peers and it was proposed this may be adversely influenced by stigma, teasing, and bullying. Both reviews concluded uncertainty as to whether psychiatric disorders and psychological problems were a cause or a consequence of childhood obesity.

Studies have indicated school-age children with obesity have a 63% higher chance of being bullied, by peers, family and friends, which can trigger feelings of shame and lead to depression, low self-esteem, poor body image and even suicide.

There is also understanding that weight-biased attitudes in schools can lead to lower educational outcomes for children and young people with obesity, which can then affect children's life chances and opportunities, and ultimately lead to social and health inequities^{cclv}.

National prevalence of excess weight

Adults

The prevalence of excess weight, in 2019^{cclvi}, was 28.0% of adults being obese and a further 36.2% being overweight but not obese in England, shown in figure 112 below. In the age group of interest, 16-24, it can be seen that 37% were overweight or obese and a higher proportion were underweight than seen in other adult age groups.

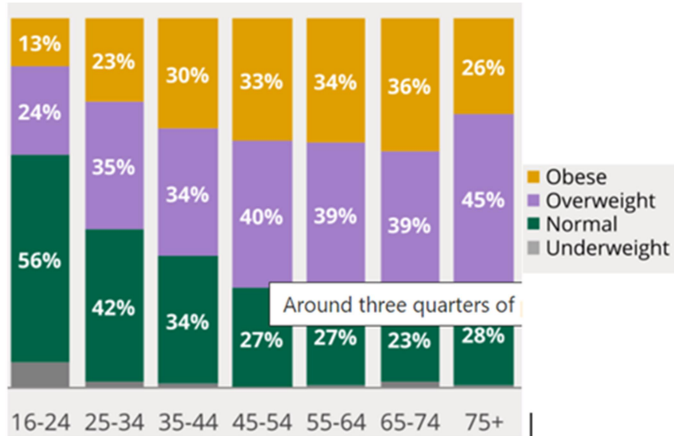


Figure 112: Prevalence of excess weight, adults, in England, 2019. Source: Baker et al, 2021 – from 'Health Survey for England'

Children and young people

During the Health Survey for England in 2019, height and weight were measured in participants over 2 years old. were measured by the interviewer^{cclvii}. They found the majority (71%) of children 2-15 years old were of a normal weight. 13% of children were overweight but not obese and 16% were obese. Boys were more likely to be obese than were girls (18%, compared with 13%).

A breakdown by age is shown below, in figure 113. One in ten children is obese by age 5, rising to one in five by age 11.

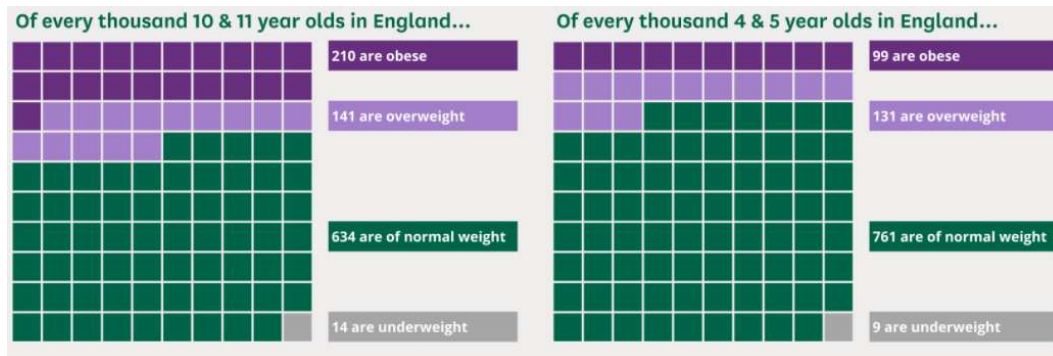


Figure 113: Prevalence of excess weight, children, in England, 2019. Source: Baker et al, 2021 – from 'National Child Measurement Programme'

They noted a strong association with the BMI status of parents; children with an obese parent were more likely to be obese. There were also associations with poverty, including the levels of obesity in the two lowest income quintiles (fifths) being almost twice that of those in the highest two, a further breakdown of which is shown in figure 114.

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Figure 114: Prevalence of excess weight in children, in England, in 2006/7 and 2019/20. Source: Baker et al, 2021

It was commented the obesity gap between the most deprived and least deprived areas has is particularly pronounced among ages 10-11, where obesity rates in the most deprived areas have risen by five percentage points but were almost unchanged in the least deprived areas.

Findings from the Millennium Cohort Study (MCS)^{cclviii} from more than 10,000 children born between 2000-2002, at age 17, showed obesity as being persistently high in the generation studied, with high rates of almost 9.1% at age 3, reaching a peak of 21.4%, or more than one in five young people, by age 17.

Rates of being overweight were also high during formative years, reaching 14.3% at age 17, or one in seven. The high prevalence was present in both boys and girls.

Figure 115 below demonstrates the above prevalence in further detail, within the age range of 3-17 years. It also shows the proportion of participants in the underweight category; these were commented on as similar at age 14 and age 17.

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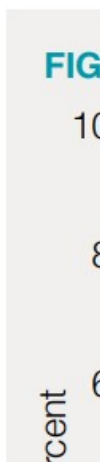


Table 2 of the Appendix
Figure 115: Body Mass Index Category by Age
Source: Centre for Longitudinal Studies, 2020

By gender, they observed, high levels of obesity in both sexes, sharply increasing between ages 7 and 11 for both, and remaining high thereafter. By age 17, 20.6% of females and 22.1% of males were obese. It also shows the proportion of participants in the underweight category; these were similar at age 14 and age 17.

of obesity in both sexes, with a sharp increase between ages 7 and 11 for both, which remain high thereafter. is sh

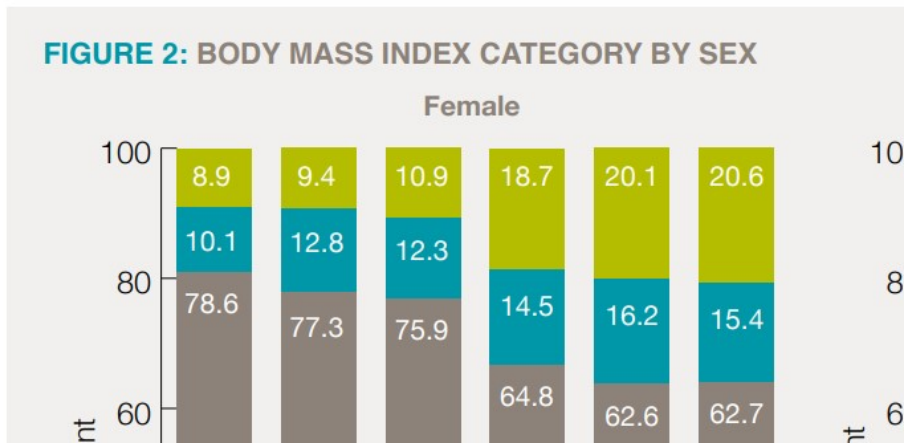


Figure 116: Body Mass Index Category by Sex
Source: Centre for Longitudinal Studies, 2020

Obesity rates among teenagers were strongly linked to household income, with those from the more deprived households the worst affected. Using income at birth as an indicator of socioeconomic status, the research showed that levels of overweight and obesity were higher among poorer children across the whole of childhood, and this socioeconomic gap became more pronounced as the cohort moved through adolescence, shown in figure 117 below. This highlights a 13.9 percentage point difference in obesity rates by age 17, between the richest and poorest.

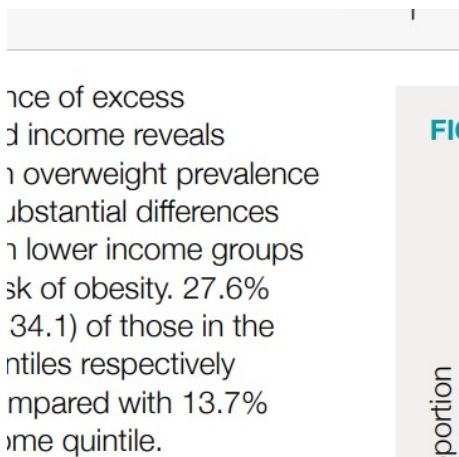


Figure 117: Obesity by Income Quintile (Proportions equate to percentages, e.g. 0.2 is equal to 20% of the population studied)
Source: Centre for Longitudinal Studies, 2020

They concluded more than one in three adolescents are entering adulthood with excessive weight, facing an increased risk of greater long-term physical and psychological health problems.

Local prevalence of excess weight

Adults

Drawn from the Active Lives Survey by Sport England, PHE data reports the prevalence of excess weight in adults as 60.6% and 60.8% in BCP and Dorset UA, respectively. England prevalence is 62.3% and levels in both local areas are considered similar to that of England.

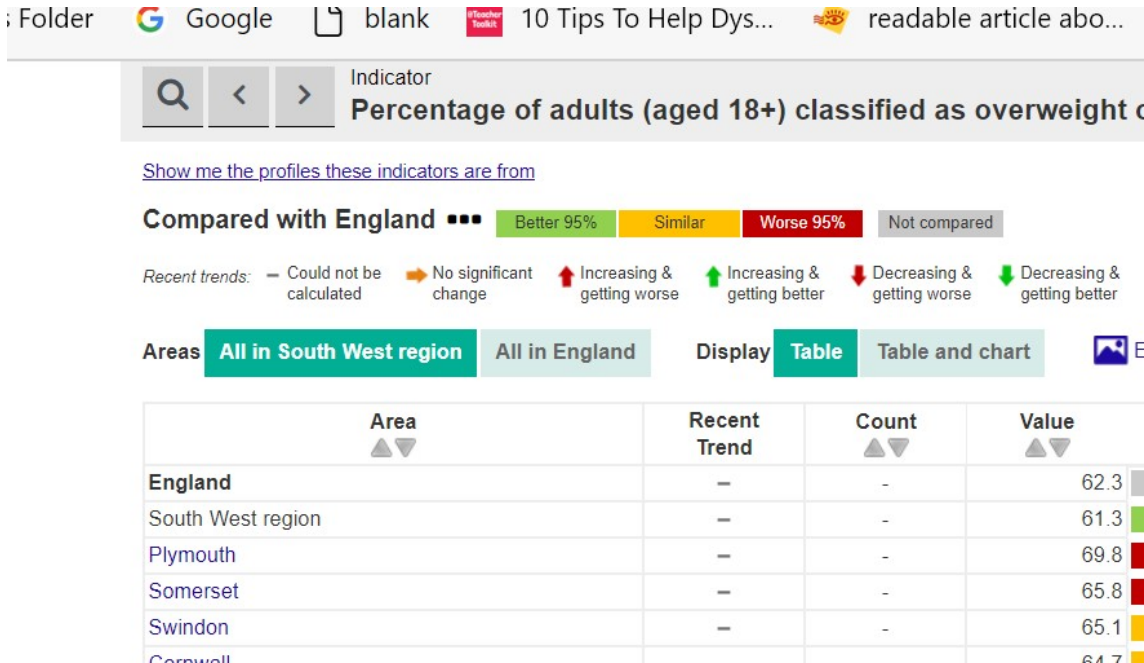


Figure 118: Prevalence of obesity, in adults, for BCP and Dorset UA in 2018/19
Source: PHE Public Health Profiles

Children

Excess weight in England in 2019/20 is illustrated in the map below where it can be seen that at 4-5 years old (reception), the county of Dorset appears to have a prevalence of 19-22%, or one in five children who are overweight or obese. At age 10-11 (year 6) the maps indicate Dorset has one in three children who are overweight or obese (30-33%).

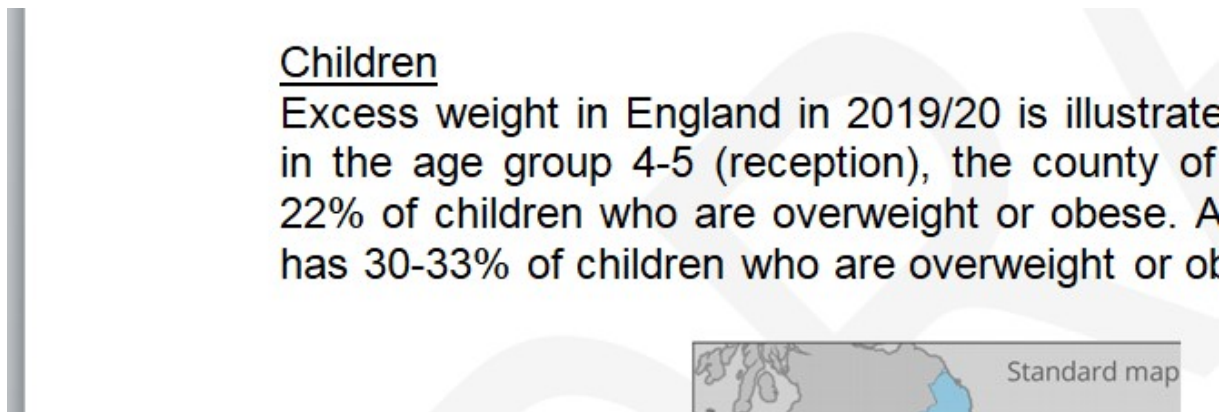


Figure 119: Prevalence of excess weight in Reception and Year 6
Source: Baker et al, 2021

Being overweight or having obesity at 4-5 years old

PHE data also shows, in 2019/20, in Reception around 20.2% of children aged 4-5 in BCP and 21.9% in Dorset UA were overweight or had obesity. The prevalence in BCP was lower than for England at 23%, whereas Dorset was similar.

Having obesity at 4-5 years old

In Reception the prevalence of obesity (including severe obesity) was 7.8% in BCP and 8.8% in Dorset UA, in line with England at 9.7%. Again, the prevalence in BCP was lower than for England, whereas Dorset was similar; this equates to one in eleven children in Dorset and one in thirteen, aged 4-5 years old, who are categorised as obese.

Being overweight or having obesity at 10-11 years old

PHE data shows in 2019/20 that around 31% of children in Year 6 (aged 10-11) in BCP and Dorset UA were overweight or had obesity.

Having obesity at 10-11 years old

Those with obesity were 18.1% in BCP and 16.9% in Dorset. These proportions are lower than that seen in England, with prevalence of 35.2% overweight or obese, and 21%, shown in figure 120 below. This equates to one in six adolescents aged 10-11 years old, in BCP and Dorset, categorised as obese.

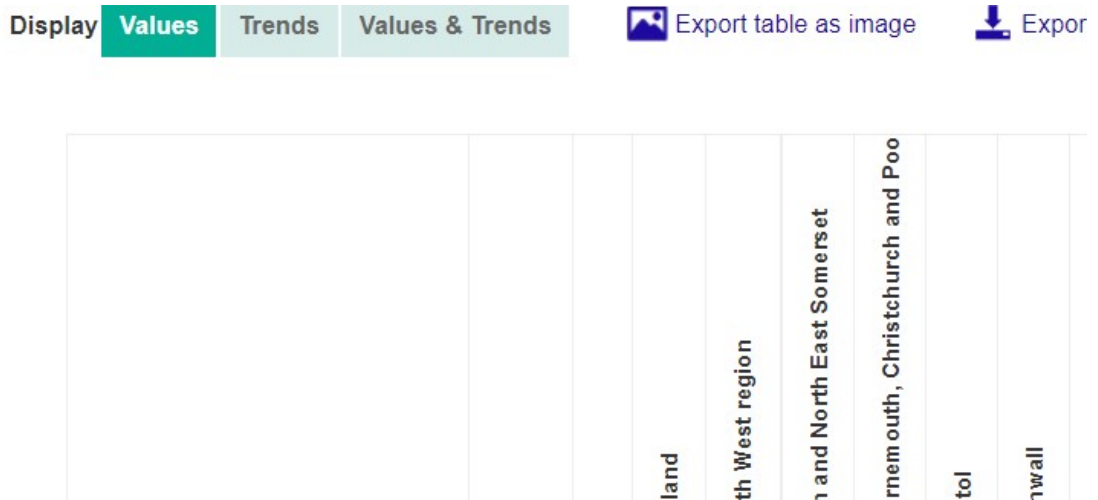


Figure 120: Prevalence of overweight/obesity in children, for BCP and Dorset UA, 2019/20
 Source: PHE Public Health Profiles

Data available on prevalence in 2018/19, in the pre-reorganisation three local authorities, was only available for obesity at Reception age and this has therefore not been included.

Those bullied

PHE^{cclix} defines bullying as behaviour intended to hurt someone either physically or emotionally, including both direct means such as aggression, intimidation and threats, or indirect, through exclusion or rejection.

Impact

Being bullied is detrimental to mental and physical health and is associated with depression, low self-esteem, poor self-concept, loneliness and anxiety. Negative effects have also been seen on adolescent life satisfaction and mental wellbeing and extend to the development of inter-personal relationships, increased school absenteeism and therefore reduced academic achievement^{cxxvii, cv}.

There are wide-reaching and longer-term impacts of bullying on mental health and wellbeing, immediate ones include the risk of self-harm, and suicide and there are increased risks of depression extending into adulthood; in individuals up to the age of 50, it has been observed bullying impacts have included a lack of social relationships, economic hardship and poor perceived quality of life^{cclix}.

Children and young people who have experienced bullying are significantly more likely to have poor academic results and lower levels of earnings than those who have not and those frequently bullied were two and a half times more likely to use mental health services, during childhood and adolescence, and one and a half times more likely in later life.

National Prevalence

Bullying is considered very common among young people, but estimates of bullying vary. It has been estimated around one in three school children in the UK experience bullying^{cxxvii}; in 2015, prevalence in England was estimated at 36% of 11 year old girls and 33% of boys reporting bullying at least once in the last two months.

In the 'What About YOUth' survey, conducted in 2014, two-thirds of 15 year old girls and nearly half of 15 year old boys said they were bullied in the previous couple of months. In the Annual Bullying Survey in 2018, undertaken in secondary schools and colleges with the majority of respondents being 12-15 year olds, a lower proportion (22%) of young people reported that experiencing bullying in the previous 12 months^{cv}.

There is also the increasing consideration of cyberbullying (bullying via electronic means); a report from 2010 estimated it affected between 20% and 40% of all young people. Recent ONS statistics, shown in figure 121, report nearly one in five (20%) UK children between 10-15 years old had experienced a type of online bullying and three-quarters had experienced some of it during school time^{cclx}.



Figure 121: Proportion of children (10 to 15 years) experiencing online bullying. Source: ONS

The NHS digital 2017 prevalence survey found one in five 11 to 19 year olds had been bullied online in the past year, with rates higher in girls (25.8%) than boys (16.7%). Young people with a mental disorder were about twice as likely to have experienced this as those without a disorder.

Local prevalence

The Tellus national survey was run three times between 2007-9, representing views of 253,755 children and young people in school years 6, 8 and 10 within 3,699 schools.

The last of the surveys in 2009 reported 12.9% of pupils in Bournemouth, 12.5% in Dorset and 11.9% in Poole reported that they had been bullied, compared to 9.6% nationally.

In addition to this 32% of pupils in Bournemouth, 33% in Poole and 25% in Dorset considered that their school dealt with bullying 'not very well' or 'badly', compared to 26% nationally.

The latest PHE data, from 2014/15, shows the percentage of pupils age 15 who had either bullied others or been bullied within the last couple of months was higher than the England benchmark for Bournemouth, and similar or slightly above for Poole and Dorset.

Table 38: Percentage bullied and bullying in the past couple of months, age 15 years

Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)
Percentage who had bullied others in the past couple of months at age 15	2014/15	10.1	12.9	10.3	11.0
Percentage who were bullied in the past couple of months age 15	2014/15	55.0	59.1	55.0	57.9

Source: PHE Public Health Profiles, chart generated by Dorset CCG

Those with an Eating Disorder

An eating disorder indicates a difficult relationship with food, to include eating too little or too much, or becoming fixated with weight, body size or shape. Food may be used as a coping mechanism or a way to feel in control.

It has been estimated that around 1.25 million people in the UK have an eating disorder, and it can affect people of any age, gender, ethnicity or cultural background. Of note, is around 25% of those with an eating disorder are male, and not everyone with an eating disorder is underweight: most people stay within a normal weight range or are overweight^{cclxi}.

There are different types of eating disorder, including Anorexia Nervosa, Bulimia Nervosa and binge eating.

There is no single identified cause of eating disorders, with the belief they develop as a result of a combination of factors, such as biological factors, psychological factors (lack of confidence or self-esteem or being a perfectionist) and social factors (bullying, difficulties with school or work, or abuse)^{cclxi}.

The NHS prevalence survey in 2017ⁱⁱ reported eating disorders were present in 0.4% of 5 to 19 year olds, with higher rates in girls (0.7%) than boys (0.1%). There was a higher proportion in young women; 1.6% of 17 to 19 year old girls had an eating disorder, seen in figure 122 below.

underpowered for examining this. (Figure

Figure 3: Eating disorders by age and sex

Base: 5 to 19 year olds

Per cent

Figure 122: Prevalence of Eating disorders by age and sex, 2017
Source: NHS Digital, 2017

Locally, prevalence was estimated in 2013. PHE profiles reported estimates that were higher in Dorset, followed by Bournemouth and Poole. These were numbers only, not rates, shown in figure 123 below.

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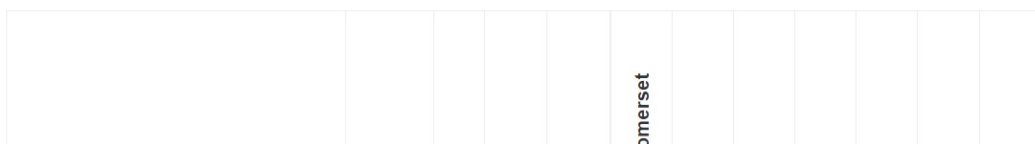


Figure 123: Prevalence of potential eating disorders among young people: estimated number aged 16 - 24
Source: PHE Public Health Profiles

Young carers

Young carers include children and young people under 18 who provide regular and on-going care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances^{cclxii}.

Children may take on carer responsibilities for parents, siblings or another family member for various reasons, including parental/carer having physical or mental health needs or a reliance on substances. It is understood that caring can result in positive impacts, but there is also a body of evidence showing the adverse impacts of caring on outcomes such as health, social activity, educational engagement and attainment and future employment opportunities^{cclxiii}.

A young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical wellbeing or educational achievement and life chances^{cclxii}.

It is also understood many young carers have difficulty in managing school and caring responsibilities, manifesting as increased levels of stress and anxiety, low self-esteem/depression, eating/sleeping problems and self-harm in comparison to other children^{cclxiv}.

2011 census data showed nearly 200,000 young carers under 18 in England, estimated to equate to around 1 in 12 secondary school pupils^{cclxv}. There are also young carers who are unknown, with some families not identifying their children and young people as carers or who do not wish to make the care situation known. It is believed a significant proportion of young carers have not disclosed their responsibilities to school and only a minority have received an assessment of needs or know of sources of help. One survey, nearly 40% of children said that no-one in the school knew about their responsibilities^{cclxiv}.

A qualitative study of young carers by the Department of Education^{cclxiii} interviewed 22 young carers. The majority of carers were caring for parents with physical and mental health conditions, but they reported additional physical and mental health concerns not diagnosed. They reported finding mental health problems the most difficult to support due to the unpredictability and type of support needed, but found mental health services often did not provide timely support for the same reasons. They found nearly a quarter were not known by services to be carers.

Estimates of the prevalence of mental health in young carers suggest around 40% of young carers have a mental health problem^{cclxvi} and that young people with caring responsibilities are twice as likely to report a mental health condition as young people in general, with 3.7% of young carers compared to 1.4% young people without caring responsibilities, shown in figure 124 below^{cclxvii}.

Percentage of young people with a mental health condition: carers v non-carers

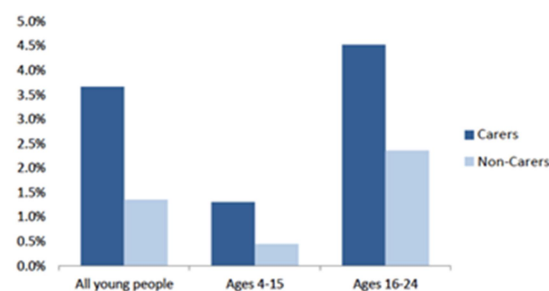


Figure 124: Percentage of young people with a mental health condition - carers v non-carers
Source: The Scottish Government, extracted from 2011 Census

Local numbers of Young Carers

In-house data reports have the number of children and young people recorded as young carers as 82 in Dorset UA at July 2020. In September 2020, there were 453 recorded young carers in BCP.

PHE data shows information only from the 2011 census, but on a more detailed basis, in figure 125 below. It indicated that in relation to proportions in England and the South West, there were higher proportions in all three authorities of children, aged 0-15, providing unpaid care. There was a higher proportion of children 0-15 providing more than 20 hours a week of unpaid care in Bournemouth, while similar levels to England were seen in Poole and Dorset CC.

Proportions of those aged 16-24, who provided unpaid care, were lower in Bournemouth and Dorset than in England, while Poole was similar. There was a similar proportion of 16-24 year olds providing more than 20 hours a week of unpaid care in Poole and Dorset CC when compared to England, while a higher level was seen in Bournemouth.

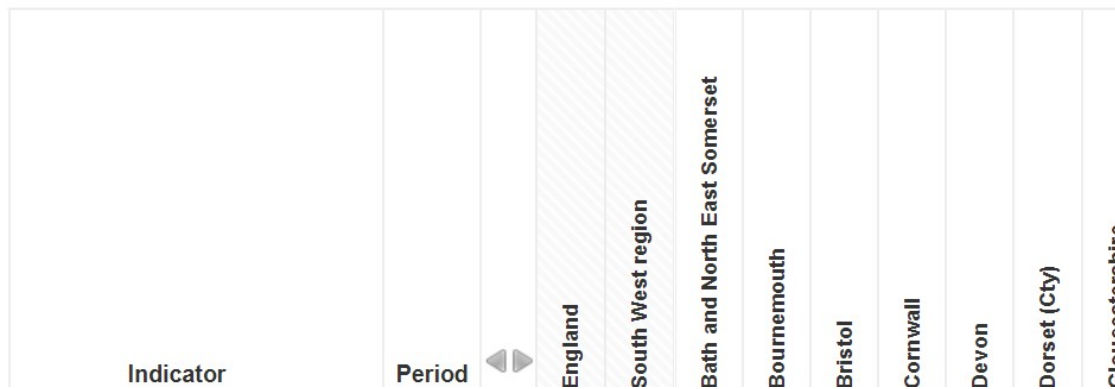


Figure 125: Provision of unpaid care in 0-15 and 16-24 year olds, 2011.
Source: PHE Public Health Profiles

NEET (Not in education, employment or training)

Young people not in education, employment or training are at increased risk of negative outcomes, including poorer health, depression or early parenthood. Increased participation in learning and employment is of benefit to individual young people but also to wider society in social mobility and economic growth.

It has already been noted in this report the connections between other risk factors and increased risks of not being in education, employment or training, such as being a care leaver, being homeless or having missed out on earlier education.

Relationship between being NEET and mental health

Young people who are NEET (not in education, employment or training) are estimated to be twice as likely as non-NEET young people to experience mental health problems. The study examining this^{cclxviii} looked also at the effects of multiple disadvantage and concluded those who were NEET, not living with an older adult and with an ‘everyday’ social welfare legal problem¹⁸ were five times more likely than those who were classed as non-NEET, non-isolated with no legal problem.

Government data in 2020^{cclxix}, concurred there was double the risk of developing mental health problems in those aged 16-24 classified as NEET, over those who were not. They also reported the proportion of 16-24 year olds classified as NEET who have a mental health problem has grown from 11.7 per cent in 2012 to 23.9 per cent in 2018, despite the rate of young people classified as NEET having decreased since 2012.

Local prevalence of young people classified as NEET

According to LAIT data, around 247 young people were NEET in BCP, recorded in 2020 (3.4% of those aged 16-17) and about 95 had ‘activity not known’. BCP figures are slightly lower than for Bournemouth UA previously, due to Poole having had lower proportions previously.

In Dorset UA there were 228 young people NEET (3.1%) and 143 ‘unknown’; these figures are higher than when previously Dorset CC. Information on the breakdown by age, gender and ethnicity is available from government statistics. This has not been included in detail, due to small numbers within each groups, however, if priority is given to this sub-group it may be useful to revisit.

Seen in figure 126 below, the South West had a slightly higher proportion (2.9%) of young people NEET than that of England (2.7%) in 2019; BCP and Dorset UA had higher rates than both (3.4% and 3.1% respectively).

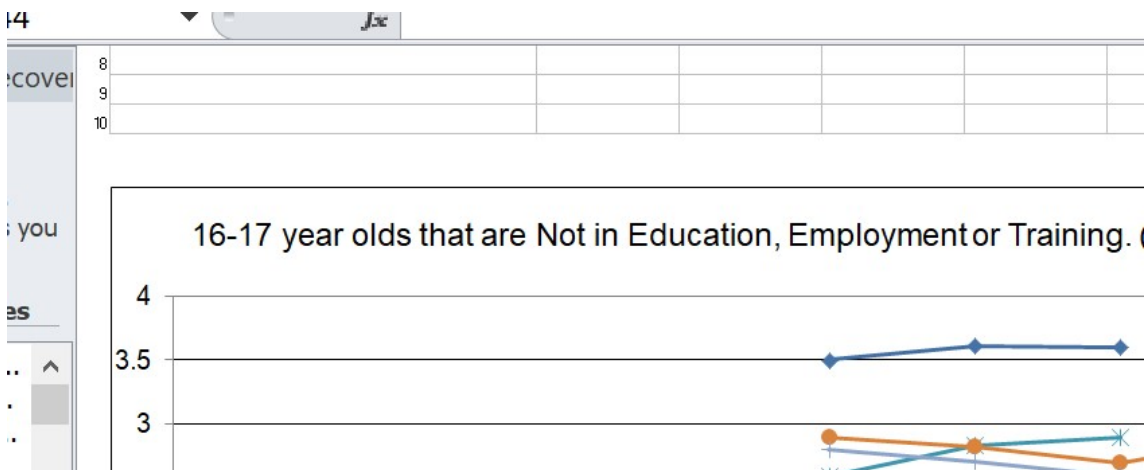


Figure 126: Proportion of 16-17 year olds ‘Not in education, employment or training’.
Source: LAIT

¹⁸ ‘Everyday’ social welfare legal problems were defined as: Rights-related problems concerning housing, homelessness, welfare benefits, debt, employment and education.

Children of military families

There was little evidence available surrounding the need for mental health support for children of military families. What exists points to an increased, and often unique, need for mental health support due to anxiety, loneliness, trauma and periods of separation from their parents. Discontinuity in learning, relationships and opportunities due to transitions of living and school environments are also recognised as challenges and risks to their achievement, progression and wellbeing

In July 2019, it was reported eleven local authorities collectively accounted for around half of all Service children^{cclxx}, one of which was Dorset. Poole was highlighted as one of seven local authorities with Service children in at least 90% of primary and secondary schools.

The map shown below in figure 127 shows the ranking of local areas by decile according to the total number of Service children on roll, with decile 10 indicating the largest numbers overall. Dorset was ranked 10, while BCP also rank highly at 9.



Figure 127: Local area ranking according to total number of Service children on roll
Source: SCP alliance^{cclxx} - November 2020

Government data from school censuses showed around 2,300 children pan-Dorset were eligible for the Service Child Pupil Premium during 2019-2020.

Table 39: Number of pupils eligible for the Service Child Pupil Premium 2019-2020

Region	Number of pupils eligible for the Service Child Pupil Premium 2019-2020
England	77,247
South West	21,226
BCP	524
Dorset	1,762

Source: Pupil premium allocations data set: 2019 to 2020 from Gov.uk^{cclxxi}

Those involved with alcohol, substances and substance misuse

Substance misuse in parents can have negative effects on children at different stages in their lives, and living in households where a parent or carer misuses substances does not mean a child will experience abuse but it creates increased risk. During pregnancy, drinking and drug use can increase the risk of birth defects, premature birth, babies being born underweight and experiencing withdrawal symptoms. Parental substance misuse can put children at risk of abuse or neglect, behavioural or emotional problems, caring responsibilities, lower school attendance and attainment, poverty, being exposed to drugs or criminal activity and ultimately being separated from parents^{cclxxii}. Substance abuse in parents is discussed further in other sections of this report.

Research shows that young people who are experiencing problems in their life are still extremely vulnerable to developing problematic drug and alcohol use. There is a body of evidence that drug use and/or drinking at a young age, and particularly heavy or regular drinking, can result in physical or mental health problems, impair brain development, and put children at risk of alcohol-related accident or injury. More broadly it is also associated with adverse effects on their physical and mental health, education, friendships, family life and with violent and antisocial behaviour, and unsafe sexual behaviour^{cclxxiii, cclxxiv}.

There are particular concerns about the relationship between drug use and mental health problems among young people. Evidence suggests young people who use recreational drugs increase their risk of poor mental health including suicide, depression, psychotic symptoms and disruptive behaviour disorders^{cclxxiii}.

Young people often present to specialist substance misuse services with a range of problems or vulnerabilities related to (or in addition to) their substance use. These include the use of multiple substances, having a mental health treatment need, being a child in care/child in need or not being in education, employment or training (NEET). Other, wider risk factors can also impact on their substance use, such as self-harming behaviour, sexual exploitation, offending or domestic abuse^{cclxxv}.

PHE report, in 2021^{cclxxv}, a number of indicators of need in young people who use substances, detailed below. NHS Digital also conducted a survey in 2018^{cclxxiii}, outlining prevalence and other details of alcohol, smoking and drug use. Where NHS Digital information has been used below, it will be referred to, otherwise it is the PHE report data.

National prevalence

PHE reports show there were over 14,000 young people in contact with alcohol and drug services during 2019/20, which is a 3% reduction on the previous year and a 42% reduction on the number in treatment since 2008/09.

Trends in young people's substance use

Cannabis remains the most common substance that young people come to treatment for, in 89% of cases, similar to levels recorded over the last 3 years.

42% of young people in treatment reported problems with alcohol, 13% with ecstasy and 10% with powder cocaine. A 19% decrease from the previous year was seen in young people reporting a problem with benzodiazepines, however, the number in the latest year remains more than double that seen in 2016 to 2017.

Alcohol usage

NHS Digital reported on the usual frequency of drinking in young people, shown in figure 128 below. 6% of all pupils said they usually drank alcohol at least once per week, with a further 11% usually drinking between once a fortnight and once a month; equating to 17% drinking alcohol at least once a month.

The proportion usually drinking once a week increased with age, from 1% of 11 year olds to 14% of 15 year olds.

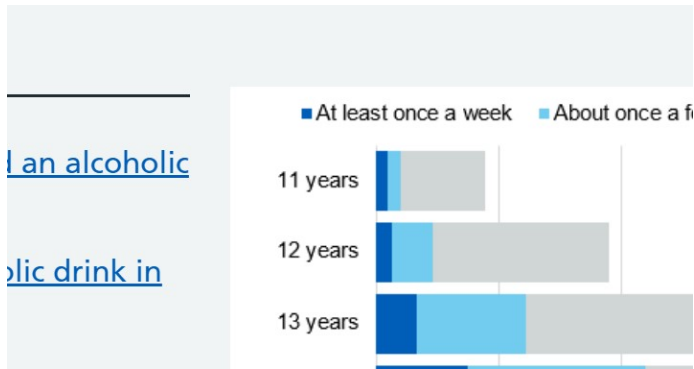


Figure 128: Usual frequency of drinking, by age, in 11-15 year olds
Source: NHS Digital

Alcohol consumption was based only on pupils who had reported drinking in the last week (10% of all pupils). They consumed an average of 10.3 units that week, and 21% of pupils who drank in the last week were estimated to have drunk more than 15 units. Younger pupils who drank in the last week were more likely to have drunk fewer units than older pupils.

Factors associated with drinking in the last week are shown in figure 129 below.

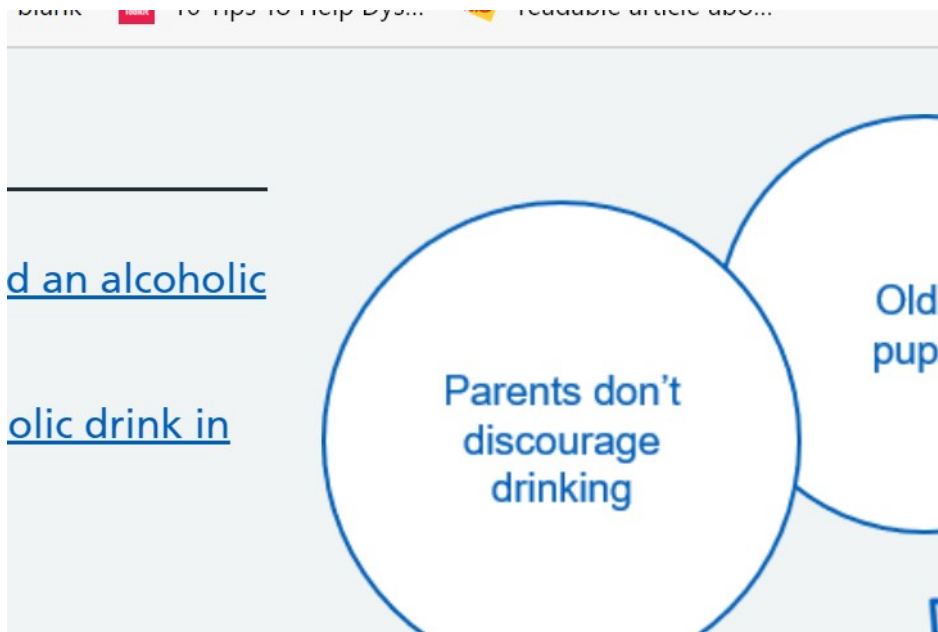


Figure 129: Factors associated with drinking in the last week, 11-15 year olds
Source: NHS Digital

Drug use

NHS Digital report the belief there is a genuine rise in drug use since 2014, even when accounting for the addition of new substances that have emerged over recent years. 25% of boys and 22% of girls had ever taken drugs, and the likelihood of having ever taken drugs increased with age, from 9% of 11 year olds to 38% of 15 year olds.

Almost one in ten (9%) had taken drugs in the last month and factors associated with taking drugs in the last month are shown in the figure 130 below.



Figure 130: Factors associated with taking drugs in the last month, 11-15 year olds
Source: NHS Digital

It was estimated being a smoker had the strongest association, followed by drinking, and then by having a family who don't discourage drug use.

Vulnerabilities among young people in treatment

The most common vulnerability reported by young people starting treatment was early onset of substance use (76%), meaning the young person began using substances before 15 years of age. This was followed by poly-drug use (56%).

Proportionally, girls tended to report more vulnerabilities than boys, particularly self-harming behaviour (31% compared with 10%) and sexual exploitation (10% compared with 1%).

Other vulnerabilities commonly reported included antisocial behaviour (32%), affected by domestic abuse (21%) and affected by others' substance use (22%). Being involved with social services within care (10%), or as a child in need (10%) or with a child protection plan (7%) were also recorded as vulnerabilities.

Other research has similarly highlighted the evidence of health inequalities related to substance misuse; children and young people within other vulnerable groups, such as those excluded from school, young offenders and care leavers, were far more likely to experience substance misuse problems^{cclxxiv}.

Mental health treatment need

More than a third (37%) of young people who started treatment stated a mental health treatment need, higher than last year (32%). A greater proportion of girls reported a mental health treatment need than boys (49% compared to 30%).

Most young people (68%) who had a mental health treatment need received some form of treatment, usually from a community mental health team.

Age and Sex of young people in treatment

The data shown in figure 131, reported two-thirds of young people in treatment were male (67%), with a median age of 15 years old for both boys and girls. The number of younger children (under 14) remained relatively low at 1,204 (8% of those in treatment).

There were 14,291 young people in treatment between April 2019 and 31 March 2020. This was a 22% increase on the 11,678 reported in the previous 2 years. The median age was 15 years old for both boys and girls. The number of younger children (under 14) in treatment was 1,204 (8% of those in treatment).



Figure 131: Age and sex of young people in treatment
Source:PHE: Young people's substance misuse treatment statistics report

Referral routes into treatment

Data was available on referral routes, seen in figure 132 below, and showed the majority came through education providers, in 32% of cases. 22% came via the youth justice system and 18% through social care services. Only 5% came via substance misuse services.

referral by self, family or friends (13%), education providers (32%), youth justice system (22%), social care services (18%), and substance misuse services (5%).

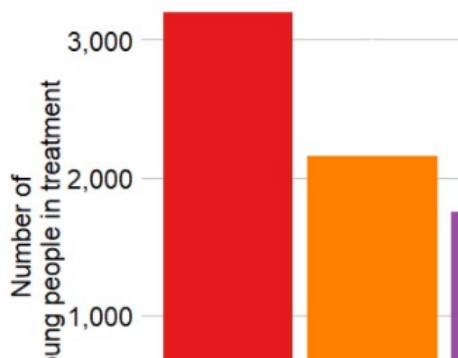


Figure 132: Referral routes to treatment in young people
Source:PHE: Young people's substance misuse treatment statistics report

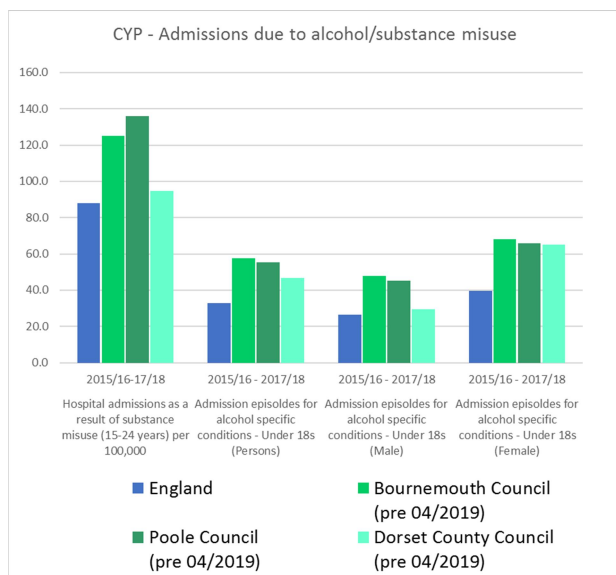
Local prevalence of substance misuse

Hospital admission rates for alcohol and other substances

The PHE Child Health Profile has reported data under the new authorities for 2018/19, showing in BCP the rate of hospital admissions in under 18s for alcohol specific conditions was 60.1 per 100,000 (135 admissions), twice that of England at 31.6, and higher than the South West rate of 44.1. The hospital admission rate for substance misuse was 133.2 per 100,000, which was again significantly higher than England at 83.1 and the South West at 104.2.

In Dorset UA in 2018/19 the rate of hospital admissions in under 18s for alcohol specific conditions was 48.9 per 100,000 (100 admissions), a third above the rate seen in England, and again higher than in the South West. The hospital admission rate for substance misuse (15-24 years) was 91.5 per 100,000, higher than in England at 83.1, but below the South West rate.

Previously reported data showed the prevalence of hospital admissions due to alcohol or substance related misuse in children and young people, across the three previous local authorities. All had higher levels than the England levels, when examining hospital admissions for alcohol or substance misuse, as can be seen below in figure 133.



Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)
Hospital admissions as a result of substance misuse (15-24 years) per 100,000	2015/16-17/18	87.9	125.1	136.1	94.6
Admission episodes for alcohol specific conditions - Under 18s (Persons)	2015/16-2017/18	32.9	57.5	55.5	46.7
Admission episodes for alcohol specific conditions - Under 18s (Male)	2015/16-2017/18	26.4	47.7	45.4	29.5
Admission episodes for alcohol specific conditions - Under 18s (Female)	2015/16-2017/18	39.6	67.9	66	64.9

Figure 133: Children and Young People – hospital admissions due to alcohol/substance misuse
Source: Dorset CCG and PHE Public Health Profiles

Those at risk of, or experiencing, sexual/criminal exploitation

Children and young people can be at risk of exploitation in a number of different ways; sexual and criminal. This may involve sexual abuse, intimidation and physical violence or financial means of control, but exploitation can take place within gangs, or within what the child or young person believes to be a trusted and consensual relationship (one involving grooming).

Child sexual exploitation is a crime with devastating and long lasting consequences for victims and families, compounded when victims or those at risk of abuse do not receive appropriate, immediate and on-going support^{cclxxvi}.

Exploitation and abuse can result in a variety of effects upon children and young people such as:

- Having difficulty in trusting people and a fear of forming new relationships
- Becoming isolated from family and friends
- Reduced educational engagement and attainment, failing exams or leaving education
- Becoming pregnant at an early age
- Experiencing unemployment
- Developing or having mental health problems
- Attempts at suicide
- Substance abuse
- Engaging in criminal behaviour
- Experiencing homelessness

A variety of factors can make it difficult to accurately assess how prevalent child sexual exploitation is. Children aged 12-15 years of age are identified as most at risk although victims as young as 8 have been identified. Young females are more often targeted, although boys are still at risk and may find it harder to disclose or be identified by others. There are other vulnerabilities which heighten the susceptibility of child sexual exploitation, shown in figure 134 below^{cclxxvi}. Some of these have already been discussed in relation to heightened risk of poor mental health, such as disability, poverty, sexual identity, amongst others.

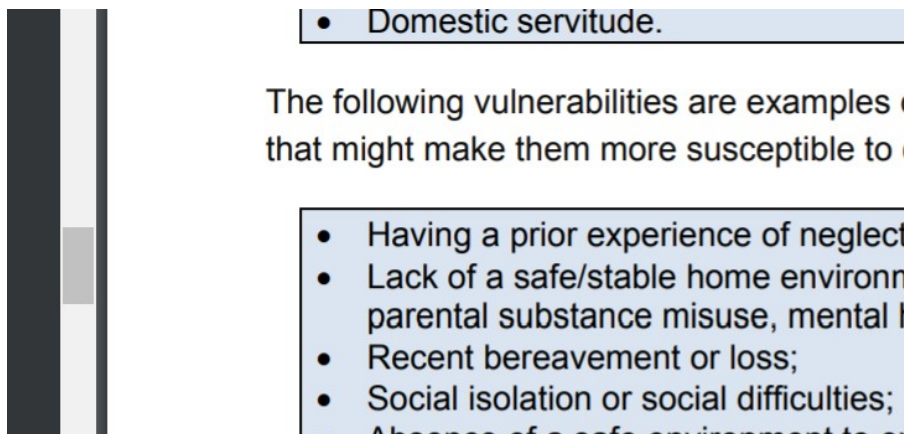


Figure 134: Examples of vulnerabilities children can experience which make them more susceptible to child sexual exploitation
Source: Department for Education^{cclxxvi}

Local data on those at risk of exploitation

Local data reported internally for BCP area stated there were 102 children identified as at risk of exploitation (criminal and/or sexual) at the end of September 2020, including 38 at significant risk, 55 moderate and 9 with emerging risk. No such data was located for Dorset.

Local data held within The Children's Society national reports in 2020^{cclxxvii} stated last year in BCP, there were 67 assessments of children in need identified the risk of child sexual exploitation, 10 identified as being at risk of trafficking and 25 identified at risk of gang affiliation.

They reported in Dorset UA there were 151 assessments of children in need with an identified risk of child sexual exploitation, with between one and five identified as being at risk of trafficking and ten identified at risk of gang affiliation.

While data is not routinely collected on the number of children at risk of criminal exploitation who are referred to children's services, the National Referral Mechanism (NRM) records referrals made, with criminal exploitation the most commonly reported cause in children^{cclxxviii}.

The NRM is a framework for identifying and referring potential victims of modern slavery, which may involve multiple forms of exploitation including criminal and sexual, and ensuring they receive the appropriate support^{cclxxix}. In children and young people, this may involve exploiting their vulnerabilities and abusing positions of power, while exposing them to sexual exploitation, slavery or forced labour, amongst other purposes. Nationally, for the first time since 2014, in 2020, the proportion of referrals for children over took that for adults, seen in figure 135 below.

4% of cases (92).

Figure 1: Number of quarterly N 2020



Figure 135: Number of quarterly NRM referrals by age group of exploitation, 2014 to 2020. Source Serious Crime Agency

The majority of children and young people referred to the NRM are recorded as UK nationals (64%). Breakdown of national data shows the gender split in child potential victims was 78% male and 22% female, that criminal exploitation was most common (55%) and the majority (93%) of those were male. Most referrals for sexual exploitation in children (90%) were for female potential victims. For those exploited as children, criminal exploitation is partially driven by an increase in the identification of 'county lines' cases. County lines are used to describe drug gangs in large cities expanding their reach to small towns. Often, vulnerable individuals are exploited to transport substances, and mobile phone 'lines' are used to communicate drug orders. Referrals were flagged as county lines referrals, accounting for 19% of all referrals received in the quarter (data table 27). The majority (85%; 346) of these referrals were made for male children.

Pan-Dorset there were 21 referrals made for children or young people referred to the NRM during Q1-Q2 of 2020 (January-June). Data suggests 21 referrals were made for those 17 and under during 2019, via Dorset Police and BCP; no data is recorded for Dorset Council in any of the official published statistics and it is unclear as to why this is.

While potentially small numbers of children referred to the NRM, there may be greater numbers at risk of exploitation, shown above, and consideration of the magnitude of effects of exploitation coupled with mutually reinforcing vulnerabilities listed would indicate a high level of need.

Factors specific to age stages

Early Years: Perinatal and parental mental health, Infancy, Early Childhood and Attachment

(Perinatal within this HNA is defined as during pregnancy until 24 months post-birth)

Mental health and wellbeing prior to, during and after pregnancy can affect both mothers and their children; advances in neuroscience, and other disciplines, clearly align psychological distress during pregnancy with significant risk factors for a range of adverse outcomes in the child^{cclxxx,cclxxxi}.

Early childhood experiences, during infancy and the first five years of life, also impact upon a child's mental wellbeing, with emotional, psychomotor, behavioural and cognitive problems in the baby and child that may extend into adulthood^{cclxxx,cxxvii}.

Parental mental health has been covered within this report, however, a further focus is provided here on maternal mental health in relation to child development during infancy and early years.

PHE report children whose mothers have depression have a five-fold increase in risk of developing mental health illness^{xxii}, and it is understood three-quarters of the cost of perinatal mental illness relates to adverse impacts upon the child rather than the mother^{iv,cclxxxi}.

A recent UK study reported one in four UK children between the ages of 0 and 16 have a mother with a mental illness, and that over half of UK children, by the age of 16, will have had a mother who has experienced mental illness^{cclxxxii}. They included 547,747 children and 381,685 mothers in their analysis. The South west had the fourth highest proportion of mothers with mental illness (25.3%), and the authors reported highest prevalence coincided with areas with the highest levels of deprivation and adult mental illness in general. They also reported children born into poverty, or to teenage parents, were more likely to be exposed to poor maternal mental health.

Although there are challenges in assessing mental health of infants, the NHS Digital prevalence study in 2-4 year olds showed the proportion with mental disorder as nearly four times higher in those with poor parental mental health (16%) over those whose parents had good mental health (4%).

[Data download](#)

Explore different factors and childhood by using

Select an age group

2-4

Select all children, boys or girls to:

All Boys Girls

Click to see how rates of mental di

Ethnic group Family functi

Figure 136: Percentage of children with a mental disorder, age 2-4, in relation to parental mental health Source: ONS^{cclxxxiii}, using NHS Digital Survey, 2017, results

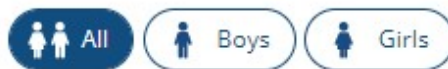
[Data download](#)

Explore different factors and childhood by using

Select an age group



Select all children, boys or girls to



Click to see how rates of mental c



Figure 137: Percentage of children with a mental disorder, age 2-4, in relation to family functioning
Source: NHS Digital Survey, 2017

It was nearly three times higher in those with poorer rated family functioning than in those with healthy functioning, at 10%, compared with 4% in 2-4 year olds who lived in families with healthy functioning.

Ambitions, therefore, to improve the mental wellbeing of mothers and children in their infancy and early years offer the potential for tangible improvement evident across a child's life course as well as economic benefits^{iv,xxix}.

It is common for women during pregnancy to experience changes to their mental health, during a time of such great transition. It is believed 10-25% of women are affected by mental health problems, such as anxiety, depression, PTSD or psychosis at some point during pregnancy or the first year after childbirth and suicide is the second cause of maternal death (after CVD)^{cclxxxiv, cclxxxiv, cclxxxv, cclxxxvi, cclxxxvii, xxix, cclxxxviii}.

Women with a history of mental health disorders prior to becoming pregnant have an increased risk of certain mental health conditions during pregnancy and in the first year after birth. Severe mental ill health during pregnancy includes bipolar affective disorder, severe depression and psychosis

Where one parent is unable to provide the responsive care infants require, the presence of another caring adult is thought to be highly protective. For example, if a mum's empathy for her newborn baby is hampered by postnatal depression, another adult's warm response to baby can help the baby to form secure attachments^{cclxxx}.

Paternal mental health can also be affected following the birth; there is limited evidence available but there is awareness that symptoms of mental health disorders may be under-recognised and underestimated in males. Paternal depression is associated with maladaptive parenting behaviours toward children and negative child outcomes and effect sizes of the relation between father's depression and parenting were comparable to findings in mothers^{cclxxxix}.

Prevalence of mental health need in fathers provides various estimates. One study^{ccxc} found 38% of first-time fathers are concerned about their mental health & two studies, including a meta-analysis in 2010, reported 10% of all new fathers worldwide experience postnatal depression^{ccxi}, half the rate of mothers at 21%.

Research suggests fathers are more at risk if their relationship with their partner is strained or if their partner is experiencing postnatal depression^{ccclxxx}. There is also the possibility of mental health issues for partners of new mothers, who are not the biological father, given the pressures new families experience.

Women with a lack of social support are shown to be at increased risk of antenatal and postnatal depression, as does having a poor relationship with a partner. ONS statistics also show infant mortality rates are higher among babies that are registered by just one parent than for other registration types.

PHE recommend establishing the number of lone parent birth registrations to provide a rough indication of the number of women in your local area that are likely to lack the support of the father during pregnancy and as a new mother^{lxxvi}.

Local prevalence data

It is possible to look in some further detail at estimates of the number of women experiencing maternal mental health problems during the perinatal period for the three local authorities, in table 40 below. These estimates are generated through national prevalence data applied to local population birth data; these figures therefore do not take account of any socio-economic or demographic differences or other which is likely to cause variation across areas.

They show approximate estimations of around 2,600 women with some form of need during the perinatal period.

Table 40: Progress indicators of Perinatal mental health: Estimated number of women requiring support during pregnancy or postnatal period

Indicator (Type of disorder)	National prevalence estimates	Bournemouth	Poole	Dorset CC
Postpartum psychosis	2 per 1,000	3	2	5
Serious mental ill	2 per 1,000	3	2	5
Severe depressive illness	30 per 1,000	48	34	79
Mild-moderate depressive illness and anxiety	100-150 per 1,000	160-240	114-171	263- 395
PTSD	30 per 1,000	48	34	79
Adjustment disorders and distress	150-300 per 1,000	479	343	790

Source: PHE Public Health Profiles (2019) – using ONS data. PHE calculated by applying national prevalence estimates (e.g. 2 in 1,000) to the total number of maternities (including stillbirth deliveries) in the area.

Local prevalence, based on a national prevalence of 10% and the number of live births in 2019, would equate to 626 fathers/partners, pan-Dorset.

In 2017 PHE reported a national average of 5.1% of births registered by just one parent^{ccxcii}. Bournemouth is recorded as having 4.8%, Poole as 4.9%, both comparable to the national average, while Dorset had a lower proportion at 3.4%.

Attachment in Infancy and Early Childhood

Infants are born with a range of innate behaviours enabling them to maximise their survival; attachment behaviour allows the infant draw others towards them at moments of need or distress. Infants who experience a 'secure' attachment relationship develop a reasonably firm expectation of feeling protected and safe, allowing them to explore their world more confidently^{ccxciii}.

Evidence has confirmed the significance of early child-parent and child-carer relationships in thriving later, both socially and cognitively. There is a significant amount of evidence demonstrating the value of sensitive and attuned parenting in the development of a baby's brain and the development of a secure attachment. Issues with attachment and parenting styles impact on the physical, mental and socio-economic outcomes of a child later in life.

The National Institute for Health and Clinical Excellence^{ccxciv} (NICE) attachment classifications defined in young children are:

- Secure (around 65%)
- Insecure (around 35%):
 - Avoidant (10–15%)
 - Resistant (also called ambivalent) (8–10%)
 - Disorganised (15-19% in general population samples; 40% in disadvantaged populations approx. 80% in maltreated populations)

NICE report estimates of around two-thirds of children in population samples having secure patterns of attachment, across cultures. This falls to one-third in disadvantaged populations and to less than a third in maltreated populations. Therefore, 30-35% of representative populations have an insecure attachment.

The NICE guidance confirms there is consistent evidence regarding primary causes of variation in secure versus insecure attachment, namely quality, sensitivity and responsiveness of care provided by consistent carers. Disorganised attachment has been consistently related to caregiving that is frightening, shows signs of carer dissociation, or is otherwise extremely insensitive; disorganised attachment is observed at highly elevated rates amongst young children who have been maltreated.

With insecure attachment patterns, mental health problems are more likely to occur; Attachment difficulties are associated with a range of emotional and behavioural problems for which child are referred for support, often to child and adolescent mental health services (CAMHS). These difficulties include both internalising problems (for instance anxiety, depression, social withdrawal and somatic complaints) and externalising problems such as difficult and challenging behaviour, aggression and threatening behaviour.

There is a heightened risk of attachment difficulties for children within certain groups. Children adopted from care, in care or in contact with social services are at high risk of both insecure and disorganised attachment. Many of the young people involved with the youth justice system have been children in care or have had multiple carers, with usually a high level of exposure to traumatic events, all of which may be associated with attachment difficulties. These children have also often had multiple educational placements, which can create a sense of dislocation and disruption to relationships, the need to negotiate new settings and relationships and to enter already established friendship groups. All of these factors can increase stress levels and decrease their ability to learn.

Proposed environmental factors associated with the development of attachment difficulties in children and young people, from the NICE guidance, are shown in figure 138 below.

	Setting Children living (Environment) the process a
Risk factor	Risk factors in <ul style="list-style-type: none"> • children who • parents in p • adolescent i • frightening c

Figure 138: Environmental factors associated with the development of attachment difficulties in children and young people
Source: NICE Guidance (NG26)

As well as environmental factors, discussed below, attachment can also be affected by complex pregnancy, abnormalities identified in the foetus, traumatic birth experiences, and the anxiety and stress of separation if babies are admitted to special care units^{cclxxx}.

For children at increased social disadvantage, evidence showed an association between socioeconomic factors (which included low income, single mothers, low education, adolescent mothers, and minority ethnic status) and attachment difficulties (both insecure and disorganised). It was noted that individually each socioeconomic factor did not have a strong association, however there was a cumulative effect whereby multiple socioeconomic factors (clustered together) increased the risk of disorganised attachment.

Meta-analyses¹⁹ performed to establish the association of insecure attachment patterns with mental health problems have been reported within the NICE guidance. They found no increase or a modest increase in prevalence of all kinds of mental health problems associated with avoidant and ambivalent patterns, but significant and greater increases in mental health problems (particularly conduct and aggression problems) amongst children displaying disorganised attachment patterns.

Oppositional defiant disorder/conduct disorder (ODD/CD) was reported as the second most prevalent type of mental disorder in children and young people in the 2017 NHS Digital survey. Meta-analyses suggest around 55% of children with ODD/CD have a pattern of insecure attachment (compared to around 30-40% in controls) of whom about 30% have disorganised attachment (compared to 15% in controls); in children with ODD/CD, the odds ratio therefore of having disorganised attachment is nearly fourfold.

Attachment difficulties are also strongly associated with difficulties later in life, for instance, externalising problems are strongly associated with a range of later issues including substance misuse and criminality.

¹⁹ Meta-analysis is a quantitative, formal, epidemiological **study** design used to systematically assess the results of previous research to derive conclusions about that body of research; to understand the consistency of effects across studies

Local data on risk factors for 'insecure' attachment

As noted within PHE local area reports on 'Mental health in pregnancy, the postnatal period and babies and toddlers' there is the opportunity to provide information on risk factors but it remains a complex and wide-ranging topic. No reliable data is available on parent-baby attachment, as it is not feasible to provide reliable estimates for the prevalence of poor social and emotional development in babies and toddlers, nor exhaustive information on factors thought to influence it.

PHE do suggest consideration of whether there is likely to be a high level of disorganised attachment in local areas, by means of examining risk factors which can lead to attachment problems, discussed below:

- Drug and alcohol misuse
- Maternal mental health
- Teenage parents
- Children in Care and child maltreatment
- Family Homelessness
- Domestic violence

Local data for each of these will therefore be examined below, where available.

Drug and alcohol misuse

Alcohol

PHE publish a number of indicators for admissions alcohol-related or alcohol-specific conditions to hospital from 2018/19 and 2019/20, all reported under the new authorities. For all indicators, including all-persons, or by males/females, and in those specifically under 40 (more likely to be parents), BCP shows rates higher than those seen in England (example in figure 139). Rates in Dorset UA are consistently below that of England and therefore of BCP also.

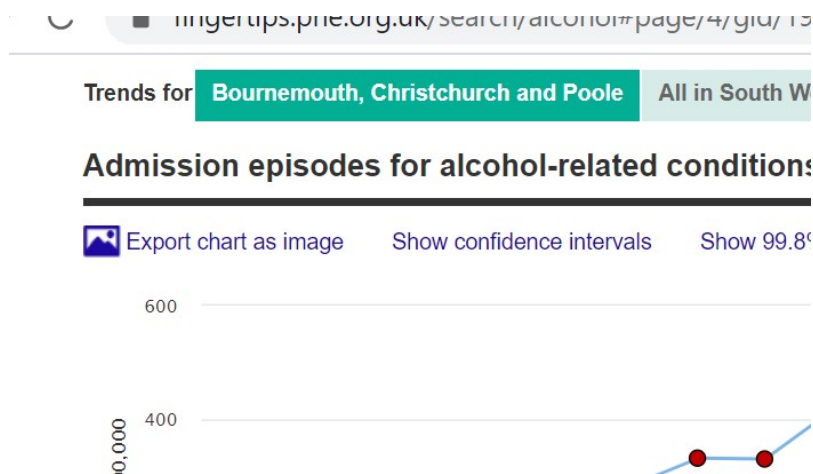


Figure 139: Example of data available: Admission episodes for alcohol-related conditions (Narrow) - Under 40s (Female), 2018/19 - BCP area
Source: Public Health Profiles

Trends in these admissions have generally been rising in BCP between 2013/14 or 2014/15 and 2018/19, and particularly so in those under 40. The trend data for females under 40 is shown in figure 139 above, where rates have nearly doubled since 2013/14.

Trends in admissions related to alcohol have, in the main, remained stable in Dorset UA and are therefore not shown as a figure.

In data gathering on parents, or other adults living with children, starting treatment for substance misuse^{ccxcv}, it is apparent PHE have removed indicators in 2020 showing rates of parents of 0-15 year olds in alcohol or drug treatment as they may be unreliable, so recent local data is not available. Nationally, PHE reported data between 2018-19, where 21% of people starting treatment were living with children, either their own or someone else's. And 31% were parents who were not living with their children. This was highest among women in treatment for opiates (mainly heroin), where 44% were parents not living with their children.

They also reported that 80% of children who live with people starting treatment were receiving no early help; 7% had a child protection plan, rising to 15% in the non-opiate group (using substances such as such as cannabis, crack and ecstasy).

Local data is available on mortality rates from drug poisoning and drug misuse^{ccxcvi}. Data for 2017-19 is provided under BCP and Dorset UA. Rates for drug poisoning were 10.3 per 100,000 population, above that of England at 7.3 and the South West at 7.6. Dorset rates were lower, given as 6.0.

In 2017-19 for deaths due to drug misuse, rates in BCP were 7.0 per 100,000 population, above that of England at 4.7 and the South West at 4.9. Dorset rates were again lower at 4.1.

Maternal mental health (Prevalence of mental health disorder in general population)

There are indicators of national level general, parental and maternal mental health prevalence, detailed within this report.

PHE suggest using the general level of mental health prevalence as a crude estimate of maternal mental health prevalence at a local level.

Adult mental health

We see in England, in 2017, there were an estimated one in six of those aged over 16 with a mental disorder (16.9%), in line with findings from the Adult Morbidity Survey in 2014. In that survey, one in five women (19%) had reported common mental disorder (CMD) symptoms, and 10% of women surveyed reported severe symptoms.

Reviewing data from 2017 in figure 140 below, differences across Dorset are evident, with increased prevalence of mental disorders above that of England and the South West region in Bournemouth at 18%, or one in six, but lower in Poole and lower again in Dorset at around one in seven (14.1%).

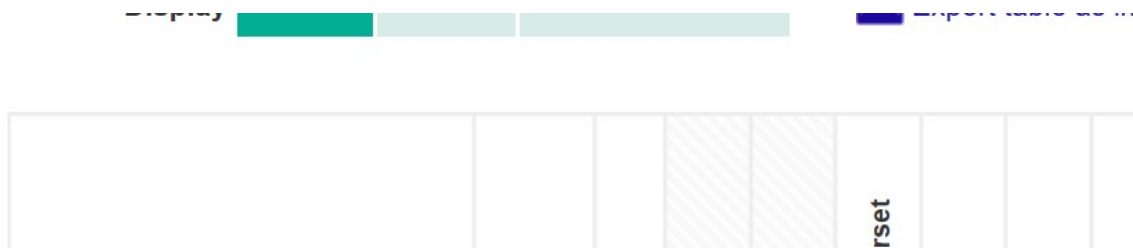


Figure 140: Prevalence of common mental disorders, in those over 16 years old
Source: PHE Public Health Profiles, accessed November 2020

Younger parents (under 25 years of age)

In the same way as all parents, younger mothers and fathers want to do the best for their children and some manage very well; but for many their health, education and economic outcomes remain disproportionately poor, affecting their life chances as well as those of their children. Every young parent exists as an individual, but there are vulnerabilities with which some young people enter parenthood: family poverty, persistent school absence by age 14, slower than expected attainment between ages 11 and 14; and being looked after or a care leaver.

These risk factors were captured in the Family Nurse Partnership trial: 46% of young parents had been suspended, expelled or excluded from school and 48% were not in education, employment or training at the time of recruitment.

It is understood some young parents will have missed out on the protective factors of high quality relationships and sex education, wellbeing and resilience, positive parenting role models and having a trusted adult in their life. For a minority, these vulnerabilities may make parenting very challenging. Almost 60% of mothers involved in serious case reviews had their first child under 21^{ccxcvii}.

PHE^{ccxcviii,ccxcvii} report mothers under 20 are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth, affecting their own wellbeing and their ability to form a secure attachment with their baby, which is recognised as a key foundation stone for positive child outcomes. They are also at increased risk of low birthweight which can significantly impact upon the child's long-term health.

Children born to teenage mothers have a 63% higher risk of living in poverty; teenage mothers are more likely than other young people to not be in education, employment or training and, by the age of 30, are 22% more likely to be living in poverty than mothers giving birth aged 24 or over. Younger fathers are twice as likely to be unemployed aged 30, even when accounting for deprivation. Recent analysis data shows some of these poorer outcomes, notably poor mental health, are experienced by young parents up to the age of 25.

Proportions differ across Dorset of births to mothers under 25. There was a higher percentage of mothers under 18 in BCP than England and higher percentage of mothers under 20 years for both authorities than seen in England. As shown earlier in this report, 2019 data showed 523 births to mothers below 25 years old. in BCP this accounted for 15% of all births and 18% (498 births) in Dorset. Dorset had a higher proportion of births to younger mothers than England and the South West, whose proportions were 17% and 16%, respectively.

For mothers under 20, 2019 data showed the proportion of births to mothers under 20 was 2.72% for England and 2.49% in the South West. BCP at 2.19% had a lower proportion of births to mothers under 20 while Dorset at 2.69% had more births than the South West, in line with England.

Births to mothers under 18 equated to 0.40% of all births in BCP and 0.33% in Dorset, both below England proportions of 0.60% and the South West at 0.56%.

Table 41: Live births by age of mother, numbers, 2019.

Age of mother	BCP	Dorset
All births	3,508	2,748
Mother aged under 18	14	9
Mother aged under 20	77	74
Mother aged 20-24	432	415
Total births to mothers under-25	523	498

Source: NOMIS, 2021.

Children in Care and Child Maltreatment

Children in Care indicators from PHE and LAIT show a mixed pattern pan-Dorset compared with England. Generally across Dorset there are lower than England rates for categories of abuse and neglect, however, in 2018, Bournemouth and Poole had slightly higher rates per 10,000 than England of children subject to a child protection plan, only with a category of abuse. Dorset had a significantly lower rate.

Homelessness

Family homelessness in 2017 was lower than in England across Poole and Dorset (no data for Bournemouth). There has been an evident rise in households in temporary accommodation between 2014/15 and 2017/18 across areas of Dorset, and homeless households in 'priority need' (70% of which are likely to contain dependent children) have shown higher rates in Bournemouth than England, Poole and Dorset, whose rates were comparable.

Further detail is available under the separate section on homelessness.

Domestic Violence

PHE refer to high levels of domestic violence in a local area indicating the population is more at risk of mental health problems during the perinatal period, and living in a household where domestic violence is occurring is also a risk factor for poor mental health in babies and toddlers^{lxxvii, cxxx}. Data on this earlier in the report, pan-Dorset due to recording across the one police authority in Dorset, showed 7,304 incidents of domestic violence in 2018 and a rate of 18.9 incidents per 1,000 population pan-Dorset, lower than the rate of 27.4 per 1,000 seen nationally.

Drawing together the risk factors which can lead to attachment problems, locally this does not present obvious conclusions, other than there may be a picture slightly more indicative of disorganised attachment patterns within Bournemouth.

Local data on protective factors in attachment

Positive attachment depends on responsive, warm and sensitive parenting. While there are gaps in the data around this, as responsiveness and sensitivity involve time-intensive studies of carer and infant interactions, breastfeeding has been shown to be a consistent predictor of positive attachment^{ccxcix}, as well as providing many immediate and long-term health benefits for both mother and infant^{ccc}.

PHE data for 2018/19 shows the proportion of babies whose first feed was breastmilk was 70.5% in Dorset UA, in line with England (67.4) but below South West proportions (75.3), and BCP was 79.7%, above all.

PHE data is partial for breastfeeding initiation or prevalence at 6-8 weeks after birth and from 2016/17 and 2014/15 respectively. PHE breastfeeding initiation showed Dorset CC area having 78.6%, above England and in line with the South West proportions, while Bournemouth showed 86%, above that of England and the South West, with no data for Poole.

Breastfeeding prevalence (totally or partially breastfed at 6-8 weeks) was highest in Bournemouth (56.2), with Poole at (47.0%) above England (43.8) and no data was published for Dorset or the South West.

LAIT data was incomplete also and did not offer any further information on breastfeeding. There was mention in LAIT that there was a lack of clarity as to the accuracy of breastfeeding prevalence data in 2017/18 following a change in collection methods.

PHE data for England 2019/20 has prevalence of breastfeeding at 6-8 weeks at 48%. Local data does not cover the same time period as the England data nor as each other but reported below is what is available to give an overview.

BCP data contained on in-house systems shows complete data for the period July 2019-February 2020 and shows a higher rate of babies being bottle-fed at 6-8 weeks than other methods of feeding. There is a drop in recording in mid-January which would correspond with the initial COVID-19 lockdown.

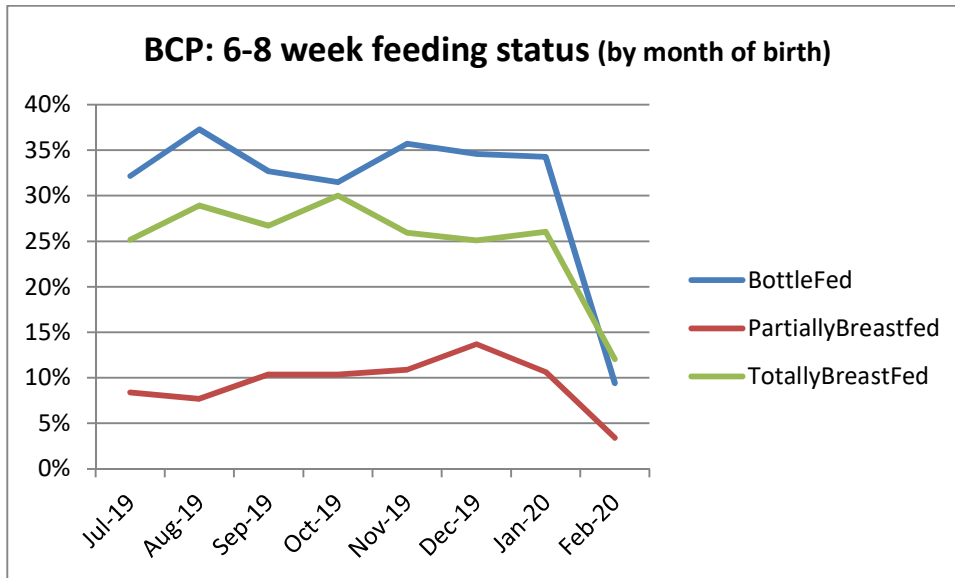


Figure 141: BCP: 6-8 week feeding status
Source: Business Objects In-house reporting system, accessed November 2020

Dorset data contained on in-house systems shows complete data for the period January-November 2019 and shows a variable picture of higher proportions at times of either babies being bottle-fed or breastfed at 6-8 weeks.

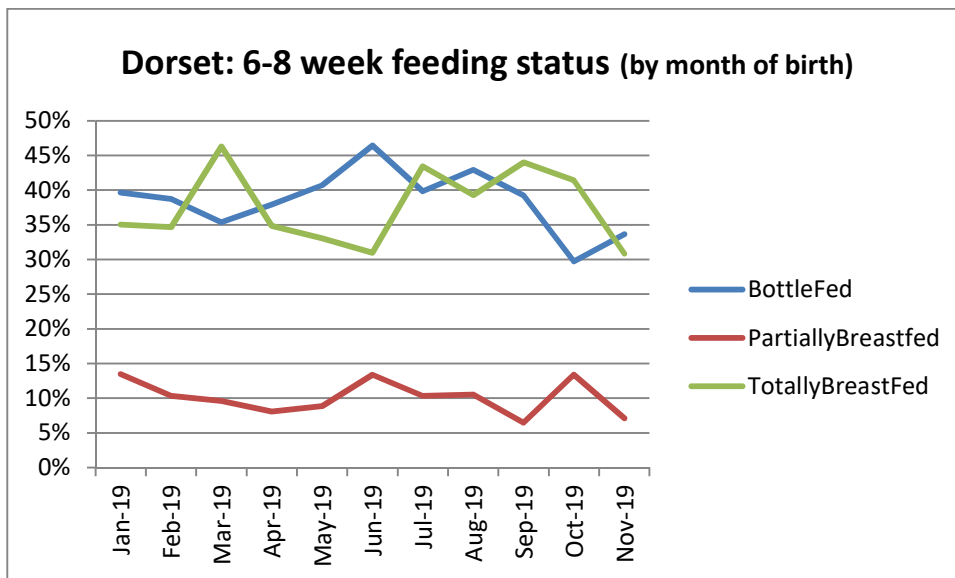


Figure 142: Dorset: 6-8 week feeding status
Source: Business Objects In-house reporting system, accessed November 2020

It is appreciated that these local figures do not correspond fully with the England information nor with each other in terms of time-periods. The rates of breastfeeding locally though, do appear higher in Dorset and nearer to England proportions than is seen in BCP.

PHE overall indicators

PHE publishes numerous indicators related to the development, mental and physical health of infants and the mental health of their caregivers, such as low birth-weight or teenage conceptions, which are more likely to be unplanned, end in abortion and, if continued, teenage families are more likely to be living in poverty and poor quality housing.

Other indicators such as babies born to mothers from minority ethnic populations are included as those mothers are more likely to breast-feed than those identifying as White. Stillbirth rate has risk factors associated with ethnicity and history of maternal mental health problems.

For that reason there are multiple indicators shown below, in figures 143 and 144, demonstrating the data pertinent to Perinatal, Infant and Child Mental Health.

The red line demonstrates the England benchmark, with the circle indicating the area value. Generally, left of the benchmark value is used to depict a 'worse' value, and a 'better' value on the right. Where there is no worse or better value, the left will show lower and higher values will be on the right. The colour indicates the significance of the value, red being significantly worse, orange being not significantly different, and green significantly better than the benchmark value. Blue can be used to show lower or higher.

BCP:

gertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133222/pat/6/r

Indicator	Period	Bournemouth, Christchurch and Poole			Region England	
		Recent Trend	Count	Value	Value	Value
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2018/19	—	215	6.4%	7.1%	20.1%
General fertility rate	2017	—	4,031	55.7	58.1	58.1
Under 18s conception rate / 1,000	2018	↓	73	13.1	13.3	13.3
Under 18s conceptions leading to abortion (%)	2018	→	42	57.5%	53.5%	53.5%
Folic acid supplements before pregnancy New data	2018/19	—	-	34.7%	32.0%	27.0%
Early access to maternity care New data	2018/19	—	2,215	55.4%	63.5%	57.0%
Obesity in early pregnancy New data	2018/19	—	-	19.6%	21.0%	21.0%
Drinking in early pregnancy New data	2018/19	—	-	-	-	-
Drug misuse in early pregnancy New data	2018/19	—	-	-	-	-
Smoking in early pregnancy New data	2018/19	—	-	12.4%	13.3%	13.3%
Smoking status at time of delivery	2018/19	—	368	10.3%	10.9%*	10.9%
Teenage mothers	2018/19	→	25	0.7%	0.5%	0.5%

Figure 143: Perinatal, Infant and Child Mental Health profile for BCP
Source: PHE Public Health Profiles

Dorset:

gertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133222/pat/6/p

Indicator	Period	Dorset			Region Eng	
		Recent Trend	Count	Value	Value	Va
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2018/19	–	80	3.2%	7.1%	21
General fertility rate	2017	–	3,082	59.6	58.1	
Under 18s conception rate / 1,000	2018	➔	70	12.1	13.3	
Under 18s conceptions leading to abortion (%)	2018	➔	43	61.4%	53.5%	5:
Folic acid supplements before pregnancy New data	2018/19	–	-	19.1%	32.0%	2:
Early access to maternity care New data	2018/19	–	1,640	54.2%	63.5%	5:
Obesity in early pregnancy New data	2018/19	–	-	24.7%	21.0%	2:
Drinking in early pregnancy New data	2018/19	–	-	-	-	.
Drug misuse in early pregnancy New data	2018/19	–	-	-	-	.
Smoking in early pregnancy New data	2018/19	–	-	13.6%	13.3%	1:
Smoking status at time of delivery	2018/19	–	274	10.3%	10.9%*	1:
Teenage mothers	2018/19	–	-	*	0.5%	1:
Caesarean section %	2018/19	–	695	27.8%	27.0%	2:

Figure 144: Perinatal, Infant and Child Mental Health profile for BCP
Source: PHE Public Health Profiles

It can be seen across BCP and Dorset there are mixed indicators of perinatal, infant and maternal health.

National Statistics on contact with mental health services during perinatal period

A set of experimental data statistics were provided in 2017 by NHS Digital, to gather data on 'Women in contact with mental health services who were new or expectant mothers'. Data from the MSDS^{ccci} was linked to data from the MHSDS, looking at interactions of women up to 12 months post-birth ('PN' period) with secondary mental health services during October 2016-March 2017. This may serve as a measure of the possible level of need we may anticipate across users of secondary mental health services.

Of the more than 1 million aged 16 or over in the perinatal period, 32,002 (3.1%) were in contact with secondary mental health services between October 2016-March 2017.

Some mothers had contact with specialist perinatal mental health services, some with other secondary mental health services, and some with both. There were six times more women seen during the perinatal period in routine mental health services than in specialist perinatal mental health services. The data does not indicate whether these were existing support mechanisms prior to pregnancy or whether they were new contacts with mental health services since conception. The report clarifies that these statistics are an overall measure of mental health of women during the perinatal period.

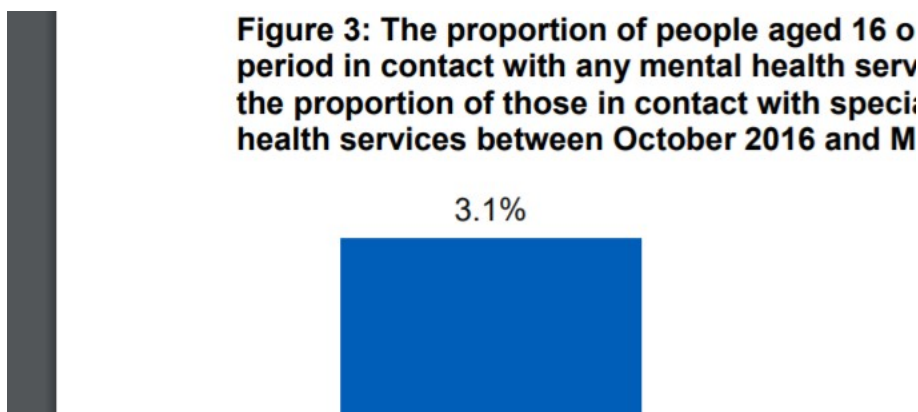


Figure 145: Proportion of people aged 16 or over in the perinatal period in contact with any mental health services, compared to the proportion of those in contact with specialist perinatal mental health services (October 2016-March 2017).

The use of services was more common in younger people; of the 1,338 people aged under 16 in their PN period 20.3% were in contact with secondary mental health services, and between 16-19 years of age contact was had in 8.0% of that population. In under 16s, this is almost 10 times the proportion of mothers over 25 years in contact with secondary mental health services, and in those aged 16-19, it is around three times. It was double in those between 20-24 years, compared with mothers over 25. These statistics support existing evidence around younger mothers experiencing increased mental health need, as discussed earlier.

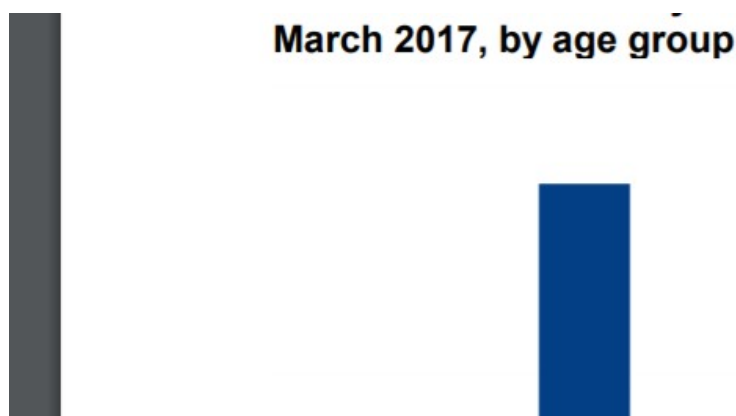


Figure 146: Proportion of people in the perinatal period in contact with secondary mental health services, by age group (October 2016-March 2017)

Adolescence

Adolescence, defined by the WHO^{ccci} as ages 10-19 years, is considered a unique and formative time, and young people may experience many challenges in adolescence. There are numerous physical, emotional and social changes that occur during adolescence and factors such as exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems.

The WHO report mental health conditions account for 16% of the global burden of disease and injury in people aged 10-19 years. Anxiety, depression and suicide are reported as leading causes of youth morbidity and mortality across the world^{cccii}. Emotional and eating disorders, along with psychosis, more commonly develop during adolescence and childhood behavioural disorders are leading causes of disease burden, significantly in early adolescence.

Multiple factors determine mental health outcomes with cumulative exposure to risk factors, already discussed, having a greater impact. Many other factors can contribute to stress specifically during adolescence, such as the desire for greater autonomy, pressure to conform with peers, exploration of sexual identity, and increased access to and use of technology^{ccci}.

Many risk-taking behaviours, including substance use, sexual risk taking or perpetration of violence, start during adolescence. Risk-taking behaviours can be both an unhelpful strategy to cope with poor mental health and can severely impact an adolescent's mental and physical well-being.

Adolescents who do have mental health conditions are increasingly vulnerable to social exclusion, discrimination, stigma, educational difficulties, risk-taking behaviours, physical ill-health and human rights violations^{ccci}.

Given half of all mental health conditions start before age 14 and 75% by age 18, and many undetected and untreated, the promotion of psychological well-being and protective factors, alongside protection from risk factors is critical to benefit their physical and mental health during adolescence and through into adulthood.

Importantly, adolescence is a time when life-long health behaviours are set in place, yet is also a time when early intervention and prevention is possible^{cv}.

International and national prevalence of mental health disorders in adolescents

Prevalence of mental health disorders during adolescence is estimated at between 10-20%, globally. There has been a lack of evidence located relating to those only within the UK, bar that in the NHS Digital 2017 survey, which reported one in seven (14.4%) 11 to 16 year olds and one in six (16.9%) young people aged 17 to 19 had a mental disorder. These figures differed by gender, as shown in figure 147 below.



Figure 147: Prevalence of any disorder in 2017, by age and sex.
Source: NHS Digital survey, 2017

The NHS Digital survey in 2017 highlighted the high prevalence of mental disorder in those in transitioning from late adolescence to early adulthood^{ccciv}. One in six (16.9%) 17-19 year olds had a mental disorder, with one in sixteen meeting the criteria for more than one mental disorder.

Emotional disorders were the most common disorder, present in 14.9% of 17 to 19 year olds. 13.1% had an anxiety disorder and 4.8% depression. Other disorder types (behavioural, hyperactivity, and other less common disorders) had an overall prevalence of less than one in fifty at this stage.

While the likelihood of having a disorder was highest at age 11 to 16 in boys, for girls, the disorder rate was highest in those aged 17 to 19 at nearly one in four (23.9%). These differences can be explained in part with differences in the types of disorder boys and girls had.

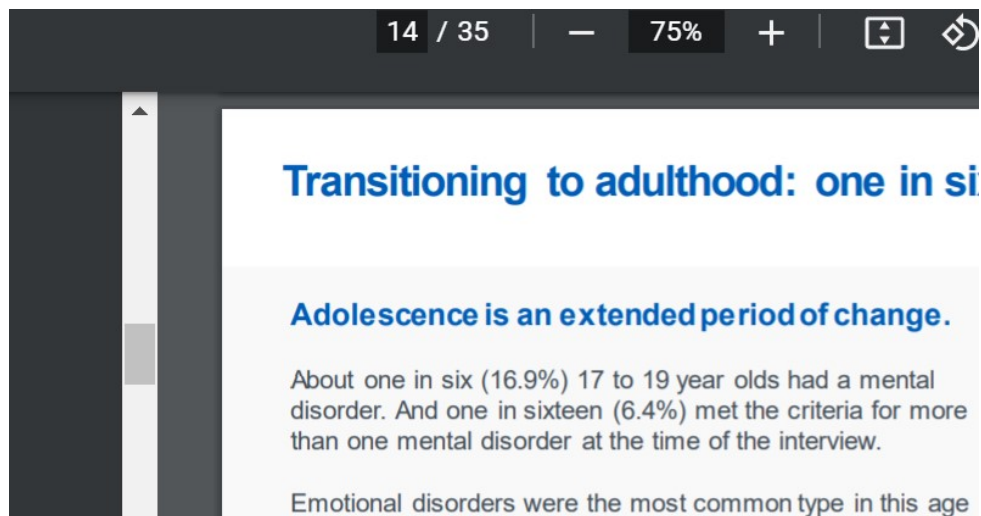


Figure 148: Prevalence of any disorder in 2017, 17-19 years old.
Source: NHS Digital survey, 2017

National data on suicide

Suicide is the third leading cause of death in older adolescents worldwide and in the UK, although rates for males between 10-24 years have showed low, stable rates previously, there has been a significant increase in rates seen during 2018 and 2019 to 8.2 deaths per 100,000 males. Additionally, although lower numbers overall and relative stability in levels of suicide have been seen in UK females aged 10 to 24 years, since 2012 the rate has increased by 93.8% to 2019 to 3.1 deaths per 100,000 females^{cccvi}.

Risk factors for suicide are multifaceted, but include substance abuse, abuse in childhood, stigma against help-seeking, inequalities in accessing care and access to means. Suicidal behaviour communication via social media is also an emerging concern within this age group^{cccii}.

Local data on population of adolescents

Globally one in six people are aged 10-19 years; in BCP one in nine of the population is aged 10-19 years and in Dorset this is one in 10²⁰.

There was no local data on the prevalence on mental disorders obtained, particular to the period of adolescence. Data on admissions for mental disorders in those aged 0-17, and for alcohol and substance misuse, are contained earlier in this report.

²⁰ 10.7% and 10.4% of total population, derived from ONS population estimates for 2019.

Admissions for self-harm in adolescents; those aged 10-14 and 15-19 years of age

The latest data, from 2017/18, shows Bournemouth, Poole and Dorset had a significantly higher prevalence of hospital admissions as a result of self-harm for 10-14 years, 15-19 years, (per 100,000 population) than the England benchmark.

Bournemouth and Poole had higher prevalence of hospital admissions as a result of self-harm than the South West region (rate of 965.7) in both the 10-14 and 15-19 age groups.

Indicator	Period	England	Bournemouth Council (pre 04/2019)	Poole Council (pre 04/2019)	Dorset County Council (pre 04/2019)
Hospital admissions as a result of self-harm (10-14 years) per 100,000	2017/18	210.4	387.7	413.7	219.3
Hospital admissions as a result of self-harm (15-19 years) per 100,000	2017/18	648.6	1083.2	1104.6	927

Figure 149: Hospital admissions as a result of self-harm per 100,000 (CYP)

Source: Dorset CCG, taken from PHE Public Health Profiles

Local data on suicide is only available for the age group 10-34 years through PHE. National data from the millennium cohort study^{CCCV} suggests 7.4% of children and young people have attempted suicide by age 17. If this was representative of children and young people pan-Dorset²¹, modelling local prevalence would suggest around that 5,592 children and young people in BCP, and 5,022 in Dorset UA, would have attempted suicide by age 17. This would total over 10,600.

²¹ 0-17 population in BCP: 75,568 and Dorset 67,868

Young adults

This section is designed to build upon the data provided in the previous 'adolescent' section, incorporating understanding of issues extending to age 25; many sources commonly report data within the age period 16-24.

References have been made to this particular age group throughout this document.

National prevalence of mental disorder

The Adult Psychiatric Morbidity Survey (APMS)^{cccv} undertaken in England in 2014/15 includes data specific to 16-24 year olds. They found 24.6% of young women aged 16-24 and 14.7% of young men showed signs of depression or anxiety. The authors concluded that young women were a high-risk group in the population.

the results from the English 2017 population
s and boys experiencing any emotional dis
shows the developmental trend for anxiety
mong young men.

Psychiatric Morbidity

Figure 150: Prevalence of depression or anxiety, 16-24 years, by gender, England
Source: Association for Young People's Health, (2019): Key Data on Young People^{cv}.

The Key Data on Young People report in 2019 findings are presented below, in relation to their associations with mental health and wellbeing.

Health behaviours and lifestyle

Adolescence and early adulthood is a time when life-long health behaviours are concreted. Physical activity declines across adolescence, and around one in four school pupils aged 11-15 are obese.

Rates of smoking, drinking and drug use in younger people have, in general, fallen over recent years. While two-thirds of young people aged 11-15 report never drinking alcohol, one in five young people aged 16-24 do smoke. The proportion of young people aged 14 sleeping for less than 8 hours a night has doubled between 2005 and 2015.

Sexual identity

In the UK 4.1% of 16-24 year olds identify as gay, lesbian or bisexual although this is believed to be an underestimate.

Conceptions and Births

In 2017, rates of conceptions in under-18s were at their lowest level since 1969, yet the UK still has higher rates of births in those under 20 years old in comparison with similar high income countries. Around 20% of pregnant young women aged under 25 report being a smoker and 25% of early pregnant young women aged 18-24 are overweight or obese.

Physical health, long-term conditions and disability

Despite the majority of those under 25 years old having good physical health, some young people experience health problems. This has been covered in some detail in the disability section of this report. In summary, around a quarter of 11-15 year olds report long-term illness or disability and one in ten aged between 10-24 have a disability affecting their ability to do normal daily activities.

Young people aged 16-20 are the group most likely to be diagnosed with asthma and age 11-14 is the peak age for diagnosis of Type 1 diabetes.

Wellbeing and mental health

In people aged 16-24, mental disorders are three times more likely in young women than men, and while suicide rates in younger people have generally fallen since the early 2000s recent increases have been seen in young men aged 15-19.

Service transitions

Of particular relevance in older adolescents or young adults is the impact of transitioning from children and young people’s mental health services (CYPMHS) to Adult mental health services (AMHS). It can be a time of upheaval and it may prove difficult for children and young people to navigate new service settings or to manage their mental health and wellbeing following discharge from CYPMHS, especially as the availability and type of support can change dramatically.

This was an area of concern raised through the local view-seeking exercise.

PHE work^{xxxv} has highlighted the significant risks that exist of young people disengaging or being lost during transition processes, which may lead to young adults presenting again in crisis or later with greater severity. They note transitions for vulnerable groups, such as those within the criminal justice system, can be particularly problematic and require careful management and close engagement with the young person and, where appropriate, their families/carers.

Local 16-24 Population

Data from 2017 showing the percentage of those aged 16-24, expressed at Ward level, is seen in figure 151 below. Areas within Bournemouth have the highest proportions, between 20-32% in Bournemouth Central, Wallisdown and Winton West and Winton East, likely in part due to the increased student population present.

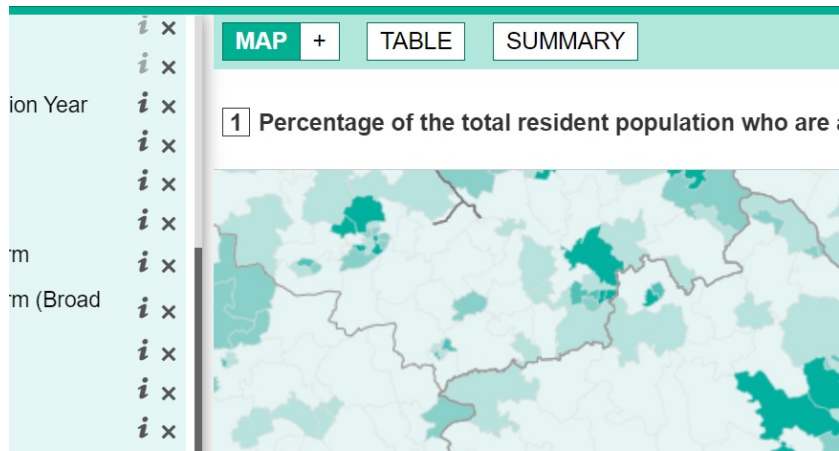


Figure 151: Percentage of the total resident population who are aged 16 to 24 years of age (%)
 Source: PHE 'Local Health' indicators

Self-harm and Suicide

Self-harm is the act of intentionally damaging or injuring one's own body, a common way of coping with or expressing overwhelming emotional distress. While people from any age, social background or circumstance may self-harm, people from certain groups are more vulnerable; higher incidence of self-harm is seen among younger people, prisoners, asylum seekers, people bereaved by suicide, some cultural minority groups and people from sexual minorities^{cccviii}.

Self-harm and suicidal behaviours, important issues in both adolescents and young adults, are frequently associated and possibly clinically related^{cccvii}. Self-harm can be with suicidal intent but can also be an act where little or no suicidal intent is involved, for example, where people harm themselves to reduce internal tension, distract themselves from intolerable situations, as a form of interpersonal communication of distress or other difficult feelings, or to punish themselves^{cccviii}. Main reasons for self-harm have been reported as being to relieve unpleasant feelings or emotions, by 76.7% of adults in the 2014 APMS survey^{clxxi}.

Suicide is a cause for concern in the younger age group; it has been the leading cause of death in the UK in recent years and suicide rates in children and young people are now rising in the UK.

2018 ONS data showed a 22% 1-year increase in suicide rate in under 25-year-olds, a greater rise than in any other age group and reported the UK suicide rate in girls aged under 20 is now the highest since recording began in 1981^{cccix,ccxxiii}.

While trends in completed suicide have shown declines, in contrast, the incidence of self-harm has risen in the UK over the past 20 years and, for some groups, is said to be among the highest in Europe^{cccviii}. In contrast to much of Europe, the UK has higher rates in younger people rather than in the older population^{cccx}.

Data on self-harm and suicide

Hospital admission rates can be a useful measure of intentional self-harm, and data is gathered on completed suicides, however, it is understood there are many children and young people who self-harm who do not come to the attention of services; it has been estimated around half of children and young people who self-harm are not seen by, or known to services.

Self-harm is one of the top five reasons for acute medical admission and individuals who self-harm have a one in six chance of repeat attendance at A&E within the year. A study of people presenting at Accident & Emergency (A&E) showed a subsequent suicide rate of 0.7% in the first year - 66 times the suicide rate in the general population^{cccxi}.

A prevalence study in 2018, to estimate the ratio of those who commit suicide, with those who present at hospital with non-fatal self-harm and those who self-harm in the community (unknown in hospital statistics), reported much higher rates of self-harm in females in the community. They found in 12-14 year olds, for every boy who died by suicide, 109 attended hospital following self-harm and 3,067 reported self-harm in the community, whereas for every girl who died by suicide, 1,255 attended hospital for self-harm and 21,995 reported self-harm in the community. In 15-17 year olds, for every male suicide, 120 males presented to hospital with self-harm and 838 self-harmed in the community; whereas for every female suicide, 919 females presented to hospital for self-harm and 6,406 self-harmed in the community.

A recent UK study^{cccxii} followed nearly 17,000 patients aged 10-19 who harmed themselves, and also found a three times higher incidence in girls than boys. They also found, although a much higher incidence was observed in younger people from deprived backgrounds, the likelihood of them having a GP referral to mental health services was nearly 25% less likely. In all young people who had self-harmed, there was a nine times increased risk of dying unnaturally, with especially noticeable increases in risks of suicide and fatal acute alcohol or drug poisoning.

The age at which self-harm is most common in young people, the peak incidence, is between ages 13 and 15^{cccxi}.

Association with mental health

There is much work which evidences strong associations between mental disorders and self-harm, suicidal thoughts and suicide attempts, with understanding that both mental disorders and social context remain powerful risk factors^{civ,cccxiii,cccxiv,cccxv}. Recent work has also established associations between self-harm and significantly lower wellbeing scores than in peers who had not self-harmed, with mean scores of 38.7 (ever self-harmed) and 46.8 (never self-harmed)^{cccxi}.

Early identification, accurate diagnosis and effective treatment of mental health conditions can help to prevent self-harm and suicide in children and young people^{cccxiv}.

Significantly however, when considering the efficacy of offering support and treatment, two-thirds of those aged 16–34 year olds did not seek help for their self-harm behaviour and in those aged 15-17 years old, only 9% sought professional help prior to self-harming, and 12% after self-harming. Furthermore, only 7% presented to hospital as a result of their last self-harm act^{cccxv}. Young people aged 16–24 were also more likely to seek help from family or friends^{cccvi,clxxi}.

National Prevalence of self-harm

The 2017 NHS Digital survey reported one in twenty 11 to 16 year olds, and one in seven 17 to 19 year olds, had self-harmed or attempted suicide at some point. Rates in girls were twice that of boys. More than half of young women (52.7%) aged 17-19 had self-harmed or attempted suicide at time of interview.

Focus on young women: one in four 17 to 19 year old girls

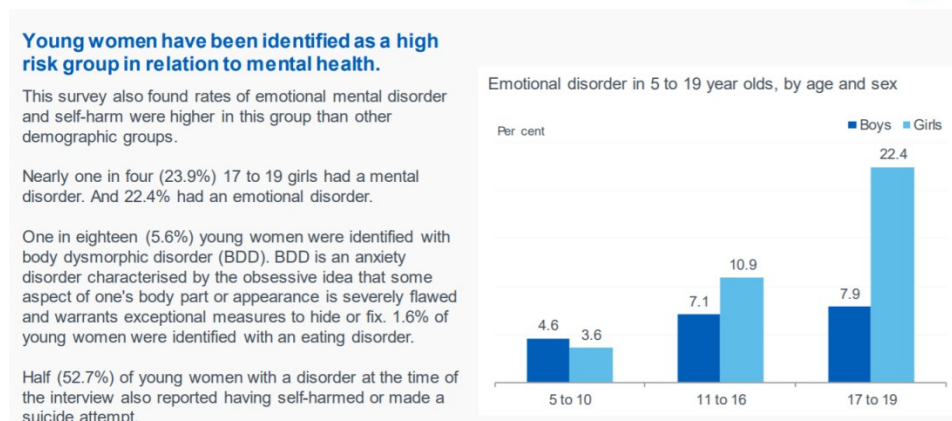


Figure 152: Emotional disorders, 5-19 year olds, by age and sex

Source: NHS Digital: Sadler et al (2018). Mental health of children and young people in England, 2017.

The APMS prevalence survey in 2016 also reported, in 16-24 year olds, one in four young women (26%) and one in ten (10%) of young men reported having self-harmed at some point in their life.

Time trends

PHE data presents trends over time for self-harm, within younger age groups, aged 10-24. Results shown within five-year age groupings (10-14, 15-19 and 20-24) illustrated rises in self-harm has been in the younger two groups rather than those in their early 20s.

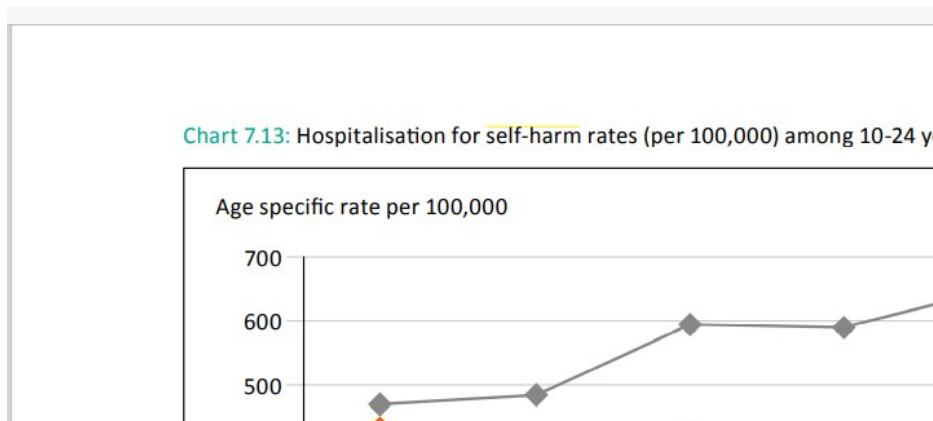


Figure 153: Hospitalisation for self-harm rates (per 100,000), among 10-24 year olds in England, 2011/12 to 2017/18
Source: AYPH 'Key Data on Young People (2019)' using PHE Fingertips data from HES.

This is in line with trends shown for self-reported self-harm data in the community. The proportion of young men between 16-24 years who reported self-harm nearly doubled from 4.2% in 2000 to 7.9% in 2014. The increase seen in young women was even greater; three times higher in 2014 than in 2000. Between 2000-2014 there was a higher proportion of women self-harming than men, but this divide grew significantly, with a sharp increase seen in younger women between 2007-2014, from 11-19%. These figures all suggest young women remain a particularly high-risk group in regards to self-harm.

**Self-harm ever (reported face-to-face
2000, 2007 and 2014**

Base: adults aged 16-24 and living in Eng



Figure 154: Self-harm ever, in 16-24 year olds, by sex
Source: Adult Psychiatric Morbidity Survey (APMS) (2016)

Local prevalence of self-harm

Local data on prevalence of self-harm and suicide is contained in the prevalence section but is also shown here in more detail.

Hospital admission rates for self-harm

In 2019/20 in BCP the rate of admissions for self-harm (age 10-24) was 814.8 per 100,000, a nearly twice that seen in England. For Dorset the rate was 707.1 per 100,000, significantly above that of England.

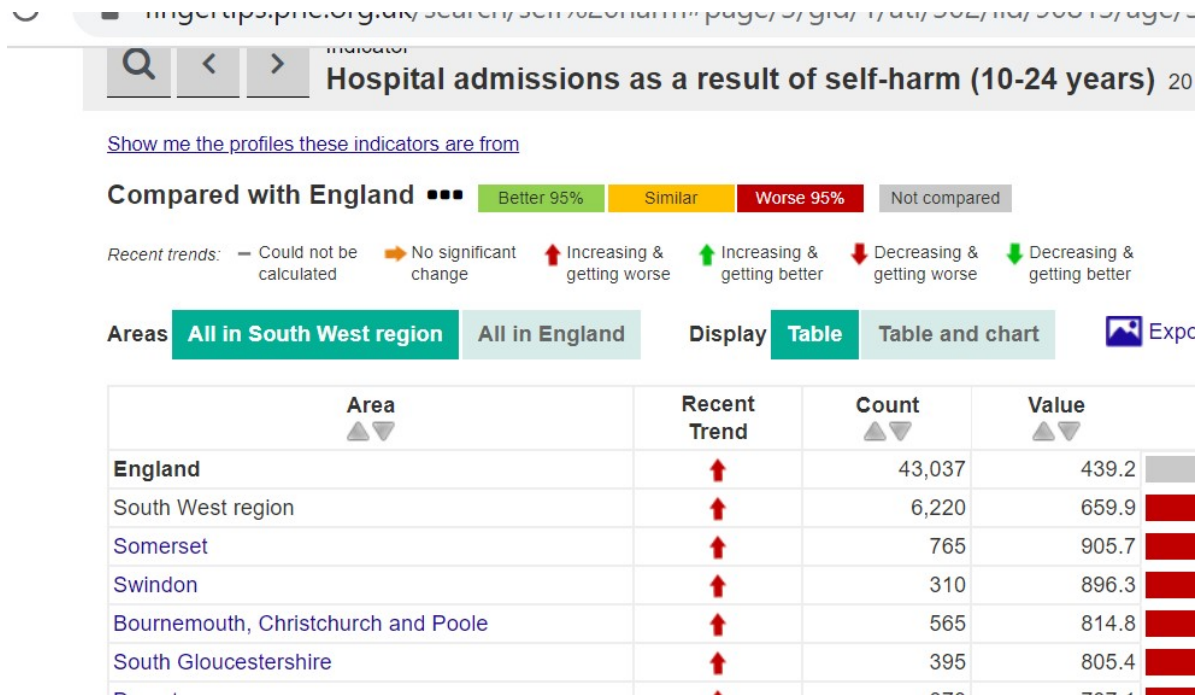


Figure 155: Hospital admissions as a result of self-harm per 100,000 (CYP), 2019/20
Source: PHE Public Health Profiles

In the year previous, in 2018/19, in BCP the rate of admissions for self-harm (age 10-24) was 627.9 per 100,000, a third above the rate seen in England, with 335 admissions. For Dorset the rate of admissions for self-harm at 817.7 per 100,000 was nearly twice the rate seen in England, with 575 admissions.

Self-harm admission rates, by age

In 2017/18 Bournemouth, Poole and Dorset authorities had a significantly higher rate of hospital admissions as a result of self-harm for 10-14 years (bar Dorset who was in line with England), at 15-19 years and at 20-24 years than the England benchmark. All three local authorities also had higher rates than seen in the South West in age groups 10-14, 15-19 and 20-24 years.

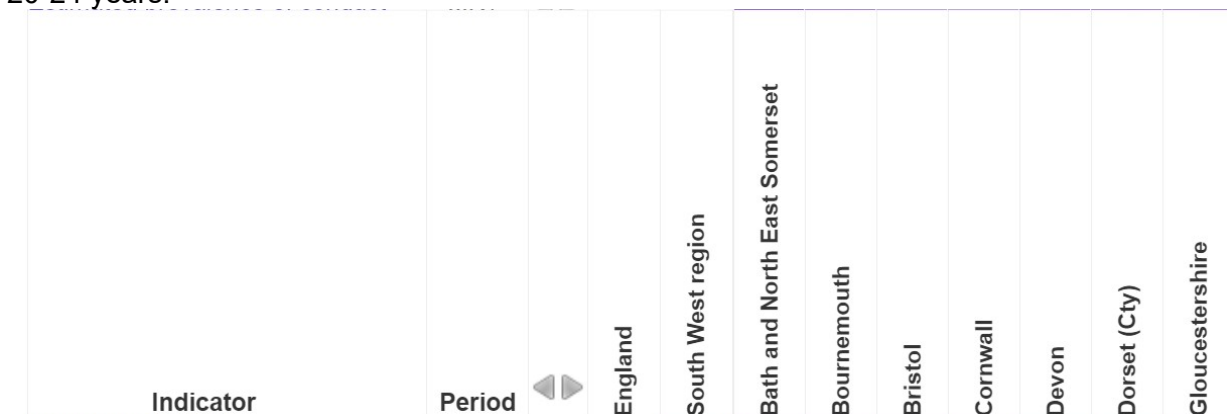


Figure 156: Hospital admissions as a result of self-harm per 100,000 (CYP), 2017/18, by age
Source: PHE Public Health Profiles

Local trends

In children and young people aged 10-24, it can be seen in figure 157 below, that despite the national picture remaining fairly stable, all three previous local authorities had rates of self-harm above that of England and all demonstrated a rise in rates from 2016/17. In the new combined authorities, rates in 2020 remain above the national and regional rates.

Bournemouth:



Poole:



Dorset:

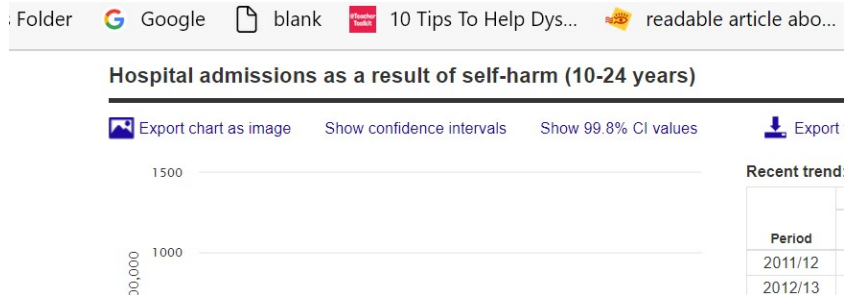


Figure 157: Hospital admissions; self-harm, 10-24 years of age from 2011/12 to 2017/18
Source: PHE Public Health Profiles

The picture remains the same when looking at the data within the five-year younger age groups. In all three previous authorities, between 2013/14 and 2017/18 rates have generally been above national rates and there have been rises again since 2016/17 in those aged 10-14, 15-19 and 20-24 years, bar the 10-14 age group in Dorset County.

All of these, within each five-year banding, are available through PHE; two examples are shown below in figure 158, showing the trends in Poole for 10-14 and 20-24 year olds.

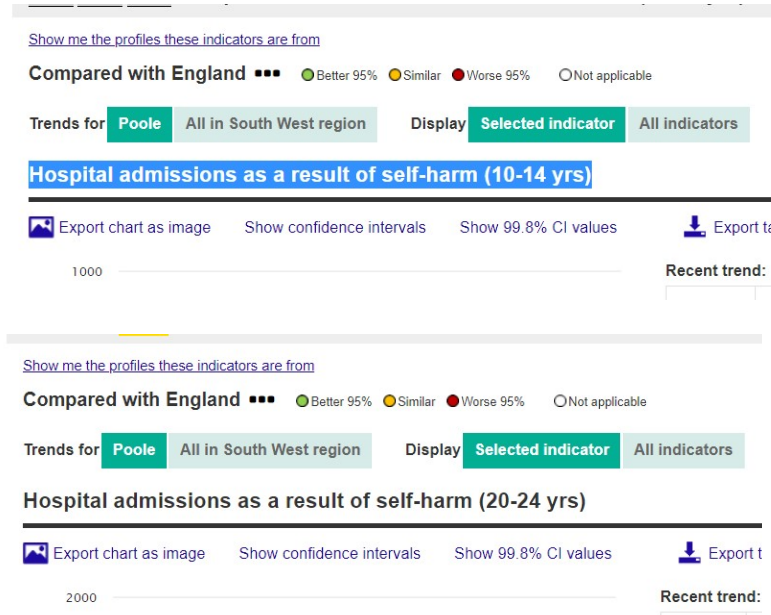


Figure 158: Hospital admissions as a result of self-harm in Poole (10-14 yrs and 20-24 years), 2011/12 to 2017/18
Source: PHE Public Health Profiles

Local stakeholder views on self-harm, from 'Your Mind, Your Say' report

This was also an area of concern raised through the local view-seeking exercise, asking for increased awareness of self-harm, suicide and prevention. Some participants shared concerns over the prevalence of self-harm amongst young people, with anxiety, depression, suicide and self-harm being common mental health issues in schools, in their experience. Participants raised that they are unsure of how to support friends in these situations, and that they believe teachers and other school staff do not know enough about these issues.

Families also expressed need for support in living with a young person who self-harms.

People who had accessed mental health services because of suicidal thoughts or self-harm reported services, from GPs to CAMHS, were not clear on how to provide support to parents or to young people in this situation. It was said that services are neglecting vulnerable young people and leaving them at risk.

Parents said they needed educating on how to support their children who self-harm, have depression, or suicidal thoughts and that they were unsure about which service to contact in critical situations.

The outcome was suggestions of further training for NHS, school staff, youth support services and mental health services. Dedicated helplines, and support for parents and carers would help, and if helplines and support were already available, then better communication about those was needed.

Suicide

Suicide is one of the leading causes of death in younger people, reported as the cause in 14% of deaths in 10-19 year olds and 29% in those aged 20-34 years old in the UK^{ccxxiii}.

Suicidal behaviours appears to progress over time: suicidal ideation is more common at the beginning of adolescence, the incidence of suicide attempts highest at the end of adolescence and the number of suicide deaths increases as adulthood begins.

Antecedents to suicide in the general population but believed to be significant to young people also are:

- isolation
- economic adversity
- alcohol and drug misuse
- recent self-harm

A recent, large study^{ccciix} to identify stresses young people face prior to taking their lives and their prior contact with services, reported on a number of additional risk factors for suicide in younger people. The main ones were self-harm, mental illness, academic pressures including exams or exam results, bereavement including by suicide, physical health conditions, drug or alcohol misuse and bullying (face-to-face and online). In a fifth of suicides social isolation or recent social withdrawal had been reported.

There were also common physical health conditions that may have had an impact, for instance asthma and dermatological problems, each constituting 10% of suicides. The most common recent life events were about relationships, housing and the workplace.

60% of young people had been in contact with specialist services or agencies, most often with mental health services. Girls were more likely than boys to have had contact with all services except justice agencies. It was more common for boys to have had no known contact with any services.

40% of those who died had 'no contact', and had low rates of mental and physical illness, self-harm and bereavement. However, indications of risk were present in some who had no service contact, including 14% of those with a diagnosis of mental illness (from a general practice or at accident and emergency department), 22% who had previously self-harmed, and 38% who had expressed suicidal ideas and/or intent.

They also showed contact with multiple agencies (i.e. mental health and social care/local authority and justice agencies) was more likely in girls than boys. The 'multiple contact' group, 9% of those who died, were more likely to have a family history of mental illness, substance misuse or domestic violence and higher rates of childhood abuse, social isolation, self-harm, alcohol and drug misuse. Nearly half (45%) of those in multiple contact were or had been looked after children.

National and local prevalence of suicide

All-persons^{cccxvi}

All-persons suicide has showed rates relatively stable between 10-12% across the South West between 2012-2018. In 2018, the South West had the third highest rate out of 9 regions.

Locally, rates above that of England were seen across Dorset during 2017-19, seen in figure 159 below. These are for all ages 10 years and above.

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Figure 159: Suicide rate, all persons/males/females, 2017-19
Source: PHE Public Health Profiles

Males

The South West had the second highest rate of male suicide in 2019 across all regions at 19.4 per 100,000 population. This was statistically significantly higher than the overall male England rate (16.7 per 100,000), seen in figure 160 below. Between 2016-18, the rate rose, with around 100 additional suicides seen across the South West by 2018.

Figure 4: Yorkshire and The Humber had the rate in 2019

Age-standardised suicide rates for English regions and registered in 2019



Figure 160: Suicide rate, males, by region, 2019
Source: ONS^{cccxvii}

Rates of suicide locally are reported under the new authorities of BCP and Dorset, in figure 161 below. It can be seen that between 2017-19, rates of male suicide were higher in BCP and significantly higher in Dorset than both SW and England rates, with 96 suicides recorded in BCP and 95 in Dorset.

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Suicide rate (Male) 2017 - 19

Export table as image Export table as CSV file

Area	Recent Trend	Count	Value
England	–	11,145	15.5
South West region	–	1,261	17.6
Torbay	–	45	27.3
Somerset	–	141	20.8
Cornwall	–	142	20.1
Dorset	–	95	20.1
Devon	–	188	18.6
Bournemouth, Christchurch and Poole	–	96	19.2

Figure 161: Suicide rate, males, 2017-19
Source: PHE Public Health Profiles

Females

For suicide rates in females, the South West had a lower rate, at 4.9 per 100,000 population, lower than the overall female England rate (5.2 per 100,000), seen in figure 162 below.

suicide rate in 2019

Age-standardised suicide rates for English regions and Wales registered in 2019



Figure 162: Suicide rate, females, by region, 2017-19
Source: ONS

When reviewing BCP and Dorset data, in figure 163 below, it can be seen that between 2017-19, rates of female suicide were significantly higher in BCP than the England and South West and somewhat higher in Dorset than England rates, in line with the South West. 42 suicides were recorded in BCP and 28 in Dorset.

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Area	Recent Trend	Count
England	–	3,643
South West region	–	405
Torbay	–	19
Bournemouth, Christchurch and Poole	–	42
Cornwall	–	45
Somerset	–	45
Plymouth	–	21
Devon	–	65
Dorset	–	28
Gloucestershire	–	44

Figure 163: Suicide rate, females, 2017-19
Source: PHE Public Health Profiles

Suicide in younger people

Data more specifically for people aged between 10 and 34 years of age, reported as a five-year average between 2013-2017 showed comparable figures to that of England and the South West, however, it does not provide an understanding of the position over the last 3-4 years, when increases have been seen locally within the total population over 10 years old.

Suicidal thoughts and attempted suicide

Perhaps of note, alongside understanding rates of suicide and hospital admissions for self-harm is the consideration of how many young people have thoughts of suicide. The APMS survey of 2014 reported around a quarter of those aged 16-24 report having had suicidal thoughts in their lifetime, higher than any other age group; around 35% of women and 20% of men had ‘suicidal thoughts ever’

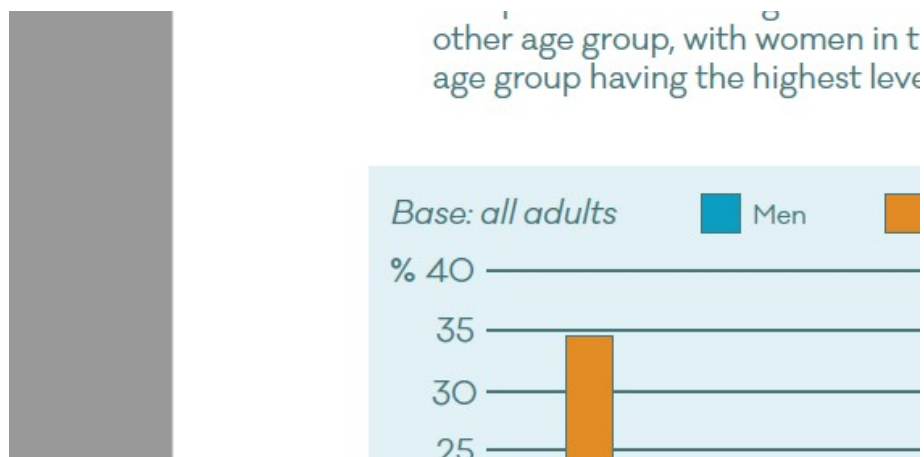


Figure 164: Suicidal thoughts ever, by sex
Source: McManus et al (2016) Adult Psychiatric Morbidity Survey

Nearly one in ten 16-24 year olds have attempted suicide in their lifetime (5% of men, and 13% of women). This is higher in LGBT+, with reports of between 11-32% of young people who identify as LGBT+ having attempted suicide in their lifetime^{cccxviii}.

Summary of Risk Factors

For children and young people with given characteristics, conditions or circumstances, the risk of experiencing or developing mental health disorder is significantly higher than in the general population.

Groups at greater risk covered within this section are wide-ranging. Children and young people from different ethnic backgrounds, with minority sexual and gender identities, who are obese, bullied, with poorer physical health states or with physical or learning disabilities, neurodiversity or special educational needs are at increased risk of experiencing mental disorders. Familial contexts known to increase the risk are those households with less healthy family functioning, low-income or with a parent in receipt of income-related benefits, with parents with poorer physical or mental health states, where children and younger people have roles as young carers or are military families. Children and young people who have experienced abuse or neglect or who are involved with social services or in care, absent or excluded from school, in contact with youth justice, homeless, asylum-seeking or not engaged in employment, education or training are also at increased risk of mental disorder.

Community and structural levels factors also include living in poverty, poorer quality or colder housing, poorer quality of education, and wider systems' inequalities and discrimination.

Health inequalities are evident in relation to mental health for children and young people within vulnerable groups, for instance, those excluded from school, young offenders, children in need and care leavers, amongst others, are far more likely to be also living in poverty, to have communication difficulties, to have SEN, to be absent or excluded from school, have reduced educational attainment, reduced social support or networks, increased risk behaviours and to experience substance misuse problems; all of which carry singular increased risk to wellbeing and mental health.

Some children and young people experience multiple risk factors, and there is complex interplay between these factors that further increase the risk of mental health disorder. This compounding effect, or mutual reinforcement, can vastly increase the likelihood of experiencing other risk factors and/or mental disorder, and have far-reaching consequences for health, achievement and opportunity, with effects extending into adulthood.

Effects of these inequalities can be seen in reduced and poorer access to, and outcomes from, in the contact some of these children and young people have with services, support. These impacts continue in reduced attainment, employment, income and future opportunity.

Protective factors that influence wellbeing and mental health

There is the understanding that while the absence of mental ill-health enables good outcomes, achievement of positive wellbeing affords children and young people better physical health, with less health-damaging behaviours, longer lives lived without ill-health, increased life expectancy and reduced risk of other diseases and mortality. They are less likely to experience social inequalities and have increased educational achievement and economic opportunity. These positive effects can be seen in those who have existing mental health conditions, when improvements are achieved.

Protective factors and resilience

Protective factors, like risk factors, can be complex, multi-factorial, wide-ranging and interlinked. Their influence on the wellbeing and mental health of children and young people operates at individual, family, community and structural levels.

Documented protective factors believed to decrease vulnerability and aid the promotion, and maintenance, of wellbeing and mental health in children and young people exist within a number of spheres^{xxii,xxxv,xxxvii}.

- **Individual** factors include positive early attachment, a healthy lifestyle, good physical health, physical activity, good communication skills, self-esteem, experiences of achievement and the ability to recognise and regulate own emotions.
- **Family** factors include good family mental wellbeing, affection and styles of parenting which are loving, trusting and supportive and someone from the family being in work.
- **Learning environment** factors such as engagement with education, opportunity to participate, positive relationships with teachers and peers and positive whole-school approaches.
- **Community** factors include participation in the wider community, a supportive network, feeling socially included and valued, good housing, feeling safe from violence and with opportunities to be active.

Resilience is considered key in developing, maintaining and promoting wellbeing and mental health. Multiple definitions of resilience exist, including an individual's 'capacity to bounce back from adversity' or 'the capacity of a dynamic system to adapt successfully to disturbances that threaten the viability, the function, or the development of that system' or something that implies the on-going dynamism of the state 'a process to harness resources to sustain well-being'^{xxxv,cccix}.

Evidence suggests action can be taken to support individuals' resilience, moderating the cumulative impact of adverse childhood experiences^{cccxx}. Developing resilience through access to a trusted adult in childhood, supportive friends and being engaged in community activities, such as sports, reduced the risks of developing mental illness; even in those who experienced high levels of ACEs. Having sources to support resilience was shown to more than halve present mental illness in adults with four or more ACEs from 29% to 14%, and ever having felt suicidal or self-harmed from 39% to 17%.

Participation in sports both as a child and adult was a further source of resilience to mental illness, with being in current treatment for mental illness reducing from 23% in adults that did not regularly participate in sports to 12% in those that did.

Wider influences were also discussed, and included:

- Stability (home, employment, school)
- Sleep
- Money
- Food
- Volunteering
- Hugs
- Hobbies (art, gaming, reading)
- Physical Activity
- Music
- Pets
- TV/film
- Shopping
- Self-care and self-regulation (impacting on decisions e.g. removing oneself from unsafe places or building personal resilience)

They also highlighted the differential exposure to both risk and protective influencing factors for different individuals, such as young carers not having much time for hobbies when considering their caring responsibilities.

Overall

The indicators PHE include within their mental health and wellbeing profile under ‘protective factors’ are shown below in figure 165, with a focus on good levels of development, in both all children and those in receipt of free school meals. They also measure the proportion of 15 year olds reporting positive life satisfaction and the mean score from the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), which covers a range of feelings and attitudes towards life.

Lastly, they report on educational attainment at GCSE level for all children and specifically for children in care.

The data relating to this in figure 165 below, is provided under the previous three local authorities and shows in 2018/19 shows that school readiness pan-Dorset was generally in line with or above the England average, although children in receipt of Free School Meals were less likely to achieve similar levels of development at the end of Reception to those who were not.

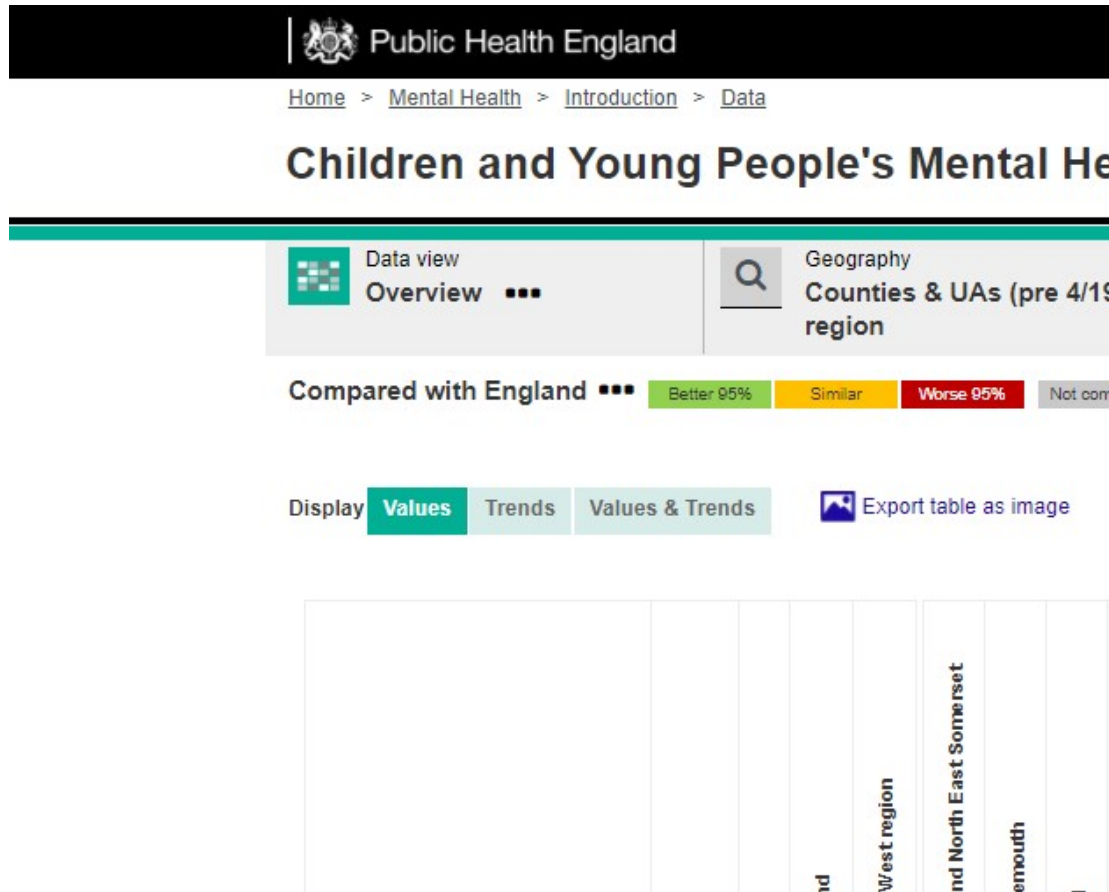


Figure 165: PHE mental health and wellbeing profile: ‘protective factors’, various years
 Source: PHE Public Health Profiles

The above data reports on attainment in the pre-2016 manner, of 5 GCSE grade attainment, which is not similarly available locally for children in care. The measures used more recently for children in care are reflected earlier in this report, under attainment 8 and progress 8 scores and showed a significant difference in the attainment of children in care over the attainment of all children.

It can be seen from figure 165 that there was a higher percentage of children achieving a good level of development in BCP than in Dorset UA. These were in line with, or above, the England percentage at 71.8%, and South West at 72%.

Physical activity

Regular, moderate-to-vigorous physical activity (MVPA) improves health and fitness, strengthens muscles and bones, develops co-ordination, maintains healthy weight, improves sleep, makes you feel good, builds confidence and social skills and improves concentration and learning.

Good physical activity habits established in childhood and adolescence are more likely to be carried through into adulthood.

Figure 166 below shows the percentage of children aged 5-16 meeting the recommended level of physical activity per week. It can be seen the percentage in BCP is in line with that of England, while Dorset was above. The figures are still only showing around half of children are meeting that aim.

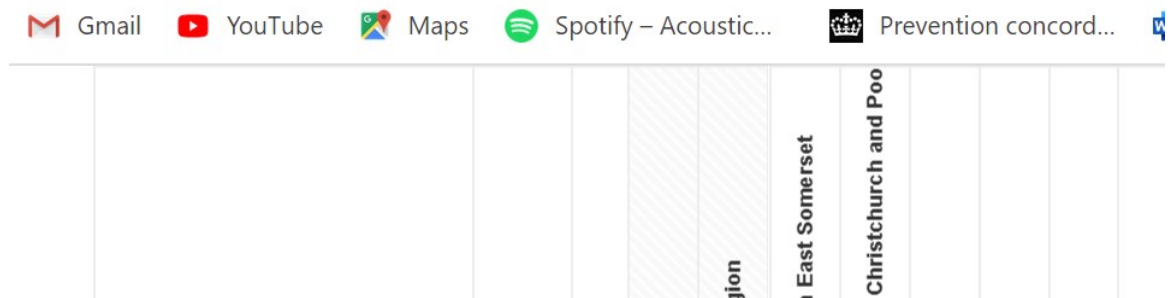


Figure 166: Percentage of children and young people who are physically active, ages 5-16, 2018/19
Source: PHE Public Health Profiles

Figure 167 below shows the percentage of young people aged 15 who were physically active for at least an hour every day²². While pan-Dorset figures are in line with that of England, the percentages show only around 15% of the local population achieves that goal.

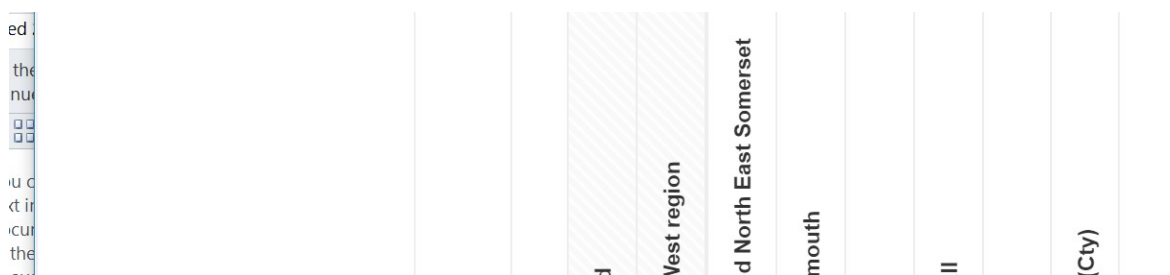


Figure 167: Percentage of young people, aged 15, physically active for at least an hour every day, and with sedentary time over 7 hours per day.
Source: PHE Public Health Profiles

The indicator in figure 167 above regarding sedentary time excluded time at school, although did include homework and study time alongside that of gaming, emailing, on-line activities and smartphone use on weekdays in those aged 15. In 2014/15 70% of young people in England were sedentary for more than seven hours a day, and similarly in Bournemouth and Poole. Dorset CC had slightly less at 61.6%.

²² E.g. moderate and aerobic walking, running, or anything that makes their hearts beat faster and breathe fast. This should include muscle/bone strengthening aspects (CDC, 2021 at <https://www.cdc.gov/physicalactivity/basics/children/index.htm>).

Access to outdoor space

The below indicators were developed using data from either all age or 16 years plus residents, but provide an indication of the amount of outdoor space accessed and available to children and young people.

Having access to green space such as woodland, is known to support wellbeing and allow people to engage in physical activity and studies show people are more likely to make use of woodland if they are closer to home. In 2015 in Bournemouth and Poole there was a greater percentage of the population with accessible woodland within 500 metres of where they live than in England, while in Dorset there was a smaller percentage, seen in figure 168 below.

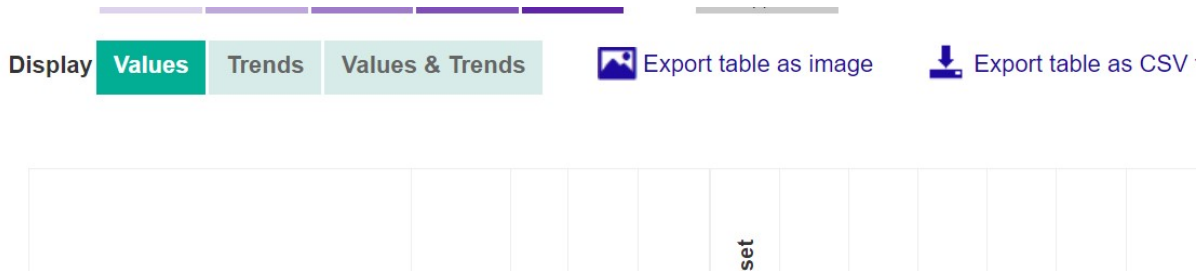


Figure 168: Access to woodland, 2015
Source: PHE Public Health Profiles

Seen in figure 169 below between 2015-16 in Bournemouth and Dorset there were greater estimated proportions of residents visiting the natural environment for health or exercise purposes in the previous seven days than in England. Poole showed no data.

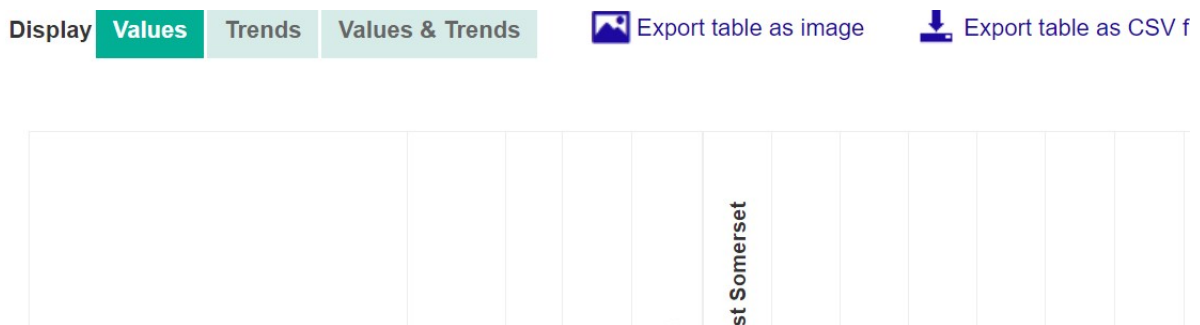


Figure 169: Utilisation of outdoor space, 2015/16
Source: PHE Public Health Profiles

Fruit and veg

Diet and nutrition are important for physical and mental health and poor diet is a major risk factor for ill-health and premature death.

In 2014/15, the proportion of young people aged 15 consuming 5 or more portions of fruit and vegetables daily was around half in England. Bournemouth and Dorset had slightly more at 57% and 58.1% respectively, while Poole was in line with England.



Figure 170: Indicators
Source: PHE Public Health Profiles

Service demand, uptake, activity and demographic information

CAMHS - National

As highlighted, the most recent survey of the mental health of children and young people in Great Britain in 2017ⁱ estimated:

- 1 in 8 children (12.8%) of 5-19 year olds had at least one mental disorder²³, up from 9.6% in the previous survey in 2004^{xvii}. 1 in 20 of 5-19 year olds met the criteria for two or more mental disorders.
- Within age groups, those identified as having at least one mental disorder were:
 - 1 in 18 of those aged 2-4 years old
 - 1 in 10 of those aged between 5-10 years
 - 1 in 7 of those aged between 11-16 years,.
- Rates were shown to increase with age; 5.5% of 2 to 4 year old children experienced a mental disorder, compared with 16.9% of 17 to 19 year olds.

From these statistics, applying mathematical rounding, it can be assumed that within an average classroom of 30 individuals, aged between 5-19 years old, four would have a mental disorder, two of which could meet the criteria for having more than two or more disorders.

With this modelling applied to the prevalence figures within smaller age range groupings, within a class of 30 children, the following could meet the criteria for one mental disorder:

- 0-4 years: 2 children
- 5-10 years: 3 children
- 11-16 years: 4 children
- 17-19 years: 5 individuals

CAMHS services – National picture

This rising prevalence has been seen in upward changes in referral rates. National NHS benchmarking reports of CAMHS services^{cccxxi} reports a clear upward trend in referrals to community CAMHS more than doubling in the eight years between 2012/13 and 2019/2020, with numbers of referrals accepted mostly mirroring the increased demand.

They do comment that despite increased capacity, demand continues to outstrip supply with increases in young people on waiting lists to access CAMHS and waiting times increasing year-on-year since 2016/17.

A combination of factors have created growing pressure on the system; financial constraints have occurred alongside rising referrals, but also increasing complexity and severity of presenting problems. This has increased the demand for all components of CAMHS, including increased length of stays in inpatient facilities^{iv}.

The NHS benchmarking reports from 2018/19 and 2019/20 show, alongside rising referrals, a national trend of long wait times in many areas and large variation in the speed of access to services. They also for the first time have explored the ethnicity breakdown of the CAMHS setting in depth, reporting that on a national level, in community settings the ethnicity breakdown shows less diversity than the general population, however, inpatient admissions see a marginal over-representation of children and young people from minority ethnic backgrounds. These findings reaffirm the need to ensure diversity in the CAMHS service offer.

²³ Mental disorders were identified according to International Classification of Diseases (ICD-10) standardised diagnostic criteria, using the Development and Well-Being Assessment (DAWBA). To count as a disorder, symptoms had to cause significant distress to the child or impair their functioning. All cases were reviewed by clinically trained raters.

An independent national report from the Education Policy Institute in 2020^{cliv}, reviewing data from 2018-19 regarding access to CAMHS, showed a number of areas of concern.

They found approximately a quarter of children and young people referred to specialist mental health services were not accepted into treatment, including those with an eating disorder and those who had self-harmed or experienced abuse.

They commented that, despite the £1.4bn of extra funding announced in 2015, the proportion of rejected referrals has not changed since their data collection began four years previous. They also commented that this is coupled with decommissioning of alternative mental health support services for those unable to access CAMHS in many areas during the past decade.

They reported widespread variation in the levels of referrals not accepted, with examples given of providers in London rejecting an average of 17 per cent of referrals, compared with around 28 per cent in the South of England, Midlands and East, and 22 per cent in the North.

The most common reasons provided for referral rejection were young people’s conditions being unsuitable for CAMHS, not meeting eligibility criteria or age specification for the service.

These findings correlated with their previous research and the authors expressed concerns over a growing number of children and young people who may have a greater complexity of need, those who do not fit clearly into diagnostic boxes or those with lower-level mental health needs and older adolescents or young adults being unable to access the support they require.

Another GP survey^{cccxxii} found 54% of referrals to CAMHS for patients aged 11-18 are not accepted. It was reported GPs only refer those ‘most at risk’ and of those accepted, 28% wait up to 12 months for treatment, while a further 27% wait three to six months.

A 2020 national GP survey of around 1000 GP’s, conducted by a mental health charity^{cccxxiii}, found 83% of GPs reported seeing more young patients with mental health difficulties than they did a year ago, however, nine out of 10 GPs said mental health services for children and young people are inadequate. 73% of those surveyed believe CAMHS services have deteriorated over the past year and 99% believe those patients they have referred to CAMHS will come to harm whilst awaiting treatment.

Figure 171 below demonstrates proportions of GPs who viewed existing services in supporting young patients with mental health problems; 87% in the South West replied extremely or very inadequate.

4.3 By region - Which of the following best describes your view on existing health and social care services to support patients aged 11-18 with mental health problems?



Figure 171: National GP survey findings, 2020: GP view on adequacy of existing services to support patients with mental health problems.
Source: Stem4^{cccxxiii}

GPs stated 54% of those children and young people between 11-18 years old referred by them to CAMHS services are rejected; yet doctors believe they are only referring 'most at risk' patients.

Shown in figure 172, less than a third of those GPs surveyed said they had the ability to refer patients rejected for CAMHS treatment to other NHS services such as talking therapies, with many feeling forced to direct patients back to overloaded school or local charity services or awaiting re-referral to CAMHS at a later stage; the vast majority of GPs reported fearing patients in this position could come to harm.

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4.11 If a patient aged 11 to 18 is rejected by CAHMS for treatment to the young person or their carer/parent?

Only 31% of GPs say they are able to refer young patients rejected by services, such as talking therapies; most refer the patients back to their own GP practice or are overwhelmed by demand.

I would refer the patient to our own GP practice

Figure 172: National GP survey findings, 2020: GP alternative avenues for support if referral rejected by CAMHS
Source: Stem4^{ccccciii}

Two potential issues are raised from the above figure, with over half of GPs (51%) advising children and young people to wait for a progression of symptoms before re-referral to mental health services and the conceivable widening of inequalities in access with a large percentage of GPs (42%) recommending the use of private treatment, which only some families would be able to afford or access.

The national GP poll also reported, of patients whose referrals were accepted, 28% wait up to 12 months for treatment, while a further 27% wait three to six months.

Dorset CAMHS - Local picture

DHC CAMHS provides a range of community mental health services for children and young people across Dorset:

- Community CAMHS teams (sometimes referred to as Core-CAMHS or C-CAMHS)
- Eating Disorders Service (EDS or YPEDS)
- Early Intervention in Psychosis (EIS)
- Out of hours Crisis service
- Liaison psychiatry
- Forensic CAMHS
- LD CAMHS
- Input into the Youth Offending Service (YOS)

The Community CAMHS service provides services across six localities in Dorset:

- Bournemouth and Christchurch
- Poole
- North Dorset
- East Dorset
- West Dorset
- Weymouth and Portland

C-CAMHS offers therapeutic interventions for those children and young people and their families without additional needs in the areas of eating disorder, learning disability or psychosis.

Service Data for C-CAMHS

It is useful to initially consider the local position against other national organisations. The most recent and previous NHS Benchmarking Network data reports from 2019/20 and 2018/19 are both shown below to highlight DHC’s position on key metrics, compared to other participants from across the UK and States of Jersey. Diamonds represent Dorset CAMHS position (CAM116) in relation to the average (mean) and middle (median) point of all data collected.

2019/20:

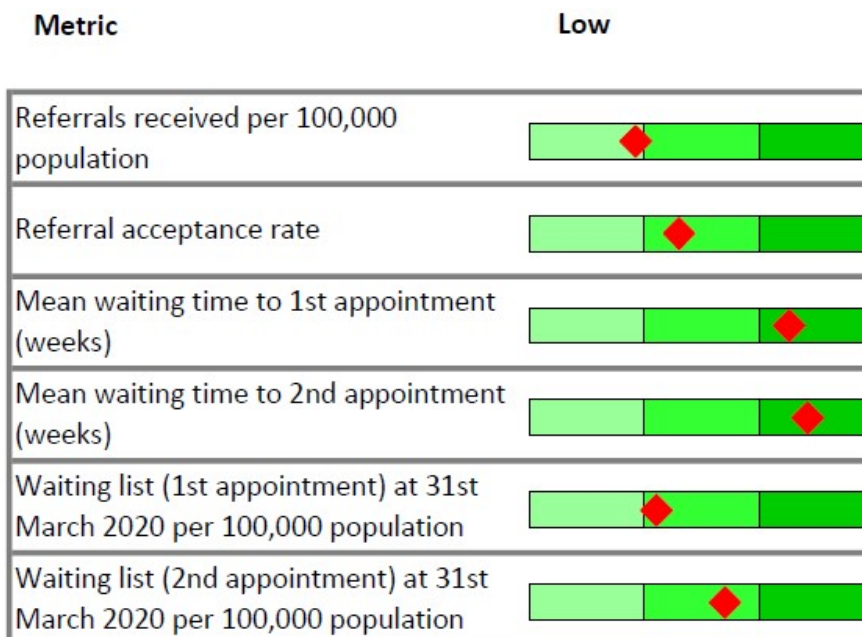


Figure 173: CAMHS Benchmarking Report, 2019/20
Source: NHS Benchmarking Network Report (2019/20)

2018/19:

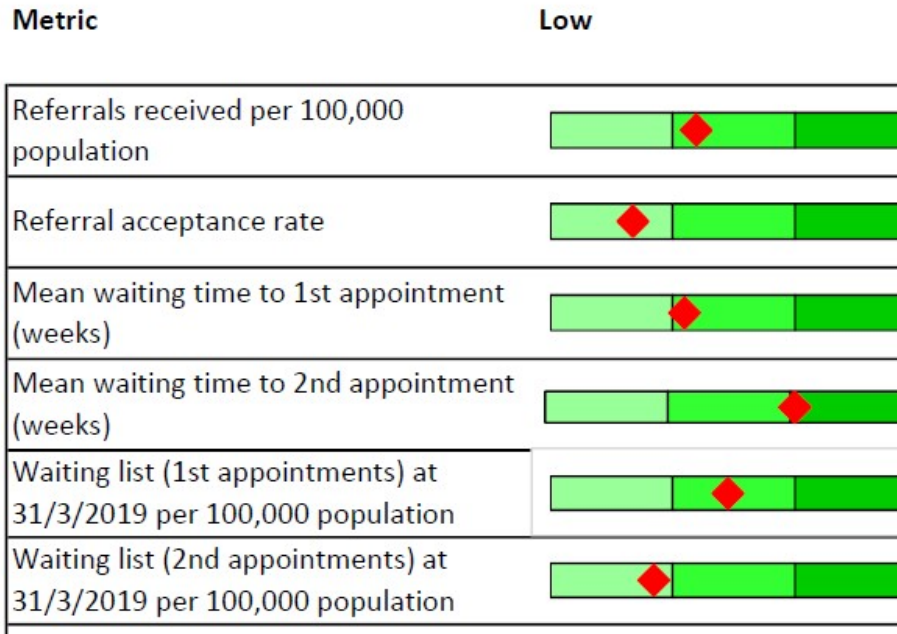


Figure 174: CAMHS Benchmarking Report, 2018/19
Source: NHS Benchmarking Network Report (2018/19)

As can be seen in figures 173 and 174 above, Dorset CAMHS has received fewer referrals than national comparators, but also historically accepted less of those received; rate of acceptance has increased by 10% over the last year moving closer to national average.

Dorset CAMHS had significantly lower waiting lists for both first and second appointments per 100,000 population, when compared with average and middle points for other organisations, and has greater numbers of patients on caseload per 100,000 population in both years.

Average waiting time to first appointment was less than the national average over both years, but has increased by two weeks in 2019/20 benchmarking data. The wait for second appointments has remained similar to the national average over the last two years.

Workforce numbers demonstrated 30 staff more, per 100,000 population, than the average in 2019/20; an increase of 14 additional staff over local figures from 2018/19. This is likely a reflection of the on-going investment, and increase in staffing, in differing offers of support for children and young people with mental health needs.

Costs in Dorset were around £900,000 higher than the national average spend per 100,000 population in 2019/20, an increase from the year previous which was around £650,000 above the national average for spend per 100,000 population.

Impact of COVID-19 pandemic

While discussing the position of the CAMHS service it is important to appreciate the effect of the COVID-19 pandemic. There has been significant impact on all areas of healthcare delivery and usage and to look only at service data over the last 6-9 months would incorporate a substantial period in which the demand for, and delivery of, the service is not representative of business as usual activity.

Therefore, where possible as much data from the 12 months preceding the COVID-19 pandemic has been used and that of the service as it has been since the beginning of the pandemic; from March 2020 until late 2020. Although the latter will reflect a different pattern of business than that preceding the pandemic, it is prudent to review as indications are that the virus will affect business as usual for the short and medium-term.

All charts are extracted from Dorset Healthcare's internal reporting system, Business Objects, either from previously generated reports such as the 'BAU Dashboard' or interpreted from raw data.

Children and young people – Five Year Forward View Access indicator

The Five Year Forward View publication shared national percentage targets for increasing access to mental health services for those children and young people with a diagnosable mental health condition, for health and other partners within the wider system to work towards. Local efforts have not achieved target thresholds previously but system intentions to achieve the 2020/21 35% target may be somewhat affected by the pandemic. There have been programmes initiated, such as revised service provision and improved data input of outcomes for appointments, to facilitate this.

Previous and YTD achievement is documented in table 42 below:

Table 42: Measurement of local achievement against national targets for access.

Year	National Target	Local Achieved
2017/18	30%	-
2018/19	32%	30%
2019/20	34%	30%
2020/21	35%	30% ²⁴

²⁴ 30% was the year to date figure at December 2020

Referrals and Discharges – Trends

Both referrals and discharges seen during the 12-month prior to March 2020 follow a similar trend, bar over the summer period for referrals which may be a usual seasonal dip. This can be seen in figure 175 below.

Following March 2020, there was a significant drop in referrals, which then began to rise in June 2020; by October 2020 there were just over half the level of referrals there had been the previous year. Discharges followed usual movement trends, but at a lower level than in the preceding 12 months.

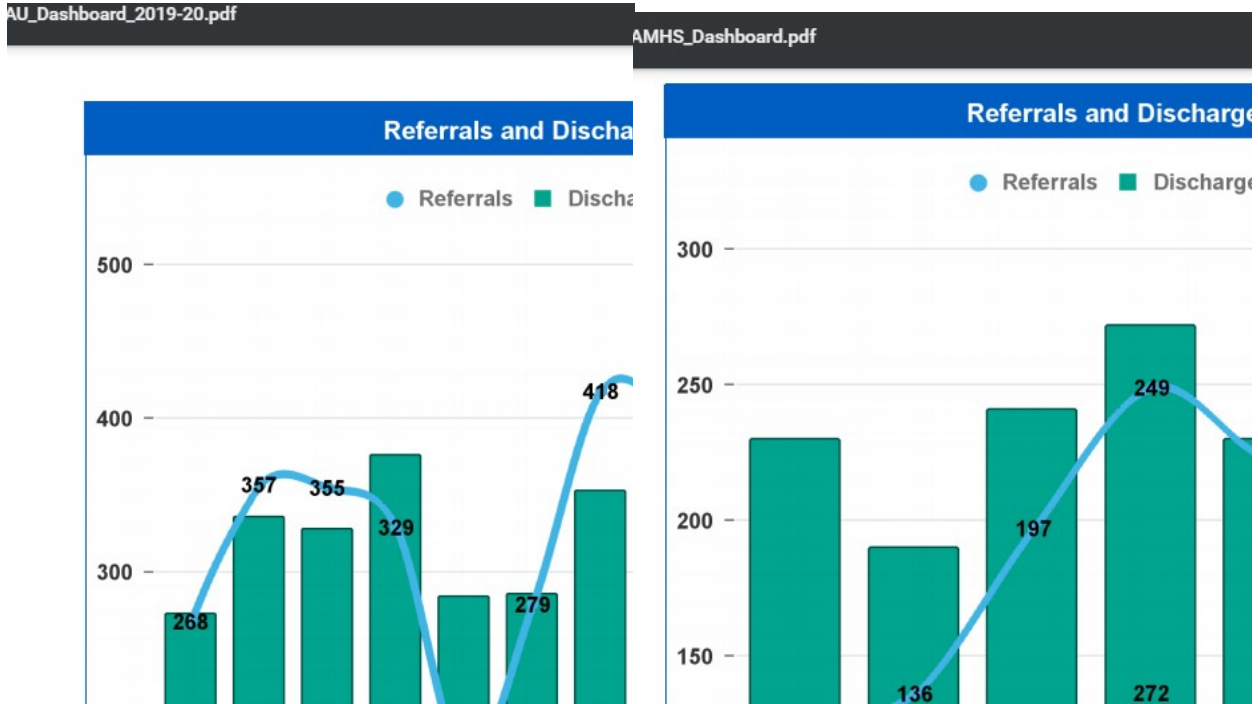


Figure 175: Dorset CAMHS: Monthly referrals and Discharges April 2019-October 2020
Source: DHC Business Objects Data Reports

The charts below, in figure 176, show the trend and growth/change in referrals over the previous 19 months. The first highlights the decline just prior to, and a large drop during, the pandemic and the second figure shows how referrals rates had declined in comparison with last year but have begun to rise slightly during the past few months.

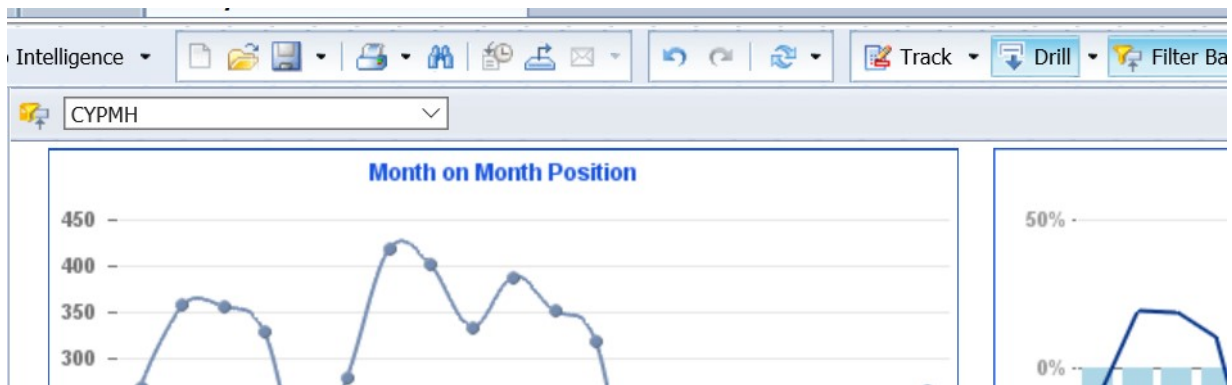


Figure 176: Dorset-CAMHS: monthly referrals April 2019-October 2020 and annual comparison
Source: DHC Business Objects Data Reports

Referrals – Detail

Shown in figure 175 above, prior to March 2020, referrals showed a variable picture of 3,975 referrals over a 12-month period, equating to an average of 331 referrals per month. From April to October 2020 there were around 1,400 referrals, which averaged 193 per month. This was a 35% decrease in referrals from the same period in 2019.

Referral priority

Comparing the period following lockdown of April-December 2020 with the same period in the previous year has not possible using routinely presented data. Data over a 12-month period of April 2019-Mar 2020 showed 13% of referrals were classed as ‘urgent’ and 1.3% as ‘emergency’. In the year to date, data between April-December 2020, the proportion of referrals classed as ‘urgent’ have remained similar at 12% thus far while those classed as ‘emergency’ have risen to around 4%.

Referral acceptance

Between April 2019 and March 2020, seen below in figure 177, the majority of months (7/12) prior to COVID-19 showed an acceptance rate within the 60-70% range, meaning 30-40% of referrals were not accepted, for reasons which are not demonstrated within this simplistic view.

The remaining five months showed acceptance rates of 73-82%, with inappropriate referrals of 18-27%.

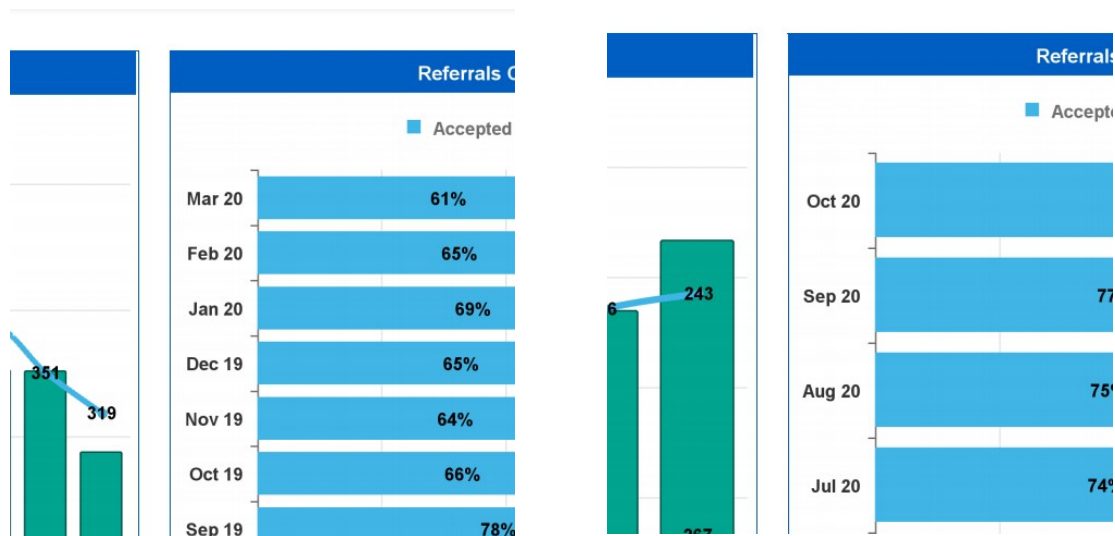


Figure 177: Dorset CAMHS: Proportions of referral accepted or inappropriate
Source: DHC Business Objects Data Reports

A greater proportion of referrals were accepted between April-October 2020, seen below, with acceptance rates of between 70-85%, with therefore between 15-30% deemed inappropriate. Examples of how these percentages equate to numbers, would be 257 accepted and 145 declined referrals from the 402 received in November 2019, and 184 accepted and 65 declined referrals from the 249 received in July 2020.

These figures highlight that, although fluctuating, a considerable proportion of children and young people are referred to a service which is not seen as the appropriate avenue for addressing their needs.

Reasons for this are not explored here, but understanding of the factors that lead to classification of referrals as inappropriate is warranted to enable increased appropriate referrals and greater understanding of other avenues for referrers.

Referral sources, from April-November 2020, show the majority come from GPs (48%), followed by A&E, Hospital-based Paediatrics, and LA Social Services (figure 178). Exploration of inappropriate referrals could explore whether there is a source of increased referrals classified as inappropriate.

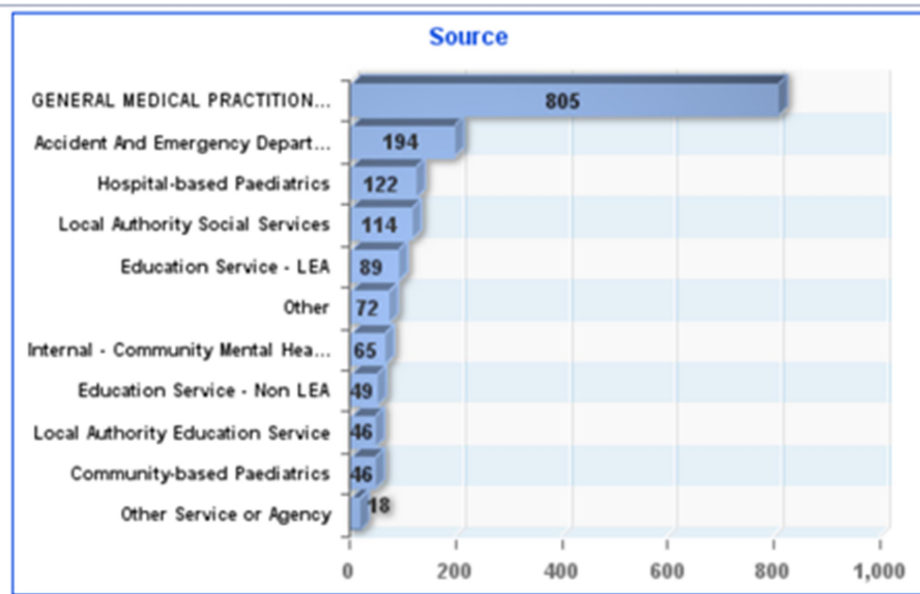


Figure 178: Dorset CAMHS: Referral sources, April-November 2020
Source: DHC Business Objects Data Reports

Waiting times

In Dorset waiting times are locally agreed between DCCG and DHC, not nationally mandated. Other areas may have different locally-agreed standards around waiting times.

4-week wait: Referral to Assessment

It can be seen below, in figure 179, that in the 12-months preceding the pandemic, between 74-82% of children and young people were seen within 4 weeks of their referral. During the pandemic rates have remained within the same range, aside from October 2020 which saw a rise to 97%. This data extraction does not allow for exploration of the reason behind the rise in October 2020. The fiscal year to date (FYTD) position for 2020 is at a slightly higher level to the year previous.

4 Week Month On Month By Service (FYTD)

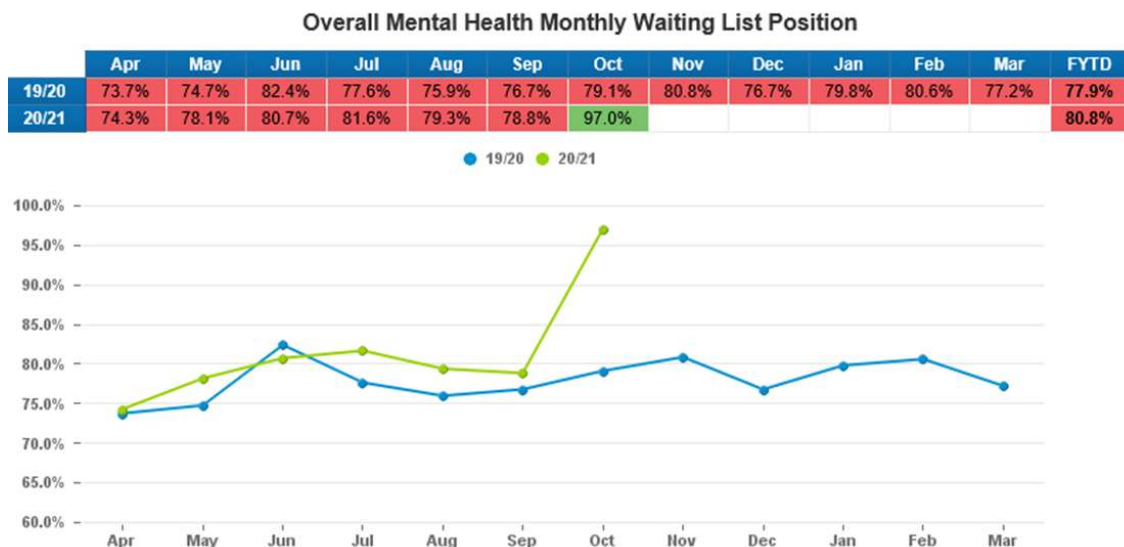


Figure 179: Dorset CAMHS: Waiting list position (4-week wait), April 2019-October 2020
Source: DHC Business Objects Data Reports

8-week wait: Referral to Assessment

It can be seen below, in figure 179, that in the 12-months preceding the pandemic, between 56-83% of children and young people were seen within 8 weeks of referral. During the pandemic the rates initially dropped between March and May 2020 to between 51-58% seen within 8 weeks. These rates stabilised to levels similar to pre-pandemic levels at between 71-86% from June onwards, leaving the FYTD position for 2020 at a similar level to the year previous.

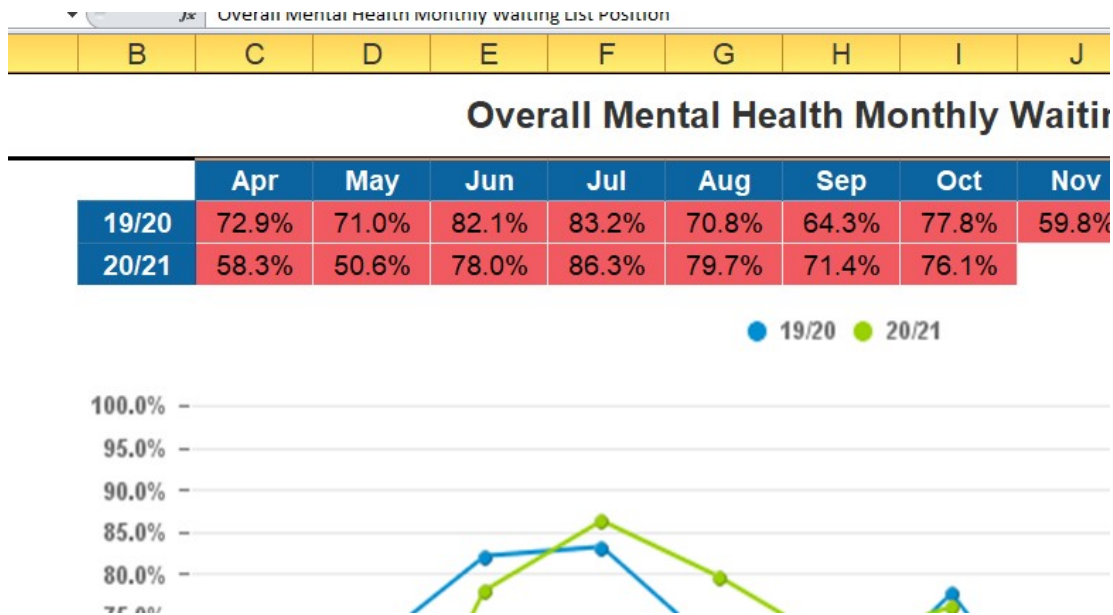


Figure 180: Dorset CAMHS: Waiting list position (8-week wait), April 2019-October 2020
Source: DHC Business Objects Data Reports

Waiting time for a first appointment

The average wait until first appointment stands at 59 days across all teams.

Average Time Waited For 1st Appointment

	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Last 12 Months
All Teams	49.3	56.5	58.7	57.3	63.7	64.0	64.4	62.9	52.3	49.9	64.4	65.2	58.5

Figure 181: Dorset CAMHS: Waiting time for first appointment, December 2019-November 2020
Source: DHC Business Objects Data Reports

Referral to Treatment time (RTT)

The data on RTT shows in the 3 months preceding the pandemic, around 64-73% compliance within a 16 week RTT time, and the picture changed considerably between March and July 2020, with a steady increase during August-October, and a more sizeable increase in those seen in November.

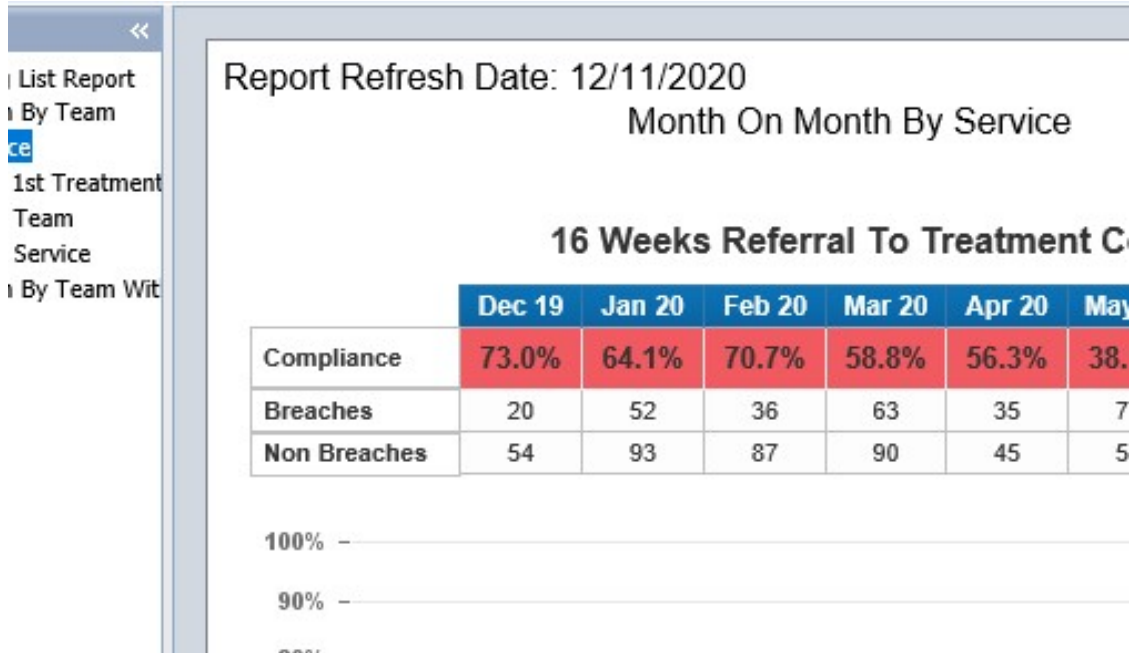


Figure 182: Dorset CAMHS: Referral to Treatment time, December 2019-November 2020
Source: DHC Business Objects Data Reports

Contacts

There has been an approximately 10% growth in contacts this year from April-October 2020, at 21,062 referrals, compared with 18,951 in the previous months of April-October 2019.

Attendance and Did Not Attend (DNA) rates

The NHS CAMHS benchmarking reports have reported a national average for DNAs of 10% of appointments outcomed as DNA over the past two years, and around 11% in the preceding 6 years.

In November 2020 DHC’s reporting system shows, for FYTD, attendance for CAMHS at around 74% and DNA rates of around 14%.

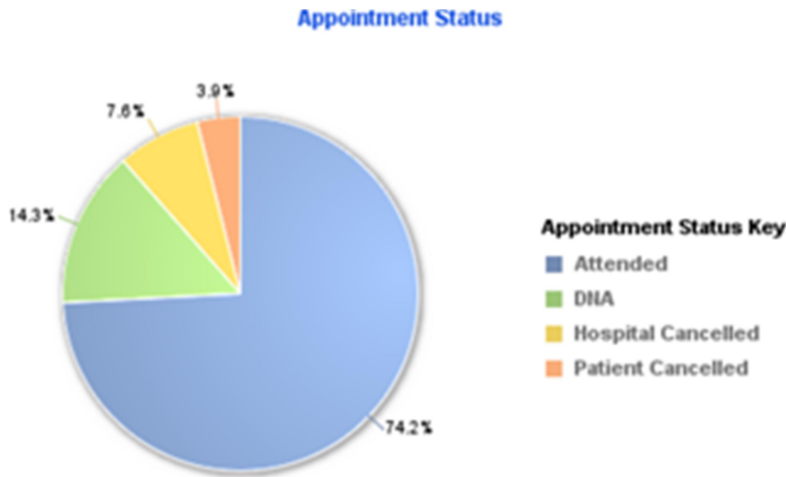


Figure 183: Dorset CAMHS: Appointment status outcomes, November 2020 (FYTD)
Source: DHC Business Objects Data Reports

Month by month report data for January-November 2020, shown in figure 184 below, shows average DNA rates of approximately 22% for first, and 16% for follow-up, appointments.

During the same period, the overall service average DNA rate of 16% is lower, drawn from data below and driven by increased numbers of follow-up appointments with lower DNA rates; it is, however, above the average DNA rate of 10% for all mental health services in the Trust.

It is noted the DNA rate may have been somewhat lower had we not had the pandemic, given the DNA rate for first appointments, and to a lesser degree the overall DNA rate, appears to have been impacted by a spike in DNA rates for first appointments, seen between March and July. Removing the ‘spike’ months of March-July would give a DNA rate of around 13% for first appointments, however, this is only a crude measure and will need to be observed over time.

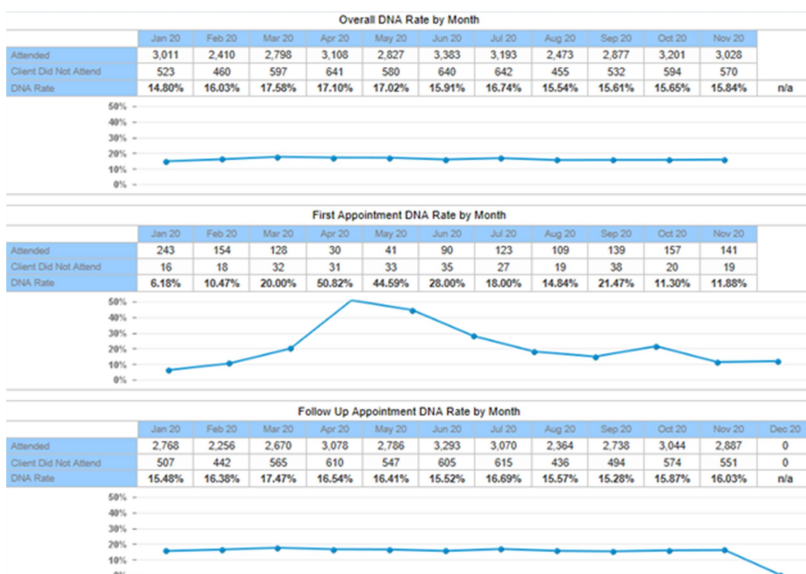


Figure 184: Dorset CAMHS: DNA rates, overall/first appointment / follow-up appointment, January-November 2020
Source: DHC Business Objects Data Reports

Caseload

Caseloads, at time of extraction, were greatest in Bournemouth & Christchurch with around three times the volume of rural areas, followed by Poole, then Weymouth and Portland areas with other rural teams having smaller caseloads. A crude measure of cases per 100,000 population, based on caseload data applied to the 2019 mid-year population of 0-18 year olds, demonstrated a rate of 1,370 per 100,000 population. This is lower than the rate of 2,168 per 100,000 seen previously in the 2018/19 NHS Benchmarking report and the 2,166 cases per 100,000 reported in the latest report, from data at 31 March 2020.

Outcome Measures

IT system reconfigurations since 2018 mean ‘paired’ (pre and post treatment) outcome measures are not available electronically but on paper-based records. To extract this data would require a paper-based retrospective audit, which is beyond the scope of this review. There has been a paper-based audit of the wellbeing practitioner offer within CAMHS, the outcomes of which are detailed below.

Wellbeing Practitioner service outcomes

Retrospective analysis was performed, within service, from data collected between April 2019 and March 2020, of 135 cases of 1-1 therapies. Reviewing interventions offered, shown in figure 185, ‘worry management’ and ‘combined interventions’ were most common, followed by ‘behavioural activation’. The majority of work completed was 1-1 therapy at 64%, with a further 22% of workload being group activities. Attendance for 1:1 therapy appointments was at 73%, with DNA rates of 11%.

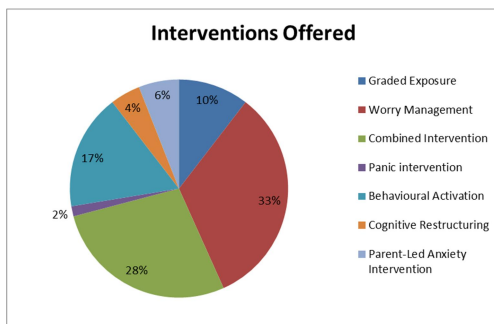


Figure 185: Dorset CAMHS Wellbeing Practitioner service: Interventions offered, April 2019- March 2020
Source: Internal DHC report

Group Session work analysed from a small sample showed 38% attendance and 43% DNAs. It was noted there may be differences between rural and urban attendance, possibly due to geography and transport links. Groups were operated within service working hours.

92 sets of ‘paired’ data (pre and post outcome of intervention measures from the same individual) were available to analyse. Figure 186 below shows level of change seen in the paired outcome measure from the ‘Revised Child Anxiety and Depression Scale’ (RCADS). The RCADS is a 47-item, youth self-report questionnaire.

Change observed in Anxiety and Depression (RCADS)

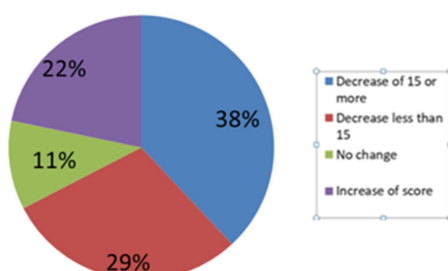


Figure 186: Dorset CAMHS Wellbeing Practitioner service: RCADS score
Source: Internal DHC report

High levels of improvement were determined as a decrease of 15 or more points, with slight improvement seen with a decrease of less than 15. Using this approach, it was seen that 67% of children and young people showed improvement, with a reduction in scores.

118 paired pre-post treatment ‘Outcome Rating Scale’ (ORS) measures were also analysed. The ORS is a simple, four-item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention. These include symptom distress, interpersonal well-being, social role, and overall well-being.

It was seen that 47 individuals showed improvement, with 12 showing deterioration and 49 no reliable change.

Table 43: Dorset CAMHS Wellbeing Practitioner service: ORS measures analysis

Significant improvement	35
Reliable improvement	22
Reliable deterioration	12
No reliable change	49

Source: Internal DHC report

Pathways

Pathways are selected on the ‘primary need’ of a child or young person, however they may have other needs that would also fit another pathway.

It can be seen from figure below that most children and young people are on pathways for ‘Co-occurring emotional difficulties’ (n=464, 23%), then ‘Both behaviour and emotional difficulties’ (n=277, 14%), followed by ‘General Anxiety Disorder/Panic’ (n=217, 11%) and then ‘Depression’ (n=187, 9%). The four of these total 57% of the pathways children and young people are on.

Breakdowns by team locations are also shown for reference.

	Bournemouth & Christchurch	East Dorset	North Dorset
ADHD	37	6	4
Attachment disorder	56	14	
Autism	60	18	7
Behavioural &/or conduct	25	6	1
Bipolar	1		
Both behaviour & emotional difficulties	120	39	21
Co-occurring emotional difficulties	166	39	68
Depression	49	13	17
Difficulties not covered by other groups	2	2	
Difficulties of severe impact	9	4	5
Eating disorder	1		
GAD/Panic	53	25	15
Gender identity	5		1
Neurodevelopmental Asses as only pathwa	27	1	2
OCD inc as a sympton of ASD/Tourettes	22	7	6
Presentation suggestive of potential BPD	1		
Psychosis	2		1
PTSD & Adjustment & Acute Stress	22	8	9
Selective mutism	2	1	
Self-Harm	11	5	1

Figure 187: Dorset CAMHS: ‘Primary need’ pathways
Source: DHC Business Objects Data Reports (extracted 11/11/20)

Discharges – Detail

Referring to figure 175 earlier in this section, it can be seen that, prior to March 2020, discharges showed a variable picture month by month with 3,900 over a 12-month period, equating to an average of 325 per month. From April to September 2020 there were 1,398 which averaged 233 discharges per month.

CAMHS Gateway (East)

In September 2020, a new ‘Gateway’ service was launched to act as the ‘front door’ of CAMHS and to ultimately reduce wait time for assessments and treatments. It will undertake all assessments for referrals, triage, signpost and provide some brief lower level intervention. Brief interventions will be offered for lower-level symptoms such as anxiety and depression, provided in a variety of ways such as 1-1, group work, webinars and computerised cognitive behavioural therapy (C-CBT).

Patients are assessed for level of need and if more help is required or more moderate/severe symptoms are experienced, they will be seen by Community CAMHS.

Currently the Gateway service is in East Dorset covering Bournemouth, Poole and Christchurch GP surgery areas, with the plan to be available across the county next year.

For those young people aged 16-18 years old, they will be able to self-refer in East Dorset during the pilot.

Referrals and Discharges – CAMHS Gateway

Shown in figure 188 below, there has been a steady increase in referrals since launching the service in September 2020, with 375 open referrals in early December 2020.

From this early picture, it can be seen referrals have increased by around 40-50 each month from September.

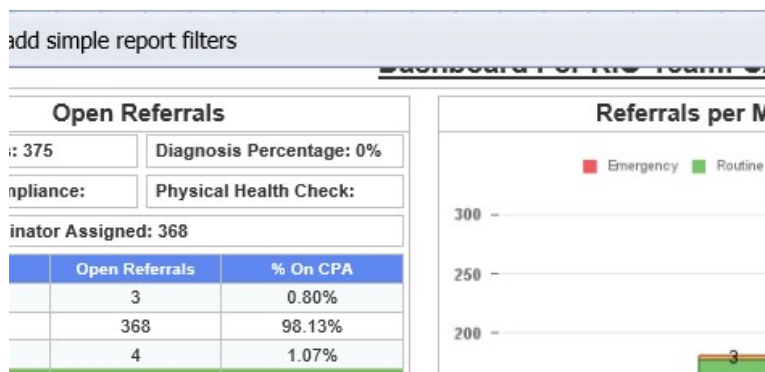


Figure 188: Dorset CAMHS: referrals for Gateway service, August 2020-December 2020 and discharges, September 2020-December 2020
 Source: DHC Business Objects Data Reports

Discharges have also shown an increasing trend, from around a quarter of referrals in the first month to half the number of referrals in November.

Demographics of referrals – CAMHS Gateway

There is a fairly even spread of referral sources across Poole and Bournemouth, with slightly higher numbers being referred within North and East Bournemouth. The majority are for those aged between 13-17 years of age, with a quarter of referrals being for those aged between 9-12 years of age; two-thirds of all referrals are for females.

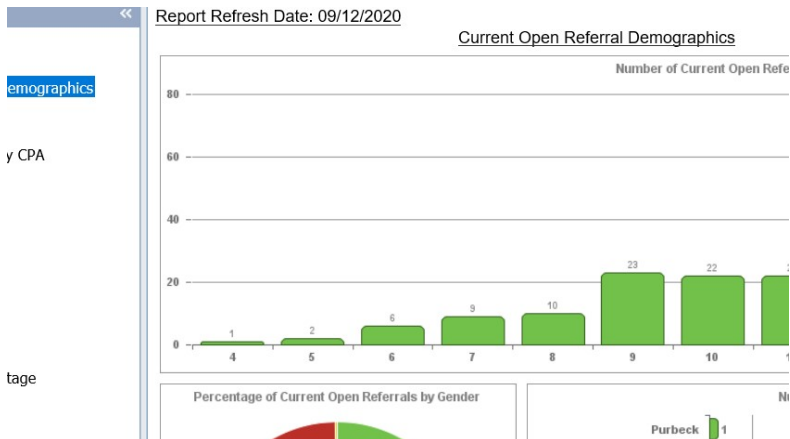


Figure 188: Dorset CAMHS: Referral demographics for Gateway service
Source: DHC Business Objects Data Reports

The ethnicity of those referred is 41% 'White British', with 38% Not Known, in figure 189 below. 9% belong to 'Any other group', 3% to another White background, and smaller proportions to other ethnic groups.

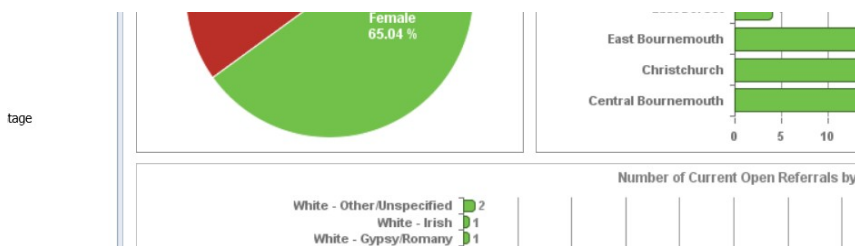


Figure 189: Dorset CAMHS: Number of referrals by ethnicity for Gateway service
Source: DHC Business Objects Data Reports

Appointment outcomes – CAMHS Gateway

From the data shown in figure 190 below, it can be seen there were significantly more follow-up appointments than first appointments.

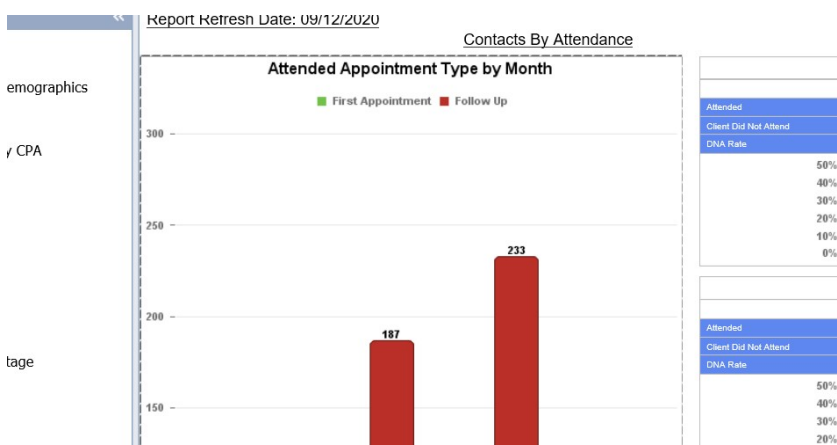


Figure 190: Dorset CAMHS: Appointment outcomes for Gateway service
Source: DHC Business Objects Data Reports

While DNA rates are somewhat higher than in other areas, this is a new service being piloted, and these are relatively small numbers. It is anticipated DNA rates will be explored as part of the evaluation process. Where there is data for larger numbers (follow up appointments in October and November 2020), the rate is more comparable to wider CAMHS rates.

Demographic Profile of those referred to community CAMHS: age/gender/ethnicity

Data from DHC's internal reporting 'Demographics of Current Open Referrals' for community CAMHS was used to generate information about the gender, age and ethnicity, and other characteristics of note, of those referred.

Gender

Referrals for females stand at 56%, while those for males are at 44%. The NHS Benchmarking reports indicate the local proportion of females on the community caseload is higher than the national average of 46-47%.

Table 44: Gender of those referred to Dorset community CAMHS

Gender	Number referred	Total of all referrals	Percentage
Female	1545	2750	56.2%
Male	1204	2750	43.8%
Not specified	1	2750	0%

Source: DHC Business Objects Data Reports

Age

The majority of referrals were for those in the 11-16 age group (67%), followed by those aged 17-18 (21%), then 4-10 years of age (11%).

Table 45: Numbers, within age ranges, of those referred to Dorset community CAMHS

Age range (years)	Number referred	Total of all referrals	Percentage
4-10	303	2750	11.0%
11-16	1844	2750	67.1%
17-18	586	2750	21.3%
19-24	17	2750	0.6%

Source: DHC Business Objects Data Reports

Currently CAMHS is a 0-18 service, unless specific young people need to remain with the service beyond that age. This 19-24 age group picture will likely increase, once changes to the service are made to include assessment and treatment for young people aged 19-24.

Ethnicity

It can be seen from the table below that around 48% of the ethnic group to which people identify with is recorded as 'Not Known' or 'Not Stated', the majority of these are by reason of 'not requested' (59% of those not known/not stated).

'White British' or 'White English' made up the majority of the captured population, at 47% of the 52% captured. Other ethnicities made up the remaining 5%, with 2.3% being of one of five 'Mixed' categorisations of ethnicity, equating to 67 children and young people. 1.5% were of a 'White' background other than White British, equating to 41 children and young people.

Table 46: Ethnicity of those referred to Dorset community CAMHS, number and percentage

Reported Ethnic Group	Number referred	Total referrals	Percentage
Any Other Group	11	2750	0.4%
Asian or Asian British - Indian/Pakistani/Any other background*	4	2750	0.1%
Black or Black British - African/Caribbean/Any other background*	7	2750	0.3%
Information not yet obtained	8	2750	0.3%
Mixed - Any other mixed background	31	2750	1.1%
Mixed - Other/Unspecified	4	2750	0.1%
Mixed - White & Asian	9	2750	0.3%
Mixed - White & Black African	9	2750	0.3%
Mixed - White & Black Caribbean	13	2750	0.5%
Not Known or Not stated (Not Requested)	783	2750	28.5%
Not Known (Unable to Request)	517	2750	18.8%
Not Stated (Client Refused)	23	2750	0.8%
Other ethnic group: Arab, Chinese, Filipino, Iranian & Kurdish (1 in each)*	5	2750	0.2%
White - Any other background	28	2750	1.0%
White - British (to include White-English(n=13))*	1283	2750	46.7%
White - Irish	4	2750	0.1%
White - Other, Polish, Other European, Turkish	7	2750	0.3%
White - Romany/Gypsy, Traveller	2	2750	0.1%

*For the purposes of reviewing very small numbers, a number of ethnic groups have been collated in one section, however, it is recognised that their perceptions/experiences of healthcare and other support mechanisms will be different. These are shown with a *. For the purposes of reviewing proportions, White English has been included within White British as it is possible to assume their perceptions/experiences would be broadly similar. Source: DHC Business Objects Data Reports

A report from DHC's in-house reporting system showed at 19/10/2020, 'Ethnicity' was not recorded in 36-62% of records across C-CAMHS teams.

Referring to data contained earlier in this report regarding ethnicity, it can be seen that proportions of referrals for individuals within minority ethnic groups are lower than population proportions of children and young people from the 2011 census data for 0-17 year olds which showed 11.9% of a minority ethnic identity in Bournemouth, 6.6% in Poole and 3.8% in Dorset.

They are also lower than school population data, which in 2019 showed BCP had 20.4% of school children from minority ethnic groups and Dorset UA had 7.9%.

Other points of note

Transitioning to adult services

The service had 99 individuals reaching 17.5 years this quarter, at time of extraction, with 283 having reached 17.5 years at the start of the quarter; 42 of these children and young people have a transition plan to AMH, GP or Steps to Wellbeing services. It is not clear from data extraction how many require a transition plan as it is noted not all young people are expected to have one in place, as they may continue to other services or be discharged.

This is an area that will need further consideration as to processes needed once the change to provide services up to the age of 25 is designed.

Specialist Mental Health Services

By the nature of offering specialist services, it is noted that the below teams, referrals and caseloads are often smaller than in comparison to the Core-CAMHS service and it can therefore be more difficult to draw conclusions about trends and gaps.

CAMHS INPATIENT DATA

General admission beds

At 10 November 2020, there were seven children and young people being treated within an in-area inpatient setting, with an average length of stay of 151 days. The shortest and longest length of stay were 79 and 252 days, respectively. With regards to gender, there was a 6:1 ratio of females: males; given the small numbers of individuals, no further demographic data was requested.

At 10 November, there were seven people placed out of area (OOA), with an average stay of 186 days; shortest and longest duration of stay were at 12 and 418, respectively; all were female.

NHS Benchmarking showed inpatient data in 2019/20 with Dorset CAMHS represented as CAM116. The local service was reported, against national averages, as having lower bed occupancy, higher average length of stays and 8 more staff per 10 beds, generally reflective of the previous year also. Lower occupancy may be viewed as a positive finding, but further data on the number of OOA placements over the same period would be needed to explore this in more detail. This data was not contained in the benchmarking report.



Figure 191: Dorset CAMHS inpatient data (bed occupancy, lengths of stay, staffing per 10 beds, staffing costs and costs per 10 beds, 2019/20)

Source: NHS Benchmarking Network Report (2019)

Forensic CAMHS

Forensic CAMHS support the mental health and risk management needs of those young people involved with the youth justice system and those presenting with high risk of harm to others. Help is provided to families and professionals who support these young people.

Referrals – Forensic CAMHS

22 referrals were received during January-November 2020 (figure 192).

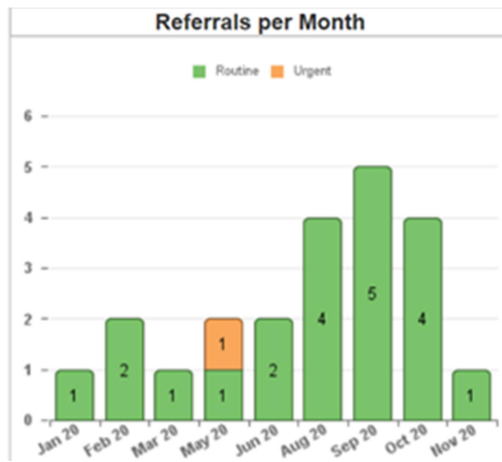


Figure 192: Referrals per month for Dorset Forensic CAMHS service
Source: DHC Business Objects Data Reports

Current referral demographics – Forensic CAMHS

Figure 193 below shows there were 13 young people aged between 10-17 open to the service at time of extraction, the majority of which are young men, with a quarter being women. 4 of these are OOA placements, with the most frequent number of in-area referrals from East Dorset and Bournemouth.

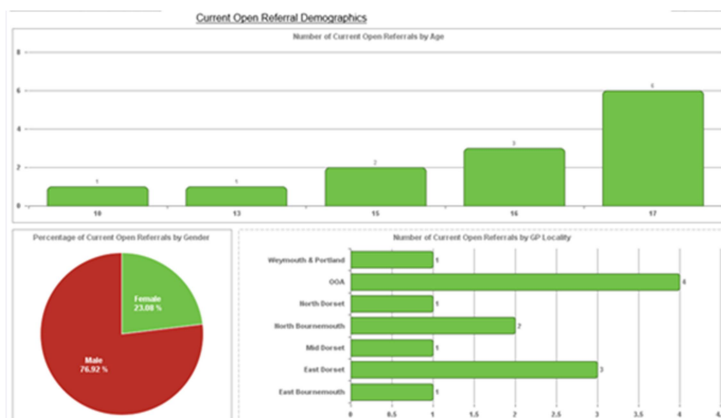


Figure 193: Referrals demographics for Dorset Forensic CAMHS service
Source: DHC Business Objects Data Reports

Figure 194 demonstrates five were of 'White British' ethnicity, eight not recorded, with one 'White Other' and one from 'Any Other Group'. Employment status for those young people was not recorded for the majority, with one recorded as studying and another not in receipt of benefits and not working.

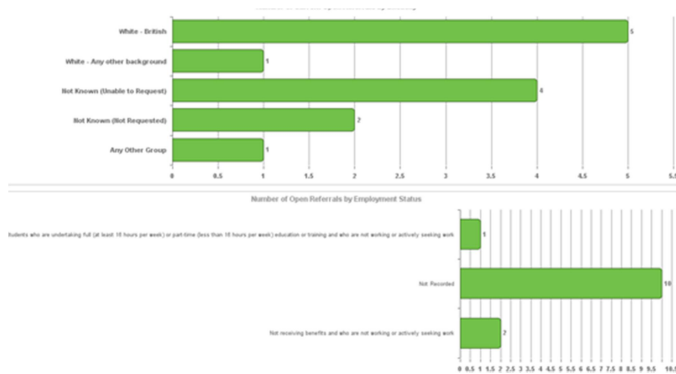


Figure 194: Referrals demographics for Dorset Forensic CAMHS service
 Source: DHC Business Objects Data Reports

Caseload – Forensic CAMHS

Caseload trends over the last three years did not show any significant changes over the last 6 months following an initial drop during the beginning of the pandemic.

Perinatal Mental Health Team

This service provides care and support for women who experience severe mental health problems during the perinatal period, up to one year post-birth.

The multi-disciplinary team provide care and treatment for women with more significant mental health needs, and supporting the developing relationship between parent and baby. Assessments, treatment and support, all tailored to an individual patient's needs, are offered within community and in-patient settings where most appropriate.

Referrals – Perinatal Mental Health Team

Perinatal services received 388 referrals from April-October 2020, averaging around 55 referrals per month. 435 referrals were received in the previous fiscal year to October 2019, averaging 62 per month, a decline of around 11%.

Current referral demographics – Perinatal Mental Health Team

There appears an increase in referrals for those between 27-32 years of age, and from across Dorset localities, with some indication of increased need within North Dorset, a more rural area (figure 195).

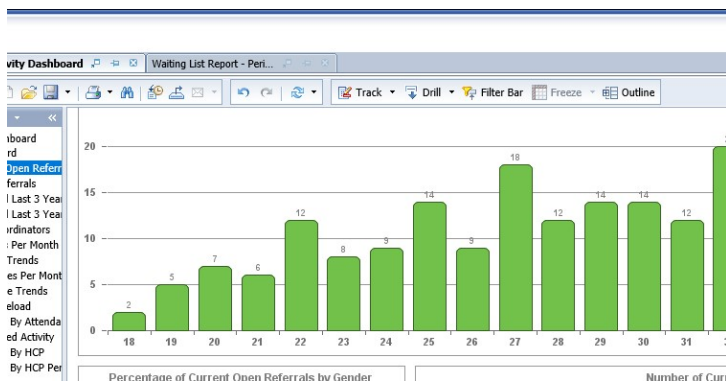


Figure 195: Referrals demographics for Dorset Perinatal Mental Health Team
Source: DHC Business Objects Data Reports

As seen in figure 196 below, 71% had ethnicity captured, 97% of whom were of 'White British' or 'White English' identity. The remaining captured 3% were of a 'White' background other than White British, and 'Mixed' or 'other group'. 29% of referrals did not have ethnicity of the service user recorded.

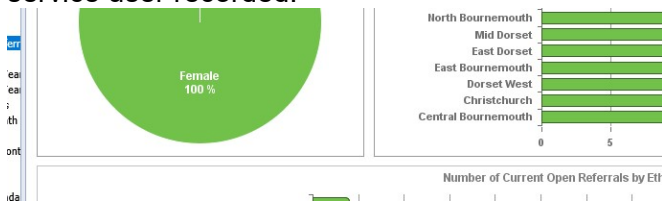


Figure 196: Referrals demographics for Dorset Perinatal Mental Health Team
Source: DHC Business Objects Data Reports

Wait times – Perinatal Mental Health Team

Perinatal Mental Health Community team data showed nearly 100% compliance for waiting lists, and on a snapshot in November, 20 women were on the waiting list, the longest waiting time being 15 days and shortest 1 day (figures 197 and 198).

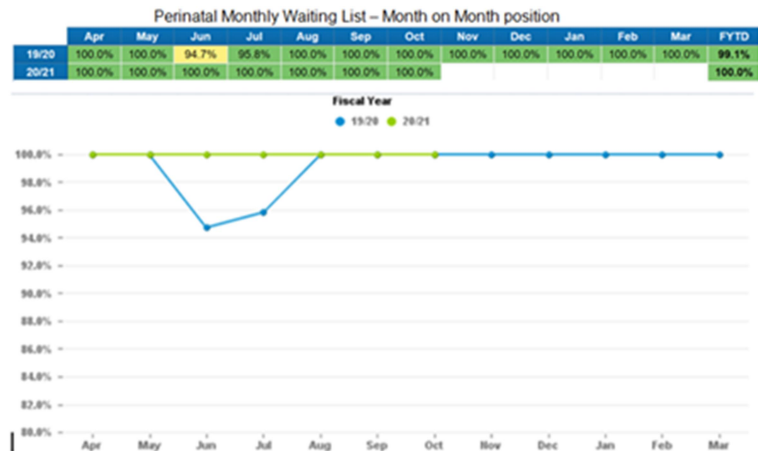


Figure 197: Dorset Perinatal Mental Health Team: waiting list month-on-month, May 2019- October 2020
Source: DHC Business Objects Data Reports

On average over the last 12-months, women have waited 6 days for a first appointment.

	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Last 12 Months
AMH Perinatal Mental Health Community	6.0	5.4	7.3	7.0	5.3	5.3	5.4	6.1	5.4	5.0	6.2	7.7	6.0

Figure 198: Dorset Perinatal Mental Health Team: average wait time for 1st appointment , December 2019- November 2020
Source: DHC Business Objects Data Reports

Caseload – Perinatal Mental Health Team

At late December 2020, there were 239 open referrals to the team, with days on caseload of 83 for those discharged and 178 for current service users.

Caseload trends show an increase in caseload seen since April 2020 at around 180, rising to near 250 in mid-December 2020 (figure 199).

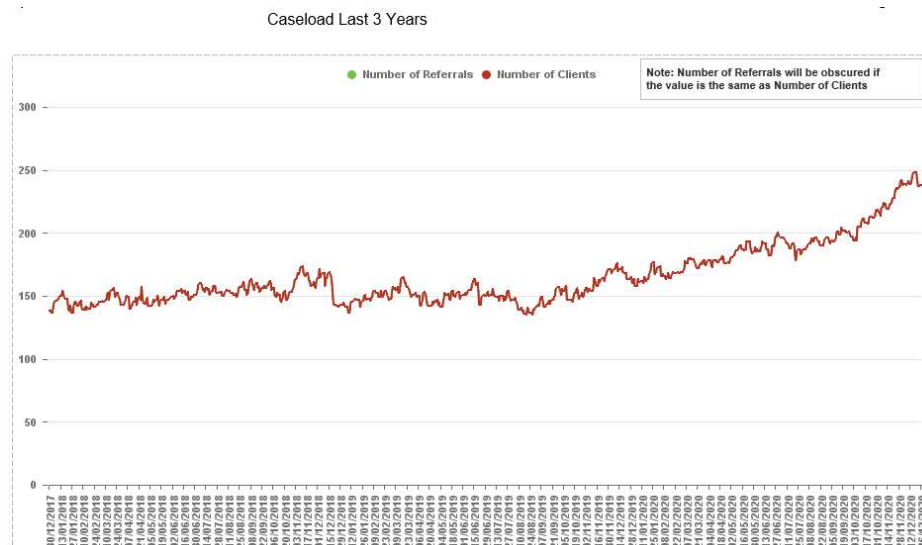


Figure 199: Dorset Perinatal Mental Health Team: caseload trends, December 2017-December 2020
Source: DHC Business Objects Data Reports

Attendance and Did Not Attend (DNA) rates – Perinatal Mental Health Team

Comparable DNA rates to CAMHS services were seen, shown in figure 200 below.

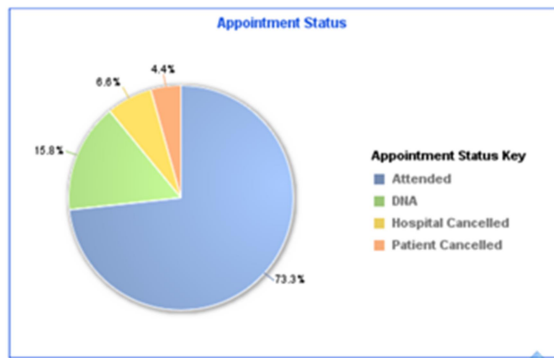


Figure 200: Dorset Perinatal Mental Health Team: waiting list month-on-month, May 2019- October 2020
 Source: DHC Business Objects Data Reports

Contacts – Perinatal Mental Health Team

There were 3,545 contacts April-October 2020, with 2,191 contacts in the same period of 2019; a 62% increase.

Inpatient ward

At end of November 2020, 4 beds were available, of which were occupied and 1 occupied but on leave. No demographic information regarding those using inpatient perinatal services was routinely available.

Autistic Spectrum Disorder

It was not possible to collect routine data for services supporting those with Autism Spectrum Disorder.

It is understood there is an Autism review currently underway aimed at understanding and addressing the service delivery gap it is perceived there is in Dorset for those with disorders such as Autism and ADHD.

CAMHS for those with Learning Disabilities (Teams: Community, SWIFTS)

SWIFTS

This is an Outreach Community Service, for those with learning disabilities who also display behaviours that challenge.

Referrals - SWIFTS

65 referrals were received between January-November 2020, with a similar picture seen prior to following the establishment of the pandemic (figure 201). These are a population of small numbers so it is difficult to see significant change. Referral trend data was reviewed to see comparison with 2019 data, but no real change was evident.

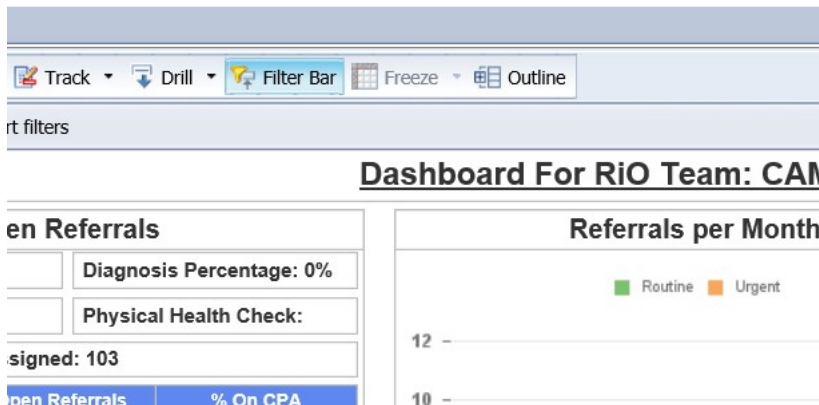


Figure 201: Dorset SWIFTS: referrals and discharges, January 2020-December 2020
Source: DHC Business Objects Data Reports

Caseload - SWIFTS

The team, at end of December 2020, had 107 service users, with the average time for remaining on caseload at 484 days, for those discharged and 708 days for those on the caseload at time of extraction.

Attendance and Did Not Attend (DNA) rates - SWIFTS

As seen in figure 202 below, the majority of appointments were attended, with more contacts seen from June 2020 onwards. DNA rates varying between 4-19% during 2020, with the majority of months having lower end DNA rates of less than 10%.

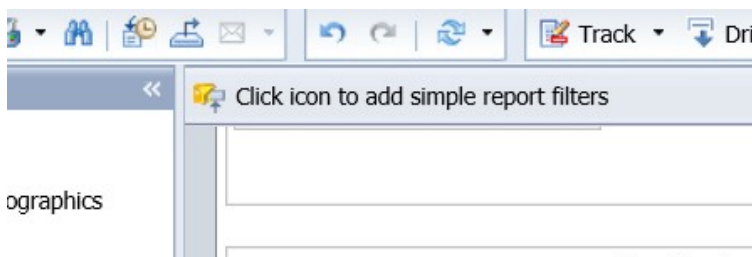


Figure 202: Dorset SWIFTS: contacts, January 2020-December 2020
Source: DHC Business Objects Data Reports

Demographics of current referrals - SWIFTS

It can be seen from figure 203 below, there is a spread of ages, with some concentration of referrals for those aged between 7-14 years of age, with three-quarters of a male gender.

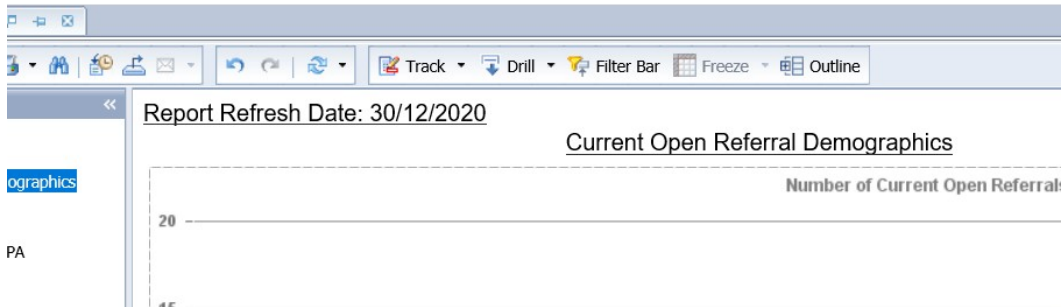


Figure 203: Dorset SWIFTS: referrals demographics
Source: DHC Business Objects Data Reports

Seen below, there is a higher concentration of referrals within the Weymouth and Portland area of 42%, and nearly a further half of referrals from predominantly more rural areas of North and West Dorset, with nearly a quarter of referrals each.

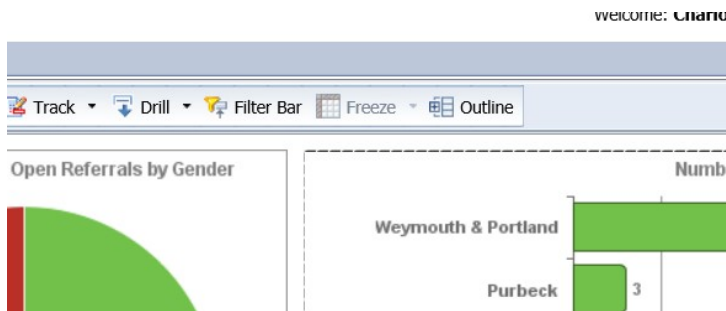


Figure 204: Dorset SWIFTS: number of referrals by locality
Source: DHC Business Objects Data Reports

The ethnicity of young people with open referrals was recorded as White British in 16%, and not known in 82%, seen in figure 205 below. Additional challenges in obtaining this information from individuals with learning disabilities is appreciated, however, it still may be possible to obtain from family, carers or key workers.



Figure 205: Dorset SWIFTS: referrals demographics
Source: DHC Business Objects Data Reports

No referrals for people of other ethnicities were recorded.

Discharges - SWIFTS

Discharge trends also showed little difference between this year and the year previous, again due to small numbers. Of note, inappropriate referrals had counted for between a third and more than half of discharge reasons in 2018/19 and 2019/20, dropping to around an eighth in 2020/21 thus far.

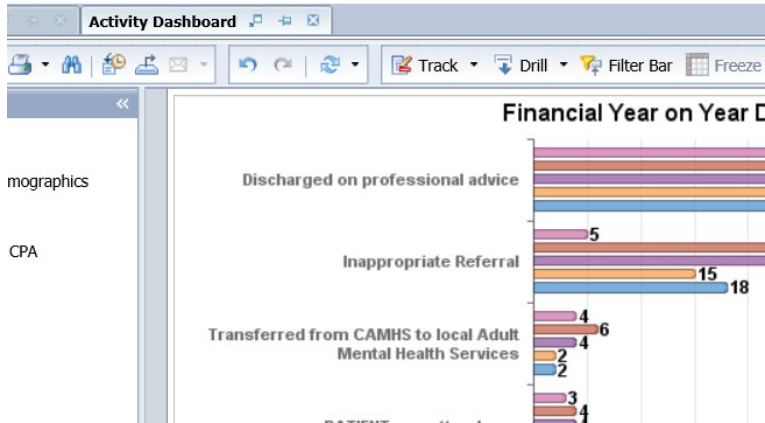


Figure 206: Dorset SWIFTS: discharge reasons, various years
 Source: DHC Business Objects Data Reports

CAMHS Learning Disability Service

This is a MDT service supporting children and young people with learning disabilities.

Referrals - CAMHS Learning Disability Service

81 referrals were received between January-November 2020, with little discernible change seen during the pandemic. These are a small number population so again is not possible to see large change. Referral trend data was reviewed to compare with 2019 data, but no significant change was evident.

Demographics of current referrals - CAMHS Learning Disability Service

It can be seen from figure 207 below, regarding age, there is a fair spread with some concentration of referrals for those aged between 8-15 years.

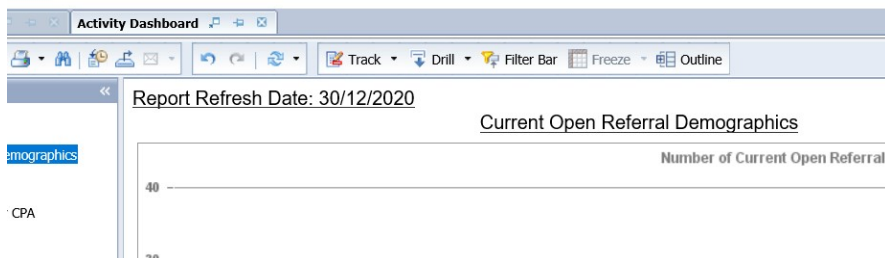


Figure 207: CAMHS Learning Disability Service – referral demographics
Source: DHC Business Objects Data Reports

Two-thirds of open referrals were for those of a male gender and one-third female (figure 208). There were higher concentrations of referrals across areas of BCP rather than rural areas.

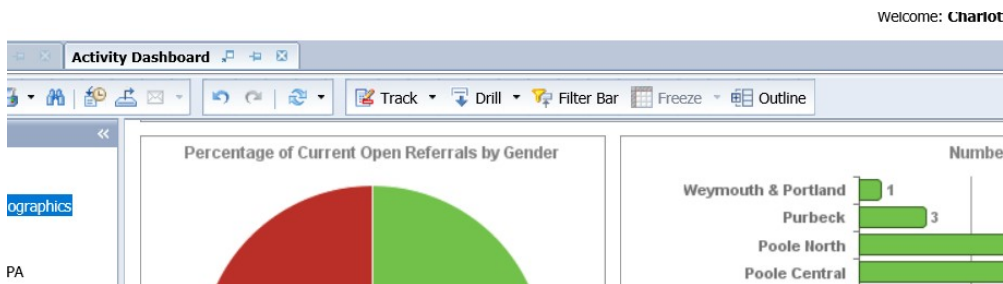


Figure 208: CAMHS Learning Disability Service – referral demographics
Source: DHC Business Objects Data Reports

As seen in figure 209 below, those of a 'White British' or 'White English' identity made up the majority of the captured population, at 86% of the 24% captured. Other ethnicities made up the remaining 14%; 6% were of a 'White' background other than White British, and 8% of Mixed, Kurdish or 'other group'. 76% of referrals did not have ethnicity of the service user recorded.

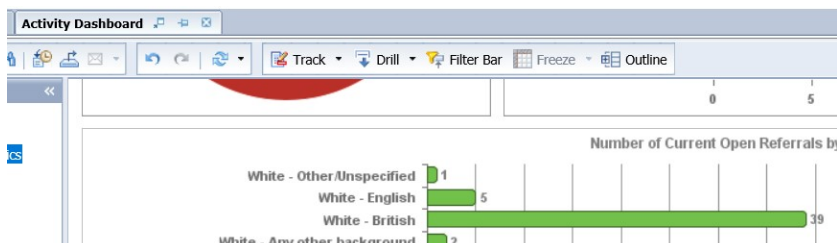


Figure 209: CAMHS Learning Disability Service – referral demographics
Source: DHC Business Objects Data Reports

Caseload - CAMHS Learning Disability Service

The team, at end of December 2020, had 219 service users open to them, with the average time for remaining on caseload at 504 days, for those discharged and 996 days for those on the caseload at time of extraction.

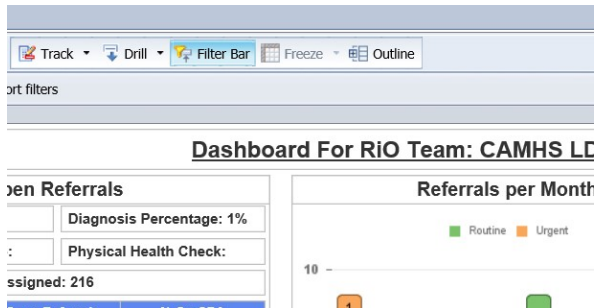


Figure 210: CAMHS Learning Disability Service – Caseload
Source: DHC Business Objects Data Reports

Attendance and Did Not Attend (DNA) rates - CAMHS Learning Disability Service

As seen in figure 211 below, the majority of appointments were attended, with a fairly steady level of contacts throughout the year; there were a substantial number of contacts in November 2020. DNA rates have remained around 6-13% during 2020, apart from November which had a rate of 3%.

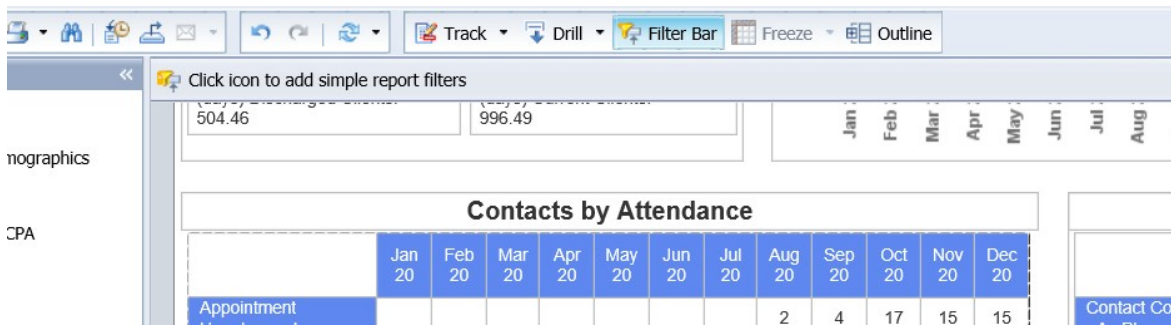


Figure 211: CAMHS Learning Disability Service – Contacts and Appointment Outcomes
Source: DHC Business Objects Data Reports

Eating Disorder Service – Young People’s Team (extracted early December)

Referrals - Eating Disorder Service – Young People’s Team

It is shown in figure 212 below, there were 227 referrals at time of extraction, with an average time on caseload of 228-246 days (current-discharged clients).

There has been a variable picture for referrals, with a drop early in ‘lockdown’ (April 2020) and a growing number seen since then. Compared with data from the previous 12 months, there has been an increase of between 5-18 referrals a month during the July-November period, and over a one-third increase in October and November 2020 compared with last year.

The proportion of ‘urgent’ referrals since July 2020 appears greater than in the three months preceding ‘lockdown’, although it has not been possible to extract comparable data for urgent referrals from the same period last year.

The screenshot shows a dashboard with the following data:

- Open Referrals: 227
- Diagnosis Percentage: 1%
- Clustering Compliance:
- Physical Health Check:
- No Care Coordinator Assigned: 151

CPA Level	Open Referrals	% On CPA
CPA	35	15.42%
CPA Out of Area	4	1.76%
None	151	66.52%

Figure 212: Eating Disorder Service – Young People’s Team - Referrals
Source: DHC Business Objects Data Reports

NHS Benchmarking data for 2019/20 showed Dorset CAMHS Eating Disorder Service had a higher than average rate of referrals, at 162 per 100,000 population, where the average was 91 per 100,000 population.

Accepted referrals were higher in Dorset at 149 per 100,000 population, over the national average of 80, the proportion of which was 92% in Dorset, compared with 89% nationally.

Demographics of current referrals - Eating Disorder Service – Young People’s Team

Figure 213 shows the majority of referrals at time of extraction were for those aged 13-18 years old, with a peak at around 15-16 years, approximately 90% of which are for females. There are a slightly higher number of referrals from areas of Dorset UA, areas which are largely rural and market towns.

In terms of ethnicity, nearly half of referrals are for those of a ‘White-British’ identity (43%), or ‘Not Known’ (53%), with 4% identifying within other ethnic groups.

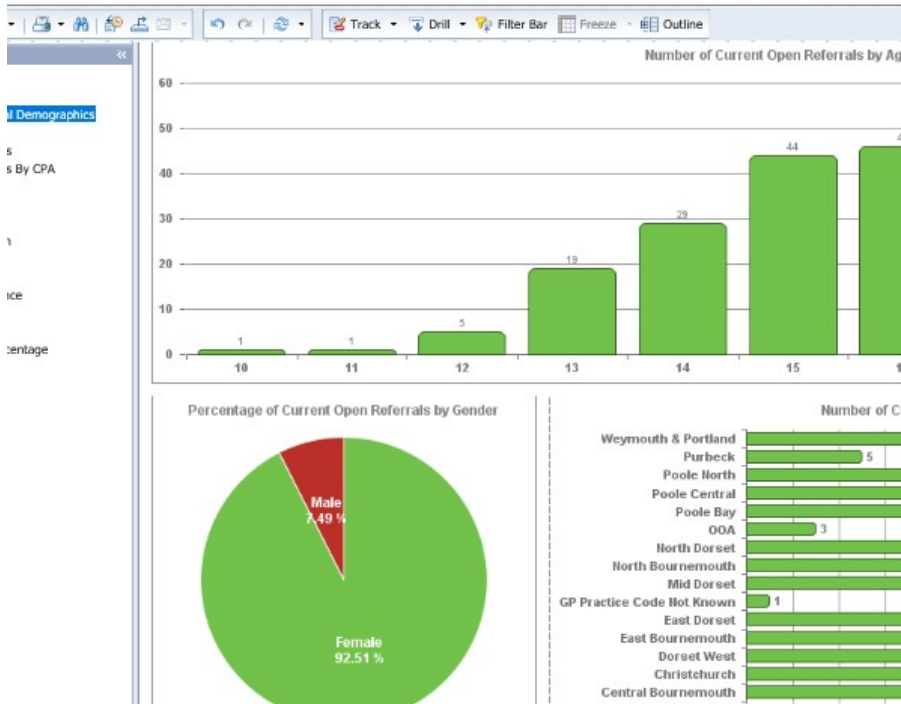


Figure 213: Eating Disorder Service – Young People’s Team – Referral Demographics
Source: DHC Business Objects Data Reports

Caseload - Eating Disorder Service – Young People’s Team

NHS Benchmarking data for 2019/20 showed Dorset CAMHS had a higher than average number of patients on the caseload, at 140 per 100,000 population, where the average was 55 per 100,000 population (figure 214).

Figure 75

Eating Disorder CAMHS: patients on the caseload per 100,000 population at 31st March 2020 (0-18)



Figure 214: Eating Disorder Service – Young People’s Team – patients on caseload, per 100,000 population
Source: DHC Business Objects Data Reports

Local data in figure 215 shows caseload trends which had remained relatively stable until October 2019 when an increase was seen, coinciding with an increase in staffing, which then showed decline from February 2020. Caseloads began to increase in early September 2020, and are were at their highest level over the last three years when data was extracted.



Figure 215: Eating Disorder Service – Young People’s Team –caseload trends
Source: DHC Business Objects Data Reports

Early Intervention in Psychosis (EIS)

Referrals and Discharges - EIS

Data was available for between April and October 2020, with 145 referrals. The caseload, at time of extraction, was around 200.

The figure below shows referrals and discharges, month 4 being April 2020 and month 10 being October 2020. There were only a small number of 20 referrals, at a fairly steady rate, averaging around 3 per month. The figure indicates around 35 individuals were discharged during the 7 months, an average of 5 per month.

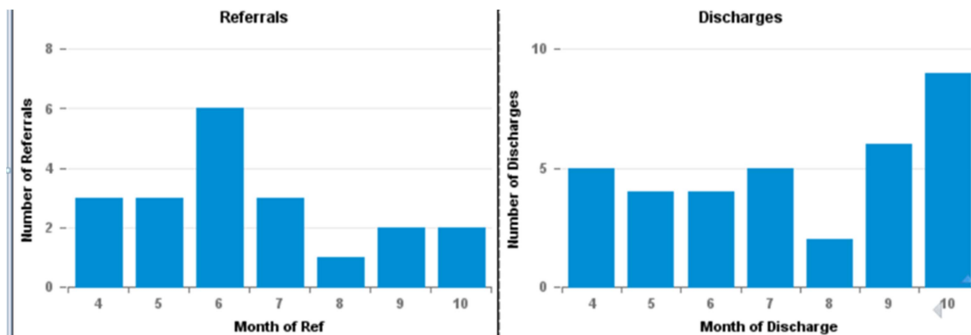


Figure 216: Early Intervention in Psychosis – referrals and discharges
Source: DHC Business Objects Data Reports

Attendance and Did Not Attend (DNA) rates - EIS

The attendance rate for this service stood at 82%, with DNA rates at around 9% over the 7 months shown below.

Contacts by Attendance							
	4	5	6	7	8	9	10
Appointment Unoutcomed			4	1	2	4	4
Attended	461	434	511	469	334	414	368
Client Cancelled	9	8	4	10	5	21	13
Client Did Not Attend	63	52	59	55	51	49	48
Hospital Cancelled	25	25	34	31	36	37	32

Figure 217: Early Intervention in Psychosis – Contacts
Source: DHC Business Objects Data Reports

Psychiatric Liaison (extracted late December)

The aim of the Psychiatric Liaison service is to enable those children and young people seen within hospitals to access to mental health care and support should they need it.

Psychiatric assessments are available for children and young people seen across Dorset Hospitals, with hospital-based specialist teams, including psychiatrists and mental health nurses, taking referrals directly from accident and emergency departments as well as acute admission units.

There is also provision of advice, assistance and psychiatric opinions and diagnosis of children and young people in hospital wards, as required.

Referrals - Psychiatric Liaison

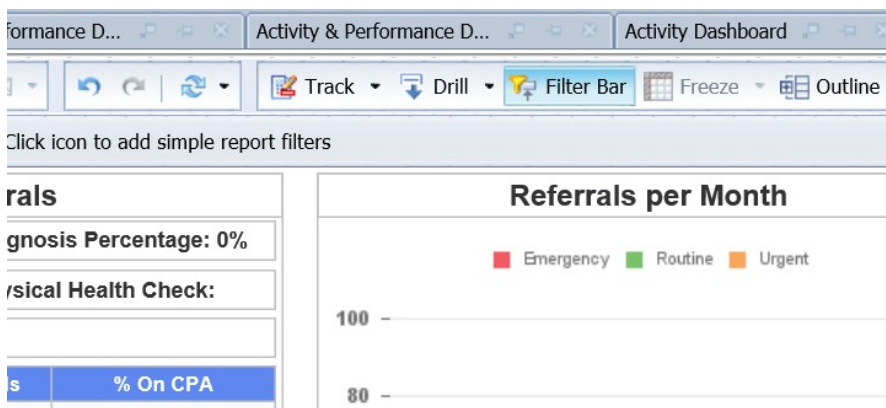


Figure 218: Psychiatric Liaison – referrals and discharges
Source: DHC Business Objects Data Reports

There was a significant drop in referrals to this service (figure 218 above) between April-June 2020, following the beginning of the pandemic, with a noticeable increase in referrals beginning July 2020. In comparison with the time period of July-November 2019 and the previous year of 2018, there has been a doubling-to-tripling number of referrals in 2020. The proportion of those classified as ‘emergency’ appear to have increased since September 2020 when reviewing against January-March 2020; there is no comparable data for the classification of referrals available for the previous year with which to compare if this appears to be a real change.

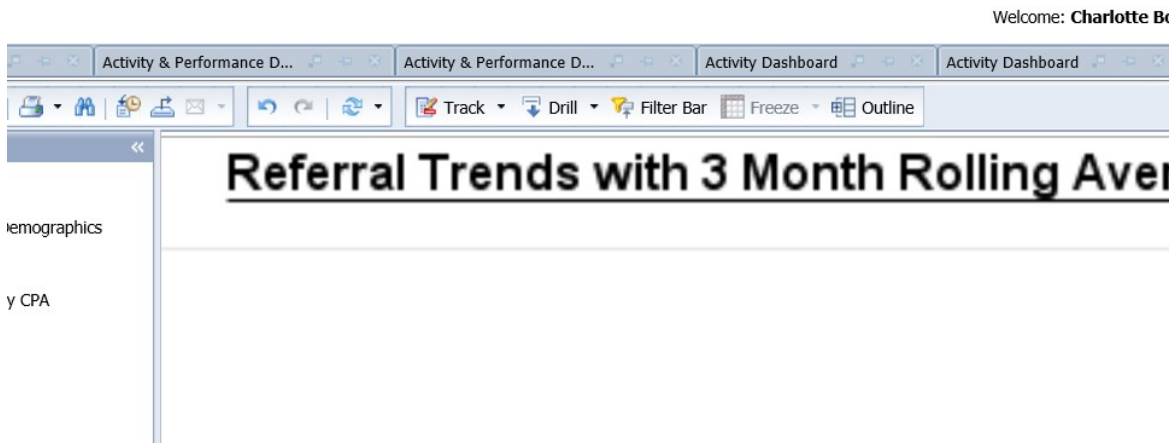


Figure 219: Psychiatric Liaison – referral trends
Source: DHC Business Objects Data Reports

Demographics of Current referrals - Psychiatric Liaison

Figure 220 shows only small numbers of referrals, but of those there is a slight increase in referrals for those aged 14-16. Nearly three-quarters are for females and an even spread is seen across all Dorset GP localities. 14% have no ethnicity recorded and, of those captured, 86% are 'White-British'.

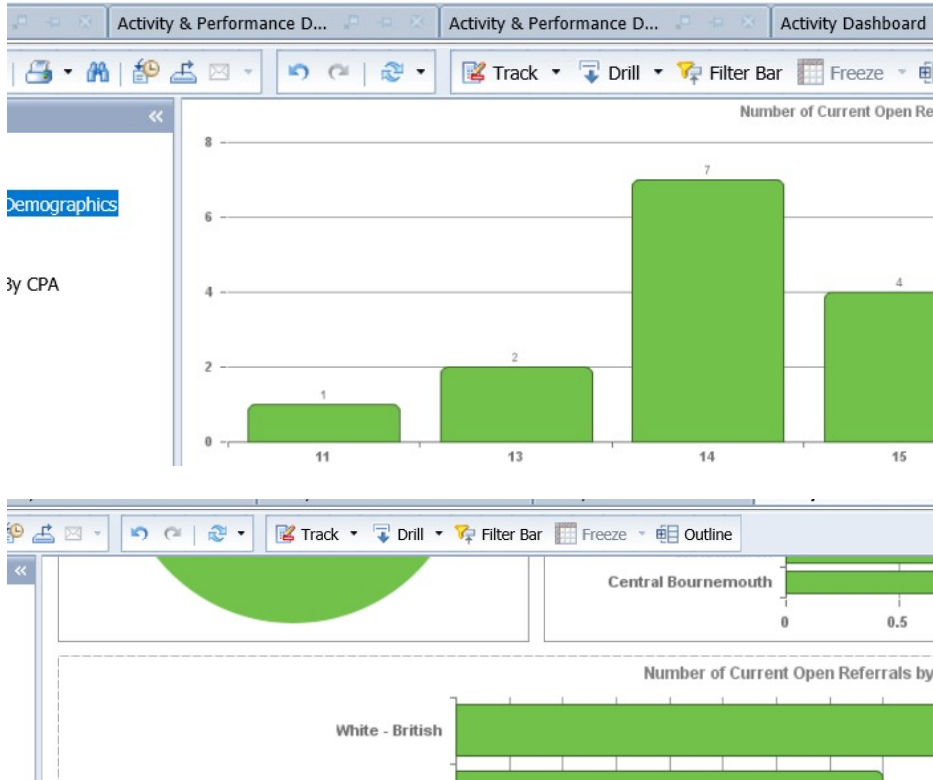


Figure 220: Psychiatric Liaison – Referral demographics
Source: DHC Business Objects Data Reports

Attendances - Psychiatric Liaison

Attendances have increased by around 10-20 referrals per month between September and November 2020, when comparing with attendances prior to the pandemic (figure 221).

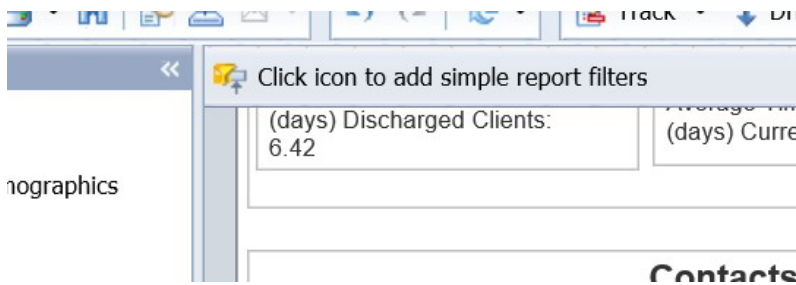


Figure 221: Psychiatric Liaison – Contacts
Source: DHC Business Objects Data Reports

Caseload - Psychiatric Liaison

There are 22 open referrals, with those discharged having been on caseload for an average of 6 days and current service users having been on caseload for an average of 42 days.

Caseload trends are available for this service (figure 222) and show that although peaks have been observed in previous years, between September and December 2020 there has been a steady rise in both referrals and clients, to the highest point observed within the last 3 years.

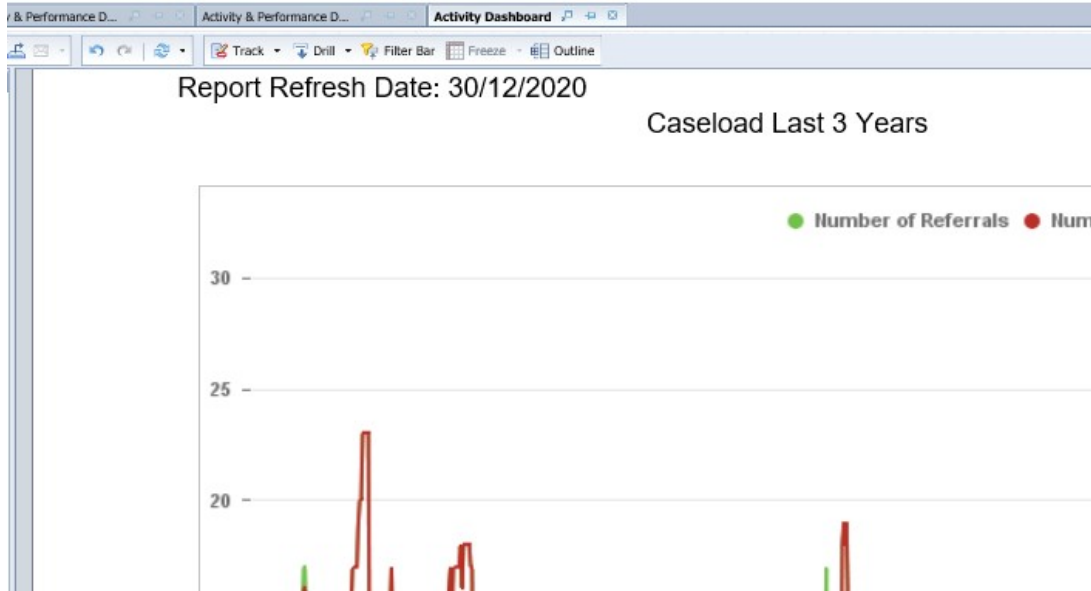


Figure 222: Psychiatric Liaison – Caseload trends
Source: DHC Business Objects Data Reports

Crisis and Home Treatment teams

Dorset have crisis and home treatment practitioners, who are able to work for a short period with a young person who is experiencing particular difficulties and challenges, such as low mood, suicidal thoughts and self-harm. Care can be provided at home to prevent admission to inpatient care.

Data was only available for the period January-August 2020, shown in figure 223.

Referrals - Crisis and Home Treatment teams

The data shows an impact during the initial stages of the pandemic, with a drop in referrals. The data available shows a slight increase seen by July and August 2020.

Caseload - Crisis and Home Treatment teams

Service users, who are now discharged, remained on caseload for an average of 5 days. No data was available for the duration on caseload for open referrals.

Attendances - Crisis and Home Treatment teams

Nearly all appointments were attended, with marginal levels of DNAs.

Initial and follow-up appointments - Crisis and Home Treatment teams

The majority of appointments were in follow-ups, with a greater proportion seen during May, June and July 2020, which may have been as a result of reduced referrals allowing greater time for follow-up appointments.

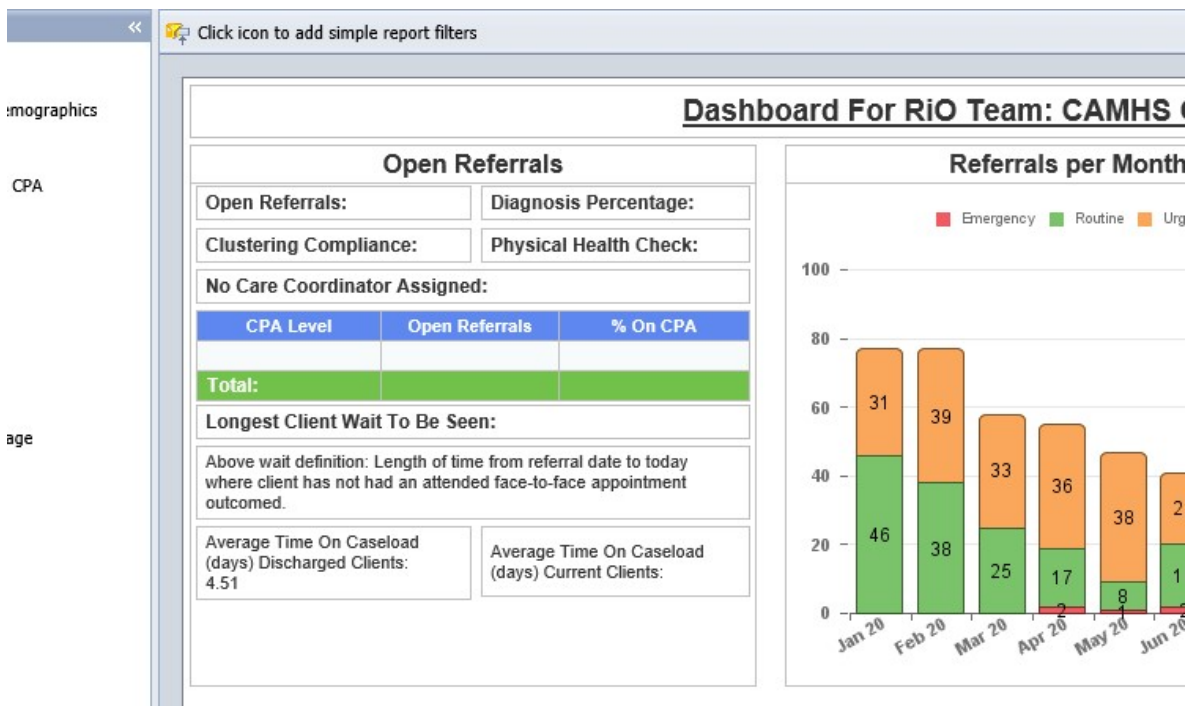


Figure 223: Crisis and Home Treatment teams – Referrals, discharges and contacts
Source: DHC Business Objects Data Reports

No further detail was routinely available for the Crisis Team service.

Additional Services co-delivered with CAMHS

Mental Health Support Teams

The purpose of Mental Health Support Teams (MHSTs) is to provide early intervention for lower-level mental health and wellbeing issues, such as mild to moderate anxiety. Working alongside existing staff and support mechanisms, they assist in the development and provision of a ‘whole school approach’ to mental health and wellbeing. The teams link with local children and young people’s mental health services and are supervised by NHS staff.

MHST teams went live in a small number of schools in Dorset during 2020, as part of an initial pilot. Future plans have been made to roll-out this mechanism to all schools across Dorset during 2021.

Of note in the sections below are that these are new teams, recording data from May 2020 only and involve, again, small numbers. This is an initial analysis of these teams’ data to provide an overview but further evaluation of this service is to be undertaken following the pilot.

BCP MHST (extracted early December 2020)

Referrals - BCP MHST

Since implementation, data for May-November 2020 shown in figure 224 below, reports the team have received 63 referrals, 63% of which were received in November 2020; this is understandable given this is a relatively new service and may take time for referral mechanisms to become accepted and understood.

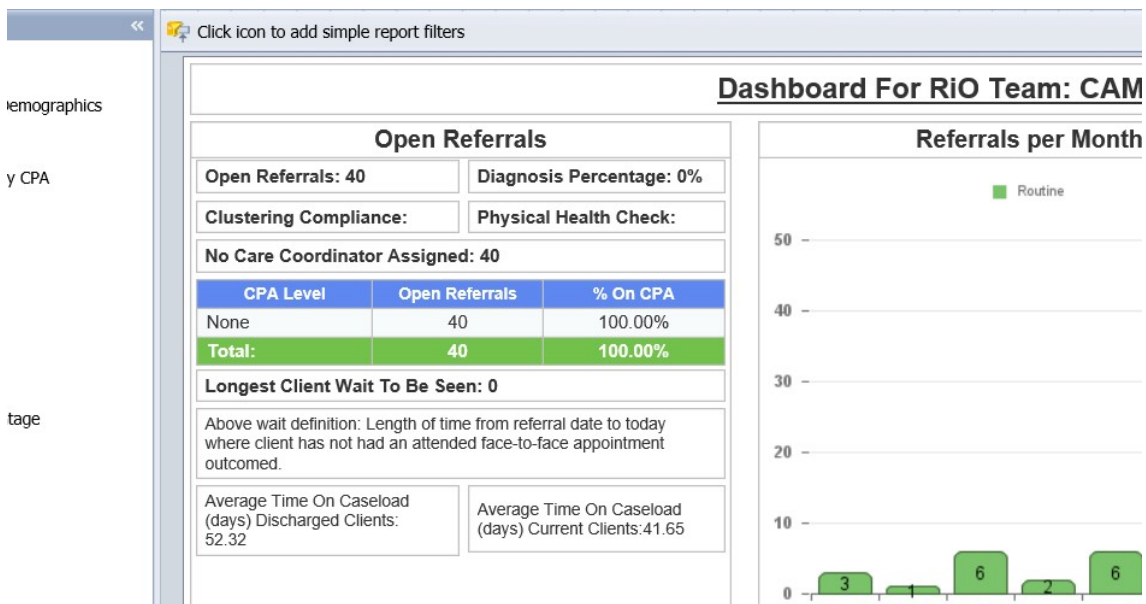


Figure 224: BCP MHST – Referrals, discharges and contacts
Source: DHC Business Objects Data Reports

Demographics of Current referrals - BCP MHST

The majority of referrals have been for those aged between 11-15, for slightly more females and for those from the Poole central, Poole Bay and North Bournemouth areas. More than half have no ethnicity recorded, and of those captured 81% are 'White-British' (figure 225).

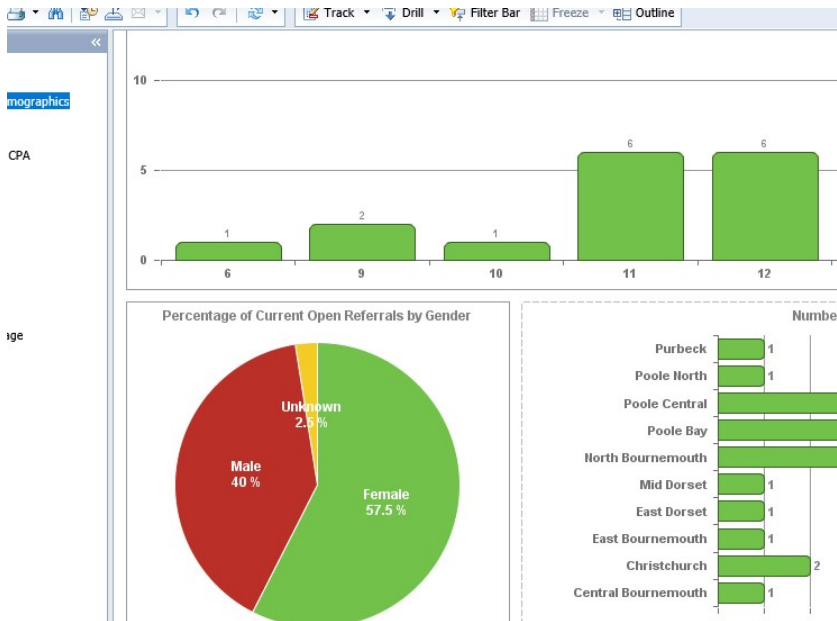


Figure 225: BCP MHST – Referral demographics
Source: DHC Business Objects Data Reports

Caseload - BCP MHST

It can be seen in figure 224 above there were 40 referrals at November 2020, with an average time on caseload of 52 days for those who have been discharged and of 42 days for those on caseload at time of extraction.

Attendance and DNA rates - BCP MHST

Attendance increased significantly in November 2020 (December data was incomplete at time of data analysis).

A new service, DNA rates have been variable from around 9-35%, with a rate of 9% in November 2020, when most attendances took place.

North Dorset MHST (extracted early December 2020)

Referrals - North Dorset MHST

Since implementation, data for May-November 2020 shown in figure 226 below, reports the team have received 49 referrals, with rising referrals in the two months before summer holidays and an increase seen again in November.

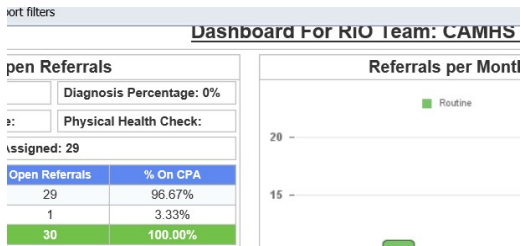


Figure 226: North Dorset MHST – Referrals and Discharges
Source: DHC Business Objects Data Reports

Demographics of Current referrals - North Dorset MHST

There has been a fairly even spread of referrals across all ages from 6-18, with the majority (two-thirds) for females, and for those from the Poole central and Poole Bay areas and North Bournemouth. 80% are recorded as 'White-British', with 20% having no ethnicity recorded (figure 227).

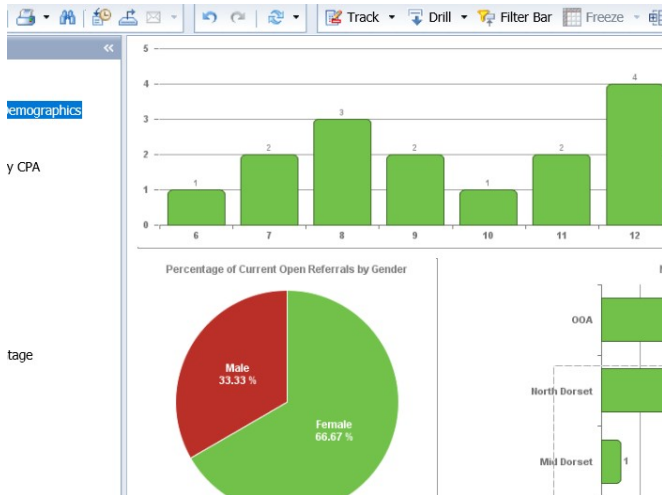


Figure 227: North Dorset MHST – Referral demographics
Source: DHC Business Objects Data Reports

Caseload - North Dorset MHST

It can be seen in figure 226 above there were 30 referrals at time of extraction, with an average time on caseload of 95 days for those who have been discharged and of 54 days for those on caseload.

Attendance and DNA rates - North Dorset MHST

Attendance has been steady since June 2020 (December data incomplete at time of analysis), in figure 228.

DNA rates have been variable at 6-26%, with rates of 6-16% seen across the last 3 full months September-November 2020.

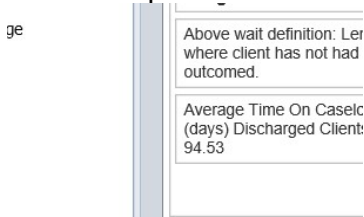


Figure 228: North Dorset MHST – Contacts
Source: DHC Business Objects Data Reports

Weymouth and Portland MHST (extracted late December 2020)

Referrals - Weymouth and Portland MHST

Since implementation, data for May-November 2020 shown in figure 229 below, reports the team have received 83 referrals, with rising referrals since the beginning of September 2020.

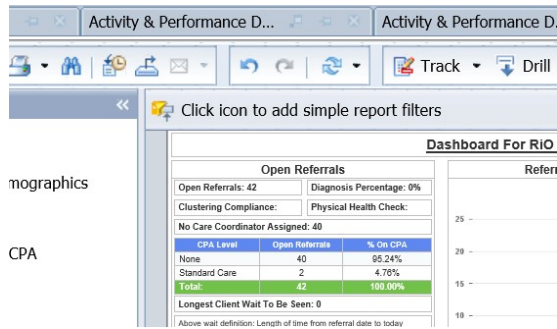


Figure 229: Weymouth and Portland MHST – Referrals and Discharges
Source: DHC Business Objects Data Reports

Demographics of Current referrals - Weymouth and Portland MHST

The majority of referrals have been for those aged between 12-15, with around two-thirds for females and nearly all for those within GP localities of Weymouth and Portland, as would be expected. 14% have no ethnicity recorded and, of those captured, 86% are 'White-British' (figure 230).

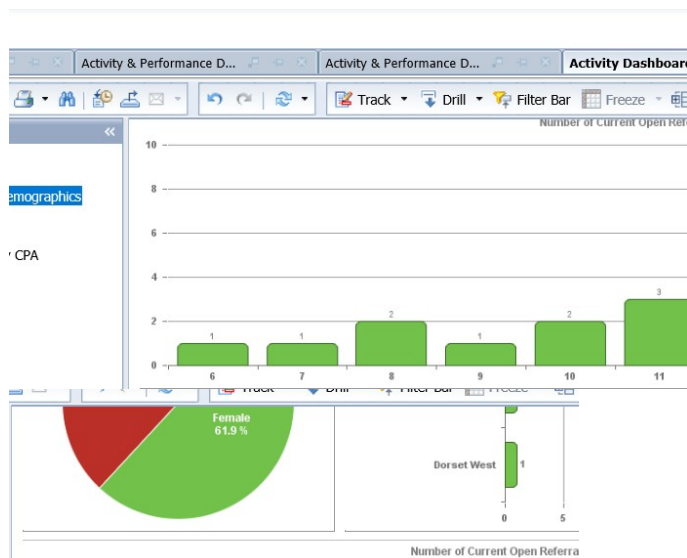


Figure 230: Weymouth and Portland MHST – Referral demographics
Source: DHC Business Objects Data Reports

Caseload - Weymouth and Portland MHST

It can be seen in figure 229 above there were 42 referrals at time of extraction, with an average time on caseload of 36 days for those who have been discharged and of 54 days for those on caseload.

Attendance and DNA rates - Weymouth and Portland MHST

Attendance has been rising since returns to school in September 2020 (December data incomplete at time of analysis). DNA rates of around 5-15% have been seen across the last 3 full months September-November 2020.

Summary - Service Section

- NHS benchmarking data for 2018/19 and 2019/20 showed, in comparison to national averages, Dorset C-CAMHS:
 - Received fewer referrals than national comparators,
 - Accepted less referrals
 - Had lower waiting lists
 - Waiting times were shorter for first appointment and comparable for second
- More recent local data shows impacts in service data during and following the COVID-19 pandemic, with lower referrals and discharges, but increased contacts. There may therefore be an impact on the 'Access' target for the year, with YTD showing below target.
- Referrals show variability, with fluctuations of between 30-150 per month. Drops were observed towards the end of school year and during school holidays in 2019, and further drops around pandemic lockdown. Referrals have increased but not yet to pre-pandemic levels.
- Accepted referrals has shown a lower proportion than benchmarking data averages in previous years, however, a varying increase has been seen since September 2019, continuing throughout the pandemic, with a 10% increase in 2019/20 from the previous year.
- Waiting times showed 74-82% of children were assessed within 4 weeks of referral and 56-83% within 8 weeks. The average wait time for a first appointment was 59 days.
- Access to treatment within 16 weeks has shown great variation, between 40-84%, with a large decrease seen during the pandemic initial lockdown period.
- Caseloads show trends of increasing, and are larger, in urban areas.
- Nearly half of children and young people are on pathways for emotional and behavioural difficulties and General Anxiety Disorder/Panic.
- CAMHS DNA rates are slightly higher than other mental health services within the Trust.
- Outcomes for most CAMHS interventions have not been available electronically (contained on paper-records). Audit of Wellbeing Practitioner service outcomes showed improvements on one detailed measure and inconclusive findings from another, shorter, measure.
- Demographic information for children and young people open to C-CAMHS show:
 - Most referrals are within the 11-16 age range, followed by 17-18 year olds and then those 4-10 years of age. When planning for future service capacity it will be essential to account for predicted growth in age group populations as outlined earlier in this report. This would be expected to change once CAMHS criteria changes to reflect inclusion of younger adults of 19-25 years.
 - A higher number of females than males are within the system, above the national proportion.
 - In respect of ethnicity, almost half are of an unknown status, while the majority of those whose ethnicity is known are of 'White-British' or 'White-English'. The proportions of those from a minority ethnic group do not appear to be reflective of suggested population proportions of minority ethnic groups of those aged 0-17 years or school population data referred to earlier in the report. The reasons for this are likely to be multi-factorial and could warrant further exploration to inform service design.

- The Gateway East project, a 'front door' initiated in September 2020, is anticipated to effect changes in levels of referrals to C-CAMHS, to offer signposting and intervention to those not deemed in need of C-CAMHS offers and to waiting lists and times. Referrals to this service are beginning to increase as the service becomes more established. The majority of referrals are for those aged between 13-17 years of age, with a quarter being for those aged between 9-12 years of age; two-thirds are for females.

Specialist Services

- A small number of children and young people across Dorset require inpatient mental health care, both locally and in other area placements. Average lengths of stay at time of extraction were longer locally when measured against 2018/19 and 2019/20 benchmarking data reports. There was reported a slight reduction in 2019/20 benchmarking data from that of 2018/19 for length of stay in Dorset.
- Within Perinatal services, during April-October 2020, referrals declined by around 11%, with contacts increasing by around 62%, over the same period last year. 20 women were observed to be on a waiting list, with an average of 6 days for a first appointment. Comparable DNA rates to CAMHS services were seen.
- Transition to Adult Services. Young people who have, or are, approaching their 18th birthday and are in receipt of CAHMS services, currently are transferring to either GP, Steps to Wellbeing or Adult Mental Health services, but data does not provide a complete picture of the process for all.

This is both nationally and locally recognised as a difficult period, and there are plans to increase the service offer to include young people up to the age of 25 for CAMHS assessment and treatment, which will close the need gap for those young people who will not meet the threshold for, or be most appropriately placed, within adult equivalent services.

- Eating Disorder Services for children and young people have received increased referrals in the last few months, compared with the previous 12 months. Local data shows they have the highest caseload observed during the last three years, at time of extraction. In comparison with national data, the service receives almost double the referrals and has almost three times the number on caseload, per 100,000 population.
- Psychiatric Liaison have seen an increase in monthly referrals since September 2020, more than seen over the previous two years, and there may be an increase in the proportion of 'emergency' referrals, but further data may be required to establish if this is a true change.
- Reviewing demographic data across specialist services has highlighted that the ethnicity of between 29-82% of those with referrals is not known.

Services provided outside of CAMHS

School Counselling

Counselling is an intervention that children or young people can voluntarily enter into, to explore, understand and overcome issues which may be causing them difficulty, distress or confusion. While there are alternative routes to counselling, including through voluntary sector community based services, private practices, GPs and CAMHS, school-based counselling does not require a diagnosis, is unique in its placement and its ability to complement school approaches and external service work.

School counselling is an integral part of the mental health services offer and there is evidence that successful school counselling can result in aiding concentration, promoting positive behaviours and increasing engagement with school and schoolwork^{cliii}.

School counselling is under review locally, with pressures on local resources and increasing demands for counselling service noted. In accordance with national understanding, reasons for referral were around personal self, relationships, health and school.

Analysis of local provision identified a number of issues, namely wide variation, lack of quality assurance processes around qualifications, registration and supervision. Despite relatively small numbers referred, long waiting times are of concern, with the majority waiting between four-six months. A summary of findings are shown in figure 231 below.

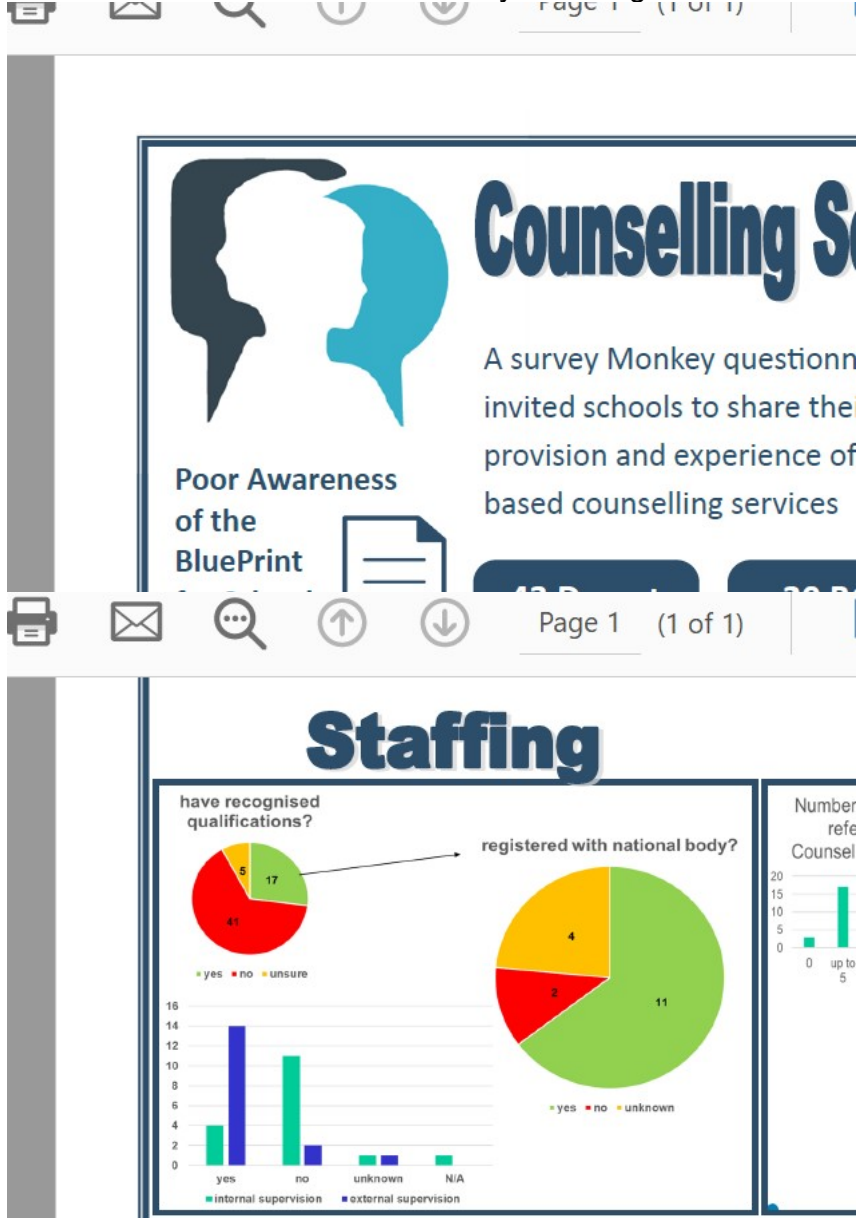


Figure 231: School Counselling in Dorset – analysis findings. Source: Public Health Dorset

School nursing

School Nursing Teams work across a number of schools, ordinarily consisting of a School Nursing Lead, Specialist Public Health Practitioners, School Health Staff Nurses and Nursery Nurses. They work using a public health approach with children, families and school staff, namely in preventing disease while promoting health and wellbeing.

They work to encourage healthier lifestyles, offer immunisations and provide information, advice and support to young people and their families, whilst working to safeguarding procedures.

There are established links with other professionals such as Community Paediatricians, Health Visitors and Speech and Language Therapists^{cccxiv}.

No service data has been obtained on throughput or outcomes, and it is unclear if these are routinely collected locally.

Digital offers

ChatHealth

ChatHealth is a School Nursing text service available to all young people aged 11-19, offering the opportunity to easily and anonymously get in touch with a healthcare professional for advice and support. Young people can use this service to get advice about a range of subjects including mental health, relationships, drugs and alcohol. Using School Nursing expertise it uses digital, age-appropriate ways to communicate with and support young people, children and families.

The service operates Monday-Friday, between 8.30am-4.30pm (except Bank Holidays). When the ChatHealth service is not manned, there is an out of hours 'bounce back' message for those who contact the service

During the 12-month period October 2019-September 2020, there were 2,770 messages received by the service and 3,083 messages were sent. Trends in the number of messages received and sent are shown in figure 232 below:

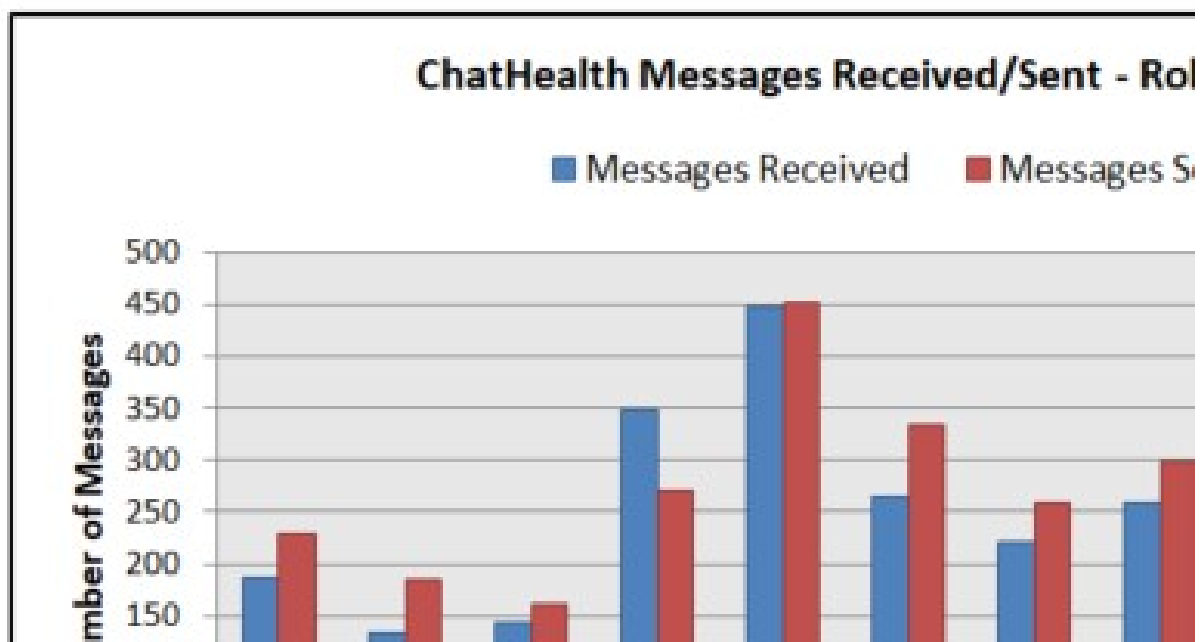


Figure 232: Number of text messages received and sent by ChatHealth service, October 2019-September 2020
Source: DHC internal report

Figure 233 below shows the trend in the number of messages received over two complete calendar years. The spike in the number of texts in June and July 2019 coincides with exam season when the number of messages received increased significantly. The second spike in February 2020 may be attributed to concerns around the emergence of COVID-19. During both of these periods the main reason for YP contacting ChatHealth was emotional health and well-being and worry.

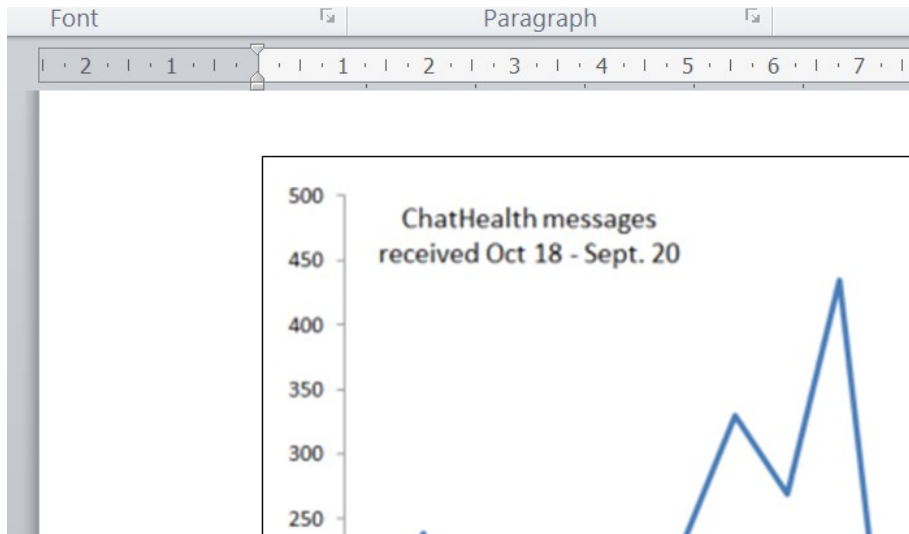


Figure 233: Number of text messages received ChatHealth service, October 2018-September 2020
Source: DHC internal report

While the ChatHealth service offers support beyond wellbeing and mental health, the three main reasons for contacting the service were related to mental health, shown in figure 234 below.

Attributes of conversations

Attributes of conversations

The top 3 reasons for people contacting the

Figure 234: Attributes of text messages conversations received through ChatHealth service, period unspecified
Source: DHC internal report

Service users feedback showed 96% of respondents found their conversation with ChatHealth helpful.

Kooth

Kooth is a confidential online support and counselling service that helps young people aged 11 – 18 who want to talk about their mental health and emotional wellbeing, staffed by counsellors, wellbeing practitioners and psychologists. Office hours are between 9am-5pm Monday-Friday.

As well as enabling direct contact, the platform also offers messaging/chat facilities, discussion boards and journals tracking events or situations to help identify those that may have positive or negative impacts upon a child or young person.

An example of outputs reported are shown below in figures 235 and 236 for the quarter October-December 2020. Much demographic information is captured and reported, and outcomes are provided in terms of ‘goal movement’ on average of 5.68 in the latest quarter, however it is not clear what these degrees of movement indicate. There is indication given of reasons for counselling support and of areas of interest accessed through articles and self-help documents, but no indication of types of concerns by chat or messaging.

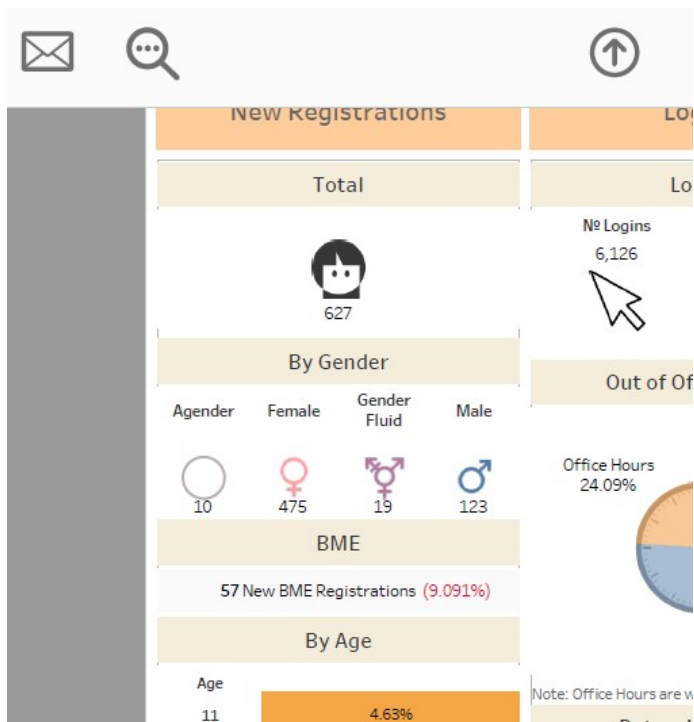


Figure 235: Quarterly output presentations, October-December 2020
Source: Kooth Quarterly report, Q3 2020/21

	Q1	Q2	Q3	Q4	Total
New Registrations	624	507	627	000	
Total Logins	6810	6391	6126	000	
Unique Young People	852	713	826	000	

Figure 236: Kooth Quarterly Outputs, April-December 2020
Source: Kooth Dorset Insights, Q3 2020/21

Data for the most recent 12-month period of January-December 2020 showed a number of outputs, including 2,494 new registrations and 25,203 total logins. The percentage of logins occurring outside of office hours ranged from 64-76% over the 12-month period. An indicator of overall satisfaction with the service, recommending to a friend, reported between 90-100%.

Shown below in figure 237 were the most prominent reasons young people accessing counselling services present with. It can be seen over the 3 quarters (April-December 2020) the main three reasons were for anxiety/stress, self-harm and either suicidal thoughts or family relationships.

Top 10 most prominent issues					
Q1			Q2		
#	Issue	SU	#	Issue	SU
1	Anxiety/Stress	71	1	Anxiety/Stress	77
2	Self Harm	43	2	Self Harm	39
3	Family Relationships..	34	3	Family Relationships..	38

Figure 237: 10 most prominent issues Service Users presented with for Counselling service, April-December 2020
 Source: Kooth Quarterly report, Q3 2020/21

Stakeholder views

A local view-seeking campaign was launched in February 2020, through to June 2020, the findings from which are contained in a separate report titled 'Your Mind, Your Say', (YMYS) compiled by Bournemouth University, held with Dorset CCG. The exercise captured views and experiences of individuals both through an online survey, conducted by the Market Research Group at Bournemouth University, and through group sessions delivered by the project team.

Views of young people were sought through meeting with engagement groups, school pupils, college students, learning disability groups alongside collection of views of parents and professionals. An audience analysis and Equality Impact Assessment were performed to ensure identification of, and engagement with, appropriate stakeholders.

Due to the pandemic later engagement activities did not take place and it is recognised the feedback is not reflective of people's experiences during the pandemic lockdown. The feedback also did not involve specific users of more specialist services such as in-patient or eating disorder.

Focus was provided through three questions, and findings compiled through thematic analysis:

1. From your experiences, what do you think is good or helpful about mental health services for children and young people in Dorset?

2. From your experiences, what do you think can be challenging or could be better about mental health services for children and young people in Dorset?

3. From your experiences, what would make the biggest difference to mental health services for children and young people in Dorset?

Also contained within the report was simultaneously view-seeking research performed by Healthwatch Dorset, to work alongside that of the 'Your Mind, Your Say' project. They conducted their research with youth groups and local organisations to capture views of young people who may not access traditional means of expressing a voice. Their focus was on those excluded from school, young offenders, young carers, young asylum seekers and young people experiencing homelessness.

The 'Your Mind, Your Say' project additionally identified eight local, regional and national view-seeking projects, involving children, young people (aged between 12 and 24) as well as parents and carers about their perceptions and experiences of mental health and supporting services.

Full details are within the report, however, findings are summarised below and in figure 238.

Positive comments, notes of concern and areas for improvement are summarised below, under 'Users and Families' and 'Professionals' views.

Users and Families' views:

Positive experiences of mental health services responses included:

- Being listened to, cared about and supported
- Experiencing high quality of care
- Being in control of medication regarded positively
- Developing good relationships with key workers and how important it is to have staff that are professional, warm and friendly
- Accessing specialist support when needed
- Good examples of services working together

Points raised by service users and families on areas of concern or potential for change are shown in figure 238 below.

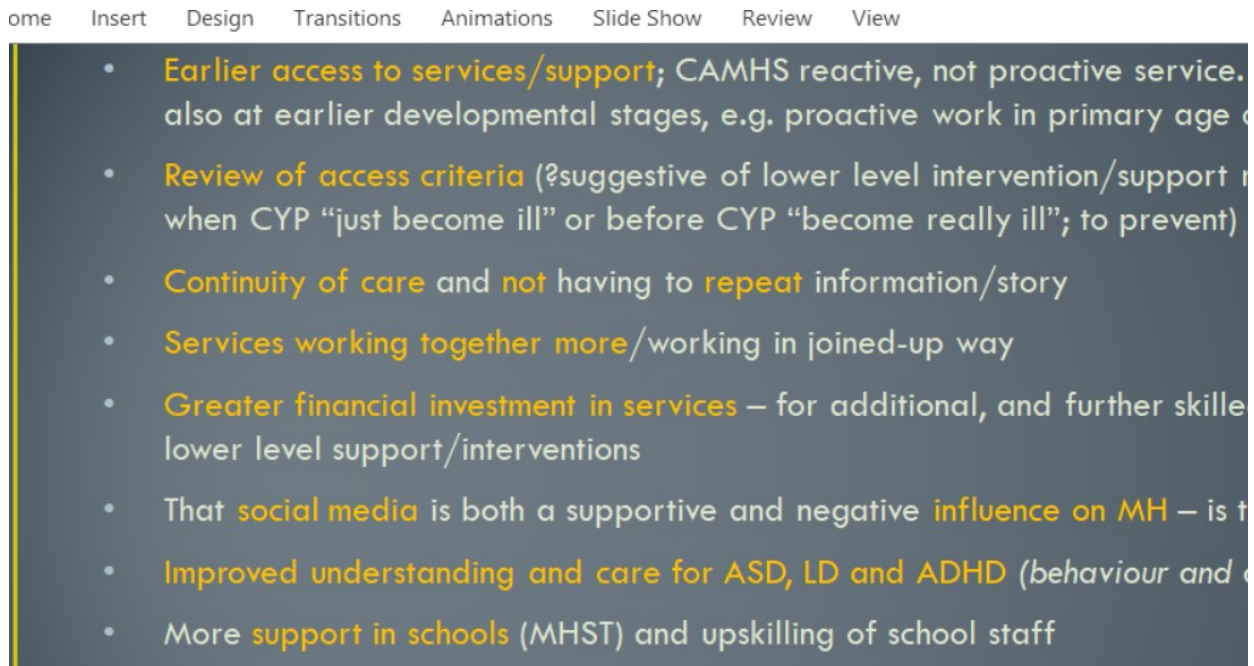


Figure 238: Service Users/Families' concerns/potential for change
Source: 'Your Mind, Your Say' report, accessible through Dorset CCG

Professionals' views

Views were provided through meetings and survey, and meetings were held with five of the community CAMHS services (the specialist inpatient unit was planned but not completed due to COVID-19).

Positive areas of feedback were received:

- Good co-working with other support services e.g. youth groups, voluntary sector, GP, Police and NHS
- Good telephone support service for mental health (Connections)
- Good text service support from School Nurses (Chat health) and UK (Shout)
- Mostly good experiences of Kooth (online support)
- Other anonymous digital support mechanisms benefit children and young people

Points raised by professionals about areas of concern or potential for change are shown in figure 239 below.

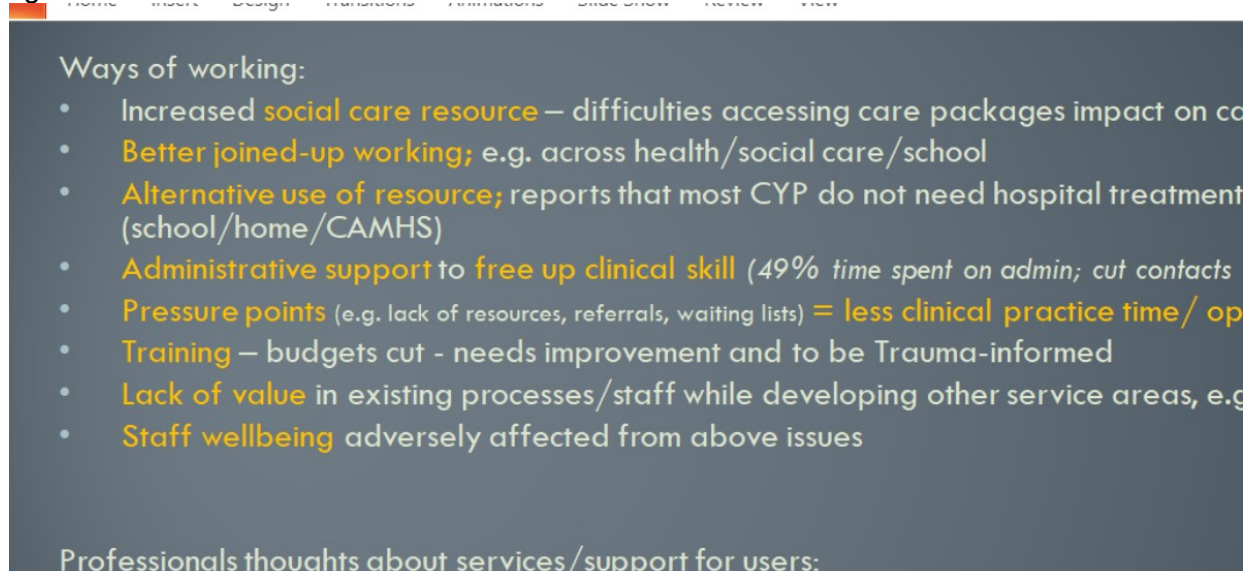


Figure 239: Service Users/Families' concerns/potential for change
Source: 'Your Mind, Your Say' report, accessible through Dorset CCG

Healthwatch Dorset

Healthwatch Dorset's concurrent engagement project focused on working with young people excluded from school, young offenders, care leavers, young asylum seekers and young people experiencing homelessness. They gained views of 23 young people, aged between 14-20 years.

Again, a more detailed summary is contained within the full 'YMYS' report, but in summary the majority of findings aligned with those of the 'YMYS':

- Importance of caring mental health support workers that really want to help
- Shorter waiting times and being able to access services when needed
- Option of continuing sessions beyond six offered
- Support worker continuity, and preparation before sessions; would avoid both re-traumatising people and reinforcing lack of continuity in relationships
- Difficulties in accessing interpreters
- Delivery of support in different settings, where children and young people feel 'comfortable' (perhaps outreach)

Additional Insights work, as part of the YMYS project

The eight additional national, regional and local engagement works identified used various methods to gather feedback from children and young people (aged 8 to 24), parents, and carers about perceptions and experiences of mental health and supporting services.

17 themes were common to all eight projects, again further detailed in YMYS report, but importantly nearly all align quite clearly with the findings of the YMYS project:

- Support and education at school
- Community support and places to go / Safe and youth friendly environment
- Access – transport, eligibility and criteria
- Timeliness of services / Early intervention and awareness
- Input, both into service design and in their treatment plan
- Transitioning into adult services
- Support and education for families (and friends) / Peer support
- Stigma
- Social media and digital channels
- Relationship between a named professional and service user
- Confidentiality and rights
- Professionals experience, skill, qualifications or training in mental health

Summary

There were a number of recurring themes cutting across all the engagement projects and it is vital these are considered in any future planning and commissioning of mental health services and support. These insights into a range of individuals' perceptions and experiences are *useful* in understanding the current offers strengths and weaknesses, and maybe offers insight into how things may operate more proactively, or in more appropriate settings, to reduce inequalities as well as provoking thought about how services look and feel to the people who run them.

Mapping of existing services and support through other mechanisms

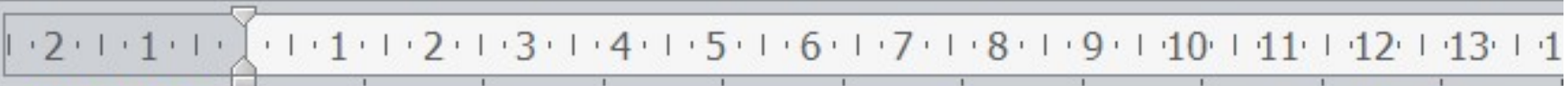
There are many different organisations that offer mental health support or services, to include:

- Healthcare, e.g. CAMHS
- Schools (including School Nursing through Public Health, School counselling, MHSTs)
- Youth services
- Others, e.g.
 - Online
 - Telephone support, e.g. Connections (local), childline (National)
 - Voluntary sector
 - Peer support groups

Further detail on services across Dorset, under different thrive groupings are contained in appendix 9.

The diagram shown below is not a comprehensive directory of services across Dorset. It is an indication of the level of services we have to meet need across the differing THRIVE segments. It is beyond the scope of this HNA to establish, for each organisation or mechanism of delivery, the:

- Appropriateness (delivering at right level of need and in the way the individual needs them to be)
- How much uptake of the service there is
- How helpful are they to the CYP (e.g. outcomes/evaluation processes)
- Whether there is equitable access



THRIVING

- Individual, e.g. Personal resilience, communication, self-regulation, sense of control
- Family relationships /parenting styles/attachment
- Friendships
- Communities and Social Networks
- Activities – meaningful, such as exercise, play, socialising
- Access to open/green/blue spaces
- Government policies – wider social circumstances, e.g. housing, employment, safe neighbourhoods, crime levels
- PSHE (personal social and health education)
- Health Services
- Early Years provision
- Whole School approach, including pastoral care
- Mental Health First Aid
- Family Information Directory/Services (BCP/DORSET)
- Educational Psychology Service (EPS)
- Chat Health
- Kooth
- Live Well Dorset (18+)
 - Bestie app – planned?

RISK SUPPORT

- Social Services
- DHC CAMHS Gateway (BCP pilot)
- CAMHS, to include
 - Crisis and home Treatment Teams (CAMHS)
 - Psychiatric Liaison service
 - Forensic CAMHS
 - CAMHS In-Patient
 - Young Peoples Eating Disorders Services.



ADVICE

- Community psychology: Families, schools and wider communities, incl. social media
- Universal services, e.g. Schools, Early years provision, School nurses, GPs, midwives, health visiting, etc
- Local:
- DHC CAMHS Gateway (BCP pilot)
- DHC CAMHS? (THRIVE report only 1 session most frequently recorded = support and signposting?)
- DHC MHST
- DHC Steps2Wellbeing (18+)
- *Primary Mental Health Worker (PMHW)*
- *SALT*
- Schools: Schools-based counselling and pastoral support, Mental Health Support Teams
- Educational Psychology Service (Age: 0 – 25):
- Emotional Literacy Support Assistants (ELSAs)/SENCO
- School – approaches: e.g. 'Academic Resilience', Attachment Friendly. Mind Your Head/Big Umbrella, Yo
- Children's Education Advisory Service (CEAS) – children of service personnel (& Local Armed Forces Com
- Dorset Mental Health Forum
- Discovery Project
- Recovery College (18+)
- Chat Health
- Kooth
- **Bestie app – planned?**
- Family partnership zones
- CiC & Care Leaver Services
- Virtual School for LAC
- Transitions Teams
- Children with Disabilities Team
- End of Life / Palliative Care services and organisations, e.g Gully's Place, Julia's House
- Family Information Directory/Services (BCP/DORSET)
- Early Help offers, including evidenced based parenting programmes/ Childrens Centres. Early Help supp

Figure 240: Mapping of existing services and support through other mechanisms, across Dorset, placed within THRIVE groupings.
Source: DHC in-house creation, with input from Dorset EWBMH Steering Group

Interventions

National policy and direction continue to reiterate that a twin-track approach of prevention and promotion alongside support and treatment is required to both enable wellbeing and good mental health and address poor mental health^{iii,iv,v,viii,xxix}. Opportunities for this during pregnancy, childhood and adolescence are significant given most lifetime mental disorder has arisen prior to adulthood.

This HNA has provided knowledge of prevalence of lower wellbeing and poorer mental health, mapping of risk factors and vulnerability, alongside highlighting contexts affecting wellbeing and mental health, all of which have implications for how universal approaches might need to be adapted to be relevant in the circumstances of people's lives.

This provides the basis for discussions on priority setting within the findings and recommendations section which will be taken forward and agreed within the wider Dorset system via the designated mechanisms. The impact of using this information to further inform the design, planning and commissioning of appropriate support and services will influence a child or young person's immediate state, and that of their family, but also their future and that of upcoming generations.

NHS England^{cccxxv}, and other publications, refer to a range of interventions including universal and targeted interventions relevant at different stages of the life course. Their recommendations are to employ interventions found in the EIF guidebook, either at universal, 'targeted selective' or 'targeted indicated'.

Over the last decade there has been a move in the provision of intervention to the concept of 'proportionate universalism', defined as "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need". The intention originally within the Marmot Review in 2010 was to reduce discrimination and stigmatisation sometimes enabled by 'targeting' specified groups for services. This concept has been discussed in the literature and a lack of practical application has been commented on many times. Careful consideration of approaches to proportionally address greater needs must be made in design and planning stages^{cccxxvi,cccxxvii,cccxxviii}.

The concept aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest. It has been proposed that can be achieved by obtaining an assessment of need and an understanding of the impact of social inequalities on health outcomes. A judgement may then be made as to how much additional resource should be allocated per 'unit' of additional need (the weighting).

There are still differing approaches suggested; 'positive selectivism' within universal proportionalism refers to targeting based on needs, irrespective of a social position; 'particularism' proposes different standards for different categories reflecting diverse circumstances and alternatively there is "targeting within universalism", combining approaches, sometimes called "progressive universalism".

Identifying what stakeholders require

A HNA framework^{ccccxix} advises that the assessment of interventions initially focuses on asking patients, professionals and other stakeholders what they want followed by a review of scientific knowledge.

The engagement exercises referred to in the previous section provide understanding of what is seen as important locally, namely:

Positive aspects:

- The continuation of high quality of care and specialist support, with positive, continuous relationships with key workers and other staff
- Being in control of decisions about care/medication.
- Value was placed on existing telephone, messaging and online support services and joined-up working with other services, including youth groups, voluntary sector, GP, Police and NHS.

Concerns/potential for change:

- The provision of earlier and easier access to intervention, not just when have more significant symptoms or have had them for a specified length of time
- Shorter waiting times
- Flexibility around the delivery of support; in different settings, where children and young people feel 'comfortable'
- Flexibility of treatment options
- Support and education at school
- Community support and places to go, which are safe and youth friendly
- Input, both into service design and in their treatment plan
- More successful transition to adult services and more support for people with ASD, LD and ADHD
- Support and education for families (and friends) / Peer support
- Increased awareness, specifically around self-harm and suicide
- Social media and digital channels support
- Confidentiality and rights

Further detail on children and young people's views on interventions, during a recent, national evidence review, is contained below.

Identifying scientific knowledge on interventions

There have been a number of comprehensive evidence reviews over the last few years around interventions of benefit to mental health and wellbeing, in children and young people, in early years, in the general population and within communities.

While all reviews and the EIF Guidebook referred to later in this section are rigorously assessed and well-evidenced, they cannot have covered all possible interventions and cannot guarantee effective outcomes if employing an interventions. The EIF guidebook highlights that other interventions should always be considered, as their guide does not aim to inhibit innovation or prohibit practices with evidence of being effective at the local level.

Public Health England: Special Interest Group (SIG) 2019 review of approaches to improving children and young people’s mental health and wellbeing^{xxxvii}

PHE have recently conducted a substantial evidence review of approaches to improving children and young people’s mental health and wellbeing, more comprehensive than would have been afforded by this needs assessment and it is considered unnecessary to duplicate that work.

They advise findings are of use to strategic and operational leads, including commissioners; public health teams; Child and Adolescent Mental Health Service (CAMHS) providers; clinicians, leads in educational settings and those leading children and young people’s mental health and wellbeing Local Transformation Plans (LTPs).

During their synthesis of systematic reviews, they covered a total of 113 interventions; the majority operating at the individual level, a few at family or school level and none at community level. There are caveats to bear in mind, as interventions had to have two evaluation studies to satisfy the criteria of supporting evidence; that means if an intervention was researched more it was more likely to be considered promising with the underpinning evaluations. Therefore other interventions may always be considered on a pragmatic, local level.

The review covered interventions aimed at those between 4-18 years of age; there are then gaps for those aged 0-5 years and beyond 18 years. Descriptions of both the promising, and all interventions, are available via links shared in appendix 10. An example of detail provided is in appendix 11.

There is a table summarising the evidence and costs of the promising interventions, an example is shown below in figure 241.

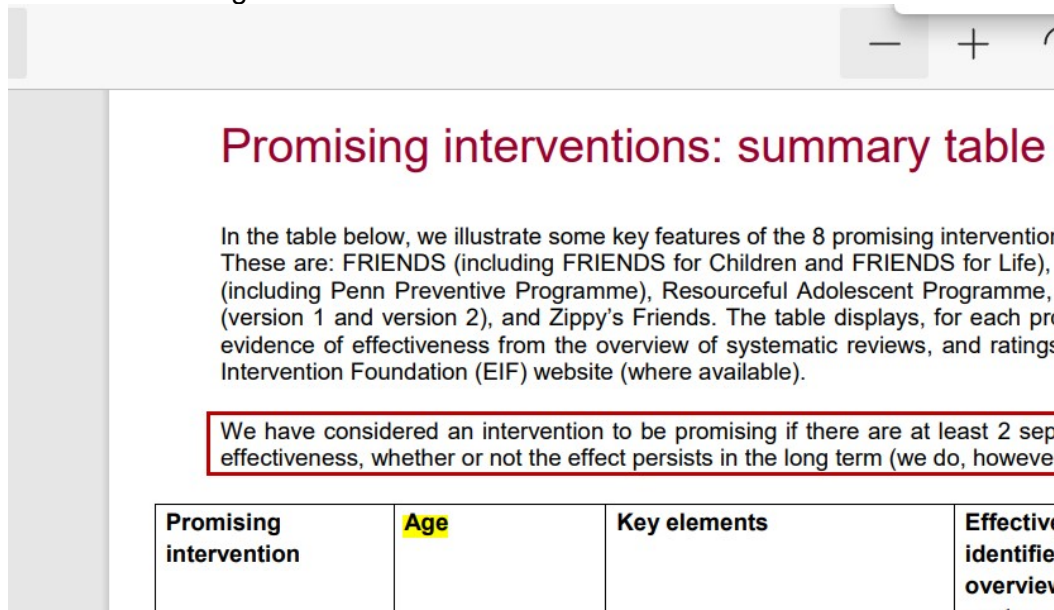


Figure 241: Promising interventions: summary table
 Source: PHE (2019), Universal approaches to improving children and young people’s mental health and wellbeing: Findings from the synthesis of systematic reviews.

They reported eight promising²⁵ interventions operating at individual, family and community levels and a further range of interventions from a review of other literature. 22 of those interventions identified were contained within the Early Intervention Foundation's Guidebook (EIF), where strength of evidence of impact and relative costs have been considered.

Children and young people's views factors they perceive to be important in keeping themselves mentally well also formed a significant part of the review. Outputs supported taking an assets-based approach to promoting mental wellbeing (recognising and building on the strengths of supportive interpersonal relationships and the characteristics of supportive places, environments and wider influences

Summary of findings

The approaches were mainly universal approaches that operate primarily at an individual level, aiming to prevent emotional and behavioural difficulties, and promoting resilience. Seven aimed at preventing mental health problems, and four at promoting resilience (with three aiming to do both). Four had evidence of positive change at 12 months follow-up.

Preventing behavioural difficulties:

Amongst individual-level interventions, there was good evidence in targeting primary-school children when aiming to preventing behavioural difficulties. An intervention for primary school children that was highlighted was 'Promoting Alternative Thinking Strategies (PATHS) programme', which led to improvements in impulsivity, hyperactivity and aggression, sustained for at least one year. In contrast, there were no promising interventions addressing behavioural problems in adolescence.

With family-level interventions there were only two interventions involving primary school children: strong evidence of effectiveness was seen in one, 'Triple P Online', found to reduce behavioural disorders for a follow up period of 6 months.

There was not sufficient evidence of any effective intervention at school-level.

Preventing emotional difficulties:

The authors remarked that very few interventions have been reliably demonstrated to prevent emotional difficulties; in the case of both children and adolescents, some interventions show a degree of short-term effectiveness, but rarely is this seen across different evaluations, and even more rarely is the effect maintained after 6 months or one year.

At the individual level there was, however, strong evidence that 'FRIENDS for Life' effectively prevents anxiety disorders after the intervention, in both younger and older children, with the positive effect on anxiety persisting up to one year in one evaluation.

The 'Penn Resiliency Programme (including its close kin Penn Preventive Programme)' and the 'Resourceful Adolescent Programme' may be considered promising for preventing depression among adolescents, although improvements over time were questionable. Another intervention for adolescents, 'LARS&LISA', successfully improved depressive symptoms post-intervention, but there was a mixed picture of benefits sustained after 6 months.

Family-level interventions were 'FRIENDS for Children', applicable to both younger children and adolescents, which was systematically shown to reduce anxiety symptoms post-intervention, with good evidence of sustained change at 12-month follow up and, in younger children, even after 3 years. It is worth highlighting the family-level variant of the Resourceful Adolescent Programme as well, for which there was some evidence of successful reduction in depressive symptoms 10 months post-intervention although there was a lack of evaluation studies.

In terms of school-level interventions, the review only identified MindMatters, but evidence for that intervention was not extensive.

²⁵ An intervention was considered to be promising if it was supported by a high level of evidence, from a synthesis of systematic reviews. There needed to be at least two separate evaluation studies showing some degree of effectiveness, whether or not the effect persisted in the long term.

Promoting resilience and capabilities:

At individual-level there were a number of interventions that showed some short-term effects in coping, self-regulation and empathy but few were evaluated in the long-term and those that did were not sustained. One, 'Zippy's Friends', had four evaluations concluding it improved coping skills and other resilience-related outcomes among primary-school children, although its long-term effectiveness was not clear.

Family-level interventions demonstrated two interventions with effective outcomes demonstrated. 'Triple P Online', was found to improve parent-child relationships for young children at least up to 6 months post-intervention. Additionally, the 'Substance Abuse Risk Reduction programme' was seen to improve parent-child interaction and communication for older children post-intervention and at one-year follow up.

Two school-level interventions were reviewed (UP and MindMatters, both for adolescents) and showed some effect on resilience-related outcomes in the short-term, but lacked longer-term outcome data.

Promoting subjective wellbeing:

There was little evidence of individual-level interventions improving subjective wellbeing. They did not identify any promising interventions, but did flag mindfulness-based interventions, such as Learning to Breathe and Mindfulness Based Stress Reduction, as being potentially the most effective.

A poor evidence base led to conclusions of being unable to advise of any promising intervention at family or school-level.

Children and young people's views within the evidence review

The views of children and young people highlighted the need to consider the background, place and demographics in understanding the differences in their wellbeing and mental health. Consistent themes that emerged were of family members and peers as important in influencing their mental wellbeing. However, there was a reluctance to sometimes discuss with parents when parents themselves may be burdened by daily life pressures or dealing with their own mental health problems. There was also fear of the consequences of sharing conversations about mental health and wellbeing with parents and a perception that parents may lack understanding of mental health problems and the skills to help.

School staff were potentially important sources of support for mental wellbeing, for some caution was given as some schools were not necessarily seen as being able to maintain confidentiality or staff were perceived as lacking the necessary skills to support.

Youth workers, voluntary and community youth agency staff, counsellors or mentors were identified as credible sources of genuine support.

Young people identified qualities they felt important in those they looked to in supporting their own wellbeing; supportive, friendly, a good listener, compassionate, non-judgemental and trustworthy. Possessing a good understanding of mental health problems, continuity and consistency of relationships were also identified as important. In some cases, young people expressed a preference for support being given from someone sharing a similar background and experience, of particular importance for LGBT young people. Clarity in understanding boundaries and confidentiality was also cited as being relevant.

Children and young people's views supported taking an assets-based approach to promoting mental wellbeing (recognising and building on the strengths of supportive interpersonal relationships and the characteristics of supportive places, environments and wider influences),. They highlighted the importance of approaches appreciating the differing exposures to risk and protective factors individuals have had and the various contexts in which young people live.

The young people also recommended action being taken to support improved mental health and emotional literacy of young people, families and professionals. Their views exposed the need to provide more effective guidance for parents.

Other relevant reviews of interventions, support or approaches

In light of the gaps in understanding the evidence base for interventions in those under 5 years of age, it may be prudent to refer to a review of evidence used within the healthy child programme was published in 2015, again by Public Health England^{ccccxx}.

This update brought together evidence about 'what works' in

- parental mental health
- smoking
- alcohol/drug misuse
- intimate partner violence
- preparation and support for childbirth and the transition to parenthood
- attachment
- parenting support
- unintentional injury in the home
- safety from abuse and neglect
- nutrition and obesity prevention
- speech, language and communication

Their work covers such interventions such as in pregnancy to reduce postpartum depression, self-help for mild-moderate depression, men-only adjunct classes for parenthood to include teenage fathers particularly.

The review focused, within each section, on evidence within the realms of:

- Prevention
- Interventions
- Identifying families in need of additional support
- Implementation issues
- Workforce skills and training

This is a very detailed document, the summary report is 40 pages and so is beyond the detail available within this section, however, once directions and priorities have been set within the Dorset system, it would be advisable to review the appropriate reviews of evidence to inform planning, along with other strands of planning strategy.

Similarly, evidence and advice contained within guidance from PHE in 'Supporting public health: children, young people and families'^{ccccxxi} provides support to local authorities and providers in commissioning and delivering maternal and child public health services from preconception up to 24 years. These are covered within stages of maternity, early years, and school aged years.

The documents include health and wellbeing, resilience, maximising learning and achievement, supporting complex and additional health needs and transition to adulthood. An extensive list of links to relevant resources and tools is also provided.

Other resources that may be of use in prioritising and planning interventions or approaches are further detailed below.

- The 'Mental health and wellbeing: JSNA toolkit' is a specific pool of evidence and resources aimed at supporting schools, service providers and commissioners in understanding and designing approaches and services.
- PHE and the London School of Economics in 2017 produced the 'Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health' report^{ccclix} which references interventions in younger people and adults. One example is a programme aimed at reducing bullying, with returns on investment for schools in behaviour and academic achievement, for CCGs in reduced requirement for CAMHS and reduced A&E attendances for self-harm, and societally_ in reductions in crime and of likelihood of going to university and increased lifetime economic productivity and benefits.
- Furthermore, the Public Health England ROI tool^{cccxxxii} provides assessment of the return on investment (ROI) for eight different interventions to promote better mental health and prevent the development of mental health problems, such as school-based social and emotional wellbeing programmes and programmes to address bullying of young people. Outputs are likely cost of providing the intervention, which sector e.g. health, education, would be likely to pay for this, and an estimate of what future costs might then be avoided within different sectors, such as health, education or criminal justice, as well as employers and wider society, as a result of improved mental health.
- A specific set of guidance for assisting leaders in education to promote emotional health and wellbeing in children and young people's is available in 'Promoting children and young people's emotional health and wellbeing' guidance from PHE^{cccxxxiii}. The document principles are informed by evidence and practitioner feedback about what works and links to Ofsted inspection criteria, practice examples and resources to support implementation.
- The PHE 'Menu of preventative interventions'^{xxxix} covers specific areas of possible interventions in the area of alcohol, diet, obesity, workplace wellbeing and mental health, and although often not specific to children and younger people, may be worthy of review with the expansion of the offer to those up to age 25.
- 'A guide to community-centred approaches for health and wellbeing' by PHE^{cccxxxiv} also presents research and learning on community-centred approaches for health and wellbeing, with a guide to the case for change, the key concepts, the varieties of approach that have been tried and tested and sources of evidence.
- Although written with a specific focus on 'Children in Need' or 'Children in Care' there are two documents which contain practical approaches and suggestions on tackling inequalities which would apply on a wider level, with signposting to resources, evidence and funding streams. They are the Department for Education's (DfE) 2019 report titled "Help, protection, education: concluding the Children in Need review" and the DfE. Home Office and Ministry of Justice's 2018 report "The national protocol on reducing unnecessary criminalisation of looked-after children and care leavers."^{clci}

Also, of note, is 'Mentally Healthy Schools'^{1ccccxxv}, overseen and resources quality assured by the Anna Freud centre, which aims to provide information, advice and practical resources to better understand and promote pupils' mental health and wellbeing, which they outline within five sections below:

Getting started: a guidance section for teachers and leaders to understand mental health and its place in school and college settings.

Resource library: quality-assured lesson plans, assembly plans and PSHE resources to support and assist in teaching and learning about general mental health and wellbeing as well as specific topics.

Risks and protective factors: a look at the issues which can undermine a child's mental health, including bullying, family breakdown and more. Includes information on identifying pupils who may be at risk and practical resources to help support and build resilience.

Mental health needs: focuses on the specific types of mental health difficulties children may struggle with. It helps school and college settings understand their role and what they can do to promote pupils' recovery.

Whole-school approach: helps school leaders develop the wider support across the school to help children, families and staff thrive.

There are many other sources of information and support, such as NICE Clinical Guidelines available for a range of mental disorders, but all cannot be summarised within this HNA.

Design and Delivery of interventions

Recommendations and priorities are to be confirmed by the Dorset Emotional Wellbeing and Mental Health Steering group and should link with the reviews of interventions in the EIF guidebook, in conjunction with other known appropriate evidence sources.

There are numerous suggestions on ways forward, and it will be worth using local experiential knowledge of what is available and lessons learnt from previous support offered. Consultation and co-design is an agreed local approach in order that services fit local need.

Universal proportionalism and the management of possible selectivism within that will also need to be carefully considered to maximise resource, impact and outcomes.

This document needs to be reviewed in conjunction with the Dorset Children and Young Peoples Mental Health Strategy and the Mental Health iThrive Implementation Plan establish direction and identify gaps in the future plans to agree the best approach to address them. It would also be advantageous to analyse current integration of pathways and initiatives. This could identify opportunities to integrate further to improve outcomes for children and young people in their childhood, adolescence and adulthood.

Matching need to current provision

Following the review of this HNA, the process will need to take place whereby discussions and decisions are made based on:

- What needs/inequities are identified
- What services we have
- What plans we already have in place
- What we then identify as gaps

This is no small task, and other published HNAs do not share much detail on this process. The needs and possible inequities in our local population have been defined as far as possible, services have been outlined and there is a Dorset Children and Young Peoples Mental Health Strategy and Mental Health iThrive Implementation Plan, The 'Findings and Recommendations' section of this report details 'Gaps' thus far identified.

Conclusion

Children and young people exist within numerous contexts, with the impacts of differing identities, families, relationships, schools, wider communities and societies; all of which impact upon their ability to process and manage their responses to events and ultimately, their wellbeing and mental health.

While the majority of children and young people live with states of positive wellbeing and mental health, some children experience poorer wellbeing and mental disorders, often living within more complex contexts and experiencing inequalities across health, education and wider, social circumstances, of income, housing and community safety.

It is clear, and well-evidenced, that wellbeing and mental health are critical determinants in children and young people's immediate and long-term outcomes persisting throughout the lifecourse and through generations. These outcomes span multiple domains such as relationships, health, education, economic productivity, housing and impact upon, or contribution to, society.

This needs assessment has highlighted key themes in relation to the wellbeing and mental health of children and young people nationally, and across Dorset, documenting levels of wellbeing and prevalence of mental disorders, populations at risk, services and the level of demand upon them alongside the views of children, young people, their families and professionals who support them.

There are consistent and cross-cutting themes, demonstrating the rising need at both lower-levels, including wellbeing and mental health, and at increased levels of need which require support and intervention. Evidence demonstrates the persistence of inequalities for children and young people in their life circumstances, in the varying risks to their mental health and their access to support or services.

Across Dorset there have been varying levels of wellbeing and of family functioning, areas of considerable poverty and deprivation, higher levels of absences and exclusions from school, of young parents and of indicators of mental disorders, seen in hospital admissions for alcohol, substance misuse and self-harm and increasing levels of suicide. Presentations to hospital are the tip of the iceberg in levels of substance misuse, self-harm and attempted suicide that goes unseen in the community.

Modelling estimates indicates around 16,000 children across Dorset would be considered to have one diagnosable mental disorder, and more than 6,000 with more than two disorders and there is rising demand nationally and locally upon child and adolescent mental health services (CAMHS).

Treatment alone does not, and cannot, meet the scale and breadth of need on either a national or local level. The needs assessment aligns with the THRIVE model and recommendations focus on effective prevention across the life-course, including action to meet the wider contextual needs of children and young people in improving mental health and wellbeing outcomes.

Mismatch exists between referrals to CAMHS and children and young people who require or are appropriate for specialist intervention. Stakeholder views highlight concerns and frustrations related to timely access to specialist services and alternative offers. This needs assessment highlights both the importance of shared understanding of local models, pathways and support across children and young people, their families and wider multi-agency communities, and the a collective effort required to develop alternatives, both within and outside of specialist service offers.

Findings and Recommendations

Key findings arising regarding the wellbeing and mental health of children and young people in Dorset have been generated through a number of mechanisms including publications, research, data and stakeholder views, at national and local levels.

The significant impacts of mental disorder to individuals, families and society are highlighted, along with national and local levels of wellbeing and prevalence of mental disorders in children and young people. Populations at increased risk of experiencing mental disorders are detailed with information on protective mechanisms. Reviews of service data have demonstrated the demand on service provision and the views of children and young people, families and staff provide richer understanding of what successes and challenges there are in trying to support children and young people in managing their mental health. The HNA moves to understanding service mapping and evidence around interventions to support wellbeing and mental health.

The consequences of mental disorder are multi-dimensional, linked with suffering, functional impairment, poorer physical health and less healthy behaviours, even within younger age groups. These factors lead to an enhanced risk of longer-term morbidity and increased mortality risk in adults and in younger people; suicide is the third leading cause of death among adolescents.

Wider effects include reduced educational attainment, social development and less healthy relationships; these extend into adulthood, through reduced chances of employment and good quality housing and the continuation of living in deprivation and poverty.

Conversely, positive wellbeing and mental health affords children better physical health, with less health-damaging behaviours and longer lives lived without ill-health. They are less likely to experience social inequalities, have increased educational achievement, increased economic opportunity and reduced mortality.

This HNA reports on the prevalence of lower wellbeing and of mental disorder, in pre-school and school-aged populations, in parents and within populations at increased risk. Risks of mental disorder are often much greater in disadvantaged and vulnerable children and young people, who are often exposed to adverse childhood experiences and inequalities. Increased vulnerability to lower wellbeing and mental disorders are, in part, explained by the inequalities they experience in social and health determinants.

The overall impression is that while the vast majority of children and young people are doing well or 'thriving', with reports of being happy, satisfied with their life and feeling a sense of their life being worthwhile, there are indicators that a significant proportion are not in such a positive position with their wellbeing or mental health. There is increasing evidence that proportions may be growing in light of the COVID-19 pandemic. Most data collected is prior to the pandemic and so may underestimate the current prevalence and reach.

The findings reported and recommendations encompass understanding and approaches acknowledging the impact of experiences during infancy and early years, through school ages into young adulthood, and the significant effect familial and social circumstances have. They suggest recognising the powerful need for promotion and prevention, in driving earlier opportunities to maintain or improve wellbeing and mental health, while also offering earlier, more accessible interventions for those who have mental disorders.

For some with lower-level need, to offer 'interventions' could be iatrogenic (cause harm) through reduction of self-efficacy, esteem and resilience. Innovation and initiatives based on research which concentrate on supporting and building personal, family and community resilience and strategies for maintaining and building good mental health and wellbeing are believed beneficial.

Mechanisms for those who require further advice and support may be warranted, to support the maintenance of positive wellbeing and mental health, but also in supporting those with emerging mild-moderate need in wellbeing or mental health.

There are existing mechanisms but some have not historically been easy to navigate or access and consideration of avenues to access may be required for children or young people, their parents or carers or professionals around them.

Within all approaches, there is the need to view children and young people and their families more holistically, understanding the impact of context and wider determinants of health and wellbeing at school, in the community or at home.

Wellbeing

Wellbeing has not always had the significance attached to it that mental health has, yet is associated with important outcomes. There are associations between self-harm and significantly lower wellbeing scores; those with lower wellbeing scores are more likely to engage in activities of risky behaviours, have poorer health, and engage less in behaviours with protective mechanisms, such as being physically active and eating healthily.

There have been a number of risk factors established for low well-being, such as difficult family relationships, sexual identity, being bullied, disability or long-term health conditions, challenges with school, being within a family under financial strain or living in deprivation, and experiencing a combination of social, familial and material disadvantages.

Nationally, children and young people's wellbeing has declined during the last 10 years; at the beginning of the COVID pandemic, nearly one in five (18%) of children were deemed to have low well-being; prior to the pandemic it had been around one in ten (10-13%). In 2018, 15 year olds in the UK were among the saddest in Europe, were the least satisfied with their lives and reported high levels of 'fear of failure' compared with other European countries. England was also ranked one of the lowest of 45 countries for overall life satisfaction in 11 year olds. Children and young people were found to have high levels of emotional complaints such as feeling low and having difficulties sleeping.

The UK also had the second largest gender gap, with nearly a quarter of girls scoring low on at least three out of four measures (life satisfaction, happiness, sadness and purpose), compared around a tenth of boys.

Confirmed local indicators of wellbeing are not recent, but there is suggestion that the current position in Dorset may be below that of England; more than one in five young people across the South West recently reported a lower wellbeing score.

Analysis suggests those engaging in protective behaviours, such as increased physical activity, less sedentary behaviours and eating recommended portions of fruit and vegetables, have higher average wellbeing scores than those engaging in activities associated with poorer health (risk factors including drinking and smoking).

Mental disorder

Prevalence of mental disorders in 5-19 year olds now stands at one in eight meeting the criteria for a mental disorder, and one in 20 meeting the criteria for having two or more disorders. Increases have been seen across genders and age groups; peaking at nearly one in four in young women having a mental disorder. The most frequent type of disorder was 'emotional' which includes anxiety and depression.

For the first time, prevalence was also studied in children of preschool age (2-4 years), finding around one in 18 met criteria for a mental disorder. Modelling across school-ages equates to around two to five children, per average school class, having a mental disorder.

Factors associated with having a mental disorder in children and young people include being of particular ethnic backgrounds, poorer own physical health or parents physical or mental health, special educational needs (SEN), less healthy family functioning and living in lower-income households.

There is greater prevalence, or risk, in children and young people with identified characteristics, conditions or particular life circumstance, detailed further below.

System indicators of mental health prevalence

At a local level, hospital admissions data provides useful indicators of levels of mental health disorders, in admissions for mental disorder, self-harm and alcohol or substance misuse.

Self-harm is associated with lower wellbeing scores, mental health disorders and suicide attempts. There is increased likelihood of self-harm in those who are female, with minority sexual or gender identities, who live with higher levels of deprivation, are young carers or who are bullied, amongst other contexts. Importantly, a large proportion of self-harm incidents go undetected.

Young people experiencing problems in their life are extremely vulnerable to developing problematic drug and alcohol use; there are adverse effects on their physical and mental health, education, friendships, family life and with violent and antisocial behaviour, and unsafe sexual behaviour.

Admission rates for mental health disorders, in those aged 0-17 years, were higher in BCP than in England while rates in Dorset UA were comparable to that of England.

Across Dorset significantly more children and young people are being admitted to hospital with self-harm and alcohol or other substance misuse related causes than both nationally and regionally. Self-harm admission rates have continued to rise since 2016 and remain above national and regional rates.

Across Dorset, suicide rates in all people over 10 years old have been higher in recent years, in both males and females, than nationally. There has not been recent data available on suicide in younger people.

Populations at increased risk

For children and young people with given characteristics, conditions or circumstances, the risk of experiencing or developing mental health disorder is significantly higher than in the general population.

Groups at greater risk covered within this HNA are wide-ranging. Children and young people from different ethnic backgrounds, with minority sexual and gender identities, who are obese, bullied, with poorer physical health states or with physical or learning disabilities, neurodiversity or special educational needs are at increased risk of experiencing mental disorders. Familial contexts known to increase the risk are those households with less healthy family functioning, low-income or with a parent in receipt of income-related benefits, with parents with poorer physical or mental health states, where children and younger people have roles as young carers or are military families. Children and young people who have experienced abuse or neglect or who are involved with social services or in care, absent or excluded from school, in contact with youth justice, homeless, asylum-seeking or not engaged in employment, education or training are also at increased risk of mental disorder.

Community and structural levels factors also include living in poverty, poorer quality or colder housing, poorer quality of education, and wider systems' inequalities and discrimination.

Health inequalities are evident in relation to mental health for children and young people within vulnerable groups, for instance, those excluded from school, young offenders, children in need and care leavers, amongst others, are far more likely to be also living in poverty, to have communication difficulties, to have SEN, to be absent or excluded from school, have reduced educational attainment, reduced social support or networks, increased risk behaviours and to experience substance misuse problems; all of which carry singular increased risk to wellbeing and mental health.

Some children and young people experience multiple risk factors, and there is complex interplay between these factors that further increase the risk of mental health disorder. This compounding effect, or mutual reinforcement, can vastly increase the likelihood of experiencing other risk factors and/or mental disorder, and have far-reaching consequences for health, achievement and opportunity, with effects extending into adulthood.

Effects of these inequalities can be seen in reduced and poorer access to, and outcomes from, in the contact some of these children and young people have with services, support. These impacts continue in reduced attainment, employment, income and future opportunity.

Characteristics, conditions or life circumstances that convey increased risk to the mental health of children and young people are detailed further below, under domains detailed individual, health, familial or societal for ease of reference. It is recognised, however, many factors have roots in other domains. There is also reference to risks by age stages.

Individual

Ethnicity

it is recognised people of different ethnic backgrounds can be at greater risk of developing mental health conditions and experience higher prevalence and severity compared with individuals of other ethnicities. Ethnicity is often associated with other factors affecting mental health, such as living circumstances and income; people from some minority ethnic backgrounds are more likely to live in overcrowded housing, poorer quality housing and poverty.

Boys from a White background were more likely to have a mental disorder, at preschool age than those of other ethnicities, while girls of other minority ethnic backgrounds had higher prevalence (breakdown by ethnicity was not available). Throughout school ages, boys from a White background showed the highest prevalence of mental disorder, however, children and young people from Mixed/Other backgrounds had similar prevalence.

It is also noted boys from Black and Asian backgrounds are more likely to be excluded from school and there is over-representation of Black and Asian young men involved with Youth Justice services, both of which carry increased risk of mental disorder.

While Dorset as a whole has lower diversity than England proportions, there was greater diversity amongst younger populations within the county, with highest levels of diversity seen in Bournemouth.

Sexual and gender identity

People with a minority sexual or gender identity have higher risk of experiencing poor mental health, including depression, suicidal thoughts, self-harm and alcohol and substance misuse. Lesbian and bisexual women under 20 were found to have significantly increased proportions of self-harm, eating disorders and suicide attempts; one in two had self-harmed, compared with one in fifteen of the general population, and one in six had attempted suicide.

Nationally around 4% of people aged 16-24 were lesbian, gay or bisexual in 2016. In 2017, amongst 14 to 19 year olds, one in ten identified as lesbian, gay, bisexual or other and they were found to be almost three times as likely to have a mental disorder than those identifying as heterosexual.

Long-term or limiting long-term illness

Having a limiting long-term illness has been associated with having a mental disorder; a quarter of 11-19 year olds with a mental disorder also had a limiting long-term illness (25.9%), compared to 4.2% of those without a mental disorder.

In contrast, children with a mental disorder had similar levels of long-term illness which did not reduce their ability to carry out day-to-day activities, compared to children without a mental disorder.

Excess weight

Having excess weight is strongly associated with poor mental health, and it is evident from as early as seven years of age that mental health and obesity are entwined and exacerbate each other, the association gradually increasing throughout childhood.

Apart from the potential to experience additional morbidity and mortality risks from the physical aspects of excess weight, there are associations with increased isolation, bullying, living in poverty and reduced educational attainment, self-harm and suicide.

Weight-biased attitudes in schools can lead to lower educational outcomes for children and young people with obesity, which can then affect children's life chances and opportunities, and ultimately lead to social and health inequities.

Excess weight is a national epidemic in children and young people, and although local data on 'overweight' or 'obese' shows a variable picture in line with England data, there remain a fifth of children aged 4-5 years old, and a third of children aged 10-11 years, across Dorset with excess weight.

Alcohol and substance misuse

Alcohol and substance misuse is associated with adverse effects on young people's physical and mental health, education, friendships and family life, as well as with violent and antisocial behaviour and unsafe sexual behaviour. Inequalities are evident; those who present to specialist substance misuse services express a range of problems or vulnerabilities related to (or in addition to) their substance use, including the use of multiple substances, having a mental health treatment need, being a child in care/child in need or not being in education, employment or training (NEET). Other, wider risk factors can also impact on their substance use, such as self-harming behaviour, sexual exploitation, exclusion from school, offending, leaving care or domestic abuse.

Most recent data has shown the prevalence of hospital admissions due to alcohol or substance related misuse in children and young people, across the two new, and three previous local authorities, were all significantly higher than in England.

Neurodiversity

Supporting children with neurodiversity is an important consideration, with impacts of each individual type of learning differences, learning disabilities or autism, their co-occurrence and associations with other risk factors such as poor general health, physical disabilities, being bullied or living in poverty and the resultant higher proportions of mental health need.

In children with autism, around 70% have one recognisable mental disorder, and 40% meet the criteria for two. Poor mental health is not an inevitable part of having Autism, however, there are documented experiences of difficulties in diagnosing mental health disorders in individuals with autism, suggestive of underdiagnoses. There are high rates of co-occurrence with learning disabilities, and despite suffering greater ill-health, people with a learning disability, autism or both often experience poorer access to healthcare.

Other conditions are also of concern, for instance, hyperactivity (ADHD) carries increased mental health risk and is associated other increased risks of mental disorder affecting longer-term outcomes. ADHD is associated with reduced engagement with school, attainment and exclusion, experiencing bullying, living with less healthy family functioning, lower social support and networks; rates of ADHD are five times higher in children in care and young people involved with Youth Justice. Effects in adulthood can include disruption to relationships, economic inactivity, possessing no qualifications and having personality, bipolar and substance misuse disorders.

Symptoms and features can overlap with symptoms of other learning difficulties, conditions or disorders. Common co-existing conditions in children with ADHD include disorders of mood, conduct, learning, motor control, language and communication, and anxiety disorders.

There are challenges in understanding the local position regarding neurodiversity; autism is commonly recognised by school-age, with data available of the primary need for SEN, where it is the fourth most frequent reason for any level of SEN support. Rates of children with a primary need for SEN support due to autism are higher in Dorset than in England, and below England in BCP. These figures indicate rates of autism only where it is recognised as a child's primary need.

There appears to be a growing trend of autism diagnosis, but a lack of pathways for post-diagnosis support have been noted by commissioners and within Dorset stakeholder views.

There is little national data on learning differences, such as hyperactivity which may be present in around one in sixty children, but there has been confusion with changing classification criteria with estimates ranging from 1% to 9% of children; no data on prevalence has been located locally.

Special Educational Needs (SEN)

Those with SEN are at a four-times increased risk of developing mental disorders; SEN is consistently a strong predictor of poorer outcomes for children and young people, in particular with education and employment, mental health and social issues. Children and young people with SEN are more likely to be absent or excluded from school, to be bullied, lack social networks, feel unsafe when out, have increased risk behaviours and report lower wellbeing.

Across Dorset, the proportions of children and young people with SEN support requirements were generally above that of England in 2019/20. There were 15-17% of boys and 9-10% of girls within the school population requiring such input.

At both primary and secondary levels in 2018, the proportion of pupils with social, emotional and mental health needs was in line with, or above, England proportions. Under the new BCP and Dorset authorities, in 2020, BCP still had a higher than England proportion, while Dorset UA showed a lower proportion.

Familial

Family functioning, including parental mental health

Relationships within families, and household circumstances, are integral to the wellbeing and mental health of infants, children and young people. Factors such as the physical and mental health of parents and levels of income are significant in the protection of wellbeing and mental health and in the development of mental disorders.

In the 2017 NHS Digital survey, children whose parents scored highly for a mental disorder were five times more likely to have an emotional or behavioural disorder than those whose parents showed little or no evidence of mental disorder. Children living in households with the least healthy family functioning were also five times more likely to have mental disorders than those living in households with the most healthy family functioning.

Population prevalence is used to indicate parental mental health which is currently around one in six, and one in four in women aged 16-24, reflective of the younger mother cohort.

Maternal mental wellbeing is known to be a key determinant of childhood wellbeing, particularly in early childhood. A recent study reported one in four UK children between the ages of 0 and 16 have a mother with a mental illness, and that over half of UK children, by the age of 16, will have had a mother who has experienced mental illness.

During 2005-2017, the South West had the fourth highest proportion of mothers with mental illness (25%), and highest prevalence coincided with areas with the highest levels of deprivation and adult mental illness in general. Children born into poverty, or to teenage parents, were also more likely to be exposed to poor maternal health.

Modelled data suggests around 14-17% of 0-4 year olds, living across Dorset, may be within a household with one of three parental risks; serious mental health condition, substance misuse or domestic violence. Between ages 0-17, between 16-18% are living in a household experiencing one risk and 5% in a household with two risks. These estimates are likely to be underestimates, given they only record the status of one adult per household.

Younger parents

Although some younger mothers and fathers manage very well for many their health, education and economic outcomes remain disproportionately poor, affecting their life chances as well as those of their children. Every young parent exists as an individual, but there are vulnerabilities with which some young people enter parenthood: family poverty, persistent school absence, lower attainment; and being looked in care or a care leaver.

It is understood some young parents will have missed out on the protective factors of high quality relationships and sex education, wellbeing and resilience, positive parenting role models and having a trusted adult in their life. For a minority, these vulnerabilities may make parenting very challenging. Almost 60% of mothers involved in serious case reviews had their first child under 21.

Children born to mothers under 20 are at increased risk of low birthweight which can significantly impact upon the child's long-term health, but vitally, those mothers are also three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth, affecting their wellbeing and ability to form a secure attachment.

Evidence has consistently shown increased risks of poorer outcomes in mothers and children under 20; increased risk of poor outcomes also exists in children born to parents under 25 years, particularly in poorer mental health.

Children within a family of parents under 20 are also at much greater risk of living in poverty, with increased risk persisting by the time the mother reaches age 30. Younger fathers are twice as likely to be unemployed aged 30, even when accounting for deprivation.

Children in Need

Children in need have worse outcomes than children as a whole; needing help and protection, even briefly, has a profound impact on children's educational outcomes. The disadvantage is often additional to other needs, although compounded for many children by also having special educational needs or living in a low-income family.

The poorer mental health, and other wider, outcomes of children who have required social services input are significant and long-standing, extending far beyond the end of input. Children in care have prevalence of diagnosable mental disorder between four and six times higher than in the general population (45-72%). Below five years of age, around one in four children entering, or in care, have recognisable mental health problems.

The educational progress and attainment of children in care is much reduced in comparison to peers who are not; they are four times more likely to have SEN, more than ten times more likely to have a statement of SEN or an Education Health and Care plan (EHC), and they are significantly less likely to progress at school, attain GCSEs or proceed to higher education. The type of SEN category tends to be different to that of peers, being namely emotional and mental health needs.

One in ten pupils in 2019/20 had been a child in need in the last 6 years, equivalent to around 3 pupils in the average classroom. In half of all secondary schools, children in need constituted 10-20% of pupils.

Local data shows variable rates and proportions within the differing categories of children in need, but generally they are comparable to, or above, that of England. Across Dorset there were higher rates of children currently in care than in England in 2020, slightly more children entering care, but also higher rates of children leaving care. Reviewing the emotional and behavioural health of children in care shows increased scores of concern across Dorset, above that of England and South West.

Variability is seen across Dorset in markers of attainment and progress of children in care, but the overall outcomes are considerably reduced compared with those not in care. There have also been indicators of increased absence from schools across Dorset for children in care, and increasing proportions becoming involved with Youth Justice services.

Societal

Poverty

Children and young people living in poverty are three times more likely to have mental health issues compared to their more affluent peers; children living in households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those whose household is in the highest fifth, and nine times as likely to have psychotic disorders.

Poverty is a cross-cutting theme, associated with many other individual risk factors. Children living in poverty are more likely to also have special educational needs, learning disabilities, be absent or excluded from school, be involved with the Youth Justice system and are more likely to continue to live in lower-income and be exposed to health and social inequalities.

Although fewer than previously, across Dorset there are still around one in eight children living in poverty.

Housing

Many children growing up in poverty are living in poorer quality and insecure housing and are forced to move frequently, often leaving behind schools, friends and a sense of belonging in their area each time they move.

Quality of housing has been shown to impact on a number of outcomes for children and young people, and particularly upon their physical and mental health. Children living in poorer-quality housing have been shown to have higher levels of stress hormones and behavioural problems. More than one in four adolescents living in cold housing is at risk of multiple mental health problems, compared with one in twenty who have always lived in warm housing; a five times greater risk. Children in social housing have exhibited worse outcomes across cognitive, mental health and physical health, than children in non-social housing.

Impacts on mental and physical health can result from the number of people living in the accommodation, the ability to adequately heat it, and the type of accommodation itself, while some research shows conditions such as dampness and overcrowding, can affect children on both a physiological and psychological basis.

It is also believed housing quality may also be a proxy measure for the quality of the home learning environment, for example, a lack of resources or disruptive family circumstances.

School absence and exclusions

Absence and exclusions from school result in reduced learning and increased social isolation in the short term and, in the longer-term, reduced educational achievement and life chances, leading to further inequalities.

Children are at a higher risk of missing school if they have poor mental health, in particular if they have conduct disorders, anxiety or depression, alongside increased likelihood for those living in poverty, who have SEND, poor physical health or a long-term health condition, who have a parent with poor mental health, caring responsibilities or who have been bullied. Boys, particularly those from mixed or black ethnic groups, are also more likely to be excluded.

Pupils excluded from school consistently show higher levels of behavioural problems, attention difficulties and perceived stress than their peers along with reduced ability in managing emotions, problem solving, goal setting, empathy and helping others. They also report lower levels of support networks within families, communities, schools and with peers.

Excluding children from school acts as a predictor for longer-term psychiatric problems and psychological distress; being excluded from school is associated with poor physical health, substance abuse, antisocial behaviour, crime, low academic achievement, unemployment and homelessness.

Locally, there are comparable or higher rates of absences and exclusions than in England. Higher proportions of children are permanently excluded than are excluded in comparable areas; proportions are above the England average, and there has been an increasing trend generally across Dorset, since 2014.

Children Missing Out On Education

Children and young people missing out on education are at significant risk of underachieving, being victims of harm, exploitation or radicalisation, and are more likely to not be in education, employment or training later in life (NEET). Reasons considered for not engaging with education include children within refugee and asylum seeking families, families who are highly mobile, those experiencing mental health problems or experiencing abuse and neglect.

Within BCP there were 637 'children missing education', at March 2020. Historical data to match that of BCP was not available for Dorset UA, but at February 2021, there were 116 open cases with 252 referrals that academic year.

Not in education, employment or training (NEET)

Increased participation in learning and employment is of benefit to individual young people but also to wider society in social mobility and economic growth.

Young people not in education, employment or training are at increased risk of negative outcomes, including poorer mental and physical health, depression or early parenthood. There are associations with risk factors, such as being a care leaver, being homeless or having missed out on earlier education.

Those who are not in education, employment or training (NEET), although small numbers across Dorset, have increased current and future risk of mental disorder, but also are indicative of young people who may be currently experiencing more complex situations or who have experienced them during childhood and adolescence.

Involvement with the Youth Justice system

Young people involved with the Youth Justice system have significantly higher levels of mental health disorders, but are also more likely to have SEN, be excluded from school, have difficulties with communication, to be a victim of crime, to be misusing substances and to have previously been a child in need. They are also much more likely to commit suicide than their non-offending peers.

There has been a variable picture of involvement with Youth Justice across Dorset. Recently, rates of first-time entrants and of those cautioned or sentenced across Dorset were higher than in England and the South West. Rates of young people aged between 10-17 receiving a conviction were only available until 2017 and were, at that point, lower locally than regionally or nationally.

Homelessness

Children from homeless households are often the most vulnerable in society, with homelessness a social determinant of health, associated with severe poverty, adverse health, education and social outcomes.

Dorset data has shown comparable or above South West rates of households in temporary accommodation, but below that seen in England, with evident rises in the most recent data across Dorset. Homeless households in 'priority need' (70% of which are likely to contain dependent children) have shown higher rates in Bournemouth than England, Poole and Dorset, whose rates were comparable. There is incomplete data for those homeless, aged 16-24.

Although there may be small numbers of homeless children reported within Dorset, consideration of the significant impacts had upon children and young people who are homeless or in temporary accommodation and in children who are potentially 'hidden homeless' is required.

Those at risk of sexual/criminal exploitation

Children and young people can be at risk of sexual and criminal exploitation; child sexual exploitation is a crime with devastating and long lasting consequences for victims and families, compounded when victims or those at risk of abuse do not receive appropriate, immediate and on-going support.

Children aged 12-15 years of age are identified as most at risk although victims as young as 8 have been identified. Young females are more often targeted, although boys are still at risk and may find it harder to disclose or be identified by others

There are vulnerabilities which heighten the susceptibility of child sexual exploitation, some of which have also been discussed in relation to their own heightened risk to mental health, such as experiencing abuse or neglect, lack of safe or stable home environment, physical or learning disability, poverty, sexual identity and homelessness amongst others.

The effects of exploitation involve distrust, isolation, reduced educational engagement and attainment or leaving education, becoming pregnant at an early age, experiencing unemployment, developing or having mental health problems, attempts at suicide, substance abuse, engaging in criminal behaviour and experiencing homelessness.

There are a number of different sources of data for local levels of children at risk of or exposed to exploitation, however, consideration of the magnitude of effects of exploitation coupled with mutually reinforcing vulnerabilities listed which indicate a high level of need.

Other populations

There are children and young people within groups requiring consideration of support for their increased risk of mental disorders who are not referred to in detail here, due to lack of robust or recent data for Dorset. They are those with disabilities, life-limiting illness, refugees or asylum-seeking, those with Gypsy, Roma or Traveller heritage, those bullied, children of military families, those with eating disorders and young carers. They all may experience combinations of a range of increased risk of mental health disorders, including reduced school attendance and increased exclusions, reduced social networks, stigmatisation, bullying, living in poverty, amongst others. While they may be smaller numbers of children, belonging to one of those groups can be equally, or more, impactful to mental health than others described in more detail.

Findings in relation to age stages

Perinatal, infant and paternal mental health

The evidence of the significant influence of parental mental health is clear, particularly so in infancy and early childhood, with effects extending into adulthood. Children whose mothers have depression have a five-fold increase in risk of developing mental health disorders, and it is understood three-quarters of the cost of perinatal mental illness relates to adverse impacts upon the child rather than the mother.

During pregnancy it is believed 10-25% of women are affected by mental health disorders, and women with a history of mental health disorders have increased risk of certain mental health conditions during the perinatal period; suicide is the second cause of maternal death.

Nationally, there were six times more women seen during the perinatal period in routine mental health services than in specialist perinatal mental health services. The data does not indicate whether these were existing support mechanisms prior to pregnancy or whether they were new contacts with mental health services since conception.

Service use was more common in younger people; in those under 16 years of age, almost 10 times the proportion of mothers aged over 25 were in contact with secondary mental health services and in those aged 16-19, it was almost 4 times. These statistics support existing evidence around younger mothers experiencing increased mental health need.

Paternal mental health can also be affected following the birth; there is limited evidence available with prevalence suggestions of 38% of first-time fathers being concerned about their mental health and 10% of new fathers experiencing depression, but there is awareness that symptoms of mental health disorders may be under-recognised and underestimated in males.

Fathers are more at risk if their relationship with their partner is strained or if their partner is experiencing postnatal depression. Paternal depression is also associated with maladaptive parenting behaviours toward children and negative child outcomes.

Attachment in infancy and early years

Positive attachment in infancy and early years is imperative to positively influence wellbeing and mental health in children and young people, and as they grow into adults.

There is no single measure of attachment, rather risk factors suggestive of higher levels of disorganised attachment, including data on children in need or adopted children, those with younger parents, maternal mental health, drug and alcohol misuse, living in poverty, family homelessness and domestic violence. Local data on the risk factors for disorganised attachment showed a variable picture pan-Dorset, with a picture slightly more indicative of disorganised attachment patterns within Bournemouth.

Ambitions to improve the mental wellbeing of mothers and children in their infancy and early years, and improve attachment, offer the potential for tangible improvement evident across a child's life course as well as economic benefits. There is growing evidence that it would be prudent to address paternal mental health also.

Early years

Development in early years is crucial for long-term growth and opportunity; disparities in child development are recognisable by the second year of life and have an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential, with associated poorer long term outcomes including mental health and general wellbeing.

Locally 90-92% of children were achieving a good level of development across Dorset, in 2018/19.

Early years provision, settings and staff have a vital role to play in supporting the mental health of young children, working on their development and educational readiness but also providing positive opportunities for attachment, socialisation and developing social skills.

There is evidence that communication skills are a protective factor for wellbeing and mental health and there are known associations with poor communication skills and mental disorders. Speech, communication and language needs are the most common type of need for pupils receiving SEN support, and second most frequent for EHCP plans, nationally and locally. Between half and three-quarters of young people involved with the Youth Justice system have difficulties with speech, language and communication.

Language is seen as a primary indicator of child well-being, impacting on children's social, emotional and learning outcomes. Strong and persistent differences in their ability to communicate through language are evident, with a child's socio-economic background an important factor.

By age 3 there is already a 17-month income-related language gap, with children from disadvantaged groups twice as likely to experience language delay. Five-year olds with poor vocabulary are three times more likely to have mental health problems as adults and two-thirds of 7 to 14 year olds with serious behavioural problems have language impairments.

While the reasons behind the word gap in the early years are complex, exposure to a breadth and depth of vocabulary and a learning-rich home environment, supported by high-quality early years provision, are essential.

Locally, more eligible children have utilised funded places at two years old in Dorset than in BCP, with higher uptake percentages than seen in the South West and England. Prior to the reorganisation, there had been a rising trend in Poole, and a fairly level trend seen in Dorset. There had been a consistently lower percentage uptake in Bournemouth. This may suggest the current percentage in BCP is reflective of higher uptake in Poole raising the BCP proportion as a whole.

In 2020, more children utilised funded places, at three-four years old, in Dorset than in BCP. Dorset was positioned higher than percentages in the South West and England, while BCP was below both. Previously, trends in Poole had been variable, and Bournemouth had seen a declining trend, while a fairly steady trend had been seen in Dorset over a number of years. Bournemouth and Poole areas had been below the South West and England proportions since 2015, bar one year in Poole. These figures may suggest areas which could benefit from targeting to increase uptake.

The quality of early years education shows in both Dorset UA and BCP, 99% of two year olds in early years funded education are within an organisation rated as 'good' or 'outstanding' by Ofsted, and for three-four year olds, 98% within BCP and 91% in Dorset are .

School readiness

General development, development in phonics and in communication and language skills, have been mostly in line with that of England and the South West, however, children in receipt of Free School Meals were much less likely to show the expected level of general and phonics development at the end of Reception.

Adolescence and young adulthood

This is a unique and formative time, and the many changes that occur, alongside known risk factors, make adolescents particularly vulnerable to reduced wellbeing and mental health disorders. Anxiety, depression and suicide are reported as leading causes of youth morbidity and mortality across the world. Many risk-taking behaviours, including substance use, sexual risk taking or perpetration of violence, start during adolescence. Risk-taking behaviours can be both an unhelpful strategy to cope with poor mental health and can severely impact an adolescent's mental and physical well-being.

Rates of smoking, drinking and drug use in younger people have, in general, fallen over recent years. While two-thirds of young people aged 11-15 report never drinking alcohol, one in five young people aged 16-24 smoke.

Protective factors are also affected, for instance, physical activity declines across adolescence, around one in four school pupils aged 11-15 are obese, and the proportion of young people aged 14 sleeping for less than 8 hours a night has doubled between 2005 and 2015.

Vitality, adolescence is a particularly crucial time to effect change, when life-long health behaviours are set in place, yet when early intervention and prevention is possible.

There is high prevalence of mental disorder in those in transitioning from late adolescence to early adulthood. One in six 17-19 year olds had a mental disorder, with one in sixteen meeting the criteria for more than one mental disorder; this rose to one in four having a mental disorder when looking at the prevalence for young women, and this prevalence continues to at least age 24.

Locally data shows Bournemouth, Poole and Dorset had significantly higher rates of hospital admissions as a result of self-harm for those aged 10-14 years and 15-19 years than the England and South West benchmarks.

Self-harm can be a precursor to suicide, and suicide is the most common cause of death for those aged 10-19. In 16-24 year olds, 10% have attempted suicide and more than a quarter have had suicidal thoughts, more so in females.

Data from the millennium cohort study also reports 7.4% of children and young people have attempted suicide by age 17. If this was representative of children and young people pan-Dorset, modelling shows around 10,600 children and young people across Dorset may have attempted suicide by age 17.

Of particular relevance in older adolescents or young adults is the impact of transitioning from children and young people's mental health services (CYPMHS) to Adult mental health services (AMHS). It can be a time of upheaval and it may prove difficult for children and young people to navigate new service settings or to manage their mental health and wellbeing following discharge from CYPMHS, especially as the availability and type of support can change dramatically.

Significant risks have been highlighted of young people disengaging or being lost during transition processes, which may lead to young adults presenting again in crisis or later with greater severity. They note transitions for vulnerable groups, such as care leavers and those within the criminal justice system, can be particularly problematic and require careful management and close engagement with the young person and, where appropriate, their families/carers.

For all children and young people at increased risk, it may be that inequalities they have experienced in life, and in particular with services, make the concepts of asking for help, accessing services and receiving support feel unknown, inaccessible and irrelevant, illogical or unappealing. While this is likely to apply to many in the 'Getting Risk Support' grouping, it also applies at other, lower levels of need. There will be some who have had bad experiences and do not wish to seek support through traditional avenues of clinics or other formal settings, within office hours, or via usual referral routes of having to ask/be identified as needing help.

Protective factors

As discussed, achievement of positive wellbeing affords children and young people better physical health, with less health-damaging behaviours, longer lives lived without ill-health, increased life expectancy and reduced risk of other diseases and mortality. They are less likely to experience social inequalities and have increased educational achievement and economic opportunity. These positive effects can be seen in those who have existing mental health conditions, when improvements in wellbeing are achieved.

Protective factors are as wide-ranging and complex as risk factors, but evidence shows many factors as being effective, including early positive attachment, healthy family functioning, communication skills, engagement with education, stability, sleep, money, food, physical activity and hobbies, amongst others. There can be differential exposure to protective factors for different individuals, such as young carers not having sufficient time for hobbies when considering their caring responsibilities.

Actions can be taken to support individuals' wellbeing and resilience, moderating the cumulative impact of adverse childhood experiences. Access to a trusted adult in childhood, supportive friends and being engaged in community activities, such as sports, reduce the risks of developing mental disorders; even in those who have experienced high levels of Adverse Childhood Experiences (ACEs). Having sources of support can halve current mental disorder in adults as well as self-harm or suicidal thoughts. Participation in sports both as a child and adult has also shown to support resilience to mental disorder significantly.

Indicators of protective factors reported include levels of development, wellbeing and life satisfaction scores and educational attainment, which have been detailed above. Other indicators are levels of physical activity, sedentary behaviour, access to outdoor space and dietary intake of fruit and vegetables.

Activity and access/use of outdoor space

Local data for activity and sedentary time are taken from 2014/15; they were generally comparable with England, however, only half of school-age children locally were meeting recommended levels of activity each week, with around 15% of those aged 15 being active for at least an hour a day. More than 60% of 15 year olds across Dorset had in excess of 7 hours a day being sedentary (outside of school).

Access to, and utilisation of, outdoor space data was drawn from all-ages in 2015/16. These factors are known to support wellbeing, allowing people to also engage in physical activity; people are more likely to make use of outdoor spaces if they are closer to home.

In 2015/16 in Bournemouth and Dorset there were greater estimated proportions of residents visiting the natural environment for health or exercise purposes in the previous seven days than in England; Poole showed no data. In 2015 in Bournemouth and Poole there were greater percentages of the population with accessible woodland within 500 metres of where they live than in England, while in Dorset there was a smaller percentage.

Intake of fruit and vegetables

Diet and nutrition are important for physical and mental health and poor diet is a major risk factor for ill-health and premature death. In 2014/15, around half of young people aged 15 consumed 5 or more portions of fruit and vegetables daily. Bournemouth and Dorset had slightly higher proportions, while Poole was in line with England.

Service Data

The HNA contains service data for mechanisms which support or treat mental health. Significant data has been available for Dorset CAMHS, with emerging data on Mental Health Support Teams, basic data collection around schools counselling, Chat Health and Kooth. Educational Psychology Services are developing mechanisms for collection of service information.

Nationally CAMHS has seen increased demand with longer waiting times, static DNAs and longer inpatient stays, amongst other indicators. GPs at national level have expressed concerns over access to CAMHS services with perceptions of long waiting lists, high levels of rejected referrals, having to advise patients to wait until the severity of complaint matches referral criteria and of not having adequate alternative, lower level support mechanisms, below that which CAMHS offers, for their patients to access.

Local CAMHS data indicates services are under pressure, with increased referrals a trend seen locally over a number of years, frequent high levels of inappropriate referrals and although more referrals are being accepted than in previous years, there are fewer referrals received and accepted than nationally. There are also slightly higher rates of DNAs than other mental health services within the Trust.

Assessment is provided within a shorter time than other national services, with considerably lower waiting lists than the average, however, wait times are a continued challenge with many waiting longer than preferable to access treatment, perceptions of which were also evidenced in view-seeking exercises. Increased complexity and severity of presenting problems is also of concern when considering numbers on caseloads and their duration or lengths of stay.

There are more staff per 100,000 population, with more patients on caseloads and costs of around £1million more per 100,000 populations, compared with national averages.

In accordance, local view seeking indicates issues with users feeling access is not timely, waits once in the system are too long, and staff report feeling excessive pressure upon them that indicates a need for relief upon the system as a whole.

New initiatives to tackle some of these pressures, and better serve local need, have begun such as the pilot 'Gateway' service in the East of the county, which includes self-referral for those aged 16-18, and the initiation of Mental Health Support Teams in a number of schools with wider rollout planned. The impact of both of these is anticipated to alleviate some of the delays in access and rejection of referrals, while providing earlier and lower-intervention.

Schools Counselling forms an important part of the offer of support across Dorset, and work is ongoing in assessing the provision and quality and to address variation.

Digital offers in ChatHealth and Kooth, offering almost-immediate access with messaging and online support available have seen continued uptake, and higher usage has been evidenced within Kooth since the COVID pandemic. Educational Psychology Service and School Nursing continue to perform their vital role within the mental health service offer.

The Dorset Implementation plan for 2022 includes a 'retreat' drop-in centre for children and young people, to be co-designed with young people.

Service mapping

This has demonstrated there is much provision of support across the different groupings within THRIVE. It is beyond the scope of this HNA to provide information on levels of access to those services or the appropriateness, quality or effectiveness of them.

While appropriate support should always be identified for young people with lower-level need, who do not meet the criteria for services, national research suggests there is great confusion about alternatives to referring to CAMHS. Local view-seeking also suggests there is much confusion in understanding alternative provision for referrers, service users and their families; this is understood to be a precursor to worsening, and crisis, situations.

For those referred to CAMHS, and eligible to access, the Gateway aims to alleviate some confusion.

Stakeholder views

National and local view-seeking has reported issues the need for earlier/lower level intervention; that “people get worse while waiting”, people are ‘rejected’ when trying to access support and that GPs don’t know always feel confident in identifying mental health need or where to send people for the most appropriate and timely input.

Children, young people, parents and carers, together with staff, have also expressed the need for alternative, easier to access provision, alongside the offer of specialist services which they value and often regard highly. They want flexible approaches which are more appropriate and responsive to their needs, with quicker access.

Staff have expressed positive comments about co-working with other services, but highlighted the on-going challenges with achieving success in co-working. There were staff comments regarding a desire for increased levels of training, knowledge and support. Pressures of waiting lists and administration were reported as factors impacting on staff morale, and comments about reductions in capacity have caused frustration.

Reduced training budgets were reported and that staff do not necessarily feel supported in developing their skills or having career progression available aside from that of management roles. Some staff felt undervalued, especially those within more traditional means of service delivery, with the advent of new models.

The significance of staff morale and retention, experience, training and knowledge extends to impacts upon service users, given the emphasis placed on the importance and impact of skills, continuity and trust in maintained relationships with staff, by users of services in view-seeking exercises.

Interventions

PHE have recently reviewed approaches to improving children and young people’s mental health and wellbeing, more comprehensive than would have been afforded by this needs assessment.

They found eight promising interventions operating at individual, family and community levels and a wider range of interventions from a review of other literature. A large number were also contained within the Early Intervention Foundation’s Guidebook (EIF), where strength of evidence of impact and relative costs have been considered.

Children and young people’s views were part of the review and they supported taking an assets-based approach to promoting mental wellbeing (recognising and building on the strengths of supportive interpersonal relationships and the characteristics of supportive places, environments and wider influences).

Interventions have been detailed within the report with evidence at higher levels but it is crucial to recognise that lack of evidence does not mean interventions are not effective; complex public health interventions are often difficult to assess. Widespread interventions, such as those across schools are examples of this. To maintain a flexible approach to interventions locally is advocated to maintain innovation and appropriateness to local circumstances.

Concluding remarks around findings

It is clear the lives of children and young people are inherently influenced by the environments in which they grow up; of families, schools and communities. The recommendations of this HNA aim to effectively respond to the needs of children and young people in protecting their wellbeing and mental health and in responding to mental health disorders. This appreciates the rising, wide-reaching prevalence and significant impact of mental disorder while capitalising on opportunities for prevention, promotion and early intervention across settings.

The views of local stakeholders have highlighted the significance and importance people attach to current mental health service provision, while concurring there is a need for earlier, easier access to support to meet lower-level need and to prevent deterioration in those with increased need.

The scale of the current and future situation cannot be resolved or met with only service and treatment options, with treatment gaps and limitations; additionally, traditional treatments and support routes are often not easy to access or receive for those most at risk. Alternative considerations to current service provision to alleviate some of those challenges, while also strongly focusing on prevention and promotion in mental health and wellbeing, are therefore essential tools in meeting need now and in the future.

Primary prevention is an area of wellbeing and mental health support that has been somewhat neglected, but one where potential impact could be great. Understanding of the factors likely to lead to potential harm of children and young people's psychological health, and the active application of strategies to try to reduce or remove these as far as possible before they affect a child's emotional wellbeing, is the cornerstone of primary prevention.

It has been suggested proportional universalism be applied, "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need". However, national guidelines and research also suggest universal and selective approaches may be required; the former to reach across the general population, and within it some individuals at greater risk, and selective strategies to proportionally and better meet the need within those identified groups, some of whom may be historically 'underserved'.

Alongside universal approaches, identifying and acknowledging inequalities, working to negate them and addressing increased need in those within different groups may affect other 'outcomes'. For instance, higher incidences of self-harm and suicide could be reduced indirectly, though work to support those from LGBT+ communities, those with adverse family circumstances such as substance or domestic abuse, those affected by perinatal mental illness or those involved with Youth justice.

Findings and recommendations are below, conveyed within nine themes. Possible routes and pathways to implementation are included, with organisational responsibility and contexts/assets to be recognised for each of the recommendations contained in more detail in the table in appendix 12

Themes and Recommendations

Theme:1 Perinatal and Infant/Early Childhood mental health (pregnancy-2 years post-birth)

Recommendations:

1a) Establish sufficiency of avenues/levels of mental health support available to pregnant women and mothers (up to two years following birth).

The significance of the role of parents and carers in a child's wellbeing and mental health has been detailed, and the significant risk to infant and early childhood mental health, with effects persisting into adulthood. Early, and extended, maternal support is an essential part of an approach to managing this, and aligns with national guidelines outlining maternal mental health provision availability for up to two years following birth.

This recommendation details that the sufficiency of both current avenues into, and varying levels of, maternal support be assessed and determined against set criteria.

There are emerging avenues of support for fathers in Dorset and, detailed under recommendation 5a, are proposed increases in access to support for parents with mental health need.

1b) Appreciate increased risks to the mental health of mothers, fathers and infants in families with younger parents (<25 years of age), along with protective factors.

There are greater risks to a child's mental health when they are born to younger parents. Children born to younger parents have increased risk of poorer outcomes in the short and long-term, such as low birthweight, physical health, educational outcomes and living in poverty. There are also greater risks to the parent's own mental health, and these risks are evident in families whose parents are aged up to 25. There is knowledge that a large proportion of younger parents may have existing vulnerabilities prior to parenthood, lack positive relationship and parenting models, have reduced attainment and opportunity as well as poorer mental health.

Understanding the essential role of protective factors, in parental mental health and that of very young children, include attachment and early years support, education and experiences, general health, physical activity, healthy eating, sleep, social networks and education/training/employment.

The recommendation is to incorporate this understanding into the design of support mechanisms and service provision so as to be accessible and appropriate to younger parents, and in designing selective, or targeted strategies for parents of younger age.

This recommendation also links to workforce development recommendation (????) in ensuring this knowledge is transferred to the training portfolio for those working with younger people at risk of earlier pregnancies and expectant, or existing, young parents.

Routes to implementation and links with existing/proposed plans for recommendations under Theme 1:

- Local Maternity Strategy (to 2019)
- Local Maternity System (to 2021)
- Perinatal Mental Health pathway development

Theme 2: Early Years approach

Recommendations:

2a) Support children and families in developing positive attachment, behaviours and communication, with focus on those in high risk situations and mitigating risks where possible.

Universal services, and other support mechanisms settings or services that work closely with children and their families during their early years, should be supported in increasing their knowledge of immediate and long-term risk factors for mental health stemming from lack of early attachment, unrecognised or unresolved behavioural challenges and poor communication skills.

Awareness of strategies, approaches and interventions which enable and assist the development of positive attachment (and parenting), behaviours and communication during the early years of a child's life, is paramount. These are fundamental foundations to be set early on, through which the ability to generate more positive wellbeing and mental health is evident.

It is necessary for assessment of how, when and where differing approaches and strategies are employed across the system and how efficient these appear to be. There are national evidence reviews and resources aiding the development of approaches should there be gaps identified.

It is also imperative that those who work with young children and their families are confident in knowing when, and how, to signpost to services for further support. It may be further education, training or support is required in aiding them to identify early those children and families who are at higher risk of developing or experiencing mental health disorders, for instance in younger parents, those living in poverty, with poorer family functioning, amongst others. People who work with young children and families have the advantage of regular, prolonged interaction with young children and their families, being uniquely placed to more easily identify those who might be at greater risk. Their relationships and actions could work to mitigate effects of those risks; it is vital to capitalise on this by providing them the means and routes to do so.

2b) High quality Early Years settings to understand risk and protective factors for wellbeing and mental health. To actively promote positive wellbeing and mental health within Early Years settings, akin to whole schools approach (support required).

Work to be conducted with Early Years settings to ensure sufficient levels of understanding of risk and protective factors are present, to strengthen where required, and to increase their ability to promote wellbeing and mental health.

Consideration of the mechanisms through which this can be achieved may benefit from drawing from the whole school approach methodology already being employed within other school-age settings. This work should include scoping whether there is Early Years specific guidance on how to support and implement such an approach.

2c) Provision of support/advice/signposting for Early Years settings when recognising child/family with increased need or at increased risk (e.g. Family Partnership Zones/family hubs).

As discussed in recommendation 2a, given the unique position Early Years settings are in with regular, prolonged contact with children and families, it is the recommendation that in circumstances where they do recognise a family with increased need or at increased risk they have the necessary knowledge and ability to provide support or advice whilst understanding when, how and where to signpost. This may involve local services reporting on understood ability to do so at different locations, or a blanket approach to education and training. This is to be established through appropriate networks.

2d) Development and provision of training to Early Years workforce, regarding infant and early childhood mental health (nationally recognised gap in understanding/skills).

To develop a training programme, in conjunction with Early Years providers and workforce, that is specific to their needs and appropriate to deliver across differing Early Years settings.

Routes to implementation and links with existing/proposed Plans for recommendations under Theme 2:

BCP:

- CYP partnership plan 'Children and Young People's Plan 2021 – 2024'
- 0-5 Best Start for Life
- 0-25 development plan (?SEND only)
- Children's Services Action Plan

Dorset UA:

'Our Children, Young People and Families' Plan.

E.g.

- 'Best Start in Life' (0-5 years; to include pre-conception/ antenatal/postnatal support). With Task and Finish Groups on:
 - 'Incredible beginnings' (intervention/practice model programme (1-5 years) incl. parental support programmes, Children's Centres, and Early Help)
 - 'Pause' project – families with multiple children placed in care
 - 0-5 workforce development group – needs of CYP workforce (H/Ed/SC/Vol) to support along continuum of need (incl PNMH).
 - School Readiness

Pan-Dorset:

- Infant mental health focus/training: via Perinatal Mental Health pathway and EY workforce development via Dorset/BCP CYP Plans
- Dorset Speech, Language and Communication Pathway Project (0-18)
- *Wellbeing for education return* – (training and development to support return to education in light of COVID-19 impacts) (**unclear if this applies to EY**)
- 'I can problem solve' program (4-12 years); complements 'Incredible Beginnings'

Theme 3: School-based approaches

Recommendations:

3a) Continued development of whole-school approach; working together across Mental Health Support Teams , schools counselling and educational psychology services involving specialist services where beneficial, to maximise effectiveness in improving wellbeing and resilience. To be achieved through raising awareness of mental health issues within the curriculum, reducing stigma around mental health and providing specific support, advice and interventions where appropriate. National recommendations share practical, universal measures as well as selective approaches for whole-school development.

Emphasis to be placed on connections between the elements of the school 'offer' to ensure children and young people can use school settings as a cohesive source of support for wellbeing and mental health. The cohesiveness of provisions should enable a child or young person to access the appropriate level of support they require, either through universal approaches via the curriculum and cultural attitudes of the school, to lower-level advice and support through the Mental Health Support Teams (MHSTs), further support within counselling and the EPS through to signposting to specialist services where needed.

3b) Improve the quality, impact and scale of school-based counselling services, with a clear single offer of support and investment across the partnership.

Work within Dorset has established variation in the provision and responsiveness of school counselling, along with a lack of quality assurance measures. This work is to be continued in driving forward a responsive, standardised offer with underlying mechanisms to provide quality assurance to schools when they utilise school-based counselling services.

3c) To establish the degree and strength of networks between schools and specialist services to raise awareness of the wider system and provide consultation and advice for settings, including through team around the school approaches.

This recommendation sets out the need to establish to what degree schools and specialist services work together to ensure children and young people are able to access the most appropriate level of support they require in the most timely manner. It will need to review knowledge sharing and establish access routes to specialist services, mechanisms for discussions of concerns and when there is a need for escalation.

There may be required the exploration of how these interactions have been/may be established along with how, and in what way, they could be developed. The aim would be to equip schools with the most effective ways of supporting children and young people primarily through universal approaches, and individual lower level support where possible, but with early recognition of the need for more specialist support and thus the facilitation of timely, direct referral to specialist services where required.

3d) Establish effective mechanisms in identifying and supporting children whose behaviours increase risk of persistent absence or exclusion, to reduce wider, immediate and long-term impacts on children and young people. Focus within primary as well as secondary settings.

Evidence within the report has identified concerning patterns of persistent absence and exclusions across Dorset schools at both primary and secondary levels and highlighted the significant impacts upon wellbeing and mental health in the immediate term but also in long-term outcomes for children and young people. The recommendation seeks to establish the effectiveness of mechanisms currently in place and to build upon these where required, using national guidance²⁶ to support schools in their efforts to support those who are persistently absent and to avoid exclusion where possible.

²⁶ Links to some national guidance is within the 'Intervention' section of the HNA, subsection 'Other relevant reviews of interventions, support or approaches'

Routes to implementation and links with existing/proposed Plans under Theme 3:

- BCP CYP Plan, Inclusion Strategy and Service Offer to Schools 2020-21
- Dorset CYPF Plan 'Young and Thriving' and 'Best education for all priority' workstreams (school age)
- SEND Learning and Improvement Plan (SEND LIP) Strategic priorities
- Dorset Speech, Language and Communication Pathway Project (0-18)
- iThrive to 25 – Dorset Mental Health Strategy and Implementation Plan

Theme 4: Preparation for adulthood

Recommendations:

4a) Understand increased risk to wellbeing and mental health present during adolescence (including general health, reduced physical activity, challenges with healthy eating/healthy weight as well as increased rates of risk-behaviours).

Adolescence is documented as a time of enormous physical, cognitive and emotional change, but with evidenced reductions in protective factors such as physical activity, healthy eating and increases in risk-behaviours such as smoking, drinking, drug-use, violence perpetration and sexual risk-taking. This recommendation aims to increase understanding across the education, social and health workforces and systems, of the changes and subsequent increased risks to wellbeing and mental health that occur during adolescence.

This is also referred to within recommendation 9d.

4b) Understand the essential role of protective factors, particularly influential during adolescence and young adulthood. They include general health, physical activity, healthy eating, sleep, social networks and education/training/employment.

Protective factors, such as positive relationships with family and peers, self-resilience and regulation, engagement with school and whole-school approaches along with general health, physical activity, healthy eating, sleep, social networks and education/training/employment, have been communicated within this needs assessment. To invest resource in facilitating protective factors and resilience is both ethically and economically sound, but additionally reduces the likelihood of undermining individuals' own strength and strategies.

Adolescence is a particularly significant period, during which young people are receptive to change as well as being a time when life-long health behaviours are set in place. Given the lower wellbeing reported and that the majority of adult mental disorders have become established by late adolescence or young adulthood, it is imperative to consider the role protective factors could have in establishing more positive outcomes and patterning of adult behaviour.

This recommendation aims to ensure understanding is across the system, to provide focus on securing efforts and resources aimed at promoting protective factors for wellbeing and mental health. Design of work around promotion of protective factors must appreciate the potential for inadvertently widening inequalities, for instance promoting healthy eating means or access to physical activity could indicate increased costs and so would not be accessible to all.

4c) Understand risk pertinent to Care Leavers, with differing support mechanisms, during late adolescence and transition periods.

Care leavers, additional to the significantly increased risks to mental health already applicable to all who have been Children in Need (those involved with social services, on child protection plans or who have been in care) and to those who are adolescents, are at further risk to their wellbeing and mental health given the complexity of arrangements during 'transition' to adulthood and in moving to services designed primarily for adults. This needs to be communicated to staff and services who work with care leavers, in developing their understanding, and to be appreciated in assessment of pathways for services.

4d) Working to understand provision in further and higher education, in colleges and universities, in supporting wellbeing and mental health. Assess whether support from mental health professionals would be beneficial in supporting/developing provision akin to WSA or other.

Across Dorset there is a gap in understanding of what support mechanisms are present or planned within Further or Higher educational settings. Although there are positive links with Bournemouth University, it is understood there are not strongly established links across further education settings with services. This recommendation highlights the need to identify what provision, at what levels, and with what links to services are available in those settings. Furthermore, to work with the providers of those institutions to understand whether support from mental health professionals would be useful in developing approaches relevant to the age groups in attendance.

Routes to implementation and links with existing/proposed Plans under Theme 4:

- BCP: 'Offer to Adolescents' within 'Children and Young People's Plan 2021 – 2024' e.g. *measures within plan, for instance, reducing attainment gaps and blended learning opportunities to improve non-attendance and exclusions*
- Dorset: CYPF Plan
- Some particular risks present in adolescence and young adulthood contained within pan-Dorset 'At risk project brief'

Theme 5: Parental needs and family functioning

Recommendations:

5a) Parents/carers – early action to improve family functioning and parental needs: mental health, alcohol/drug misuse or domestic violence (known to significantly affect wellbeing and mental health of children).

The recommendation seeks to enable and prioritise support/services at the earliest opportunity for parents/carers who have known mental health need, who are identified as misusing substances (alcohol or drugs) or whose household is experiencing domestic violence. This responds to the knowledge that these are known significant risk factors in the development of mental health disorder in children and young people. For mental health, there is also the known bi-directional association between a child or young person's mental health and that of their parents or carers.

Links with the relevant adult services, or organisations which support these needs, would be required to establish current frameworks and pathways around access to mental health, substance misuse services for parents or support for domestic violence situations. PHE recommend ensuring alcohol treatment systems provide prompt access for parents who are identified as harmful/dependent drinkers with agreed pathways between services to maximise support and reduce risks to children and families. Local authorities are also expected to establish clear pathways to alcohol treatment and commission interventions for families where parental alcohol misuse may pose a risk.

5b) Parents/carers – support if child has mental health need (and if in services, to assess child in context of family), along with assessing feasibility of rapid access to IAP services available for all parents.

The recommendation seeks to enable support/services at the earliest opportunity for parents/carers of those whose child is known to have a mental health disorder, acknowledging again the bi-directional association between the mental health of both children/young people and their parents/carers.

If a child is already involved with services for mental health, for assessment and treatment to appreciate the context in which the child or young person and their family exist. This is in line with national guidelines on approaches for assessment and treatment. The feasibility of rapid access to IAP services available for all parents would also be recommended.

5c) Ensuring access to advice, support or services to address wider, social determinants of health, wellbeing and mental disorder

Children living with life circumstances, such as in poverty and low-income households, in poorer quality, colder, overcrowded or temporary housing are have significantly increased risk to wellbeing and mental disorders and poorer wider, long-term outcomes. They are more likely to have special educational needs, a learning disability, be absent or excluded from school, be involved with the criminal justice system and , through lower attainment, are more likely to continue to live in lower-income and continue to be exposed to health and social inequalities.

Living in such circumstances also increases the risk of poorer parental mental health and less healthy family functioning.

Services working with children and families, therefore, require the understanding of the significance of the context in which children, young people and their families are living and have the knowledge and resources to signpost access, support or services able to assist or address such risk factors wherever possible.

Similarly knowledge of the significance, and signposting mechanisms, for protective factors, such as access outdoor space, physical activity and dietary advice is of use in working to mitigate the impact of risk factors and life circumstances.

Routes to implementation and links with existing/proposed Plans under Theme 5:

Pan-Dorset:

iThrive to 25 – Dorset Mental Health Strategy and Implementation Plan

BCP:

- Children and Young People's Plan 2021 – 2024'
- Family Investment Fund (COVID)

Dorset UA:

CYPF plan: 'Delivering locally priority' addressing Early Help offers, as well as family support with focus on children in families with one of 'toxic trio' (parental substance use or mental health need or domestic abuse).

Theme 6: Enabling navigation and sufficiency of services to support thriving or getting help, including effective self-management

Recommendations:

6a) Assess system sufficiency in meeting wellbeing and mild-moderate mental health need, aligning with 'THRIVE' groupings of thriving/advice-support/getting help.

Work to be undertaken to appreciate the access to information, advice, support and services available to children, young people and their families with concerns over wellbeing or mental health. It has been expressed in stakeholder views, and is appreciated within the system, that easy access to information, guidance and support is an issue.

Locally, initiatives such as mental health support teams, digital offers, whole-school approaches, co-working with charitable organisations, self-referral to CAMHS in parts of the county and crisis safe space provision have been undertaken or are currently being considered or developed. There is consideration to be made regarding a proportion of children, including those with increased risk factors, who may not feel able to access these routes for a variety of reasons.

Self-referral to CAMHS for 16-18 year olds in the East of Dorset, via the Gateway service, has been one mechanism employed which enables easier access to specialist services and dependent on evaluation, may be rolled out further. Referrers, however, still need to meet the CAMHS threshold for assessment and that may be beyond the wellbeing and mild-moderate mental health need.

The Discovery College also provides mental health recovery information and learning and offers peer support mechanisms, for those aged 13-25 years.

This HNA recognises the ongoing considerable work in schools developing 'whole school' approaches. The school offer of pastoral support, school counselling, Educational Psychology services and the formation in some schools of Mental Health Support Teams (MHSTs) is an appropriate way to meet this level of need. It is understood, however, that MHSTs are not yet available in all schools, with planned roll-out, and there is variability in access and quality in other elements of the school offer across the county.

Indications of lower wellbeing and wide-ranging prevalence of mental health disorders, coupled with age-restrictions on accessing support and widespread confusion over routes to access appropriate levels of information, advice, support or services suggests a gap will persist in this area unless further consideration is made.

As such, a focus is needed on identifying how the system supports access to information, guidance and support where necessary, and using different approaches. This may involve consideration of a 'single point of access' model or consideration of 'drop-in', mobile or pop-up provision to increase accessibility to support mental health and wellbeing at levels below crisis, the need for which was repeatedly referred to by staff, service users and families during view-seeking work.

There are other avenues through which support may be appropriately delivered at lower-levels of need, such as through local, peer and community networks. It would be beneficial for co-production strategies with children, young people and their families to be used to gain understanding to support the design of any further offers, appreciate factors such as ease of access as well as the appropriateness, quality and clarity of information, guidance or support required.

6b) Clarity of offer across providers.

Work is required in defining the degree to which current offers, across the system, support the wellbeing and mild-moderate mental health need (within 'Thriving' and Getting Advice quadrants).

6c) Identifying opportunities for promoting protective factors, including physical activity (effective in supporting wellbeing through to reducing impact of ACEs).

Work to be undertaken to establish current avenues, levels and sufficiency of primary promotion or prevention strategies or activities, whilst identifying where further opportunities may exist.

These should have a focus on understanding the factors which lead to psychological harm and actions evidenced to ameliorate their impact or effects. Careful consideration should be made to ensure these do not widen inequalities inadvertently, such as through requiring additional expenditure, parental support or increased cognitive ability.

Routes to implementation and links with existing/proposed Plans under Theme 6:

BCP: Children and Young People's Plan 2021 – 2024'

Dorset UA: CYPF plan

Drugs and Alcohol strategies

Theme 7: Establishing approach to those within higher-risk groups (including those not in need of specialist services but affected by wider circumstances).

Recommendations:

7a) Understand current mechanisms which support recognition of children and young people within groups shown to be at higher-risk of poorer wellbeing or developing mental disorders and where gaps may exist.

Any child or young person can experience mental health problems, however, some groups of children and young people are at increased risk because of their background, belonging to a marginalised group, social circumstances or life events. For some, the increase in risk is as much as five or six times the likelihood of developing mental health disorders.

Work to be undertaken to determine processes across the system which work to recognise children and younger people either deemed higher-risk or with identified need²⁷. Identifying those with existing need, or who are at increased likelihood of developing such a need, allows for the opportunity to make available support or services at the earliest opportunity, at the most appropriate level and through most appropriate avenues.

Once gaps are identified, to develop strategy to support gaps.

7b) Understand mechanisms for accessing support or intervention for those identified as at higher-risk or with identified need.

Aligning with recommendation 7a, to determine the avenues and processes through which children and young people and their families are able to access both support and services for those deemed higher-risk or with identified need²⁷. It is recognised, for those with more complexity of need, there are still beneficial gains which can also be made from accessing information, advice or support within other THRIVE quadrants, at lower levels.

It may be that the inequalities experienced by children or young people who have risk factors present make the concepts of asking for help, accessing services or receiving support feel inaccessible and irrelevant, illogical or unappealing. While this is likely to apply to many in the 'Getting Risk Support' grouping, it also applies at lower levels of need. There will be some who have had bad experiences and may not wish to seek support through traditional settings or institutions, within clinics or other formal settings, within office hours, or via usual referral routes of having to ask/be identified as needing help.

To understand other models of success in offering alternative routes to advice, support or intervention, ideally through co-production with children, young people, families and professionals.

7c) Specific focus on support and services for those at higher risk of mental disorder. This should incorporate those identified as within the 'risk support' quadrant of THRIVE and those who may not be identified as within that cohort, but whose risk remains above that of the general population, as detailed in the HNA²⁷.

Recommendation is to have a priority focus on the provision of support and services for children and young people who are identified as within a higher-risk grouping, as detailed with the HNA²⁷. Different cohorts will engage to certain or lesser extents and need different strategies to support.

²⁷ **Higher-risk groups listed are those, within which, children and young people are or have:**

Children in Need (incl. CiC, CP, post adoption); 'Adverse childhood Experiences' ACEs; SEND; Disabilities; Autism or Neurodiversity; living in poverty; LGBT+; young parents; young carers; in adverse domestic situations (Parental MH, substance misuse, domestic violence); at risk of persistent absence and exclusions; in contact with youth justice; overweight; bullied; homeless; asylum seeking or with refugee status; children of military families; of particular ethnicities/cultures; NEET; involved with substance misuse; at risk of criminal or sexual exploitation

Aligning with recommendation 7b, recognising that increasing equitable access to support is not making the same offer for all. For individuals within groups that experience marginalisation and who may have had poor experiences when accessing health or other care mechanisms, who may have different preconceptions or experience additional challenges in seeking support, there may be a requirement for proactive, innovative approaches to increase awareness, engagement and access to support or intervention. Consideration is required to make services feel accessible and relevant to those who may have had poor connections in the past. Reviewing clinical guidance and co-developing programmes of support should ascertain the range of most appropriate methods of supporting their individual needs.

Approaches for children and young people who do 'not engage' with services or who miss appointments should be reviewed to ensure that vulnerable children and young adults are not discharged from services without consideration of the reasons behind this. This can include capturing data on the current barriers that lead to children and young people not engaging with services, and exploring potential interventions which have the potential to facilitate their engagement.

7d) Consider expansion of conversations and assessments in support and services to identify needs not traditionally considered as direct drivers of wellbeing or mental health, but which are known risk factors for mental health.

As detailed within the HNA, there are underlying factors which present, some repeatedly, as drivers of wellbeing or mental health which are not traditionally covered in many support conversations or more formal assessments.

Identification of ethnicity has been shown to be incomplete across many services, sexual or gender identity, social or household circumstances such as bullying and living in poverty are not routinely explored. Needs related to support for young carers, assessments and treatment pathways for autism or neurodiversity, screening for potential speech, language and communication difficulties in those with SEND, who are absent/at risk of exclusion from school or who are at risk of being/are involved with youth justice may be possible to elicit/design in order to reduce the impacts of these underlying risk factors .

7e) System assessment of how supporting specific needs around criminal and sexual exploitation, gang involvement and criminal behaviour.

Recommend that work is undertaken to provide understanding of what support structures or services are available, across the system, to specifically work with young people experiencing the risks listed above. It would be valuable for providers of support or services to understand the co-occurrence and compounding nature of risk factors.

While small numbers of children are reported under these groupings, the effects of these behaviours, often coupled with other, mutually reinforcing vulnerabilities or risk factors, indicates high levels of need in those affected.

7f) Improve preparation for, and transition, between child and adult specialist services.

Concern has been expressed about the transition to adult services for those approaching age 18 and only limited data has been gathered during this needs assessment. It is therefore recommended that assessment of system processes for transitioning to adult services, including specialist mental health services, takes place and makes consideration of their effectiveness and user satisfaction (where available). If re-design of processes is required, to co-produce with young people to ensure changes are relative to need.

Routes to implementation and links with existing/proposed Plans under Theme 7:

- iThrive to 25 – Dorset Mental Health Strategy and Implementation Plan
- At risk project brief
- Mental health integrated community care review (MICC review)

Pan-Dorset:

- CYP Plans, including e.g. 'No wrong Door' approach for CiC
- Safeguarding/MASH
- Safeguarding Children Partnership CAROLE model
- Youth Justice Plan

BCP:

- Mapping Early Help services

Dorset

- CYP plan
- Development of single pathway for supporting EWBMH for CiC
- Community safety partnership

Theme 8: Specialist Services

Recommendations:

8a) Understand accessibility, timeliness and relevance of current offers, especially to those within groups less likely to access or benefit from support. This may include those with previous negative experiences of systems, people with less represented identities such as those from LGBT+ or ethnic minority communities, based on differing geographies, those not in school-based education and those unable to access within the school day.

The current design and delivery of specialist services requires consideration in light of the information contained within the HNA, to ensure referral, assessment and treatment pathways are timely and accessible, while feeling relevant and appropriate. This is particularly important, as significant proportions of those at greatest risk of mental disorders may find traditional offers and routes to accessing services difficult or unsuitable. This can be for a number of reasons, involving family circumstances, logistics, previous negative experiences of contact with services or institutions. It is strongly recommended co-design/production of this process is employed to achieve the greatest understanding of how these offers can best meet the needs of those who require access the most.

8a) Understanding equity of access, experience and outcome.

In understanding reach and impact, updating of key indicators within this report on a yearly basis, where possible would be recommended, to understand and evaluate the reach of services and assess if changing demographic patterns require any amendment to offers or service delivery.

It is understood there is work underway on improving data completeness, including that of demographic data. Assess if further data on other indicators is captured currently or may be possible to capture, such as indicators of sexual identity, poverty and parental mental health.

Work is also ongoing to increase the capture of outcomes of treatment electronically; this is essential in understanding the effectiveness of treatments offered and whether adaptation is required. In the absence of electronic data availability, a paper-based audit could be undertaken to appreciate the outcomes of recent cohorts, to assist in the planning of future services.

There are tools available to assist with the reduction of inequalities in service planning and delivery, such as the Public Health England (PHE) generic Health Equity Audit Tool (HEAT) and recent guidance from the Commission for Equality in Mental Health. Health Equity Audits could also be undertaken to assess the position in reducing inequalities.

8c) Concurrent development of 'crisis' and 'pre-crisis' offers to enable children and young people to access suitable alternatives to awaiting a worsening of symptoms or taking actions to relieve distress such as self-harm or substance misuse.

As expressed through data and stakeholder views, there is a need for timely and accessible support, signposting and/or treatment. This will, in part, be met, through the proposed 'Crisis Safe Space' drop-in centre, accommodating any child or young person who presents with a need for advice, support or treatment. In addition to this centre, there is a telephone support service for anyone in crisis, including children and young people.

Given the location of the drop-in centre, in one geographical area, an alternative mechanism through which children and young people across Dorset can access 'pre-crisis' support or services needs to be considered, both in supporting wellbeing and mental health where there is lower-level need, to prevent deterioration or the activation of responses to distress, such as self-harm.

Again, it is essential that these proposals are considered with young people involved, in order that they most appropriately meet their needs.

8d) Ensure clarity and sufficiency of services for sexually harmful behaviour or services related to exploitation.

This has been identified as a gap within the HNA, and in relation to recommendation 7e, this recommendation advocates building understanding of which services are appropriate and available to those children and younger people involved in such situations, and to what degree they would meet the needs of those children and young people.

Routes to implementation and links with existing/proposed Plans under Theme 8:

Pan-Dorset:

iThrive to 25 – Dorset Mental Health Strategy and Implementation Plan

Theme 9: Workforce development**Recommendations:****9a) Embed whole system understanding of, and commitment to, the THRIVE approach, including the role of lifecourse and wider contextual factors in improving mental health and wellbeing.**

The HNA has highlighted the importance of considering wellbeing and mental health and responding to the development of mental disorders. An understanding has been provided of the impact across the lifecourse that can be had if insufficient gains are made for the individual. Equally important is to further understand the context in which a child or young person exists, and the impact that different wider contextual factors can have upon the ability of a child or young person to maintain or protect their own wellbeing and mental health, along with the compounding effects of multiple factors being present for some individuals.

9b) Building upon positive effects expressed by staff in successful co-working across health and social care.

Stakeholder views have shown the value that patients, families and staff place upon specialist services. The success of these services heavily depends on successful co-working across organisations, and this will be more imperative as other earlier recommendations include increased significance placed on the cohesion of support mechanisms, alongside specialist services, in delivering the most effective outcomes for children and young people across Dorset.

The recommendation therefore suggests capturing and capitalising upon the known successful elements that have fostered successful co-working, as expressed within the stakeholder views, and building upon that good practice as these plans develop.

9b) Recruitment, training and supervision processes to incorporate 'Trauma-informed Care' (TIC) approach.

The TIC approach incorporates understanding of the impacts of trauma upon individuals and their developed responses to trauma, along with how these may present, such as through poor mental or physical health or substance misuse, amongst others. Prevalence is explored, and approaches and techniques for managing interactions with individuals who have experienced trauma to support and avoid re-traumatising them are integral.

Clarity is needed to define who will access this training across the system.

9c) Embed awareness and understanding of factors that protect wellbeing and mental health and those that increase the risk of lowering wellbeing, developing mental disorder, self-harm and suicide, in workforce development plans for those who work with children and young people across the system.

As above, the HNA has highlighted the importance of considering those factors which act upon wellbeing and mental health, both positively and negatively and responding to the development of mental disorders. An understanding has been provided of the impact across the lifecourse that can be had if insufficient gains are made for the individual. Equally important is to further understand the context in which a child or young person exists, and the impact that different wider contextual factors can have upon the ability of a child or young person to maintain or protect their own wellbeing and mental health, along with the compounding effects of multiple factors being present for some individuals

9d) Consistent awareness and support for children and young people to navigate support available across all THRIVE groups.

As discussed earlier and within the HNA there is understanding across the system, reiterated within view-seeking, that navigation of, and access into, the support and services available to those with any level of need is confusing.

This is a complex problem, and it is understood discussions about the most suitable way to proceed continue. The recommendation would be to formalise these discussions and to make reference to national examples of best practice, for example, through some of the Implementing Thrive workstreams that have taken place around the country and are reported on.

Routes to implementation and links with existing/proposed Plans under Theme 9:

- East/West workforce development plans
- Dorset CYP plan
- BCP 'CYP plan'

To include sectors of:

- Health
- Social care
- Education

It is also recommended that the 'Gaps' section below is referred to, to establish where gaps can be completed to provide the most rounded view of findings from the HNA.

Gaps in provision and knowledge

Earlier, lower level interventions

The needs assessment does not have full appreciation of the availability of earlier, lower level interventions provided throughout the wider system and suggests systems discussions about the current position of offers and how well that serves the need identified within this HNA.

There is concerning national research reporting that 40% of GPs recommend seeking private treatment for children and young people's mental health due to difficulties in accessing appropriate support; this has the effect of widening inequities in access for those who cannot afford to do so.

Future planning may wish to utilise existing resources/assets to enable services and support to deliver through existing channels and organisations, community or otherwise. It is therefore prudent to obtain a firm understanding.

There has been a suggestion made of exploring the usefulness of earlier, easily accessible, lower-level guidance and intervention provision, through a professionally staffed advice and support service, perhaps of a telephone or online medium. This would be considered to move beyond the advice currently offered through the digital services of Chathealth and Kooth, such as that offered to adults within Steps2Wellbeing who offer evidence-based interventions and follow individuals through the process and assess outcomes.

Wellbeing data

The last data available locally on wellbeing indicators was taken from surveys in 2014/15. As remarked Sport England are reported to have 2018/19 and possibly 2019/20 data detailing wellbeing in children and young people at local authority level. It has not been possible to locate or obtain this.

Autism and other neurodevelopmental conditions

Substantive data on children and young people affected by neurodiverse conditions are not available either nationally or locally.

Post-diagnosis service for autism and other neurodevelopmental conditions and support for schools in supporting those with such conditions appears to be a shortfall in provision. It is important to consider awareness rising of the recognition of behaviours which may indicate mental health need above that usually experienced with such conditions.

Disabilities

There is a lack of data and research into the increased risk, believed present, of mental disorders those with disabilities.

Asylum seeking or refugee children

Local data collection has not provided a full picture of how many children and young people are in the Dorset area identified as unaccompanied asylum seeking children or with refugee status was reported.

Gypsy, Roma and Traveller children and young people

Gypsy and Traveller Liaison, Dorset Council provided an estimation of numbers within Dorset, but it may be prudent to explore other avenues of data to verify.

Those bullied

Data is only available from 2014/15 and is therefore maybe not representative of the current situation, given considerable work within the school system to support more positive cultures.

Eating Disorders

Estimated prevalence is available only from 2013. Again this may not best reflect the current situation, especially given there are reported increases since the COVID-19 pandemic began.

Young carers

Data used was from 2011, and it would be beneficial to update

Parental, Maternal and Paternal Mental Health

It was not fully understood what pathways are specifically aimed at these groups in providing wellbeing or mental health support, and where the co-ordinated information lies. It is understood there is a local initiative within Dorset Healthcare to provide support to fathers, but sufficient detail on engagement and whether that meets need has not been determined.

Siblings

The level of need in siblings of children and young people who have a mental health disorder has not been established in this HNA.

Early Years specialist provision

Prevalence surveys suggest a possible need for a level of specialist provision for children under 5 years.

Currently, the CAMHS service directs parents of younger children to resources for support but no service offer is available. It is not understood if specialist services would be the most appropriate level of intervention, or whether needs would be better met by other universal interventions and support.

Understanding whether there is anything akin to a 'whole-school' approach within Early Years education settings has also been beyond the scope of this review, but it may be that developing, or complimenting, approaches within these settings may be beneficial in providing more universal support at such a crucial time in a child's development.

College/University support

No information was gathered during this HNA support available through college and universities and the usage, quality assurance or outcomes for any services they do provide. There are large numbers of children in post-16 education in Dorset, around 6,000 at colleges and around 19,000 at University level.

Transitions to adulthood

National expression has been made for services to address needs up to the age of 25, not currently provided except occasionally on an individual case basis. This plan is within the local implementation plan for 2022, to co-design with stakeholders.

There was little understanding obtained within this needs assessment of how transition from childhood to adulthood at 17-18 years of age is planned and managed, and how transition planning is developed. This should be of less concern in the future with the move to a service offer for up to age 25. This however, is planned for 2022 and it may be consideration of the process is to be made to ensure we currently meet the needs of those who will transition prior to the planned changes.

Direct referral route

While it is recognised this may take careful planning in capacity forecasts, self-referral schemes are run for other services and are part of the Gateway pilot project.

This would potential increase access to services for all, but importantly for those from marginalised groups, by removing additional barriers to access. Some families choose not to engage with other routes (for example where a family does not go to their GP). Review of uptake in self-referral for Gateway pilot may provide useful information on numbers accessing self-referral routes and whether this could be widened to enable easier access for all but also in helping to reduce inequalities in access.

Service data - Outcomes of treatment

Currently little evidence is available relating to paired outcomes, due to on-line recording issues; data can only be sourced via paper audit.

The resolution of this is an ongoing process under development currently, expected to provide data on outcomes for the users of services, in addition to process and activity data.

Service data – Collection of demographic information

This has been commented upon within the findings and recommendations.

Service and support mechanisms mapping

This needs assessment has reviewed current local services, alongside previous service mapping work, and developed a functional map, but it is beyond this review to appreciate the relevance, appropriateness or effectiveness of those wider offers.

Mapping of services and support mechanisms across Dorset has, numerous times, proved challenging with wide-ranging offers, at different ages and for differing conditions. The challenges in collating and maintaining this has been recognised, along with the inability to assure the quality, appropriateness and effectiveness of an individual organisation's approach. If directories are considered, to aid individuals, families professionals and communities the consideration of successful implementation elsewhere may be helpful, and perhaps an approach whereby organisations take personal responsibility for maintaining information, in order to remain on directory.

Systems Mapping

Arising from the HNA, and aligning with recommendations within the review of interventions conducted by PHE, this may offer understanding of whether collaborative working is at the level offering experience and efficiencies in supporting CYP and where there are gaps.

Stakeholder views expressed the need for collaborative working strongly and NICE refers to the requirement to assess and manage other influences on a child's mental health when treating (in respect of co-morbidities, developmental, social and educational difficulties), requiring collaboration with health, education & social care.

It may therefore be valuable to undertake a systems mapping exercise, of which there is support in doing so. Mapping would also allow appreciation of where in the system there is opportunity for leveraging and actioning recommendations. The King's fund remark upon the key role local systems must play; with a range of services and organisations, including the NHS and public health services, local authorities, schools, adult education, youth justice, drug and alcohol services, and voluntary and community groups needing to work together to reduce inequalities and improve child and adolescent mental health.

PHE, NHSE, LGA and The Health Foundation have collaborated to support local areas in employing complex systems mapping to facilitate the development of a whole systems approach to children and young people's mental health.

Appendices

Appendix 1

Further detail on the 'burden of disease'

isease (BoD) studies – goals, principles and measures

1 / 3

What is 'burden of disease'?

Burden of disease is concept that was developed in the Public Health, the World Bank and the World Health death and loss of health due to diseases, injuries and world.¹

The burden of a particular disease or condition is esti

- the number of years of life a person loses as a cor DALY). One DALY represents the loss of one year of box for more explanation and examples).

Looking at burden of disease using DALYs can reveal health. For example, the Global Burden of Disease 20 neuropsychiatric conditions are the most important ca the world, accounting for around 33% of all years live 15 years and over, but only 2.2% of deaths.² Therefore traditionally regarded as having a major impact on the is completely altered when the burden of disease is est

Appendix 1, Diagram1: Burden of disease.

Source: WHO (nd). [What is the burden of disease?](https://www.who.int/foodsafety/foodborne_disease/Q%26A.pdf). [online]. https://www.who.int/foodsafety/foodborne_disease/Q%26A.pdf

Appendix 2

Information from a number of national and local datasets, such as PHE Public Health Profiles, ONS Census and surveys and the Department of Education's Local Authority Interactive Tool (LAIT) have been used to create a profile of need for the area looking at indicators aligned to vulnerability and risk and protective factors for mental health.

Public Health England Public Health Profiles (Fingertips)

The Children and Young People's Mental Health and Wellbeing Profile in the tables in the following section below has been produced by Public Health England's (PHE) National Mental Health Intelligence Network, presenting indicators from the web based 'fingertips profile'.

Public health contributes to reducing the causes of mental illness and aims to improve mental health and wellbeing by:

- i. promoting mental health and wellbeing in all children and young people, to prevent mental health problems from developing
- ii. identifying and targeting those most at risk of mental health disorders and those who are likely to experience inequities in access to prevention or treatment activities
- iii. striving for early identification of, and intervention for, mental health problems to treat appropriately and prevent their progression
- iv. targeting groups with established mental health problems to help promote recovery and prevent recurrence.

This profile can be used jointly by local councils, schools, youth justice and health organisations to inform local discussion and debate around local planning and commissioning of interventions and services that help promote mental health and wellbeing, and provide interventions and services to address early intervention and mental illness. It can also be used to inform the production of local Joint Strategic Needs Assessments.

As the Mental Health Services Dataset matures, indicators will be added to the profile covering early intervention and access to quality interventions and services and outcomes. Indicators are presented at upper tier local authority level and can be used to compare local areas to the England average. Some values are based on modelled estimates, or on small numbers, so care should be taken with interpretation. It is always important to assess the data from this profile together with local data and knowledge.

Department of Education Local Authority Interactive Tool (LAIT)

The Department of Education has developed the **Local Authority Interactive Tool (LAIT)** to provide easy access to a wide range of data related to children and young people sourced from various departments across government. It acts as a single central evidence base that helps support the Accountability Framework and Transparency Agenda.

The Tool provides the functionality to 'benchmark' an authority nationally and against either its Region or Statistical Neighbours. The data items are presented largely in the form of tables and charts, which can be varied and 'exported' from the system for use elsewhere.

Appendix 3

Dorset is a county in South West England, covering an area of 1,024 square miles (2,652km²) and is bordered by Devon to the west, Somerset to the south west, Wiltshire to the north-east and Hampshire to the east.

On the 1 April 2019, Dorset's local authorities merged to form to two Unitary Authorities – Dorset Council and Bournemouth, Christchurch and Poole Council (Diagram 1).

The new unitary authorities in Dorset are:

- **Bournemouth, Christchurch and Poole**, consisting of the old unitary authorities of Bournemouth and Poole as well as the non-metropolitan district of Christchurch
- **Dorset Council**, which merged the five remaining non-metropolitan districts of East Dorset, North Dorset, Purbeck, West Dorset, and Weymouth and Portland, as well as the former county council

The county town is Dorchester which is in the south-west of Dorset. The largest urban areas are Poole, Bournemouth, Christchurch and Weymouth & Portland. Around half the population lives in the south east area, while the rest of the county is largely rural with a low population density.



Appendix 3, Diagram 1: In April 2019, Dorset's local authorities merged to form to two Unitary Authorities Dorset Council and Bournemouth, Christchurch and Poole Council.



Appendix 3, Diagram 2. The county of Dorset showing Unitary Authorities' boundaries pre and post 04/2019 reorganisation.

Appendix 4

Potential resource allocation

Original work performed by Dorset CCG made reference to resource allocation that may be required to support the mental health needs of children and young people across Dorset.

The diagram shows the THRIVE groupings and the input required within each segment.



Adapted from: Wolpert et al. (2016). *THRIVE Elaborated (2nd ed.)*^{xxxviii}

The THRIVE authors predicted resource allocation to Thrive Quadrants:

	Hypothetical Resource use (direct appts only)	Hypothetical % overall resource use
Getting advice	10%	8%
Getting help	66%	56%
Getting more help	16%	14%
Getting risk support	8%	7%
Thriving	NA	15% ²⁸
Total	100%	100%

Author apportioning taken from Wolpert et al. (2016). *THRIVE Elaborated (2nd ed.)*: *THRIVE AND PAYMENT SYSTEM DEVELOPMENT*. [online]. <https://www.annafreud.org/media/4817/thrive-elaborated-2nd-edition.pdf>

²⁸ THRIVE Finance Analysis in the THRIVE Elaborated (2nd ed.): " Thriving: There is no hard-and-fast rule for how much resource should be allocated to this category and as yet no economic evaluations that can robustly guide policy in this regard. Reports from current practice suggest that in many areas around 10-15% of the budget in children and young people mental health services is allocated to support community resilience programmes; consultation with teachers, health visitors and others; and other forms of intervention to support widespread wellbeing and mental health. It is anticipated that in any case-mix-adjusted payment system it is likely this work would need to be top sliced to be able to continue"

Appendix 5

Disorders were grouped into four broad types

Emotional disorders

- Include anxiety disorders (characterised by fear and worry), depressive disorders (characterised by low mood and energy, and low self-esteem), and mania and bipolar affective disorders
- One in twelve (8.1%) 5 to 19 year olds had an emotional disorder, with anxiety disorders (7.2%) were more common than depressive disorders (2.1%).

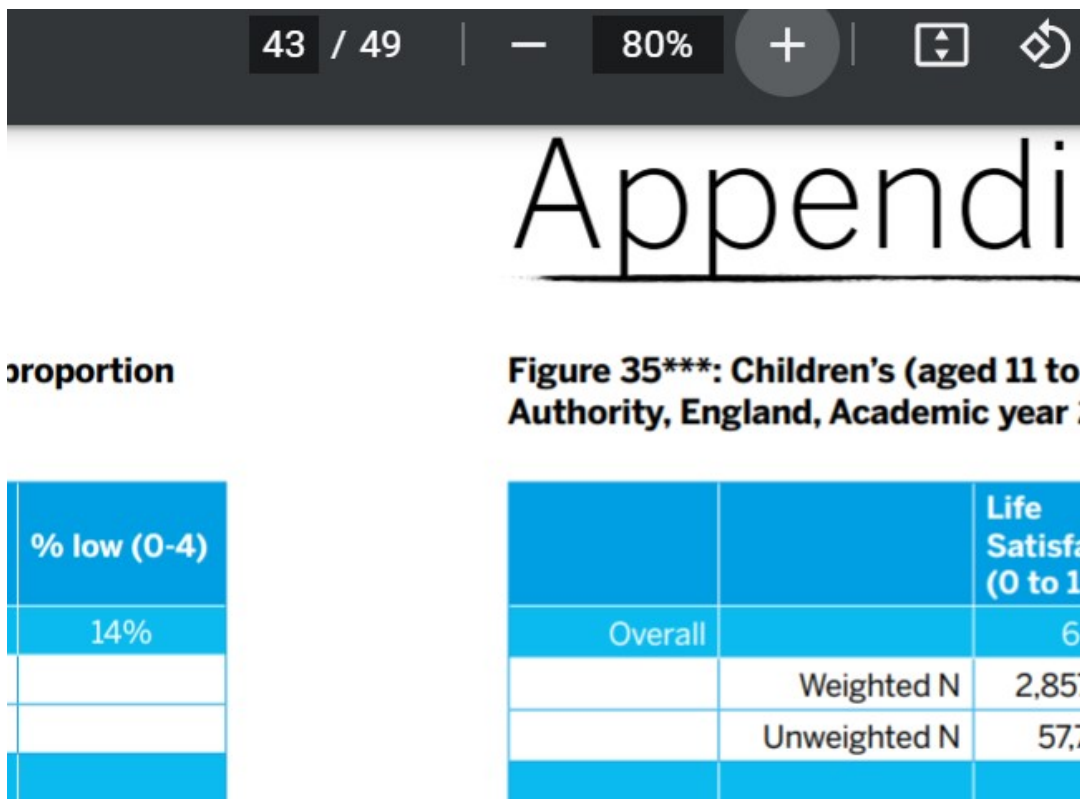
Behavioural (or conduct) disorders

- A group of disorders characterised by repetitive and persistent patterns of behaviour that are considered inappropriate for others, and social norms or rules, are violated.

Appendix 5, Diagram 1: Types of mental disorder.
Source: NHS Digital (2018). MHDS, 2017.

Appendix 6

'Appendix D' of 'The Good Childhood Report' in 2020 states data is available at a local authority level for 'mean well-being' in 2018/19. It has not been possible to access the information at the specified locations.



Appendix 6, Diagram 1: Children's wellbeing scores (average), by LA, 2018/19.

Source: Children's Society (2020). Good Childhood Report 2020. [online]

<https://www.childrenssociety.org.uk/information/professionals/resources/good-childhood-report-2020>

Appendix 7

Permanent links for the tables used are below. 'Table showing 'Age and gender - by SEN provision, type of need and school type' for SEN No Statement or EHC and Statement or EHC from 'Special educational needs in England' in Bournemouth, Christchurch and Poole Council, Dorset and England for 2019/20':

<https://explore-education-statistics.service.gov.uk/data-tables/permalink/bc37ccb6-66f5-4ef0-91a7-3514958c6696>

and

for 'Table showing Headcount for 'Age and gender - by SEN provision, type of need and school type' for Autistic Spectrum Disorder, Hearing Impairment, Missing, Moderate Learning Difficulty, Multi- Sensory Impairment, Other Difficulty/Disability, Physical Disability, Profound & Multiple Learning Difficulty, SEN support but no specialist assessment of type of need, Severe Learning Difficulty, Social, Emotional and Mental Health, Specific Learning Difficulty, Speech, Language and Communications needs, Visual Impairment, No SEN, SEN No Statement or EHC and Statement or EHC from 'Special educational needs in England' in Bournemouth, Christchurch and Poole Council and Dorset for 2019/20'

<https://explore-education-statistics.service.gov.uk/data-tables/permalink/4a96b679-099d-4fb1-b532-2685103e382b>

Appendix 8




Table 1 Risk factors for mental health in refugee children
<i>Parental factors</i>
Post-traumatic stress disorder (PTSD)
Maternal depression ²⁴
Torture, especially in mother ¹⁴
Death of or separation from parents
Direct observation of the helplessness
Underestimation of stress levels in children
Unemployment of parents ¹²
<i>Child factors</i>
Number of traumatic events—either

Appendix 8, Diagram 1: Framework for contextualising risk factors for poor mental health in refugee children^{ccxxvii}

Appendix 9

The below detail has been provided through Dorset CCG documentation and explains in more detail the support available across Dorset, aligned with THRIVE Segments, as at November 2020.

Getting Advice

Educational Psychology Service Teams support schools, working with children and young people when they have a need for emotional and mental wellbeing support. Educational psychologists provide services that span across more than one quadrant. They provide a telephone helpline and brief consultation support to schools and families within this domain.

I can problem solve is an evidence-based programme that helps CYP to grow in confidence and ability to work through questions and come up with solutions themselves. It is aimed at early years and primary aged children and evidence identifies that it reduces impulsivity and emotional reactivity and improves peer relationships.

BRAVE is an evidence-based approach to supporting young people towards good emotional and mental wellbeing with a guided programme of CBT based online support.

Mind Your Head or **Big Umbrella** are evidenced based programmes developed by National Mind and available in some schools currently across Dorset.

Academic Resilience is an umbrella approach to working with the whole school in understanding what resilience means within the context of their specific school identifying the strengths and the areas for development. It takes a co-production approach and is unique to each steering and community. There is already a "whole school" approach to physical education and emotional wellbeing embedded within many schools across Dorset. This approach may well reach into getting help too.

Attachment Friendly Schools is a whole school approach to developing a relationship-based approach to teaching and learning. It provides schools and settings with training and consultation to develop trauma informed practice and ultimately improve outcomes for children and young people who require a relationship-based approach to learning. It can have an impact across all areas of the Thrive model.

Discovery Project is mental health recovery education (based on mental health recovery education for adults). It offers online and activity-based learning to help CYP understand their MH needs and learn skills that enable them to manage their own mental health and wellbeing.

Schools in Dorset and BCP provide pastoral and counselling support; they also have Emotional Literacy Support (ELSA).

Youth Health Champions and Peer support training is being provided in schools across Dorset where young people receive training and then go on to support other young people.

Voluntary Community Social Enterprise (VCSE) Organisations across Dorset there are a number of Voluntary Community Social Enterprise (VCSE) organisations working with CYP to enhance their skills, build their confidence and provide with the ability to grow, develop and thrive. The NHS Long Term Plan includes the ambition to work much more closely with VCSE organisations within Dorset and our intention is to build those partnerships with VCSE organisations.

Getting Help

CAMHS Gateway is a recent development, being piloted within the BCP area initially in respect of longer waiting times in the area. If successful, the aim will be to increase the number of young people who can access mental health support and CAMHS services, but aiming to reduce waiting times. The Dorset-wide roll out is expected to be from September 2021. The CAMHS Gateway will make sure more CYP are able to get the right help at the right time with no young person waiting longer than four weeks to access a CAMHS practitioner in the CAMHS Gateway Service.

CAMHS (we will have to change the name) will be available for children, young people up to age of 25yrs. At present parent infant attachment support is only provided for up to age of 2 years. It is our intention to review and improve the service and provide attachment support up to the age of 5 years so both children and their parents/carers get the best start in life.

Support will be offered to parents and carers who have CYP with MH needs and parents/carers who themselves have their own MH needs. This extended attachment support service will be developed with parents and carers so that it matches their needs. In addition, support will be provided for parents of children who have a diagnosed conduct disorders.

The NHS Long Term Plan ambition is to improve **Young Peoples Eating Disorders Services**. This means that no young person waits longer than 1 week for assessment where their case is urgent or more than 4 weeks for less urgent cases.

Training to manage **Deliberate Self-Harm** will be made available to more people, not just those being treated in CAMHS. We may want to adapt the FLASH (Families Learning About Self Harm) training and make it available to carers, teachers, Local Authority staff and other health professionals etc.

Educational Psychology provides services that span across more than one domain to support schools to identify and overcome barriers to learning including emotional wellbeing and mental health. They work with children and young people, families and other professionals providing a consultation approach following the graduated approach of assess, plan, do and review. The purpose of their work is to improve specific child focused outcomes.

Help will be available for 16-25-year olds dependent on need and where possible tailored to an individual rather than using a one size fits all approach. This is described in more detail in Section 8.

At present Dorset has **Mental Health Support Teams** in some schools. The NHS and Health Education England are gradually increasing the number of MHST within England and we will continue to grow the number of teams so that there are teams working with all Dorset schools and colleges. **The MHST in schools** and colleges provide support relating to common mental health conditions such as anxiety and depression. The teams support teachers and pupils with information and advice about MH needs and ways to support children and young people in managing anxiety and panic attacks. The team can also provide support for individuals or groups through Cognitive Behaviour Therapy (CBT) based approaches along with providing advice and identifying MH needs in schools.

Kooth is an online counselling service available for young people 11-19-year olds. Kooth provides on-line counselling to support young people in several different ways when they have particular mental health or emotional wellbeing problems. Kooth reports its delivery aligns to the Thrive Framework and works with children and young people needing advice and signposting, help, more ongoing help or immediate risk support, with NICE informed clinical models.

Chat Health is a telephone text messaging service available to children and young people to ask questions via texting, the young person will receive texts back with advice and answers to their questions. This service is commissioned by Public Health Dorset.

Getting More Help

Child & Adolescent Mental Health Services (CAMHS) provide specialist treatment for CYP who have serious or complex mental health concerns. Interventions within CAMHS are delivered by a range of health professionals such as Psychiatrist, Psychologist, Nurses, Occupational Therapists, Family Therapists etc. Each young person supported within CAMHS will be allocated a care-coordinator to ensure that there is one member of the CAMHS Team with full oversight of their treatment plan.

Intellectual Disabilities (ID) CAMHS provides treatment and support for children and young people who have intellectual disabilities and mental health concerns.

Emotional well-being and mental health in schools and colleges is crucial as most children and young people spend a lot of their time there. **The Mental Health Support Teams** can make sure that any child or young person who needs more support has advice and support to be able to access the CAMHS Gateway where appropriate. As these teams develop, they will work with CYP and schools on particular mental health issues in schools and work on areas that children and young people tell us are important to them.

Educational Psychology provides services that span across more than one domain to support schools to identify and overcome barriers to learning including emotional wellbeing and mental health. They carry out detailed assessments to contribute towards education, health and care needs assessments to identify needs and co-produced outcomes and educational provision to achieve these.

The School Nursing service will continue to be available to children and young people in schools across Dorset and provide health advice and support for CYP in schools.

Getting Risk Support

Children and young people at risk

Across Dorset there are young people who are at risk and these risks can have a real impact on the rest of their lives.

There are children and young people at risk of neglect, abuse, criminal and other types of exploitation. Some young people engage in risky sexual behaviour which puts them at risk of contact with the criminal justice services. The young people may be children in care or care leavers, not in education, employment or training (NEET) and have a complex range of needs that cannot be met easily by traditional CAMHS, or Local Authority, services.

Young people who have experienced early adversity are more likely to need continuing support from services as they grow and mature. They are much more likely to have physical and mental health conditions, while experiencing poorer outcomes across their lives than children and young people who have not experienced traumatic situations.

These children and young people may not be in a position to access or benefit from treatment or support offered in the traditional ways. However, some negative impacts of early adversity can be lessened with emotional wellbeing and mental health support

CAMHS provide risk management for children and young people who have serious mental health concerns and their behaviour could put them at risk of injury or other harm.

ID CAMHS works with young people who have intellectual development conditions and mental health concerns.

Forensic CAMHS is available for young people who become involved in the criminal justice system and have serious mental health concerns. This team links closely with the Dorset Youth Offending Service (YOS) and Criminal Justice Liaison and Diversion Service.

Youth Offending Service is delivered by the Local Authority with MH professionals employed within the service. YOS work with CYP who commit offences and support them to not commit further offences. Much of their work is linked to the criminal justice system but the service does provide other support to CYP's such as speech and language therapy, literacy and psychological support.

The **Connection** is an all age crisis telephone service available to any child or young person (or parent of the young person) who is reaching crisis point and includes those not being supported by Gateway or CAMHS

The **Psychiatric Liaison service** has CYP MH specialists at all three Acute Hospitals in Dorset: Royal Bournemouth, Poole General and Dorset County.

There is the intention to develop a **Crisis Safe Space** for children and young people which is aligned with the Retreats already available to adults. The Crisis Safe Space service will enable children and young people to get MH crisis support without appointment and in places they may attend such as youth centres and clubs.

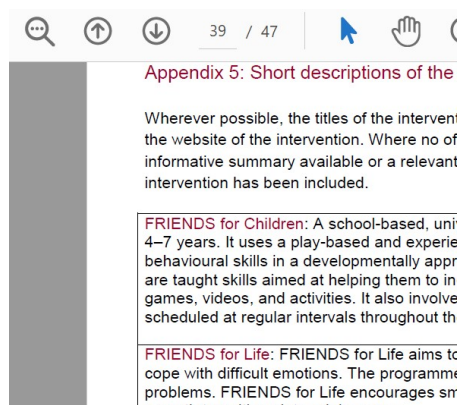
Crisis Home Treatment Teams are being developed by the NHSE to support CYP who have been identified as needing a hospital admission. The teams will aim to provide intensive support for CYP in their own homes in order to prevent the admission. The teams will provide a genuine alternative to hospital for children and young people.

Appendix 10

Links to summary of findings and summary tables contained in PHE (2019) 'Universal approaches to improving children and young people's mental health and wellbeing. Findings from the synthesis of systematic Reviews':

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842169/Findings_from_the_synthesis_of_SRs.pdf

Short description of 'promising' interventions, example below. Available from PHE Universal approaches to improving children and young people's mental health and wellbeing (2019) at 'https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842176/SIG_report.pdf'



Short description of **all interventions** available from Gov.uk under 'Children and young people's mental health: prevention evidence from PHE, titled 'Short descriptions of interventions identified from the synthesis of systematic reviews' at:

<https://www.gov.uk/government/publications/children-and-young-peoples-mental-health-prevention-evidence>

Appendix 11

Short descriptions of the promising interventions, from PHE review of interventions^{xxxvii}.

Wherever possible, the titles of the interventions listed in the table below are linked to the website of the intervention. Where no official website exists, a link to the most informative summary available or a relevant research paper which describes the intervention has been included. FRIENDS for Children: A school-based, universal intervention for children aged between 4–7 years. It uses a play-based and experiential learning approach to provide cognitive behavioural skills in a developmentally appropriate manner. During each session children are taught skills aimed at helping them to increase their coping skills through stories, games, videos, and activities. It also involves group sessions for parents which are scheduled at regular intervals throughout the programme.

FRIENDS for Life:

FRIENDS for Life aims to teach adolescents self-regulation and how to cope with difficult emotions. The programme also teaches creative alternatives to solving problems. FRIENDS for Life encourages smiling, happiness and bravery, and facilitates smooth transitions into adolescence.

LARS & LISA (as described in Pössel et al., 2008):

A manualised school-based prevention programme, originally developed for 8th-graders using 2 psychologists as trainers. It is based on the social information processing model. It consists of 2 sessions on forming a group and motivating them to participate; 4 cognitive sessions which focus on understanding the relation between cognitions, emotions, and behaviours and teach how to identify and challenge negative cognitions; 4 social sessions which train participants in assertiveness and social competence skills. Two adolescent coping role-models (Lars and Lisa) accompany the students through all the topics, showing how to cope with difficult situations and change dysfunctional thoughts and behaviour, appearing in many exercises and films with examples throughout the program. Implemented techniques involve role play, transfer to everyday life, positive reinforcement, etc.

Penn Preventive Program (PPP):

A universal programme delivered in school settings. It is designed to build young people's resilience and promote realistic thinking and adaptive coping. Programme sessions include lessons on topics including: feelings and thoughts, dealing with family conflict, assertion and negotiation, coping skills, social skills training, decision making, and problem solving.

Penn Resiliency Programme (PRP):

An 18-lesson curriculum aimed at 11–13-year olds (although it has been used with a range of different age groups). The lessons are taught by a PRP trained teacher and generally taught during PSHE lessons. The programme enables young people to develop skills to be more resilient in dealing with situations both in and out of school. Young people develop skills in emotion control and emotional awareness, problem solving, assertiveness, peer relationships, and decision making.

Appendix 12

HNA CYP Wellbeing and MH - Themes and recommendations table - working document

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
1) Perinatal and Infant/Early Childhood mental health (pregnancy-2 years post-birth)	a) Establish sufficiency of avenues/levels of MH support available to pregnant women and mothers (up to two years following birth).	- Local Maternity Strategy (to 2019)	- Dorset CCG	- GP/Midwife/Health Visitor - Dorset Maternity Matters Website – SPOA to self-refer	-
	b) Appreciate increased risks to the mental health of mothers, fathers and infants in families with younger parents (<25 years of age), along with protective factors.	- Local Maternity System (to 2021)	- Reference Group (H/SC and local reps) – (led by CCG?)	- DadPad App - Community PNMH service - Mother and baby inpatient unit (specialist support)	-
		- Perinatal Mental Health pathway development	- Dorset CCG	- Connections - Psych Liaison (emergency)	-
					-
					-

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
<p>2) Early Years approach</p>	<p>a) Support children and families in developing positive attachment, behaviours and communication, with focus on those in high risk situations and mitigating risks where possible.</p>	<p>BCP:</p> <ul style="list-style-type: none"> - CYP partnership plan 'Children and Young People's Plan 2021 – 2024' - <i>0-5 Best Start for Life</i> - <i>0-25 development plan (?SEND only)</i> - Children's Services Action Plan 	<p>- BCP LA</p>	<p>-</p>	<p>- BCP Family Investment Fund – COVID-19 related impact ("<i>providing help for children and families to make up lost ground and restore 'lost childhoods'.</i>")</p>
	<p>b) High quality early years settings to understand risk and protective factors for wellbeing and mental health. To actively promote positive wellbeing and mental health within Early Years settings, akin to whole schools approach (support required).</p>	<p>Dorset: 'Our Children, Young People and Families' Plan. E.g.</p> <ul style="list-style-type: none"> - 'Best Start in Life' (0-5 years; to include pre-conception/antenatal/postnatal support). With Task and Finish Groups on: <ul style="list-style-type: none"> - 'Incredible beginnings' (intervention/practice model programme (1-5 years) incl. parental support programmes, Children's Centres, and Early Help) - 'Pause' project – families with multiple children placed in care - 0-5 workforce development group – needs of CYP workforce (H/Ed/SC/Vol) to support along continuum of need (incl PNMH). - School Readiness <p><i>Infant mental health focus/training: via Perinatal Mental Health pathway and EY workforce development via Dorset/BCP CYP Plans</i></p>	<p>- Dorset LA (Strategic Alliance Board for Children, Young People and Families: partners include Health, Police, EY settings, VCS).</p> <p>- BSIL project work (action 9): "Early identification of needs within early years settings and childminders" (Liz Curtis-Jones)</p>	<p>-</p>	<ul style="list-style-type: none"> - Recognise EY settings vary; public, private and voluntary providers (larger/smaller settings/childminders and support to adapt to differences between providers - Establish what 'whole-school' early years approach should look like. - Learning from other school-aged models, e.g. 'wellbeing for education return', MHFA training (incl parents). wellbeing focus, ELSA, behavioural focus for training - Establishing consistency of approach in early years setting, with support around using evidence-based informed approaches.
	<p>c) Provision of support/advice/ signposting for early years settings when recognising child/family with increased need or at increased risk (e.g. FPZ/family hubs).</p>	<ul style="list-style-type: none"> - <i>Wellbeing for education return – (EY?)</i> (training and development to support return to education in light of COVID-19 impacts) 	<p>-</p>	<p>-</p>	<p>-</p>
	<p>d) Development and provision of training to EY workforce regarding infant and early childhood mental health (<i>nationally recognised gap in understanding/skills</i>).</p>	<p>-</p>	<p>-</p>	<p>-</p>	<p>-</p>

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
		<ul style="list-style-type: none"> - Dorset Speech, Language and Communication Pathway Project (0-18) 	Dorset CCG (<i>pan-Dorset</i>)	-	-
		<ul style="list-style-type: none"> - 'I can problem solve' program (4-12 years); complements 'Incredible Beginnings' 	- Dorset Educational Psychology Service	-	-
3) School-based approaches	<p>a) Continued development of whole-school approach, working together with MHST schools counselling and educational psychology services, involving specialist services where beneficial, to maximise effectiveness in improving wellbeing and resilience. To be achieved through raising awareness of mental health issues through the curriculum, reducing stigma around mental health and providing specific support, advice and interventions where appropriate. National recommendations share practical, universal measures as well as selective approaches for whole school development.</p> <p>b) Improve quality, impact and scale of school-based counselling services, with a clear single offer of support and investment across the partnership.</p> <p>c) To establish degree and strength of networks between schools and specialist services to raise awareness of the wider system and provide consultation and advice for settings, including through team around the school approaches.</p> <p>d) Establish effective mechanisms in identifying and supporting children whose behaviours increase risk of persistent absence or exclusion, to reduce wider, immediate and long-term impacts on children and young people. Focus within primary as well as secondary settings.</p>	<p>BCP CYP Plan, Inclusion Strategy and Service Offer to Schools 2020-21</p> <p>Dorset CYPF Plan 'Young and Thriving' and 'Best education for all priority' workstreams (school age)</p> <p>(SEND Learning and Improvement Plan (SEND LIP) Strategic priorities.</p> <p>Dorset Speech, Language and Communication Pathway Project (0-18)</p>	<ul style="list-style-type: none"> - BCP LA - Dorset LA - Dorset CCG (<i>pan-Dorset</i>) 	<ul style="list-style-type: none"> - Whole-school approach - Kooth - ChatHealth text messaging service - EPS - ELSAs - Discovery Project Dorset - BRAIVE (B-MAP) iCBT - Mental Health Support Teams (expanding to 50% coverage by 2023) - School inclusion services - Peer-models, (to include potential for 'peer-navigator; type role, as per recommendation below) - CAMHS 	<ul style="list-style-type: none"> - Consideration of 'front door'/SPOA approach ('Physical' or 'Digital'), to support individuals, families and professionals to access appropriate resources and routes into activities known as protective factors, particularly for those in the Thriving, Getting advice/support and Getting Help quadrants - Maintain focus on preventative mechanisms, such as physical activity - Continue efforts to develop quality assurance around school counselling provision - All schools to have designated MH leads by 2025.

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
4) Preparation for adulthood	<p>a) Understand increased risk to wellbeing and mental health present during adolescence (incl. general health, reduced physical activity, challenges with healthy eating/healthy weight as well as increased rates of risk-behaviours).</p> <p>b) Understand the essential role of protective factors, particularly influential during adolescence and young adulthood. They include general health, physical activity, healthy eating, sleep, social networks and education/training/employment.</p> <p>c) Understand risk pertinent to Care Leavers, with differing support mechanisms, during late adolescence and transition periods.</p> <p>d) Working to understand provision in further and higher education, in colleges and universities, in supporting wellbeing and mental health. Assess whether support from mental health professionals would be beneficial in supporting/developing provision akin to WSA or other.</p>	<p>BCP: 'Offer to Adolescents' within 'Children and Young People's Plan 2021 – 2024' e.g. <i>measures within plan, for instance, reducing attainment gaps and blended learning opportunities to improve non-attendance and exclusions</i></p> <p>Dorset: CYPF Plan</p> <p>Some particular risks present in adolescence and young adulthood contained within Dorset 'At risk project brief' (detailed below)</p>	<ul style="list-style-type: none"> - BCP LA - Dorset LA - Dorset EWBMH SG 	<ul style="list-style-type: none"> - Clare Hurley (APS) interfaces with Bournemouth University regarding in-house MH and emotional wellbeing support – working group with APS & CAMHS service leads. Good network with CAMHS, IAPT, and PCNs and with uni. 	<ul style="list-style-type: none"> - Consideration of 'front door'/SPOA approach ('Physical' or 'Digital'), to support individuals, families and professionals to access appropriate resources and routes into activities known as protective factors, particularly for those in the Thriving, Getting advice/support and Getting Help quadrants <p>Establish support to some colleges. MHST working with some colleges (BCP/?Weymouth)</p>

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5) Parental needs and family functioning	<p>a) Parents/carers – early action to improve family functioning and parental needs: mental health, alcohol or substance misuse (known to affect wellbeing and mental health of children).</p> <p>b) Parents/carers – support if child has mental health need (and if in services, to assess child in context of family).</p> <p>c) Ensuring access to advice, support or services to address wider, social determinants of health, wellbeing and mental disorder.</p>	<p>Dorset MH strategy and Implementation Plan</p> <p>BCP:</p> <ul style="list-style-type: none"> - Children and Young People's Plan 2021 – 2024' - Family Investment Fund (COVID) <p>Dorset:</p> <p>CYPF plan 'Delivering locally priority' addressing Early Help offers, as well as family support with focus on children in families with one of 'toxic trio' (parental substance use or mental ill-health or domestic abuse)</p> <p>-</p>	<ul style="list-style-type: none"> - Dorset EWBMH SG - BCP LA - Dorset LA 	<ul style="list-style-type: none"> - Universal services - Early Help offer - CAMHS including Crisis Home Treatment - AMH (APS) - Infant Mental Health workstream - Dorset 'Better Births Early Adopter Needs and Analysis report' 2017 - GPs - Health Visitors - Social Services - Housing Services - CAB - 	<ul style="list-style-type: none"> - Linking with maternity, GP and family planning in preparation for parenthood. - Consideration of needs of those who have been adopted and adoptive parent's MH needs

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/ opportunities
<p>6) Enabling navigation and sufficiency of services to support thriving or getting help, including effective self-management</p>	<p>a) Assess system sufficiency in meeting wellbeing and mild-moderate mental health need, aligning with 'THRIVE' groupings of thriving/advice-support/getting help. Promotion of wellbeing and mental health through protective factors and prevention of lower wellbeing and mental disorder through easier and earlier information, advice, support and intervention.</p> <p>b) Clarity of offer across providers.</p> <p>c) Identifying opportunities for promoting protective factors, including physical activity (effective in supporting wellbeing through to reducing impact of ACEs).</p>	<p>BCP: Children and Young People's Plan 2021 – 2024'</p> <p>Dorset: CYPF plan</p> <p>Drugs and Alcohol strategies</p> <p>Emphasis on 'Local Offer' review: accessible and publicised</p>	<ul style="list-style-type: none"> - BCP LA - Dorset LA - Dorset EWBMH SG 	<ul style="list-style-type: none"> - Early Years settings/HV - WSA - MHST - School counselling - Access to Green/Blue spaces and opportunities to be active - Peer-models, e.g. Discovery Project, school-based wellbeing champions, Youth Sports Trust ambassadors, Youth Health Champions 	<ul style="list-style-type: none"> - Consideration of 'front door'/SPOA approach ('Physical' or 'Digital'), to support individuals, families and professionals to access appropriate resources and routes into activities known as protective factors, particularly for those in the Thriving, Getting advice/support and Getting Help quadrants. - Potential 'Peer Navigator' role within CMHS Gateway working with those who do not meet criteria for CAMHS. Discussion to be had about wider role of 'peer-navigator' to address need in those below referral threshold of CAMHS (?part of SPOA approach). - Retreat will be available for anyone's determination of 'crisis'. - Establish workstreams with VCSE to further understand their .potentially significant role in shaping support or in provision. - Understand access to support, activities or education around preventative (protective factors), such as physical activity.

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/ opportunities
<p>7) Establishing approach to those within higher-risk groups (including those not in need of specialist services but affected by wider circumstances)</p>	<p>a) Understand current mechanisms which support recognition of children and young people within groups shown to be at higher-risk of poorer wellbeing or developing mental disorders and where gaps may exist.</p> <p>b) Understand mechanisms for accessing support or intervention for those identified as at higher-risk or with identified need.</p> <p>c) Specific focus on support and services for those at higher risk of mental disorder. This should incorporate those identified as within the 'risk support' quadrant of THRIVE and those who may not be identified as within that cohort, but whose risk remains above that of the general population, as detailed in the HNA. Groups are those who are or who have:</p> <ul style="list-style-type: none"> • Children in Need (incl. CiC, CP, post adoption) • ACEs • SEND • Disabilities • Autism or Neurodiversity • living in poverty • LGBT+ • young parents • young carers • in adverse domestic situations (Parental MH, substance abuse, domestic violence) • at risk of persistent absence and exclusions • in contact with youth justice • overweight • bullied • homeless • asylum seeking or with refugee status • children of military families • of particular ethnicities/cultures • NEET • involved with substance or alcohol abuse • at risk of, or experiencing, criminal or sexual exploitation <p>d) Consider expansion of conversations and assessments in support and services to identify</p>	<p>- 'iThrive to 25'</p> <p>- At risk project brief</p> <p>- Mental health integrated community care review MICC review –</p> <p>BCP/Dorset:</p> <ul style="list-style-type: none"> - CYP Plans, including e.g. 'No wrong Door' approach for CiC - Safeguarding/MASH <p>Pan-Dorset Safeguarding Children Partnership CAROLE model</p> <p>BCP:</p> <p>Mapping Early Help services</p> <p>Dorset</p> <p>CYP plan</p> <ul style="list-style-type: none"> - development of single pathway for supporting EWBMH for CiC - Community safety partnership - Youth Justice Plan 	<p>- Dorset EWBMH SG / Dorset CCG</p> <p>- Dorset CCG/DHC partners</p> <p>- Dorset LA</p> <p>- Dorset and BCP LA</p> <p>- Multi-agency: LAs/CCG/Police</p>	<p>- Early Help models</p> <p>- CiC: virtual school (Dorset/BCP)</p> <p>- BCP: Designated mentor for CiC</p> <p>- Dorset: ASPIRE' support for adopted children</p> <p>- Youth Justice Service, including its health team and its trauma-informed practice model</p>	<p>- Thrive model also highlights children and young people at increased risk also can benefit from lower-level intervention, as well as Health Promotion and Protection initiatives.</p> <p>- Access to specialist MH support/input for Early Help/CiN meetings</p> <p>- To map the full spectrum of support aimed at supporting physical and mental health available to those in higher-risk groups, such as children in need, and the avenues through which they can access these.</p> <p>- 2019 'Children in Need review' has specific evidence-based recommendations and areas for action around education, social care and supporting families and communities.</p> <p>- The 'National protocol on reducing criminalisation of looked-after children' also offers a framework for best practice for those working with children in care, in all types of placement, and care leavers up to age 25.</p>

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
	<p>needs not traditionally considered as direct drivers of wellbeing or mental health, but which are known risk factors for mental health.</p> <p>e) System assessment of how supporting specific needs around criminal and sexual exploitation, gang involvement and criminal behaviour.</p> <p>f) Improve preparation for, and transition, between child and adult specialist services.</p>				

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
8) Specialist Service offers	a) Equity of access, experience and outcome. Understand accessibility, timeliness and relevance of current offers, especially to those within groups less likely to access or benefit from support. This may include those with previous negative experiences of systems, people with less represented identities such as those from LGBT+ or ethnic minority communities, based on differing geographies, those not in school-based education and those unable to access within the school day.	I Thrive to 25 – MH strategy and implementation plan -	- CCG and DHC	- CAMHS - Youth Justice Service health team	-
	b) Understanding equity of access, experience and outcome.	-	- CCG and DHC	-	
	c) Co-developing 'crisis' and 'pre-crisis' offer to enable children and young people to access suitable alternatives to awaiting a worsening of symptoms or taking actions to relieve distress such as self-harm or substance misuse.	- Retreat - Harbour project - Gateway (16-18 in BCP (those referred to CAMHS))	-	-	
	d) Ensure clarity and sufficiency of services for sexually harmful behaviour or services related to exploitation.	- Harmful sexual behaviour review	- Children's commissioners within LA/CCG and other partners (Joint Commissioning Board oversight)	- Youth Justice Service (HSB specialists and YJS health team) - FCAMHS	- Establish local HSB pathways that include specialist consultations, reflective supervision and suitable workforce development

Theme	Recommendation	Route for Implementation and Links with existing/proposed Plans	'Organisational' responsibility	Current Context/Assets to recognise	Future potential/opportunities
9) Workforce development	<p>a) Embed whole system understanding of, and commitment to, THRIVE approach, including the role of lifecourse and wider contextual factors in improving mental health and wellbeing.</p> <p>b) Building upon positive effects expressed by staff in successful co-working across health and social care.</p> <p>c) Recruitment, training and supervision processes to incorporate 'Trauma-informed Care' (TIC) approach.</p> <p>d) Embed awareness and understanding of factors that protect wellbeing and mental health and those that increase the risk of lowering wellbeing developing mental disorder, self-harm and suicide, in workforce development plans for those who work with children and young people across the system.</p> <p>e) Consistent awareness and support for children and young people to navigate support available across all THRIVE groups</p>	<p>- East/West workforce development plans</p> <p>- Dorset CYP plan</p> <p>- BCP 'CYP plan'</p> <p>- Health</p> <p>- Social care</p> <p>- Education</p>			•

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