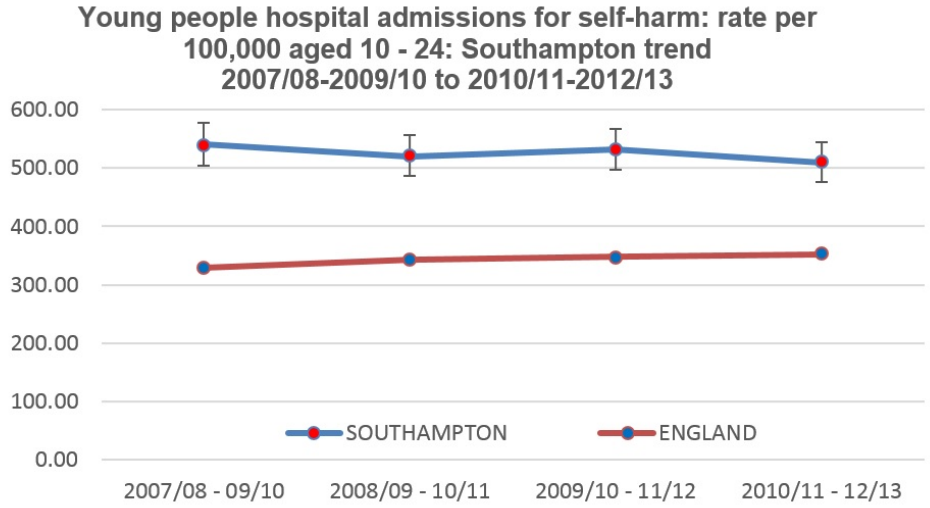
KEY ISSUES AND NEEDS FOR CHILDREN AND YOUNG PEOPLE'S WELLBEING

Our City's Joint Strategic Needs Assessment (JSNA) shows that nearly 5,500 of our children and young people have mental health problems, two thirds with conduct disorders. The estimated need for children with moderately severe problems requiring attention from professionals trained in mental health (Tier 2) is 3,590 children and young people.

- Evidence suggests that resilience in early life helps to protect against risky behaviour, improve academic results, develop skills to increase employability, increase mental wellbeing and enable quicker and better recovery from illness.
- Mental resilience is the capability to 'bounce back' from adverse experiences, and succeed despite adversity. Exposure to risk factors is more likely to lead to vulnerability, whereas protective factors lead to increased resilience.
- Taking action on well-being and resilience can reduce costs in other areas e.g. reducing truancy can produce a saving of £1,318 per year per child, and reducing exclusion can save £9,748 in public value benefits, 89% of which goes to local authorities.

The directly age standardised hospital admission rate as a result of self-harm for children aged 10 to 24 years in Southampton is 400.9 per 100,000 (2012/13). This is significantly higher than England, and has remained similar from 2007/08 to 2012/13. Crude rates of hospital admissions are shown in figure 1 below.

Figure 1:



Source: PHE Children's and Young People's Mental Health and Wellbeing Profile

Southampton has recently analysed the numbers being seen by the Deliberate Safe Harm (DSH) team in the emergency department but also those seen within the 'one stop shop' service provided by the voluntary organisation 'No Limits'. Figures 2 and 3 are from the DSH team and show that females are presenting to the ED more than males and that 64% are presenting with a medication overdose.

Figures 4-7 are from No Limits and show that the peak age of attending their clinics/drop-in sessions is 14-15 years old (fig 4) but that the frequency (amount of times attended) increases with age, with the 21-24 year olds attending around 50 times a year compared to 10-20 times for 14-15 year olds (fig 5).

Figure 6 looks at ethnicity and frequency of access. The data seems to show that young people of Asian, black, East Asian and mixed race descent are attending significantly less than young people of white descent. This highlights a need to look more in to the outcomes for different young people. Finally figure 7 looks at the postcodes of those attending and highlights the differences across the city and the continued need to undertake in-depth needs analysis of the different cluster areas.

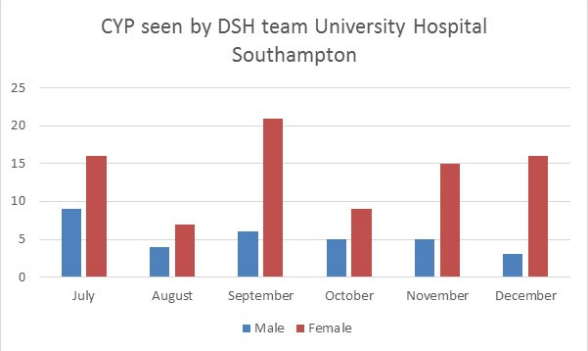


Fig 2

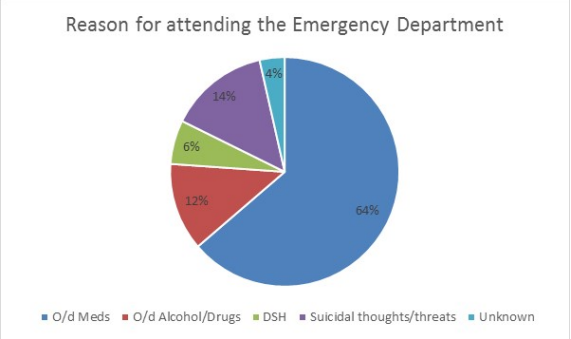


Fig 3

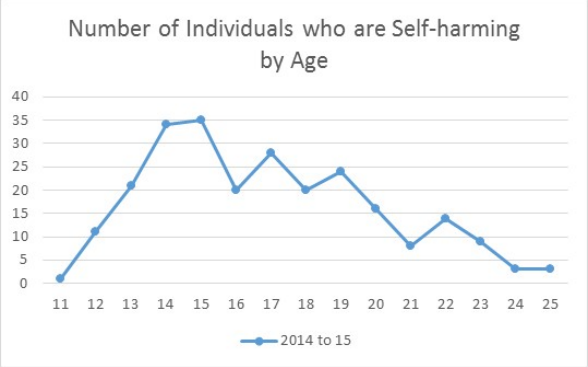


Fig 4

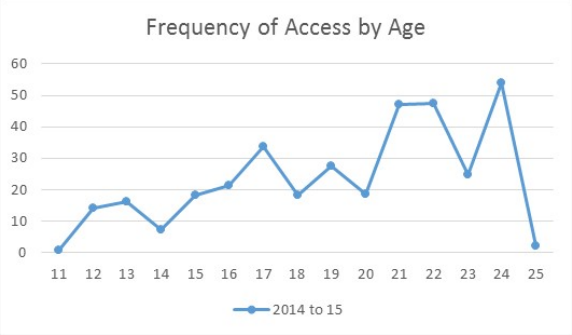


Fig 5

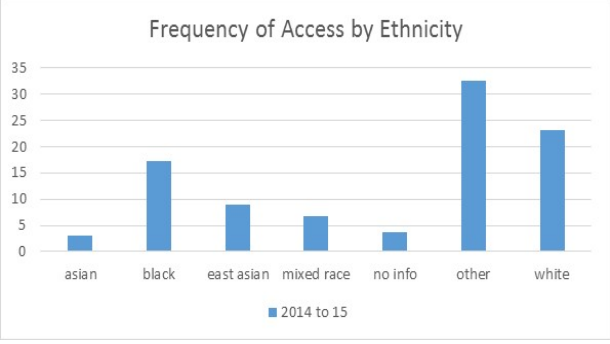


Fig 6

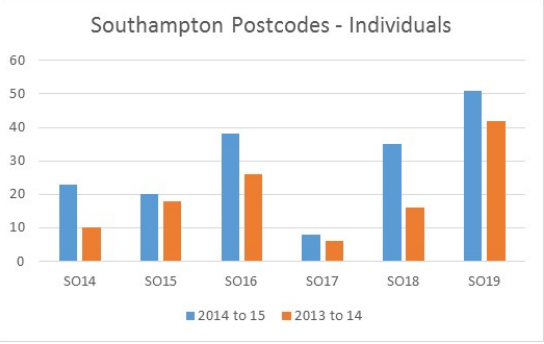


Fig 7

Within our child health profile, Southampton is significantly worse than England for 11 of the 32 indicators, this includes a high rate of looked after children, teenage pregnancy and

hospital admissions for mental health conditions (see CHIMAT website for more information).

We also know that it is important to prevent the development and accumulation of ill-health at the earliest stage possible. Some 50% of adult mental illness (excluding dementia) starts before age 15, and 75% by age 18. Children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes. Furthermore, mental health problems in childhood and adolescence in the UK result in increased costs of between £11,030 and £59,130 per child annually.

20% of children have a mental health problem in any given year at any time. Our local data shows a particular increase in related issues such as post school attendance and exclusions and youth offending peaking in the school years of 8 and 9 (age 12 to 14). Both national and local evidence also highlights a specific point of anxiety for children and young people is in the transition from primary to secondary school (year 6 to 7; age 10 to 12). This transition period was also identified by children and young people as a priority issue and the pupil survey in Southampton 2012 found year 9 and 11 as peak for pupils who worry.

HeadStart needs analysis maps a series of indicators across school, lower super output area (very small geographical areas) and wards. The indicators used include; special educational needs; indicators of deprivation using child indicators, pupil premium data, ethnicity, prior attainment, attendance, late for school, persistent absence, exclusions, Ofsted judgement, safeguarding, youth offending, crime, pupil referral attendees, CAMHs referrals. A weighting was given to some indicators where they reflect more accurate mental health and well-being e.g. SEN, CAMHs. The data was then aggregated geographically and ranked by level of collective need.

This data shows a broad range of needs spread across the City with specific areas evidencing substantially higher needs. The difference across secondary schools in terms of collective needs is much less pronounced than primary schools.

Needs analysis has evidenced that overall the HeadStart target population is;

- Children and young people aged 10 to 16 years.
- Primary (age 10-11) and secondary school pupils, with a particular focus on years 8 and 9 (age 12-14).
- Children making the transition (year 6 to year 7) between primary school and secondary school.
- All children living in Southampton and/or attending Southampton Schools (aged 10 to 16) with greater focus on CYP living in areas or attending school where there are the highest levels of needs.

Priority focus will be on reaching children who:

- Are persistently absent, missing or disengaged from school.
- Children living with or have lived with domestic violence and abuse.
- Children demonstrating offending or anti-social behaviour and/or whose behaviour puts them at risk of exclusion and/or family crisis.
- Children identified themselves, professionals, or by friends/family as needing help and support ‘to cope’ and thus displaying behaviours and feelings associated with reduced emotional well-being or potential risk of emerging mental health problems.

Headstart will operate on a locality basis with joined up multi-agency provision in 3 areas / 6 clusters. Some provision or elements of the programme will be targeted to identified levels

and type of need. This could reach some (but not all) primary schools with particularly high levels of need.

Outcomes will be monitored using the baseline data gathered for the needs analysis.