STRATEGIC NEEDS ASSESSMENT

Children and Young People 2017
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1. Introduction

This Strategic Needs Assessment (SNA) for Children and Young People provides a collection of supporting information that helps to define and frame the population challenges in Dumfries & Galloway at a strategic level. Needs assessments are technical documents that consist of the current policies and evidence that influence the topic area, as well as numbers and statistics that describe the local population.

The SNA provides a wealth of background intelligence about issues that will influence our ability to respond to the needs of our population in the future. The data used in this report is based upon a combination of published national statistics and local data sources. Context is provided where possible by comparing Dumfries & Galloway to the national Scottish average and by including some trends over time.

It is important to note that the SNA is a collection of evidence that reflects the context in which to understand the population of Children and Young People in Dumfries & Galloway, rather than a description of the services that currently exist to support them. This needs assessment is a snapshot in time of what is known about children and young people; it is likely that our knowledge and understanding will change over time. It is intended that people planning services will be able to use this evidence as a reference when it comes setting the scene for making decisions.

Understanding this population, their needs and the wider influences that impact on wellbeing, sets the context and foundation for the development of strategic plans that will improve outcomes for our Children and Young People.

This SNA:

- Describes the profile of the population of Children and Young People in Dumfries & Galloway
- Identifies areas in which further data sources may be desirable but which are not currently available, or that require greater time/staffing resource to tap into
- Outlines the strategic and policy context for the work of the Community Planning Partnership
- Collates relevant data, on a wide range of topics, benchmarked where possible against the rest of Scotland
- Offers findings from the wider literature to support the strategic planning of interventions and support that will enable improved outcomes for all Children and Young People in the region.

Please note that the SNA does not include information on finance, resources or workforce.
The ‘National Policy Context’ section highlights a number of key policies, relevant to all sections of the SNA as they have relevance to all families in Scotland.

In compiling this SNA eight recurrent, cross-cutting themes were identified: inequalities, parenting, early intervention, child centredness, listening to Children and Young People, working together, transitions and rurality. These are discussed in the section ‘Overarching Themes’. Throughout the document a ‘themes’ symbol (shown left) is used to denote their interconnectedness.

‘Understanding Our Population’ outlines the current and predicted population of children and young people in the region and identifies patterns in births, life expectancy and mortality.

The subsequent eight chapters relate to each of the SHANARRI Indicators of wellbeing: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included. Each chapter contains relevant topics (for example unintentional injuries and accidents appear in the Safe chapter) all containing a strategic/policy context, review of the evidence and local data and analysis.

Occasionally some of the information presented here includes small numbers. These have been replaced with 5 or 10 as appropriate, and the corresponding totals altered so as to ensure that individuals cannot be identified from this information and that confidentiality is maintained. This is done in accordance with national guidelines.

References can be found at the end of each chapter.

Also throughout the document are blue boxes (like this one) that highlight technical notes about information, ‘gaps in our knowledge’ and recommendations.
2. The National Policy Context

The Scottish Government has placed Children and Young People at the heart of strategy development and articulated its aspiration to ensure that every child has the best possible start in life. Additionally, current legislation seeks to improve the delivery of children’s rights, building on the requirements set out in The United Nations Convention on the Rights of the Child (UNCRC)\(^1\)

The UK government ratified the UNCRC in 1991, therefore Scottish Government have an obligation to implement it and to ensure that children, young people and adults know about and understand the Convention. The UNCRC consists of 54 articles, 1-41 set out how Children and Young People should be treated, and the remaining 13 articles articulate the requirement to ensure that the rights of every child and young person are respected, protected and fulfilled. Four articles are afforded special emphasis, as they are fundamental to the implementation of all other rights. These are referred to as the four general principles of the UNCRC and are:

- Non-discrimination (article 2),
- Best interests of the child (article 3),
- Right to life, survival and development (article 6),
- Respect for the views of the child (article 12).

The World Health Organisation has articulated a number of “Millennium Development Goals” which have relevance to Children and Young People. They include the eradication of extreme poverty and hunger, the achievement of universal primary education, the promotion of gender equality and the empowerment of women, the reduction of child mortality, improved maternal health, combating infectious diseases including HIV, ensuring environmental sustainability and global partnerships for economic development.

The Children and Young People (Scotland) Act 2014\(^2\), was passed by the Scottish Parliament in February 2014. The Act places a new duty on Scottish Ministers to: keep under review whether there are steps they might take to strengthen their approach to implementation of the UNCRC; take actions which they believe to be appropriate in response and be prepared to justify the impact of those actions; to promote awareness and understanding of the UNCRC; and introduces new reporting requirements (every three years) designed to support increased scrutiny of the public sector’s approach to implementing the Convention.
The Act is very wide-ranging as it also:

- Creates new systems to support Children and Young People, focused on the principle of early intervention
- Increases the powers of Scotland’s Commissioner for Children and Young People
- Makes changes to early learning and childcare
- Provides extra help for looked after Children and Young People in care
- Provides free school dinners for children in Primary 1-3.

In Scotland, the policy landscape in respect of Children and Young People is underpinned by Getting it right for every child (GIRFEC) and Curriculum for Excellence (CfE). Scottish Government expects partners to adopt and promote a range of common approaches in delivering services for young people underpinned by the GIRFEC approach and the principles of prevention and early intervention.

The GIRFEC approach overarches all policies relating to Children and Young People. It is a national approach which enables early, single and multi-agency intervention when there is a concern about a child or young person’s wellbeing before the issue escalates.

**Please Note:** GIRFEC is described in greater detail in Section 4.

Curriculum for Excellence (CfE) aims to provide a coherent, flexible and more enriched educational curriculum from age 3-18 years. Within CfE, which has been implemented in every school in Scotland since 2010; learning in Health and Wellbeing ensures that Children and Young People develop the knowledge, skills and attributes which they need for mental, emotional, social and physical wellbeing now and in the future. At its core, CfE seeks to enable each child or young person to be:

- A successful learner
- A confident individual
- A responsible citizen
- An effective contributor

The Early Years Collaborative (EYC), established in 2012 is a nation-wide improvement programme, involving a coalition of community planning partners, to drive the application of a consistent model of improvement science across early years work to accelerate the pace of change in this area. Five “stretch aims” have been developed which underpin the work of the collaborative:

- To ensure that women experience positive pregnancies which result in the birth of more healthy babies, as evidenced by a reduction of 15% in the rates of stillbirth and infant mortality, by 2015
To ensure that 85% of children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child’s 27-30 month review, by end 2016

To ensure that 90% of children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child primary starts school, by end 2017

To ensure that 90% of children within each Community Planning Partnership have reached all of the expected developmental milestones and learning outcomes by end of Primary 4 by end-2021

By 2016, all leaders in the Early Years Collaborative demonstrate the skills and knowledge to lead for improvement and delivery of a successful collaborative

Key themes have emerged which cut across the first four stretch aims. These are areas of work for which there is a high degree of confidence that shifts in their delivery will result in improved outcomes for children. The themes are early support for pregnancy and beyond, attachment, child development and learning, continuity of care in transitions, 27-30 month child health review, parenting skills and family engagement to support learning, addressing child poverty, health and wellbeing and play. The identification of these themes has shifted the focus of the EYC work from age-related activities to broader improvement interventions across the early years.

In recent decades in Scotland, greater integration of public services has been proposed as fundamental to achieving improvements in health and wellbeing for the whole population culminating in the development of the Public Bodies (Joint Working) (Scotland) Act 2014, which requires the NHS and local authorities to work together to deliver integrated health and social care services to adults. This legislation requires the development of joint strategic plans which are expected to focus upon delivering improved outcomes for users and carers through improved alignment of investment with identified needs and the evidence base relating to delivering better outcomes.

The integration of services for Children and Young People is also allowable under the provisions of the legislation, and this is likely to particularly impact those Children and Young People who require support from a wide range of services including health, social care, housing, welfare benefits, education, transport and leisure. The groups of Children and Young People most likely to be affected by the integration of health and social care are:

- Those in transition between children, young people’s and adult services
- Children and Young People leaving care
- Vulnerable Children and Young People
- Young Carers

Recent work undertaken by the Centre for Excellence for Looked After Children In Scotland (CELCIS) and Children in Scotland commissioned by Social Works Scotland (previously ADSW) concluded that whilst adult integration presents a significant opportunity, benefits for Children and Young People will
only be realised if their needs are considered and factored into decisions. Therefore; the importance of comprehensive strategic needs assessment, subsequent strategic commissioning and engagement with service users cannot be underestimated.⁷

The strategic narrative Achieving Sustainable Quality in Scotland’s Healthcare: A 20:20 Vision (September 2011)⁸ provides the context for taking forward the required actions to improve efficiency and achieve financial sustainability. Key challenges include Scotland’s public health record, changing demography and the economic environment. The ‘20:20’ Vision also confirms the Scottish Government’s commitment to the values of NHS Scotland: collaboration and cooperation, partnership working, with people and with the voluntary sector; of continued investment in the public sector rather than the private sector; of increased flexibility, provision of local services and of openness and accountability to the public.

The Welfare Reform Act (2012)⁹ introduced a £26,000 annual benefit cap on families, reductions in housing benefit payments and the inclusion of child benefit payments within the £26,000 cap. Furthermore the 2015 budget announced further reductions, down to £23,000 for families in London and £20,000 cap for those out with the capital. The four UK Child Health Commissioners have expressed concern over these reforms as having a disproportionate, negative impact on children since families living on low household incomes will need to divert money away from necessities for children’s health and wellbeing such as heating, warm clothing, and nutritious food in order to cover other household costs.

The spectrum of policies, including those relating to health, education, environment, housing transport and social justice influence the lives of Children and Young People by either directly or indirectly, aiming to narrow the gap between the health of the best and worst-off young people in Scottish society - that is, to reduce health inequalities. Scottish Government policy development is increasingly shaped by asset based approaches as a means to tackle the deep rooted social problems that persist across Scotland. Central to this work is the idea of helping people to be in control of their lives by developing the capacities and capabilities of individuals and communities. It draws on existing approaches that foster effective and appropriate involvement of the people and the professionals who serve them. The asset based approach to health improvement is widely recognised as offering the most coherent and evidence based approach to the maximisation of health and wellbeing.

Current policy generally reflects a dual strategy of enhancing protective factors for health and wellbeing while seeking to reduce risk factors. Policy makers are increasingly focused on moving away from single issues towards an integrated, multiple risk behaviour approach which recognises that risky behaviours occur.

Health inequalities in childhood can have a lasting effect throughout life and Children and Young People continue to experience health problems which are preventable.
We must continue to ensure that our work targets the needs of the most vulnerable children. Vulnerable groups include Children and Young People who:

- are under 5 years of age
- have complex physical and mental health needs
- have learning disabilities
- are in need of protection from physical, sexual and emotional abuse
- are living in a substance misusing household
- are experiencing domestic abuse
- are looked after
- are Young Carers
- are homeless

All of Scotland’s Children and Young People need to be safe, healthy, achieving, nurtured, active, respected, responsible and included if we are to achieve our ambitions for them and accomplish the long term vision of a healthy Scottish population.

References


3 Scottish Government; Getting it right for every child: http://www.gov.scot/Topics/People/Young-People/gettingitright (last accessed 28th October 2015)


5 Scottish Government; Early Years Collaborative: http://www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative (last accessed 28th October 2015)


7 CELCIS; Integrating Health and Social Care in Scotland: Potential impact on children’s services March 2014; http://www.celcis.org/resources/entry/integrating_health_and_social_care_in_scotland_potential_impact_on_children (last accessed 28th October 2015)


3. Overarching Themes

In this section:

- Child Centred
- Inequalities
- Early Intervention
- Parenting
- Rurality
- Transitions
- Working in Together
- Listening to children, young people and families

3.1 Child Centred

Child centredness is a way of engaging with children and young people in which their needs and wishes are paramount. Child centred approaches represent opportunities to tackle seemingly intractable problems of poverty and inequality. As children are the starting point for breaking intergenerational cycles of disadvantage the wellbeing of children translates into the wellbeing of a nation.\(^\text{10}\)

*Getting It Right For Every Child (GIRFEC)* promotes this child centred approach, founded on the principles of early intervention, through appropriate, proportionate and timely support. Acknowledging that the vast majority of children and young people receive all the support they need to ensure their wellbeing from their parents, carers and families. This approach ensures that from birth all Scotland's children, young people and their families have additional consistent and co-ordinated support, when they need it. It specifically promotes co-ordinated action by services to improve the life chances and outcomes for all children and young people.

3.2 Inequalities

3.2.1 The Strategic and Policy Context

Despite the drive to provide better healthcare to communities across Scotland and the knowledge that overall, Scotland’s health is improving, the rate of improvement in the poorer areas of Scotland remains significantly slower than in the more affluent areas. Inequality in health and wellbeing outcomes continues to exist across Scottish society. In his 2011 annual report (December 2012), *Scotland’s Chief Medical Officer* stated that the most significant issue he had to face was the problem of health inequalities.\(^\text{11}\)

The origins of health inequalities are complex and are to be found in the many interactions between social, economic, educational and environmental determinants. Action is required across all the determinants of health and wellbeing.
The publications “Equally Well: Report of the Ministerial Task Force on Health Inequalities”, along with the “Early Years Framework” and “Achieving Our Potential: A Framework for Tackling Poverty and Income Inequality in Scotland”, set out the Scottish Government’s and the Convention Of Scottish Local Authorities’ (COSLA’s) shared approach to tackling the major and intractable social problems that have affected Scotland for generations. These three social policy frameworks recognise that children’s start in life, cycles of poverty and poor health are interlinked. These are complex problems, involving complex solutions, and which require a long-term approach. Scottish Government policy advocates early intervention, moving from crisis management to prevention and breaking cycles of poor outcomes in people’s lives. In addition, the Child Poverty Act 2010 sets out UK-wide targets relating to the eradication of child poverty. It legislates the duty of the UK Government to ensure that the child poverty targets are met in relation to the year commencing 1 April 2020. These targets relate to levels of child poverty in terms of: relative low income; combined low income and material deprivation, absolute low income and persistent poverty.

3.2.2 The Evidence

“Life chances” can cover a range of opportunities that people can experience as they become adults and into later life. These opportunities include the probability of being in employment, the chances of obtaining educational qualifications and the chances of good physical and mental health. Life chances are closely related to the socio-economic characteristics of their families, such as parental income, socio-economic status and parental education. Also, outcomes and achievements in adulthood are closely linked to cognitive and social competencies developed in childhood. Good cognitive abilities are associated with educational attainment and with higher wages. Social skills contribute to later life outcomes; for example, learning attention and social adjustment are associated with reduced likelihood of being involved in criminal activity.

When socio-economic factors are accounted for, it appears that children from non-British ethnic groups make greater progress than white British children and achieve better than expected educational outcomes (except for Black Caribbean children who underachieve). It is thought that this due to the provision of good home learning environments (HLE) which partly ameliorate the impact of economic disadvantage. However, those from ethnic minorities are more likely to be unemployed and receive lower wages.

Adults with disabilities since childhood are more liable to experience multiple disadvantages (living in poverty, lack of educational qualifications, more likely to be economically inactive) and disabled young people appear to underachieve both academically and in the workplace despite holding similar aspirations to non-disabled children.

The “gender gap” in educational attainment and in wages in adulthood is well recognised, not only as an UK issue, but one that can be seen across Europe. There is some evidence that these differences may be related to biological and social differences and occupational segregation. In relation to
3. Overarching Themes

lesbian, gay, bisexual and transgender people, there is very little evidence on the interaction between experiences in the early years and later life outcomes, largely because the datasets that collate information on the early years and on life outcomes do not collect information on sexual orientation. However, a number of studies\textsuperscript{16,17} indicate that homophobic bullying is a problem in secondary schools that may impact on educational attainment and decisions relating to post 16 education and occupational choice.

There is a large body of literature that demonstrates that early years developments and adult outcomes are strongly related to family characteristics and to parental behaviour. The quality of the home learning environment and parental aspirations are found to be particularly important for children’s development\textsuperscript{18}. Good quality pre-school education has been found to be particularly beneficial to children from poor socio-economic circumstance but is least likely to be accessed by them.

Increasingly the evidence supports the relationship between parental education, income, Healthy Life Expectancy and outcomes. However more work needs to be undertaken to understand the impact of these and gender, ethnicity and disability. In addition, more research should be undertaken to explore the reasons why disabled Children and Young People do not reach their full potential. Childhood poverty and social deprivation are among the main explanatory factors for poor life outcomes and tackling these is likely to be the most effective way of improving equality of opportunities and outcomes.

3.3 Early Intervention

3.3.1 The Strategic and Policy Context

Early intervention has relevance to a wide range of policy but is particularly applicable in early years, which will often be the earliest and best opportunity to intervene. In addition to a wealth of evidence demonstrating that investment in early years and early intervention leads to improved outcomes for Children and Young People, there is also powerful international evidence showing that investment in the early years yields significant savings later in an individual’s life.

The Scottish Government has initiated a significant shift to preventative spend through the establishment of an Early Years Taskforce. The taskforce co-ordinates policy across government and the wider public sector to ensure that early years spending is prioritised by the whole public sector.

3.3.2 The Evidence

A key facet of any early intervention policy is building the capacity of individuals, families and communities to secure the best outcomes for themselves; moving from the position of intervening when a crisis happens towards prevention, building resilience and providing the right level of support
before problems materialise. Children and Young People are a natural focus of early intervention. Many risks start to become apparent during childhood and there is good evidence to suggest that the earlier the action to prevent or mitigate risk and harm, the better.

The foundations for health and wellbeing are laid down from the earliest moments of pre birth life. However, it is increasingly evident that it is in the first years of life that inequalities in health, education and employment opportunities are passed from one generation to another. The interconnectedness of mental and physical health and wellbeing throughout the life course and across generations is progressively more recognised.

There is a now a compelling and growing evidence base of the impact of adverse experiences in the early years on subsequent childhood and across the life course. A child brought up in a stable and nurtured environment is better placed to succeed in life, than a child from a less secure background. Therefore the biggest gains in improved outcomes and reduced inequality will come from supporting parents and by creating communities which are positive places in which to grow up.

The early years’ framework, 2008 which focused on pre-birth to age eight years signalled local and national government’s joint commitment to break this cycle through prevention and early intervention. The framework marked a fundamental shift away from dealing with the symptoms of inequality such as violence, poor physical and mental health, low achievement and attainment at school and moves the focus towards identifying and managing the risks early in life that perpetuate inequality.

The principles of early intervention to reduce inequalities, have the same outcomes for all and for all to have the same opportunities are taking action to identify those at risk of not achieving these outcomes, making sustained and effective interventions where these risks have materialised and shifting the focus from service provision to capacity building. The themes that have emerged from these principles need not be confined to the early years and have relevance for children, young people and families more generally.

- Building parenting and family capacity pre and post birth
- Creating communities that provide a supportive environment for children and families
- Delivering integrated services that meet the holistic needs of children and families
- Developing a suitable workforce to support this work

The health and wellbeing challenges of Children and Young People during the school years demonstrate very clearly the changes in family life and society over recent decades. The health challenges for children are focussed around mental health and wellbeing, family life and relationships, maintaining a healthy weight and achieving good levels of physical activity. Changes in family dynamics, technological advancements, social media and the effects of advertising and the commercialisation of childhood represent challenges and opportunities for those involved in children’s lives on a day to day basis and for the wider policy environment.
Adolescence is increasingly recognised as a distinct developmental stage representing the transition from childhood to adulthood and may be considered the last intervention stage before adulthood. Adolescence is as a key transitional stage where:

- Young people experience key biological, cognitive, emotional, and social changes.
- These changes build on the experiences of childhood, and create foundation skills for adult life.
- Further change is taking place in the brain with remodelling of the basic structures of the brain affecting impulse control, intuition and logic.
- Young people are particularly prone to risk-taking and experimentation as they learn to manage new capabilities and greater freedom.
- These behaviours are a normal part of establishing independence, but can also lead to negative and sometimes serious outcomes for a young person.

Youth health data describes the health and associated health needs of this population. The information provides outcomes from infancy and childhood and provides insight into the potential outcomes into the future. Taking a person centred approach to youth service development presents real opportunities to engage with young people on the issues and topics that are of particular relevance to them and increases the likelihood of successful outcomes.

Children of parents experiencing mental illness and substance abuse are now widely acknowledged as being at very high risk for a range of adverse health outcomes, both physical and mental, as well as poor social and relationship patterns and educational attainment. Evidence also shows that growing up in poverty can have a profound and lasting impact on children’s outcomes. This is not simply an issue of exclusion experienced as a direct result of a lack of material resources, but is a range of interconnected issues, such as stress and poor health.

The key to a life course approach is the appreciation of the influence of family dynamics and the associated strengths and pressures on the wellbeing of Children and Young People. This is of particular importance in relation to parental mental illness and addictions and also plays out through economic adversity and disadvantage. The interface between adult services and the wider planning of services for citizens are therefore important factors in promoting health and wellbeing of all Children and Young People across the population.

### 3.4 Parenting

#### 3.4.1 The Strategic and Policy Context

Parenting underpins mental and physical health and wellbeing across the life course and is a key factor in ensuring that all children have the best possible start in life. The National Parenting Strategy...
will support parents and carers of children up to 18 years. Work is ongoing in respect of further development and implementation of the commitments in the National Parenting Strategy. This includes taking forward a specific workstream on parenting of teenagers.

A wide range of policy and guidance documents including A Refreshed Framework for Maternity Care in Scotland (2011), The Maternal and Infant Nutrition Framework for Action and Pre-Birth to Three: Positive Outcomes for Scotland’s Children and Families (December 2010) recognise the requirement to work collaboratively with and provide support to parents. In addition A New Look at HALL 4: The Early Years: Good Health for Every Child provides a framework for connecting a range of different policies and spheres of activity that support Children and Young People’s health and development in the early years and beyond.

### 3.4.2 The Evidence

Positive experiences of being parented, with the establishment of constructive relationships in early life supports most people to become good parents themselves. Conversely, adverse experiences of being parented may present challenges when becoming a parent and the intergenerational impact of poor parenting can have profound effects.

Being a parent is one of the most challenging and important roles in society. The vast majority of parents will seek to provide nurturing and enabling environments for their children: some may struggle due to wider life circumstances and adverse experiences. Many parents however will seek additional help and support as the different ages and stages of their children bring different challenges. Sometimes the particular needs and/or vulnerabilities of Children and Young People require additional advice and support. As most children live with their parents, improving a child’s life chances may often come through supporting and enabling parents.

Those who work with Children and Young People need to be ready to identify, assess and intervene to address parenting needs in a timely, accessible and appropriate manner. Early and effective parenting interventions can be one of the best preventive spend options available, leading to reductions in children’s behaviour and conduct difficulties throughout the life course.

There are no specific tools that can be applied in a universal or targeted manner to identify or assess parental capacity and capability. However, there are a number of indicators that may suggest that parents have reduced capacity or capability to parent.

For example, uptake of benefits and free school meals does not necessarily mean that a family needs additional support, it may indicate that they have to live on a tight budget, which in turn may put pressure on a parent or carer. Issues of rurality, social isolation, reduced transport, education, and leisure and employment opportunities may negatively impact on the wellbeing of parents and consequently reduce their capacity to parent.
A large body of evidence shows that well implemented parenting programmes with a focus on positive parenting can be very effective in improving child behaviour. They also improve the behaviour of siblings and the mental health and wellbeing of participating parents. Programmes focused on children with the most severe problems produce the highest benefits for parents and children and have the highest returns. The services most commonly approached by parents are schools and General Practitioners, but these services often have poor awareness of the significance of early behavioural problems and of where to access effective and responsive local support. Initial discussions between services and parents about children’s behavioural patterns provide critical opportunities to identify parents who may benefit from early intervention. Parents stressed the importance of referrers using carefully considered language during initial contacts; language should reinforce benefits and outcomes which are meaningful for them.

The National Academy for Parenting Research (NAPR) based at Kings College, London has an internationally recognised research programme to help bring real change to the way practitioners work with parents. Their aim is to ensure that practitioners are aware of and applying the results of evidence based parenting research to their everyday practice when working with children, parents and carers. Their Commissioning Toolkit is an online database which evaluates and rates the quality and effectiveness of 51 parenting programmes.

3.4.3 The Local Context

Within Dumfries & Galloway a number of parenting programmes have been developed and are currently being delivered by statutory and third sector agencies. These programmes are:

- The Psychology of Parenting Project (PoPP)
- Parents as First Teachers (PAFT)
- The Solihull Approach
- Mellow Bumps and Babies

In addition to these evidence based parenting programmes there are other interventions and supports which parents and professionals have told us are highly valued in terms of improving knowledge and understanding, leading to more positive parenting of children. These supports include specific training courses and learning opportunities available to parents in Dumfries & Galloway, Sleep Counselling for parents and carers of Children and Young People with additional needs and the Carers Centre which provides information, advice and support for anyone who cares for a relative or friend who is affected by a long term illness and/or disability. In addition, the Autistic Spectrum Disorders Integrated Network (ASDIN) is a network of professionals made up of staff from Health, Education and Social Work. It is a specialist service which offers a range of training, advice and support to parents, carers and staff from any agency that works with or is involved with Children and Young People who have ASD or social interaction and communication difficulties.
A Quarriers consultation with a selection of parents of children with learning disabilities revealed a number of themes:

- Communication
- Diagnosis
- Understanding and Support
- Organisation of daily living

This group of parents reported that they had not been offered parenting programmes, which they may have benefited from; however all acknowledged the difficulties in committing to regular programmes out with the home setting and the logistics that this would entail.32

3.4.4 The Future Delivery of Parenting Services

In 2009, Dumfries & Galloway Community Planning Partnership (CPP) published the report “Positive About Parenting”33 which set out a framework for developing parenting support services across the region. The overarching vision articulated in the document was:

“We want to deliver services and provide resources to parents and carers across Dumfries & Galloway that help ensure their children are safe; healthy; nurtured; achieving; active; respected and responsible; and included.”

However, the Joint Inspection of Services for Children and Young People34 highlighted a number of areas where improvements in parenting support were required, in particular for those families with high levels of need and vulnerability.

With reference to parenting the report noted that:

’Some families benefit from participating in very effective parenting programmes … (but) … Support for parents who need additional help to develop their parenting skills is variable. Families are not always able to attend these programmes depending on availability and where they live.’

The follow up inspection in May 2015 continued to note the limited availability of parenting programmes for vulnerable, pregnant women and highlighted the need for a strategic response to develop and deliver family and parenting support focused on effective early intervention and prevention approaches35.

Therefore, Positive About Parenting – Moving Forward 2015, sets out clear strategic priorities for the development of parenting supports over the next year, specifying a small number of high impact actions which will underpin consistent region-wide provision to families that require additional support.
Based on the national policy drivers, feedback from the joint inspection and local consultation events, the identified key areas within this strategy are as follows:

- Governance and communication
- Workforce development
- Improving access to information
- Improving access to services
- Improving delivering of one-to-one and group based parenting support

The short term actions that will deliver these improvements will support the long-term goal of building comprehensive future services that improve outcomes for all Children and Young People. The strategy will be reviewed and a revised version produced with the next (long term) Children’s Services Plan.

3.5 Rurality

Dumfries & Galloway is one of the most rural areas of Scotland, where issues such as transport, access to services and rural deprivation can have a particular impact. In mainland Scotland, Dumfries & Galloway has the third highest proportion (19.6%) of the population living in remote rural locations, behind Argyll and Bute and the Highlands\(^\text{36}\). In Dumfries & Galloway 44% of all children live in rural areas (23% accessible rural and 21% remote rural).

3.5.1 The Strategic and Policy Context

Scotland’s strategy on health and the environment \textit{Good Places Better Health for Scotland’s Children (2011)}\(^\text{37}\) asserts that place has a particular influence on the health and wellbeing of Children and Young People and their future health and wellbeing as adults.

In recognising the relationship between health, wellbeing and the physical environment the policy sets out the rationale in relation to the creation of healthier places. In order to create healthier places there must be an understanding of the key physical elements of these places and engagement with communities to discover what they need where they live and find ways to build capacity and make meaningful improvements.

3.5.2 The Evidence

Relationships between rurality and outcomes are many and complex and interact with a number of other determinants. On the whole, rurality appears to be beneficial for health, with increased life expectancy,\(^\text{38}\) smaller inequalities in life expectancy,\(^\text{39,40}\) lower levels of illness\(^\text{41}\) and lower infant mortality\(^\text{42}\) in more rural areas (though some of these inequalities may be partially explained by social mobility between urban and rural areas\(^\text{43}\)). However, there are also potential negative consequences
to living in rural areas, including higher morbidity and mortality due to unintentional injury;\textsuperscript{44} reduced access to services which may be relatively distant;\textsuperscript{45,46} increased social isolation;\textsuperscript{47,48} and greater potential for social exclusion.\textsuperscript{49} Furthermore, recruitment of health and other professionals can be more challenging in rural areas, adding further strain on services.\textsuperscript{50}

It is worth noting that there is some debate as to what extent differences in health between rural and urban areas may be explained by different population composition in terms of deprivation.\textsuperscript{51} It can be challenging to adjust for deprivation in studies comparing rural and urban areas as area-based measures of deprivation are particularly poor for assessing rural deprivation.

\textbf{Please Note:} Effects of rurality on outcomes may well be different for Children and Young People than for adults. Only studies investigating populations in England, Scotland, Wales or Ireland (Northern or Republic) were included as both the nature and effects of rurality are likely to be different in diverse parts of the world.

Although rurality is associated with better health in general, this is not always the case. A very large study in Northern Ireland confirmed higher mortality rates in urban areas for adults but found increased mortality rates for Children and Young People in rural areas.\textsuperscript{52} While this relationship has not been found in Scotland, it shows that lower mortality rates in rural areas are not inevitable.

On the whole, the mental health of Children and Young People is thought to be better in rural areas than in urban areas. This is reflected in data showing lower levels of GP consultations for mental health problems in young people in rural areas.\textsuperscript{53} An English study of children’s behaviour also found that children in less sparse rural areas had fewer conduct and peer problems compared to those in urban areas.\textsuperscript{54} However, a study of suicide in England and Wales found results similar to other industrial countries showing that rates of suicide in young adults are increasing faster in rural or remote areas than in urban centres. In some cases, rural rates of suicide appear to have overtaken urban rates.\textsuperscript{55} As such, the positive association between rurality and mental health should not be taken for granted.

Furthermore, it is important to recognise that experience of mental health and its determinants may be different in rural areas. A qualitative study of adolescents in Northern Scotland suggests that perceptions of the benefits and detriments of social connectedness may be different between rural and urban areas with potential implications for mental health and appropriate interventions.\textsuperscript{56} Likewise, a small qualitative study in Ireland found that mothers with a mental health condition in a rural area perceived enhanced stigma due to the “close-knittedness” of their communities.\textsuperscript{57}

The eating behaviour of children and adolescents appears to be healthier in rural compared to urban areas. A study of adolescent eating behaviour found that consumption of vegetables was greater for adolescents in rural areas of Scotland and that crisp and sweet consumption was lower than for adolescents in urban areas.\textsuperscript{58} This has been further supported by a large cohort study in England.
which shows higher quality diets in 10 year old children in rural areas compared with their urban peers.\textsuperscript{59} A large study of dental health amongst five year olds across Scotland also found that dental health was significantly better in rural areas than in urban areas.\textsuperscript{60}

Physical activity rates, on the other hand, appear to be significantly lower in rural areas. A small study in England found that children in a rural area spent less time outdoors and engaged in less physical activity than children in a suburban area.\textsuperscript{61} While this was a very small study, its findings are further supported by a large study conducted in the East of England which found that adolescents in rural areas were significantly less likely to be fit or highly fit than their urban counterparts.\textsuperscript{62} A small Irish study also found primary school children in a rural area to be leading sedentary lifestyles.\textsuperscript{63} Furthermore, this evidence mirrors that seen in the UK Household Longitudinal Study showing people living in urban areas are significantly more likely to engage in active travel.\textsuperscript{64}

In contrast with the generally very positive impact of rurality on health, a very large study of cases of childhood cancer across England, Scotland and Wales between 1969 and 1993 found that children were most likely to develop cancer if they lived in affluent areas and rural areas.\textsuperscript{65} Infectious disease rates are generally lower in rural areas compared to urban areas. For example, a study in England found that rates of meningococcal disease were significantly lower in rural areas.\textsuperscript{66} However, specific barriers have been identified for infectious disease services in rural areas. A qualitative study investigating perceptions of Children and Young People in rural areas with regards to sexual health services found that they were particularly concerned with issues of confidentiality and anonymity.\textsuperscript{67}

Finally, a small Scottish study looking at illicit drug use in young people in adjacent rural and urban local authorities did not find any relationship between rurality and drug use.\textsuperscript{68}

Health outcomes for Children and Young People are, on the whole, better in rural areas than in urban areas. However, there are some outcomes which defy this trend and further rural-specific considerations need to be taken in the provision of services and understanding of local health needs.

A small study of 52 two-parent families living in rural communities in North East Scotland, South West Scotland and Northern England\textsuperscript{69} found that the advantages of rural life were felt to outweigh the limitations. Advantages included freedom, safety, access to nature and high quality schools for the children, together with reciprocal help, community neighbourliness and trust. Limitations were felt to be limited public transport or activities for teenagers, fewer employment opportunities and limited access to specialist healthcare. Work and child care responsibilities were adjusted to maximise time spent with the children. Most of the men and some women had full time employment, including multiple jobs, and many jobs were casual or seasonal and hence insecure and low paid. Flexible informal childcare was often used when both parents needed to work.
3.6 Transitions

3.6.1 The Strategic and Policy Context

Transition is an active process that unfolds over a number of years and not a single event such as leaving school. Transitions for children can happen concurrently across a range of services, including health, education, housing, welfare and social care. It is equally important to plan and support later transitions such as leaving college or entering the world of work.

The principles of effective transition are supported by the following legislation and policy:

- The United Nations Convention on the Rights of the Child (UNCRC)
- The Children and Young People (Scotland) Act 2014
- Social Care (Self Directed Support) (Scotland) Act 2013
- The Keys to Life 2013
- A Fairer and Healthier Scotland 2012
- Scottish Strategy for Autism 2011
- NHS Scotland Quality Strategy 2010
- The Looked After (Scotland) Regulations 2009
- These Are Our Bairns 2008
- Adult Support and Protection (Scotland) Act (2007)
- Better Health Better Care, Action Plan 2007
- Protection of Vulnerable Groups Act 2007
- The Education (Additional Support for Learning) (Scotland) Act 2004
- Children (Leaving Care) Act 2000
- Adults with Incapacity (Scotland) Act (2000)
- Children (Scotland) Act 1995

More detailed information concerning legislation, policy, practice, young people telling their transition stories and other key matters of concern (e.g., transport, challenges in urban/remote areas and data/IT systems) is available on the Scottish Transitions Forum website (here). The Scottish Transitions Forum has committed to continually assess the evidence that informs these publications and to release annual updates until 2017.

3.6.2 The Evidence

Children experience great change as they progress from infancy to adolescence and adulthood; during which they must learn to negotiate new social and emotional contexts (schools, play, workplace and public space). Psychological, physical, and social processes intersect over the life course that shape experiences and outcomes. How transitions are managed and negotiated are
significant for all Children and Young People and are of particular importance for those with additional or complex needs.

In April 2013, “The Big 9” problems with transition and proposed solutions were published by the Scottish Transitions Forum in “The Principles of Good Transition 1”; with the aim of influencing policy and fundamentally changing the way that transitions for Children and Young People with additional support needs is managed.

The publication noted that young people moving through transitions are not a homogenous group and come from a wide range of different circumstances and that Children and Young People with additional support needs (e.g. learning disability, autism, sensory impairments, mental ill health, emotional and behavioural issues, exceptional health care needs and young people in care), require appropriate help to express their views and be part of deciding their own future.

The Big 9 are:

- Person-centred approaches are often lacking or inconsistent
- Lack of the voice of the young person in transition planning
- Planning starts too late
- Lack of support for future transitions
- Lack of information for young people and their carers
- Confusing legislative and policy framework
- Support is not co-ordinated between services
- Too many young people are not regarded as eligible for support
- Confusing language

Solutions include person-centred approaches, independent advocacy, early intervention, and support up to age 25 years, accessible information inclusive of the young person’s communication needs, a joined-up policy landscape, and dedicated transition teams in each local authority, needs-based eligibility criteria and a common and agreed language between agencies, young people and their families. Many of these solutions sit within the implementation and embedding of GIRFEC into daily practice.

“The Principles of Good Transition 2” (2014) was published to provide guidance to all agencies who work with Children and Young People. The guidance seeks to improve the quality of care and help for young people with additional support needs that are making the transition to young adult life; since the challenges associated with it are widely recognised as often being difficult.

To help achieve this change, the document provides a framework of seven principles for use by Scottish Government, other agencies and practitioners who are responsible for planning and delivering support for Children and Young People with additional support needs in:
The active process of transitions occurs throughout the life span and is not a single event such as leaving school. It is equally important to plan and support later transitions such as leaving college or entering the world of work.

Transitions for children with additional support needs happen concurrently across a range of services, including health, education, housing, welfare and social care. Therefore, effective transitions processes depend on the different organisations involved having a shared understanding of how the support they provide contributes to the overall well-being of the young person.

The seven principles to improve transitions are:

**Principle 1:** All plans and assessments should be made in a person centred way
**Principle 2:** Support should be co-ordinated across all services
**Principle 3:** Planning should start early and continue to age 25 years
**Principle 4:** Young people should get the support they need
**Principle 5:** Young people, parents and carers must have access to the information they need
**Principle 6:** Families and carers need support
**Principle 7:** Legislation and policy should be co-ordinated and simplified

These principles are supported by the legislation and policy noted above (please see section xx).

Here is an example of the challenges faced, highlighted by a parent with children who have additional support needs:

“Now that my eldest son is 18 the isolation of living in a small community with poor transport means that he can’t access work. Because there is no support to help him with his Asperger’s he will probably never get a job - and the same will be true of my other son. I will have to continue to support them for the rest of their lives, but as my tax credits and child benefit are stopped as they grow older, it means I live in a deeper and deeper poverty. No one cares. No one helps. No one knows about us at all.”

Female carer, 51-60, Annandale & Eskdale, Nov 2014
In Dumfries & Galloway, for those Children and Young People with a single long term condition such as diabetes; a system of transition to adult health services is well established.

However, a number of young people with complex needs, over the age of 18 years continue to have their medical care managed by paediatric health care teams. This is due in part to the perceived lack of adult health services appropriately equipped to provide the required levels of support and care. Work is currently ongoing to understand the barriers to transitioning these young people to adult health services.

The Keys to Life (2013) recommends that as part of the planning for their transition, education authorities must consider whether young people with additional support needs require extra help with their plans. If they do, planning must begin no later than one year before a known transition (like post-school transition). Education authorities must therefore exchange information with other agencies (including social work services and skills development Scotland and Health Boards) to inform their plans to support the young person.

In March 2014, the report “Transition to primary school” articulated factors that affected children’s transition to primary school and provided comment on the range and type of existing evidence. The key points identified from the review of evidence were:

- It is difficult to isolate the effect of specific factors on children’s adjustment to school
- Relationships are important
- Effective transitions programmes incorporate three strands involving children, parents and teachers
- Teachers can use practical examples to help children become familiar with school
- Parent’s concerns about transitions may not reflect children’s experiences
- Collaborative working between preschool and primary school teachers may be difficult to achieve

In drawing together findings from international research in the fields of psychology, sociology, and education the report highlighted the complexity of the transition process and the importance of positive relationships between children, parents and schools during this time. Children’s transition to primary school involves physical, social and philosophical changes; adjustment to these changes may not be a linear process and can be influenced by a variety of factors. Effective transition to primary school programmes have three strands, helping children become familiar with the school, informing parents about the school and informing teachers about children’s development and prior experiences.

However, there is a lack of research from Scotland about how key Scottish polices (such as GIRFEC) are used in practice during school transition. There are also notably few studies that describe successful collaborative working (except for children with disabilities) and some studies fail to include the perspectives of children themselves.
“Education is not a seamless progression from primary to secondary, children are not treated as individuals but just treated as being of a similar level of education, no consideration given to those that have worked hard and are perhaps needing more challenging education. This leads to frustration within the household and could be avoided with a more seamless education.”

Community Survey 2014, F, 31-40, Wigtownshire

3.7 Listening to Children, Young People and Families

“It may be best to assume that all children of whatever age are capable of contributing to discussions concerning their lives.”

3.7.1 The Strategic and Policy Context

The Scottish Government’s broad strategic framework for improving outcomes emphasises the importance of the engagement of Children and Young People to prevent withdrawal from services; such as in the More Choices More Chances Strategy (2006), which focuses on reducing the number of 16-19 year olds disengaging from learning or who are not in education, employment or training. The strategy promotes multi-agency collaboration as the driver for improvement, focusing on prevention, intervention and sustainability. Promoting Positive Outcomes (2009) jointly published by Scottish Government and COSLA provides a framework for tackling anti-social behaviour and recognises the importance of prevention, integration, engagement and communication.

Walk the Talk, a strategic initiative designed to improve young people’s access to health services provided by the NHS, local authorities and the voluntary sector has been in existence since 1999; and is based on research that highlighted a clear need for health professionals to further develop appropriate and accessible services for young people. Concerns raised by young people at the time included: a lack of consultation with young people; concerns over patient confidentiality; limited access to youth focused services; and a lack of information designed specifically for young people.

The Lowdown is an information website and confidential phone line, aimed specifically at young people who are most at risk of poor health outcomes. Developed by the Scottish Government in partnership with Young Scot, it looks to address fundamental inequalities and develop resilience among young people by offering reliable and relevant information delivered in straightforward language. It provides information on mental wellbeing, physical health, sexual health and relationships of all kinds.

3.7.2 The Evidence

“Co-production” is the process of active dialogue and engagement between people who use services and those who provide them. It is a process which puts service users on the same level as the
service provider. It aims to draw on the knowledge and resources of both to develop solutions to problems and improve interaction between citizens and those who serve them.

Utilising the principles of co-production, The First National Sitting of the Children's Parliament held on 1st April 2015 captured a range of views from Children and Young People about what they need to ensure that Scotland becomes the best place in the world in which to grow up and demonstrated the significant insight that children have into their own lives. A range of barriers at home, in school and in the community to children being healthy, happy and safe was identified by Children and Young People during the first sitting. They included:

- Being shouted at
- Unhappy stressed parents
- Lack of money and healthy food
- Bullying
- Not having the things needed for school
- Trying to learn when feeling unwell
- Not having a safe place to play
- Not having friends
- People having a negative view of Children and Young People

The Children’s Parliament has issued a call to action to address these barriers and support the involvement of Children and Young People in policy development. For example the Children’s Parliament provides a training programme for children, parents and carers, teachers, children’s services practitioners and policy makers, the purpose of which is to inspire creative environments for the meaningful participation of children. There are also community and schools programmes on offer which recognise that using creative processes is a more effective way of engaging children than trying to fit children into established adult processes and practices of consultation.

“*My life, my support, my choice: a vision for coordinated care and support for Children and Young People with complex lives*” has been published by National Voices and Think Local Act Personal. The report seeks to capture and build understanding of the specific desires and needs of Children and Young People.

Locally, the findings from a project to explore the experience of parents of a child with learning disabilities (discussed in the parenting section of this SNA); and the findings from a e-befriending survey for Children and Young People with Autism Spectrum Disorder (ASD), align with those from the D&G Story Dialogue Conference (all 2014), which sought to understand the real lived experiences of Children and Young People, their families and carers, and service providers. The high level themes that emerged from the story dialogue were:
In addition the survey focused on Children and Young People with ASD revealed a strong desire to engage more fully with peers (both with a diagnosis of ASD and without), learn skills that would support independent living (socialisation, managing money and travel) and engagement in leisure activities after school and at weekends. In particular having a “buddy” (someone of similar age to share activities with) and the opportunities to join social groups were both highly rated at 77% and 71% respectively.

The final report from the Story Dialogue Conference indicated a number of key areas for action/recommendations under the above themes, which could usefully fall under the overarching activities in embedding Getting It Right For Every Child and would also encompass the findings of the other reports noted here. These recommendations involve changes in systems and processes, practice, culture and values. In this way the report articulates a whole-system approach to the improvement of services that impact on outcomes for children, young people, their families and carers.

3.8 Working Together

3.8.1 The Strategic and Policy Context

Effective partnership working between the NHS and local authorities is widely recognised as a prerequisite for achieving good health and social care outcomes. For the last decade in Scotland the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways.\(^3\),\(^4\).

In the early years of joint working between community health and social care services, and particularly under the auspices of “Joint Future”, there was a strong focus on improving processes, on the assumption that good partnership working arrangements would lead to improving outcomes. Joint structures, financial frameworks and assessment procedures were all seen as critical to enabling good joint working across statutory organisations. However, it was also recognised that changes to systems, processes and structures alone cannot deliver improvements – the quality of leadership, vision, communication and behaviours in Partnerships are also all critical factors.
3. Overarching Themes

More recently, work has been undertaken to develop and test an Integrated Resource Framework (IRF) for health and social care services in Scotland, with four test site Partnerships, Highland, Lothian, Ayrshire and Arran, and Tayside. The IRF responds to the observation made by many of those working in health and social care that they could deliver better outcomes for people if resources could be moved around the health and social care system more effectively to support shifts in the balance of care.

At the same time, it is evident that significant challenges remain, including real terms reductions in budgets for NHS Boards and councils, an ageing population and Children and Young People with greater complexities of need leading to increasing levels of demand. To that end, there is a broad consensus that there is a need for closer partnership working between NHS Boards and Councils.

In addition, the role of the Third Sector and Independent Sector in achieving Scottish Government’s vision for public service reform and influencing the wellbeing and prosperity of the region must be acknowledged and understood.

3.8.2 The Evidence

Partnership working has been particularly driven by the Policy of the last Labour administration (UK) which throughout the decade up to 2010 aimed to make the Third Sector more coherent, efficient and aligned to the delivery of a range of public services. There has been a longstanding interest by government in the promotion of partnerships across the public sector. Since the 1980s there has been greater involvement in the delivery of public services by what were then called voluntary and community sector partners. Externalisation, both to private and third sectors, has been a continual theme of reform of public services, which for example has seen over half of social housing services transferred to third sector providers in just over 20 years. Since the formation of the coalition government in 2010 these drivers have not lessened, but to some degree strengthened, in particular the interest in externalisation was reinforced by the requirement for greater efficiency made more pressing by the financial crisis and the resulting cuts to public spending.

Effective partnership working is widely believed to be a precondition for achieving good health and social care outcomes. For the last decade in Scotland the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways. However, it is also recognised that changes to systems, processes and structures alone cannot deliver improvements; the quality of leadership, vision, communication and behaviours in Partnerships are also critical factors. In adopting a partnership approach to planning and service delivery Children and Young People should be able to access effective, efficient and well coordinated care services from a range of providers. By overcoming fragmentation and minimising organisational barriers between providers of care it should be possible to improve outcomes.
The Kings Fund Report Improving the Public’s Health: a resource for Local Authorities 2013, notes the long history of partnership working to deliver health improvements in England, through local strategic partnerships. However; the report acknowledges that the evidence demonstrating successful partnership working, (with the exception of some health action zones) is relatively weak. Two recent systematic reviews show that there is little evidence to date that partnership working has lead to demonstrable improvements in health outcomes.

Evaluation of the Child Healthy Weight Programme (CHWP) identified the characteristics of successful service delivery partnerships, including the differing types of expertise and experience of working at a community level or within a range of settings held by various professional groups. Working across professional boundaries is often, however, not straightforward. Some of the learning around effectively working as part of an inter-disciplinary or an inter-agency service partnership comprises:

- Devolution of the responsibility for coordination to appropriate levels
- Respecting differences in values and practices of service partners
- Provision of free training opportunities for everyone involved in delivery
- Provision of regular feedback for all on progress

Learning from the CHWP demonstrates that effective strategic and operational partnerships are critical to delivery of these programmes. However, the evaluation of CHWP shows that partnership working with parents and young people is equally important. A vital start to the promotion of these types of partnership is the provision of comprehensive information to parents and young people in advance of the programme. Such information should include the aims of the programme, what the benefits of the programme will be, consent arrangements, and how the best interests of their child will be safeguarded. Partnerships therefore have to be viewed as a useful tool which together with a clear focus on outcomes based on the evidence of what works can deliver improvements in both experience of care and outcomes. Public health reforms have created the environment necessary to facilitate that focus. Strong outcomes frameworks, joint health and wellbeing strategies and the use of health impact assessment (HIA) tools will be critical in delivering the ambitions of Scottish Government in improving public health.

3.8.3 Dumfries & Galloway Community Planning Partnership

Community planning brings together public, private and third sector, working together and with local communities to deliver better services. Overseen by the strategic partnership, a range of forums and partnerships support different themes with the overarching ambition of creating better life chances for the population of the region. Community planning promotes engagement in decisions about services to ensure they meet the needs of the populace. The integration of health and social care will deliver more co-ordinated approaches to provide services and supports to the population of Dumfries & Galloway, across the four localities, Annandale & Eskdale, Nithsdale, Stewartry and Wigtownshire.
3.8.4 Third Sector Dumfries & Galloway

The third sector is a term used to describe the range of organisations that are neither the public sector nor the private sector. This includes organisations that have a social or environmental purpose, voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, cooperatives, credit unions and mutuals and all of those people who volunteer and work within these organisations.

An organisation is generally regarded as being in the third sector if it:

- Has a positive community purpose, motivated by a desire to achieve social goals
- Is run by an unpaid voluntary committee or board of trustees/directors
- Is not set up to distribute profit to private shareholders and reinvests any surplus in pursuit of their goals
- Is not run by or affiliated to a political party or a statutory body of government

In its report *The State of The Sector November 2014*, Third Sector D&G presented a snapshot of the size, scale and scope of the local sector in 2013, informed by responses to a local consultation survey in summer 2014 and data from the Office of the Scottish Charity Regulator (OSCR). The findings showed that there were 851 charities with a registered address in the area in 2013, however, as noted above, the sector comprises many more types of organisation than the registered charities and establishing their number is difficult due to their diverse range, the relatively small size of many organisations and the changeable nature of the sector.

The numbers of people employed in the Third Sector in the region is not known, although according to Scottish Household Survey Data, people in Dumfries & Galloway give 3.7 million hours of volunteering each year. This equates to 36% of the adult population (54,000), higher than the national Scottish average of 29%.

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4. Getting It Right For Every Child (GIRFEC)

In this SNA, key Scottish Government policies that aim to support Children and Young People’s health and wellbeing, reviews of the literature, data and benchmarking are organised around the eight GIRFEC indicators of wellbeing.

GIRFEC specifically aims to promote co-ordinated action by services to improve the life chances for all Children and Young People in Scotland. To achieve this it encourages a shared understanding by all services of a child’s wellbeing in eight areas i.e. that Children and Young People must be Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included (‘SHANARRI’).

These are the basic requirements for all Children and Young People to grow and develop and reach their full potential. The Scottish Government believes that a child or young person’s network of support will almost always have at its heart their parents, carers and family. However, Children and Young People will progress differently depending on their circumstances and every child and young person has the right to expect appropriate support from adults and services if and when they need it, to allow them to develop as fully as possible across each of the wellbeing indicators.

GIRFEC is founded on ten core components which can be applied in any setting and in any circumstance:

- A focus on improving outcomes for children, young people and their families based on a shared understanding of wellbeing
- A common approach to gaining consent and to sharing information where appropriate
- An integral role for children, young people and families in assessment, planning and intervention
- A co-ordinated and unified approach to identifying concerns, assessing needs, and agreeing actions and outcomes, based on the wellbeing indicators
- Streamlined planning, assessment and decision-making processes that lead to the right help at the right time
- Consistent high standards of co-operation, joint working and communication where more than one agency needs to be involved, locally and across Scotland
- A Named Person for every child and young person and a Lead Professional (where necessary) to co-ordinate and monitor multi-agency activity
- Maximising the skilled workforce within universal services to address needs and risks as early as possible
- A confident and competent workforce across all services for children, young people and their families
- The capacity to share demographic, assessment, and planning information electronically within and across agency boundaries.
As the GIRFEC approach is threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families, sections 6 to 13 are organised around the eight GIRFEC wellbeing indicators. It is important to note however, that in many cases information referred to within one indicator will also be relevant to other indicators and that GIRFEC is equally applicable across the age range from pre-birth, birth, infancy, early years and adolescence. This is how the Scottish Government describes wellbeing:

“What is wellbeing?”
Wellbeing is broader than child protection and how we tend to think about welfare.

To help make sure everyone – children, young people, parents, and the services that support them – has a common understanding of what wellbeing means, we describe it in terms of eight indicators. The eight wellbeing indicators are commonly referred to by their initial letters – SHANARRI: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.⁹⁶

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5. Understanding the Population

In this section:
- Geography of the Region
- Population Estimates
- Population Projections
- Patterns in Births
- Patterns in Child Mortality
- Life Expectancy

5.1 Geography of the Region

5.1.1 Geography

Dumfries & Galloway is a mostly rural region in south-west Scotland. It covers 6,426 square kilometres with a total population of approximately 149,670 people.97

Many specialised services need to be accessed in the central belt at either Glasgow or Edinburgh, but some services over the English border in Carlisle are also used. Caution should be used when interpreting Annandale & Eskdale activity figures to determine whether any activity has been under-reported due to being attributed to England.

Figure 1: Map of Dumfries & Galloway illustrating traditional localities
5. Understanding Our Population

The region has four traditional localities:

- Annandale & Eskdale
- Nithsdale
- Stewartry
- Wigtownshire

The main towns are Dumfries (and we often include Locharbriggs when we say ‘Dumfries’, which combined have 38,900 residents), Stranraer (10,600), Annan (9,000), Lockerbie (4,300), Dalbeattie (4,200), Castle Douglas (4,200) and Newtown Stewart (4,100). (Source: Census 2011).

All other towns and settlements have populations of fewer than 4,000 people and are shown in the table of settlements on the map below (minimum 500 residents). At the 2011 Census, around one third of all people (31.6%) in Dumfries & Galloway were living in settlements with fewer than 500 people.

**Figure 2: Map of Dumfries & Galloway illustrating settlements**
5.1.2 Rurality

Rurality has been identified as one of the overarching themes that impacts Children and Young People’s lives and influences the way services are delivered. This section specifically describes the rural nature of the region.

The Scottish Government has released a series of urban rural classifications since 2000 as part of a commitment to develop an understanding of the issues facing urban, rural and remote Scotland and acknowledging that issues such as transport, education and health can have particular challenges for rural communities. The Scottish Government Urban Rural Classification 2013-2014 is the latest of these. Areas are defined by their population density (urban vs. rural) and by their distance to a larger urban setting (accessible vs. remote).

Nearly half of all people in Dumfries & Galloway (45.8%) live in areas classified as rural, which is defined as living in settlements with fewer than 3,000 people. The only urban areas are the towns of Dumfries and Stranraer, though neither of these is classified as a large urban area. In terms of accessibility, just over a quarter (27.2%) of the population live in areas classified as remote, which is defined as further than 30 minutes drive away from a large town. Figure 3 illustrates the areas of Dumfries & Galloway that are classified as remote (bright green + yellow) and rural (light blue + yellow).

Figure 3: Map of Dumfries & Galloway showing Scottish Urban Rural Classification 2013-14.
Around a half or more of the population in three localities, Annandale & Eskdale (58.0%), Stewartry (51.1%) and Wigtownshire (49.8%) live in a rural area (either accessible or remote). Stewartry has the highest proportion (68.4%) of the population living in areas classified as remote (either remote small town or remote rural). In mainland Scotland, Dumfries & Galloway has the third highest proportion (19.6%) of the population living in remote rural locations, behind Argyll and Bute and the Highlands. In Dumfries & Galloway 43% of all children live in rural areas (23% accessible rural and 21% remote rural), as shown below.

Figure 4: Proportion of population aged 18 and under in each 6-fold Urban Rural Classification category by locality, Dumfries & Galloway, 2016

A consultation carried out in 2014 with the Children and Young People of Crossmichael (an accessible rural village of fewer than 500 people located in Stewartry) gave a flavour the impact of rurality on young people. Half the respondents (aged between 12 and 18 years) could not identify anything special about living in Crossmichael, citing poor public transport, lack of places to hang out and age appropriate activities as negative aspects of village life.

Please note: Geographic Deprivation is discussed in more depth in Section 9.1
5.2 Estimate of the Current Population

There were almost 29,000 young people aged 18 or under living in Dumfries & Galloway in 2015, representing 19% of the population. This is slightly lower than the proportion of people aged under 19 in Scotland (20%).

The number of young people in Dumfries & Galloway in the four locality areas is shown in Table 1 and Table 2. Over one third of young people live in Nithsdale (11,645, 41%) a quarter live in Annandale and Eskdale (7,278, 25%), 19% live in Wigtownshire (5,413) and 15% live in Stewartry (4,311).

Table 1: Estimated Population by locality, age band and sex, Dumfries & Galloway, 2015

<table>
<thead>
<tr>
<th></th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 to 3</td>
<td>682</td>
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<td>395</td>
<td>568</td>
<td>2,799</td>
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<td>4 to 11</td>
<td>1,654</td>
<td>2,529</td>
<td>933</td>
<td>1,163</td>
<td>6,279</td>
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<td>12 to 18</td>
<td>1,436</td>
<td>2,255</td>
<td>889</td>
<td>1,037</td>
<td>5,617</td>
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<td><strong>Total</strong></td>
<td>3,772</td>
<td>5,938</td>
<td>2,217</td>
<td>2,768</td>
<td>14,695</td>
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<td><strong>Females</strong></td>
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<td></td>
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<td></td>
<td></td>
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<td>0 to 3</td>
<td>625</td>
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<td>377</td>
<td>533</td>
<td>2,609</td>
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<td>4 to 11</td>
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<td>6,089</td>
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<td>12 to 18</td>
<td>1,325</td>
<td>2,132</td>
<td>806</td>
<td>991</td>
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<tr>
<td><strong>Total</strong></td>
<td>3,506</td>
<td>5,707</td>
<td>2,094</td>
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<td><strong>Persons</strong></td>
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<td></td>
</tr>
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<td>0 to 3</td>
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<td>2,228</td>
<td>772</td>
<td>1,101</td>
<td>5,408</td>
</tr>
<tr>
<td>4 to 11</td>
<td>3,210</td>
<td>5,030</td>
<td>1,844</td>
<td>2,284</td>
<td>12,368</td>
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<tr>
<td>12 to 18</td>
<td>2,761</td>
<td>4,387</td>
<td>1,695</td>
<td>2,028</td>
<td>10,871</td>
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<tr>
<td><strong>Total</strong></td>
<td>7,278</td>
<td>11,645</td>
<td>4,311</td>
<td>5,413</td>
<td>28,647</td>
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</tbody>
</table>

Source: Mid-2015 Small Area Population Estimates, NRS
Table 2: Estimated Population by locality and single age, Dumfries & Galloway, 2015

<table>
<thead>
<tr>
<th></th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
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<tbody>
<tr>
<td>Population aged 0*</td>
<td>347</td>
<td>523</td>
<td>176</td>
<td>245</td>
<td>1,291</td>
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<tr>
<td>Population aged 1</td>
<td>303</td>
<td>538</td>
<td>189</td>
<td>292</td>
<td>1,322</td>
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<td>Population aged 2</td>
<td>326</td>
<td>588</td>
<td>190</td>
<td>288</td>
<td>1,392</td>
</tr>
<tr>
<td>Population aged 3</td>
<td>331</td>
<td>579</td>
<td>217</td>
<td>276</td>
<td>1,403</td>
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<tr>
<td>Population aged 4</td>
<td>429</td>
<td>608</td>
<td>225</td>
<td>282</td>
<td>1,544</td>
</tr>
<tr>
<td>Population aged 5</td>
<td>395</td>
<td>629</td>
<td>219</td>
<td>296</td>
<td>1,539</td>
</tr>
<tr>
<td>Population aged 6</td>
<td>404</td>
<td>638</td>
<td>226</td>
<td>267</td>
<td>1,535</td>
</tr>
<tr>
<td>Population aged 7</td>
<td>414</td>
<td>615</td>
<td>217</td>
<td>299</td>
<td>1,545</td>
</tr>
<tr>
<td>Population aged 8</td>
<td>394</td>
<td>661</td>
<td>238</td>
<td>307</td>
<td>1,600</td>
</tr>
<tr>
<td>Population aged 9</td>
<td>396</td>
<td>649</td>
<td>230</td>
<td>279</td>
<td>1,554</td>
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<tr>
<td>Population aged 10</td>
<td>400</td>
<td>668</td>
<td>226</td>
<td>277</td>
<td>1,571</td>
</tr>
<tr>
<td>Population aged 11</td>
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<td>562</td>
<td>263</td>
<td>277</td>
<td>1,480</td>
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<tr>
<td>Population aged 12</td>
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<td>601</td>
<td>235</td>
<td>267</td>
<td>1,492</td>
</tr>
<tr>
<td>Population aged 13</td>
<td>328</td>
<td>570</td>
<td>245</td>
<td>262</td>
<td>1,405</td>
</tr>
<tr>
<td>Population aged 14</td>
<td>371</td>
<td>603</td>
<td>239</td>
<td>278</td>
<td>1,491</td>
</tr>
<tr>
<td>Population aged 15</td>
<td>408</td>
<td>589</td>
<td>220</td>
<td>295</td>
<td>1,512</td>
</tr>
<tr>
<td>Population aged 16</td>
<td>382</td>
<td>657</td>
<td>256</td>
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<td>1,586</td>
</tr>
<tr>
<td>Population aged 17</td>
<td>454</td>
<td>719</td>
<td>269</td>
<td>330</td>
<td>1,772</td>
</tr>
<tr>
<td>Population aged 18</td>
<td>429</td>
<td>648</td>
<td>231</td>
<td>305</td>
<td>1,613</td>
</tr>
<tr>
<td><strong>Total 0 to 18</strong></td>
<td><strong>7,278</strong></td>
<td><strong>11,645</strong></td>
<td><strong>4,311</strong></td>
<td><strong>5,413</strong></td>
<td><strong>28,647</strong></td>
</tr>
</tbody>
</table>

Persons 27-30 months+ | 98       | 183   | 61    | 95 | 437
Persons aged 0-3     | 1,307    | 2,228 | 772   | 1,101 | 5,408
Persons aged 0-4     | 1,736    | 2,836 | 997   | 1,383 | 6,952
Persons aged 4-11    | 3,210    | 5,030 | 1,844 | 2,284 | 12,368
Persons aged 12-18   | 2,761    | 4,387 | 1,695 | 2,028 | 10,871

Source: Mid-2015 Small Area Population Estimates, NRS

*The number of children under 1 year is undercounted due to delays in registering babies with GPs, therefore the age 0 figure refers to the number of births registered with NRS in the calendar year preceding 01/06/15.

+Figures taken from the number of children registered with a GP on the Community Health Index (CHI) snapshot at 01/06/2015 (local records)
5.3 Population Projections

Increased life expectancy and lower birth rates mean that over the next 25 years, younger people will make up a smaller proportion of the population than is currently the case.

Figure 5: Projected child population of Dumfries & Galloway, 2014–2039

Source: NRS Population Projections 2014-based

The latest population projections from the National Records of Scotland (NRS) indicate that there will be 3,040 fewer people aged 18 or under living in the region by 2039, a decrease of 10%.

The number of young people aged 4 to 11 or aged 12 to 18 are both projected to decrease by 11% from 2014 figures. Those aged 4 to 11 will decrease from 12,308 (2014) to 10,963 (2039) and those aged 12 to 18 will decrease from 11,179 to 9,954 in the same period. The number of children under 4 is also projected to decrease by 8.4% from 5,593 to 5,125 in that time.

Please note: The figures quoted here are based on the 2014 population projections. Figures in Table 1 and Table 2 are based on mid-2015 estimates.

The working age population of Dumfries & Galloway is predicted to decline by 12.9% by 2039. There will be a reduction in the size of the working age population from about 90,200 in 2014 to approximately 78,600 in 2039. These changes will result in a decrease in the size of the available workforce of almost 11,600 people over the next few decades, as shown in Table 3.
Please note: Information about the migration of Children and Young People into and out of the Dumfries & Galloway region is not readily available, nor is it clear what the long-term outcomes are for young people who access further education and employment outside the region.

Table 3: Projected working age population (2014-based) and dependency ratio

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2019</th>
<th>2024</th>
<th>2029</th>
<th>2034</th>
<th>2039</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-15</td>
<td>23,927</td>
<td>23,375</td>
<td>22,726</td>
<td>22,247</td>
<td>22,185</td>
<td>21,833</td>
</tr>
<tr>
<td>Pensionable Age</td>
<td>35,785</td>
<td>38,481</td>
<td>41,450</td>
<td>45,191</td>
<td>48,121</td>
<td>48,826</td>
</tr>
<tr>
<td>All Dependents</td>
<td>59,712</td>
<td>61,856</td>
<td>64,176</td>
<td>67,438</td>
<td>70,306</td>
<td>70,659</td>
</tr>
<tr>
<td>Work age</td>
<td>90,248</td>
<td>86,334</td>
<td>82,942</td>
<td>78,585</td>
<td>74,264</td>
<td>72,223</td>
</tr>
<tr>
<td>Dependency ratio</td>
<td>66.2</td>
<td>71.6</td>
<td>77.4</td>
<td>85.8</td>
<td>94.7</td>
<td>97.8</td>
</tr>
<tr>
<td>All ages</td>
<td>149,960</td>
<td>148,190</td>
<td>147,118</td>
<td>146,023</td>
<td>144,570</td>
<td>142,882</td>
</tr>
<tr>
<td>% work age</td>
<td>60%</td>
<td>58%</td>
<td>56%</td>
<td>54%</td>
<td>51%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Source: Population Projections for Scottish Areas (2014-based), NRS

These figures demonstrate that the number of dependent Children and Young People is likely to slightly decline over the next 20 years. However, in the same time period the number of dependent older adults will increase substantially. Therefore, it will be important to support our Children and Young People to attain their full potential and maximise their wellbeing in order to achieve sustainable skills and abilities in the general population supporting the economic and cultural stability of the region as our population ages. As the integration of health and social care begins to address the challenges of the aging population, it is also important we do not diminish the priority we give to Children and Young People and the services that support them.

5.4 Patterns in Births

In 2015 there were 1,256 babies registered in Dumfries & Galloway. Between 1974 and 1994, there was an average of around 1,700 babies born each year but this number gradually fell, to an all time low in 2015. The number of births has fallen each year since 2009, as shown below.
Figure 6: Number of births registered in Dumfries & Galloway each year

Year on year change in the number of births at the locality level can vary considerably: between 0 and 60 births’ difference from one year to the next. Typical numbers of births between 2007 and 2015 for the DGRI were between 0 and 41 each week, with an average of 24 and for the Galloway Community Hospital the range was 0 - 6 respectively with an average of 1.2 births per week.

The figures quoted below are for locality of residence; almost 70% of children registered for Wigtownshire are born at the DGRI in Nithsdale.

Table 4: Number of births registered by locality of residence each year

<table>
<thead>
<tr>
<th>Year</th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>376</td>
<td>636</td>
<td>190</td>
<td>305</td>
<td>1,507</td>
</tr>
<tr>
<td>2008</td>
<td>364</td>
<td>606</td>
<td>186</td>
<td>274</td>
<td>1,430</td>
</tr>
<tr>
<td>2009</td>
<td>367</td>
<td>645</td>
<td>203</td>
<td>292</td>
<td>1,507</td>
</tr>
<tr>
<td>2010</td>
<td>344</td>
<td>606</td>
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<td>306</td>
<td>1,445</td>
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<tr>
<td>2011</td>
<td>337</td>
<td>603</td>
<td>182</td>
<td>274</td>
<td>1,396</td>
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<tr>
<td>2012</td>
<td>333</td>
<td>578</td>
<td>186</td>
<td>293</td>
<td>1,390</td>
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<tr>
<td>2013</td>
<td>307</td>
<td>568</td>
<td>170</td>
<td>282</td>
<td>1,327</td>
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<tr>
<td>2014</td>
<td>324</td>
<td>531</td>
<td>168</td>
<td>263</td>
<td>1,286</td>
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<tr>
<td>2015</td>
<td>312</td>
<td>516</td>
<td>165</td>
<td>262</td>
<td>1,256</td>
</tr>
<tr>
<td>Average 2010-2015</td>
<td>326</td>
<td>567</td>
<td>177</td>
<td>280</td>
<td>1,350</td>
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</table>

Source: Weekly NRS births records, available only to the health board

Rural areas tend to have higher fertility rates than urban areas, particularly in younger women. Figure 7 illustrates the age specific fertility rates for 2015. This is calculated as the number of births per 1,000 women of that age.
5. Understanding Our Population

Figure 7: Fertility rates (per 1,000 women) by age group and region, 2015

Source: Vital Events Reference Tables NRS

If the women of childbearing age in Dumfries & Galloway experienced throughout their childbearing years, the age-specific fertility rates from 2015, the average number of children (per woman) that would be born is 1.66; this is known as the Total Fertility Rate. The equivalent figure for Scotland is 1.56. The replacement rate in societies with low mortality is just over 2, where adults have just enough babies to replace themselves. The total fertility rate in most western countries has been below 2 for decades but rates have recently been rising. In other words, local women are having slightly more children than average, but still not enough to keep the population from falling.

5.5 Patterns in Child Mortality

Scotland has a higher mortality rate in Children and Young People compared with many other Western European countries. In Scotland each year, there are approximately between 350 and 450 deaths of people aged under 18, with most of them occurring in children aged under 1 year. There tends to be relatively few deaths of children of most other ages, the exception being those aged 16 and over.

The national picture shows that during 2012-15:

- Over half of deaths in childhood occur during the first year of a child’s life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and socio-economic disadvantage
- Suicide remains a leading cause of death in young people in the UK, and the number of deaths due to intentional injuries and self-harm have not declined in 30 years
- After the age of one year, injury is the most frequent cause of death; over three quarters of deaths due to injury in the age bracket of 10-18 year olds are related to traffic incidents.
- In Dumfries & Galloway there were 9 deaths in 2014 and 11 deaths in 2015 amongst people aged 0-19 years old.

Table 5: Child Mortality, by sex and age group, Scotland, 2009-2015

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<thead>
<tr>
<th>Age Group (years)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>5 Year Average 2009-13</th>
<th>2010-14</th>
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<tr>
<td>0 to 3</td>
<td>160</td>
<td>139</td>
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<td>117</td>
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<td>4 to 11</td>
<td>19</td>
<td>25</td>
<td>24</td>
<td>31</td>
<td>19</td>
<td>29</td>
<td>23</td>
<td>24</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>12 to 18</td>
<td>83</td>
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<td>51</td>
<td>53</td>
<td>54</td>
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<td>64</td>
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<td>50</td>
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<tr>
<td><strong>0 to 18</strong></td>
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<td><strong>241</strong></td>
<td><strong>232</strong></td>
<td><strong>231</strong></td>
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<tr>
<td>Female</td>
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<td>107</td>
<td>101</td>
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<td>4 to 11</td>
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</tr>
<tr>
<td>12 to 18</td>
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<td>19</td>
<td>40</td>
<td>24</td>
<td></td>
<td>37</td>
<td>33</td>
<td>29</td>
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<tr>
<td><strong>0 to 18</strong></td>
<td><strong>181</strong></td>
<td><strong>170</strong></td>
<td><strong>166</strong></td>
<td><strong>139</strong></td>
<td><strong>155</strong></td>
<td><strong>144</strong></td>
<td><strong>118</strong></td>
<td><strong>162</strong></td>
<td><strong>155</strong></td>
<td><strong>144</strong></td>
</tr>
<tr>
<td>Both sexes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 3</td>
<td>272</td>
<td>256</td>
<td>271</td>
<td>246</td>
<td>216</td>
<td>230</td>
<td>203</td>
<td>252</td>
<td>244</td>
<td>233</td>
</tr>
<tr>
<td>4 to 11</td>
<td>36</td>
<td>35</td>
<td>43</td>
<td>52</td>
<td>31</td>
<td>41</td>
<td>31</td>
<td>39</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>12 to 18</td>
<td>135</td>
<td>120</td>
<td>84</td>
<td>72</td>
<td>94</td>
<td>70</td>
<td>73</td>
<td>101</td>
<td>88</td>
<td>79</td>
</tr>
<tr>
<td><strong>0 to 18</strong></td>
<td><strong>443</strong></td>
<td><strong>411</strong></td>
<td><strong>398</strong></td>
<td><strong>370</strong></td>
<td><strong>341</strong></td>
<td><strong>341</strong></td>
<td><strong>307</strong></td>
<td><strong>393</strong></td>
<td><strong>372</strong></td>
<td><strong>351</strong></td>
</tr>
</tbody>
</table>

Source: National Records Scotland (NRS); *Death Time Series Data* \(^{102}\)

**Please Note:** The child mortality figures quoted here are based solely on data from the National Records Office Scotland and include deaths registered in Scotland. These figures do not include cases where the death of a Scottish resident is registered in England or Wales. Although it is thought to be a very rare event, potentially the death of a child normally resident in Dumfries & Galloway may occur and be registered in England or Wales, especially given that Dumfries & Galloway shares a border with England. Local estimates indicate that this has occurred less than 5 times in the past 8 years. In addition, it is not possible to include further breakdown of child mortality figures for Dumfries & Galloway as the numbers are too small and there is a high risk of breaking confidentiality.

5.5.1 **Stillbirths**

Stillbirths (death of baby before or during birth after 24 weeks of gestation) occur for a variety of reasons, sometimes the cause is never known. There are some known predisposing factors but the main one is pre-term birth. Between 2001 and 2015 the annual average rate was 4.2 deaths per 1,000 live births (equivalent to an average of 6 deaths per year). The rate in Dumfries & Galloway in 2015 was 4.8 per 1,000 live and still births; however as shown in below, the small numbers involved means that there is considerable variation from year to year.
Deaths in infants and children are now relatively rare events. Factors that have contributed to the long term decline in mortality include: improved nutritional status, sanitation and healthcare as well as wider availability of vaccinations and better access to antenatal and postnatal care. Mortality rates remain highest for children under the age of one year (infant deaths) and the majority of these deaths occur in the first few days after birth. Risk factors include the age of the mother, low birth weight and multiple births.

After early childhood, deaths due to unintentional injuries, particularly arising from road traffic accidents, play an increasingly prominent role. For older children or young people, intentional self-harm and drug and alcohol misuse add to the number of deaths from external causes.

Mortality surveillance, although a basic measure, gives important indication of priorities for the planning and commissioning of services as the proportion of deaths particularly in older Children and Young People that can be linked to external causes and higher risk behaviours remain a continuing concern at local and national level. 

5.5.2 Babies with Low Birthweight

Low birthweight (less than 2,500g) is a major determinant of infant mortality and morbidity. A number of factors have been shown to be associated with low birthweight and/or preterm births. These include maternal smoking, maternal age, deprivation, previous obstetric history, drug/alcohol use, hypertension and multiple births. Although the numbers are small for Dumfries & Galloway, comprising less than 6% of births 2013 to 2015, there is a clear deprivation gradient. Children born to families from the most deprived areas are 40% more likely to be of low birth weight than those born in other areas (see Figure 9).
5.5.3 Reviews of Child Deaths

A sudden unexpected death in infancy (SUDI) occurs when there is no known pre-existing condition which would make the death predictable. The term “cot deaths” are often used to describe such deaths. “Infancy” in this context is extended to include deaths in those aged 0-24 months. Sometimes such a death may be termed Sudden Infant Death Syndrome (SIDS) where there is no pathology or risk factors present (these are a sub-set of SUDIs). SUDIs fortunately, occur very rarely, but when they do arise, a full investigation is undertaken. As the cause is not known, the death cannot be registered and the Procurator Fiscal is notified. Police will act on behalf of the Procurator Fiscal, but they are also normally automatically notified by the Scottish Ambulance Service, or the NHS Emergency Department. After post-mortem investigations are complete, some cases remain unexplained and in these instances, SUDI may be entered on a death certificate.

Currently in Scotland reviews are carried out in certain circumstances but there is no consistent process for reviewing a child’s death. A number of different formal and informal mechanisms exist to examine some childhood deaths but there is considerable geographical variation across Scotland, and mechanisms are often designed only for certain categories of childhood deaths. Data collection and the sharing of any lessons learned are also limited. In D&G the SUDI toolkit is followed, which clearly outlines the role of each agency/profession after a SUDI.

The Scottish Government announced in May 2014, its intention to implement a new Child Death Review system\(^{105}\): The aim is to make it standard practice for a multi-agency review to be undertaken that will examine the circumstances of every child’s death (under the age of 18 years and care leavers up to 26\(^{th}\) birthday to align with the Children and Young People (Scotland) Act 2014). The objectives
are to identify any factors that could reduce childhood deaths and to ensure any lessons to be learned are passed to the relevant agencies. The final report from the Child Death Reviews Steering Group is awaited.

5.3 Life Expectancy at Birth

Life expectancy is an important measure of the health of the population. Life expectancy in Scotland has been slowly rising over time for both men and women, though Scotland still ranks lowest for UK life expectancy for both men and women. Note that life expectancy figures are not available for locality level geography but have been produced at intermediate geography level for the ScotPHO profiles\textsuperscript{106}; which are discussed below.

Over the last twenty years, life expectancy at birth in the UK has increased by 5.4 years for men and 3.8 years for women. Scotland has improved at a faster rate than the UK for men, 5.5 years for men but a slower rate, 3.7 years, for women over the last 20 years. In Dumfries & Galloway women in particular have improved better than either Scotland or the UK average, increasing by 4.0 years over 20 years.

**Table 6: Change in life expectancy at birth over 20 years**

<table>
<thead>
<tr>
<th></th>
<th>UK Males</th>
<th>UK Females</th>
<th>Scotland Males</th>
<th>Scotland Females</th>
<th>Dumfries &amp; Galloway Males</th>
<th>Dumfries &amp; Galloway Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-94</td>
<td>73.7</td>
<td>79.0</td>
<td>71.7</td>
<td>77.4</td>
<td>73.0</td>
<td>77.5</td>
</tr>
<tr>
<td>2012-14</td>
<td>79.1</td>
<td>82.8</td>
<td>77.2</td>
<td>81.1</td>
<td>78.0</td>
<td>81.5</td>
</tr>
<tr>
<td>Difference</td>
<td>5.4</td>
<td>3.8</td>
<td>5.5</td>
<td>3.7</td>
<td>5.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Source: NRS, Office for National Statistics, Life Expectancy 2012-14

Life expectancy is not currently published for locality areas; the latest figures published by ScotPHO\textsuperscript{107} are for intermediate geography areas (which are a similar population size to postcode sectors), of which there are 35 across D&G. Table 7 illustrates the highest and lowest life expectancy for intermediate geography (IZ) areas in each locality (note these do not perfectly match the locality boundaries).

Please note: Due to the sample sizes, IZ life expectancy is calculated as a 5 year average, and typical figures have a margin of error of plus/minus 2.7 years for men and 2.3 years for women. The figures quoted in Table 7 are in years and whether the figure is statistically significantly better/worse (as relevant) than Scotland is marked by *. The IZ figures for Gretna & Eastriggs and Langholm & Canonbie have been omitted; these are felt to have spuriously high life expectancy reported due to the exclusion of deaths in England in the national calculations.
There are large differences in life expectancy across the region highlighting the inequalities experienced by some people. Boys born today in Annan South have a life expectancy of 80.4 years whereas boys born today in Stranraer Central have a life expectancy of 69.7 years, a difference of 10.7 years. For girls born today life expectancy has an even greater range of 12.1 years between best life expectancy in Georgetown (89.8) and worst life expectancy in Dumfries West (77.7).

Table 7: Highest and lowest IZ life expectancy (years) by locality, 2009-13

<table>
<thead>
<tr>
<th>IZ</th>
<th>LE</th>
<th>IZ</th>
<th>LE</th>
<th>IZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td>Lowest</td>
<td>Diff</td>
<td>Highest</td>
<td>Lowest</td>
</tr>
<tr>
<td>Ann &amp; Esk</td>
<td>80.4*</td>
<td>75.7</td>
<td>4.7</td>
<td>84.1*</td>
</tr>
<tr>
<td>Anch South</td>
<td>Annn North</td>
<td>73.0*</td>
<td>7.2</td>
<td>89.8*</td>
</tr>
<tr>
<td>Stew</td>
<td>78.9*</td>
<td>77.5</td>
<td>1.4</td>
<td>86.4*</td>
</tr>
<tr>
<td>Machars South</td>
<td>69.7*</td>
<td>8.6</td>
<td>82.5*</td>
<td>78.5*</td>
</tr>
<tr>
<td>D &amp; G</td>
<td>80.4*</td>
<td>69.7*</td>
<td>10.7</td>
<td>89.8*</td>
</tr>
</tbody>
</table>

* Significantly different (p<0.05) from Scotland average

Source: ScotPHO 2015 Online Health and Wellbeing Profile

References


5. Understanding Our Population


6. SAFE

‘Children and Young People should be protected from abuse, neglect or harm’

In this section:
- Child Protection
- Parental Substance Misuse
- Looked After Children and Young People
- Domestic Abuse
- Violence and Youth Justice
- Unintentional injuries & accidents
- Sexual Health
- Immunisation

Young children experience their world through their relationships with parents and other caregivers. These relationships shape the development of children’s physical, emotional, social, behavioural and intellectual capacities; which ultimately affects their health and wellbeing as adults. Therefore, safe, stable, nurturing relationships and environments are essential to ensure that children reach their full potential.

6.1 Child Protection

For various reasons, and in order to protect them from harm, children may be taken into care or placed on the child protection register or both. In Scotland, three main trends have been identified in child protection registrations in recent years. These are:

- Reduction in the length of time on the register
- Increasingly younger children on the register
- Decreasing referral to the Children’s Reporter (for Care or Protection) but steady numbers on the register or in care in 2011/12 and 2012/13

Nationally, over one half of children on the Child Protection register are aged under 5 years (51% in 2013) and a small proportion are registered before birth (5% in 2013)\textsuperscript{108}.

For each child registered there may be a number of reasons for inclusion on the child protection register. Nationally over one fifth report parental substance misuse and nearly one quarter report emotional abuse and neglect.
6. Safe

6.1.1 The Strategic and Policy Context

The Children (Scotland) Act 1995\textsuperscript{109} states that local authorities have a duty to protect and promote the wellbeing of children in need in their area. This includes giving families appropriate support to help ensure their children are getting the best start in life.

The National Guidance for Child Protection in Scotland\textsuperscript{110} provides a national framework within which agencies and practitioners at local level can understand and agree processes for working together to safeguard and promote the welfare of children. It sets out expectations for strategic planning of services to protect Children and Young People and highlights key responsibilities for services and organisations.

The guidance is for all services, agencies, professional bodies and organisations, and for individuals working within adult and child services that face, or could face, child protection issues. Protecting children means recognising when to be concerned about their safety and understanding when and how to share these concerns, how to investigate and assess such concerns and fundamentally, what steps are required to ensure the child’s safety and well-being.

To support the implementation of the guidance, a number of other initiatives are in place including:

- A national risk assessment framework for child protection
- A national learning and development framework that articulates the expected skills and competencies in relation to child protection
- Updated practice guidance Getting Our Priorities Right for practitioners working with children and families where substance misuse is an issue
- A new scrutiny model for the inspection of children’s services

For health professionals, child protection guidance\textsuperscript{111} was published in December 2012. It is intended to act as a practical reference point for all healthcare staff working within an adult and child service. It is supplementary to and should be read in conjunction with the National Guidance for Child Protection in Scotland.

6.1.2 The Evidence

In March 2009 Lord Laming published the findings of a review investigating the progress being made across the UK to implement effective arrangements for safeguarding children (The Protection of Children in England: a progress report\textsuperscript{112}). The review was commissioned as a response to “baby Peter” case being made public in 2008. In 2010 Professor Munro was commissioned to conduct an independent review of child protection in England\textsuperscript{113}. Munro suggested that good practice was evident in many parts of the UK. In 2010 Ofsted reported that training and professional development of social workers had progressed considerably since the Laming Review. At that time there seemed
be, however varying views on the quality of supervision available to social workers, with Ofsted citing positive experiences and Hunter (2009) reporting that there had no improvement in this aspect of practice following the first Laming Review in 2003.

The findings of Holmes et al 2010\textsuperscript{114} suggested that agencies were continuing to develop and improve their information sharing, however the same study recommended that further improvements were required in this important aspect of safeguarding work. Barlow and Scott 2010\textsuperscript{115} reported that universal services are ideally placed to assess families, particularly during pregnancy and the postnatal period. As such they argue the case for the development of multi-disciplinary teams, which place social workers in the heart of teams working in children’s centres schools and maternity services. A significant increase in referrals and demands for placements to social care teams, in the wake of the “baby Peter” case was found to increase pressure on social work teams; however a considerable number of these requests did not meet the current threshold for intervention\textsuperscript{116}. There were also concerns that as a result of the Laming Review, attention was focused on cases similar to Baby Peter’s thus inadvertently diverting attention away from other groups of vulnerable children\textsuperscript{117}. The Social Work assessment of children in need; what do we know? Messages from Research (March 2011)\textsuperscript{118} concluded that there are clear messages from research about the factors that help promote effective practice and improve the quality of assessments for vulnerable children in order to provide interventions that improve the lives of children and their families.

The 2012 audit and analysis of significant case reviews\textsuperscript{119} found that only 14% of children were on the child protection register and 20% were looked after, 93% of the families reviewed were known to social services. In addition the research highlighted the high prevalence of parental substance misuse and criminality, which may lead to parental neglect of Children and Young People. The Scottish Government’s Review of Child Neglect in Scotland\textsuperscript{120} confirms that neglect is highly associated with any, or combinations of: parental substance misuse, mental health problems, domestic abuse and parental learning difficulty.

The 2014 publication “Safeguarding Scotland’s Vulnerable Children from Child Abuse (Children in Scotland)\textsuperscript{121}” noted the improvements since 1995 in Scotland in the protection of vulnerable children. The introduction of wide ranging legislation, GIRFEC principles, multi-agency partnerships and the introduction of foster care standards were cited as drivers in this improvement. Nevertheless, the report advised that work must continue to ensure that every child is protected and can achieve wellbeing. In particular, three areas for improvement were noted, addressing the needs of children who fall just below “thresholds” for intervention, simplifying the complex legislative landscape and aligning efforts towards the implementation of GIRFEC. A constant finding in child protection enquiries is the failure of adult and children’s services across health and social care to work together effectively. Declan Hainey’s Fatal Accident Enquiry\textsuperscript{122} confirms this failing.

These findings were supported in the NSPCC third annual “state of the nation” report: How Safe are our Children? 2015\textsuperscript{123}. The report provides an overview of the child protection landscape and
compiles the most robust and up-to-date child protection data that exists across each of the four nations in the UK. Noting the high profile of sexual abuse and systemic failings to identify and protect at-risk children\textsuperscript{124} set against a backdrop of ongoing government activity which included the announcement in Scotland of a national statutory inquiry on the historical abuse of children in care, it emerged that in some areas of the UK sexual abuse has become so common that it is seen by children as a normal way of life. However the report urges that we must not lose sight of neglect, the most common cause of being entered onto a child protection register and reinforces the need for early intervention noting that in Scotland there is already a statutory duty for early intervention\textsuperscript{146,125}.

6.1.3 The Local Picture

Statistics on children in care and those who are thought to be at significant harm are collected and submitted to the Scottish Government by local authorities. Other data are obtained by interrogation of the Child First system and derived from the individual submissions made.

As of 31\textsuperscript{st} July 2014 there were 111 children on the child protection register in Dumfries & Galloway. Figure 10 summarises the concerns identified at case conferences for these children. Please note that a child could have more than one concern recorded.

**Figure 10: Concerns identified at the case conference of children who were on the child protection register at 31st July 2014; Dumfries & Galloway**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child placing themselves at risk</td>
<td>*</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>*</td>
</tr>
<tr>
<td>Child exploitation</td>
<td>*</td>
</tr>
<tr>
<td>Other concern</td>
<td>14</td>
</tr>
<tr>
<td>Parental alcohol misuse</td>
<td>30</td>
</tr>
<tr>
<td>Non-engaging family</td>
<td>34</td>
</tr>
<tr>
<td>Neglect</td>
<td>34</td>
</tr>
<tr>
<td>Parental drug misuse</td>
<td>34</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>40</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>41</td>
</tr>
<tr>
<td>Parental mental health problems</td>
<td>41</td>
</tr>
<tr>
<td>Parental substance misuse</td>
<td>49</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>63</td>
</tr>
<tr>
<td>All children on register at 31 July 2014</td>
<td>111</td>
</tr>
</tbody>
</table>


*Value suppressed to maintain confidentiality
Please note: The figures quoted in this document are those published by the Scottish Government on an annual basis. Documents produced for internal use by health and social care services may include more up-to-date figures. However, past experience suggests the overall number of children on the child protection register does not vary significantly over time.

The 2015 data should not be compared to data from before 2012 on category of abuse/risk. The Scottish Government published revised National Guidance for Child Protection in Scotland in December 2010 which expanded the categories for abuse/concerns identified at case conferences. As a result, many of the categories in 2012 may have been included in other categories previously or would not have been counted as they have no equivalent in previous years.

Also, Figure 10 Error! Reference source not found.includes information on parental substance misuse, which counted conferences at which either parental drug misuse and parental alcohol misuse were involved.

Table 8: Movement on and off the child protection register; Dumfries & Galloway; 2014-2015

<table>
<thead>
<tr>
<th></th>
<th>Number on Register</th>
<th>Number case conferences (initial, pre-birth &amp; transfer in)</th>
<th>Number of registrations</th>
<th>Child protection registrations as a % of pre-birth, initial &amp; transfer in case conferences held</th>
<th>Number of deregistrations</th>
<th>Number on Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>112</td>
<td>212</td>
<td>169</td>
<td>80%</td>
<td>190</td>
<td>91</td>
</tr>
<tr>
<td>Scotland</td>
<td>2,877</td>
<td>6,054</td>
<td>4,393</td>
<td>73%</td>
<td>4,522</td>
<td>2,751</td>
</tr>
</tbody>
</table>

Source: Children’s Social Work Statistics; Scottish Government (2016)
1 This figure has been revised since original publication.
2 Children on the child protection register can be transferred between local authorities or move in or out of Scotland during the year. The number on the register in 2014 does not equal the number on the register in 2013 plus registrations minus de-registrations.

Child Protection is the business of all employees in the Community Planning Partnership from Executive Directors and senior managers to front line staff. All staff are expected to participate in awareness training at induction and specific policies on appropriate actions to take are available across the partnership. On-going learning and development opportunities to ensure awareness of the importance of keeping children safe are critical. Timely sharing of information where there may be concerns about the safety of a child underpin effective interventions to keep children safe.

Front line practitioners who see children and families may be the first to be aware that families are experiencing difficulties in caring for their children and should always share information about
suspicions of abuse or neglect with the Named Person and relevant partner agencies (social work services, NHS, the police or the Children’s Reporter) at an early stage. When treating or caring for adults, all practitioners must consider whether the patient poses a risk to children or young people and take action quickly if they think this risk exists. Risk factors can include having parents with mental health or substance misuse issues, living in a home where domestic abuse takes place, or living in poverty.

There are also opportunities to work on safety issues for Children and Young People within the educational curriculum and many of these opportunities are already addressed in activities to support emotional resilience, bullying and transitions.

6.2 Children Affected by Parental Substance Misuse (CAPSM)

Parents who misuse drugs and/or alcohol are less likely to attend to the emotional, physical and developmental needs of their children in both the short and long term. Such children may well be vulnerable as a consequence and increased risk from physical and emotional harm in their environment. Alcohol and Drug Partnerships (ADPs), which are local multi-agency partnerships in each of the local council areas in Scotland, are charged with ensuring that the issues faced by CAPSM are addressed.

Obtaining actual numbers of children affected is difficult. The Scottish Government 2010/12 CAPSM strategy cites estimates of 40,000-60,000 children (equivalent to approximately 5%) affected by parental (one or both) drug misuse of which 10,000-20,000 may be living with at least one parent with drug misuse. It also includes an estimate of 65,000 (about 7%) of children affected by parental alcohol misuse in Scotland. It is likely, however, that these are underestimates.

One indicator of the prevalence of CAPSM is the rate of maternities recording maternal drug misuse. These rates measured as three year rolling averages from 2005 to 2012, show an increase in the overall national average. However, trends should be interpreted in the context of improving recording as drug use is now a mandatory data requirement in the maternity dataset.

6.2.1 The Strategic and Policy Context

The Scottish Government recently reviewed its dedicated guidance (Getting Our Priorities Right) for all children’s and adult service practitioners working with vulnerable children and families where problem alcohol and/or drug use is a factor. This guidance is grounded in the core principles that govern the Scottish Government’s common approach to improving services for children, young people, adults and families - that early intervention is critical to ensure that problems in vulnerable families do not become more damaging and more difficult to address later. It is steeped in the GIRFEC approach to services and complements the revised National Child Protection Guidance (2010). Lastly, it supports the wider Recovery Agenda for families facing substance use issues,
ensuring that child protection, recovery and wider family support concerns are brought together as part of a coordinated approach to giving children, young people and families the best support possible.\textsuperscript{126}

### 6.2.2 The Evidence

The physical and social impacts of substance misuse on individuals who are drinking to excess and/or taking illicit drugs are clear and often severe. What is more, substance abuse disorders and other psychiatric disorders are often co-morbid, with each exacerbating the other.\textsuperscript{127} In combination, there are also numerous effects of such disorders on the people around these individuals, in particular on Children and Young People whose parents or caregivers are experiencing such issues. Within this summary, substance misuse is taken to include problem drinking.

There are a number of mechanisms by which parental substance misuse may affect outcomes for Children and Young People. One review of the effects of tobacco and alcohol upon children’s health divided mechanisms into three key pathways: direct exposure to the substances (e.g. in the womb); living with parents who may become ill from using these substances; and children’s modelling of parental substance misuse.\textsuperscript{128}

The earliest direct effects of parental substance misuse upon a child can occur in the womb. Outcomes associated with prenatal substance exposure include low birth weight,\textsuperscript{129} infant feeding difficulties,\textsuperscript{130} increased infant irritability, poor neonatal neurobehaviour,\textsuperscript{131} withdrawal symptoms,\textsuperscript{132,133} stunted cognitive and physical development and later child behavioural problems. Furthermore, each of these outcomes is itself a determinant of poor outcomes later in life for affected individuals. It is important to note that prenatal exposure to different illicit substances will have very different effects upon these outcomes. However, it is outside the scope of this document to explore these details in depth.

Another prominent effect of parental substance misuse is upon the likelihood of children to develop similar disorders. It is well established in the academic and medical literature that children of substance abusing parents are at least twice as likely, and perhaps as much as ten times as likely, to have an alcohol or drug use disorder by early adulthood.\textsuperscript{134} Parental substance misuse has also been found to be associated with poor mental health of Children and Young People.\textsuperscript{135} Such poor outcomes continue into adulthood with psychiatric issues more prevalent in those whose parents have had substance abuse disorders.\textsuperscript{136}

In addition, parental substance misuse affects the quality of parenting. Parental substance misuse significantly increases the likelihood of child abuse\textsuperscript{137}, neglectful parenting, and improper parenting practices,\textsuperscript{138} with potentially harmful short- and long-term consequences for Children and Young People.\textsuperscript{139,140} Improper parenting practices, such as corporal punishment, have been found to be strongly associated with subsequent behavioural problems such as delinquency.\textsuperscript{141,142} In combination,
these worsened outcomes highlight the importance of parental substance misuse for child development, with significant impact across each of the wellbeing indicators.

6.2.3 The Local Picture

Within Dumfries & Galloway both child and adult-focussed services were charged with identifying children who were cared for by a substance misusing adult. Data collected between 2008 and 2012 showed that over six hundred such children had been identified and their circumstances assessed. The NHS CAMHS service includes staff who work exclusively with CAPSM children and children affected by their own substance misuse. The service works with an average caseload of around sixty five at any one time. In addition, the Aberlour Trust offer a parenting outreach service in Dumfries and Annan focussing on CAPSM children and working both directly with children and with parents and children together. This service is core funded by a partnership including the Alcohol and Drug Partnership, the Holywood Trust and Lloyd’s TSB Foundation.

Figure 11: Prevalence of parental substance misuse; Dumfries & Galloway compared Scotland; 2014

Source: ScotPHO, 2015

Figure 11 depicts the prevalence of parental substance misuse in Dumfries & Galloway compared with rates across Scotland. This chart clearly indicates that the rate of parental substance misuse for both alcohol and drugs is higher in Dumfries & Galloway than the national rate. However, counter to this, the recorded prevalence of women who are pregnant and use drugs is lower than the rate across Scotland.
Please note: This information is based on relatively small numbers and so confidence intervals have been used to establish whether the different between Dumfries & Galloway and Scotland is genuine. Also note this information is not available for different age groups.

It is not clear from the reported figures as to why there should be a divergent pattern for Dumfries & Galloway compared to Scotland for different indicators of parental substance misuse. It is possible that there are inconsistencies in recording data.

6.3 Looked After Children and Young People

Looked After Children and Young People (LACYP) are unable to live at home without supervision and most experience a range of different care settings during their time in care.

A child or young person is referred to as “Looked After” when they are in the care of their local authority. Children may become looked after on a voluntary basis e.g. at the request of parents or the child, or may become looked after subject to a court order or compulsory measure of supervision. The setting in which the child or young person is in care of the local authority varies greatly and can frequently change. The child or young person may be supported by the local authority to live in their family home (LACYP, looked after) or in an alternative care setting (LAACYP, looked after and accommodated) e.g. in foster care, with a family member/friend (kinship care) or prospective adoptive parents, a residential care home, a residential school or a secure unit. 143

6.3.1 The Strategic and Policy Context

The 2007 report Looked After Children and Young People: We Can and Must Do Better 144 identified a number of actions that were required to support looked after Children and Young People to improve their educational outcomes. Action 15 of the report advised that all looked after Children and Young People have timely assessments of their health and wellbeing needs and that appropriate measures are in place to take account of these assessments.

This action led to the publication of CEL 16 (2009)145 which recommends the steps NHS Boards should take to ensure that they are fulfilling their responsibilities:

- Have offered every (at the time) looked after child a health assessment by April 2010
- Offer every looked after child and young person a health assessment within four weeks of notification to the Health Board of that individual coming into the system by March 2010
6. Safe

- Offer a mental health assessment to every looked after child and young person by 2015, this should be implemented in line with “Mental Health of Children and Young People Framework for Promotion Prevention and Care”.

In addition to the above assessments being undertaken the person undertaking the assessment should take responsibility for ensuring a care plan is delivered/co-ordinated as appropriate. The NHS Board is also required to have in place a system to report the progress in meeting these requirements on both assessment and health outcomes annually to the Scottish Government.

Additionally, The Children’s and Young People’s Act (Scotland) 2014 made legislative changes to ensure that services work together to improve outcomes for all Children and Young People. One aspect of the Act extends the role of Corporate Parent across the Public Sector with support from Local Authorities to Young People in care, extending up to and including the age of 25 years. There is a statutory requirement for Local Authorities to provide throughcare which will prepare young people for leaving care. Young people leaving care generally go to independent living (16 to 18 years) at a younger age than the general population.

### 6.3.2 The Evidence

Children and Young People who become looked after experience challenging life circumstances which can adversely affect their health and wellbeing.

Whilst there are many individual studies which report on the health needs of this group, a recent Health Needs Assessment of Looked After Children in Glasgow and Scotland highlighted the lack of routine data available to make accurate comparisons about the health needs of this population to similar deprivation groups.

The literature does however; clearly demonstrate that there is a high incidence of mental health problems in this population group. There is also a greater need for sexual health services in this population, but less access to good quality and consistent sources of sex and relationship education due to greater absenteeism from school and due to movements between schools. Both the shorter (within 3 months of leaving care) and longer term health outcomes have been found to be worse than that of the general population at the same age. These include drug and alcohol abuse, mental health problems, emotional and behavioural difficulties, other health issues such as incomplete immunisations, foetal alcohol effects and disabilities, homelessness and unemployment.

Therefore, Looked After Children and Young People have greater needs for health services and health improvement both during care, prior to being taken into care and on leaving care.
For those Children and Young People in residential care, further barriers exist to accessing care including the unavailability of out of school hour appointments and those in secure care are likely to be most at risk of not accessing mental health services due to the complexity of their needs.

LACYP are vulnerable to early risk-taking behaviour. Entry to care should provide the opportunity to promote healthier behaviour; therefore in 2010 Scottish Government started the process of exploring the possibility of incorporating key learning from Health Promoting Hospitals and Health Promoting Schools with a view to adopting a similar approach within residential care placements for looked after children in Scotland. This work has lead to the development of a draft logic model for Health Promoting Care Placements (August 2015).

6.3.3 The Local Picture

During 2013 a review was undertaken to establish the available information on the number of Children and Young People who were looked after (LACYP and LAACYP) in the region and the NHS service provision for assessment and follow up of their health and wellbeing needs. This review was driven by service capacity challenges to the Looked After Child Health Team, Public Health Staff and Children and Adolescent Mental Health Services (CAMHS) and for the Child Clinical Psychology Service. In addition, any dubiety that had existed as to the responsibility for the health and wellbeing of children from other Board areas placed in the region was resolved with the publication of CEL 06 (March 2013)\textsuperscript{151}, and guidance on health assessments from Scottish Government was anticipated, with a requirement to undertake health assessments within 4 weeks of notification of Looked After Status.\textsuperscript{152}

The review noted:

- Challenges in gaining accurate data on the number of LACYP
- Issues in systems and process that allowed the NHS to identify when a child becomes looked after
- Challenges presented by the new guidance on the responsible commissioner
- Gaps in service provision and areas in which CEL 06 requirements were not being met

Issues that are particular to Dumfries & Galloway are:

- The high numbers of LAACYP in kinship care arrangements
- The presence of private residential units which provide up to 80 beds for LAACYP from anywhere in the UK
- The unknown number of private foster carers who may provide care for LAACYP from other Local Authority areas
Local experience suggested that the physical health needs of this population group are significant and vary dependant on age; with younger children having greater experience of conditions related to neglect including; skin conditions, dental health problems and incomplete vaccination programmes. This younger age group also seem to have greater experience of visual problems, asthma and failure to reach developmental milestones. Older children often have a number of risk taking behaviours that present threats to their future health and wellbeing.

Following this review, a Looked After CYP Health team was established to ensure timely and comprehensive assessment of need and co-ordination of appropriate interventions to meet the identified needs of individual Children and Young People. In addition a LAC Champions Board has been established with representation from LACYP, senior managers from NHS and Local Authority and elected members. The Corporate Parenting (Strategy) Group has oversight of the Corporate Parenting Action Plan and reports on progress to the Children’s Services Executive Group.

Table 9 to Table 12 summarises information published by the Scottish Government regarding looked after children in the Dumfries & Galloway region. As at 31st July 2015, there were 409 looked after children. The figures for Dumfries & Galloway are in line with Scotland except for the proportion of looked after children who are “at home with parents”. Here, the proportion for Dumfries & Galloway (42%) is higher than the proportion across Scotland (25%). It is not clear from these figures how many looked after children Dumfries & Galloway are responsible for are accommodated outside of the region. Equally, there is no information on the number of looked after children who are the responsibility of another local authority who are accommodated in Dumfries & Galloway.

**Table 9: Characteristics of Looked After Children and Young People, Dumfries & Galloway, 31st July 2015**

<table>
<thead>
<tr>
<th></th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. Looked after children</td>
<td>409</td>
<td>15,404</td>
</tr>
<tr>
<td>Gender of children looked after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>223 (55%)</td>
<td>8,297 (54%)</td>
</tr>
<tr>
<td>Female</td>
<td>186 (45%)</td>
<td>7,107 (46%)</td>
</tr>
<tr>
<td>Age of children looked after (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>118 (29%)</td>
<td>3,153 (20%)</td>
</tr>
<tr>
<td>5-15</td>
<td>242 (59%)</td>
<td>10,371 (67%)</td>
</tr>
<tr>
<td>16+</td>
<td>49 (12%)</td>
<td>1,880 (12%)</td>
</tr>
<tr>
<td>Children known to be from minority ethnic groups**</td>
<td>*</td>
<td>567 (4%)</td>
</tr>
<tr>
<td>Children known to have additional support needs**</td>
<td>34 (8%)</td>
<td>2,032 (13%)</td>
</tr>
</tbody>
</table>

Source: Scottish Government

1 Table excludes children who are on a planned series of short term placements.
2 Figures for 2014-15 are provisional and may be revised in 2015-16.
3 Cells containing * represent numbers that are suppressed to maintain confidentiality.
4 “Minority Ethnic Group” includes the ethnic groups Mixed Ethnicity, Black, Asian, and Other Ethnic Background.
5 Until 2012 the additional support needs category was presented as ‘disability’. This has been amended as the information collected does not meet the definition of ‘disability’ outlined in the Equality Act 2010.
### Table 10: Children starting and ceasing to be looked after, Dumfries & Galloway; 2014-15\(^1,2\)

<table>
<thead>
<tr>
<th></th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children looked after on 31 July 2015</td>
<td>409</td>
<td>15,404</td>
</tr>
<tr>
<td>Children looked after on 31 July 2015 as a percentage of the 0-17 population(^3)</td>
<td>153%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Starting to be looked after during 1 August 2014 to 31 July 2015</td>
<td>178</td>
<td>4,198</td>
</tr>
<tr>
<td>Ceasing to be looked after during 1 August 2014 to 31 July 2015</td>
<td>148</td>
<td>4,367</td>
</tr>
</tbody>
</table>

Source: Scottish Government\(^{153}\)

1. Table excludes children who are on a planned series of short term placements. A child may start and cease to be looked after more than once during the year and will be counted once for each episode of care starting and ending.
2. Figures for 2014-15 are provisional and may be revised in 2015-16.

### Table 11: Children looked after by type of accommodation; Dumfries & Galloway; 31st July 2015\(^1,2\)

<table>
<thead>
<tr>
<th></th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>At home with parents</td>
<td>172 (42%)</td>
<td>3,927 (25%)</td>
</tr>
<tr>
<td>With friends / relatives</td>
<td>100 (24%)</td>
<td>4,158 (27%)</td>
</tr>
<tr>
<td>With foster carers provided by LA</td>
<td>101 (25%)</td>
<td>3,891 (25%)</td>
</tr>
<tr>
<td>With foster carers purchased by LA</td>
<td>*</td>
<td>1,587 (10%)</td>
</tr>
<tr>
<td>In other community(^3)</td>
<td>*</td>
<td>312 (2%)</td>
</tr>
<tr>
<td>In local authority home/ Voluntary Home</td>
<td>*</td>
<td>697 (5%)</td>
</tr>
<tr>
<td>In other residential care(^4)</td>
<td>28 (7%)</td>
<td>832 (5%)</td>
</tr>
<tr>
<td>Total looked after children</td>
<td>409</td>
<td>15,404</td>
</tr>
</tbody>
</table>

Source: Scottish Government\(^{153}\)

1. Table excludes children who are on a planned series of short term placements.
2. Figures for 2014-15 are provisional and may be revised in 2015-16.
3. In other community includes with prospective adopters.
4. Other Residential Care includes Crisis care and secure Accommodation and in residential school.
5. Cells containing * represent numbers that have been suppressed to maintain confidentiality.
Table 12: Percentage of care leavers beyond minimum school leaving age with a pathway plan and a pathway co-ordinator, Dumfries & Galloway, 2014/15\(^1\)\(^2\)

<table>
<thead>
<tr>
<th></th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of care leavers during 1 August 2014 to 31 July 2015</td>
<td>28</td>
<td>1,266</td>
</tr>
<tr>
<td>Percentage with a pathway plan</td>
<td>36%</td>
<td>74%</td>
</tr>
<tr>
<td>Percentage point change since 2013-14</td>
<td>-64%</td>
<td>-5%</td>
</tr>
<tr>
<td>Percentage with a pathway co-ordinator</td>
<td>36%</td>
<td>79%</td>
</tr>
<tr>
<td>Percentage point change since 2013-14</td>
<td>-64%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Scottish Government\(^1\)\(^5\)

(1) Table excludes children who are on a planned series of short term placements.
(2) Figures for 2014-15 are provisional and may be revised in 2015-16.
(3) It may be the case that some young people who don’t have a relevant pathway plan/coordinator may be receiving similar support from adult services instead.

6.4 Domestic Abuse

Children and Young People living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. It is estimated that 100,000 children in Scotland live with domestic abuse.

6.4.1 The Strategic and Policy Context

The refresh of Safer Lives, Changed Lives: A shared approach to tackling violence against women in Scotland\(^1\)\(^5\) (2009) aims to develop a more strategic approach to tackling domestic abuse, with a focus on prevention. The impact of domestic abuse on children and families has been well documented and further information on it can be found in the National Domestic Abuse Delivery Plan for Children and Young People (2008)\(^1\)\(^5\).

Initiatives involving young people include Voice Against Violence and Mentors in Violence Prevention. In Voice Against Violence (VAV), the Scottish Government and its partners worked closely with an advisory group of young experts aged between 18 and 23 with personal experience of domestic abuse. VAV, which is no longer in existence previously advised Ministers and other partners on how to make a lasting difference to children and families across Scotland. This initiative was the first in the history of the Scottish Government (and in the wider UK) which engaged with young survivors in such a way.
6.4.2 The Evidence

Domestic violence can affect children in a number of ways, either as direct recipients of the violence or as witnesses to violence between members of their household. As many as a quarter of children are estimated to be witnesses to domestic abuse, and between one and two thirds of children who suffer physical abuse themselves also live with domestic abuse. Children, particularly boys, who suffer abuse, are more likely to become perpetrators of domestic violence in adulthood. Domestic violence can be physical, verbal (including threats), emotional or sexual. The majority of domestic abuse occurs between a male perpetrator and a female victim. When children are present in the household, they can be involved in this violence in a number of ways including being in their mother’s arms when she is abused; as witnesses; as hostages; or defending their mother.

The earliest point at which a child can experience domestic abuse is within the womb, with studies showing that women who experience domestic abuse while pregnant receive more extensive injuries to the breasts and abdomen. Such a pattern of injuries suggests that the unborn child is often a co-target of the violence along with the mother. As such, this “double intentioned violence” can be considered an early form of child abuse. It is estimated that as much as 20 percent of domestic abuse begins during pregnancy.

It is important to recognise that some of the most striking effects of domestic abuse upon children come not from direct abuse, but from living with or witnessing domestic abuse among others (chiefly parents or guardians). Domestic abuse between parents is reported to be the most frequently reported form of trauma for children. In approximately 90% of domestic abuse cases, children are in the same or the next room when the abuse takes place.

Children and Young People living in households affected by domestic abuse experience high rates of depression and anxiety, post-traumatic stress symptoms, guilt due to an inability to protect their parent, and behavioural and cognitive developmental issues. Behavioural problems can include aggressive and antisocial behaviour as well as fearful and inhibited characteristics. A large meta-analysis of 118 studies of the psychosocial outcomes of children exposed to domestic violence found that while witnesses of domestic abuse were found to have significantly worse outcomes than non-witnesses, outcomes for victims of direct abuse were not found to be significantly worse than those witnessing abuse. Furthermore, these mental health issues often extend into the adult lives of children affected by domestic violence.

Abuse of a child’s mother also has the potential to undermine her relationship with the child. This can be through making the mother physically incapable of providing appropriate parental care; undermining her authority by abusing (including sexually), belittling or humiliating her in front of the child; or undermining the woman’s mental health in such a way that she is less able to care for her child. Ultimately the extent of these impacts will depend, along with other factors, upon the severity of the abuse suffered by the mother which in extreme cases can result in the death of the
mother, either directly through abuse or indirectly through suicide. As with other forms of abuse; sexual abuse of children also often occurs within the context of a household where domestic abuse takes place.

Age is a further factor mediating the relationship between living with domestic abuse and outcomes for Children and Young People, for example:

- Babies living with domestic violence experience high rates of ill health, poor sleeping habits and disrupted attachment patterns.
- Pre-school children show the highest levels of behavioural disturbance and self-blame for adult anger.
- Older Children and Young People show experience more effects of disruption of school and social environments.\(^{177}\)

Finally, it is crucial to remember that, in the most extreme cases, domestic violence can lead to the serious injury or death of a child or young person.\(^{178}\)

**6.4.3 The Local Picture**

In Dumfries & Galloway, the Domestic Abuse and Violence Against Women Partnership (DAVAWP) has adopted the Scottish Government’s definition of domestic abuse:

> *Domestic abuse (as gender-based abuse), can be perpetrated by partners or ex partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends.)*

This encompasses but is not limited to the following:

- physical, sexual and psychological violence occurring in the family, within the general community, or in institutions, including: domestic abuse; rape; incest and child sexual abuse;
- sexual harassment and intimidation at work and in the public sphere; commercial sexual exploitation, including prostitution, pornography and trafficking;
- dowry related violence;
- female genital mutilation;
- forced and child marriages;
- honour crimes
Domestic abuse involving lesbian, gay, bisexual or transgender (LGBT) people can involve some specific issues such as using the threat of “outing” as a means of control, or be linked with sexual identity and a belief that the abuse is occurring because the person is LGBT.

There is very limited information on the number of incidents of domestic abuse where children are present. The Scottish Crime and Justice Survey (SCJS), a large-scale survey measuring people’s experience and perceptions of crime in Scotland\textsuperscript{179} found that one third (33\%) of respondents experiencing partner abuse within the last 12 months reported that children were living in their household when the most recent incident took place, 67\% of these children were present when the incident took place. In 72\% of these cases (42 respondents) the children heard or saw what had happened and within this group, 13\% of incidents resulted in the children becoming involved in the incident and 7\% resulted in the children being hurt or injured.

Figures published by Police Scotland indicate that a total of 1,230 incidents of domestic abuse occurred in Dumfries & Galloway during 2014/15. If Dumfries & Galloway is representative of the rest of Scotland, it is reasonable to estimate the one third (410 incidents) occurred at household were children reside.

Information published by the Scottish Children’s Reporter Administration (SCRA) on referrals to children’s hearings indicates that during the 2014/15 financial year, 108 children were referred because “he/she has, or is likely to have, a close connection with a person who has carried out domestic abuse”.

Please note: for a description of children’ hearings, the SCRA and further information, please see Section 12.4.

During 2014 11\% of children on the D&G Child Protection Register were there as a result of domestic abuse; however, the overlap with other reasons for entry on the register for example parental substance misuse or emotional abuse is not clear. Throughout 2013/14, 914 children were involved across 1,421 incidents of domestic abuse reported to the police.

A working group within D&G is overseen by the Child Protection Committee that has responsibility for maintaining an overview of the issue of child sexual exploitation and developing an action plan.

In relation to services for Children and Young People, Dumfries and Stewartry Women’s Aid (DSWA) have 3 full time Children’s Workers who are funded through the Scottish Government’s Children’s Services Fund. One to one support, group activities and mothers and children support sessions are provided both within and out with “Refuge” settings. In the period 1\textsuperscript{st} January – 31st December 2014 these workers supported 123 Children and Young People in Nithsdale, Annandale & Eskdale and Stewartry.
**The Caledonian System**

This is an integrated approach to addressing men’s domestic abuse and to improve the lives of women and children. It works with men convicted of domestic abuse related offences to reduce their re-offending while offering integrated services to women and children. During the last 4 years, a total of 106 women have been offered the Caledonian Women’s Service. At present, of these 46 are entitled to the service and will be at varying levels of active engagement. There are 122 children within the families of these women whose lives are affected by domestic abuse.

**Routine Enquiry of Abuse in Health Care Settings**

This approach involves asking all people presenting to a service direct questions in relation to abuse. In Dumfries & Galloway, Routine Enquiry takes place in maternity, substance misuse and sexual health services. Between April 2014 and March 2015 this resulted in the initiation of 10 child protection procedures.

**Refuge Services**

The numbers of Children and Young People considered for refuge services in this period are noted in.

**Table 13: Number of Children and Young People considered for refuge services; Dumfries & Galloway; 2014**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Children/Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to Refuge Overnight</td>
<td>13</td>
</tr>
<tr>
<td>Not Admitted to Refuge Overnight</td>
<td>-</td>
</tr>
<tr>
<td>Declined offer</td>
<td>8</td>
</tr>
<tr>
<td>CYP did not get back in touch</td>
<td>8</td>
</tr>
<tr>
<td>Other*</td>
<td>≤5</td>
</tr>
<tr>
<td>No Overnight Admission but Accepted Outreach Support</td>
<td>12</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
</tr>
<tr>
<td>Refuge Provided by Another Provider*</td>
<td>≤5</td>
</tr>
</tbody>
</table>

Source: Refuge Services

* Numbers suppressed to prevent disclosure
Please note: Within Dumfries & Galloway Education, Social Work and NHS Services all provide services to men, women and children impacted by violence against women. We do not have means of identifying these numbers. The data we have is also, often, devoid of context. When incidents of abuse are recorded we fail to recognise the patterns of abusive behaviour that often exist.

There are no third sector support services for children under 12 affected by sexual abuse within Dumfries & Galloway but without full knowledge of the extent of the issue and the requirement for such resources we are unable to ascertain the need. South West Rape Crisis and Sexual Abuse Centre provide support to children aged 12 and over, impacted by sexual abuse.

6.5 Unintentional Injuries and Accidents

Children must be allowed to develop physically and socially and to engage with the environments in which they live in order to enjoy an active life. Any preventive measures that are put in place have to strike a balance between children’s need for active exploration and development and adults’ responsibility to keep them free from death and serious injury.

6.5.1 The Strategic and Policy Context

Delivering emergency care effectively is a reliable measure of whole-system performance and a pre-requisite for the delivery of a range of Local Delivery Plan standards and community care outcomes. There are a number of interconnected strategic and policy approaches that underpin this work. They include Better Health: Better Care\textsuperscript{180} and A Framework for the Sustainable Provision of Unscheduled Care\textsuperscript{181} which, in developing the framework considered the work of the Child Health Support Group on Emergency Care for Ill and Injured Children and Young People in Scotland.

The Child Safety Strategy: Preventing Unintentional Injuries to Children and Young People in Scotland (May 2007)\textsuperscript{182} acknowledges that Children and Young People are entitled to have healthy lifestyles free from the risks of death or serious or disabling injury.

In addition, Good Places Better Health\textsuperscript{183} recognises that both social and physical environments have a significant impact on the health of Scotland’s people and that action is required to create safe, health nurturing surroundings for everyone to promote wellbeing and ameliorate the effects of unhealthy environments such as obesity, asthma and accidental injury. The strategy acknowledges the importance of neighbourhoods, the home, transport and safe streets in maintaining the safety and wellbeing of the population.
6.5.2 The Evidence

Unintentional injury is one of the main causes of death and is the most common cause of emergency admissions in children aged under 15 in Scotland\(^{184}\), and is second only to cancers as a cause of death for children aged between 1-14 years. Death rates from unintentional injury among children in Scotland are more than three times higher for children in the most deprived quintile compared with the least deprived and almost twice as many boys than girls are killed in accidents. The child death rate from unintentional injuries in Scotland is significantly higher than in England and Wales.\(^{185}\)

Policies and programmes exist that encourage Children and Young People to walk, play and take part in sport and active leisure pursuits to improve and maintain their general health and wellbeing. These activities can however lead to increases in the numbers of injuries. The challenge is to ensure that these injuries are neither life-threatening nor disabling.

While we may wish to reduce the numbers and severity of all injuries, some cannot be prevented without seriously restricting children’s activities or only at great cost; as many of the injuries that children suffer are consequences of their natural development or being active, such as learning to walk or playing sports. For pragmatic reasons, not least limitations in resources, prevention activities have to be prioritised. This means focusing on the accidents that result in death, serious injury or disability; events that are costly in treatment or social terms and those for which there are prevention programmes where there is good evidence of effectiveness.

Accidents that are numerous also deserve attention. While they may not individually cause serious injuries, taken together their burden is large. Where there is good information on how to reduce the numbers or severity of such events, the appropriate preventive measures should be implemented. Wherever possible, prevention programmes should be based on reliable evidence of what is known to be effective. Where evidence is not readily available, best practice should be employed.

A number of key reviews of effectiveness are available that can usefully support local and national initiatives\(^{186,187,188,189}\). Consequently, consideration should be given to ending any existing programmes that cannot be shown to be reducing casualty rates, increasing knowledge, or improving behaviour or attitudes, or that do not employ what is now regarded as best practice. However, it should be remembered that intervention programmes may have benefits that extend beyond reducing casualties. Also, programmes located within local communities have to be measured (or reviewed) within the context of wider health improvement gains. Injury prevention programmes can act as vehicles to strengthen communities, create employment opportunities, enhance personal development, create or reinforce partnerships between agencies, build capacity and link to other initiatives, such as volunteering. Equally, they may contribute to other health and wellbeing initiatives that are already government priorities, such as the drive for greater physical activity.
As part of the development of the Child Safety Strategy, a survey of Children and Young People was commissioned from Children in Scotland, which provided a valuable insight into their views, experiences and concerns. In particular, the survey revealed that Children and Young People do worry about being injured in an accident; however they think they already know all they need to know to stay safe, or reject the whole idea that accidents can be prevented and some respondents wanted to learn more about accident prevention and how to keep themselves safe. There were marked differences in safety related attitudes and behaviours based on gender and age.

Not all children are at the same risk of death and injury. Roberts and Power (1996) demonstrated that when those from the poorest families are compared with the most affluent they are:

- 5 times more likely to die as a pedestrian
- 15 times more likely to die in a house fire
- Overall, 5 times more likely to be killed

Similar research published in 2006 showed that the gap between children from the most affluent families and those in which there was long-term unemployment or a history of worklessness had widened. The difference in injury rates overall was a factor of 13.

In non-fatal events, research shows that the poorest children are likely to suffer injuries that require hospital admission and that when they are admitted their injuries are likely to be more serious than those experienced by children from more affluent families.

To optimise success in reducing injuries and accidents, coordinated multifaceted approaches using educational measures and environmental changes must be used. These approaches should be aimed at children, parents and carers and the public more generally. Publicity campaigns, the development and enforcement of legislation and the empowerment of communities are also essential. In schools, safety and risk education can lead to an understanding of safety and create a culture within which other initiatives can be more easily developed. Linked to this is the need for children, young people, their families and carers to understand and more accurately assess risks.

6.5.3 The Local Picture

Accident & Emergency

Accident and Emergency (A&E) services are provided at Dumfries & Galloway Royal Infirmary and Galloway Community Hospital. There are also Minor Injury Units in Castle Douglas, Kirkcudbright, Moffat and Newton Stewart.

In the calendar year 2015/16, there were 9,803 unplanned attendances at Accident and Emergency departments in Dumfries & Galloway by children aged 18 or under resident in the region (see Figure
children under 5 years accounted for 36% of these attendances (3,517) and 27% (2,637) were for 14 to 18 year olds.

Please note: Children and Young People may be sent directly to the Paediatric Short Stay Admissions Unit (PSSAU) attached to Ward 15 by their GP rather than via Accident & Emergency. Information relating to the PSSAU can be found in Section 7.6.2.

Figure 12: Unplanned A&E Attendances, Children (Aged 18 or Under), Dumfries & Galloway and Scotland, 2015/16

![Bar chart showing unplanned A&E attendances by age group.]

Source: EDIS and TED, NHS Dumfries & Galloway

Figure 13 shows that attendances are higher for Nithsdale and Wigtownshire residents, reflecting the influence that proximity to hospital has on these data. Wigtownshire and Nithsdale have the greatest proportion of attendances by children under 3 (33% and 32% of attendances respectively).
Table 14 shows the most common reasons for attendance for 3 age groups. The most common reason for attendances in children aged 5 or over was ‘Limb problem’. Further analysis highlighted that this was the symptom description for 51% of attendances by 10 to 14 year olds. In the under 5 age group the most common reason for attendance was ‘Unwell Child’ (18% of attendances in this age group).
Unintentional Injuries

In 2014/15, there were 219 emergency admissions for unintentional injuries of children aged under 19. The proportions across the SIMD 2012 deprivation quintiles were similar to population distribution for this age group. There was a higher proportion of admissions by children resident in Nithsdale (45%) when compared to the population (40%) in this area. Road traffic accidents accounted for 25 (11%) admissions and most of these were for children aged 12 to 18. Almost a third of admissions (31%, 67) were for injuries at home and 48% of these were for children aged 0 to 3 years.

Table 15: Unintentional Injury admissions by age group and type; Dumfries & Galloway; 2014

<table>
<thead>
<tr>
<th></th>
<th>0 to 3 years</th>
<th>4 to 11 years</th>
<th>12 to 18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road Traffic Accident</td>
<td>*</td>
<td>*</td>
<td>20 (25%)</td>
<td>25 (11%)</td>
</tr>
<tr>
<td>Home</td>
<td>32 (63%)</td>
<td>21 (24%)</td>
<td>14 (17%)</td>
<td>67 (31%)</td>
</tr>
<tr>
<td>Work</td>
<td>*</td>
<td>*</td>
<td>11 (14%)</td>
<td>21 (10%)</td>
</tr>
<tr>
<td>Other</td>
<td>16 (31%)</td>
<td>54 (62%)</td>
<td>36 (44%)</td>
<td>106 (48%)</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>87</td>
<td>81</td>
<td>219</td>
</tr>
</tbody>
</table>

Source: ISD Scotland

*Suppressed for disclosure

The Health Behaviours of School Children 2015 survey found that across Dumfries & Galloway 42% of young people reported that they had been injured at least once in the past 12 months. This was significantly lower than for Scotland at 45%. At 15 years, boys were more likely than girls to be injured (45% compared with 33%).

Table 16: Proportion of young people who have been injured at least once in the last 12 months; Dumfries & Galloway; 2014

<table>
<thead>
<tr>
<th></th>
<th>11 years</th>
<th>13 years</th>
<th>15 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boy</td>
<td>46%</td>
<td>49%</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Girl</td>
<td>43%</td>
<td>39%</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>Both</td>
<td>44%</td>
<td>44%</td>
<td>39%</td>
<td>42%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

Significantly fewer young people with injuries in Dumfries & Galloway required hospital treatment for the most serious injury (41%) compared with the Scotland (46%). Boys were only slightly more likely to require hospital treatment (43%) than girls (40%) locally with little age differences in the proportion needing hospital treatment if injured.

At home (25%) or at a sports facility (23%) were the most likely places for injury to occur with girls more likely to be injured at home (31%) compared with boys (20%) while boys were more likely to be injured doing sports or a recreational activity (35%) than girls (17%).
Figure 14: Place where most serious injury happened, Dumfries & Galloway, 2014

In Scotland there has been a small but steady decline in the prevalence of injuries among boys from 55% in 2002 to 50% in 2014. There has been little change in the prevalence of injuries among girls during this time period.

### 6.6 Sexual Health

Sexual Health appears in the “Safe” section of this needs assessment as it relates to a range of behaviours and risks broader than making healthy choices including:

- A significant proportion of Children and Young People in Scotland have experienced child sexual abuse, which whilst substantially under-reported, prevalence studies show rates of 7 to 30% of girls and 3 to 13% of boys
- There are evidenced links between living with domestic abuse and being directly physically and/or sexually abused by the same perpetrator
- Research into the backgrounds of Children and Young People involved in prostitution has shown the following contributory factors: severe adversity in the home resulting in involvement in the care system; childhood sexual abuse; running away from home (or being in statutory care)
- Domestic abuse within teenage relationships is also commonplace. Several independent studies have shown that 40% of teenagers are in abusive dating relationships
- Younger people (aged 13 to 15 years old) are as likely as older adolescents (aged 16 and over) to experience particular forms of violence. For girls, having an older partner, and especially a “much older” partner, was associated with the highest levels of victimisation
• Increasing exposure to sexualised imagery and pornography creates issues relating to sexual health, gender inequality and violence against women. It can be difficult for young people to challenge the representations of women and men they daily encounter in their interaction with popular culture and find other, more realistic and unbiased examples with which they can identify.

• There is still a perception of commercial sexual exploitation (CSE) as ‘excitement’ and even ‘empowering’ for women. The harm caused by prostitution, lap dancing, and other forms of CSE is often not recognised. It is often sold as a viable career opportunity to young women and as desirable entertainment for men; moreover the links of these industries with the sex trafficking industry is not always recognised.

6.6.1 The Strategic and Policy Context

The Sexual Health and Blood Borne Virus Framework sets out the Scottish Government’s agenda in relation to sexual health, HIV, hepatitis C and hepatitis B 2011-15. The Framework has five high level outcomes, all of which are relevant to young people:

• Fewer newly acquired blood borne viruses (BBVs), sexually transmitted infections (STIs) and fewer unintended pregnancies
• A reduction in the health inequalities gap in sexual health and BBVs
• People affected by BBVs lead longer, healthier lives
• Sexual relationships are free from coercion and harm
• A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non stigmatising and supportive

The Framework recommends that a multi-agency approach is taken to supporting young people around sexual health and BBVs. In particular, local authorities are identified as taking a leadership role in addressing teenage pregnancy. It also confirms that sexual health and relationships education remains critically important. It is now well established that providing accurate age and stage appropriate information can support young people to avoid sexual activity until they are physically and emotionally ready.

Local Authorities and other statutory and Third Sector organisations are asked to work together to implement Reducing teenage pregnancy - Guidance and self assessment tool, published by Learning Teaching Scotland in 2010.

This brings together the range of current evidence and advice on the partnerships, strategies and interventions that need to be in place locally if teenage pregnancy rates are to be reduced. By reviewing this evidence and using the self-assessment tool on an annual basis, local authorities and their partners can build on existing good practice to address teenage pregnancy in the long term.
Other prevention activity relating specifically to young people includes encouraging the continued provision of drop-in services for young people in or close to schools, particularly in areas of greatest need and the delivery of Relationship, Sexual Health and Parenthood (RSHP) education to all young people, including those not in school. This aspect of the curriculum is intended to enable Children and Young People to build positive relationships as they grow older and should present facts in an objective, balanced and sensitive manner within a framework of sound values and an awareness of the law on sexual behaviour.\textsuperscript{196}

Currently, the draft Scottish Government Pregnancy and Parenthood in Young People Strategy is out for consultation.\textsuperscript{197}

\textbf{6.6.2 The Evidence}

There is a deficiency of surveys collecting risk behaviour data among young people; therefore, although risk behaviours in young people are widely considered to cluster together, our understanding of the degree and pattern of risk behaviour clustering is limited; in particular, sexual risk behaviour (which is not collected by SALSUS, the national survey of risk behaviour in school children). Much of the evidence in the published literature derives from USA based studies. However, there is emerging evidence to support the development and implementation of broader based programs that address some of the social, educational and economic determents of positive sexual health.

Evidence from the USA (cited in Sexual health interventions targeted at Children and Young People, Health Scotland 2010\textsuperscript{198}) indicates that early years interventions which tackle these broader determinants can have positive long term impacts on sexual health outcomes. Interventions with parents tend to focus on three dimensions of the parent child relationship, communication, parental involvement in their child’s social life, and parental monitoring of their child’s behaviour. These interventions combined with school based sex and relationship education is found to be an important approach to improving sexual health outcomes. It is worth noting that some populations of young people are underrepresented in the evidence base and these include LGBT, Children and Young People with learning disabilities and homeless young people.\textsuperscript{199} Wider research suggests that looked after young people are particularly at risk of poor sexual health and exploitation. Isolation, stigma and lack of trust are significant predictors of early parenthood\textsuperscript{200}.

Recognition of the complex social picture and of the nature of the transitions from childhood to adolescence and then adulthood must be taken into account when designing programs aimed at influencing health behaviour in young people.\textsuperscript{201}

A number of factors influence the success of these transitions including social mobility, education, personal competence and resilience as well as gender, socioeconomic status and family support. In addition key societal factors including cultural norms and attitudes, marketing and media and access
to leisure and social facilities all play an important role in influencing risk taking behaviour in young people.

**Lessons learnt from Greater Glasgow & Clyde**

In 2014 NHS Greater Glasgow & Clyde together with local authority partners undertook a consultation with young people about sexual health. The consultation arrived at a number of key themes. It is highly likely that these themes would be applicable to people in Dumfries & Galloway:

- Young people feel that they are growing up in a society that puts great pressure on them to be sexually active but find adults reluctant to discuss adolescent sexual development as a natural part of growing up and embarrassed to help them with what “being ready” for sex means.
- Anal sex has emerged as behaviour that warrants focussed attention in relation to young people. Almost one in five young people between 16 and 24 years old has experience of heterosexual anal sex. There is also emerging evidence that female partners feel pressured to do this. Over half of men who have sex with men had their first experience of anal sex as a teenager.
- Gendered norms continue to impact on young people – boys are expected to be knowledgeable, experienced and boast about sexual activity while girls are expected to protect their reputation and for their participation in sex to be one of gradually decreasing resistance to male advances. There is also an unintentional gendered approach to parenting around sexual health leading to gaps in young people’s knowledge and understanding.
- For young women who experienced sexual abuse or rape, most commonly the perpetrator was an intimate partner; for young men the perpetrator was most commonly a family member or friend.
- Regarding their digital lives: most young people had sent or received sexually explicit material; young women feel pressure to conform to stereotypical imagery presented in the media; and young people perceived that adults were ill informed of their online lives and therefore not equipped to provide the right support.
- Young people feel less comfortable discussing relationships and sexual health after age 13/14 and by age 16/17 are more likely to talk to their peers.
- Young people cite opening times, and locations to be the main barriers to accessing sexual health services.
6.6.3  The Local Picture

Teenage Pregnancy

Figures published by ISD Scotland indicate that in 2014 across Dumfries & Galloway there were 136 pregnancies in women aged under 20 years at the time of conception. This is equivalent to an incidence rate of 34.4 pregnancies per 1,000 women aged 15 to 19 years (95% CI: 40.4-28.9) which is comparable to the national rate across Scotland of 33.7 pregnancies per 1,000 women aged 15 to 19 years. Figure 15 depicts the teenage pregnancy rates for different age groups for Dumfries & Galloway compared to Scotland since 1994. The three age groups in Dumfries & Galloway follow very similar patterns to that displayed across Scotland although there is a greater degree of variation due to the small numbers of people involved. In addition, since 2007 there appears to be a steady decrease in teenage pregnancy rates both in Dumfries & Galloway and Scotland amongst under 18s and under 20s. The pregnancy rates for under 16s have remained fairly constant.

Figure 15: Teenage pregnancy rates for Dumfries & Galloway and Scotland by mother’s age at conception

Source: NRS registered births and stillbirths & Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967.

Looked After Children and Sexual Health Risk Assessments

Looked After Children are considered to be a priority group by Sexual Health Services in Dumfries & Galloway. Looked After Children and vulnerable young people are referred to a sexual health nurse who carries out a comprehensive sexual health risk assessment and are reviewed on a 3 monthly basis. Recently a review of the service considered a data sample of 65 looked after children who had received a risk assessment between February and March 2015:
The majority of looked after children referred were female (57 girls, 87.7%).

The majority of looked after children referred for a sexual health risk assessment were aged 14 years (22 children; 33.8%) or 15 years (21 children; 32.3%) although the ages ranged from 12 to 16 years at their first attendance.

The most prevalent primary reason for a referral for a sexual health risk assessment was “age at first sex” (19 children; 29.2%); followed by “multi-agency involvement” (17 children; 26.2%) and “domestic abuse” (9 children; 13.8%). Other primary reasons for referral included “non consensual sex”, “alcohol/drugs”, “mental health” and “parental drug misuse” amongst others.

The review highlighted that Sexual Health Dumfries & Galloway provided a high level of service continuity with a designated link worker co-ordinating service provision, and had built strong, trusting relationships with Looked After Children and Young People, residential care homes, carers and social services. Some challenges were also raised such as the erratic behaviour of some Looked After Children and Young People, multiple risk taking behaviours and a lack of background information for some children.

The recent Health Behaviours of School Children 2015 survey found that thirty percent (30%) of Dumfries & Galloway 15 year olds, 32% of girls and 27% of boys reported that they had had sexual intercourse. This is significantly higher than the overall prevalence rate for Scottish 15 year olds (26%) where 27% of girls and 24% of boys nationally have reported that they have had sex.

In Scotland the proportion of 15-year olds who reported having had sexual intercourse remained broadly stable between 1998 and 2010. However, between 2010 and 2014 the proportion of girls that report having had sex declined from 35% to 27%.

**Figure 16: Proportion of 15 year olds who have ever had sexual intercourse, Scotland 1998 to 2014.**

![Graph showing the proportion of 15-year olds who have ever had sexual intercourse in Scotland from 1998 to 2014.](source: Health Behaviours of School Children 2015)
Over a quarter of these young people (27%) first had sex at the age of 13 or younger and a further 28% at the age of 14. Locally a higher proportion of boys had sexual intercourse at age 13 or younger compared to girls, whilst a higher proportion of girls were reported to have first had sexual intercourse at age 15 or older. The proportion of 15 year olds who, when first had sex, were younger than 15 was not significantly different in Dumfries & Galloway (55%) compared with Scotland (56%).

Table 17: Proportion of 15 year olds who have had sexual intercourse by age when they first had sex, Dumfries & Galloway and Scotland, 2014.

<table>
<thead>
<tr>
<th></th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>13 years or younger</td>
<td>36%</td>
<td>19%</td>
</tr>
<tr>
<td>14 years</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>15 years or older</td>
<td>37%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children

A condom was the most common form of contraceptive used during the last sexual intercourse (38% using condom only and 20% using condom and contraceptive pill). The contraceptive pill (only) was used by 35% of 15 year olds. More than a quarter (27%) of 15 year olds reported neither using a condom nor the contraceptive pill when they last had sex.

Figure 17: Use of contraception in 15 year olds when last had sexual intercourse, Dumfries & Galloway, 2014

Source: Health Behaviours of School Children
6.7 Immunisations

Immunisation programmes protect infants, Children and Young People and family/community members from vaccine-preventable infectious diseases and associated risks to health, wellbeing and learning. They are one of the biggest successes of universal health care in recent times. The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. Therefore individuals who cannot be vaccinated will still benefit from the routine vaccination programme. This concept is called population (or ‘herd’) immunity. For example, babies below the age of two months, who are too young to be immunised, are at greatest risk of dying if they catch whooping cough. Such babies are protected from whooping cough because older siblings and other children have been routinely immunised as part of the childhood programme.

6.7.1 The Strategic and Policy Context

The overarching policy for immunisations across the UK is outlined in Immunisation Against Infectious Diseases, otherwise known as “The Green Book” which contains the evidence base for the policy with the individual disease epidemiology and evidence on the efficacy and safety of the appropriate vaccines. It also contains general information on immunisation administration and best practice.

6.7.2 The Evidence

According to the UK Health Protection Agency (HPA), vaccination is the second-most effective public health intervention worldwide (after clean water) for saving lives and promoting good health. When vaccine coverage is high enough to induce high levels of population immunity, infections may be eliminated, for example vaccination against smallpox enabled the infection to be declared eradicated from the world in 1980. But if high vaccination coverage were not maintained, it would be possible for the disease to return. The World Health Organization (WHO) is currently working towards the global eradication of poliomyelitis. Independent experts and World Health Organisation studies have shown that vaccines are far safer than therapeutic medicines and most “vaccine scares” have been shown to be false alarms. Misguided safety concerns in some countries have led to a fall in vaccination coverage, causing the re-emergence of pertussis (whooping cough) and measles.

The benefits of immunisation programmes can be identified at individual; family, community and population level and include:

- Eradication
- Elimination
- Control of mortality, morbidity and complications
- Mitigation of disease severity
- Prevention of infection
- Protection of the unvaccinated population
- Source drying
- Prevention of related diseases and cancer

The benefits of vaccination extend beyond prevention of specific diseases in individuals. Vaccination makes good economic sense, and meets the need to care for the weakest members of societies. Reducing global child mortality by facilitating universal access to safe vaccines of proven efficacy is a moral obligation for the international community as it is a human right for every individual to have the opportunity to live a healthier and fuller life. Achievement of the Millennium Development Goal 4 (two-thirds reduction in 1990 under-5 child mortality by 2015) will be greatly advanced by, and unlikely to be achieved without, expanded and timely global access to key life-saving immunizations such as measles, Hib, rotavirus and pneumococcal vaccines\textsuperscript{205}.

6.7.3 The Local Picture

Immunisations are offered across the United Kingdom as agreed by the Joint Committee on Vaccinations and Immunisations (JCVI), which sets out a core childhood immunisation programme\textsuperscript{206}.

In addition, non-routine immunisations such as BCG are usually offered to babies who are at increased risk from Tuberculosis (TB) according to UK criteria and given at birth\textsuperscript{203} and Hepatitis B is offered to any new born child whose mother or close family has been infected with hepatitis B and/or is at increased risk due to parental intravenous drug use.

Following recommendations in July 2012 from the JCVI, the seasonal flu vaccination programme has been extended to all children aged two to 17 years. In addition there is a requirement to provide Mantoux testing and BCG immunisation for any child over 16 years of age who is identified to be in a risk category for TB infection according to national policy. From September 2015, Meningococcal (MenB) is included in the childhood schedule from 2 months of age.

Table 18 summarises the completion rates for each vaccine and different stages in children’s lives. The proportion of immunisations completed is very high in Dumfries & Galloway with no rate being lower than 95.7\%. Across the board, the completion rates for Dumfries & Galloway are higher than the national Scottish completion rates.
### Table 18: Immunisation uptake for Dumfries & Galloway; 2015/16

<table>
<thead>
<tr>
<th>Stage</th>
<th>Vaccine</th>
<th>% Complete Dumfries &amp; Galloway</th>
<th>% Complete Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Primary Immunisation Course by 12 months of age</td>
<td>DTP/Pol/Hib</td>
<td>98.5</td>
<td>97.2</td>
</tr>
<tr>
<td></td>
<td>MenC</td>
<td>98.7</td>
<td>97.5</td>
</tr>
<tr>
<td></td>
<td>PCV</td>
<td>98.3</td>
<td>97.1</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>96.2</td>
<td>92.9</td>
</tr>
<tr>
<td>Completed Primary and Booster Immunisation Course by 24 months of age</td>
<td>DTP/Pol/Hib</td>
<td>98.8</td>
<td>97.9</td>
</tr>
<tr>
<td></td>
<td>Hib/MenC</td>
<td>98.1</td>
<td>95.4</td>
</tr>
<tr>
<td></td>
<td>PCVB</td>
<td>98.0</td>
<td>95.3</td>
</tr>
<tr>
<td></td>
<td>MMR1</td>
<td>97.7</td>
<td>95.4</td>
</tr>
<tr>
<td>Completed Primary and Booster Immunisation Course by 5 years of age</td>
<td>DTP/Pol/Hib</td>
<td>98.5</td>
<td>98.1</td>
</tr>
<tr>
<td></td>
<td>Hib/MenC</td>
<td>97.0</td>
<td>96.2</td>
</tr>
<tr>
<td></td>
<td>DTP/Pol</td>
<td>97.2</td>
<td>93.7</td>
</tr>
<tr>
<td></td>
<td>MMR1</td>
<td>96.8</td>
<td>97.1</td>
</tr>
<tr>
<td></td>
<td>MMR2</td>
<td>96.6</td>
<td>93.1</td>
</tr>
<tr>
<td>Completed Primary and Booster Immunisation Course by 6 years of age</td>
<td>DTP/Pol</td>
<td>97.4</td>
<td>95.2</td>
</tr>
<tr>
<td></td>
<td>MMR1</td>
<td>97.8</td>
<td>96.7</td>
</tr>
<tr>
<td></td>
<td>MMR2</td>
<td>96.9</td>
<td>94.4</td>
</tr>
</tbody>
</table>

Source: SIRS (ISD Scotland)

D = Diphtheria vaccine  
T = Tetanus vaccine  
P = Pertussis vaccine  
Pol = Polio vaccine  
Hib = Haemophilus influenzae type b vaccine  
PCV = Pneumococcal conjugate vaccine  
MenC = Meningococcal serogroup C conjugate vaccine  
PCVB = Pneumococcal Conjugate Vaccine Booster  
MMR1 = Measles, mumps, and rubella vaccine (1 dose)  
MMR2 = Measles, mumps, and rubella vaccine (2 doses)

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Immunisation Scotland; www.immunisationscotland.org.uk/when-to-immunise/immunisation-schedule.aspx (last accessed 8th September 2015)
7. HEALTHY:

‘Children and Young People should experience the highest standards of physical and mental health, and be supported to make healthy, safe choices’

In this section:

- Maternal & Foetal Health
- Nutrition & Healthy Weight
  - Child Health Weight
  - Breast Feeding
- Mental Health
- Secondary (Hospital) Care
- Youth Health

Efforts to enrich early life represent Scotland’s best hope of breaking the intergenerational cycle of disadvantage. Therefore efforts should be made to ensure a safe and healthy pregnancy, a nurturing childhood and to support families to bring up their children in a safe, healthy, supportive and stimulating environment. Information is presented here generally following the life course.

7.1 Maternal & Foetal Health

The importance of health and wellbeing in pregnancy for both pregnant women and their babies cannot be under estimated. This SNA considers lifestyle factors and mental health and wellbeing for pregnant women. (Pre conceptual care and the needs of pregnant women with long term health conditions such as diabetes or epilepsy are outwith the scope of this report.)

7.1.1 Antenatal Booking & Screening Programmes

There is evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have a poorer experience of that care. Access to high quality, relationship based antenatal care with a strong focus on prevention, promotion of health, early intervention and support as early as possible in pregnancy is vitally important.  

In the year ending 31st March 2015, the number of maternities that were booked by the 12th week of gestation in Dumfries & Galloway was 1,035 (85.8%). The rate of booking by the 12th week of gestation was lower in Dumfries & Galloway that the national Scottish rate (86.2%).
Table 19: All maternities\(^1\) booked by the number of week gestation; Dumfries & Galloway and Scotland\(^2\); 2014/15\(^p\)

<table>
<thead>
<tr>
<th>Gestation at booking (completed weeks)</th>
<th>Number of women</th>
<th>Running Total (%)</th>
<th>Running Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - 5</td>
<td>26</td>
<td>26</td>
<td>2.2%</td>
</tr>
<tr>
<td>6</td>
<td>49</td>
<td>75</td>
<td>6.2%</td>
</tr>
<tr>
<td>7</td>
<td>122</td>
<td>197</td>
<td>16.3%</td>
</tr>
<tr>
<td>8</td>
<td>214</td>
<td>411</td>
<td>34.1%</td>
</tr>
<tr>
<td>9</td>
<td>226</td>
<td>637</td>
<td>52.8%</td>
</tr>
<tr>
<td>10</td>
<td>207</td>
<td>844</td>
<td>70.0%</td>
</tr>
<tr>
<td>11</td>
<td>124</td>
<td>968</td>
<td>80.3%</td>
</tr>
<tr>
<td>12</td>
<td>67</td>
<td>1,035</td>
<td>85.8%</td>
</tr>
<tr>
<td>13</td>
<td>45</td>
<td>1,080</td>
<td>89.6%</td>
</tr>
<tr>
<td>14</td>
<td>28</td>
<td>1,108</td>
<td>91.9%</td>
</tr>
<tr>
<td>15</td>
<td>11</td>
<td>1,119</td>
<td>92.8%</td>
</tr>
<tr>
<td>16 - 42</td>
<td>78</td>
<td>1,197</td>
<td>99.3%</td>
</tr>
<tr>
<td>No booking date(^3)</td>
<td>0</td>
<td>1,197</td>
<td>99.3%</td>
</tr>
<tr>
<td>Other(^4)</td>
<td>9</td>
<td>1,206</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>1,206</td>
<td>-</td>
<td>53,222</td>
</tr>
</tbody>
</table>

Source: ISD Scotland\(^{208}\) (www.isdscotland.org/Health-Topics/Maternity-and-Births/Births/)

1 Excludes records where mother has delivered at home or at non-NHS hospital.
2 Scotland data includes delivery records where NHS board of residence is unknown or outside Scotland.
3 No booking date recorded therefore gestation at booking cannot be calculated.
4 Includes records where booking date is after delivery date, or booking date incorrect, or gestation at booking <2wks or >42wks.

\(^p\) Provisional.

Screening during pregnancy identifies mothers and babies who may have rare but serious conditions for which early treatment can improve their health and prevent severe disability or even death.\(^{209}\) NHS Dumfries & Galloway pregnancy screening pathways are informed by national (Scottish) protocols derived from the UK National Screening Committee guidance which are subject to continual review and scrutiny by the committee. The time-line for pregnancy and newborn screening is depicted on the following page.

All pregnant women in Dumfries & Galloway are offered the universal screening programmes for Down’s syndrome, structural anomalies, certain communicable diseases (HIV, Hepatitis B, syphilis and rubella) and haemoglobinopathies. Women living in disadvantaged circumstances are more likely to miss screening opportunities while the increased likelihood of delayed ante-natal booking may also mean women miss the window of screening where there are time limits on a screening programme. Not having English as a first language may also be a barrier to accessing services.
Pregnancy and Newborn Screening Timeline

Start folic acid supplements

Give and discuss pregnancy information at first point of contact

Screening test for Sickle Cell and Thalassaemia disorders (ideally before 10 weeks).

Routine blood tests: Haemoglobin, group rhesus and antibodies as early as possible (8-12 weeks) or as soon as a woman arrives for care, including labour—these may be repeated later during pregnancy.

Dating scan

Blood test for Syphilis, Hepatitis B, HIV and Rubella susceptibility as early as possible or as soon as a woman arrives for care, including labour.

Nuchal translucency scan for Down’s syndrome (11-13 weeks)

Early screening test for Down’s syndrome.

Foetal anomaly scan (18-21 weeks)

Later screening test for Down’s syndrome.

Give and discuss newborn screening information

Routine examination of the newborn (by 72 hours)

Newborn blood spot test: PKU, CHT, CF, MCADD, SCD (ideally on day 5)

Newborn hearing screening test (from birth to 4 weeks)

Physical examination (by 8 weeks)

Screening involving blood test
Screening involving serum test
Screening involving ultrasound scan
Newborn blood spot test
Hearing screening test
Physical examination

PKU - Phenylketonuria
CHT - Congenital Hypothyroidism
CF - Cystic Fibrosis
MCADD - Medium Chain Acyl CoA Dehydrogenase Deficiency
SCD - Sickle Cell Disorder
7.1.2 Vulnerable Pregnant Women

In Dumfries & Galloway, a newly established multi-agency Vulnerability Improvement Team will be supported by local Early Years Collaborative improvement advisors, with an initial focus on using improvement methodology to implement change related to the Pre-birth Protocol for Vulnerable Pregnant Women and Babies.

The aims will include:

- Completion of a wellbeing assessment at booking for all pregnant women
- Ensure a child’s plan is in place for all of those identified as being vulnerable

7.1.3 Alcohol, Tobacco and Drug Use in Pregnancy

Alcohol

No safe level of alcohol use has been established in pregnancy. Alcohol is toxic to the developing foetus and can result in structural abnormalities and neuro-developmental difficulties that are likely to have implications for health, wellbeing and achievement across the life course. Currently there are no reliable routine data available to quantify the rates of alcohol misuse in pregnancy.

Foetal Alcohol Syndrome (FAS) at the severe end of impairment has an incidence of 1-2 in 1000 live births. Infants with FAS will have a range of congenital anomalies that may require corrective surgery and life-long engagement with specialist health care services while requiring on-going support from health and social care services and related additional support needs throughout their education. Foetal Alcohol Syndrome Disorder (FASD) which has an incidence of around 1 per 1000 live births is less understood and children with FASD are likely to experience difficulties in behaviour, learning, relationships and educational attainment throughout the life course.10 11 12

Smoking

Smoking during pregnancy can cause serious health problems and can increase the risk of infant mortality by an estimated 40% with increased associated risk of birth defects, prematurity and low birth weight. Risk increases with the amount smoked. Exposure to second-hand smoke also increases the risk of complications. It is recognised that smoking prevalence generally increases with deprivation. In Scotland in the year ending March 2015, 29.3% of pregnant women in the most deprived areas reported smoking at first booking compared with only 4.5% in the least deprived areas.13

In Dumfries & Galloway in 2015, data indicates that overall 24.5% (295 women) of expectant mothers were smokers. There was also a clear gradient according to deprivation measured by SIMD where
36% of mothers-to-be from areas in quintile 1 (the most deprived) were smokers compared to 14% in quintile 5 (least deprived).

**Figure 18: Proportion of births by maternal smoking status; Dumfries & Galloway; 2015**

Source: Scottish Birth Record

**Drugs**

Since the 1980s there has been a notable increase in problem drug use nationally and internationally. Over the last few years there have been indications that drug taking amongst the general population of Scotland has started to decrease. The Scottish Crime and Justice Survey reported that the proportion of adults aged 16-59 year who reported using drugs with the previous 12 months has reduced from 6.2% in 2012/13 to 6.0% in 2014/15. However, for many women and their partners, substance misuse remains a significant problem and impacts negatively on their ability to function and manage their day-to-day life, employment, parental and family responsibilities. Therefore, a significant number of children will suffer adverse health and wellbeing outcomes by their parent's use of substances. The effects of drugs on the foetus include intra-uterine growth restriction, pre-term delivery, increased rates of still birth, neo-natal death and sudden infant death. The true extent of drug taking in pregnant women is unknown, as reliable figures are difficult to obtain.

Evidence suggests that women who misuse alcohol, tobacco or drugs, and their infants, have better outcomes if they take up antenatal care early and if they use services consistently throughout pregnancy.

The KCND pathway (Keeping Childbirth Natural and Dynamic) which was first published in 2009 and has been adopted by the Scottish Government in 2011 to support the implementation of GIRFEC,
provides a framework for care planning and on-going risk assessment from first point of contact with the midwife throughout pregnancy to and into the post-natal period. One of the risks identified as part of the pathway is a history of alcohol and/or drug misuse within the last 12 months i.e. prior to conception.

Women who consume excess alcohol, smoke or use drugs may be vulnerable and living with a wide range of other challenging circumstances (poverty, poor mental health, family conflict, homelessness). Poorer pregnancy outcomes are multi-factorial and are also affected by socio-economic deprivation. It is therefore essential that a co-ordinated, multi-agency approach is in place for all women who require specialist advice or support in pregnancy and their care should reflect this.

Please note: further information on parental substance misuse is available in Section 6.2

7.1.4 Maternal Obesity

The foundations for health and wellbeing are laid at the earliest stages of life through the nutrition a baby receives during pregnancy, and the diet of the mother prior to conception. Maternal obesity, defined as a BMI ≥ 30 kg/m² at the first ante-natal booking appointment, is an indicator of increased risk to the health of the mother and child. Obesity in women during pregnancy is associated with an increased risk of developing type 2 diabetes, impaired glucose tolerance, gestational diabetes and bigger, heavier infants. Obese women also have higher rates of induction of labour, caesarean section and post-partum haemorrhage. In addition, maternal obesity is associated with increases in the risk of stillbirth, congenital abnormalities, premature birth and neonatal death.

The Healthy Start Scheme was introduced in 2006 and replaced the Welfare Foods Scheme. The scheme helps low income families by providing vouchers for free fresh milk, infant formula, fresh fruit and vegetables to young children and pregnant women, as well as free vitamin supplements. The scheme also encourages earlier and closer contact with health professionals who can give advice on pregnancy, breastfeeding and healthy eating.

Survey data suggests that, taken as a whole, women of reproductive age including those who have adequate calorie consumption, have poor dietary intakes of some key nutrients including iron, calcium, folic acid, and vitamin D and have low iron and vitamin D status. During pregnancy there is increased demand for these key nutrients and for vitamin D and folic acid the increased amount required cannot be met from food sources alone; therefore, it is recommended that all pregnant women take a daily supplement of each, in addition to increasing their calorie consumption. Women are advised to take Vitamin D ten micrograms daily during pregnancy and while breastfeeding. Before conception and until the 12th week of pregnancy, women are advised to take folic acid 400 micrograms daily to reduce the risk of having an infant with a neural tube defect.
Healthy Start management reporting is provided on a regular basis to all Scottish Health Boards. The reports provide aggregated details of the number of individuals and households who are engaged with the scheme and an estimate of the number of those potentially eligible for help at a time point.

The foundations for health and wellbeing are laid at the earliest stages of life through the nutrition a foetus receives during pregnancy, and the diet of the mother prior to conception. Maternal obesity, defined as a BMI ≥ 30 kg/m² at the first ante-natal booking appointment, is an indicator of increased risk to the health of the mother and child. The nutritional status of pregnant women and the risks of obesity in pregnancy are discussed in the universal services chapter of this document.

Maternal obesity is determined when mums-to-be attend their antenatal booking. Figures published by ISD Scotland for the financial year 2014/15 indicate that of the 1,206 bookings that occurred, 576 women (47.8%) were overweight or obese in Dumfries & Galloway (Table 20). This is lower than the proportion across Scotland for the same time period, 48.6%.

**Table 20: Maternal body mass index at antenatal booking, Dumfries & Galloway; 2014/15**

<table>
<thead>
<tr>
<th>BMI Group</th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>35 (2.9%)</td>
<td>1,544 (2.9%)</td>
</tr>
<tr>
<td>Healthy</td>
<td>561 (46.5%)</td>
<td>24,720 (46.4%)</td>
</tr>
<tr>
<td>Overweight</td>
<td>321 (26.6%)</td>
<td>14,585 (27.4%)</td>
</tr>
<tr>
<td>Obese</td>
<td>255 (21.1%)</td>
<td>11,306 (21.2%)</td>
</tr>
<tr>
<td>Unknown BMI</td>
<td>34 (2.8%)</td>
<td>1,067 (2.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,206</strong></td>
<td><strong>53,222</strong></td>
</tr>
</tbody>
</table>

Source: SMR02, ISD Scotland

These figures also highlight a clear deprivation gradient across Scotland using SIMD. Of those whose BMI at ante-natal booking is known, a higher proportion (52.9%) of mums-to-be living in the most deprived areas of Scotland (quintile 1) were overweight or obese than mums-to-be living in the least deprived areas of Scotland (quintile 5), 41.0%. There is also pattern by age group with expectant mums aged 35 years or older more likely to be overweight or obese (52.0%) compared to those aged under 20 (33.4%). There is an apparent relationship between maternal obesity and the mode of delivery with a higher proportion of obese expectant mothers (19.1%) requiring an emergency caesarean section compared to healthy weight expectant mothers (10.9%). There is also a greater tend for elective caesarean sections amongst obese expectant mothers (21.3%) compared to their healthy weight counterparts (14.4%).

The national figures also highlight a relationship between maternal obesity and infant birthweight. Amongst mothers who were obese at antenatal booking, 18.1% gave birth to a child with a heavy birthweight (child weighs greater than 3,999g), whereas amongst mothers who were of a healthy weight at antenatal booking 11.3% gave birth to a child with a heavy birth weight.

Please Note: Further information on birthweight can be found in Section 7.4.2.
7.1.5  Maternal Mental Health & Post Natal Depression

Becoming pregnant and having a baby is for many women a positive experience, however a significant minority (up to 15%) experience mood disorders and depression that would benefit from being identified and managed appropriately. For a very small number of new mothers who have a previous history of mental illness or disorder, identification and prompt management is imperative to prevent high risk of harm to infant and mother from self harm or suicide (severe post natal illness can be expected in 1-2 women/1,000).

Low mood can negatively impact the relationship between a mother and her newborn child. The early experiences of nurturing and attachment that a baby receives will have a life-long influence on their ability to develop the necessary emotional, social and cognitive skills that are required throughout life.

Currently, it is estimated that for every 1,000 live births, 100-150 women will suffer a depressive illness and one or two women will develop a puerperal psychosis. Based on the average number of births in the last three years (2013-2015) this would amount to approximately 125-200 women each year experiencing post-natal depression across the region and 1-3 mothers each year experiencing puerperal psychosis. Estimates of post-natal depression by applying these rates to number of births at a locality level are shown in Table 21.

Table 21: Estimated number of mothers in a year experiencing post-natal depression; population base average of births 2013-2015

<table>
<thead>
<tr>
<th></th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated numbers</td>
<td>30-49</td>
<td>51-86</td>
<td>16-26</td>
<td>26-43</td>
<td>125-200</td>
</tr>
<tr>
<td>(range)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SIGN: Postnatal depression and puerperal psychosis guideline, 2002

Please note: Further information on children’s mental health is available in Section 7.5.

7.2  Newborn Screening Programmes

Programmes of screening and surveillance of all newborns and children are implemented in the UK to effectively support child health and development. Health promotion programmes are also provided to complement these. The guidance in Scotland describes some of these although further screening tests and surveillance checks have been implemented since this guidance was published. All families should receive the core programme of routine contacts for screening, checks, immunisations and health promotion advice and support. Within this programme, some visits to the home are important to ensure a full assessment of the family's needs.
The recommendations in *Hall 4* reflect a move away from a wholly medical model of screening for disorders, towards greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk.

The following definitions from Hall 4 clarify the differences between screening, surveillance and health promotion:

**Child health screening:** The use of formal tests or examination procedures on a population basis, to identify those who are apparently well; but who may have an underlying disease or defect so that they can be referred for a definitive diagnostic test. Some defects can only be detected by health professionals if a search is made or through the use of specific screening tests.

**Child health surveillance:** Routine child health checks and monitoring.

**Health promotion:** Planned and informed interventions that are designed to improve physical or mental health or prevent disease, disability and premature death. Health in this sense is a positive holistic state.

The following sections describe the screening programmes covering the newborn and in childhood. Surveillance programmes are also described and a section on the potential for health improvement in the antenatal and postnatal periods.

NHS Dumfries & Galloway newborn screening pathways are informed by national (Scottish) protocols derived from the UK National Screening Committee guidance which are subject to continual review and scrutiny by the committee. There are also nationally defined indicators for the screening programmes that local performance is assessed against.

**Please note:** Details on the health protection afforded by immunisations is outlined previously in this document under the SHANARRI Indicator “Safe”, Section 6.7.

The newborn bloodspot screening programme aims to identify all babies born with:

- Congenital hypothyroidism
- Phenylketonuria (PKU)
- Cystic fibrosis
- Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)
- Sickle cell disorders.

The Newborn Hearing Screening Programme seeks to identify all babies born with a permanent bilateral hearing loss of greater than 40dB in the better ear. However, children with unilateral losses,
mild losses, Auditory Neuropathy Spectrum Disorder and temporary losses are also identified through the screening programme and require ongoing management within audiology services. The detection of hearing loss at birth ensures that babies and families can be offered early interventions to support the baby’s social, emotional and learning potential by offsetting any difficulties that arise from not being able to hear.

7.3 Childhood screening programmes

7.3.1 Preschool Vision Screening

Pre-school vision screening seeks to identify children with reduced vision; the commonest causes of which are undiagnosed refractive error (need for glasses) or strabismus (squint). Both of these conditions can cause amblyopia (lazy eye) which is a reversible deficit of vision that affects between 2 and 5% of the population. This has to be treated within the sensitive period for visual development (0-8 years) with better outcomes the younger the treatment is commenced.

7.3.2 Child Health Surveillance

All Children and Young People are offered routine health reviews at various stages of their life, in accordance with the recommendations of Health for All Children 2005. Each surveillance contact presents a scheduled opportunity for a discussion with parents and/or carers regarding how the child is growing and developing. Problems and concerns can be explored in a holistic manner, prompt investigation undertaken and appropriate management started.

It is increasingly recognised that language deficits can be indicative of poorer outcomes in later life whilst neuro-developmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD), foetal alcohol syndrome and autism spectrum disorders may also benefit from early identification and interventions. With the incidence of ADHD of 5%, ASD 1% and learning disability of 8%, the number of children who would benefit from timely identification and assessment of needs is considerable.

No single screening tool is yet available to identify those who are most likely to have a condition that could result in developmental disadvantage. Those involved in children’s lives, particularly in the early years, therefore need to have the necessary skills and competencies in child development to identify an at risk child, assess them appropriately and refer them into services where necessary. Family and parental circumstances, concerns and issues need to be recognised as part of managing children holistically.

6-8 Week Review

General practitioners and health visitors are jointly accountable for this assessment which incorporates a physical examination of eyes, heart, hips and testicles, weight, length and head circumference. Immunisations, feeding and parental wellbeing will also be discussed. Nationally
there are 5.5% of all potential 6-8 week reviews missing from the Child Health Surveillance Programme (CHSP) pre-school system.

Health Plan Indicator (HPI)

The HPI reflects the changing needs of the child and family as situations and circumstances change. The HPI is a snapshot of a moment in a child’s life and is an indicator for use by practitioners as a measure of the mutually agreed support for the child and family. An assessment of needs will determine whether support for the family in addition to universal services is required.

27-30 Month Review

This review is undertaken by health visitors and there is national interest in the uptake of the review, difficulties identified, outcomes recorded and numbers of children achieving their developmental milestones. The contact is also a stretch aim for the Early Years Collaborative. Key to improving uptake and recording of outcomes will be the assessment model and related use of formal validated assessment tools to better identify children with needs that would benefit from early and appropriate interventions.

Please note: Table 22 contains the number of first reviews and 6-8 reviews undertaken in Dumfries & Galloway.

Figures published by ISD Scotland for 2014/15 indicate that there were 1,426 children eligible for a 27-30 months review in that time\(^2\). Of these 1,358 (95.2%) received a review by a health visitor. Across Scotland the crude rate was 86.7%. Of the children reviewed, 1,059 (78.0%) had no “concerns” recorded, the remaining 20.0% had a least one “concern” recorded. The types of concerns included ‘social’, ‘emotional’, ‘behavioural’, ‘attention’, ‘speech, language & communication’, ‘gross motor’, ‘fine motor’, ‘vision’ and ‘hearing’. The most commonly recorded new concern was ‘speech, language & communication’ with 106 (10.6%) having this concern recorded at their review.

There is no consistency across Scotland in the tools used for these assessments; therefore it is not clear whether local figures can genuinely be comparable to the levels of developmental problems in children across the country. However, the commonest problems identified across Scotland, regardless of tools used are related to speech, language and communication.
Further assessment of children takes place in the pre-school setting (age 3-4 years) and also at school entry age 5 years. This ongoing assessment presents opportunities for incremental assessment of need and allows for the evaluation of interventions previously undertaken.

Recently a national refreshed Universal Health Visiting Pathway has been developed that presents a core home visiting programme to be offered to all families by health visitors as a minimum standard. It consists of 11 home visits to all families, three of which include a formal review of the family and child’s health by the health visitor (13-15 months, 27-30 months and prior to starting school). It covers the antenatal to pre-school period and provides an opportunity for health visitors, children and their parents to build a strong relationship, in which health visitors can appropriately support families including acting as a gateway to other services. This early engagement will provide health visitors with a sound foundation for their role as the named person for children under 5 years of age.

The Pathway is based on several underlying principles:

- Person-centredness
- Building strong relationships from pregnancy
- Offering support during the early weeks and planning future contacts with families
- Focusing on family strengths, while assessing and respectfully responding to their needs.
Additional supporting evidence which underpins the pathway will be published separately. The precise outcomes to be gathered at local and national level are still to be finalised. These outcomes will inform this work going forward and the national evaluation of the Pathway.


7.4 Nutrition & Healthy Weight

A healthy balanced diet is vital to long term health and the positive habits learned in childhood can last a lifetime. Following a life course approach the information in the next section describe nutrition & healthy weight amongst the Child and Young Person population of Dumfries & Galloway:

7.4.1 The Strategic and Policy Context

The Scottish Government is taking a range of actions to help Children and Young People gain the skills and knowledge they need to make healthier food choices.

Preventing Obesity and Overweight in Scotland Route Map (2010) and Action Plan (2011) makes a long-term commitment to tackling overweight and obesity. It sets out the factors that contribute to obesity, the scale of the problem, and the changes that are needed to our living environments in order to shift it from one that promotes weight gain to one that supports healthy choices and hence healthy weight. It recognises that obesity is not just a health issue – it is a consequence of our culture, society and lifestyle. The Route Map has an action plan which contains actions relating specifically to improving the diet of young people.223,224

Recipe for Success: Scotland’s National Food and Drink Policy (2009) aims to promote Scotland’s sustainable economic growth by ensuring our focus on food and drink addresses quality, health and wellbeing, and environmental sustainability, recognising the need for access and affordability. This policy underpins work on reformulation, assessment against the Scottish Dietary Goals, improving consumer awareness and exploring ways to constrain non-broadcast marketing of high fat, salt, sugar foods to children225.

The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 places a duty on schools and local authorities to ensure that health promotion is at the heart of a school’s activities. A school is health promoting if it provides activities and an environment which promotes the physical, social and mental and emotional health and wellbeing of pupils. This will help to ensure that our Children and Young People are taught about the importance of health and wellbeing in its widest sense. The ‘Nutritional Requirements for Food and Drink in Schools (Scotland) Regulations 2008’, introduced in June 2008, set high standards for food and drink provided in schools ensuring that pupils are offered healthy,
balanced and nutritious food at school, allowing them to try new foods and develop healthy eating habits from a young age. Supporting guidance was published in September 2008.\textsuperscript{226}

As part of the Health and Wellbeing curriculum in CfE, all Children and Young People will participate in practical, enjoyable food activities which will help build knowledge and learning about good food choices with the aim of understanding diet and developing lifelong healthy eating habits.

During 2015 the revised guidance on nutrition for early year's providers was published (Setting the Table: Nutritional Guidance and food standards for early year’s child providers in Scotland, NHS Health Scotland 2015). The guidance articulates the importance of the role of childcare providers (including Local Authority and private nurseries, family centres and childminders) in shaping the future eating patterns of Scotland’s young children. In affirming standards for the provision of food and offering practical examples, the guidance aims to make it easier for providers to understand the positive difference they can make to a child’s future health and wellbeing. The early years are widely recognised as a crucial time to reduce health inequalities, and the provision of healthy meals and snacks in childcare settings can be hugely influential, particularly for vulnerable families; as those children who attend full time placements may receive as much as 90% of their daily food (with part time attendees receiving as much as 40%) out with the home.

Scottish Government interventions/initiatives to support food and health policy for Children and Young People and ongoing in D&G include:

- Child Healthy Weight Intervention Programme
- The Healthier Scotland Cooking Bus
- Community Food and Health Scotland (e.g. Let’s Cook, Building Healthy Communities food and health initiatives)
- Healthy Living Award
- Healthy Living Programme
- Setting the Table
- Better Eating, Better Learning
- Beyond the School Gate

\textbf{7.4.2 The Evidence}

The Maternal and Infant Nutrition Framework for Action\textsuperscript{227} aims to improve maternal and infant nutrition in Scotland, recognising that the diet and nutritional status of the mother before conception and during pregnancy, the feeding received by the infant in the first few months of life, the process of weaning onto solid foods and the diet and nutrition status of the growing infant all contribute significantly to the long term health of the population.
Breastfeeding is indisputably the best nutrition for infants and is recommended exclusively for the first six months of life and then as part of a mixed nutritious diet up to two years of age and beyond. Good nutrition, particularly amongst 0-2 year olds provides strong foundations for the very young while a well balanced and nutritious diet ensures older children are less likely to be obese\textsuperscript{228, 229}. The major impacts from poor nutrition are generally not manifested until adulthood where the risk of heart disease, stroke and high blood pressure is higher.

Breast milk provides a complete source of nutrition for the first six months of life and contains a range of immunological substances that cannot be manufactured\textsuperscript{230, 231}. Breastfeeding reduces the incidence of infectious and respiratory illnesses, boosts children’s immune systems and helps protect both the mother and child from chronic conditions later in life. Breastfeeding also provides a positive psychological and emotional bond between the mother and child which has many benefits throughout the rest of the child's life. It therefore has a major role to play in promoting wellbeing and reducing health inequalities.

However, it is important that babies aged around six months are started on solid food, with the introduction of suitable foods in addition to breast milk or formula milk to establish a healthy and varied diet. This ensures that a diverse and nutritionally adequate diet is already in place when breast milk or formula milk is no longer given\textsuperscript{230}.

Eating well is a long term investment in health and wellbeing and habits formed in childhood have been shown to influence the risk of major chronic diseases in adulthood. Breakfast consumption is an important component of nutrition and as part of a healthy diet can positively impact children’s health and wellbeing.\textsuperscript{232} Omitting breakfast has long been understood to be associated with poor nutritional habits\textsuperscript{233} such as consumption of snacks and larger meal portions for the rest of the day.\textsuperscript{234} Overweight and obesity are also linked to poor eating habits.\textsuperscript{235} Conversely, eating breakfast daily is associated with healthy body weight, due to even distribution of calorie intake throughout the day.\textsuperscript{236}

Fruit and vegetable consumption are protective against a spectrum of major diseases such as cancers and heart disease and pupils who consume these once a day or more are more likely to meet physical activity guidelines than those who do not.\textsuperscript{237}

### 7.4.3 The Local Picture: Breastfeeding

Recent local breastfeeding data analysis has highlighted an increase in exclusive breastfeeding at birth from 55.2% in 2003/2004 to 57.5% in 2013/2014.\textsuperscript{238} However, there continues to be significant drop off in exclusive breastfeeding at the subsequent data collection points; 44.5% at hospital discharge; 32.9% at Health Visitor First Visit and 23.1% at 6-8 weeks review\textsuperscript{239}. Table 22 below shows that while exclusive breastfeeding rates are lower in Dumfries & Galloway at first health visitor visit than for Scotland, the drop-off at 6-8 weeks in 2015/16 was slightly better and has improved from a drop of around 10% to 6%.
Research and further analysis is required to better understand the drop off rates so that evidence based action to address this issue can be put in place. A local longitudinal research study has just been completed with antenatal and postnatal women that aimed to investigate, by qualitative methods, a comprehensive list of psychosocial factors that have not been previously examined in this way.

Local partnership activity, based on the Scottish Government Framework ‘Improving Maternal and Infant Nutrition: A Framework for Action’ (Scottish Government 2011), continues to be progressed. Specific examples of interventions include:

- An accredited region wide Breastfeeding Peer Support Programme which provides breastfeeding peer support on a one-to-one and group basis within antenatal and postnatal periods. Areas in which breastfeeding rates are known to be low are targeted. A total of 1091 notifications were received in the last financial year (2014/15). There are currently 34 Breastfeeding Peer Support volunteers across Dumfries & Galloway.
- The UNICEF UK Baby Friendly Initiative (BFI) continues to be implemented for both Maternity and Health Visiting Services. Maternity Services achieved Stage 3 (full) UNICEF UK BFI accreditation in February 2014 and Health Visiting Services achieved Stage 3 (full) accreditation in February 2015.
- A breast pump loan scheme was established in August 2013, assisting some of the most vulnerable babies in Dumfries & Galloway to receive breast milk either exclusively or as part of mixed feeds. The scheme was initially established in partnership with ‘Mum2mum Friends’, a local voluntary support network and is now managed through NHS Maternity Services. 136 mothers have been supported so far this financial year (2015/16).

The challenges of promoting breastfeeding with extensive lobbying from infant formula companies must be acknowledged. The wider obesogenic (obesity encouraging) environment is also challenging for pregnant and post natal women with considerable commercial pressure as weaning is commenced.

One of the ways that aims to ameliorate the impact of these influences is the provision of breastfeeding support via Facebook. This is a closed and closely moderated group where women can access support and information from the NHS Dumfries & Galloway Breastfeeding Support Service and other breastfeeding women. The group was established in September 2014 and there are currently 277 members. In addition, improvement methodology delivered through the Early Years Collaborative work is testing ways of providing better support for women in relation to infant feeding.

Table 22 and Figure 20 provide an overview of breastfeeding statistics for Dumfries & Galloway. Nationally, only breastfeeding status at first visit and 6-8 week review is reported. This is what is included in Table 22. Locally available data used in Figure 20 also indicates what mother’s breastfeeding status at birth and hospital discharge.
### Table 22: Breast Feeding at First Visit and 6-8 week review by Year of Birth; Dumfries & Galloway

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dumfries &amp; Galloway</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of reviews</td>
<td>1,451</td>
<td>1,399</td>
<td>1,378</td>
<td>1,355</td>
<td>1,265</td>
<td>1,211</td>
<td>1,282</td>
</tr>
<tr>
<td>% Breastfed¹</td>
<td>43.3</td>
<td>42.0</td>
<td>44.0</td>
<td>41.9</td>
<td>43.1</td>
<td>41.0</td>
<td>39.0</td>
</tr>
<tr>
<td>% Exclusively breastfed</td>
<td>32.9</td>
<td>33.2</td>
<td>34.5</td>
<td>31.5</td>
<td>33.0</td>
<td>31.8</td>
<td>29.6</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of reviews</td>
<td>50,902</td>
<td>54,946</td>
<td>56,800</td>
<td>55,602</td>
<td>54,592</td>
<td>54,604</td>
<td>53,572</td>
</tr>
<tr>
<td>% Breastfed¹</td>
<td>45.7</td>
<td>46.9</td>
<td>47.0</td>
<td>47.2</td>
<td>48.4</td>
<td>48.3</td>
<td>49.3</td>
</tr>
<tr>
<td>% Exclusively breastfed</td>
<td>36.3</td>
<td>36.4</td>
<td>35.9</td>
<td>35.2</td>
<td>35.4</td>
<td>35.2</td>
<td>35.6</td>
</tr>
</tbody>
</table>

Source: ISD Scotland240

¹ Includes mixed breast and formula fed

### Figure 20: Exclusive Breastfeeding at Birth, Hospital discharge, first visit and 6-8 week review by Scottish Index of Multiple Deprivation (SIMD) 2012 local quintiles; Dumfries & Galloway; Year of Birth 2013/14

Source: Health Intelligence Unit, CHSP-PS Aug 2014

In the Figure 20, the drop-off in breastfeeding rates between birth and 6-8 week review is clearly evident. This chart also clearly highlights the inequalities gap between the most and least deprived areas of Dumfries & Galloway. There is a clear deprivation gradient in breastfeeding rates, with 41%...
of mothers exclusively breastfeeding at birth in the most deprived areas compared to 63% of mothers in the least deprived areas. At 6-8 weeks the percentages dropped to 15% of mothers exclusively breastfeeding in the most deprived areas compared to 25% in the least deprived areas.

**Birthweight**

Please note: a description of birthweight by deprivation is provided in Section 9.1.

Table 23 summarises the proportion of babies by category of birthweight and gestational age since 2009 to 2015. The proportion of babies who have a healthy birthweight in Dumfries & Galloway in 2015 was 91.4%. This is marginally higher than the national Scottish rate at 90.0%. There was a lower proportion of babies with a low birth rate in Dumfries & Galloway (2.6%, approximately 31 babies) compared to Scotland (2.9%) and the proportion of babies with a heavy birthweight was also lower in Dumfries & Galloway (5.9%, approximately 70 babies) compared to Scotland (7.1%) The proportion of babies with a healthy birthweight has remained fairly constant over the past 7 years.

**Early Years**

There are expectations set out for pre-school providers, schools and their partners regarding food and health education within **Setting the Table, Better Eating Better Learning, and Beyond the School Gate**. A range of actions are being taken forward:

**Beyond the School Gate** and **Better Eating Better Learning Self-Evaluation** has been completed by the Education Services. Schools are being encouraged to utilise the Better Eating Better Learning self-evaluation tool to inform planning.

It is recognised that it would be beneficial to build more consistent approaches across Dumfries & Galloway. Therefore a resource providing information and advice to support improved skills and outcomes in food and health education is under development; also linking this work to healthy weight and oral health. This work will include the delivery of training and support in implementation of the **Nutritional Guidance for Early Years Providers** locally, during 2015/16. Implementation of the guidance will:

- Champion the importance of a well-balanced diet and positive choices with children and parents
- Assist providers to work with families who face the biggest challenges in providing a healthy diet for their children
- Highlight the importance of food as a tool for social development and learning
7. Healthy

Table 23: Percentage of babies by birthweight category (appropriate to gestational age\(^3\)); Dumfries & Galloway and Scotland; 2009 – 2015

<table>
<thead>
<tr>
<th>Gestation (wks)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low: Under 5th percentile</strong>(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-31</td>
<td>7.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>32-36</td>
<td>3.0</td>
<td>1.5</td>
<td>6.1</td>
<td>0.0</td>
<td>3.5</td>
<td>0.0</td>
<td>8.7</td>
</tr>
<tr>
<td>37-41</td>
<td>2.0</td>
<td>3.1</td>
<td>3.0</td>
<td>2.1</td>
<td>3.4</td>
<td>2.2</td>
<td>2.4</td>
</tr>
<tr>
<td>42+</td>
<td>11.1</td>
<td>3.7</td>
<td>0.0</td>
<td>9.1</td>
<td>15.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>2.2</td>
<td>3.0</td>
<td>3.1</td>
<td>2.1</td>
<td>3.5</td>
<td>2.0</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Healthy: Between 5th and 95th percentiles</strong>(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-31</td>
<td>84.6</td>
<td>71.4</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>77.8</td>
<td>100.0</td>
</tr>
<tr>
<td>32-36</td>
<td>87.9</td>
<td>87.9</td>
<td>84.8</td>
<td>95.7</td>
<td>89.5</td>
<td>89.4</td>
<td>91.3</td>
</tr>
<tr>
<td>37-41</td>
<td>89.6</td>
<td>89.3</td>
<td>87.9</td>
<td>89.8</td>
<td>89.1</td>
<td>91.1</td>
<td>91.3</td>
</tr>
<tr>
<td>42+</td>
<td>88.9</td>
<td>96.3</td>
<td>85.7</td>
<td>90.9</td>
<td>84.6</td>
<td>100.0</td>
<td>91.7</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>89.5</td>
<td>89.3</td>
<td>87.8</td>
<td>90.1</td>
<td>89.1</td>
<td>91.1</td>
<td>91.4</td>
</tr>
<tr>
<td><strong>Large: Over 95th percentile</strong>(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-31</td>
<td>7.7</td>
<td>28.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>22.2</td>
<td>0.0</td>
</tr>
<tr>
<td>32-36</td>
<td>9.1</td>
<td>10.6</td>
<td>9.1</td>
<td>4.3</td>
<td>7.0</td>
<td>10.6</td>
<td>0.0</td>
</tr>
<tr>
<td>37-41</td>
<td>8.4</td>
<td>7.6</td>
<td>9.0</td>
<td>8.2</td>
<td>7.6</td>
<td>6.7</td>
<td>6.2</td>
</tr>
<tr>
<td>42+</td>
<td>0.0</td>
<td>0.0</td>
<td>14.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>8.3</td>
<td>7.7</td>
<td>9.1</td>
<td>7.8</td>
<td>7.4</td>
<td>6.9</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Source: ISD Scotland, SMR02\(^{244}\) (www.isdscotland.org/Health-Topics/Maternity-and-Births/Births/)

1 - Centiles for Birthweight Charts for Gestational Age for Scottish Singleton Births, Sandra Bonnellie et al, BMC Pregnancy & Child Birth 2008

In order to match to the birthweight charts cases with unknown gestation, birthweight & parity were excluded as were cases with estimated gestation outwith the range 24-43 weeks & undetermined gender.

2 - Excludes home births, births at non-NHS hospitals & multiple births.

3 - Scotland data includes births where NHS board of residence is unknown or outside Scotland.

4 - Some numbers for NHS Boards may be quite small when broken down by gestational group and the resulting percentages may show large fluctuations from year to year.

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Machars School Cluster is working in partnership with Education Scotland to lead a specific Better Eating Better Learning pilot. As part of this, two Primary schools plan to take forward a Developing Healthy School Communities programme in conjunction with local partners.
Child Healthy Weight Programme (age 2-15 years)

Measurement of body weight is collected as part of routine health checks throughout a child’s life. Poor nutritional intake can result in under- or overweight children and obesity can lead to physical and mental health problems, such as heart disease, diabetes, cancers, low self-esteem and depression.

Body Mass Index surveillance data for all Primary 1 children in Scotland shows stable rates for overweight and obesity over the last 10 years at 21-23%. Data for children of all ages shows rates of overweight and obesity at approximately 32%, with stable rates in girls but rising rates in boys. The prevalence of female overweight and obesity in Scotland in 2011 was 60% and has been relatively stable since 2008 (Scottish Health Survey).

Scottish Government set a national target to reduce the rate of increase in the proportion of children outwith the healthy weight range by 2018. This was underpinned by an NHS HEAT target until 2014 for the provision of child health weight programmes incorporating diet, physical activity and behaviour change components and with an emphasis on involving parents and carers as well as children themselves.

In Dumfries & Galloway, the Child Healthy Weight Service, “Go4It!” (2008-2014) has developed a generic model, offering a person-centred, outcome focused approach to working with children and families, providing support for realistic and sustainable behaviour change. Both one to one and group sessions continue to be offered in each locality. These options are available and agreed based on need.

Multi-disciplinary and multi-agency working has increased, resulting in an expansion of agencies and teams linking to the service and supporting changes in behaviour. Examples include the Education Service undertaking joint projects and also the community based Let’s Cook project which builds cooking skills within families. Work is ongoing with partners that provide services for the most vulnerable children and families, for example Aberlour and CAMHS, in order to extend the reach of the service.

There is some variation in the additional support being offered across our four localities and these are in response to variation of local circumstances. They include for example:

- flexible length of involvement in the programme
- provision of free transport to 1:1 or group sessions
- provision of free exercise clubs/groups
Following completion of the HEAT target for Child Healthy Weight, a local target of 93 interventions was set and 111 were completed. 52% of those individuals who have completed interventions live in SIMD quintile areas 1 or 2, a further 23% in quintile 3, 19% in quintile 4 and the remaining 6% are in quintile 5 areas. The referral and service pathway developed during the HEAT target phase from 2008-2014 has been retained. The local record keeping and reporting set up to monitor progress against the HEAT target have continued, with the exception of entering data into the Child Health Surveillance Programme.

Please note: There are two sets of thresholds currently used in Scotland to identify children in different weight categories: epidemiological thresholds and clinical thresholds.\(^{243}\) Epidemiological thresholds are used to define children at risk of under- or overweight and are used primarily to assess the health of the whole child population and monitor the changes in the proportion of children at risk of unhealthy weight that have been seen in Scotland over recent years. Clinical thresholds are used to define children with a level of under- or overweight that may warrant clinical intervention, such as consideration of any underlying cause, advice on healthy eating and appropriate levels of physical activity, or referral to more intensive child healthy weight services.

Table 24: BMI Distribution of Primary 1 School Children by Epidemiological and Clinical categories; Dumfries & Galloway; 2014/15

<table>
<thead>
<tr>
<th>BMI Centile</th>
<th>Number of children measured</th>
<th>Underweight</th>
<th>Healthy weight</th>
<th>Overweight</th>
<th>Obesity</th>
<th>Overweight &amp; obesity combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;=2nd</td>
<td>2nd - 85th</td>
<td>85th - 95th</td>
<td>&gt;=95th</td>
<td>&gt;=85th</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>1,424</td>
<td>0.1%</td>
<td>73.9%</td>
<td>14.4%</td>
<td>11.6%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Scotland</td>
<td>54,761</td>
<td>1.1%</td>
<td>77.1%</td>
<td>12.0%</td>
<td>9.8%</td>
<td>21.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;=0.4th</td>
<td>0.4th - 91st</td>
<td>91st - 99th</td>
<td>99th - 99.6th</td>
<td>&gt;=99.6</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td></td>
<td>-</td>
<td>82.4%</td>
<td>10.5%</td>
<td>4.3%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td>0.3%</td>
<td>84.8%</td>
<td>8.7%</td>
<td>3.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ISD Scotland; Primary 1 Body Mass Index (BMI) Statistics\(^{244}\)

In 2014/15 using the epidemiological thresholds, in Dumfries & Galloway 26.0% of Primary 1 children were at risk of being overweight or obese. Using the clinical thresholds, in Dumfries & Galloway 17.7% of primary 1 children are already overweight, obese or severely obese. In both cases these figures are significantly higher than the national Scottish rate (21.8% and 14.9% respectively). Figure 21 illustrates that the proportion of primary 1 children who are overweight or heavier has consistently been higher in Dumfries & Galloway compared to Scotland since 2006/07. Although there is some variation from year to year, the proportion of children who are overweight or heavier appears to remain fairly constant over time.
Figure 21: Percentage of Primary 1 School Children recorded as Overweight, Obese or Severely Obese by epidemiological (“at risk...”) and clinical categories; Dumfries & Galloway; 2004/05 to 2013/14

[Graph showing percentage of children over different years and regions]

Source: ISD Scotland; Primary 1 Body Mass Index (BMI) Statistics

Health Behaviours of School Children 2015 survey

The Health Behaviours of School Children (HBSC) 2015 survey asked 11 to 15 year olds about their eating habits and weight control.

Please note: Results from the HBSC 2015 survey relating to physical activity can be found in Section 10.

Over a half (55%) of young people in Dumfries & Galloway in 2014 reported having a family evening meal with parents on every day. This is significantly higher than for Scotland where this figure was 50%. The proportion eating a daily family meal declines with age from 63% of 11 year olds to 48% of 15 year olds. Five percent of 11 year olds, 6% of 13 year olds and 11% of 15 year olds in the region reported never having a family meal.

Nearly two-thirds (63%) of pupils eat breakfast every morning on school days. The proportion eating breakfast on school days declines with age with significantly less 13 year old girls eating breakfast every day compared with boys at this age. Over the last 12 years in Scotland there has been a persistent gender difference with girls less likely to eat breakfast every day on school days compared with boys.
By far the majority of 11 year olds (97%) eat lunch in school either by way of a school lunch or packed lunch. For secondary pupils however the most common option is for pupils to buy food outside of school at lunchtimes (59% and 49% respectively for 13 and 15 year olds).

Table 25: Type of lunch eaten by pupils on school days, Dumfries & Galloway, 2014.

<table>
<thead>
<tr>
<th>Lunch type</th>
<th>11 year olds</th>
<th>13 year olds</th>
<th>15 year olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>School lunches</td>
<td>57%</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td>Packed lunch</td>
<td>40%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Go home</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Buy lunch outside</td>
<td>0%</td>
<td>47%</td>
<td>59%</td>
</tr>
<tr>
<td>Don't eat lunch</td>
<td>0%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

Over a third of young people eat fruit daily (34%) and vegetables daily (38%) in Dumfries & Galloway. There is a decline in the proportion eating fruit daily with age, though the decline in proportions eating vegetables daily is less pronounced. For 11 year olds a greater proportion of girls are more likely to eat daily fruit and vegetables than boys. Daily consumption of sweets (30%), crisps (18%) and chips (9%) is similar between boys and girls. Daily consumption of soft drinks increases with age from 14% of 11 year old pupils to 26% of 15 year olds.
Figure 23: Proportion reporting daily consumption of fruit, vegetables and coke or other soft drinks, Dumfries & Galloway, 2014

Source: Health Behaviours of School Children 2015

Compared with Scotland the proportion reporting daily consumption of fruit was significantly lower in Dumfries & Galloway, as was consumption of sweets. Daily consumption of other items was similar in the region compared with Scotland with no other significant differences.

Figure 24: Proportion reporting daily consumption of various food and drink items, Dumfries & Galloway and Scotland, 2014.

Source: Health Behaviours of School Children 2015

Across Scotland there has been an increase in the proportion of both boys and girls eating daily fruit and vegetables since 2002. Daily sweet consumption declined between 2002 and 2010 but was slightly higher again in 2014 although was still lower than the 2002 position. The proportion of both boys and girls reporting daily consumption of both crisps and chips in 2014 is around half of that reported in 2002. The proportion drinking daily coke or other soft drinks is less than in 2006.
Table 26: Proportion reporting the daily consumption of various food and drink items for boys and girls in Scotland, 2002 and 2014 comparison only (2006 vs 2014 for soft drinks).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit</td>
<td>36%</td>
<td>42%</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td>Vegetables</td>
<td>36%</td>
<td>42%</td>
<td>30%</td>
<td>34%</td>
</tr>
<tr>
<td>Sweets</td>
<td>47%</td>
<td>33%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Crisps</td>
<td>40%</td>
<td>17%</td>
<td>40%</td>
<td>17%</td>
</tr>
<tr>
<td>Chips</td>
<td>22%</td>
<td>10%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Soft drinks</td>
<td>32% (2006)</td>
<td>27%</td>
<td>25% (2006)</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

In Dumfries & Galloway girls were overall twice as likely as boys to be on a current diet (18% girls v 9% boys) with 13 year old girls more likely to be trying to lose weight compared with 11 year old girls. Across Scotland there has been little change between 2002 and 2014 in the proportion of boys or girls who were trying to lose weight.

Figure 25: Proportion of young people who are currently trying to lose weight, Dumfries & Galloway, 2014.

Overall 33% of young people in the region, 23% of boys and 44% of girls considered that they were too fat. The proportion increased with age for both boys and girls but was always greater amongst girls than boys. In Scotland overweight perceptions since 1990 amongst girls peaked at 48% in 1998 and fell to 41% in 2014. The proportion of boys who considered themselves too fat increased from 20% in 1990 to 25% in 2014.
Figure 26: Proportion of young people in Dumfries & Galloway who report that their body was too fat, 2014.

Self reported height and weight were used to calculate a Body Mass Index (BMI) and although a valid height and weight was not provided by all respondents survey data was presented for 15 year olds. Two thirds (67%) of 15 year olds in the region were classified as having normal weight, using standard BMI cut-offs for children and adolescents. Nineteen percent were considered to be overweight or obese and 15% underweight. The proportion classified as overweight or obese in Dumfries & Galloway 15 year olds was significantly higher than Scotland where this figure was 14%.

Table 27: Weight in 15 year olds based on BMI classification groupings, Dumfries & Galloway, 2014

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>14%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Normal weight</td>
<td>64%</td>
<td>71%</td>
<td>67%</td>
</tr>
<tr>
<td>Overweight</td>
<td>19%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Obese</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Overall 18% of 13 and 15 year olds in Dumfries & Galloway considered that they were quite or very good looking. This was significantly lower than the figure for Scotland (22%). Boys were more likely than girls to believe that they are very good looking or quite good looking at both 13 years (28% vs 12%) and 15 years (23% vs 9%).

Across Scotland in HBSC surveys between 1990 and 2014, boys have always reported their looks more favourably than girls. Since 2006, the proportion of boys reporting good looks has remained consistent; however girls have become increasingly less likely to report good looks over this period. As such, the gender gap in perceived looks is now at its widest in the past 24 years (boys 32%, girls 12%).
7.5  Mental Health

The importance of enabling and supporting mental health in infancy is now indisputable. The foundations for health and wellbeing are laid down from the earliest moments of pre-birth life and the early years’ experiences of nurturing and attachment that a baby receives will have a huge influence on that infant’s ability to develop emotional, social and cognitive skills necessary throughout its life. The need to promote good infant mental health is crucial to ensure that the Scottish Government’s vision for all children to be confident individuals, effective contributors, successful learners and responsible citizens is met.

Mental health is a continuum that combines both mental wellbeing (the combination of feeling good in terms of emotions and life satisfaction and functioning effectively such as self-acceptance, positive relationships, purpose in life and autonomy) and mental illness; diagnosed conditions such as depression, anxiety (sometimes referred to as common mental health problems) as well as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness). In addition, mental disorder is defined as a diagnosis of mental illness, a learning disability or personality disorder.

7.5.1  The Strategic and Policy Context

The Mental Health Strategy for Scotland: 2012-2015\(^\text{245}\) identified Child and Adolescent Mental Health as one of four ‘Key Change Areas’. The commitments set out within the strategy focus on improving both short and long term mental health outcomes from infancy. The strategy supports and adopts the three Quality Ambitions for Scotland; that health and care is person-centred, safe and effective.

In addition, the Strategy builds on ongoing work with Child and Adolescent Mental Health Services (CAMHS) and a range of other initiatives including the publication of standards for integrated care pathways for child and adolescent mental health services\(^\text{246}\) and the publication of Mental Health Indicators for Children and Young People.\(^\text{247}\)

The health and wellbeing outcomes in Curriculum for Excellence are supported by the delivery of Relationship, Sexual Health and Parenthood (RSHP) education to all young people; therefore providing the opportunity for linkages with other health improvement issues and risk-taking behaviours such as alcohol and drug misuse, smoking, and mental health. In addition, “See me”, the national campaign against the stigma surrounding mental ill health, has produced a Children and Young People resource pack aimed at 13-15 year olds\(^\text{248}\) designed to support the health and wellbeing outcomes in CfE.
7.5.2 The Evidence

Mental health is now generally considered to consist of two dimensions, mental health problems and mental wellbeing. Good mental health therefore is deemed to be more than the absence of mental health problems and the growing recognition of mental wellbeing has generated increased interest in developing indicators for measurement.\(^{249}\)

A 2004 UK survey\(^ {250}\) found one in ten children between the ages of 5 and 16 years to have a clinically diagnosed mental health disorder. Estimates vary, but research suggests that 20% of children have a mental health problem in any given year, and about 10% at any one time.\(^ {251}\) Rates of mental health problems among children also increase as they reach adolescence. Some groups of Children and Young People are particularly at greater risk of having mental health difficulties, notably Looked After Children and Young People, those with Learning Disabilities, Young Carers, those experiencing conflict at home, refugees and those from minority groups such as gypsy travellers.

However, there are no readily accessible figures to demonstrate the need or numbers of infants who are vulnerable to poor mental health. Risk factors can be considered as those related to the infant, those related to the infant and influenced by parental approaches and those related to the external environment. There are clear opportunities to identify and assess vulnerability through the child health surveillance programme core contacts as discussed in the universal service provision section of this report.

Opportunities to improve mental health and wellbeing continue into childhood and adolescence across all settings and require:

- Recognition of the ways in which the lives of family members are linked and the intergenerational impact of life circumstances
- Development of a co-production approach to health promotion, encouraging service users to become partners in service provision and development.
- Utilisation of asset based approaches where individuals, settings and communities identify and use the assets and skills they have
- Interventions that support Children and Young People’s sense of personal competence for making life choices
- An awareness of the unique systems of support developed by members of various cultural groups, and encouragement of the use of those supports in times of vulnerability or crisis

The extensive inequalities across a wide range of mental health outcome indicators demonstrates the need for both targeted and population wide strategies to ensure more equal opportunities and outcomes between genders, ages and socio-economic groups.\(^ {252}\)
7.5.3  The Local Picture

Community Adolescent Mental Health Services (CAMHS)

The Health Advisory Service in their report *Together We Stand* used the following tiered Model to describe Child and Adolescent Mental Health Services.

**TIER 1** Primary / direct contact services such as GPs, Health Visitors, School Health Nurses, Teachers and Social Workers

**TIER 2** Early interventions for mild / moderate problems. Consultation and support to Tier 1 provided by Primary Mental Health Workers

**TIER 3** Assessment and treatment provided by specialist staff for complex problems

**TIER 4** Very specialist treatment and care often requiring spells of inpatient care

Tiers 2-4 are provided by the Child and Adolescent Mental Health Service (CAMHS), while Tier 1 is provided by the universal services.

Primary mental health workers (PMHWs) come from various professional backgrounds (e.g. mental health nursing, social work, paediatric nursing, allied health professionals). They provide consultation and training about child and adolescent mental health and take on cases directly where focussed, targeted, therapeutic intervention at an early stage is likely to have a long-term benefit to the mental welfare of the young person or their family. They take referrals from a wide range of sources including schools, GPs, health visitors, police and social work. PMHWs are able to refer Children and Young People on to more specialist services as required.

CAMHS are part of the Women, Children’s and Sexual Health Directorate, and include the Community Intensive Treatment Service and Young People's Substance Misuse Service (CAMHS, CITS and ISSU18) which provide the following range of services:

- An outpatient and community service for all Children and Young People (up to 18 years of age) with mental health needs
- Acute assessments of and ongoing treatment in relation to mental ill health within the children’s ward, adult medical wards and Midpark Hospital, as needed for people up to 18 years of age
- A Children and Young People’s substance misuse service working with young people who misuse drugs or alcohol or who are affected by living with carers who misuse drugs and /or alcohol
- Supporting young people and their families when young people are admitted to either of the two regional psychiatric units in Glasgow
Referral rates have gradually increased and during 2014 passed 1000 new referrals plus support for ongoing clients. This is in keeping with the national trend for an increase in referrals to CAMHS services. Also the development of Community Intensive Treatment Services for young people at Tier 4 means future developments will include the need for development of local day services.

**Child Psychology Services**

The Child Clinical Psychology Service is made up of Consultants, Clinical Psychologists and Psychological Therapists offering a skill-mix approach to psychological therapies for Children and Young People from 0 to 18 years. Increased funding since 2008 from the Scottish Government and NHS Dumfries & Galloway has increased staffing from 1.8 wte to 7.7 wte. This has significantly increased access to psychological therapies for children, young people and their families in Dumfries & Galloway. The skill-mix approach allows us to offer intervention for mild to moderate difficulties at an early stage whilst allowing more senior clinicians to work with more complex and severe cases such as complex trauma, abuse and severe cases of depression and anxiety.

There are three specialist sub-teams offering psychological interventions to young people with long-term physical health conditions, to those Looked after and to those with neurodevelopmental difficulties. The team offer advice to other professionals within the NHS, local authority and third sector to increase the psychological knowledge of the broader workforce working with Children and Young People and their families. Staff are trained in evidence-based psychological therapies such as CBT (cognitive behavioural therapy), IPT (interpersonal psychotherapy), DDP (dynamic deconstructive psychotherapy) and ACT (acceptance and commitment therapy). We have therapists who are accredited and working towards accreditation in all of these therapies. We offer supervision to others who use these models and we offer training for those wanting to start. Training and supervising non-psychologists in the wider workforce increases access to psychological knowledge whilst allowing this specialist team to reduce waiting times.

We work closely with our colleagues in adult services both in relation to young people in transition but also in relation to the impact of parental issues on the wellbeing of young people in our region.

The total number of referrals in 2014/15 to Child and Adolescent Mental Health Services (CAHMS) in Dumfries & Galloway was 1,092. The total number of referrals less those rejected was 879. Figure 27 depicts the referral rate per 1,000 people aged under 18 years to CAHMS for Dumfries & Galloway compared to Scotland. The referral rate in Dumfries & Galloway is consistently higher than that of Scotland.

**Please note:** It is not possible to give a direct comparison of referral rates across NHS Boards as CAMHS services vary in the age of population served. Some areas provide services for all those under 18, while others offer services to those over 16 only if they are in full time education. The ‘referrals per 1,000 people under 18’ gives an indication of the relative differences in demand.
7. Healthy

Figure 27: Referrals to Child and Adolescent Mental Health Services; Dumfries & Galloway; 2013/14 – 2014/15

Source: ISD CAMHS Waiting Times database

Figure 28 depicts both the percentage of children who were referred to CAHMS and seen within 18 weeks and the median number of weeks waited in each financial quarter. Table 28 summarises the number of CAMHS appointments attended by locality (including consultant, mental health worker and support mental health worker appointments).

Figure 28: Percentage of children referred to CAHMS seen within 18 weeks of referrals and the median number of weeks waited by children referred; Dumfries & Galloway; 2013/14 - 2015/16

Source: ISD CAMHS Waiting Times database
### Table 28: CAHMS outpatient appointments by locality; Dumfries & Galloway; 2014/15

<table>
<thead>
<tr>
<th>All Clinics</th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Out with Area / Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>162</td>
<td>289</td>
<td>91</td>
<td>117</td>
<td>*</td>
<td>659</td>
</tr>
<tr>
<td>Return</td>
<td>1369</td>
<td>2383</td>
<td>626</td>
<td>1017</td>
<td>8</td>
<td>5403</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1531</strong></td>
<td><strong>2672</strong></td>
<td><strong>717</strong></td>
<td><strong>1134</strong></td>
<td><strong>8</strong></td>
<td><strong>6062</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISSU (18 clinics only)</th>
<th>New</th>
<th>Return</th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>17</td>
<td>150</td>
<td><strong>167</strong></td>
</tr>
<tr>
<td>Return</td>
<td>30</td>
<td>310</td>
<td><strong>340</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>167</strong></td>
<td><strong>340</strong></td>
<td><strong>507</strong></td>
</tr>
</tbody>
</table>

Source: Qlikview Outpatients; NHS Dumfries & Galloway

* Suppressed for non-disclosure

### Table 29: Mental health admissions (number of children) to adult wards and children & adolescent units; Dumfries & Galloway; 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult Ward</th>
<th>Child &amp; Adolescent Unit</th>
<th>Total</th>
<th>Under 18 Population</th>
<th>Adult ward admissions per 100,000</th>
<th>Child &amp; Adolescent unit admissions per 100,000</th>
<th>Total admissions per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>2009-10</td>
<td>10</td>
<td>≤5</td>
<td>10</td>
<td>28,558</td>
<td>≤8</td>
<td>35.0</td>
</tr>
<tr>
<td></td>
<td>2010-11</td>
<td>10</td>
<td>≤5</td>
<td>10</td>
<td>28,153</td>
<td>≤8</td>
<td>35.5</td>
</tr>
<tr>
<td></td>
<td>2011-12</td>
<td>8</td>
<td>≤5</td>
<td>8</td>
<td>28,907</td>
<td>≤8</td>
<td>27.7</td>
</tr>
<tr>
<td></td>
<td>2012-13</td>
<td>12</td>
<td>≤5</td>
<td>12</td>
<td>28,253</td>
<td>≤8</td>
<td>42.5</td>
</tr>
<tr>
<td></td>
<td>2013-14</td>
<td>21</td>
<td>≤5</td>
<td>21</td>
<td>27,737</td>
<td>≤8</td>
<td>75.7</td>
</tr>
</tbody>
</table>

Scotland

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult Ward</th>
<th>Child &amp; Adolescent Unit</th>
<th>Total</th>
<th>Under 18 Population</th>
<th>Adult ward admissions per 100,000</th>
<th>Child &amp; Adolescent unit admissions per 100,000</th>
<th>Total admissions per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>219</td>
<td>142</td>
<td>361</td>
<td>1,042,147</td>
<td>21.0</td>
<td>13.6</td>
<td>34.6</td>
</tr>
<tr>
<td>2010-11</td>
<td>208</td>
<td>158</td>
<td>366</td>
<td>1,037,839</td>
<td>20.0</td>
<td>15.2</td>
<td>35.3</td>
</tr>
<tr>
<td>2011-12</td>
<td>165</td>
<td>198</td>
<td>363</td>
<td>1,042,058</td>
<td>15.8</td>
<td>19.0</td>
<td>34.8</td>
</tr>
<tr>
<td>2012-13</td>
<td>203</td>
<td>228</td>
<td>431</td>
<td>1,038,464</td>
<td>19.5</td>
<td>22.0</td>
<td>41.5</td>
</tr>
<tr>
<td>2013-14</td>
<td>233</td>
<td>241</td>
<td>474</td>
<td>1,035,394</td>
<td>22.5</td>
<td>23.3</td>
<td>45.8</td>
</tr>
</tbody>
</table>

Source: ISD Scotland; CAHMS Benchmarking Toolkit (www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/Child-and-Adolescent-Mental-Health/)

Table 29 and Table 29 summarise the number of children admitted to hospital for mental health reasons and the number of associated bed days. In Dumfries & Galloway the rate of admission has risen in the past 2 years. The rate of admission across Scotland has also risen but not by as much.

Table 31 summarises the number of referrals made to Psychological Services for children between 2011/12 and 2014/15. There does not appear to be a consistent trend from year to year however, 2014/15 saw the greatest number of referrals across the region (502 referrals).
Table 30: Bed days for mental health admissions to adult and children & adolescent units; Dumfries & Galloway; 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult Ward</th>
<th>Child &amp; Adolescent Unit</th>
<th>Total</th>
<th>Under 18 Population</th>
<th>Adult ward bed days per 100,000</th>
<th>Child &amp; Adolescent unit admissions per 100,000</th>
<th>Total bed days per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>2009-10</td>
<td>78</td>
<td>530</td>
<td>608</td>
<td>28,558</td>
<td>273.1</td>
<td>1,855.9</td>
</tr>
<tr>
<td></td>
<td>2010-11</td>
<td>158</td>
<td>397</td>
<td>555</td>
<td>28,153</td>
<td>561.2</td>
<td>1,410.2</td>
</tr>
<tr>
<td></td>
<td>2011-12</td>
<td>25</td>
<td>47</td>
<td>72</td>
<td>28,907</td>
<td>86.5</td>
<td>162.6</td>
</tr>
<tr>
<td></td>
<td>2012-13</td>
<td>201</td>
<td>238</td>
<td>439</td>
<td>28,253</td>
<td>711.4</td>
<td>842.4</td>
</tr>
<tr>
<td></td>
<td>2013-14</td>
<td>106</td>
<td>181</td>
<td>287</td>
<td>27,737</td>
<td>382.2</td>
<td>652.6</td>
</tr>
<tr>
<td>Scotland</td>
<td>2009-10</td>
<td>4,027</td>
<td>10,096</td>
<td>14,123</td>
<td>1,042,147</td>
<td>386.4</td>
<td>968.8</td>
</tr>
<tr>
<td></td>
<td>2010-11</td>
<td>5,922</td>
<td>13,527</td>
<td>19,449</td>
<td>1,037,839</td>
<td>570.6</td>
<td>1,303.4</td>
</tr>
<tr>
<td></td>
<td>2011-12</td>
<td>2,723</td>
<td>16,583</td>
<td>19,306</td>
<td>1,042,058</td>
<td>261.3</td>
<td>1,591.4</td>
</tr>
<tr>
<td></td>
<td>2012-13</td>
<td>5,107</td>
<td>15,568</td>
<td>20,675</td>
<td>1,038,464</td>
<td>491.8</td>
<td>1,499.1</td>
</tr>
<tr>
<td></td>
<td>2013-14</td>
<td>3,429</td>
<td>15,871</td>
<td>19,300</td>
<td>1,035,394</td>
<td>331.2</td>
<td>1,532.8</td>
</tr>
</tbody>
</table>

Source: ISD Scotland; CAHMS Benchmarking Toolkit (www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/Child-and-Adolescent-Mental-Health/)

Table 31: Referrals to Psychological Services for children by age group and locality; Dumfries & Galloway; 2011-12 - 2014/15

<table>
<thead>
<tr>
<th>Year</th>
<th>Age Group</th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>0-3</td>
<td>*</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>4-11</td>
<td>37</td>
<td>72</td>
<td>24</td>
<td>27</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>69</td>
<td>114</td>
<td>21</td>
<td>60</td>
<td>264</td>
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<tr>
<td></td>
<td>Total</td>
<td>111</td>
<td>197</td>
<td>53</td>
<td>89</td>
<td>450</td>
</tr>
<tr>
<td>2012-13</td>
<td>0-3</td>
<td>*</td>
<td>12</td>
<td>*</td>
<td>*</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>4-11</td>
<td>24</td>
<td>63</td>
<td>13</td>
<td>25</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>48</td>
<td>102</td>
<td>36</td>
<td>51</td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>76</td>
<td>177</td>
<td>50</td>
<td>81</td>
<td>384</td>
</tr>
<tr>
<td>2013-14</td>
<td>0-3</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>4-11</td>
<td>29</td>
<td>72</td>
<td>26</td>
<td>28</td>
<td>155</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>55</td>
<td>123</td>
<td>26</td>
<td>49</td>
<td>253</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>86</td>
<td>202</td>
<td>53</td>
<td>79</td>
<td>420</td>
</tr>
<tr>
<td>2014-15</td>
<td>0-3</td>
<td>*</td>
<td>18</td>
<td>*</td>
<td>*</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>4-11</td>
<td>44</td>
<td>83</td>
<td>26</td>
<td>32</td>
<td>185</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>75</td>
<td>142</td>
<td>31</td>
<td>38</td>
<td>286</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>121</td>
<td>243</td>
<td>62</td>
<td>76</td>
<td>502</td>
</tr>
</tbody>
</table>

Source: Psychology department; NHS Dumfries & Galloway

Locally generated figures indicate that 63 admissions were made in 2013/14 by children aged 12 – 18 years for self harm.

Educational Psychology Services

Educational Psychology services are provided by Dumfries & Galloway Council and offer support to Children and Young People from 0-24 years of age, however the main focus is on children of school age.
Advisory services focus on child development, learning or behaviour and on determining the kinds of educational provision appropriate to meet the individual’s needs. The service works in partnership with parents, teachers, social workers and sometimes directly with children. The types of issues that educational psychology interventions can help with are:

- Developmental delay
- The education of Children and Young People with disabilities
- Transition from nursery to Primary Schools and from Primary to Secondary School
- Educational difficulties
- Challenging behaviour
- Emotional difficulties
- Post school planning
- Bullying
- Grief and bereavement

**Wellbeing**

The Health Behaviours of School Children (HBSC) 2015 survey asked 11 to 15 year olds about their wellbeing. Young people scored their life satisfaction using the Cantril Ladder (adapted version for children). A score of six or greater (on a scale of 0-10) was defined as high life satisfaction. In Dumfries & Galloway the majority (88%) of young people were highly satisfied with their life and this was similar to Scotland’s young people (87%).

Overall 41% of young people in the region reported feeling very happy with life although happiness decreased with age and more boys than girls reported feeling very happy with life in each age group. The proportion of young people who always felt confident was 13% with fewer girls reported feeling confident at each age group. Overall 18% of young people never felt left out. Girls were almost twice as likely as boys to feel left out. Excellent health was reported by 23% of young people, ranging from 34% of 11 year olds to 16% of 15 year olds. Overall prevalence estimates for feeling very happy with life, always feeling confident and never feeling left out were similar to that found for Scotland. However a significantly lower proportion of people reporting excellent health in Dumfries & Galloway (23%) compared with Scotland (26%).

The three most common health complaints that young people reported having more than once per week were sleep difficulties, irritability and nervousness.

Medicine to relieve headache had been taken by 48% of 13 year olds and 54% of 15 year olds in the last month and medicine to relieve stomach ache had been taken by 24% of 13 year olds and 30% of 15 year olds in this period.
Figure 29: Wellbeing measures for young people in Dumfries & Galloway, 2014

![Graphs showing wellbeing measures for young people in Dumfries & Galloway, 2014](image)

Source: Health Behaviours of School Children 2015

Figure 30: Health complaints reported more frequently than once per week, Dumfries & Galloway, 2014

<table>
<thead>
<tr>
<th>Symptom</th>
<th>11 yrs</th>
<th>13 yrs</th>
<th>15 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep difficulties</td>
<td>16%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Irritability</td>
<td>13%</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td>Nervousness</td>
<td>11%</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td>Feel low</td>
<td>7%</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>Headache</td>
<td>9%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Backache</td>
<td>4%</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>Feel dizzy</td>
<td>6%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Stomach ache</td>
<td>5%</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

Having multiple health complaints was defined as having two or more symptoms more than once a week. The proportion reporting multiple health complaints increased with age and was higher amongst girls aged 13 and 15 compared with boys.
Figure 31: Proportion of young people reporting multiple health complaints, Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

7.6 Secondary (Hospital) Care Activity

7.6.1 Hospital Admissions

Table 32 summarises the number of episodes (each individual ward admission counted separately) and continuous inpatient stays (CIS) for children normally residing in Dumfries & Galloway aged 0-18 years in 2015/16 (excludes holiday makers). The total number of admissions was 3,324. The rate of admission is similar to that for Scotland across all age groups except children aged 0-4, which is higher than Scotland. Figure 32 displays that trend in the rate of admission and indicates that the rate for Dumfries & Galloway has remained similar to the rate for Scotland for the last 5 years, both of which are rising over time.

Figure 32: Continuous Inpatient Stays for children (aged 0-18), all specialties, rate per 100,000 population; Dumfries & Galloway and Scotland; 2011/12 - 2015/16

\(^{p}\) Provisional data
Source: ISD Scotland
Table 32: Number of discharges (episodes and continuous inpatient stays (CIS)) for children (aged 0-18) from all specialities by age group and admission type; Dumfries & Galloway; 2015/16

<table>
<thead>
<tr>
<th>Admission Type</th>
<th>No. of episodes</th>
<th>No. of CIS</th>
<th>Episodes/100,000 pop’n</th>
<th>CIS/100,000 pop’n</th>
<th>Scotland</th>
<th>Episodes/100,000 pop’n</th>
<th>CIS/100,000 pop’n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>352</td>
<td>349</td>
<td>5,063</td>
<td>5,020</td>
<td>4,980</td>
<td>4,935</td>
<td></td>
</tr>
<tr>
<td>Emergency inpatients</td>
<td>1,215</td>
<td>1,181</td>
<td>17,477</td>
<td>16,988</td>
<td>14,643</td>
<td>14,363</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>86</td>
<td>12</td>
<td>1,237</td>
<td>173</td>
<td>1,805</td>
<td>242</td>
<td></td>
</tr>
<tr>
<td>All admission types</td>
<td>1,653</td>
<td>1,542</td>
<td>23,777</td>
<td>22,181</td>
<td>21,428</td>
<td>19,539</td>
<td></td>
</tr>
<tr>
<td>5 – 9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>388</td>
<td>388</td>
<td>4,992</td>
<td>4,992</td>
<td>5,201</td>
<td>5,170</td>
<td></td>
</tr>
<tr>
<td>Emergency inpatients</td>
<td>357</td>
<td>355</td>
<td>4,593</td>
<td>4,567</td>
<td>4,135</td>
<td>4,065</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>22</td>
<td>1</td>
<td>283</td>
<td>13</td>
<td>578</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>All admission types</td>
<td>767</td>
<td>744</td>
<td>9,867</td>
<td>9,572</td>
<td>9,913</td>
<td>9,311</td>
<td></td>
</tr>
<tr>
<td>10 – 15 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>278</td>
<td>277</td>
<td>3,106</td>
<td>3,095</td>
<td>3,926</td>
<td>3,909</td>
<td></td>
</tr>
<tr>
<td>Emergency inpatients</td>
<td>375</td>
<td>367</td>
<td>4,189</td>
<td>4,100</td>
<td>3,688</td>
<td>3,616</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>46</td>
<td>5</td>
<td>514</td>
<td>56</td>
<td>574</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>All admission types</td>
<td>699</td>
<td>649</td>
<td>7,809</td>
<td>7,251</td>
<td>8,188</td>
<td>7,594</td>
<td></td>
</tr>
<tr>
<td>16 – 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>196</td>
<td>193</td>
<td>3,943</td>
<td>3,883</td>
<td>4,258</td>
<td>4,239</td>
<td></td>
</tr>
<tr>
<td>Emergency inpatients</td>
<td>194</td>
<td>191</td>
<td>3,903</td>
<td>3,842</td>
<td>4,795</td>
<td>4,627</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>43</td>
<td>5</td>
<td>865</td>
<td>101</td>
<td>1,452</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>All admission types</td>
<td>433</td>
<td>389</td>
<td>8,711</td>
<td>7,825</td>
<td>10,505</td>
<td>9,062</td>
<td></td>
</tr>
<tr>
<td>18 years and under</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>1,214</td>
<td>1,207</td>
<td>4,238</td>
<td>4,213</td>
<td>4,602</td>
<td>4,574</td>
<td></td>
</tr>
<tr>
<td>Emergency inpatients</td>
<td>2,141</td>
<td>2,094</td>
<td>7,474</td>
<td>7,310</td>
<td>6,908</td>
<td>6,765</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>197</td>
<td>23</td>
<td>688</td>
<td>80</td>
<td>1,048</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>All admission types</td>
<td>3,552</td>
<td>3,324</td>
<td>12,399</td>
<td>11,603</td>
<td>12,559</td>
<td>11,477</td>
<td></td>
</tr>
</tbody>
</table>

p Provisional data
Source: ISD Scotland

7.6.2 Paediatric Short Stay Assessment Unit (PSSAU)

Paediatric emergency admission rates over the last ten years have continually increased despite the average length of stay reducing, with many patients staying less than 24 hours²²⁵. This trend represents an increase in referrals for common self-limiting conditions, resulting in increased workloads and reduced capacity of inpatient facilities. There are several contributory factors, for example, higher parental anxiety regarding minor conditions, changes to Out of Hours services, 4 hour waiting time targets in Emergency Departments and lack of resources to provide further observation and assessment in primary care. As a result Short Stay Paediatric Assessment Units (PSSAUs) are becoming more commonplace and are said to improve patient experiences and improve efficiency.

NHS Dumfries & Galloway were similarly experiencing a high volume of referrals to secondary care, some of which required only a short period of stay. Therefore a Paediatric Short Stay Assessment Unit (PSSAU) was developed in July 2011. The unit has been effective by reducing admission rates, demonstrating increased efficiency by ensuring prompt assessment and decision making. In addition
only a very small percentage of those discharged home re-presented within 48 hours to secondary care, suggesting accuracy of the assessment, treatment and discharge process.

The Paediatric Short Stay Assessment Unit (PSSAU) keeps a basic record of the number of attendances seen each month. Table 33 summarises this information. During the 10 months between October 2014 and July 2015 there were 1,212 attendances to the PSSAU. A 2 month audit of the records for June and July 2015 indicates that 37.1% of children attending the PSSAU are aged 0 to 3 years old; 51.4% of children attending were aged 4 to 11 years old; and 11.4% of children attending were aged 12 to 18 years.

Please note: The records kept by the PSSAU contain basic information. It is recommended that their data system be integrated with mainstream IT systems in order to provide a fuller picture of the service provided and the ability to analyses the data in different ways.

Table 33: Number of attendances at the Paediatric Short Stay Assessment Unit (PSSAU); Dumfries & Galloway; October 2014 - July 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-14</td>
<td>129</td>
</tr>
<tr>
<td>Nov-14</td>
<td>128</td>
</tr>
<tr>
<td>Dec-14</td>
<td>133</td>
</tr>
<tr>
<td>Jan-15</td>
<td>121</td>
</tr>
<tr>
<td>Feb-15</td>
<td>108</td>
</tr>
<tr>
<td>Mar-15</td>
<td>131</td>
</tr>
<tr>
<td>Apr-15</td>
<td>127</td>
</tr>
<tr>
<td>May-15</td>
<td>111</td>
</tr>
<tr>
<td>Jun-15</td>
<td>100</td>
</tr>
<tr>
<td>Jul-15</td>
<td>124</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,212</strong></td>
</tr>
</tbody>
</table>

Source: Paediatric Short Stay Assessment Unit; NHS Dumfries & Galloway

7.6.3 Outpatient Clinics

Table 34 summarises the number of new attendances at outpatient clinics for children in Dumfries & Galloway for 2014/15. The total number of new attendances was 19,084.

Please note: Only specialities where there was more than 100 new attendances have been included in the table. Also, activity for Child and Adolescent Mental Health Service (CAHMS) can be found in Section 7.5.3.
### Table 34: Number of new outpatient attendances by Children and Young People (0-18 years); Dumfries & Galloway; 2015/16

<table>
<thead>
<tr>
<th>Specialty</th>
<th>0 to 3</th>
<th>4 to 11</th>
<th>12 to 18</th>
<th>0 to 18</th>
<th>DGRI &amp; GCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthoptics</td>
<td>1307</td>
<td>358</td>
<td>94</td>
<td>1759</td>
<td>643</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>511</td>
<td>626</td>
<td>278</td>
<td>1415</td>
<td>750</td>
</tr>
<tr>
<td>Audiology</td>
<td>448</td>
<td>744</td>
<td>169</td>
<td>1361</td>
<td>1,353</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedic Surgery</td>
<td>308</td>
<td>230</td>
<td>344</td>
<td>882</td>
<td>882</td>
</tr>
<tr>
<td>Ear, Nose, Throat</td>
<td>161</td>
<td>300</td>
<td>172</td>
<td>633</td>
<td>633</td>
</tr>
<tr>
<td>Child Psychology</td>
<td>1</td>
<td>176</td>
<td>329</td>
<td>506</td>
<td>3</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>165</td>
<td>186</td>
<td>84</td>
<td>435</td>
<td>435</td>
</tr>
<tr>
<td>Dermatology</td>
<td>46</td>
<td>101</td>
<td>194</td>
<td>341</td>
<td>313</td>
</tr>
<tr>
<td>Child Physiotherapy</td>
<td>128</td>
<td>141</td>
<td>68</td>
<td>337</td>
<td>3</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>41</td>
<td>277</td>
<td>318</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>2</td>
<td>138</td>
<td>173</td>
<td>313</td>
<td>313</td>
</tr>
<tr>
<td>Child Occupational Therapy</td>
<td>79</td>
<td>214</td>
<td>18</td>
<td>311</td>
<td>3</td>
</tr>
<tr>
<td>Podiatry</td>
<td>13</td>
<td>107</td>
<td>171</td>
<td>291</td>
<td>49</td>
</tr>
<tr>
<td>Dietetics</td>
<td>134</td>
<td>74</td>
<td>54</td>
<td>262</td>
<td>198</td>
</tr>
<tr>
<td>General Surgery</td>
<td>49</td>
<td>60</td>
<td>75</td>
<td>184</td>
<td>184</td>
</tr>
<tr>
<td>Orthotics</td>
<td>34</td>
<td>94</td>
<td>45</td>
<td>173</td>
<td>158</td>
</tr>
<tr>
<td>Adolescent Psychology</td>
<td>37</td>
<td>118</td>
<td>155</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Oral Max Fax</td>
<td>12</td>
<td>22</td>
<td>82</td>
<td>116</td>
<td>116</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>92</td>
<td>92</td>
<td>92</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>8</td>
<td>18</td>
<td>45</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,407</strong></td>
<td><strong>3,680</strong></td>
<td><strong>3,153</strong></td>
<td><strong>10,240</strong></td>
<td><strong>6,562</strong></td>
</tr>
</tbody>
</table>

Source: Qlikview; NHS Dumfries & Galloway

### 7.7 Youth Health

Whilst the first few years of life are recognised as a crucial stage in child development, adolescence is a further time of significant growth and change. From the evidence, we know that this development happens on a number of fronts - biological, cognitive, emotional, and social.

#### 7.7.1 The Strategic and Policy Context

No single Scottish Government Directorate has policy responsibility for young people’s health and wellbeing and there is no overarching framework that sets out the Scottish Government’s approach to youth health and youth health improvement. However, NHS Health Scotland and the Scottish Government established the Youth Health Improvement Strategic Leads Group in 2012. Membership of the group includes strategic leads for youth health improvement (YHI) from each of the territorial NHS Boards in Scotland. Since its establishment, the group has focused its efforts on developing a shared understanding of the youth health improvement agenda in Scotland, including key issues and areas for improvement. For the purposes of this work the terms youth, young people and adolescents are used interchangeably and refer to those aged 9-25 years. In this context, health improvement
refers to any actions to promote wellbeing/good health and prevent health problems/illness. The term health refers to health and wellbeing.

7.7.2 The Evidence

Internal (biological, cognitive and emotional) and external (relationships, responsibilities, levels of autonomy and environmental) changes during adolescence bring new challenges and opportunities which influence health outcomes, either positively or negatively.

Adolescence is therefore a time when healthy development during the early years can be consolidated or compromised and unhealthy development during the early years can be compensated for or compounded. Consequently; being healthy during adolescence matters as it impacts on a young person’s educational achievements, employability, and relationships and influences future behaviours such as parenting, affects health outcomes in adulthood and shapes the health of future generations.

However, we know that the health of some young people in Scotland is compromised. Scottish data shows us that young people are not doing well in the following areas: wellbeing, obesity, sexual health, physical activity, mental health problems and violence. There is also clear evidence of inequalities in health among young people.

Young people often identify mental wellbeing as being especially important to them. Mental wellbeing has a range of influences. It helps protect young people against behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol. It can also influence educational attainment and youth unemployment, two areas of significant priority in Scotland. Research also shows positive correlations between mental wellbeing and healthy behaviours such as physical activity and a good diet and negative correlations with drug misuse, smoking and alcohol consumption.

There is also growing evidence that different health-promoting and health-risk behaviours have shared influences. For example, risky sexual behaviour and smoking, alcohol misuse and cannabis use have low income and poor housing as a shared risk factor and school connectedness as a shared protective factor. It is increasingly being argued in the international literature on adolescent health and by local health boards, voluntary sector youth organisations and researchers in Scotland that policy makers should move away from siloed, single issue approaches to addressing youth health, to one which takes an integrated life course approach.

In addition, the evidence demonstrates the value of engaging with young people in understanding their wellbeing needs and planning the delivery and evaluation of interventions that seeks to support wellbeing. Youth engagement can enhance a young person’s sense of connectedness, belonging and feeling of being valued, which can contribute to good mental wellbeing.
In conclusion; the evidence would therefore suggest that Scottish Government policy on youth health improvement might helpfully be strengthened to reflect a focus on well-being, prevention and person centeredness.

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8. ACHIEVING

‘Children and Young People receive support and guidance in their learning – boosting their skills, confidence and self esteem’

In this section:
- Early Learning and Childcare
- The School Years
- Destination of School Leavers

Children learn through the totality of their experiences, through their family and community as well as through the pre-school and school environments. Curriculum for Excellence, the 3–18 years curriculum (CfE), aims to ensure that all Children and Young People in Scotland develop the attributes, knowledge and skills they will need to flourish in life, learning and work. The information and data presented here are organised following the life course.

8.1 Early Learning and Childcare

Each child is unique and the learning process is complex. Effective learning needs to build on what the learner already knows and understanding of the ways in which children learn.

8.1.1 The Strategic and Policy Context

The Children and Young People Act (Scotland) 2014 strengthens the role of early years support in all children’s lives by increasing the provision and flexibility of free early learning and childcare from 475 hours a year to a minimum of 600 hours for every 3 and 4 year old and looked-after 2 year olds. The early level of Curriculum for Excellence (CfE) spans pre-school and primary as it is designed to meet the needs of most children from 3 years to the end of Primary 1, thus promoting better continuity and progression of learning across the early learning and childcare and primary education settings. Many of the core messages of CfE will already be familiar to early years learning and childcare practitioners as they relate to the importance of:

- Active, experiential learning
- A holistic approach to learning
- Smooth transactions
- Learning through play
Building the Curriculum 2 explores practical ways to introduce a more active approach to teaching and learning in early years.

8.1.2 The Evidence

The availability of high quality, affordable ELCC for young children from birth to starting primary school is an important priority for Scotland and is also a key priority for the European Union. The European commission communication 2011 stated that early childhood education and care (ECEC) is “the essential foundation for successful lifelong learning, social integration, personal development and later employability. Complementing the central role of family, ECEC has a profound and long lasting impact which measures taken at a later stage cannot achieve.”

Early learning and childcare is defined as service, consisting of education and care, of a kind which is suitable for children who are under school age, acknowledging the importance of interactions and other experiences which support learning and development in a caring and nurturing setting.

While all social groups benefit from high quality ELCC, children from the poorest families gain most from universal provision and the benefits of high quality ELCC provision continue at age 14, with particular benefit for children whose families had a poor early years home learning environment.

The term “image of the child” is often used by practitioners and a high level of value is placed on taking account of the interests of the child. The European Commission describes this as:

“Each child is unique and a competent and active learner whose potential needs to be encouraged and supported. Each child is a curious, capable and intelligent individual. The child is a co-creator of knowledge who needs and wants interaction with other children and adults. As citizens of Europe children have their own rights which include early education and care”.

The role of parents and carers remains central to their children’s learning and must therefore be valued and involved in all aspects of ELCC, as the home is the first and most important place in which children grow and develop. Play and learning are interconnected and play is a fundamental part of healthy development for all children. For example in play children utilize their life experiences and rehearse their future.

Attachment is viewed as one of the most important factors in child development, especially in brain development and the development of emotional and social skills. Children who experience positive care giving are likely to develop secure attachments conversely children exposed to negative experiences are significantly more likely to have disorganised attachments which negatively impact their life chances.
Young active learners need to widen their experiences and learning in all areas of development, in particular in relation to first transitions which could have a significant impact on the child’s capacity to cope with change in both the short and long term.

8.1.3 The Local Picture

Please note: Work is currently ongoing to collate information regarding Early Learning & Childcare and to address this gap in our knowledge.

8.2 The School Years

8.2.1 The Strategic and Policy Context

Curriculum for Excellence (CfE) includes all of the experiences which are planned for Children and Young People through their education, wherever they are being educated. By recognising and planning learning around different contexts and experiences, the curriculum aims to make better connections across learning. The curriculum areas ensure that learning takes place across a broad range of contexts, and offer a way of grouping experiences and outcomes under recognisable headings; thus articulating the national aspirations for every young person:

The eight curriculum areas are:

- Expressive arts
- Health and Wellbeing
- Languages
- Mathematics
- Religious and moral education
- Sciences
- Social Studies
- Technologies

Successful implementation of CfE is dependent upon supporting Children and Young People to make connections between different areas of learning, a positive ethos and climate of respect and trust across the school community, opportunities for achievement both in the classroom and beyond, giving pupils a sense of satisfaction and building motivation, resilience and confidence and the effective involvement of parents in their children’s learning. In line with the Parental Involvement Act 2006, the Scottish Government is working in partnership with local authorities, Education Scotland, National Parent Forum of Scotland and other key partners to promote parental involvement in education at all levels.

Some children need extra support to help them learn. This might be because of short or long term medical conditions, family circumstances, bullying, language and communication disorders or sensory
The Education (Additional Support for Learning) (Scotland) Act 2004 provides the framework for education authorities and other agencies to support all children to overcome barriers to their learning. It provides duties on authorities to identify, plan and provide for the additional support needs of pupils for whose education they are responsible. In November 2012, the Doran Review of services for children with additional support needs (ASN) found that there was good practice in Scotland to support families, but that improvements could be made. The establishment of the Doran Project Board has been driving forward work on a joined up and strategic approach to commissioning national services that will provide better outcomes for Children and Young People with ASN.

Guidance for schools and local authorities published in 2011, Included, Engaged and Involved Part 2 stresses that exclusion is an extremely serious option of last resort, to be used within an ethos of prevention, early intervention and support for learners.

In 2014, the National Guidance on education for Children and Young People unable to attend school due to ill health was published by Scottish Government to provide advice and information for education authorities in relation to their statutory duty, under section 14 of the Education (Scotland) Act 1980, to make special arrangements for pupils to receive education elsewhere than at an educational establishment in the case of prolonged ill-health.

8.2.2 The Evidence

The relationship between poverty, attainment and achievement is well characterised. However, there is less understanding or consensus as to „what works” in terms of interventions and strategies for raising attainment among children from deprived backgrounds. This is partly a result of the way in which educational research is currently conducted in Scotland. However, it is also a product of the shift from targeted to universal provision, both of which are perceived to have a key role to play in policy development. Initiatives that began with a specific focus on the most disadvantaged children living in the poorest areas of are often „rolled out” to all schools, and it is the children of the more affluent members of society that gain most. However, there is substantial evidence from qualitative studies conducted in the UK that effective strategies to improve educational outcomes for children living in poverty include:

- Rigorous monitoring and use of data
- Raising pupil aspirations using engagement/aspiration programmes
- Engaging parents (particularly hard-to-reach parents) and raising parental aspirations
- Developing social and emotional competencies
- Supporting school transitions
- Providing strong and visionary leadership

There is a substantial body of research which indicates that poverty has a devastating impact upon the lives of young people across the UK. Data from a longitudinal study of
children Growing Up in Scotland indicate that nearly one quarter of three-to-four-year-old Scottish children are “persistently poor”. This is defined as living in “income poverty” in at least three of the four years from 2005-06 to 2008-09. Moreover, the indications are that children living in these circumstances are disproportionately likely to face social, emotional and behavioural difficulties (SEBD), be overweight and to have multiple other problems. All of these factors will have an impact upon their future levels of attainment and achievement. It is apparent that the link between social disadvantage and low attainment is evident in many countries. However, it is particularly marked in the UK, where levels of inequality are greater than in many other countries. It has been argued that deep-seated inequalities in many areas of life have a negative impact upon the lives of all citizens.

Scotland’s Commissioner for Children and Young People suggests that directing resources towards those who need them most is the most effective way of achieving genuine progress. However, the short-term nature of much investment in education is a major limiting factor. It is not possible to overcome the negative effects of inter-generational poverty within the framework of a short-to-medium-term investment. The main conclusion from their review of policy and practice is that what is required is a policy sea change rather than more specific short-term interventions. While there is evidence that these can be effective in the short-term, particularly if they are targeted at the most disadvantaged individuals and communities, there is a paucity of data that indicate their long-term effectiveness.

8.2.3 The Local Picture

Schools, School Rolls & Teaching Staff

Across Dumfries & Galloway there are 99 primary schools, 16 secondary schools, and 2 special schools.

In 2016 there were 1,485 teachers: 651 primary school teachers and 687 secondary school teachers (Figure 33), the remainder, 147 teachers, are either centrally employed or pre-school teachers. The majority of primary school teachers are female (2016 results indicate 89.9% are female, 10.1% are male) whereas amongst secondary school teachers the proportion of male teachers is greater (2014 results indicate 60% are female, 40% are male).
In 2016 there were 18,658 children at school: 10,634 in primary schools and 8,007 in secondary schools. Figure 34 depicts the number of school children each since 2002 and the projected number of school children to 2021. The number of school children has decreased over time and is expected to continue to decrease. As Figure 33 indicates, between 2008 and 2014 the number of teachers at primary and secondary schools also decreased. However, the proportional decrease during this time amongst teachers was less than the proportional decrease amongst pupils (i.e. the number of pupils has decreased at a faster rate than the number of teachers). Table 35 summarises this decrease. Consequently, the ratio of the number of children to every teacher has decreased (Figure 35). Furthermore, in recent years (2015 and 2016) the number of primary teachers has started to increase further impacting upon the pupil teacher ratio. In 2016 for every 1 primary school teacher there were 16.3 pupils and for every 1 secondary school teacher there were 11.7 pupils.

Table 35: Change in the number of teachers and the number of pupils; Dumfries & Galloway; 2004-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary Teachers</th>
<th>Primary Pupils</th>
<th>Primary Ratio</th>
<th>Secondary Teachers</th>
<th>Secondary Pupils</th>
<th>Secondary Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>641</td>
<td>11,724</td>
<td>18.3</td>
<td>788</td>
<td>9,585</td>
<td>12.2</td>
</tr>
<tr>
<td>2016</td>
<td>651</td>
<td>10,634</td>
<td>16.3</td>
<td>687</td>
<td>8,007</td>
<td>11.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Difference</th>
<th>% change 2004-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+10</td>
<td>+1.6%</td>
</tr>
<tr>
<td></td>
<td>-1,090</td>
<td>-9.3%</td>
</tr>
</tbody>
</table>

Source: Teacher Census 2016; Dumfries & Galloway Council
**Figure 34: Number of Primary and Secondary School Pupils; Dumfries & Galloway; 2002-2016 and projections to 2021**

Source: Dumfries & Galloway Council

**Figure 35: Teacher to Pupil Ratio for primary and secondary schools; Dumfries & Galloway; 2004-2016**

Source: Dumfries & Galloway Council
The School Environment

The 2015 Health Behaviours of School Children Survey showed that less than a quarter (22%) of young people in Dumfries & Galloway said they ‘liked school a lot’ with responses higher in younger pupils and declining with age. At age 11, boys are less likely than girls to report liking school a lot, however there were no significant gender difference at ages 13 and 15. These patterns were similar across Scotland.

Figure 36: Proportion of young people who report liking school a lot in Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

Nearly two-thirds (65%) of Dumfries & Galloway pupils perceived their performance was good or very good academic performance. Perceived performance was higher in younger pupils (72% of 11 year olds) compared with older pupils however (62% of 13 year olds and 59% of 15 year olds).

Overall 37% of pupils reported that they felt some or a lot of pressure from schoolwork. Pressure increased with age and was significantly higher in 15 year old girls (77%) compared with 15 year old boys (49%). Trends from Scotland data show that girls and boys feeling pressured by school work in 2014 (45% and 37%, respectively) were higher than in 2010 for both genders, continuing an upward trend since 2006. For boys, school work pressure in 2014 was at a level similar to a previous peak in 2002. However, for girls, perceived school work pressure now exceeds any previous level over the past 20 years.

In Dumfries & Galloway just under two-thirds of pupils (64%) thought that their classmates were kind and helpful, with no significant gender differences but the proportions reporting high classmate support fell with age from 77% of 11 year olds, 59% of 13 year olds to 54% of 15 year olds.

The proportion of young people reporting high teacher support was substantially higher in primary pupils (11 year olds) at 54% compared with older (secondary pupils) at 18% and 17% of 13 and 15 year olds respectively.
Figure 37: Proportion of young people who felt pressurised by schoolwork in Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

For all the school environment measures there were no significantly different results for overall prevalence estimates in Dumfries & Galloway in 2014 compared with Scotland.

Exclusions

A recent report from Dumfries & Galloway Council considered school exclusions for the school year August 2015 to July 2016. During this time period a total of 270 children were excluded over 465 incidents of exclusion. As a proportion of the total school roll for the year, this is equivalent to 1.4% of school children. Table 36 summarises the number of incidents and number of children excluded during this period.

Amongst primary school children, the report found that the greatest number of children excluded occurred in school years P6 and P7 (children aged 10 and 11). The majority of excluded pupils were boys (45 pupils, 79.0%). 22 pupils (38.6% of all primary pupils excluded) were excluded twice or more within the school year. The report also highlighted that a small number of children were associated with more than one third of exclusions: there were 46 incidents of exclusions (nearly half of all incidents in primary schools) amongst just 11 primary school pupils (19% of all primary pupils excluded). The most common reasons for exclusion were general or persistent disobedience (21%), physical assault with no weapon against pupil (21%) and verbal abuse of staff (18%), which combined account for 59% of the total number of 103 exclusions. Please note that pupils can have more than one reason for exclusion recorded.
Table 36: Number of children excluded from school at least once and the number of exclusions, primary and secondary schools; Dumfries & Galloway; 2012/13 – 2015/16

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>2012/13</td>
<td>55</td>
<td>219</td>
</tr>
<tr>
<td>2013/14</td>
<td>60</td>
<td>199</td>
</tr>
<tr>
<td>2014/15</td>
<td>66</td>
<td>206</td>
</tr>
<tr>
<td>2015/16</td>
<td>57</td>
<td>213</td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway Council

Amongst secondary school children the greatest number of exclusions occurred amongst pupils in S3 (children aged 14) and that the proportion of girls being excluded was greater than that of primary school children (60 girls excluded, 28%; 153 boys excluded, 72%). 69 secondary pupils were excluded twice or more during the school year (32% of all secondary pupils excluded). As with primary school children, a small number of secondary school children were associated with a larger proportion of exclusion incidents: 20 children (9.4% of secondary pupils excluded) were associated with 103 exclusion incidents (28.5% of secondary exclusion incidents). The most common reasons for exclusion amongst secondary school pupils were verbal abuse of staff (26%) physical assault with no weapon against pupil (19%) and general or persistent disobedience (18%), which combined account for 63% of the total number of 362 exclusions. Please note that pupils can have more than reason recorded.

8.2.4 School Attainment

Young people achieve qualifications at different stages throughout the senior phase of their education (school years S4 to S6; typically pupils aged 15-17 years). In 2014 new qualifications were introduced for young people in S4, S5, and S6 as part of their Senior Phase in Curriculum for Excellence: National Qualification 4 which is internally assessed in school and verified by the SQA and National Qualification 5 which is a combination of internal assessments and a final examination in May each year. These qualifications are designed and quality assured by the Scottish Qualifications Authority (SQA) and delivered by schools, in accordance with SQA guidelines and requirements.

Please note: Due to the differences in approaches it is not possible to compare the new national qualifications with previous year’s results. It is also a challenge to compare Dumfries & Galloway results with the national performance due to different approaches across schools nationally.

Table 38 summarises the number of pupils attaining Highers between 2012 and 2016 and indicates that proportion of pupils attaining Highers has increased. For example, amongst S5 pupils in 2016 55.9% attained at least 1 Higher compared to 2012 when 47.0% attained at least one Higher, an increase of 8.9 percentage points.
Table 37: Number of entrants and passes for National Qualifications; Dumfries & Galloway; 2014-2016

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th></th>
<th>2015</th>
<th></th>
<th>2016</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entries</td>
<td>Passes</td>
<td>Percent</td>
<td>Entries</td>
<td>Passes</td>
<td>Percent</td>
</tr>
<tr>
<td>National 4</td>
<td>3159</td>
<td>3025</td>
<td>96%</td>
<td>4189</td>
<td>3963</td>
<td>95%</td>
</tr>
<tr>
<td>National 5</td>
<td>4783</td>
<td>4228</td>
<td>89%</td>
<td>7590</td>
<td>6675</td>
<td>88%</td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway Council

Please note: Higher qualifications traditionally taken in S5 and S6 by pupils progressing have also changed to assess pupils on learning under Curriculum for Excellence, therefore the results shown in Table 38 for S5 and S6 are for a combination of ‘old’ Highers and ‘new’ Highers depending on the individual pupil’s progression at school.

Also shown in Table 38 are the results for pupils by the end of S6 achieving at least one Advanced Higher, this is an optional qualification which forms part of the Scottish secondary education system. It is normally taken by students aged around 16-18 years old after they have completed Highers, which are the main university entrance qualification.

Table 38: Percentage of pupils attaining Highers by year group; Dumfries & Galloway; 2012-2016

<table>
<thead>
<tr>
<th>Year Group</th>
<th>Number of Highers</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>5 year trend</th>
<th>Difference from last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5</td>
<td>1 or more Higher</td>
<td>47.0%</td>
<td>47.0%</td>
<td>50.9%</td>
<td>54.0%</td>
<td>55.9%</td>
<td>up 8.9%</td>
<td>up 1.9%</td>
</tr>
<tr>
<td></td>
<td>3 or more Highers</td>
<td>27.7%</td>
<td>28.0%</td>
<td>30.1%</td>
<td>32.2%</td>
<td>34.9%</td>
<td>up 7.2%</td>
<td>up 2.7%</td>
</tr>
<tr>
<td></td>
<td>5 or more Highers</td>
<td>12.4%</td>
<td>13.2%</td>
<td>14.5%</td>
<td>14.2%</td>
<td>15.1%</td>
<td>up 2.7%</td>
<td>up 0.9%</td>
</tr>
<tr>
<td>S6</td>
<td>1 or more Higher</td>
<td>52.9%</td>
<td>55.2%</td>
<td>57.3%</td>
<td>60.8%</td>
<td>60.5%</td>
<td>up 7.6%</td>
<td>down 0.3%</td>
</tr>
<tr>
<td></td>
<td>3 or more Highers</td>
<td>36.5%</td>
<td>40.0%</td>
<td>40.8%</td>
<td>43.2%</td>
<td>42.5%</td>
<td>up 6.0%</td>
<td>down 0.7%</td>
</tr>
<tr>
<td></td>
<td>5 or more Highers</td>
<td>25.3%</td>
<td>27.9%</td>
<td>27.5%</td>
<td>31.4%</td>
<td>29.9%</td>
<td>up 4.6%</td>
<td>down 1.5%</td>
</tr>
<tr>
<td></td>
<td>1 or more Advanced Higher</td>
<td>15.1%</td>
<td>19.1%</td>
<td>17.2%</td>
<td>19.7%</td>
<td>17.3%</td>
<td>up 2.2%</td>
<td>down 2.4%</td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway Council

The Census 2011 showed that in Dumfries & Galloway there were 7,191 females aged 16 to 24 and 9% of these had no qualifications. A further 42% had level 1 qualifications (O Grade, Standard Grade, Access 3 Cluster, Intermediate 1 or 2, GCSE, CSE, Senior Certificate or equivalent, GSVQ Foundation or Intermediate, SVQ level 1 or 2, SCOTVEC Module, City and Guilds Craft or equivalent, Other school qualifications not already mentioned (including foreign qualifications).
8.3 Destination of School Leavers

Research tells us that for most people, work is good for long term health outcomes. For those in employment, work can provide fulfilment and offers individuals a degree of control over decisions that bring benefits to health. In contrast, unemployment is associated with a higher risk of death and increased mental health problems. Job insecurity is also damaging to health, and has been linked to higher rates of hospital admissions, increases in heart disease and deterioration in mental health. Therefore Scottish Government's ambition is that all young people stay in learning after 16 since this is the best way of improving their long-term employability.

8.3.1 The Strategic and Policy Context

In response to the economic downturn and the resultant adverse effects on young people’s prospects in the labour market, the Government introduced Opportunities for All in its Programme for Government in September 2011.288

This is an explicit commitment to an offer of an appropriate place in learning or training for every 16-19 year old not currently in employment, education or training. Opportunities for All brings together a range of existing national and local policies and strategies as a single focus to improve young people’s participation in post 16 learning or training, and ultimately employment, through appropriate interventions and support until at least their 20th birthday. This commitment became a live offer from 1 April 2012 and will ensure that the post-16 system delivers for all young people; focused on supporting those who have disengaged, seeking to re-engage them with appropriate interventions including the world of work.

Participating in learning beyond age 16 is the best way for a young person to improve their long-term employment prospects; successful post-16 transitions are key to enabling this. 16+ Learning Choices, the Scottish Government’s post-16 transition planning model, supports delivery of both Curriculum for Excellence and Opportunities for All. It facilitates the offer of an appropriate place in learning or training for every 16-19 year old in advance of them leaving school and before leaving subsequent episodes of learning or training. The offer focuses on personalisation, choice and progression and will encompass relevant supports to help young people to progress on their career path.289

The More Choices More Chances Strategy (2006)290 is part of the Government’s broad strategic framework for improving outcomes for all young people and focuses on reducing the number of 16-19 year olds disengaging from learning or who are not in education, employment or training. It recognises the wide and complex composition of this group and the barriers which prevent or limit individuals’ engagement and promotes multi-agency collaboration as the driver for improvement, focusing on prevention, intervention and sustainability by ensuring that:
CfE provides opportunities tailored to individual need, with flexibility and appropriate support (as early as possible) for those who need it.

Every young person has an offer of post-16 learning and a clear pathway into it, with supported transitions and sustained opportunities.

Learning is a financially viable option, by considering the financial support available to young people.

The right support is available to young people to find out about, engage with and sustain learning and employment.

Joint commitment to action between central and local government, employers, learning providers and support agencies to develop the service infrastructure required to meet the needs of those at risk of disengaging and those who have already done so.

Skills Development Scotland have modernised their service delivery in line with the Scottish Government’s Career Strategy (March 2011)\textsuperscript{291}. This involved refocusing the way they work to offer a modern service that uses the latest technology, training and labour market research to ensure more individuals than ever before get the right support to help them build lasting careers. Career services will focus on providing a universal offer to all, directed predominantly through Skills Development Scotland's online service - My World of Work\textsuperscript{292}.

The Government Economic Strategy and the Programme of Post-16 Education Reform acknowledges the challenges in ensuring that young people are well placed to take advantage of new and emerging jobs. In order to deliver a cross Government approach to the issue, the Scottish Government has appointed a dedicated Minister for Youth Employment. This is the first such appointment anywhere in the UK and will ensure that all parts of Government work with employers, training providers and third sector organisations to support young people across Scotland. The Scottish Government's Youth Employment Strategy, Action for Jobs – Supporting Young Scots Into Work\textsuperscript{293}, makes the approach to delivering a national response to the national challenge of youth unemployment clear.

Skills for Scotland: Accelerating the Recovery and Increasing Sustainable Economic Growth (2010)\textsuperscript{294} makes clear the Scottish Government's commitment to training and skills and sets out a flexible, responsive partnership approach to new and emerging economic opportunities, including those in the low carbon economy. A key priority is to support employers by better understanding and assessing the skills required for future success, and ensuring that the supply of skills, training and qualifications is sufficiently responsive.

Valuing Young People – principles and connections to support young people achieve their potential (2009)\textsuperscript{295} is the key policy driver for youth work services. It recognises that the vast majority of young people make a valuable contribution to their communities today and will play a leading role in building a more successful Scotland in the future. Nurturing and supporting young people will help them navigate the challenges of adolescence and the transition into adulthood. Valuing Young People is designed to support statutory and voluntary organisations and services to deliver positive futures for...
all young people, while recognising that some may need more help than others at certain times in their lives.

Its principles draw on those that have been established in a range of related policies, including the Getting it right for every child and young person approach, Curriculum for Excellence and More Choices, More Chances.

The Scottish Government places great value on the role that youth work/community learning and development plays in delivering preventative services that help to improve young people’s life chances and employment prospects. Young people who become successful learners, confident individuals, responsible citizens and effective contributors, are young people who are more likely to make healthy and positive life choices in the longer term.

The Scottish Government is currently working with partners including Education Scotland and national youth work organisations to develop a new Strategic Action Plan for Youth Work. This Action Plan will underpin the Strategic Guidance for Community Learning and Development, and build on the actions set out in Moving Forward: a Strategy for Improving Young People’s Chances through Youth Work, published in 2007.

8.3.2 The Evidence

There are significant economic benefits associated with undertaking and completing further education, with improved job security and promotion prospects. The 2011 report by London Economics demonstrated the strong earnings and employment effect associated with vocational qualifications over the span of the individuals working life. In addition education is said to underpin personal well being and social cohesion in a number of ways. There is little evidence of education directly improving physical health, however positive mental health is shown as a consequence of learning during adult life; furthermore Feinstein et al 2003 demonstrated positive and substantial changes in health behaviours such as becoming more physically active and giving up smoking.

Research undertaken in 2009 considered the impact of lifelong learning on intergenerational social mobility, and found that education and training undertaken in later life is associated with upward social mobility in individuals. Moreover there is some economic evidence which links education to reduced levels of criminal activity; the findings indicate that there is a negative relationship between educational attainment and offending, and suggest that reducing the proportion of individuals with no academic qualifications by 1% would result in a 1.1% reduction in offending.

Therefore the evidence demonstrates that there are strong and consistent economic and noneconomic benefits associated with undertaking further education and skills training. Individuals economic outcomes improve as a result of learning, demonstrated in terms of employment opportunities, prospects and earnings. In addition non-economic benefits include improvements in
8. Achieving 

self confidence, an increased likelihood of becoming more involved in community activities, the ability to make better use of leisure time and enhanced intergenerational transmission of skills through improvements in the ability to assist children with school work and being better able to manage health issues or disabilities. Completion of further education and training also had a positive association with measures of general well being.302

8.3.3 The Local Picture 

Dumfries & Galloway Council published a report summarising the results of the School Leavers Destination Return (SLDR) for people who left school in July 2015. The returns were completed twice, once in October 2015 (referred to as the ‘initial’ return) and again in April 2016 (referred to as the ‘follow up’ return). Table 39 summarises the results for Dumfries & Galloway compared to Scotland.

Table 39: Destination of school leavers; Dumfries & Galloway and Scotland; People who left school in July 2015

<table>
<thead>
<tr>
<th>Destination</th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
<th>% point change</th>
<th>Dumfries &amp; Galloway</th>
<th>Scotland</th>
<th>% point change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial</td>
<td>Follow up</td>
<td></td>
<td>Initial</td>
<td>Follow up</td>
<td></td>
</tr>
<tr>
<td>Higher Education *</td>
<td>37%</td>
<td>35%</td>
<td>-2.0</td>
<td>38.3%</td>
<td>36.4%</td>
<td>-1.9</td>
</tr>
<tr>
<td>Further Education *</td>
<td>30.1%</td>
<td>24.9%</td>
<td>-5.2</td>
<td>27.8%</td>
<td>23.5%</td>
<td>-4.3</td>
</tr>
<tr>
<td>Training *</td>
<td>2.2%</td>
<td>2.3%</td>
<td>0.1</td>
<td>3.8%</td>
<td>2.8%</td>
<td>-1.0</td>
</tr>
<tr>
<td>Employment *</td>
<td>22.2%</td>
<td>29.5%</td>
<td>+7.3</td>
<td>21.7%</td>
<td>28.2%</td>
<td>+6.5</td>
</tr>
<tr>
<td>Voluntary Work *</td>
<td>0.3%</td>
<td>0.2%</td>
<td>-0.1</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.0</td>
</tr>
<tr>
<td>Activity Agreement *</td>
<td>1.1%</td>
<td>1.0%</td>
<td>-0.1</td>
<td>0.9%</td>
<td>0.8%</td>
<td>-0.1</td>
</tr>
<tr>
<td>Unemployed Seeking</td>
<td>4.7%</td>
<td>4.4%</td>
<td>-0.3</td>
<td>5.4%</td>
<td>5.7%</td>
<td>+0.3</td>
</tr>
<tr>
<td>Unemployed Not Seeking</td>
<td>1.1%</td>
<td>2.2%</td>
<td>+1.1</td>
<td>1.1%</td>
<td>1.6%</td>
<td>+0.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.2%</td>
<td>0.5%</td>
<td>-0.7</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.1</td>
</tr>
<tr>
<td>Positive Destinations (marked *)</td>
<td>93.0%</td>
<td>92.9%</td>
<td>-0.1</td>
<td>92.9%</td>
<td>92.0%</td>
<td>-0.9</td>
</tr>
<tr>
<td>Total Leavers</td>
<td>1,603</td>
<td>1,596</td>
<td></td>
<td>53,834</td>
<td>53,654</td>
<td></td>
</tr>
</tbody>
</table>

Source: School Leavers Destination Returns 2016

The results for Dumfries & Galloway are largely similar to that of Scotland. The proportion of people from Dumfries & Galloway who go on to higher or further education is marginally higher than for the rest of Scotland, as is the proportion who go on to employment. This is probably a reflection of the different opportunities available to school leavers in Dumfries & Galloway and the relative distance to further education institutions compared to other areas of Scotland however, there is little statistical evidence available to prove or disprove this conjecture.

Please note: It is recognised that there is a lack of wider information regarding positive destinations regarding Children and Young People from Dumfries & Galloway. Also, there is a lack of information on employability and skills, and additional support for learning plans for Children and Young People. It is recommended that work be undertaken to further explore this topic.
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http://www.myworldofwork.co.uk/ (last accessed 28th October 2015)


9. NURTURED:

‘Children and Young People have a nurturing and stimulating place to live and grow’

In this section:
- Deprivation
- Poverty
- Housing
- Homelessness
- Environment
- Place
- Play
- Oral Health
- Health Inequalities

A child’s early experience of being nurtured and developing a bond with a caring adult affects all aspects of behaviour and development; hence in order to pass successfully through childhood, children require sensitive nurturing care to build the capacities for trust, empathy and compassion.

9.1 Deprivation

The link between deprivation and health is well documented, with people living in the most deprived circumstances tending to have lower life expectancy and poorer outcomes for a range of health measures.

9.1.1 The Strategic and Policy Context

Child poverty in Scotland is affected by a mix of devolved and reserved policy measures. The Child Poverty Act\(^3\) requires that the UK Government produce a UK-wide child poverty strategy. This will be relevant to tackling child poverty in Scotland in so far as it covers reserved policy measures which apply to and impact on Scotland, such as policy on personal taxation and benefits. The Child Poverty Act also requires Scottish Ministers to produce a Scottish strategy.

The Child Poverty Strategy for Scotland focuses on policy matters that are devolved to the Scottish Parliament and Scottish Ministers. It provides that it is the duty of the UK Government to ensure that the child poverty targets are met in relation to the year commencing 1 April 2020. These targets relate to levels of child poverty in terms of: relative low income, combined low income and material deprivation, absolute low income and persistent poverty.

In a range of policies and strategic frameworks to improving the wellbeing outcomes of Children and Young People, deprivation is acknowledged as a causative factor. These strategic approaches include the framework for tackling anti-social behaviour, Promoting Positive Outcomes (March...
9.1.2 The Evidence

Deprivation is normally measured in Scotland using an area-based measure called the Scottish Index of Multiple Deprivation (SIMD16). This measure encompasses seven major domains: income, access to amenities, education, housing, crime, employment and health. As such, deprivation is a complex concept which attempts to cover the major resources required to live what is considered an adequate standard of life and to participate in society. Each of these domains of deprivation is interlinked and the term is therefore often used interchangeably with socioeconomic status or position, terms which usually refer more narrowly to income, education, occupation and employment.

As described elsewhere in this document, socioeconomic inequalities lead to great inequalities in health outcomes for Children and Young People, with the most deprived children experiencing the worst health. It is well established in the literature that poorer children in the UK are at significantly higher risk of low birth weight, obesity, under nutrition, poor dental health, poor social and emotional adjustment, lower cognitive development and educational achievement, and death in childhood. Infant mortality rates (deaths before one year of age) are also significantly higher in lower occupational groups compared to higher. Children and Young People from deprived communities are also more likely to live in households with domestic violence and to engage in criminal and anti-social behaviour (see other sections for further detail).

Educational outcomes, as well as being a component of deprivation in adulthood, are also greatly affected by deprivation. Attainment gaps between children from poorer neighbourhoods and those from wealthier neighbourhoods can be seen across age groups through the education system. In the early years, this attainment gap is most clearly seen in Scotland between children of parents with high educational attainment and those of parents with low educational attainment. By 5 years of age, children of parents with degree-level qualifications are 18 months ahead of their peers of parents with no qualifications in terms of vocabulary, and 13 months ahead in terms of problem solving ability. This attainment gap continues and can be seen in literacy and numeracy in primary school, widening through time into secondary school. Ultimately, this means that children from poorer communities leave school with lower levels of attainment than their peers from wealthier communities. This will contribute to many inequalities throughout their lives, including in employment, health, social mobility and income, potentially continuing the effects into the next generation.
9.1.3 The Local Picture

Across Scotland there are 6,976 small geographical areas called datazones that are ranked in order of deprivation from 1 as the most deprived to 6,976 as the least deprived. Datazones are then split into fifths (quintiles), tenths (deciles) or twentieths (vigintiles) and given a SIMD rank where 1 is the most deprived and 5, 10 or 20 are the least deprived. Across NHS Dumfries & Galloway there are 201 datazones of which 17 are in quintile 1, the 20% most deprived category. Error! Reference source not found. below gives a breakdown for the different localities in Dumfries & Galloway. The areas where there is the highest concentration of geographical deprivation are northwest Dumfries, Central Stranraer and Upper Nithsdale.

However, research has shown that while SIMD16 and other measures of geographic deprivation are good at highlighting locations where there is concentrated deprivation in an urban setting but, within the rural setting, such as Dumfries & Galloway, where deprivation is less concentrated; there are severe limitations. For example, analysis has shown that within the datazones that are in the 20% most deprived nationally, 20.4% of the region’s income deprived and 21.3% of the region’s employment deprived people are included. This suggests that deprived individuals are distributed across the region more evenly and that 79.6% of income deprived and 78.7% of employment deprived people live in areas of Dumfries & Galloway considered to be less deprived according to SIMD 2016.

Despite the limitations, SIMD can successfully be used to identify gradients in health inequalities. The link between deprivation and poorer health outcomes is well documented. For example, data for Scotland for 2015/16 show that the percentage of children of a healthy weight in Primary 1 decreases as deprivation increases. In the least deprived areas, 81.3% of children were classified as healthy weight while in the most deprived areas 73.0% were classified as healthy weight. There is also evidence to show that teen booster immunisation uptake is lower in more deprived areas, rates of breastfeeding are lower, and the likelihood of mothers smoking during pregnancy is much higher; in the year ending March 2016, 26% of mothers living in the most deprived areas of Scotland were current smokers at their booking visit compared to only 4% in the least deprived areas.

Alternative methods for identifying people in deprived circumstances use individual indicators of deprivation rather than area-based measures. These can include factors such as family income and parental employment status, benefits status, education achievement and socio-economic classification to name a few. Assessing deprivation and, in particular, poverty is discussed in depth in the recent profile published by the Crichton Institute: “Poverty and Deprivation in Dumfries & Galloway”.

The recommended approach when looking at deprivation at a regional level is to produce local quintiles whereby all the datazones within Dumfries & Galloway are ranked according to the results for SIMD 2016 and then split into 5 equal groups where group 1 comprises the 20% most deprived within
### Table 40: Number of datazones and estimated number of children within 20% most deprived (Q1) across Dumfries & Galloway by national and local SIMD 2016 quintiles

<table>
<thead>
<tr>
<th>Datazones</th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% most deprived areas across Scotland</td>
<td>51</td>
<td>79</td>
<td>31</td>
<td>40</td>
<td>201</td>
</tr>
<tr>
<td>20% most deprived areas across Dumfries &amp; Galloway</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>20% most deprived areas across Scotland</td>
<td>7</td>
<td>21</td>
<td>0</td>
<td>12</td>
<td>40</td>
</tr>
<tr>
<td>Living in 20% most deprived areas across Scotland</td>
<td>201</td>
<td>969</td>
<td>0</td>
<td>325</td>
<td>1495</td>
</tr>
<tr>
<td>Living in 20% most deprived areas across Dumfries &amp; Galloway</td>
<td>680</td>
<td>1626</td>
<td>0</td>
<td>856</td>
<td>3,162</td>
</tr>
<tr>
<td>Living in 20% most deprived areas across Scotland</td>
<td>369</td>
<td>1,899</td>
<td>0</td>
<td>604</td>
<td>2,872</td>
</tr>
<tr>
<td>Living in 20% most deprived areas across Dumfries &amp; Galloway</td>
<td>1,296</td>
<td>3,231</td>
<td>0</td>
<td>1,754</td>
<td>6,281</td>
</tr>
</tbody>
</table>

Source: SIMD 2016; Scottish Government

Dumfries & Galloway and group 5 the 20% least deprived. Table 40 summarises the number of datazones and estimated number of Children and Young People living in the most deprived areas and Figure 38 demonstrates how people aged 18 and under are distributed across the quintiles in each locality. Note that while Nithsdale has the highest proportion of children living in quintile 1 neighbourhoods (17%) if you expand the scope to quintile 2 as well, Nithsdale has 38% of young people living in the 40% most deprived neighbourhoods whilst Wigtownshire has 72% of young living in the 40% most deprived neighbourhoods.

Population pyramids of the people living in the most deprived SIMD16 local quintile 1 have a markedly different shape to those living in the least deprived quintile 5. Note how the proportion of older residents is much smaller compared to Children and Young People in areas with worse deprivation.

The maps in Figure 40 and Figure 41 show the differences between national and local quintiles. Stewartry locality has no areas designated as being in the most deprived quintile.
Figure 38: Proportion of population aged 18 and under in each Scottish Index of Multiple Deprivation Quintile, Dumfries & Galloway, 2016

Source: Scottish Index of Multiple Deprivation 2016, Scottish Government, CHI registrations Nov 2016

Figure 39: Population Pyramids depicting the number of people by age group from the most deprived and the least deprived areas of Dumfries & Galloway, 2015

Figure 40: SIMD2016 deprivation map of Dumfries & Galloway – national quintiles

Figure 41: SIMD2016 deprivation map of Dumfries & Galloway – local quintiles
Free School Meals

From January 2015 free school lunches were made available to all primary 1 to 3 children in Scottish local authority schools. Free meals are also available to all children whose families receive certain benefits including Income Support, Job Seeker’s Allowance, Universal Credit and Part VI of the Immigration and Asylum Act. The free meals are also available to young people aged 16 to 18 who receive any of these benefits in their own right. Therefore the eligibility for free meals may be seen as an indicator of low household income.

In March 2016 following the primary 1 to 3 free lunch scheme, the Healthy Living Survey recorded free school meal information for secondary schools and also for primary schools for all pupils primary 1 to 7 and separately for primary 4 to 7. Using the information on the primary 4 to 7 pupils the survey recorded that 1,063 (17.1%) of pupils were registered for free school meals, indicating that they came from families on benefits. Of these pupils, 80.3% had taken a free meal.

The survey recorded 995 (12.7%) secondary school pupils registered for free school meals, of these pupils 59.6% had taken a free meal.

Please note: Anecdotal evidence suggests there is considerable local activity around foodbanks (e.g. local churches providing daily hot meals) however, there is a lack of aggregated information about the use of these services to support our understanding.

The First Base Agency, Dumfries which runs a Food Bank provides 5000 emergency food parcels annually for families in Dumfries.

Fuel Poverty

Fuel Poverty is the term used to describe the situation where a household has to spend more than 10% of its income on household fuel use. Dumfries & Galloway has particularly high rates of fuel poverty compared to Scotland as a whole, as illustrated in Figure 42.

The latest Scottish House Conditions Survey (2012-2014) reported that in Dumfries & Galloway over a third of all households (31,740; 46%) and 27% of families (4,900 households) were living in fuel poverty. The Scottish average over the same time period was 35% of households and 21% of family households in fuel poverty.

High levels of fuel poverty are found in Dumfries & Galloway for a number of reasons. There is a higher proportion of difficult to heat homes, with dwellings in rural areas more likely to be affected by damp, condensation and have poorer energy efficiency than homes in urban areas. Rural areas also tend to have lower incomes and higher costs of living, compounded by limited choice and higher cost of fuel in these areas.
High rates of fuel poverty are a particular issue for households with small children, as they are more likely to spend a greater proportion of their time at home than working-age people. The impact of fuel poverty and persistent cold housing in particular, can be detrimental to the health and wellbeing of Children and Young People. Nationally, the Scottish Household Conditions Survey indicated that 5% of the fuel poor in Scotland have a child under 5 years old in the household. Single parents are nearly 3 times more likely to experience fuel poverty than couples with children. Interestingly, single parent households are more likely than other household types to live in energy efficient houses, probably because they are also more likely to be in social housing. This would suggest that solutions to their fuel poverty should focus on income rather than efficiency.

**Anti-poverty Strategy**

Scottish Government Policy recognises that poverty is an enduring and persistent problem. There is increasing economic pressure on low income families and individuals and it is widely acknowledged that the effects of cuts in public spending are likely to impact disproportionately on those already living in poverty.

Dumfries & Galloway is one of the lowest paid regions in Scotland and there is no doubt that this, coupled with the rural challenges of the region contributes to the pattern of poverty in the region. Preventing and mitigating the complex and intricate causation and effects of poverty requires interventions and approaches from a range of organisations and services; particularly around children and families, employment, finance, fuel, health and wellbeing and transport.
The Dumfries & Galloway Anti-Poverty Strategy 2015-2020 recognises the complex challenges involved in addressing poverty and adopts an approach which focuses activity on the needs of the most vulnerable.

The Dumfries & Galloway Anti-Poverty Strategy 2015-2020 vision:

“People will be prevented from falling into poverty, supported to escape from poverty and able to lead independent, safe, happy and fulfilled lives”.

Work is progressing on establishing structures to implement the Anti-Poverty Strategy and arrangements are being made to use the existing Financial Inclusion Working Group as the basis for a Co-ordination Group. This Group will include representatives from communities facing different types of poverty. This will ensure that the Strategy is driven forward in way which is consistent with equality arrangements and ensure that underlying action plans are developed by and with people who have experience of the issues and barriers associated with poverty.

In relation to Children and Young People, work is ongoing locally that acknowledges that school costs can act as a barrier to those from low income families participating fully in school life and can lead to feelings of isolation from peers. Therefore, the “Cost of the School Day” work will look to “poverty proof” schools in the region, uncovering effective approaches which are already taking place and looking to work with schools to raise awareness of the issue and remove hidden costs in the school day. Consequently, every child in Dumfries & Galloway will be enabled to make the most of the school day, have the same opportunities as their peers and be protected from stigma, regardless of how much money they have at home.

Housing

It is widely recognised that housing and the place where people live can impact their health. Housing is a social determinant of health and poor housing can contribute to health inequalities. The impact of poor housing can affect different groups of people in different ways. For example, children living in cold homes have demonstrated reduced weight gain and increased severity of asthma: amongst adults, poor housing is linked to poorer general health and wellbeing.

Figure 43 shows that the number of households with 2 adults and children or with 3 or more adults and children is projected to decrease by 2037 from 12,661 households to 10,030 households. The number of households with single occupancy or with 1 adult and 1 or more children is forecast to increase by 23% by 2037 from 3,510 households to 4,326 households, with 1 adult male households showing the greatest increase (33%).

Children in single parent households are in one of the groups most at risk of poverty therefore may need more support from health, social services or Third Sector providers.
Over the next ten years the number of single parent households is expected to increase by 23% to 4,300, with the biggest increases being amongst the 30-34 (37%) and 35-39 (34%) age groups. In the 16-19 year age group, there is a projected decrease of 39% from 56 to 34 households. These changes are shown in Figure 44.

Source: National Records Scotland
The proportion of single parent households is projected to increase from 5.1% to 6.2% of households. These changes are important in how we develop services to support single parents and their children. Developing appropriate housing and care options will be a particularly key consideration in planning for the future. Housing will be needed not only for single parent families but for single adult households with access rights to children.

**Homelessness**

Tackling and preventing homelessness is a key priority in fighting poverty and inequality in Scotland, underpinned by the achievement of Scotland’s 2012 Homelessness Target. From the end of 2012, the right to settled accommodation has been extended to all those assessed as unintentionally homeless by local authorities. These housing rights are unprecedented in Europe. Prevention, particularly among young people, was a key focus of the Joint 2012 Steering Group which the Scottish Government established with COSLA in 2009 to drive progress towards meeting the target.

The Steering Group promoted a Housing Options approach to homelessness which involves early intervention and considers all of the options available to an individual and requires local authority homelessness services to work closely with other services in a range of areas important to young people including employability, mediation and financial advice.

The Scottish Government also recognises that local authority homelessness services and other relevant agencies must work together to best meet the needs of Children and Young People facing homelessness. It published homelessness guidance for the Best Interests of Children in 2010. Health and Homelessness Standards for Health Boards were established in 2005 and work continues to ensure links are maintained to the housing/homelessness sector.

Recently the PREVENT1 intervention has been introduced that aims to provide advice and support to people in danger of becoming homeless to prevent it from happening. These policy and service initiatives appear to be having an impact within Dumfries & Galloway as the number of applications for homelessness made to the local authority has decreased steadily since approximately 2004/05 (Figure 45).

The Scottish Government's latest statistics from the PREVENT1 initiative for the period 1st October 2015 to 31st March 2016 show that 370 prevention applications were made in Dumfries & Galloway. On 31st March 2016, there were 48 households with pregnant women or children in temporary accommodation. This included 76 children.
Health Inequalities

Addressing health inequalities requires action across all the social determinants of health. If we are to have the greatest chance of influencing the determinants of health and wellbeing, efforts should be focused on action to improve the quality of care for children and families. These objectives include safe and healthy pregnancies, nurturing childhoods and support for families to bring up their children in a safe, healthy, supportive and stimulating environment.

A wide-ranging policy context and a variety of approaches are being taken forward to address inequalities in health and wellbeing and ameliorate the effects of the intergenerational cycle of disadvantage. These and the local context are explored earlier in the “Overarching Themes” section of this report.

9.2 Oral Health

Good oral health should be established in the child’s earliest years. Parents have a key role to play and a healthy diet has considerable impact on preventing and reducing dental decay. Early dental registration (by 6 months) and regular contact with the dental team will provide essential support to ensure good oral health for all children.

Dental neglect is defined by the British Society of Paediatric Dentistry as “the persistent failure to meet a child’s basic oral health needs, likely to result in the serious impairment of a child’s oral or general health or development”, such neglect can be an indicator of a wider picture of unmet need. Dental caries is one of the most common diseases of childhood, yet it is entirely preventable, it is also
the most frequent reason that children in Scotland undergo general anaesthesia\textsuperscript{356}. There is evidence that untreated caries in pre-school children is associated with lower body weight, growth and quality of life\textsuperscript{357}. Therefore, in the context of early intervention dentists have a key role to play in assessing the wellbeing of the child as children are reliant on their families or carers to ensure their dental/oral wellbeing. Failure to ensure this and/or continual failure to attend dental appointments or complete courses of treatment may be an indicator of wider wellbeing concerns.

\subsection*{9.2.1 The Strategic and Policy Context}

\textbf{Childsmile} is a national programme designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services. Families with new born babies and young children are offered the opportunity through Health Visitors and Oral Health Support Workers to register their children with an NHS Dentist and visit the dental practice where they will receive tailored oral health advice and preventive services for their children.

The development of Childsmile was underpinned by SIGN Guidelines 47 (2000) and 83 (2005), which presented the case for a programme aimed at prevention of decay through evidence based activity. This included supervised tooth brushing, twice yearly fluoride varnish application, community based oral health promotion and regular visits to the dental team. In 2014 these guidance documents were superseded by SIGN Guideline 138\textsuperscript{358} which focuses on 121 interventions carried out by the dental team with Children and Young People aged 0-18 years. Key recommendations include those noted above and the application of fissure sealants to permanent molars as soon after eruption as possible.

\subsection*{9.2.2 The Evidence}

The review of the evidence of oral health programmes and interventions\textsuperscript{359} noted the steady improvement in oral health in both children and adults over the last several decades. The 2009-10 adult dental health survey highlighted a reduction in prevalence of some common oral health conditions between 1998 and 2009. The decline in dental caries has been supported by the ready availability of fluoridated toothpaste since the 1970s.\textsuperscript{360}

In relation to pre-school age children, a 2009 Swedish study\textsuperscript{361} suggested that nursery based fluoride milk programmes could be effective reducing tooth decay. A more recent UK study indicated that supervised tooth brushing in nursery schools with fluoride\textsuperscript{360} toothpaste for home use is associated with significant improvements in the oral health of 5 year old children at a population level. Research\textsuperscript{362} suggests that community based oral health promotion and education programmes delivered to low-income mothers and/or parents of 2 year olds may be associated with preventing tooth decay.

European and UK research demonstrate that primary and secondary school based fluoride varnish programmes can be effective at preventing or reducing enamel caries amongst children in at-risk or...
socio-economically deprived communities, but are less effective amongst children in low risk or non-deprived areas.\textsuperscript{363}

A recent trial in school children in North West England\textsuperscript{364} found limited evidence of effectiveness of fluoride varnish application in a public health programme. However, there are several differences between this trial and the Childsmile Nursery Programme that warrant further investigation. Firstly the North West England trial was undertaken in older children (7-8 years), while the Childsmile nursery programme focuses on 3 and 4 year olds, secondly the English trial used significantly less fluoride varnish which may have been insufficient to provide the required levels of prevention, thirdly the Childsmile Nursery Programme also includes supervised tooth brushing, finally the Childsmile programme focuses on children from more deprived areas who are at greater risk of developing dental caries.

Evaluation and research in all of the key domains underpinning Childsmile’s evaluation strategy, which include participation, service impact and health and behavioural outcomes, will contribute to further building the evidence base for oral health interventions.

\section*{9.2.3 The Local Picture}

The rate of decayed missing and filled teeth is reducing across Scotland as demonstrated by the reports of the Dental Inspection Programme carried out as:

- A Basic Inspection, for all children in Primary 1 and Primary 7
- A Detailed (epidemiological) Inspection, for a representative sample of this group, concerning P1 and P7 children in alternate years

Nationally from 2005 to 2015, the proportion of children in P7 with no obvious decayed teeth increased year on year from 53\% to 75\%. However, there remained a significant gradient between the poorer dental health of children living in the most deprived to the better dental health of those living in the least deprived areas.

In 2014/15, 89.5\% of D&G P1 children received a basic dental inspection. Of these, 9.6\% received a letter for their parents advising that they seek immediate dental care for severe decay or abscess. An additional 21.3\% received a letter advising parents to seek dental care in the near future for treatment of tooth decay, wear or damage, poor oral hygiene or for orthodontic treatment.

In 2014/15, 92.2\% of D&G P7 children received a basic dental inspection. Of these, 2.7\% received a letter for their parents advising that they seek immediate dental care for severe decay or abscess. An additional 57.7\% received a letter advising parents to seek dental care in the near future for treatment of tooth decay, wear or damage, poor oral hygiene or for orthodontic treatment.
In 2013/14, 22% of D&G P1 children received a detailed dental inspection. Of these, 65% had no obvious tooth decay. In those children with obvious tooth decay, the mean number of affected teeth was 3.6. The Care Index (% of obvious caries experience treated restoratively) for P1 children was 12.5 compared to the Scotland figure of 14.2.

**Figure 46: Children who received 2 or more FV Treatments within NHS Dumfries & Galloway, by non-population weighted SIMD (2012) Quintile; 2012/13 and 2013/14**

<table>
<thead>
<tr>
<th>SIMD 2012 Quintile</th>
<th>2012/13 Number of children (%)</th>
<th>2013/14 Number of Children (%)</th>
<th>Absolute difference between 2012/13 and 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children aged 3 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - most deprived</td>
<td>88 (24%)</td>
<td>118 (34%)</td>
<td>10%</td>
</tr>
<tr>
<td>2</td>
<td>51 (15%)</td>
<td>61 (18%)</td>
<td>3%</td>
</tr>
<tr>
<td>3</td>
<td>34 (12%)</td>
<td>58 (21%)</td>
<td>10%</td>
</tr>
<tr>
<td>4</td>
<td>25 (10%)</td>
<td>31 (12%)</td>
<td>3%</td>
</tr>
<tr>
<td>5 - least deprived</td>
<td>28 (11%)</td>
<td>45 (15%)</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3 -</td>
<td>3 -</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>229 (15%)</td>
<td>316 (21%)</td>
<td>6%</td>
</tr>
<tr>
<td>Children aged 4 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - most deprived</td>
<td>150 (41%)</td>
<td>141 (40%)</td>
<td>-1%</td>
</tr>
<tr>
<td>2</td>
<td>60 (19%)</td>
<td>79 (25%)</td>
<td>6%</td>
</tr>
<tr>
<td>3</td>
<td>49 (16%)</td>
<td>59 (20%)</td>
<td>4%</td>
</tr>
<tr>
<td>4</td>
<td>19 (8%)</td>
<td>34 (13%)</td>
<td>5%</td>
</tr>
<tr>
<td>5 - least deprived</td>
<td>48 (17%)</td>
<td>47 (17%)</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3 -</td>
<td>7 -</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>329 (22%)</td>
<td>367 (24%)</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>558 (18%)</td>
<td>683 (23%)</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: ISD Scotland

**Figure 47: Children, Under 18 - Dental Registrations and Participations by SIMD 2012 Quintile; Dumfries & Galloway; 30th September 2015**

Source: ISD Scotland, MIDAS
Figure 48: Children under 18 - Dental Registrations and Participation by Age Group; Dumfries & Galloway, 30th September 2015

![Graph showing dental registrations and participation by age group.](image)

Source: ISD Scotland, MIDAS

Figure 47 depicts the proportion of children aged under 18 years who are registered with a dental practice, and of those, the number who have visited (participated) their dental practice in previous 2 years. This chart indicates that there is no association between registration and deprivation for children with similar registration rates across all the SIMD quintiles. This pattern is similar to that seen in previous years. However, the figures do suggest an association between deprivation and participation, with children living in the most deprived areas least likely to see their dentist within 2 years (81% for the most deprived compared to 91% for the least deprived SIMD quintiles).

Figure 48 depicts the proportion of children aged 18 and under who are registered and who have participated by age group. The highest national participations levels were reported for children aged 0-2 (98%). This is largely as a consequence of the definition for participation (i.e. contact within 2 years). For all children, the participation rate was over 85% although it decreased with age, to 81% for the 13-17 age group.

The Health Behaviours of School Children (HBSC) 2015 survey found that overall 76% of young people reported brushing their teeth at least twice each day. A significantly higher proportion of 13 and 15 year old girls compared with boys brush this frequently.

In Scotland the proportion of young people brushing their teeth at least twice a day increased between 1998 and 2014 and the gender difference decreased from 17 percentage points to 13.
Figure 49: Proportion of young people in Dumfries & Galloway who brush their teeth at least twice daily, 2014.

Source: Health Behaviours of School Children 2015

Figure 50: Proportion of boys and girls that brush their teeth at least twice daily, Scotland, 1998 to 2014

Source: Health Behaviours of School Children 2015

9.3 Place

Good Places Better Health (GPBH, 2011)\textsuperscript{365} is the Scottish Strategy on health and the environment. This strategy recognises that environment (both the social and physical environment) has a significant impact on the health of Scotland’s people and that action is required to create safe, health nurturing environments for everyone. GPBH has completed its prototype phase which considered the question “What is needed to deliver places that nurture good health for children?” In particular the prototype put forward ten recommendations that addressed four health challenges facing children in Scotland: Obesity, Asthma, Unintentional Injury and Mental Health and Wellbeing as they affect children 0 – 8
years old. The recommendations covered neighbourhoods (including safe, healthy neighbourhoods; well maintained and managed public spaces; increased opportunities for outdoor play and access to the natural world; and supporting social capital within communities), the home (including warm dry homes; generously proportioned, flexible and functional homes; and homes within lifetime communities), and transport (including child friendly active travel and public transport; and safe streets).

9.3.1 Family Life

In 2014 two thirds (66%) of young people in Dumfries & Galloway reported that they live with both parents; 20% with a single parent, 13% live in a family with a step parent and 2% have some other sort of living arrangements. This was nearly identically to the picture found across Scotland.

Figure 51: Family structure of young people in Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

The Family Affluence Score (FAS) is a validated measure used in the HBSC that gives an approximation of young people’s parents’ socio-economic status. Children are classified as either having a low, medium or high affluence derived from a range responses to a number of questions. These asked young people a) the number of cars in their family, b) the number of computers at home, c) the number of family holidays taken abroad in the previous 12 months, d) if they have their own bedroom, (e) the number of bathrooms in their home and (f) whether their household has a dishwasher.

Dumfries & Galloway had a significantly lower proportion (14%) of young people classified as having Low Family affluence compared with Scotland (17%). However in terms of perceived family affluence the proportion of young people in Dumfries & Galloway who thought that their family was very or quite well off was actually significantly lower in the region (51%) compared with Scotland (57%). Between
1998 and 2014, Scottish young people have become increasingly likely to describe their family as ‘very well off’, from 9% to 19% among girls, and from 12% to 22% among boys.

Figure 52: Family affluence of young people in Dumfries & Galloway and Scotland, 2014.

![Family Affluence Chart](chart.png)

Source: Health Behaviours of School Children 2015

Generally young people find it easier to talk to their mothers (82%) than their fathers (66%), but ease of communication with both parent’s declines with age. Boys and girls find it equally easy to talk to their mother, but boys find it consistently easier to talk to their father than girls.

Figure 53: Proportion of young people finding it easy to talk to mother and father in Dumfries & Galloway, 2014.

![Ease of Communication Chart](chart2.png)

Source: Health Behaviours of School Children 2015
A measure of family support young people receive was calculated from questions including emotional support, problem solving and decision making. People could score questions on a scale of 1 (minimum family support) to 7 (maximum family support) with those averaging a score of 5.5 or higher over these measures said to have high family support. In Dumfries & Galloway the proportion of pupils that perceived high family support declined with age from 67% of 11 year olds with 49% of 15 year olds. This same pattern was also found throughout Scotland.

9.3.2 Neighbourhood Environment

In Dumfries & Galloway in 2014 two-thirds (66%) of 13 and 15 year olds always feel safe in their local area. This is a significantly higher proportion of secondary pupils than across Scotland where the figure was only 59%. Locally just under three quarters (71%) of secondary pupils reported that the area that they live in is a good or really good place to live which is similar to Scotland (73%).

In terms of general perceptions of their local area respondents from young people aged 13 years and 15 years in Dumfries & Galloway were significantly more likely to agree compared with Scotland that people would say hello and stop to talk to them in the street (77% vs 72%) but significantly less likely to say that their local area was a good place to spend free time (48% vs 59%).

Figure 54: Proportions that agreed with general perception statements of their local area, Dumfries & Galloway and Scotland, 2014.

Source: Health Behaviours of School Children 2015
By combining responses to all of the six local area items the proportion of young people who were determined as having a favourable perception of their local area (positive responses across all 6 items) was just under a fifth (18%) which was significantly lower than Scotland (22%).

Nearly two-thirds (62.6%) of 13 and 15 year olds in Dumfries & Galloway reported the regular (at least weekly) use of greenspace. Around a half of pupils were classified as heavy greenspace users where the duration of greenspace use lasted 2 or more hours in a week (ranging from 58% of 13 year old boys to 47% of 15 year old girls).

9.4 Play

The Early Years Framework defines early years as pre-birth to 8 years old, however many aspects of the Framework are equally relevant to children beyond the age of 8. It recognises the right of all young children to high quality relationships, environments and services which offer a holistic approach to meeting their needs. Such needs should be interpreted broadly and encompass play, learning, social relationships and emotional and physical wellbeing. This approach is important for all children but is of particular benefit in offering effective support to those children and families requiring higher levels of support.

Please note: Information regarding Children and Young People’s physical activity can be found in Section 10 (Active).

9.4.1 Peer Relations

In Dumfries & Galloway just over four fifths (84%) of 13 and 15 year olds have 3 or more close friends of the same sex. This is significantly lower than the national figure where 87% report 3 or more friends of the same sex.

Just over a fifth (21%) of young people spend time with friends outside of school on a daily basis before 8pm with 12% spending time with friends on a daily basis after 8pm. Boys at all ages were slightly more likely to spend time with friends after school both before and after 8pm.

The majority (88%) of 13 and 15 year olds in Dumfries & Galloway find talking to their best friend easy. A higher proportion of girls in find talking to their best friend easy compared with boys although this is only significantly different in 13 year olds (92% girls vs 81% boys) compared with 15 year olds (92% girls vs 86% boys).

Overall just over half (56%) of young people in Dumfries & Galloway report daily contact with their friends using either the phone, texting, email, instant messenger or other social media. This is significantly lower than the national prevalence of 61%.
Figure 55: Proportion spending time outside of school on a daily basis in Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

Figure 56: Daily electronic media contact with friends in Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

Just over half of all young people in the region (56%) reported high peer support although this is higher in girls (63%) compared with boys (49%).
9.4.2 Bullying and Fighting

Children, young people and adults often differ in how they define bullying and its frequency. Most children engage in rough or teasing play with one another, therefore distinguishing bullying from typical childhood play can be challenging. The difference often lies in the relationship between the bully and victim and in the intent of the interaction. In play children usually do not use their full physical strength while those who bully often do, in play children often regroup after they play whereas they separate after bullying and in play children often chose their roles (e.g. good guy/ bad guy) yet in bullying the roles of bully and victim remain stable. Bullied children may be reluctant to seek help and the context in which the child operates may be one that tacitly supports bullying. Even when a group of children hold anti-bullying attitudes they are often constrained by group norms that discourage defending the victims.

The Health Behaviours of School Children (HBSC) 2015 found that across Dumfries & Galloway 15% of young people reported that they had been bullied at least 2-3 times in the past couple of months and this was significantly higher than Scotland (14%). A small percentage of young people (4%) reported having bullied others at least 2-3 times in the past couple of months and this was higher in 15 year old boys compared with 15 year old girls.

Please note: Information on violence against Children and Young People can be found in Section 6 (Safe). Information on offending amongst Children and Young People can be found in Section 12 (Responsible).

Figure 57: Proportion of young people reporting that they either had been bullied at least 2-3 times in the past couple of months or had bullied others bullied at least 2-3 times in the past couple of months, Dumfries & Galloway, 2014.
A small proportion of young people reported having been cyber bullied at least 2-3 times in the past couple of months with 5% having been bullied via electronic media messages and 3% via electronic media pictures.

Boys were more than twice as likely (13%) to report being involved in a physical fight 3 or more times in the past year than girls (5%). Boys and girls aged 11 were most likely to have been fighting (20% and 7% respectively).

Nationally the proportion of young people that report being bullied has increased between 2010 and 2014, especially among girls.

Table 41: Proportion of young people involved in a physical fight 3 or more times in the last year.

<table>
<thead>
<tr>
<th></th>
<th>11 years</th>
<th>13 years</th>
<th>15 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boy</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Girl</td>
<td>6%</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Both</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

Figure 58: Proportion of young people that reported having been bullied 2-3 times or more in the last couple of months, Scotland, 2014.

Source: Health Behaviours of School Children 2015

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10. ACTIVE:

‘Children and Young People have opportunities to take part in a wide range of activities – helping them to build a fulfilling and happy future’

In this section:
- Sport & Physical Activity
- Organised Activities

Physical activity is vital for a child’s development, physically active play and learning experiences that link to children’s and young people’s interests, abilities and identity lay the foundations for a healthy and active life into adulthood and old age.

10.1 Physical Activity

Physical inactivity is increasing and is one of Scotland’s major health challenges, contributing to nearly 2,500 deaths (adults and children) in Scotland each year. The Scottish Government is committed to getting and creating a healthier and fitter nation. A wide-ranging policy context and a variety of approaches are being taken forward to support and encourage increased physical activity and ameliorate the effects of physical inactivity. These and the local context will be explored further in the “Active” section of this report.

10.1.1 The Strategic and Policy Context

The Scottish Government aims to increase and maintain the proportion of physically active people in Scotland, through the continued implementation of the National Physical Activity Strategy Let’s make Scotland more active (2003) which is consistent with World Health Organisation (WHO) policy and the five main strategies of the Ottawa Charter for Health Promotion (1986).

The report on physical activity for health from the UK’s Chief Medical Officers Start Active, Stay Active includes guidelines on the volume, duration, frequency and type of physical activity required across the life course to achieve general health benefits. It is aimed at the NHS, local authorities and a range of other organisations designing services to promote physical activity.

Reaching Higher (2007) is Scotland’s national strategy for sport which sets out the roles and responsibilities for all key stakeholders along with plans for its delivery and evaluation.
To further support these strategies a number of approaches are being taken forward which include:

- Developing a National Walking Strategy
- Taking forward a national physical activity implementation plan which will explore opportunities to embed physical activity in all areas of government policy
- The Youth Sport Strategy aims to make sport and physical activity a habit that stays with young people throughout their lifetime
- Investing almost £3 million on physical activity projects including Paths for All and Active Girls aimed at those furthest away from meeting the recommended physical activity guidelines
- Developing 150 Community Sports Hubs, half of which will be based in schools by 2016

National programmes such as Active Schools which highlights the importance of children doing at least 60 minutes activity a day and The ‘Take Life On’ campaign (focused on physical activity, healthy eating, wellbeing and alcohol consumption) encourage simple switches in our daily lives that make a real difference to our wellbeing and promote a healthier, more active lifestyle.

10.1.2 The Evidence

The prevalence of physical inactivity provides a significant public health challenge in Scotland; therefore Let’s Make Scotland More Active (2003) recognises that changing both behaviour and the environment will be a long term process. The aspiration is 80% of Children and Young People to be active daily for 60 minutes or more in moderate to vigorous physical activity, by 2022, consequently a 1% annual increase is required for the duration of the strategy if this target is to be achieved. In 2011, physical activity guidelines were published for the first time for children less than 5 years. Current guidelines make a distinction between children capable of walking and those not yet walking with recommendations for each summarised in table 1 below.

**Table 42: UK Physical Activity Recommendations**

<table>
<thead>
<tr>
<th>Early years (under 5 years)</th>
<th>Children and Young People (5 to 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical activity encouraged from birth</td>
<td>• Engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day</td>
</tr>
<tr>
<td>• Children capable of walking unaided should be active daily for at least 180 minutes throughout the day</td>
<td>• Vigorous activities, including those that strengthen muscles and bones, should be carried out on at least 3 days a week</td>
</tr>
<tr>
<td>• Extended periods of sedentary activities should be limited</td>
<td>• Extended periods of sedentary activities should be limited</td>
</tr>
</tbody>
</table>

Physical Inactivity (PI) is a global pandemic, responsible for up to 10% of non-communicable disease deaths and should be considered a public health priority. The public health challenge of the prevalence of physical inactivity in Scotland is evident; the lives of 2,500 Scots are lost annually due to PI with the cost to the overall economy totalling £91 million annually. The evidence
demonstrates that physical activity is beneficial throughout our lives and behaviour levels established in the early years, through childhood and adolescence influence activity levels in adulthood. The more active people are the greater the health benefits they obtain. The specific health benefits may differ across the lifespan, however being active at the recommended levels delivers better health outcomes from cradle to grave.  

The importance of play as a form of physical activity in the early year’s development cannot be underestimated. Play contributes to a happy, healthy childhood, the development of lifelong skills and short and long term health outcomes. The benefits of physical activity and movement in the early years for children not yet walking are the development of motor skills, improved cognitive development, contribution to healthy weight and enhanced bone and muscular development. For those children capable of walking, the benefits include the development of movement and coordination, improved cardiovascular health, contribution to healthy weight and improved bone health. In both groups, physical activity supports learning and the development of social skills.  

Children and Young People who are active for 60 minutes or more every day can gain physiological and psychological benefits. The physiological benefits include improved cardiovascular fitness and metabolic health, improved bone health, reduced risk of type 2 diabetes, reduced body fat and maintenance of a healthy weight and stronger muscles. Psychological outcomes of physical activity in children include improved social skills, integration into peer groups and extended social networks, improved self-esteem, with a greater effect for children with perceptual, emotional and learning disabilities, reduced anxiety and the potential for reduced depression and improved self-confidence in young people aged 10-16 years undertaking a high activity level. In addition there is some evidence for a positive association between physical activity and academic performance.

10.1.3 The Local Picture

The principle of collective effort is a key tenant within the publication of the Scottish Government’s Active Scotland Outcomes Framework. The framework provides ambitions for sport and physical activity in Scotland for the next 10 years and includes six national outcomes for physical activity:

- We encourage and enable the inactive to be more active
- We encourage and enable the active to stay active throughout life
- We develop confidence and competence from the earliest age
- We improve the active infrastructure – people and places
- We support wellbeing and resilience in communities through physical activity and sport
- We improve opportunities to participate, progress and achieve in sport

To ensure a clear implementation plan was set out to deliver the outcomes framework the Scottish Government published ‘A More Active Scotland – Building a Legacy from the Commonwealth Games’ (2014). This plan sets out a 10 year programme for physical activity committing to individual and collective actions required across a range of settings to deliver a more active and healthier nation.
These settings include the environment, the workplace, NHS and Social Care, Education, Sport and Active Recreation and Communications. Importantly, the plan was developed from the findings and principles set out in the Toronto Charter for Physical Activity (2010)\textsuperscript{383}, a paper that provides both the case for investing in physical activity while providing evidence of the interventions or actions with the strongest impact in promoting, fostering and raising activity levels.

There are two key strategic partnerships in Dumfries & Galloway to support an increase in physical activity.

The Dumfries & Galloway Physical Activity Alliance has been established to support the local delivery of “A More Active Scotland” for each stage of the life course. This strategic alliance of partners has representation from each setting referenced in the national plan and aims to lead, support and coordinate action to create positive environments and opportunities that support regular and sustainable physical activity.

SportScotland and Education Scotland have developed an integrated model for the delivery of Physical Education, Physical Activity and Sport (PEPAS) in school children. Dumfries & Galloway Council (Education Services/Leisure and Sport) and SportScotland have applied this principle and established a local PEPAS structure that works collectively to increase physical activity levels and support the achievement of 2 hours/periods of physical education per week. A quality physical education programme will be planned, facilitated and evaluated by GTCS registered teachers and take place during timetabled school time with all learners participating.

In addition, the Council’s Planning and Environment Service continue to support active and sustainable travel through infrastructure and behavioural change programmes that enable and encourage more active travel to school. School pupils in Dumfries & Galloway who actively travel for more than 5 minutes per day were on average 31 minutes (30 minutes more active during the day (n=10,224 days) than those where active travel was five minutes or less (n=8,608 days))\textsuperscript{384}. For 2014, Hands Up Survey data shows a consistent trend with 56.3% of primary and secondary pupils actively travelling in 2008, rising slightly to 58.7% in 2014 this is higher than the national average of 50.4% in 2014\textsuperscript{385}.

Dumfries & Galloway Council Active School and Community Sport service continue to deliver the Active Schools programme in partnership with SportScotland. The programme aims to provide additional high quality opportunities that encourage children to be active before and after school, lunchtime and at weekends. This is achieved through a network of Active School and Community Sport officers working towards recruiting coaches and volunteers to facilitate programmes in schools while encouraging pupils to take part in local community sport programmes. The programme in Dumfries & Galloway provided 8,613 activity sessions for 175,508 participants in the 2013-2014 academic years, an increase of 49% from the previous year total of 117,722. The coach and volunteer network grew from 325 to 388 supporting the sustainability of local provision within the school and community sport network.
Nationally, the 2015 Scottish Health Survey (September 2016) revealed that 73% of children (77% of boys and 69% of girls) met the physical activity guidelines including school-based activity (i.e. do 60 minutes of moderate activity, including school based activity every day of the week). Although there was little change between 2008 and 2011 in this measure for boys, the proportion of girls meeting the recommendations increased from 64% in 2008. Let’s Make Scotland More Active National Target is 80% for children by 2022.

As data from the national survey is not available at NHS Board level, a local physical activity self-report schools survey was piloted in 2012 and rolled out in 2013 and 2015. The 2015 Dumfries & Galloway School Physical Activity Survey collected data from school children in primary seven, secondary one, three and five. The key findings from the 2015 schools survey (N=3,147) are summarised below:

- One in five Children and Young People in 2015 were active to recommended levels of physical activity for health (22%)
- The proportions were higher for males (26%) compared to females (17%) and this difference was statistically significant
- Differences were also significantly higher for primary pupils (29%) compared to secondary pupils (18%) and this was true for both males and females
- There were significantly fewer females achieving the guidelines in 2013 (15%) compared to 2012 (23%). This had increased to 17% in 2015 (not statistically different from 2013)

**Figure 59: Percentage of school children meeting 60 minutes physical activity on 7 days per week by age; Dumfries & Galloway; 2015 (95% confidence intervals)**

Source: Dumfries & Galloway School Physical Activity Survey 2015
Base: All respondents with valid year group = 3,147
Figure 60: Percentage of school children meeting 60 minutes activity on 7 days per week by gender; Dumfries & Galloway; 2015 (95% confidence intervals)

Source: Dumfries & Galloway School Physical Activity Survey – 2015
Base: All respondents with valid gender = 3,147

Within schools Dumfries & Galloway Council’s Education Services has achieved the Scottish Government’s commitment that every pupil will benefit from two hours of quality physical education in primary school and two periods in S1-S4 from August 2014. A quality physical education programme will be planned, facilitated and evaluated by GTCS registered teachers and take place during timetabled school time with all learners participating.

The Active School and Community Sport service has achieved sustained growth over the past three years. This is evidenced by the total increase in participant numbers attending facilitated programmes from 117,722 in 2012 to 175,508 in 2013 and 214,360 in academic year 2014. In 2014, 54% of total attendances were boys to 46% females. The number of activity sessions offered through the network almost doubled from 5,547 in 2012 to 10,976 in 2014.

There is a clear trend between total active schools and community sport attendances and age. Total attendance in physical activity programmes in 2014 increased through primary education from 12,086 in primary one to 29,382 in primary seven. In contrast, total attendance levels decline through secondary education from 18,895 in secondary 1 to 4,623 in secondary 6. This supports findings from the Regional Schools Physical Activity survey (2013). Data from Active Schools and Community Sport reiterates the transition from primary to secondary school as a time where physical activity levels decline. Total attendance in programmes declined by 35.7% between primary 7 and secondary one in 2014 (24.8% boys/46.9% girls).

With the positive rise in overall participation it is not surprising that the number of individuals delivering programmes has also increased from 325 in 2012 to 478 in 2014 with 79% and 86% being volunteers.
respectively supporting the sustainability of local provision within the school and community sport network. The number of qualified volunteers has increased 159 to 275 between 2012 and 2014, supporting the delivery of high quality sustainable physical activity and sport provision.

The Health Behaviours of School Children (HBSC) 2015 asked 11 to 15 year olds about physical activity and sedentary behaviour. The survey found that two fifths (20%) of young people living in Dumfries & Galloway in 2014 met the recommended physical activity guidelines of 60 minutes of moderate or vigorous physical activity every day. This compares with a figure of 18% across Scotland. There was a gender difference in activity levels with guidelines achieved in 23% of boys and 17% of girls. The proportions meeting the guidelines fall with age and are significantly higher in boys than girls for 11 year olds. Across Scotland there has been a small improvement in the proportion of boys and girls meeting physical activity guidelines in 2014 compared with 2010, however rates have not improved relative to 2002.

**Figure 61: Proportion of young people meeting recommended physical activity guidelines, Dumfries & Galloway 2014.**

![Graph showing the proportion of young people meeting physical activity guidelines by age and gender.]

Source: Health Behaviours of School Children 2015

Half (50%) of young people in the region reported taking part in vigorous activity in their leisure time for 4 or more times in a week. Frequency declined with age and was always greater in boys compared with girls. Fifty-seven percent of young people reported that the duration of vigorous activity in their leisure time lasted for 2 or more hours in a week. Unlike the frequency of vigorous activity there was very little drop off in the duration reported by young people with increasing age (59% of 11 year olds, 59% of 13 year olds and 55% of 15 year olds).
Figure 62: Proportion of young people in Dumfries & Galloway reporting vigorous exercise 4 or more times a week, 2014.

Walking was the most common way to get to school at all ages (51% of 11 year olds, 40% of 13 year olds and 15% of 15 year olds) with the greatest change being the increase in bus use by secondary pupils. This is reflected in travel time to school with 89% of 11 year olds at school within 15 minutes but this drops to 55% of 13 and 15 year olds.

Table 43: Mode of transport to school, Dumfries & Galloway, 2014.

<table>
<thead>
<tr>
<th>Mode of transport</th>
<th>11 years</th>
<th>13 years</th>
<th>15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>51%</td>
<td>40%</td>
<td>39%</td>
</tr>
<tr>
<td>Bicycle</td>
<td>6%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Bus or train</td>
<td>8%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Car</td>
<td>33%</td>
<td>23%</td>
<td>24%</td>
</tr>
<tr>
<td>Other means</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
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</tbody>
</table>

Boys were more likely at all age groups to watch television for 2 or more hours a day on weekdays (69% boys vs 58% girls) and to play computer games for 2 or more hours a day on weekdays (65% boys vs 47% girls) and weekends (78% boys vs 57% girls). Compared with Scotland the overall prevalence for sedentary behaviours was not significantly different in Dumfries & Galloway.
Figure 63: Proportion of boys and girls spending 2 or more hours daily on a range of sedentary activities, Dumfries & Galloway 2014.

Source: Health Behaviours of School Children 2015

The Dumfries & Galloway School Physical Activity Survey in 2013 asked young people for reasons why people do not like to take part in physical activity from a range of barrier statements. The top three biggest perceived barriers were ‘The weather is too bad’ (50%), ‘Don’t have enough time’ (38%) and ‘Rather do other things’ (37%). Barriers that did not seem as much of a problem included ‘Not having the right clothing’ (12%), ‘Not interested in physical activity’ (19%) and ‘Don’t have right money’ (19%).

A higher proportion of girls compared with boys agreed with each of the barriers for not taking part in physical activity with the largest gender gap for feeling embarrassed (33% girls compared to 12% boys). The proportion of pupils agreeing with the barrier statements was always higher for secondary pupils compared with primary pupils and increased with age in secondary school. For example ‘Too much homework’ was perceived as a barrier for 16% of Primary 7 pupils but 64% of Secondary 5 pupils and ‘Don’t have enough time’ increased from 24% in Primary 7 pupils to 62% in Secondary 5 pupils.

10.2 Organised Activities

There is a wide range of activities available for Children and Young People to participate in across Dumfries & Galloway. Organised activities can include sporting clubs (such as football teams, tennis clubs and swimming teams); clubs that aim to develop skills for life (guides and scouting); and other hobbies and past times such as art groups, amateur dramatics and music groups. Youth centres also provide an environment where Children and Young People participate in a range of activities and develop a range of life skills. Organised activities are available for all different age groups; from
mother and baby groups to soft play groups for toddlers and sports groups for early teens to name a few.

Table 44: Proportion of young people agreeing as ‘very true’ or ‘quite true’ to a range of perceived barriers for not taking part in physical activity; Dumfries & Galloway; 2013

<table>
<thead>
<tr>
<th>Agree with Barrier statement</th>
<th></th>
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<tbody>
<tr>
<td>Weather too bad</td>
<td>50%</td>
</tr>
<tr>
<td>Don't have enough time</td>
<td>38%</td>
</tr>
<tr>
<td>Rather do other things</td>
<td>37%</td>
</tr>
<tr>
<td>Too much homework</td>
<td>36%</td>
</tr>
<tr>
<td>Not got right equipment</td>
<td>33%</td>
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<tr>
<td>Difficult to get to places</td>
<td>31%</td>
</tr>
<tr>
<td>Embarrassed</td>
<td>22%</td>
</tr>
<tr>
<td>Don't have right money</td>
<td>19%</td>
</tr>
<tr>
<td>Not interested</td>
<td>19%</td>
</tr>
<tr>
<td>Don't have right clothing</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway School Physical Activity Survey, 2013

For new parents or those with children with additional needs, organised activities can ameliorate feelings of social isolation and present real opportunities for peer support amongst parents. In the early years, organised activities with other young children can support developing social and cognitive skills. The evidence supports the importance of organised physical activities for boys and note that barriers to participation in these activities can lead to boredom and feelings of being trapped with older young men more likely to continue to report being involved in organised sporting activities as they progress into adulthood. Conversely, active young women have been found to dislike the competitiveness in traditionally organised team sports although they will participate in them if the activities provide opportunities for fun, relaxation, and social support.

There is limited information on the number of organised activities available in Dumfries & Galloway as there is no central directory. The Dumfries & Galloway Physical Activity Survey 2013 found that 32% of girls and 44% of boys were a member of a local community sports club or programme outside of school (Figure 64). Dumfries & Galloway Council lists 121 different groups across the region for young people and a further 73 groups for pre-school and children however, there is no indication how current this information is.
Figure 64: Percentage of school children that are a member of a local or community sports club or programme by gender; Dumfries & Galloway; 2015

![Percentage of school children by gender and sports club or programme](image)

Source: Dumfries & Galloway School Physical Activity Survey 2015
Base: All respondents with valid gender = 3,139

10.2.1 Social Capital and Children & Young People

The academic literature regarding Social Capital for children is relatively sparse. The vast majority of Social Capital research has been undertaken using adult samples. Even where Children and Young People are the focus of investigation, their outcomes are normally correlated with community social capital rather than the Social Capital as experienced by the children themselves. There appears to be some progress on this within the literature, with one recent study developing a brief tool to measure adolescent Social Capital\(^387\). Furthermore, local work is being undertaken between NHS Dumfries & Galloway and the University of Glasgow to investigate Social Capital among Children and Young People within the region. It is hoped that this will lead to the development of a comprehensive Children’s Social Capital Index for Dumfries & Galloway.

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11. RESPECTED

‘Children and Young People are given a voice and are involved in the decisions that affect their wellbeing’

Children and Young People have the right to freedom of expression, which includes the “freedom to seek, receive and impart information and ideas of all kinds” in any medium. This should only be restricted when necessary to respect the rights of others or protect public safety/morals.

11.1 The Strategic and Policy Context

The Children and Young People Act (Scotland) 2014 combines proposals to improve the delivery of children’s rights and services and are aimed at improving the focus of services around all Children and Young People while providing targeted improvements for specific groups. Consequently, all Children and Young People should benefit from the introduction of the Named Person and the proposals to embed children’s rights, while other provisions focus on children in the early years or the special needs of looked-after children. It addresses strategic planning as well as the planning around individual children.

The Act is wide-ranging in its proposals, although each set of proposals builds on the foundation of a common vision for all Children and Young People. The Act will:

- Embed children’s rights in the design and delivery of policies and services through duties on: Scottish Ministers to advance and raise awareness of the rights of Children and Young People, as set out in the UN Convention on the Rights of the Child (UNCRC); the wider public sector to report on what they are doing to advance these rights; and extending the power of the Children’s Commissioner to enable him to investigate potential infringements of rights of individual Children and Young People

- Improve the way services support children and families by creating a single point of contact around every child and young person through the role of the Named Person; by ensuring that
there is single, coordinated planning around all children who require support from services; by placing a definition of wellbeing on statute and duties on public bodies to report on outcomes

- Strengthen the role of early years support in all children’s lives by increasing the provision and flexibility of free early learning and childcare from 475 hours a year to a minimum of 600 hours for every 3 and 4 year old and looked-after 2 year olds

- Ensure better permanence planning for looked-after children by: extending support to young people leaving care for longer (raising their entitlement age to 25); giving legal recognition to Kinship Carers through a new Kinship Care Order; extending corporate parenting across the public sector through a new duty; and making adoption quicker and more effective by making compulsory the use of Scotland’s national Adoption Register

The Social Care (Self-Directed Support) (Scotland) Act 2013 provides children with social care needs with a variety of options to arrange their care and support. Direct payments or individual service funds involve identifying a budget for the child to take an active role in directing their support. This is provided as an alternative to services which would otherwise be arranged by the local authority on the child's behalf. Thereby offering disabled children and their families’ greater choice in how their assessed needs should be supported; thus shifting the balance of care to be more person centred and outcomes focused. Implementation of the Act demands a similar reform in culture and approach for local authority, third and private sector providers of children’s support. Self-directed support will work best when professionals take a collaborative or co-production approach that focuses the social care assessment on a person’s outcomes and assets rather than their needs and deficits. Legislation on self-directed support, applying to councils’ support to disabled children and Young Carers, was passed by the Scottish Parliament in November 2012.

Enabling young people to develop as responsible citizens with respect for others and commitment to participate responsibly in political, economic, social and cultural life is a key part of the purpose of Curriculum for Excellence.

Pupil Councils are present in schools across Scotland and they have proven how successful they can be in developing learner voices. Pupil participation is also promoted and supported through Eco-Schools, Rights Respecting Schools and related approaches to promoting health and wellbeing. The Scottish Government is working with organisations including Young Scot, Children in Scotland, the Children’s Parliament, the Scottish Youth Parliament, Youthlink and Scotland’s Commissioner for Children and Young People to help ensure Children and Young People are actively involved in shaping issues impacting on them. Youth awards show the value of young people's voluntary effort to develop their skills and improve the communities around them. Amazing Things is a key document for youth work organisations, schools, colleges, universities, and employers capturing the youth awards.
The Scottish Government launched its new strategic guidance for community learning and development (CLD) on 11 June 2012. The guidance: describes how CLD delivers SG policy outcomes in communities; clarifies the Scottish Government’s expectations of Community Planning Partnerships and other public sector partners for how CLD services should be delivered; highlights the role of CLD in public service reform and in delivering the outcomes of the Review of Community Planning; and re-emphasises the Scottish Government’s commitment to CLD’s aims and describes how these will be part of an overall strategic approach to be taken forward by a range of partners including Government itself, Education Scotland and the CLD Standards Council.

Implementation of the CLD strategic guidance will be delivered by Community Planning Partnerships with leadership and support from Education Scotland and other national and local third sector partners.

11.2 The Evidence

The growing focus on the child’s wellbeing, along with the ratification of the United Nations Convention on the Rights of Children in 1990, has highlighted the importance of parents, Carers and practitioners in children’s services recognising the child’s right to be treated with respect and dignity at all times, regardless of their age, gender or social, religious and cultural background and regardless of what they may have done or failed to do. Respect and being respected are multi-dimensional concepts which include:

- A focus on the child's feelings of self-worth, including their sense of belonging, their self esteem, and their sense of being loved and cared for and of being trusted by their friends and parents or Carers. This goes with a sense of not feeling stigmatised, discriminated against or demeaned
- The right of the child or young person to express their views on matters that directly affect them and to have those views given due weight in accordance with their age and maturity by the adults who care for them or come into contact with them in a professional or personal capacity
- Being consulted by their Carers and key professionals about any important decisions which will directly affect their lives, and being provided with the appropriate information to make an informed judgement about these decisions and to be able to provide informed consent
- The child or young person is entitled to have their views, and any disclosures about their private lives, treated in confidence unless these disclosures raise concerns about their wellbeing
- A predisposition to see the child or young person as an individual with a unique personality and his or her own individual needs

Children and Young People are denied respect when they are labelled, defined or perceived in terms of a particular characteristic: their ethnicity, religion, language, culture, disability, condition or by the
Respected problem which may have brought them to the attention of children’s services. Respect is fundamental to the child’s wellbeing. The child who is treated with respect is also more likely to be safer, emotionally and physically healthier, happier, more nurtured, more likely to feel and be included, more likely to achieve and more likely to respect themselves and others and behave in a considerate and responsible way.

For example, at an ideological level, children’s involvement in social work decision making is increasingly seen as important. A wide range of efforts have therefore been directed towards embedding participation into policy and practice. Nevertheless, many Children and Young People report negative experiences. This suggests that practice tends to be more messy, difficult and compromised than the policy might suggest. The 2006 study by MacLeod, showed that while social workers reported making extensive efforts to listen to children and to enable their participation, very few young people reported a sense that their views had been heard and taken into account. This finding was supported by the later work of Vis and Thomas who studied children’s participation in Norwegian child care and protection services. They found that consulting with children was not sufficient to ensure their participation in decision making. The researchers defined participation as a case in which (a) the child had some understanding of what was going on and had expressed views about the decision, and (b) the child’s views had affected the decision, as reported by the case manager. Of 43 cases where managers reported talking to children to facilitate their participation in decision making; only around half were found to meet these two criteria. In an overview of research on children’s participation in child protection processes, Schofield and Thoburn suggest that a trusting relationship with a dependable, skilled, professional helper is crucial. This may be a social worker, but in some cases an independent advocate will be better able to fulfil this role.

The relationship between choice, control and respect was further explored by Brophy in relation to the safeguarding of children during court cases. The research demonstrated that ensuring the safety and wellbeing of Children and Young People during court processes matters as there are severely detrimental and far reaching consequences for children whose private and intimate lives are made public and in which they had no choice. Treating Children and Young People with respect benefits them by ensuring that their rights are upheld, and that they are able to take an active, responsible and valued role in their communities. It will benefit services and organisations by making sure that they are well equipped to uphold children’s rights, and therefore deliver their services effectively. It will benefit communities by supporting them to include Children and Young People as active citizens, bringing people together and promoting positive relationships.

### 11.3 The Local Picture

A range of engagement activities with Children and Young People are undertaken across the region by statutory and Third Sector organisations. Dumfries & Galloway has adopted the National Standards for Community Engagement and participation and engagement work is based on the
Integrated Children’s Services Engagement Framework. However, there is as yet no coordinated mechanism by which the results of these activities and the subsequent changes to services (if required) as a response to this feedback is collated, analysed and shared.

The establishment of the Multiagency Engagement Group for Children and Young People (2015) is seeking to understand the complexity of these activities and determine the most effective way to share the lessons from listening to our population. Work is ongoing to determine what engagement activity is done, by whom, how frequently, how and where this is reported and what if anything has changed in response. The long term aim of the work undertaken by the group is the development of a strategic approach to engagement and participation with children, young people and families in which duplication and inconsistency are reduced and there are structures and processes in place that support the sharing of experiences and views that will improve planning, service delivery and outcomes.

The following sections are examples of recent and ongoing consultation activities.

11.3.1 Consultation and Engagement with Children and Young People

“a RIGHT blether”

This national consultation with Children and Young People across Scotland in 2010 provided an opportunity for Children and Young People to take part in a national vote and have their say about what is important in their lives. Voting took place online, at schools and local centres. Children and Young People were asked to vote on four categories: “in the home”, “where we learn”, “in the community”, and “in Scotland”. 1,474 votes were cast from Children and Young People from Dumfries & Galloway (2% of the total votes cast across Scotland). A report summarised the national results (regional results have not been published):

- Help us to be safe and secure in our home” achieved 42% of votes (33% voted for “Help us all have a loving, caring home” and 21% voted for “help us be able to keep things private”)
- 42% voted for “help us have the same chances, not matter how much money our families have” (35% voted for “help to create more experiences for us to learn skills for jobs” and 23% voted for “help improve the way our ideas are listened to and acted on”)
- Similarly 42% voted for “help us feel safe and respected” (40% voted for “help us have places to go that are fun and cheap or free” and 18% voted for “help us have the right transport that doesn’t cost too much money”)

The Health Behaviours of School Children (HBSC) Survey

This four yearly national survey undertaken with 11, 13 and 15 year olds collects quantitative data with local extracts about young people’s well-being, health behaviours and their social context. D&G
recently commissioned a boosted sample in order to access more local level data, the next surveys will take place autumn 2017. The Education Service and DG Health and Wellbeing Unit are primary recipients of the data however, all those working with Children and Young People, in and out of school, can use the data to inform monitoring, prioritising, reporting and service planning.

**Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)**

This two yearly national survey undertaken with S2 and S4 pupils (mainly 13 and 14 years) collects quantitative data with local data extracts and seeks to understand the prevalence, frequency of use, sources and attitudes in relation to tobacco, alcohol and drugs. National reports are produced and used to inform the national and local priorities for addressing harmful smoking, drinking and drug misuse. The most recent update was published October 2016.

**The Physical Activity and Wellbeing Survey**

Undertaken with Children and Young People, by DG Health and Wellbeing Unit, this activity collects quantitative data to discover views on physical activity experiences, attitudes and participation levels. The work concludes in September each year with the production of a report by December, presented to the Physical Activity Alliance, Active Schools, Education and NHS.

**Schools for the Future Consultations**

In taking forward Scottish Government’s Schools For the Future Programme two projects are underway in the region; Dumfries Learning Town and Dalbeattie Learning Campus. In both cases, the approach has been to work with children, families and communities to develop new ways for schools to support learning for all ages. In Dalbeattie Primary/High School and Cluster Primaries approximately 100 children were involved and 500 pupils from Dumfries also took part in the visioning work to form the brief for Dumfries Learning Town:

- “More chance to be able to follow your ambition”
- “To be able to express who we are more and know ourselves as individuals and not part of a year group”
- “I would like to tell people about the things that I know”
- “I would like my learning to go slower so I can take in more”

**The Listen2Us Project**

The project works with looked-after Children and Young People and care-leavers with the aim of supporting Children and Young People to become actively engaged in designing, shaping and evaluating the services they receive. Following a consultation exercise led by looked after Children and Young People with their peers and participation by local looked after young people in a major
national event, a commitment was given by Chief Officers to endorse the establishment of a Looked After Champions Board which is now active.

The Barnardo’s Hear4U Independent Advocacy Service

This service ensures that Children and Young People who are looked-after, subject to the Mental Health Care and Treatment Act or subject to Child Protection Hearings (8-18 years of age), are appropriately involved when decisions about them are made. The service acts to:

- Safeguard individuals who are in situations where they are vulnerable
- Speak up for and with people who are not being heard, helping them to express their views and make their own decisions and contributions
- Ensure that young people's own views are heard and adequately represented and to empower the child/young person
- Promote choices to young people
- Provide independent advocacy, related support and information in an age-appropriate and child/young person centred manner.
- Develop and promote children's and young people's involvement in service planning.

Personal and Social Education (PSE)

Ongoing surveys and focus groups are undertaken with Secondary School pupils (S1-S6) regarding development of their Personal and Social Education (PSE) and health and wellbeing. Quantitative and qualitative data is collected with the aim of ensuring that PSE and health and wellbeing learning experiences better meet the needs of young people. Reporting is within individual school reports which are used to inform school planning and work with partners such as DG Health and Wellbeing Unit.

11.3.2 Consultations and Engagement with Children, Young People and Families

School Improvement Planning (SIP) and Standards and Quality Report (SQR)

Undertaken at individual school level, with children, young people, parents and partner agencies, focus groups and questionnaires are used to gather both quantitative and qualitative responses aiming to reflect, review, assess impact and help inform change. SIP and SQR are statutory reports which are produced by schools each year; therefore the activity is ongoing throughout the school year with reports produced in May/June. As a single service activity, these reports are shared with the Education Department and are the focus of school improvement discussions. Parent, Children and Young People versions are created to inform them of findings and actions.
11.3.3 Consultation and Engagement with Parents and Families

D&G Early Learning and Childcare Survey

4,000 families with children aged up to 4 years were contacted to provide information on their use of childcare services and how, when and where they would like to see the Scottish Government’s additional provision of 600 Hours of Early Learning and Childcare provided. The survey achieved a high response rate (2027 responses) and feedback relating to the way in parents wish to be communicated with will be used to inform future consultations.

Supporting Autism Together

Supporting Autism Together aims to help meet the support needs of local families affected by autism. During 2012 a questionnaire was sent to 120 parents with children on the autism spectrum asking them about the issues they faced and the type of information they wanted. In addition, 36 parents from across the region participated in either the focus groups or home visits and said they wanted:

- A place to go locally
- Somewhere to meet and talk with other parents
- Help to look at things that were difficult
- Support to try to find a way forward
- Ongoing access to support when they needed it
- To find out more about autism and social communication

This information resulted in a complete reshaping of service delivery.

NHS D&G Maternity Link

NHS D&G’s Maternity Liaison Committee, is a dedicated team of local service users, healthcare professionals and representatives of other agencies who work with families during and after pregnancy. Ongoing consultation takes place to ensure that people who access maternity services are listened to with a view to improving the care and support they receive. For example in developing the “optimum” programme, a pilot of a change to service provision for women with a BMI of 40 and over Maternity Link members were asked for opinions and suggestions and one previous service user provided invaluable information on the care she received in her pregnancies and has advised on the team approach.
11.3.4 Other Consultation and Engagement Activities

The Domestic Abuse and Violence Against Women Partnership (DAVAWP)

The partnership works to ensure that service users affected by violence against women have a role in developing policy and practice along with service providers. DAVAWP holds an annual song writing competition which aims to encourage young people to create songs relating to domestic abuse and other forms of gender based violence, increase their understanding and raise public awareness of the issues. This innovative approach to engaging young people was Highly Commended by the Association of Social Care Communicators in 2012 and is being duplicated in North Lanarkshire.

During 2013, in partnership with the D&G Child Protection Committee DAVAWP undertook an on-line survey with young people in which:

- 94% of respondents agreed that a healthy relationship is about love, trust, honesty, respect, equality and freedom
- 56% recognised that domestic abuse happens in teenage relationships (although 32% were “unsure” and 12% disagreed)
- 83% agreed that at least one person they knew had “sexted” (however, 72% said they had never sexted an image of themselves)

In 2014 the DAVAWP undertook a further survey to ascertain views regarding violence against women, 502 people responded, 79.04% female (n396) and 20.56% male (n103) with 0.2% nil response to this question. Most of the respondents identified as heterosexual and ranged between 16-65 years. A substantial number of respondents:

- Were aware of the Partnership and familiar with key campaigns like posters, helpline cards and the DAVAWP Song Writing Competition for Young People
- Were able to identify most forms of gender based violence
- Were able to identify the role of alcohol in impairing someone’s ability to give sexual consent
- Could clearly identify patterns of coercive control in a non-violent setting.
- Would consider taking action in the hypothetical situation that someone they know suffered domestic abuse
- Acknowledged the exploitative nature of prostitution

On the other hand, the findings indicated that issues relating to commercial sexual exploitation and the role of demand in keeping the industry thriving were not agreed with by a considerable number of respondents. Constraints imposed by structural / societal inequalities on prostituted women’s choices were not clearly identified by a considerable number of respondents.
The Story Dialogue Event

During April 2014 a Story Dialogue event was held to explore the real lived experiences of Children and Young People, their families and Carers, and service providers to support the strategic planning of services and the achievement of improved outcomes for Children and Young People. The high level themes that emerged from this event were the importance of communication, early intervention, multiagency working, transitions, culture and values, holistic approaches and service improvement. This approach to listening to individual’s experiences was well received by participants, for example:

- “The power of the storytellers provided brought to the fore the importance of reflecting, improving and providing the best outcomes for our young people across the region. The range of partners and the openness and discussion promoted thought and highlighted opportunities for integrated and partnership working. It is really important that the outputs from the event are progressed and communicated quickly to retain momentum. The closing presentation from the Police provided a really inspirational close to the event.”

- “A really meaningful way in which to capture the views of the people we are committed to serve. I hope that we can build on the experiences of those who were courageous in sharing their stories and ensure that work progresses across all our partnerships so that we ultimately improve life changes for Children and Young People and have the confidence of our population.”

Crossmichael: A sense of place

During 2014 a study was designed and undertaken by a young person living in the village, to determine what impact living in Crossmichael has on the wellbeing of Children and Young People and to explore what they felt would improve their lives. Questionnaires distributed via the Primary School and Youth Club elicited 32 responses from Children and Young People and interviews with a small number of adult residents were also undertaken. The results showed that:

- 100% of the under 12 years children felt they belonged and were accepted in the community where they lived, compared to just 45% of 12-17 year olds who felt neither accepted nor listened to
- 12 – 17 year olds (11) identified green spaces and accessible public transport as the key elements of “good places” in which to live
- While generally showing a poor uptake of organised activities, this group stated a need for specific venues and activities aimed at their age group
- Adults showed an understanding of the lack of resources for Children and Young People, particularly in finding safe places for play
- The adult respondents noted both a range of useful skills and willingness to help make positive changes that have the potential to benefit the community as a whole
The findings were presented to Crossmichael Community Council who are planning to engage with CLD to develop resources to improve the facilities for Children and Young People in the village, building on the skills and abilities of the adult population.

**GIRFEC Third Sector Workshops**

During May and July 2014 a series of workshops with representatives of local Third Sector organisations were facilitated by the D&G Child Health Commissioner and Consultant in Public Health for Children and Young People. The aim of these events was to further develop a dialogue, identifying the unique contributions of Third Sector organisations and consider how partners might work together in achieving improved outcomes for children, young people and families. Participants identified the particular strengths of Third Sector organisations as being:

- Person centred
- Flexible
- Outcome focused
- Having specialist knowledge and expertise
- Less bureaucratic systems

This work is being taken forward with the formation of a Third Sector Early Years Forum under the auspices of Dumfries & Galloway Third Sector.

In addition to the above work, there is evidence that the general principles in the UNCRC are being taken forward locally including:

**Promoting the best interests of the child**

- There is guidance on retaining 16 and 17 year olds within the child’s hearing system, as removing this provision would not be in their best interests

**Respect for the views of the child**

- In recruiting staff for the Looked After Children Health Team, looked after young people were members of the interview panels during the appointment process in establishing this team
- Attendance of young people at ‘Permanency Panel’\(^{406}\) to ensure that their views are understood
- The introduction of the ‘Young Carers Card’\(^{407}\) to ensure appropriate sharing of information regarding the cared for person with the Young Carer
Protecting children from discrimination

- ‘The Usual Place’ offers opportunities to achieve. Set up in November 2011 with the aim of being the first fully accessible community cafe in Dumfries town centre providing employment and training opportunities for young people with additional support needs.

Evidence to show where improvements have been made to further children’s rights

- Education on sexual violence counteracts many media depictions of sexual violence and orientation.
- The Dumfries & Galloway Autism Strategy brings together cross-policy area measures to address the wellbeing of people with ASD across the life course.
- Young people are able to access mental health services; NHS Dumfries & Galloway accept about 1000 referrals a year and have no waiting list. Psychiatric referrals are seen immediately.
- NHS Dumfries & Galloway have been successful in a bidding for 3 year government funding for a Participation and Engagement Lead to embed and share participation in CAMHS/ISSU18 and the Specialist Looked After services initially with the long term aim to roll out across the Women and Children’s Directorate.
- Domestic Abuse Pathfinder in Dumfries & Galloway seeks to enable parents, families, practitioners and communities to identify at the earliest possible stage where support is needed for a child or young person affected by domestic abuse and to provide support.
- Looked After Champions Board Looked After Children and Care Leavers meet quarterly with senior heads of service to develop action planning that supports peers going into and leaving care based on Rights and Responsibilities.
- The Listen2Us report articulates recommendations from young people and also highlights the support provided by Barnardo’s Hear4U project.
- The Scottish Young Carers’ Festival 2014 Organised by The Princess Royal Trust for Carers, the two-day Festival brings together Young Carers from all over Scotland. Its aim is to provide a break from caring, try out different activities and question politicians. It identifies met and unmet rights and gives young people the right to be recognised as a Young Carer.

The work of embedding the rights of the child into local policy and practice is being taken forward across all agencies and services under the guidance of the Multiagency Engagement Group for Children and Young People. This undertaking will link with other recent developments such as the creation of a “GIRFEC Questions” template, designed to find out whether the changes being made in children’s services are making a positive difference to the lives of Children and Young People. The ambition is that whenever there is a consultation with young people, this set of questions will always be part of it. This ensures the continuance of collecting the views of Children and Young People about whether they are getting the help they need. Furthermore, the Youth Involvement Framework,
produced following a review of existing structures for youth democracy and representation will improve opportunities for young people to be heard.

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12. RESPONSIBLE

‘Children and Young People take an active role within their schools and communities.’

In this section:
- Young Carers
- LAC Champions Board
- Offending
- Risky Health Behaviours
- Responsible Citizens & Volunteering

Children and Young People who have self belief and a genuine sense of their own worth and who take responsibility for their actions develop independence and the ability to achieve their full potential. Therefore, enabling young people to develop as responsible citizens with respect for others and commitment to participate responsibly in political, economic, social and cultural life is a key part of the purpose of Curriculum for Excellence; and an important indicator of wellbeing.

12.1 Young Carers

Young Carers (aged 4 to 15 years) and Young Adult Carers (aged 16 to 24 years) are Children and Young People who have a caring responsibility for a parent, sibling and/or grandparent with an illness, disability, mental health or substance misuse problem which has an impact on their life. Young Carers are entitled to be Children and Young People first and ensure that they have access to appropriate services and opportunities to develop their health and wellbeing and educational needs.

12.1.1 The Strategic and Policy Context

The Dumfries & Galloway Young Carers Strategy 2009-2011 415 continues to be a relevant and a live document for all Young Carers living throughout Dumfries & Galloway. A revised Dumfries & Galloway Young Carers Action Plan 2012-2017 has been adopted as a complimentary plan to the original strategy in order to ensure we make a difference in the lives of Young Carers and their families throughout Dumfries & Galloway.

The local strategy and action plan recognise that Young Carers comprise a group of young people who have specific support needs. It is acknowledged that they provide (or intend to provide) a substantial amount of care on a regular basis and the provision of such care is likely to have a significant impact on their life.
These local strategic documents align with the expectations and outcomes identified in Getting it Right For Young Carers: Young Carers Strategy for Scotland 2010-2015 which acknowledges the invaluable role of Scotland’s Carers. It recognises that many young people can benefit from providing care to a relative or friend affected by illness, disability or substance misuse. However, the Scottish Government in partnership with COSLA are committed to ensuring that Young Carers are relieved of inappropriate caring roles and are supported to be Children and Young People first and foremost.

The Scottish Government also recognises that inequalities affect Carers in rural areas, including inaccessibility of services, the additional costs in caring and transport issues. This strategic approach builds on a number of key Scottish Government policy developments, including the Children and Young People Act, Additional Support for Learning, More Choices, More Chances and, in particular, GIRFEC. It presents a number of measures that aim to ensure that Scotland's Young Carers are supported to achieve better outcomes and to become successful learners, effective contributors, confident individuals and responsible citizens.

12.1.2 The Evidence

Whilst there is a significant body of literature and evidence pertaining to all Carers there is very little evidence in relation to the impact that caring responsibilities have on the lives of Young Carers. In addition, almost all of this evidence is UK wide rather than Scotland specific.

There is no definitive agreed number of Young Carers in Scotland although several sources estimate between 80,000 and 120,000 of Scotland’s Children and Young People have caring responsibilities. Estimated figures estimate that the value of unpaid care saves the Scottish economy £10 Billion pounds annually and Scottish government suggests that 1.6 billion of this amount is saved by Young Carers. However recent statistics published by the Scottish government estimates that 4% of the under 16 child population i.e. 29,000 have unpaid caring responsibilities. Scottish Government acknowledges the difficulties in identifying Young Carers. In 2014 schools in Scotland identified nearly 1,200 school age children who required additional support for learning because of their caring responsibilities. 28% of Young Carers in the most deprived areas care for 35 hours per week or more; compared with only 17% in the least deprived areas.

In 2013 The National Union of Students published a report that examined the experiences of student Carers. The report highlighted that only 36% of student Carers felt able to balance work, study and relationships compared to 53% of students without caring responsibilities. Approximately half of those interviewed felt that their academic attainment had been negatively affected by their caring responsibilities and over half had seriously considered leaving their course of study compared to 39% of the general student population.

During 2014, 165 Young Carers responded to an online survey and approximately 60 Young Carers attended three focus groups to explore the impact of their caring responsibilities on their finance,
education, social life and ability to access future opportunities. The research demonstrated the following themes; affording basic needs, funding further education, travel costs and money to socialise with friends. Some Young Carers reported feeling guilty for spending money on leisure activities as they felt this money should be used to support the family; thus contributing to feelings of isolation and loneliness. Furthermore, those Young Carers who enter full time education (21 Hours per week) are no longer entitled to receive Carers Allowance. Young Carers also expressed anxiety both as a result of their caring responsibilities, and affording transport which often limited their ability to attend classes.

Coping with the stresses and demands of caring and a willingness to continue in a caring role are both associated with lower levels of stress in Carers. Therefore the importance of maintaining the health and wellbeing of Carers is widely recognised as important, caring can also have a positive effect on wellbeing, family life and friendships through the development of self esteem, confidence and independence.

Any form of support for Young Carers should be timely, person centred and based around the needs of their caring situation.

12.1.3 The Local Picture

Information released by Scotland’s 2011 Census indicated that there are 282 Young Carers (aged 4-15 years) across Dumfries & Galloway and 666 Young Adult Carers (aged 16-24 years). Information has not been released providing a greater age breakdown at regional level as the numbers are likely to be very small for some regions. However, assuming the age distribution is similar to that of Scotland, an estimated 480 Children and Young People aged 4 to 18 years are Carers in Dumfries & Galloway.

The Census also reveals that of the 282 Young Carers, 83% (234 children) provide less than 20 hours of care per week, 8% (22 children) provide between 20 and 34 hours of care per week, and 9% (26 children) provide 35 hours or more care per week (Table 45).

Please note: Carer figures produced in the Census are based on self reported data and it is acknowledged that there may be under-reporting of the number of young people who are Carers as they may not recognise themselves as being a “Carer”.

Nationally, information from the Census indicates that a higher proportion of children from deprived backgrounds provide care and that those Young Carers from deprived backgrounds are more likely to provide more than 20 hours of care per week. It is reasonable to assume that a similar pattern exists for Young Carers and Young Adult Carers in Dumfries & Galloway.
Table 45: Estimated Young Carers (aged 4-15 years) and Hours of Unpaid Care provided by locality*; Dumfries & Galloway; 2011

<table>
<thead>
<tr>
<th></th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people aged 0 to 15</td>
<td>6475</td>
<td>10378</td>
<td>3432</td>
<td>4879</td>
<td>25164</td>
</tr>
<tr>
<td>Hours of unpaid care provided a week:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides no unpaid care</td>
<td>6399</td>
<td>10272</td>
<td>3391</td>
<td>4820</td>
<td>24882</td>
</tr>
<tr>
<td>Provides 1 to 19 hours</td>
<td>63</td>
<td>88</td>
<td>35</td>
<td>48</td>
<td>234</td>
</tr>
<tr>
<td>Provides 20 or more hours</td>
<td>13</td>
<td>18</td>
<td>6</td>
<td>11</td>
<td>48</td>
</tr>
<tr>
<td>Provides Any Care</td>
<td>76</td>
<td>106</td>
<td>41</td>
<td>59</td>
<td>282</td>
</tr>
</tbody>
</table>

Source: Census 2011, Table DC3103SC - Provision of unpaid care by sex by age, postcode sector
*Locally calculated figures for Locality based on aggregating Postcode Sectors (Not Exact Match to Locality)
Wigtownshire = DG80, DG86, DG87, DG88, DG89, DG90, DG97, DG98 DG99
Stewartry = DG54, DG64, DG71, DG72, DG73
Nithsdale = DG11, DG12, DG13, DG14, DG20, DG27, DG28, DG29, DG34, DG35, DG46
Annandale & Eskdale = DG109, DG111, DG112, DG112, DG125, DG126, DG130, DG140, DG165

In August 2015, 272 Young Carers were being supported by the Young Carers Project throughout Dumfries & Galloway.

The Dumfries & Galloway Young Carers Project continues to grow from strength to strength. Over the last year the project has:

- Supported the roll out of the Young Carers Card (80 Young Carers now have a card)
- Developed support for Young Carers who are caring for a parent with a substance misuse problem who often need additional and longer periods of 1:1 support throughout their caring role
- Provided short breaks for many Young Carers to ensure that they grow in confidence, enhance their self-esteem, health and wellbeing
- Developed a partnership with the Scottish Fire Service to promote fire safety within their homes and support in an emergency
- Developed a partnership with Stewartry, Kirkcudbright and Dalbeattie Rotary for Young Carers in the Stewartry
- Young Carers have undertaken training opportunities to build skills and confidence e.g. First Aid, healthy eating, “realize your potential”
- Created Young Carer Checklists for NHS, schools, Social Work and voluntary organisations in line with the implementation of the Young Carers Strategy
- Delivered 125 group support sessions to Young Carers throughout the region
- Delivered 1176 one to one appointments, providing support and advice to Young Carers
- 17 Young Carers attended the National Young Carers Festival
This year following feedback from Young Carers a Young Adult Carers group (aged 18 -29 years) has been created in order that there can be a seamless transition from being a Young Carer to a Young Adult Carer. There are currently 50 Young Adult Carers supported in Dumfries & Galloway.

### 12.2 Looked After Children and Young People

#### Please note: Information on Looked After Children can be found in Section 6 (Safe).

#### 12.2.1 The Local Picture

Looked After Children and Young People in the region are supported by the LISTEN2US Project which seeks the views and experiences of looked after young people across Dumfries & Galloway, to provide them with the opportunity to influence, shape, design and improve the range of services they receive. In this way, care experienced Children and Young People are supported to develop self-belief and become responsible citizens with a demonstrable commitment to improving the life circumstances of others.

For example, the D&G Looked After Children and Young People’s Champions Board was established following consultation by a local group of care experienced young people with their peers and the participation of young people from the LISTEN2US project at a major national event called “It’s Time to Listen”. Subsequently, a local ‘Meet the Bosses’ session with senior Council and NHS managers was held and the Chief Executive of the Council along with the Chair of the Social Work Committee signed a pledge on behalf of the Community Planning Partnership to:

*‘Commit to setting up a Champions Board involving looked after young people and Community Planning Partners to make recommendations for improvements and to act on them’.*

The “Champions Board” which includes senior officers from Local Authority and elected members meets regularly and two care experienced young people from the Champions Board sit on the multi-agency Corporate Parenting Group, responsible for delivering the D&G Corporate Parenting Action Plan.

Other activities include:

- Further consultations with care experienced young people
- The development of a Facebook page
- The achievement of SCQA in Participative Democracy
- Rewording and launch event of the Looked After Young People’s Promise
- The development of a peer mentoring programme
- Free access to all Council sport and leisure facilities as part of the implementation of the Corporate Parenting Action Plan
12.3 Responsible Citizens

Please note: Information on Children and Young People who volunteer is very limited. Young volunteers are considered to be people aged 12 to 25 years old. Currently the Scottish Household Survey only considers people aged 18 plus and whether or not they volunteer.

12.3.1 The Local Picture

Duke of Edinburgh Award (DofE)

Dumfries & Galloway Council’s Community Learning Development (CLD) Service pays a license fee to the Duke of Edinburgh’s Award to run the DofE as a Licensed Organisation. This allows the Council to register, oversee and support DofE groups in Dumfries & Galloway.

Table 46 lists the schools that are currently registered to deliver DofE Programmes as part of their extra-curricular activities.

Table 46: Schools registered to deliver the Duke of Edinburgh (DofE) Award; Dumfries & Galloway; 2015

<table>
<thead>
<tr>
<th>Stranraer Academy</th>
<th>Dumfries High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirkcudbright Academy</td>
<td>St Joseph’s College</td>
</tr>
<tr>
<td>Castle Douglas High School</td>
<td>Lockerbie Academy</td>
</tr>
<tr>
<td>Dalbeattie High School</td>
<td>Annan Academy</td>
</tr>
<tr>
<td>Dalry Secondary School</td>
<td>Langholm Academy</td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway Council

Wallace Hall Academy is currently registered to deliver DofE Programmes as part of their curricular and extra-curricular activities.

As an authority, the majority of young people undertaking their DofE are predominantly of school age, and the larger numbers of young people undertake the DofE at a school group, as noted in the following graphs and charts. School and youth group DofE completions are both rising, while reflecting the increase in participation.
Table 47: Number of children enrolled in Duke of Edinburgh (DofE) Award by level; Dumfries & Galloway; 2009/10 - 2013/14

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>150</td>
<td>175</td>
<td>220</td>
<td>245</td>
<td>248</td>
</tr>
<tr>
<td>Silver</td>
<td>60</td>
<td>110</td>
<td>62</td>
<td>84</td>
<td>83</td>
</tr>
<tr>
<td>Gold</td>
<td>22</td>
<td>26</td>
<td>29</td>
<td>38</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>232</strong></td>
<td><strong>311</strong></td>
<td><strong>311</strong></td>
<td><strong>367</strong></td>
<td><strong>375</strong></td>
</tr>
</tbody>
</table>

Source: Dumfries & Galloway Council

Figure 65: Number of children who completed the Duke of Edinburgh (DofE) Award by centre type; Dumfries & Galloway; 2009/10 - 2013/14

Source: Dumfries & Galloway Council

12.4 Offending

12.4.1 The Strategic and Policy Context

The Scottish Government published the Youth Justice Strategy ‘Preventing offending getting it right for Children and Young People’ on 17 June 2015. The strategy sets out priorities for 2015 to 2020 building on the progress already made since the publication of the previous youth justice strategy in 2008 and the national roll out of the whole system approach in Scotland in 2011.

Preventing Offending by Young People – A Framework for Action, June 2008, reflected a new approach to dealing with young people who offend, or who are at risk of offending, and aimed to deliver better outcomes for them. The Framework consisted of five key themes that provided the basis of implementation: prevention, early and effective intervention, managing high risk, victims and
community confidence, planning and performance. The ethos of the approach suggests that many young people could and should be diverted from statutory measures, prosecution and custody through early intervention and robust community alternatives.

In addition, in March 2009, the Scottish Government and COSLA jointly published their Framework for tackling antisocial behaviour, ‘Promoting Positive Outcomes’ drawn together following a thorough review of national antisocial behaviour policy and recognition that prevention and early and effective intervention should be at its heart. The four pillars of the Framework are prevention, integration, engagement and communication.

The CashBack for Communities Programme is a unique Scottish initiative where the ill-gotten gains of crime, recovered through the Proceeds of Crime Act 2002 are invested into community programmes, facilities and activities largely, but not exclusively, for young people to the ultimate benefit of Scottish communities affected by crime and anti-social behaviour. Money is provided to support a wide range of sporting, cultural, educational and mentoring activities for Children and Young People aged 10 - 25 years. The Programme includes a number of partnerships with Scottish sporting, arts, business, and community and youth associations and provides much needed funding to sports and community facilities. Projects range from diversionary work to more long-term potentially life changing intervention projects, which aim to turn an individual’s life around and provide them the opportunity of a positive destination such as employment, education, or volunteering.

“Youth Justice” is the term used to encapsulate “individuals, institutions and services with which young people up to the age of 18 come into contact as a results of their involvement in offending behaviour.” The vast majority of youth offenders are dealt with through children’s hearings rather than the criminal courts. Children’s hearings receive referrals for cases in which either the child has been harmed or is at risk of harm or abuse from others (non-offence referrals); or where the child’s own behaviour is of concern including committing an offence (offence referrals). Children under the age of 8 have no legal capacity to commit an offence and therefore cannot be prosecuted in criminal courts and can only be referred to the children’s hearings as a non-offence referral. Children aged between 8 and 12 can be referred to the children’s hearings for both non-offence and offence reasons but cannot be prosecuted in criminal courts. Children aged 12 or over can be prosecuted in criminal court subject to guidance of the Lord Advocate on appropriate cases, but the majority are referred to children’s hearings. The children’s hearings seek to determine what measures are required to address the behaviour and welfare of the child.

Please note: Information on non-offence referrals to children’s hearings can be found in Section 6.4.
12.4.2 The Evidence

A small proportion of Children and Young People become involved in antisocial and criminal behaviour; the causes and consequences of such offending are many and varied. It is important to note that the number of children under the age of 18 who are in custody is at an all-time low, with 66 in custody in 2014 across Scotland. Likewise, referrals to the Children’s Hearings System on offence grounds have dropped dramatically in recent years, with approximately 2,800 referrals in 2013/4.\(^\text{431}\)

Youth offending is both a cause and consequence of a range of negative factors affecting children’s outcomes. The academic literature suggests that youth perpetrators of crime are more likely than peers to be victims of crime and adult harassment or abuse and to be from deprived and disadvantaged households and communities.\(^\text{432,433,434,435,436}\) Furthermore, a disproportionately very high number of Children and Young People in custody have been in care, lived with someone other than a parent or been homeless shortly before incarceration.\(^\text{437,438,439}\) Children and Young People in the youth justice system have also been found to have experienced higher rates of bereavement than their peers.\(^\text{440}\)

Educational levels of Children and Young People in the youth justice system have also been found to be low. Studies of English and Welsh youth justice systems identified high levels of special educational needs; low levels of literacy and numeracy; and disproportionately high numbers of young people who have previously been excluded from school.\(^\text{441,442,443,444}\) Furthermore, children in the youth justice system are more likely to have speech and communication problems as well as learning difficulties and disabilities.\(^\text{445,446}\)

In addition, there is a large body of evidence that mental health disorders and their symptoms are found to be more common among young offenders than non-offenders; and that this is a mixture of cause and effect.\(^\text{447}\) These young people are more likely to be engaged in self-harming and suicidal behaviour; experiencing symptoms of post-traumatic stress; and experiencing symptoms of depression.\(^\text{448,449,450,451}\) Moreover, such offenders are more likely to be affected by conduct disorders; consuming illicit drugs and alcohol; experiencing disordered patterns of eating; undertaking risky sexual behaviour; and experiencing family breakdown or high levels of conflict with caregivers.\(^\text{452,453,454,455,456,457}\) In turn, youth involvement in crime or violence increases the likelihood that the young person will later experience self-harming or suicidal behaviour.\(^\text{458}\)

A large Scottish longitudinal study found that early- to mid-teen years are most crucial in a young person’s pathway to offending. Early-onset offending children (those whose first conviction occurred around 9-10 years of age) had high levels of family breakdown and conflict; high levels of truancy and disaffection with school; and were mostly from deprived neighbourhoods. However, key differences were seen between those Children and Young People with early onset of offending who went on to become chronic offenders and those who did not. Chronic offenders experienced sharp increases in truancy, greater school exclusion and more adversarial police contact while such factors stabilised or
declined significantly between the ages of 13 and 15 for those who did not become chronic offenders.\textsuperscript{459}

12.4.3 The Local Picture

Annual statistics are published by the Scottish Children’s Reporter Administration\textsuperscript{460}. The following are some key results from the statistics for the financial year 2015/16:

- 583 children were referred to a children’s hearing in Dumfries Galloway. 1,022 referrals were made in total. 56% or children referred were male, 44% were female.
- 132 children (22.6%) were referred for an offence reason. 502 children (86.1%) were referred for a non-offence reason. 51 children (8.7%) were referred for both offence and non-offence reasons. The age breakdown of all children referred to a children’s hearing is provided in Table 48.
- The rate of referral for non-offence reasons in Dumfries & Galloway was 21.2 children referred per 1,000 population. This was higher than the rate for Scotland at 15.0 children referred per 1,000 population.
- The rate of referral for offence reasons in Dumfries & Galloway was 10.9 children referred per 1,000 population. This too is higher than the national rate for Scotland at 6.2 children referred per 1,000 population.
- The majority of referrals in Dumfries & Galloway are made by the police (79.0%).

The most recent edition of the “Criminal Proceedings in Scotland Statistical Bulletin” is for the financial year 2014/15. This report provides statistics for Scotland and indicates the there were only 12 under 16s across Scotland who had a charge proved during the 2014/15. It is understood that this statistic refers to children prosecuted through criminal courts. The next age group provided by the report is ages 16 to 20 years (inclusive). For this age group 8,612 people across Scotland had a charge proved during 2014/15. There will be children aged 16 and 17 included in this group although the exact proportion is unknown. The report does not provide regional level information.
### Table 48: Children and Young People referred to children’s hearings by age; Dumfries & Galloway; 2015/16

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>No. Children Referred (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>46 7.9%</td>
</tr>
<tr>
<td>1</td>
<td>35 6.0%</td>
</tr>
<tr>
<td>2</td>
<td>27 4.6%</td>
</tr>
<tr>
<td>3</td>
<td>29 5.0%</td>
</tr>
<tr>
<td>4</td>
<td>26 4.5%</td>
</tr>
<tr>
<td>5</td>
<td>30 5.1%</td>
</tr>
<tr>
<td>6</td>
<td>34 5.8%</td>
</tr>
<tr>
<td>7</td>
<td>26 4.5%</td>
</tr>
<tr>
<td>8</td>
<td>34 5.8%</td>
</tr>
<tr>
<td>9</td>
<td>36 6.2%</td>
</tr>
<tr>
<td>10</td>
<td>19 3.3%</td>
</tr>
<tr>
<td>11</td>
<td>30 5.1%</td>
</tr>
<tr>
<td>12</td>
<td>31 5.3%</td>
</tr>
<tr>
<td>13</td>
<td>53 9.1%</td>
</tr>
<tr>
<td>14</td>
<td>66 11.3%</td>
</tr>
<tr>
<td>15</td>
<td>71 12.2%</td>
</tr>
<tr>
<td>16</td>
<td>30 5.1%</td>
</tr>
<tr>
<td>0-3</td>
<td>137 (23.5%)</td>
</tr>
<tr>
<td>4-11</td>
<td>235 (40.3%)</td>
</tr>
<tr>
<td>12-18</td>
<td>251 (43.1%)</td>
</tr>
</tbody>
</table>

**Total No. Children**  583

Source: Scottish Children’s Reporter Administrator⁴６１

### 12.5 Health Behaviour

#### 12.5.1 Smoking

Smoking remains the principle preventable cause of ill-health and premature death in Scotland. Therefore, Scottish Government Policy now gives a greater focus to prevention and early intervention approaches focused on preventing young people from taking up smoking.

**The Strategic and Policy Context**

The publication of *A Breath of Fresh Air for Scotland (2004)*⁴６２ provided the platform for a major expansion of smoking cessation services in Scotland leading to record numbers of quitters by 2010 and the smoking ban. Whilst not directly aimed at Children and Young People the denormalisation of smoking and reduced exposure to second hand smoke positively impact on young people’s attitudes and health outcomes. *Scotland’s Future is Smoke-free (2008)*⁴６３ was specifically aimed at accelerating action to prevent Children and Young People from starting to smoke. Action in the plan is set out under 4 broad headings:
12. Responsible

- Health Promotion and Education
- Reducing the Attractiveness Of Tobacco Products
- Reducing the Availability of Tobacco Products
- Reducing the Affordability of Tobacco Products

This led to the Tobacco and Primary Medical Services (Scotland) Act 2010 which, amongst a range of measures, included the ban on the display of tobacco in shops, banned cigarette vending machines, new offences of underage and proxy purchase and new police powers of confiscation.

The Scottish Government launched its current Tobacco Control Strategy, Creating a Tobacco-Free Generation on 27 March 2013. Preventing young people from starting to smoke and protecting them from exposure to second hand smoke continue to be key themes. Scotland is the third nation in the world to set an ambitious target to become tobacco-free, by having less than 5 per cent of the population choosing to smoke by 2034.

The Evidence

Smoking initiation is associated with a wide range of risk factors including parental and sibling smoking, the ease of obtaining cigarettes, smoking by peers, socio-economic status, exposure to tobacco marketing and depictions of smoking in the media. Children who live with adults or siblings who smoke are three times more likely to take up smoking themselves than children of non-smoking households. There is a strong association between smoking and other substance misuse. The earlier the age of uptake of smoking the greater the harm is likely to be because early uptake is associated with subsequent heavier smoking, higher levels of dependency and lower chances of quitting. Smoking in childhood has long been understood to cause serious risks to respiratory health in both short and long term, and impairs lung growth, initiating premature decline in lung function which may lead to increased risk of chronic obstructive lung disease in adulthood. Early and persistent smoking increases the risks of developing lung cancer and heart disease. Research suggests that knowledge about smoking is a necessary component of anti-smoking campaigns, but alone does not affect smoking rates, it may however result in later initiation of smoking. Studies suggest that children are up to four times more price sensitive than adults; therefore higher pricing may prove to be a deterrent as demonstrated by the dramatic rise in Canadian cigarette prices during the 1980s which significantly reduced youth consumption of tobacco.

Globally an estimated 40% of children are reported to be exposed to passive smoking. In the UK, around 2 million children are estimated to be regularly exposed to second hand smoke in the home. Smoke free legislation came into effect in 2006 in Scotland prohibited smoking in enclosed public places, workplaces and work vehicles, private dwellings and vehicles were not covered under the legislation. Prior to the introduction of the legislation, concerns were raised that children’s health would be adversely affected as smoking may be displaced back into the home. However, there is
no published peer reviewed evidence to show that the smoke free legislation has lead to an increase in smoking in the home, research conducted across the UK has observed that the overall level of second hand smoke exposure among children has fallen substantially. Evidence from England suggests that the legislation has lead to an increased proportion of parents making their home smoke free.

NHS Health Scotland has considered the NICE recommendations (guidance 23) and has adopted them for Scotland with minor amendments. Details of which are contained in The Scottish Perspective on NICE public Health guidance 23 (Feb 2010). The five thematic recommendations encompass whole –school approaches, adult led interventions, peer-led interventions, training and development and coordinated approaches. These approaches acknowledge that no single intervention or programme can prevent Children and Young People from smoking, but rather express a need for a comprehensive approach embracing individual, social, community and societal issues in which different elements may act synergistically.

The Local Picture

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) asks young people aged 13 and 15 about their smoking habits and provides information at a national and regional level. The results from the most recent survey (2013) for Dumfries & Galloway indicated that:

- 1% of 13 year olds and 16% of 15 years olds report that they are either regular or occasional smokers.
- 87% of 13 year olds and 61% of 15 years olds had never tried smoking
- Amongst 15 year olds and of those who are reported as regular smokers, 67% source their cigarettes by asking “someone else to get them from a shop” and 53% report being given cigarettes by friends, siblings or parents.
- Amongst 15 year olds, the use of electronic cigarettes (e-cigarettes) is largely confined to those who report being a current smoker or having tried smoking. For example, amongst 15 year olds who are regular smokers, 71% report either trying an e-cigarette or using them on a regular basis, whereas amongst 15 years old who have never smoked only 2% report trying an e-cigarette once. It should be noted that order in which young people try e-cigarettes compared to regular cigarettes is not reported in SALSUS.

The Health Behaviours of School Children (HBSC) 2015 survey found similar prevalence levels for smoking across Dumfries & Galloway to the latest SALSUS survey. The HBSC survey found that for young people in the region less than 1% of 11 year olds, 12% of 13 year olds and 24% of 15 year olds reported having ever smoked. Fewer young people reported that they were current smokers; less than 1% of 11 year olds, 5% of 13 year olds and 13% of 15 year olds. Daily smoking was reported by 2% of 13 year olds and 7% of 15 year olds. The overall prevalence for all young people having ever smoked tobacco (12%), were current smokers (6%) or were daily smokers (3%) in Dumfries &
Galloway were not significantly different to Scotland. At a national level fewer 15-year old boys and girls were current smokers in 2014 compared with 2010 (14% of boys and girls in 2014 versus 17% of boys and 19% of girls in 2010).

Figure 66: Percentage of Young People who report being a regular smoker; Dumfries & Galloway; 2006 – 2013

![Graph showing percentage of young people who report being a regular smoker from 2006 to 2013.](image)

Source: SALSUS 2013
Base: young people surveyed in 2013, 13 years olds = 358, 15 year olds = 359

Figure 67: Proportion of 15 year olds who report having tried an e-cigarette at least once or are currently using e-cigarettes by smoking status; Dumfries & Galloway; 2013

![Graph showing proportion of 15 year olds who report having tried an e-cigarette at least once or are currently using e-cigarettes by smoking status.](image)

Source: SALSUS
The Strategic and Policy Context

The Scottish Government published its national drug strategy The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem, in 2008. It focused on: increasing the rate of recovery from drug misuse; preventing drug use; reducing the supply of illegal drugs; and, protecting children at risk as a result of parental drug misuse.

Drugs education is positioned and embedded within wider health and wellbeing education. Key prevention activities include the Scottish Government substance misuse information campaign, Know the Score; the Scottish Government funds the Scottish Crime and Drugs Enforcement Agency to deliver Choices for Life, the Substance Misuse Education Programme (alcohol, tobacco and drugs) for Scottish school children, from P7 to S6; and work with young people to develop innovative sources of information on substance misuse.

As part of the health and wellbeing curriculum in schools, all Children and Young People will learn about a variety of substances including alcohol, medicines, drugs, tobacco and solvents. They will explore the impact risk taking behaviour has on life choices and health.

The Evidence

Substance misuse is concerning for Children and Young People because of the disproportionate effect it can have on their physical and emotional health development, education and family life. Most young people will experiment with substances and for a few, this will become problematic. Factors
that influence substance misuse among Children and Young People encompass environment, family, individual experience, mental health and education.\textsuperscript{483}

For the most part there are distinct differences between adults and young people around the type of substance used, when and in what situations. It is important that substance misuse; interwoven as it is with the issues of domestic violence and poor mental health, is seen in the context of the wider children and family agenda and not in isolation, as the biggest influence on young people’s attitudes to substance use is their family.\textsuperscript{484}

Among 10-15 year old an increased likelihood of drug use can be linked to truancy, exclusion from school, homelessness, being looked after and offending.\textsuperscript{485} Illicit drug use in the UK is most prevalent among young people aged between 16-24 years, particularly those who are vulnerable.\textsuperscript{487} Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death; and may also lead to increased risks of STIs. However, not all substance misusers will problem problematic adult substance misusers or experience other, wider problems even if not treated. The report \textit{Specialist Drug and Alcohol Services for Young People a cost benefit analysis}\textsuperscript{488} suggests that between 30-40\% of moderate/heavy alcohol and cannabis users would develop substance misuse problems as adults, whilst the remainder would experience natural remission (even if not treated). The proportion is however higher for those young people who use class A drugs during adolescence.

Research demonstrates that integrated approaches that address the root causes and wider determinants of drug dependence, whilst building effective recovery approaches for those who misuse substances deliver the best outcomes in this population.\textsuperscript{489,490,491}

The Local Picture

The SALSUS survey for 2013 reported on the number of 13 and 15 year olds who misused drugs. The key findings for Dumfries & Galloway are:

- The proportion of adolescents who are misusing drugs appears to be decreasing. Amongst 13 year olds the proportion who have ever misused drugs has dropped from 7\% in 2006 to 4\% in 2013. Amongst 15 year olds the proportion has dropped from 21\% in 2006 to 18\% in 2013.
- Cannabis is the most commonly misused drug (9\% of 15 year olds), followed by stimulants such as ecstasy and cocaine (3\% f 15 year olds).
- Amongst 15 year olds who misused drugs 43\% reported obtaining drugs from an older friend, 32\% reported obtaining drugs from a friend the same age, 11 \% reported obtaining drugs from some they knew of but not personally, and 10\% reported obtaining drugs from a sibling.
Figure 69: Percentage of Young People who have ever misused drugs; Dumfries & Galloway; 2006-2013

Source: SALSUS 2013
Base: young people surveyed in 2013, 13 years olds = 352, 15 year olds = 355

The Health Behaviours of School Children 2015 found that across Dumfries & Galloway 4% of 13 year olds and 12% of 15 year olds reported use of cannabis at least once in their life. Regular cannabis use was reported by 2% of 15 year olds and heavy use by 1% of 15 year olds.

Table 49: Cannabis use in young people in Dumfries & Galloway, 2014.

<table>
<thead>
<tr>
<th></th>
<th>Ever used Cannabis</th>
<th>Used Cannabis in last month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13 years</td>
<td>15 years</td>
</tr>
<tr>
<td>Boys</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>Girls</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Both</td>
<td>4%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Health Behaviours of School Children 2015

12.5.3 Alcohol

The Strategic and Policy Context


Examples of key national prevention activities that focus on Children and Young People include:

- You, Your Child and Alcohol - refreshed advice for parents and Carers published in January 2011. This provides information and supports parents/Carers to talk to young people about the effects of alcohol consumption.
Thinking Differently – Young People and Alcohol is a funding opportunity (2013-16) created by a number of UK funders working in partnership, which seeks to identify ways of reducing alcohol-related harm in young people, their families and communities in Scotland by the delivery of innovative early intervention approaches targeted at young people.

In addition, approaches not directly aimed and Children and Young People, that however have the potential to positively influence outcomes for Children and Young People include:

The HEAT Standard for delivery of alcohol brief interventions (ABIs) will help to ensure that those who are drinking at harmful or hazardous levels receive early support to cut down. Presently there is no evidence on the efficacy of delivery to those under 16. This does not preclude delivery of ABIs to young people, therefore potentially benefiting young people with alcohol issues, while indirectly benefitting those whose parents or Carers have alcohol issues.

In addition, strengthened legislation through:

- The Licensing (Scotland) Act 2005
- The Alcohol (Scotland) Act 2010.
- The Alcohol (Minimum Pricing) (Scotland) Act 2012

These laws penalise those who sell alcohol to underage consumers, restricts promotions/marketing and targets the very cheap cider and vodka products that are attractive to young people.

The Evidence

The 2009 publication, Influences on how Children and Young People learn about behaviour towards alcohol suggests that there is strong evidence linking a wide range of parental and family factors in the development of attitudes and behaviour to alcohol in young people. These include peer influence, advertising and media influences, ethnicity, religion and culture as well as other factors that increase risk taking behaviour such as child abuse, truanting and poor school performance.

Adolescents who misuse alcohol are more likely to suffer from changes in appetite, weight loss, eczema, headaches and sleep disturbance. Young people may suffer from the chronic conditions associated with excess alcohol consumption in adults, including deaths from liver disease. Alcohol abuse in adolescents, during a developmentally sensitive period poses a particular danger to the emerging brain facilities of executive functioning and long term memory; and feels of depression may occur. Stress and anxiety based drinking is linked with long term and more severe negative outcomes. In addition school performance and friendships with peers may be affected. Some young people may display aggressive behaviour as a consequence of excessive alcohol consumption; however their family circumstances and personality will be also contributing factors. Alcohol consumption is associated with an increased likelihood of engaging in sexual activity, particularly at a
younger age, unprotected sex, teenage pregnancy and the probability of contracting sexually transmitted diseases. The Scottish School Adolescent lifestyle and Substance Use Survey (2006) found that over one third of 15 year olds had consumed alcohol during the previous week.

Systematic reviews have found evidence for the effectiveness of a number of family-based interventions. However, many of the studies reviewed emanate from the USA, therefore the programmes and approaches may not be applicable to the UK where consumption of alcohol, particularly in young people is different.

Scotland’s strategic approach to tackling excessive consumption of alcohol is broad based and includes, minimum pricing, the cessation of loss leading promotions, increasing awareness on a population basis and links to other strategic approaches such as safer streets. Effective alcohol policy has been shown to encompass a range of interventions including regulatory measures, support and treatments and changes in culture and attitudes, aimed at the whole population with specific targeted interventions for high risk groups.

The Local Picture

The SALSUS asked young people about their drinking habits. The key results for Dumfries & Galloway were:

- In 2013 amongst 13 year olds, 40% reported that they had had at least one alcoholic drink. Amongst 15 year olds this 81%
- Young people appear to be having alcohol drinks less frequently. Amongst 13 years olds the number of young people who reported having had at least one alcoholic drink in the past week has decreased from 18% in 2006 to 5% in 2013. Amongst 15 year olds this has decreased from 40% in 2006 to 18% in 2013
- Amongst 13 year olds, 48% reported having been “drunk” at least once. Amongst 15 year olds this 75%
- Amongst 13 year olds, 38% reported obtaining alcoholic drinks from home with or without permission; 34% obtained alcoholic drinks from a relative; and 21% obtained alcoholic drinks from a friend. Amongst 15 year olds, 45% reported obtaining alcoholic drinks from a relative, 43% obtained alcoholic drinks from a friend, and 21% obtained alcoholic drinks from home with or without permission

The Health Behaviours of School Children 2015 survey found that the proportion drinking on a weekly basis increased with age from 1% of 11 year olds, 4% of 13 year olds and 15% of 15 year olds. At 15 years boys were more likely to drink on a weekly basis (19%) compared with girls (10%). Having been drunk two or more times was reported by 1% of 11 year olds, 8% of 13 year olds and 30% of 15 year olds. Overall prevalence rates for alcohol consumption in the region were not significantly different to that found in Scotland.
Figure 70: Percentage of young people who report ever having had an alcoholic drink; Dumfries & Galloway; 2006 – 2013

Source: SALSUS
Base: young people surveyed in 2013, 13 years olds = 362, 15 year olds = 362

Figure 71: Alcohol consumption in 13 and 15 year olds, Dumfries & Galloway, 2014.

Source: Health Behaviours of School Children 2015

At a national level the rates of weekly drinking have been declining since 1998 with weekly drinking reported amongst 15-year olds in 2014 now lower than that in 1990 and with rates approximately halving since the last survey in 2010.
Figure 72: Weekly drinking in 15 year olds, Scotland, 1990-2014

Source: Health Behaviours of School Children 2015

12.5.4 Gambling

Gambling is increasingly being acknowledged as a concern for public health as it is widely recognised that some people who gamble experience harm as a direct result. Problem gambling has been defined as "gambling to a degree which compromises, disrupts or damages family, personal or recreational pursuits."

There is very little data available on the prevalence of gambling as, by its very nature, gambling is often a hidden problem and very difficult to capture in surveys in a consistent manner. There is no data available at local authority level.

Locally, a consultation carried out in Wigtownshire found that gambling was becoming more prevalent amongst Children and Young People. There has been an increase in the availability of gambling opportunities such as on-line gambling and gaming as well as a significant increase in the promotion of gambling through mainstream advertising. The participants in the consultation also perceived that more boys were gambling than girls, that there was peer pressure to gamble, and that gambling may be a learned behaviour as many parents gamble and some parents were facilitating gambling. However, there was an understanding amongst participants that gambling could have a detrimental impact on relationships, school work, personal finance and general wellbeing to name a few.

Please note: Given that there is a lack of data at a local level relating to gambling; that it has an increasing prominence as a health and social care issue; and that early indication from the Wigtownshire consultation suggest that this is locally a growing problem, further work should be carried out to assess the extent of gambling and problem gambling across Dumfries & Galloway.
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13. INCLUDED

‘Getting help and guidance to overcome social, educational, physical and economic inequalities; accepted as full members of the communities in which they live and learn’

In this section:
- Equality & Diversity
  - Ethnicity
  - LGBT
  - Gypsy Travellers
- Disabled Children & Young People
  - Short Breaks
  - Learning Disabilities
  - Autism

When Children and Young People feel included, they show greater caring and compassion towards others and they feel safer and more secure. Inclusion is a protective factor for the mental health and wellbeing of Children and Young People. Being included and learning to include others is very important in emotional and social development; conversely, those who experience exclusion are at increased risk of a variety of negative outcomes such as poor mental health and low self-esteem.

13.1 Equality and Diversity

13.1.1 The Strategic and Policy Context

No one should be denied opportunities because of their race or ethnicity, their disability, their gender or sexual orientation, their age or religion. Public authorities, including the Scottish Government, make decisions that affect the lives of people in Scotland and therefore have a duty to consider how to promote equality, foster good relations, address past inequalities and ensure that policies and actions are not unjustly discriminatory. Equality is thus an integral part of Government business and the public sector equality duty provides a framework to deliver on this effectively. A commitment to equality of opportunity is evident in the key documents that set the context and direction of Scottish Government: Scotland’s Economic Strategy, Programme for Government 2014-15\(^5\) and the Budget. A range of legislation has been made or introduced which advances equality. This includes:

Acts:
- Marriage and Civil Partnership (Scotland) Act 2014
- Human Trafficking and Exploitation (Scotland) Bill
- Carers (Scotland) Bill
- Children and Young People (Scotland) Act 2014
- Disabled Persons’ Parking Badges (Scotland) Act 2014
• Housing (Scotland) Act 2014
• Post-16 Education (Scotland) Act 2013
• Procurement Reform (Scotland) Act 2014
• Public Bodies (Joint Working) (Scotland) Act 2014
• Scottish Independence Referendum (Franchise) Act 2013
• Social Care (Self-Directed Support) (Scotland) Act 2013
• Victims and Witnesses (Scotland) Act 2014
• Welfare Funds (Scotland) Act 2015

Bills:
• British Sign Language (Scotland) Bill
• Carers (Scotland) Bill
• Community Empowerment (Scotland) Bill
• Education (Scotland) Bill
• Human Trafficking and Exploitation (Scotland) Bill

Policies:
• ‘Equally Safe’ – Scotland’s Strategy for Preventing and Eradicating Violence Against Women and Girls
• ‘New Scots’ refugee integration strategy
• 50:50 by 2020
• Scottish Youth Employment Strategy
• Digital Participation Strategy
• Carers Strategy
• Child Poverty Strategy
• Affordable Housing Supply Programme
• Additional Support for Learning
• Living Wage
• Fuel Poverty Strategy
• Public Service Reform

New policies that help to advance equality are building on the foundations of previous ones, and strengthening the overall benefits to communities, which will in the long-term improve the life chances of Scotland’s Children and Young People whatever their race or ethnicity, their disability, their gender or sexual orientation, their age or religion.

Gypsies/Travellers represent an ethnic grouping (under the Equality Act 2010) that comprises several smaller, distinct ethnic groups, including Roma, English Travellers, Irish Travellers, and Scottish Travellers (although this last group is only recognised within Scotland502, and not across the United
Characteristics of this group include distinct languages, culture and beliefs, and a life style that tends towards permanent or seasonal nomadic travel.

The Scottish Government (along with the European Union, United Nations, and World Health Organization) recognise that Gypsies/Travellers as a group experience greater discrimination and marginalisation, and established the equality outcome: “Gypsies/Travellers experience less discrimination and more positive attitudes towards their culture and way of life.”

13.1.2 The Evidence

The 2008 publication “Early years, life chances and equality: A literature review” explored the impact of early years on life chances for different groups of the UK child population and identified a large body of academic literature showing there is substantial ‘intergenerational persistence’, that is, life chances of individuals are closely related to the socio-economic characteristics of their families, such as parental income, socio-economic status and parental education. It also appears that outcomes and achievements in adulthood are closely linked to cognitive and social competencies developed in childhood. In addition, the quality of the home learning environment and parental aspirations are found to be particularly important for children’s development. In this review, in relation to ethnicity; when socio-economic factors are taken into account, while there are big differences between different ethnic groups, children from other ethnic groups make greater progress than white British children and achieve better than expected educational outcomes (except for Black Caribbean pupils, who underachieve). It appears that parents from many ethnic groups have high aspirations for their children and provide them with a good home learning environment and these factors partly counteract the negative effects of economic disadvantage.

Disabled children and their families have many needs in common both with other disabled children and with non-disabled children. However, their circumstances may vary, depending on impairment, location, culture, language, ethnicity, and means of communication or family structure. These factors can influence the extent of the assistance required and the best ways of meeting their needs. Poverty and social disadvantage are the most pressing problems affecting disabled children from some BME backgrounds. In addition, some BME communities are disproportionately affected by some disorders of genetic origin, low birth weight and psychotic disorders compared to the general population. Data on the prevalence of disability in children from asylum seeking or refugee families is scarce; families may not report impairments due to perceptions relating to their applications for UK residency status. Needs may, therefore, be hidden. The most common theme differentiating the needs of disabled children from BME backgrounds and their families from White children is one of degree rather than type. The literature suggests that the needs of most families are essentially similar: it is the capacity and willingness of services to respond where the differentiation lies. The largest numbers of disabled children in residential placements are teenage boys diagnosed with emotional and behavioural difficulties, children with more complex needs and children with very challenging behaviours. Also large numbers of disabled children living away from home, including many with the
most severe impairments, are placed in foster care settings. Working in partnership, building community resilience and developing a sense of enablement are all fundamental to improving outcomes for disabled Children and Young People.

Girls do better at school at all stages of the National Curriculum. This gender gap is not UK-specific and is replicated across OECD (The Organisation for Economic Cooperation and Development) countries, including the UK, USA, Canada, Australia, New Zealand, South Korea, Japan and many European nations. The main explanations of this phenomenon come from two different perspectives, biological and social. However, this academic attainment is not mirrored in earnings; UK statistics show that women’s wages are, on average, 20 per cent less than men’s wages. There are a number of explanations for the gender pay gap; some of them relate to experiences and choices made in childhood and adolescence. More specifically, the gender pay gap can be partly explained by occupational segregation, that is, women tend to work predominantly in stereotypical ‘female’ occupations. These occupational choices are, in turn, linked to the choice of subjects studied at school: boys tend to pursue technical and science-oriented subjects, while girls choose arts, humanities and social sciences. It is believed that these patterns occur because science is considered to be a more ‘masculine’ subject, while humanities and arts are more feminine or emotional. There is some evidence that educators may also contribute towards these trends, consciously or unconsciously encouraging boys and girls to pursue ‘gender appropriate’ subjects.

There is very little evidence on the interaction between the experiences in early years and later life outcomes for lesbian, gay, bisexual or transgender (LGBT) people. This is largely because the datasets that contain information both on early years and on life outcomes do not collect information on sexual orientation.

In 2012, LGBT Youth Scotland undertook a survey on Life in Scotland for LGBT young people, aged between 13-25 years which explored LGBT young people's experiences of feeling accepted and included in their families and communities and how safe they felt in Scotland on the whole. The results show that feeling included and accepted in the wider community and in families is important to LGBT young people's success in each of the areas of education, health, and safety. The survey found that those who feel accepted in the wider community are significantly more likely to be; employed (53.9% vs. 38.6%) in education (73.3% vs. 59.6%), and confident reporting hate crime to the police (63.3% vs. 29.8%). This group is also significantly less likely to consider themselves to have mental health problems (31.2% vs. 66.7%). This reaffirms existing evidence that young people’s ability to fulfil their potential as active citizens and to lead safe and healthy lives is in many ways linked to their inclusion and acceptance in society. Being socially excluded on the basis of sexual orientation or gender identity can therefore have serious implications for LGBT young people's lives. Overall, just 57.4% of all respondents said they felt included and accepted in the wider community and 68.1% said they felt included and accepted in their own family. In addition, the type of location in which young people live was also found to have an impact on whether they thought either Scotland or their local areas were good places to live, with those from urban areas more likely to
consider Scotland and their local area as “good places”. The results from this survey indicate that a significant percentage of young LGBT people do not feel included and accepted in the wider community or in their families, and see homophobia, biphobia and transphobia as problems in both their local areas and in Scotland as a whole.

Gypsy/Travellers are widely acknowledged to be a significantly deprived population and this has a direct impact upon many aspects of their lives including education, health and housing. Gypsy/Traveller pupils have significantly lower educational attainment and school attendance than the Scottish population, or any other ethnic group. They also have the second highest rate of exclusion from school, and are significantly above the Scottish average\(^\text{519}\). This lack of educational attainment continues through life, with half (almost double the national average) leaving school with no qualifications, and only 16% (compared to 26% of all Scottish young people) gaining a degree level qualification\(^\text{512}\).

Most of the health problems experienced by the Gypsy/Traveller population appear to be related to poor socio-economic conditions, and this is supported by similar rates of poor health and disability across all of the ethnic subgroups found within the United Kingdom\(^\text{513}\). Although Gypsy/Traveller mothers do not experience a greater incidence of many pregnancy related disorders (including postnatal depression) they have been reported to have greater rates of Caesarean section, miscarriage, stillbirth, and greater numbers of infant deaths than the wider population\(^\text{513}\). Studies of childhood immunisation uptake in Gypsies/Travellers suggest that less than half of children from this community have a full immunisation programme, which may result from cultural issues and concerns, as much as access to services\(^\text{514,515}\).

Gypsies/Travellers are more likely to live in caravans than any other ethnic group, and the least likely of all groups living in rural areas to have access to a car. For some part of their life more than 50% of Gypsies/Travellers will have no access to running water\(^\text{518}\), which is higher than other groups. In other respects (overcrowding, types of heating, tenancy) Gypsies/Travellers had poorer accommodation than average for the Scottish population, but on a similar level to many other ethnic minority groups who do not experience the same degree of poor health.
13.1.3 The Local Picture

Ethnicity

The following table describes the local ethnic profile of resident Children and Young People from Dumfries & Galloway however, the Census 2011 is the only complete source of information and therefore this profile may have changed since this was last undertaken.

Table 50: Number of children by ethnic origin; Dumfries & Galloway; Census 2011

<table>
<thead>
<tr>
<th>Age</th>
<th>0 to 4</th>
<th>5 to 9</th>
<th>10 to 14</th>
<th>15</th>
<th>16 to 17</th>
<th>Children (0-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: Gypsy/Traveller</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>28</td>
</tr>
<tr>
<td>White: Scottish</td>
<td>6,791</td>
<td>6,457</td>
<td>7,157</td>
<td>1,618</td>
<td>3,328</td>
<td>25,351</td>
</tr>
<tr>
<td>White: Other British</td>
<td>449</td>
<td>606</td>
<td>865</td>
<td>182</td>
<td>430</td>
<td>2,532</td>
</tr>
<tr>
<td>White: Irish</td>
<td>17</td>
<td>19</td>
<td>12</td>
<td>*</td>
<td>*</td>
<td>61</td>
</tr>
<tr>
<td>White: Polish</td>
<td>101</td>
<td>56</td>
<td>47</td>
<td>*</td>
<td>23</td>
<td>227*</td>
</tr>
<tr>
<td>White: Other White</td>
<td>74</td>
<td>52</td>
<td>45</td>
<td>*</td>
<td>21</td>
<td>192*</td>
</tr>
<tr>
<td><strong>White: Total</strong></td>
<td>7,440</td>
<td>7,196</td>
<td>8,134</td>
<td>1,821</td>
<td>3,814</td>
<td>28,405</td>
</tr>
<tr>
<td>Mixed or multiple groups</td>
<td>92</td>
<td>86</td>
<td>51</td>
<td>11</td>
<td>10</td>
<td>250</td>
</tr>
<tr>
<td>Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British</td>
<td>15</td>
<td>15</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>44</td>
</tr>
<tr>
<td>Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British</td>
<td>45</td>
<td>28</td>
<td>28</td>
<td>*</td>
<td>*</td>
<td>101</td>
</tr>
<tr>
<td>Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>23</td>
</tr>
<tr>
<td>Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British</td>
<td>21</td>
<td>15</td>
<td>24</td>
<td>*</td>
<td>12</td>
<td>72*</td>
</tr>
<tr>
<td>Asian, Asian Scottish or Asian British: Other Asian</td>
<td>14</td>
<td>16</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>47</td>
</tr>
<tr>
<td><strong>Asian, Asian Scottish or Asian British: Total</strong></td>
<td><strong>100</strong></td>
<td><strong>80</strong></td>
<td><strong>71</strong></td>
<td><strong>20</strong></td>
<td><strong>25</strong></td>
<td><strong>296</strong></td>
</tr>
<tr>
<td><strong>African: Total</strong></td>
<td>16</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>34</td>
</tr>
<tr>
<td><strong>Caribbean or Black: Total</strong></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>12</td>
</tr>
<tr>
<td><strong>Other ethnic groups: Total</strong></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>31</td>
</tr>
<tr>
<td><strong>All people</strong></td>
<td>7,660</td>
<td>7,378</td>
<td>8,270</td>
<td>1,856</td>
<td>3,864</td>
<td>29,028</td>
</tr>
</tbody>
</table>

Source: Census 2011
* Suppressed for disclosure

Lesbian, Gay, Bisexual, Transgender (LGBT)

There is currently limited data and evidence collected on the experiences of LGBT people in Scotland. The LGBT campaign group Stonewall suggest that between 5% and 7% of the UK population are LGBT\(^{516}\). This implies that of the 28,772 children aged 0-18 in Dumfries & Galloway, an estimated 1,726 will be LGBT (Table 51).
Table 51: Estimated number of LGBT children (aged 0-18 years) by Locality; Dumfries & Galloway

<table>
<thead>
<tr>
<th>Localities</th>
<th>Annandale &amp; Eskdale</th>
<th>Nithsdale</th>
<th>Stewartry</th>
<th>Wigtownshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Child Population (&lt;19)</td>
<td>7,385</td>
<td>11,554</td>
<td>4,309</td>
<td>5,524</td>
<td>28,772</td>
</tr>
<tr>
<td>Estimated LGBT (6%)</td>
<td>443</td>
<td>693</td>
<td>259</td>
<td>331</td>
<td>1,726</td>
</tr>
</tbody>
</table>

Source: Stonewall Scotland; NRS

Gypsy Traveller Young People and Children

The Scottish population of Gypsy/Travellers is unknown; the 2011 Census included ‘White – Gypsy/Traveller’ as an option for ethnic group for the first time, and 4,212 individuals identified themselves as such, with 102 Gypsies/Travellers in Dumfries & Galloway. However, organisations working with Gypsies/Travellers estimate that the population may be closer to 15,000 across Scotland. Standardisation of Census data shows that the community has relatively higher fertility and higher mortality than the Scottish population.

Within Dumfries & Galloway there are two Council Traveller sites – one in the west of the region at Glenluce, with 14 pitches, and one in the east at Collin, with 18 pitches. The Glenluce site has an older, more stable community, currently with four caravans on site. The Collin site has more families, often staying for shorter periods, and currently has 15 caravans on site. Each pitch has a hard standing for one to two caravans, and a permanent utility structure with electricity, running water, a shower, and plumbing for a washing machine. The sites are currently considered to be in a poor state of repair, and require maintenance and upgrading. Children at the Collin site are able to attend Collin primary school, and a designated Public Health Nurse (health visitor) attends as required. The 2011 Census indicated that there were 20 school age Gypsies/Travellers in Dumfries & Galloway.

Since 2011 there have been 33 recorded illegal encampments (median 4, range 1 – 17 per year) in Dumfries & Galloway, and Scottish data suggests that each encampment would hold an average of 5.2 caravans. NHS Dumfries & Galloway records system only has 14 patients recorded who list their ethnicity as ‘White: Gypsy/Traveller’, which may represent a lack of willingness to disclose ethnic background on the part of Gypsies/Travellers, or reception staff making assumptions about patients (“If they look Scottish, and sound Scottish, we’ll call them Scottish”). Data from the 2011 Census indicates that there are 28 children aged under 18 years whose ethnicity is Gypsy – Traveller (Table 50).

13.2 Children and Young People with Disabilities

The Scottish Government is committed to equality for disabled Children and Young People in Scotland, and to ensuring that all children can achieve their potential. Early identification and support is of particular importance to disabled children, who are more likely to need targeted support from
specialist services. Children and Young People with disabilities may be deemed to be vulnerable and can suffer a range of inequalities in health and wellbeing. Delays in diagnosis, difficulties in accessing services and rural issues, including availability of transport and leisure and employment opportunities negatively impact on the life chances of this population and adversely affect the quality of life of their families and Carers.

13.2.1 The Strategic and Policy Context

Equally Well\textsuperscript{521}, along with the Early Years Framework\textsuperscript{522} and Achieving Our Potential\textsuperscript{523} set out the Scottish Government’s and COSLA’s overarching social policy framework for tackling social, educational, physical and economic inequalities in Scotland. There are a plethora of policies and initiatives which support this framework. Those that aim to tackle health and other inequalities among disabled Children and Young People include:

The National Review of Services for Disabled Children and Young People (2010)\textsuperscript{524} considered the landscape of disabled children’s services and set out actions for improvement. Their Action Plan was published in February 2011. Since then, the Scottish Government and partners have been working to implement the actions in the plan and a progress report was published in June 2012. Actions in the plan include the following policy areas:

- Short breaks
- Developing practice briefings on Getting It Right For Every Child for practitioners working with disabled children
- Moving and Handling Guidance
- Outcome and implications from the Doran Review
- Consultation with Children and Young People
- Housing
- Poverty
- Child protection and disabled children
- Integrated inspection services
- Staff training

The United Nations Convention on the Rights of the Child\textsuperscript{525} applies to all children and of particular relevance to disabled children are sections 12; 23 and 31, to seek their views and enable their participation and inclusion in activities.

13.2.2 The Evidence

Good health is integral to Children and Young People with disabilities in order to participate in and experience the richness of life as it is for all children; yet many children with developmental disabilities face health disparities stemming from the very nature of their disability. These are health problems
that may adversely affect their well being and set the stage for life as an adult that may be further, and perhaps unnecessarily, compromised. Some evidence of these health problems for adults with a developmental disability is provided by the European Union Pomona Project:\textsuperscript{526:}

Mental health problems in Children and Young People with developmental disabilities may remain undetected and/or may be misinterpreted as behaviour disorders.\textsuperscript{527} Signs of physical discomfort such as head banging that may be due, for example, to toothache may be misinterpreted as challenging behaviour instead of a sign of pain and a demand for help.

The high use of psychotropic medication amongst people with developmental disabilities\textsuperscript{528} and long term medication intake necessary for epilepsy and/or psychiatric disorders may have undesirable side effects, such as osteoporosis and a lower level of consciousness leading to falls, fractures and other incidents.

People with developmental disabilities are also at risk for lifestyle-related co-morbidity.\textsuperscript{529} The inability to read written health promotion materials may result in, for instance, a lower participation in population screening programmes.\textsuperscript{530,531} However, it should be noted that personal risk-taking health behaviour such as smoking and excessive alcohol intake can be reduced in this population.\textsuperscript{532,533}

People with developmental disabilities are socially and economically disadvantaged: generally they have low incomes, small social networks without many friends and a weak representation at the policy level.\textsuperscript{534} Emerson and Hatton\textsuperscript{535} noted that in the UK children with developmental disabilities were significantly more likely than those without developmental disabilities to:

- Be male
- Have been exposed to a greater variety of adverse life events (e.g., abuse, serious accidents, bereavement, domestic violence)
- Be brought up by a single parent (nearly always a single mother)
- Live in poverty
- Live in a poorly functioning family (e.g., one that is characterized by disharmony
- Have a mother who is in poorer health
- Have a mother who has mental health needs
- Live in a family with lower educational attainments and higher rates of unemployment; and
- Have fewer friends

While developmental disabilities affect children living in families across the socioeconomic spectrum, a disproportionate number are born into, grow up in, and as adults continue to live in poverty. In order to optimise the life chances of Children and Young People an early intervention, life course approach that supports access to services and positive transitions is required.
13.2.3 The Local Picture

Within the region, the number of Children and Young People with additional support needs is increasing, particularly noticeable in the population groups affected by Autism Spectrum Disorder (ASD) and disabilities, including Learning Disabilities.

Learning Disabilities

The definition of Learning Disabilities is articulated as...

“People with Learning Disabilities have a significant lifelong condition that started before adulthood that affected their development and which means they need help to understand information, learn skills and cope independently.”

Whilst this strategy noted improvements of the acceptance and being valued of people with learning disabilities in their own communities; progress is required across the life course as people with learning disabilities still die 20 years earlier than the general population. Therefore the emphasis of the current strategy is on health and wellbeing. The strategic recommendations are early, needs-led targeted assessment and planning (e.g. transition from primary to secondary school); and the involvement of wider services as appropriate, in keeping with the GIRFEC principles and approach.

Parenting children with learning disabilities is a complex and challenging situation, demonstrated by a short study that explored parenting programmes for this population group in Dumfries & Galloway during 2014. In discussion, parents shared their experiences and the areas for improvement that emerged were communication, diagnosis, organisation of daily living, understanding and support.

Parents experienced a lack of specialist knowledge from some health professionals including Paediatricians however, almost universally, parents had positive things to say about their pre-school child’s involvement with Educational Visitors, their Health Visitors and Allied Health Professionals such as Paediatric Speech and Language Therapy, Physiotherapy and Occupational Therapy. There was a general reluctance among parents to view Social Workers as being a helpful resource for them and their family – although they understood that referral to Social Work Services provided access to services. Many parents had limited understanding of the eligibility criteria and referral process to Social Work Services. This was a shared frustration among a wide range of professionals from Third Sector organisations and statutory agencies.

The purpose of the project was to inform thinking around the provision of parenting support for parents of a child with learning difficulties/disabilities taking into account the real lived experiences of Children and Young People, their families and Carers, and service providers. In order to address the health inequalities that impact on children with learning difficulties/disabilities, understanding of need and interventions that support the development of resilience within families is essential.
The report made a number of recommendations in relation to considering whether the current provision of support to parents of a child with a learning difficulty/disability is the right approach to meet the needs of this vulnerable group, and if so, whether resources are being used to their full potential.

- The development of a clearly defined and communicated vision and strategy regarding disabled children in Dumfries & Galloway which underpins policy and practice across all sectors and is easily understood by families and practitioners
- The development of a clear support pathway which clarifies eligibility criteria and referral process for services
- For those parents who would clearly benefit from a parenting programme aimed at families with a disabled child we suggest exploring the delivery of Parents as First Teachers Special Needs Curriculum and Stepping Stones Triple P

**Physical Disabilities**

Social work services data (December 2014) indicates that the number of children with complex and profound disabilities referred to their services for support has significantly increased from 34 in 1997, 149 in 1999, 215 in 2005 and 280 in 2014. The current projections are that these figures will continue to increase year on year. The increase can be attributed chiefly to the increased prevalence of autism spectrum disorder (ASD), the increased survivorship of early gestation babies and increased incidence of complex need due to long term or life threatening conditions.

According to available data from social work systems (Framework I), less than half of the Children and Young People identified as disabled have a single diagnosis. This is particularly pronounced in the 0-4 year’s age group with 25% of children having two recorded diagnosis and a further 25% having at least three recorded significant medical conditions. Of the disabled children placed in residential schools, 58% have more than one recorded diagnosis.

Information provided by Dumfries & Galloway Council indicates that there are 47 young people aged 14 to 18 years with disabilities who have highly complex needs (September 2015). These young people will require to transition to adult services over the coming few years.

This data highlights the complexity of need within this population group and indicates the breadth of potential interventions or supports that may be required to ensure that each child reaches their full potential. There is no doubt that caring for a child or children with complex needs is challenging for families, many of whom have little extended family support and may even be obliged to give up paid employment.
As well as provision from statutory services, a number of Third Sector organisations work with children with disabilities to provide targeted interventions. For example, Headway Child and Family Outreach Service provide advice, information and support to families with children affected by acquired brain injuries region wide. Quarriers, a Scotland wide voluntary organisation, works locally in partnership with D&G Council Social Work Services to provide a range of supports to Children and Young People with complex disabilities and their families throughout the region; including specific work with fathers.

Please note: Currently there is no central register of all Children and Young People with a learning or physical disability. The only figures available are for those who are in contact with Social Work Services. It is understood that there will be other children who are not in contact with these services. It is recommended that further work be undertaken to establish a more accurate picture of learning and physical disability amongst Children and Young People to support future service provision and planning.

13.2.4 Short Break Services for Children and Young People

The Strategic and Policy Context

As noted above, Equally Well\textsuperscript{521}, along with the Early Years Framework\textsuperscript{522} and Achieving Our Potential\textsuperscript{523} set out the Scottish Government’s and COSLA’s overarching social policy framework for tackling social, educational, physical and economic inequalities in Scotland. There are a plethora of policies and initiatives which support this framework. Those that focus on short breaks for disabled Children and Young People are:

- **The National Review of Services for Disabled Children and Young People (2010)** considered the landscape of disabled children’s services and set out actions for improvement one of which is short breaks for Children and Young People with disabilities as defined in the Children (Scotland) Act 1995\textsuperscript{537}.

- **The Social Care (Self-Directed Support) (Scotland) Act 2013**\textsuperscript{538} offers disabled children and their families’ greater choice in how their assessed needs should be supported; thereby shifting the balance of care to a more person centred and outcomes focused approach. Direct payments or individual service funds involve identifying a budget for the child to take an active role in directing their support. This is provided as an alternative to services which would otherwise be arranged by the local authority on the child’s behalf and may include the provision of short breaks.
The Evidence

For over 30 years, short breaks have been part of the support provision for families with a disabled child. Short breaks are designed for disabled children to spend time in the company of other people than their primary family Carers, both to give family Carers a break and to allow children the opportunity to have new experiences with a wider range of people outside the immediate family.

The existing research literature provides some evidence of a range of benefits of short breaks as well as a number of problems related to accessing and using them. However the strength of this evidence is variable and studies have not been able to conclusively demonstrate causal links between, for example short breaks and well-being. Research exploring the impact of short breaks on families with disabled children found that family/Carer satisfaction is highest with aspects related to the people involved in providing breaks and lowest with aspects of the processes involved in getting and keeping short break provision.

Benefits identified for children include enjoyment of high levels of attention, opportunities for new experiences and chances to form friendships and socialise with peers and workers as well as participation in activities and confidence and/or independence building.

The benefits of short breaks identified for parents and Carers include reduced levels of stress and opportunities for rest and relaxation. Several studies have identified the importance of opportunities for uninterrupted sleep. These benefits have in turn been connected with parents’ ongoing or increased capacity to continue to care for the disabled child.

Research also demonstrates that sibling’s opinions of short breaks are generally positive. Siblings are concerned that their brothers and sisters have a safe and enjoyable break, they also report benefits for themselves including having a break or a rest, being able to do a wider range of things and receiving more attention from their parents. In addition, reduced stress and improved functioning within the family as a whole were found to be beneficial. Siblings also disliked some aspects of short breaks including being worried about their brother or sister while they were away, missing their brother or sister, feeling guilty about enjoying themselves without their brother or sister and missing out on the fun their brother or sister was having.

Issues identified with short break provision include a lack of flexibility, insufficient availability of trained staff and negative reactions from children such as homesickness and distress.

Overall, overnight (both centre-based and family or paid carer supported) and centre-based short breaks were found to provide families with more hours of short break support and were more likely to be used by older children, with more complex disabilities, health needs and physical needs, but lower levels of actively challenging behaviour involving other people. However, they may not be optimally focused in terms of accepting younger children, children with more actively challenging behaviours, or...
children of family Carers who require overnight or centre-based short breaks to improve their own health and well-being.

The changing needs of families over time provide significant challenges to agencies planning and delivering short break services. Consequently the availability of a wide range of different services appears to help families and they further benefit if services are as accommodating as possible. Systems for accessing short breaks work best when they are simple and responsive; capable of taking account of a wide range of factors and open to finding flexible solutions.

The Local Picture

An overnight short breaks service for disabled children, based in Dumfries has been jointly funded by NHS Dumfries & Galloway and Dumfries & Galloway Council since 2001. A purpose built unit known as Acorn House was opened in June 2012 with accommodation for up to ten children or young people at any one time. This unit provides a short break service (as defined by the Children (Scotland) Act 1995)\(^{561}\) for individuals referred by Children and Families Social Work services across Dumfries & Galloway.

Children and Young People are referred from across the region and with a wide range of conditions, but the most common reasons for referral are, Autism Spectrum Disorder (ASD) and Learning Disability. A further 60 diagnoses relating to complex disabilities or additional support needs have also been identified from social work data as affecting this group of children. The number of overnight short breaks varies between 29 and 120 annually depending on the individual needs of the child. During the financial year 2013/14 provided 2,587 nights worth of overnight short breaks and 28,298 hours of daytime short breaks (Table 52 and Table 53).

Table 52: Number of overnight short breaks (nights) provided to children aged 0-17 years; Dumfries & Galloway; 2013/14

<table>
<thead>
<tr>
<th>In a Care Home</th>
<th>At Home</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Short Breaks (nights)</td>
<td>987</td>
<td>1,600</td>
<td>0</td>
</tr>
<tr>
<td>Overnight Short Breaks (as % of total nights)</td>
<td>38%</td>
<td>62%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Scottish Government\(^{662}\)
Table 53: Number of hours of daytime short breaks (hours) provided to children aged 0-17 years; Dumfries & Galloway; 2013/14

<table>
<thead>
<tr>
<th></th>
<th>In a Care Home</th>
<th>Day Care centre</th>
<th>At Home</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime Short Breaks</td>
<td>0</td>
<td>9,500</td>
<td>18,798</td>
<td>0</td>
<td>28,298</td>
</tr>
<tr>
<td>(as % of total hours)</td>
<td>0%</td>
<td>34%</td>
<td>66%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Scottish Government

The current service at Acorn House is accessed by 38 children across Dumfries & Galloway. It is acknowledged that the service is currently not accessed on an equal basis geographically, however within the last few years there has been a noticeable decline in the number of referrals from the West of the region. Parents tell us that the 150 mile round trip is challenging for many children, reduces the duration of the short break and can impact significantly on children’s educational needs if they are in Acorn House during the school week.

Noticeably, there is an increasing trend for families and Carers of children with disabilities to request short breaks closer to home. Of the 280 children identified as having a disability by Social Work services, only 13.5% (38) are supported for the provision of short breaks by Acorn House.

Quarriers provided 569 short breaks in family placements for 28 children with complex disabilities (10% of total) throughout the region in 2014-15. A further 52 children (18.5% of total numbers) received self directed support to have their needs met in their localities. There are currently 16 children with disabilities placed in residential schools outwith Dumfries & Galloway. For families in the extreme east and west of the region, travel to the short break service has an associated disruption to the child and the family routine that is becoming less attractive.

These figures indicate an appetite for a range of supports that can be employed to meet the needs of children outwith a residential setting, maintaining the children in their local communities.

“As the parent/Carer of an autistic child I feel there needs to be better services and quicker assessment times in place. As well as better training information and resources for parents/Carers and professional. I also feel we all have a personal responsibility to help ourselves but better facilitation/services to motivate us to do that is vital. So more self help services that work 1:1 or small groups of likeminded people where we become more self aware of our personal medicine (not drugs but what works in our life that's positive) but my aim is better services for my autistic son”

13.3 Autism Spectrum Disorder

Autism is a lifelong developmental disorder more commonly referred to as autism spectrum disorder (ASD) but also known as autism spectrum condition (ASC). ASD affects people differently with some
individuals being able to live independently. Others will need very specialist support. What everyone will have in common is difficulty in 3 areas of functioning, referred to as the triad of impairments\textsuperscript{563}:

- Communication – both verbal and non-verbal, e.g. difficulties with use and interpretation of voice intonation, facial expressions and other communicative gestures
- Reciprocal social interaction – this includes the ability to understand what someone else might be thinking in a real-time situation and to understand the need for social ‘give and take’ in conversation and overall interaction
- Restrictive, repetitive and stereotypical routines of behaviour – these may involve enthusiasms held by a person with ASD (which may be very restricting for their family, friends and colleagues but may also be psychologically distressing or inhibiting for the individual with ASD)

### 13.3.1 The Strategic and Policy Context

In 2011 a national ten year strategy for autism was published by the Scottish Government. It addresses the entire autism spectrum and the whole lifespan of people living with Autistic Spectrum Disorder (ASD) in Scotland. The Strategy builds on the previous work in improving diagnosis and assessment of ASD; the efforts to develop consistent standards of care and support and a recognition that resources must be matched to need, underpinned by relevant research and training for all those involved in caring for, supporting and providing services for people affected by ASD.

The national strategy acknowledged good practice in the delivery of health and social care, and promoted the personalisation agenda. The pivotal role of partnership working between statutory organisations, third and independent sector and central government is explicitly stated within the national strategy, in maximising the benefits to people affected by ASD. This approach is also central to “The same as you?” and “Getting It Right for Every Child”.

Ten indicators for best practice in the provision of effective services for people with ASD are included within the document. These indicators include a local autism strategy, developed in collaboration with a wide range of stakeholders and a self evaluation framework to support monitoring of practice.

### 13.3.2 The Evidence

The diagnosis of individuals with Autism has risen rapidly with comparative prevalence rates reported in the research literature in some instances increasing by a factor of 26 (from 4.5 per 10,000\textsuperscript{564} to 116.1 per 10,000\textsuperscript{565} in just four decades lending support to the now popular notion of an “autism epidemic”. A topic of discussion and debate within both the popular media and the research literature (e.g. developmental disability, education, paediatric and other journals) regards the increase in the incidence and prevalence of autism spectrum disorders over time, the reasons for this increase, whether or not the increase is apparent or actual and whether this increase constitutes what may be
considered to be an epidemic of autism. In reviewing a number of studies on prevalence, Fombonne and du Mazaubruns (1992)\(^5\) which found a prevalence of 4.9 per 10,000 population in France compared to Chakrabartis and Fombonne's (2001)\(^6\) study in Staffordshire with a prevalence rate of 62.6 per 10,000 through to Baird et al\(^7\) study of autism in South Thames (2006) with a prevalence rate of 116.1 (2006) it is clear the reported prevalence of autism is on the rise. However, it is worth noting that the studies have varied in their methodology in relation to the screening and diagnostic processes used and this demonstrates the multiple and evolving pathways by which a diagnosis of autism may be reached. In addition, in looking at the history of autism over seven decades there have been evolving diagnostic concepts of the disorder and how it should be defined and identified.\(^8\)

Another concept that has been referred to in relation to being a causative factor in the increased prevalence of autism is that of diagnostic substitution.\(^9\) Researchers have suggested that the diagnostic substitution of one condition (e.g. intellectual disability) to autism has been taking place and may explain up to one third of the increased prevalence of school aged children diagnosed with autism.\(^10\) A range of environmental factors have been hypothesized to be part of the reason for the increased incidence and prevalence of autism. The well known “vaccine hypothesis” postulated by Wakefield (1998)\(^11\) among others and relating to the Measles, Mumps, Rubella and Thimerosal containing vaccinations must be mentioned as despite being effectively disproved.\(^12\) The study of autism is rife with speculation and that a range of other environmental factors have been thrown up as hypotheses for causation or contribution to increased prevalence ranging from influences like watching more television\(^13\), an increased intake of foliate by pregnant women\(^14\) and maternal residence near to sources of environmental pollution.

### 13.3.3 The Local Picture

In 2014 the Dumfries & Galloway Autism Strategy\(^15\) was published, supported by a number of action plans, within which are a number of activities relevant to children, young people and their families.

There are estimated to be around 1,332 people with ASD in the region, of which around 400 Children and Young People are in mainstream education; this equates to 2% of the current school population compared to the national figure of 1.5%. The numbers of pupils with a diagnosis of ASD in school in Dumfries & Galloway has been rising steadily over time, roughly at a rate of 10% per year.

The Communication Disorders Assessment Team (CDAT) provides accurate and consistent diagnosis of Autism Spectrum Disorders (ASD). The core team includes Speech and Language Therapists, Consultant Child and Adolescent Psychiatrists, a Community Paediatrician, Educational Psychologists and an Occupational Therapist who have expertise in ASD diagnosis, as recommended in the Scottish Intercollegiate Guidelines Network (SIGN) guidelines 2007.

The service is split geographically into West and East teams who are currently developing and operating a new model of assessment allowing some children to be assessed more quickly by those
who already know them. Any child identified within the community as possibly being on the Autism Spectrum could be referred for assessment. The practitioners working with that child gather the necessary information (e.g. detailed case history, school reports and observation in social settings). At least two of the professionals involved develop a report and match it against the autism diagnostic criteria. The results are discussed and agreed with all practitioners involved and the child’s parents.

Should there be any dubiety about the results or if significant complexities were identified at referral then the case would move on to tier 2; assessment undertaken by the CDAT Team.

Table 54: Data from the Communication Disorders Assessment Teams (CDAT); Dumfries & Galloway; September 2015

<table>
<thead>
<tr>
<th>West</th>
<th>East</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total on list = 26</td>
<td>Total on list = 82</td>
</tr>
<tr>
<td>Allocated = 10</td>
<td>Allocated = 23</td>
</tr>
<tr>
<td>On hold – n/a</td>
<td>On hold = &lt;5 (various reasons)*</td>
</tr>
<tr>
<td>Waiting = 16</td>
<td>Waiting = 59*</td>
</tr>
<tr>
<td>Current waiting time for next person on list is 19 months (referred Feb 2014).</td>
<td>Current waiting time for the next person on the list is 20 months (referred Jan 2014)</td>
</tr>
</tbody>
</table>

*Data suppressed to prevent disclosure.
Source: CDAT

Community practitioners have to date requested 75 Tier 1 Community Assessment Packs with 12 assessments completed to by professionals in the community following training and support from CDAT.

At the most recent team meetings (July and September 2015) no further names were allocated to team members for completion due to the lack of capacity within the team. Given this it is clear that the waiting time will continue to increase. Referrals are no longer being accepted for the old system. Referrers are directed to the new model of a two tiered process.

A proportion of children have complex needs as well as ASD and a small number of children with ASD have been placed out of region in independent residential facilities as the most appropriate solution in maintaining their safety and supporting educational attainment.

There is concern amongst parents about the length of time taken to assess Children and Young People for ASD and the level of support available to them:

“Autism diagnosis process is far too lengthy and is not supporting the ethos of early intervention or GIRFEC. Teachers seem uneducated about ASD and support services such as SAT are underfunded and only available for a couple of hours a month. Speech and Language and CAMHS were great but more support is needed to teach front line educators how to work with children on the autistic spectrum.”

Community Survey 2014
"Now that my eldest son is 18 the isolation of living in a small community with poor transport means that he can't access work. Because there is no support to help him with his Asperger's he will probably never get a job - and the same will be true of my other son. I will have to continue to support them for the rest of their lives, but as my tax credits and child benefit are stopped as they grow older, it means I live in a deeper and deeper poverty. no one cares. no one helps. no one knows about us at all."

Community Survey 2014

Please note: It is recognised that there is a lack of information regarding the prevalence and incidence of ASD. The figures presented here only describe the existing waiting times for an assessment. There is no indication of how long it takes before Children and Young People present with symptoms for ASD and are then referred, or the time between receiving an assessment and receiving support.

References


511 https://www.lgbtyouth.org.uk/ (last accessed 27th October 2015)


Scotland's Census 2011 - National Records of Scotland Table DC2101SC - Ethnic group by sex by age

Scottish Government; Equally Well 2008; http://www.gov.scot/Publications/2008/06/25104032/0 (last accessed 27th October 2015)

Scottish Government; Early Years Framework; www.gov.scot/Publications/2009/01/13095148/0 (last accessed 8th September 2015)


13. Included

554 SHARED CARE NETWORK (2008) Breaking down the barriers: how short breaks are helping families with children with autism to be "more like other families". Shared Care Network.


562 Scottish Government; www.gov.scot/Topics/Statistics/Browse/Health/Data/Carers; (last accessed 9th February 2017)


572 http://www.bmj.com/content/342/bmj.c7452 (last accessed 27th October 2015)


## Glossary

### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABI</td>
<td>Alcohol Brief Intervention</td>
</tr>
<tr>
<td>ACT</td>
<td>Acceptance and Commitment Therapy</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ADP</td>
<td>Alcohol and Drug Partnership</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorders (also known as Autism Spectrum Conditions (ASC))</td>
</tr>
<tr>
<td>ASDIN</td>
<td>Autistic Spectrum Disorders Integrated Network</td>
</tr>
<tr>
<td>ASN</td>
<td>Additional Support Needs</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Viruses</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guerin (BCG) Tuberculosis vaccine</td>
</tr>
<tr>
<td>BFI</td>
<td>Baby Friendly Initiative</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic groups</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CAPSM</td>
<td>Children Affected by Parental Substance Misuse</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CDAT</td>
<td>Communication Disorders Assessment Team</td>
</tr>
<tr>
<td>CEL</td>
<td>Chief Executive Letter</td>
</tr>
<tr>
<td>CELCIS</td>
<td>Centre for Excellence for Looked After Children In Scotland</td>
</tr>
<tr>
<td>CIE</td>
<td>Curriculum for Excellence</td>
</tr>
<tr>
<td>CHI</td>
<td>Community Health Index</td>
</tr>
<tr>
<td>CHSP</td>
<td>Child Health Surveillance Programme</td>
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<tr>
<td>CHWP</td>
<td>Child Healthy Weight Programme</td>
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<tr>
<td>CIS</td>
<td>Continuous Inpatient Stays</td>
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<tr>
<td>CITS</td>
<td>Community Intensive Treatment Service</td>
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<tr>
<td>CLD</td>
<td>Community Learning and Development</td>
</tr>
<tr>
<td>COSLA</td>
<td>Convention Of Scottish Local Authorities</td>
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<tr>
<td>CPP</td>
<td>Community Planning Partnership</td>
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<tr>
<td>CSE</td>
<td>Commercial Sexual Exploitation</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>D&amp;G</td>
<td>Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>DAVAWP</td>
<td>Domestic Abuse and Violence Against Women Partnership</td>
</tr>
<tr>
<td>DDP</td>
<td>Dynamic Deconstructive Psychotherapy</td>
</tr>
<tr>
<td>DGRI</td>
<td>Dumfries &amp; Galloway Royal Infirmary</td>
</tr>
<tr>
<td>DoE</td>
<td>Duke of Edinburgh Award</td>
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<tr>
<td>DSWA</td>
<td>Dumfries and Stewartry Women's Aid</td>
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<tr>
<td>DTP/Pol/Hib</td>
<td>Diptheria, Tetanus, Acellular Pertussis (Whooping Cough), Polio and Haemophilus Influenza type B vaccination</td>
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<tr>
<td>ECEC</td>
<td>Early Childhood Education and Care</td>
</tr>
<tr>
<td>ELCC</td>
<td>Early Learning and Childcare</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<tr>
<td>EYC</td>
<td>Early Years Collaborative</td>
</tr>
<tr>
<td>FAS</td>
<td>Foetal Alcohol Syndrome</td>
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<tr>
<td>FASD</td>
<td>Foetal Alcohol Syndrome Disorder</td>
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<tr>
<td>FV</td>
<td>Fluoride Varnishing</td>
</tr>
<tr>
<td>GCCH</td>
<td>Galloway Community Hospital</td>
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<tr>
<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
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<tr>
<td>GIRFEC</td>
<td>Getting It Right For Every Child</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GSVQ</td>
<td>General Scottish Qualification</td>
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<tr>
<td>GTCS</td>
<td>General Teaching Council for Scotland</td>
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<tr>
<td>GUS</td>
<td>Growing Up in Scotland</td>
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<tr>
<td>HALL4</td>
<td>? one L or two?</td>
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<tr>
<td>HBSC</td>
<td>Health Behaviours of School Children</td>
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<tr>
<td>HEAT</td>
<td>Scottish Government set standards and targets on: Health Improvement Efficiency Access to treatment Treatment</td>
</tr>
<tr>
<td>HIA</td>
<td>Health Impact Assessment</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLE</td>
<td>Home Learning Environments</td>
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<td>HPA</td>
<td>Health Protection Agency</td>
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<td>HPI</td>
<td>Health Plan Indicator</td>
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<tr>
<td>IPT</td>
<td>Interpersonal Psychotherapy</td>
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<tr>
<td>IRF</td>
<td>Integrated Resource Framework</td>
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<tr>
<td>ISD</td>
<td>Information and Statistics Division</td>
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<tr>
<td>ISSU18</td>
<td>Young People's Substance Misuse Service</td>
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<tr>
<td>IZ</td>
<td>Intermediate Zone</td>
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<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccinations and Immunisations</td>
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<tr>
<td>KCND</td>
<td>Keeping Childbirth Natural and Dynamic</td>
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<tr>
<td>LA</td>
<td>Local Authority</td>
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<tr>
<td>LAACYP</td>
<td>Looked After and Accommodated Children and Young People</td>
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<tr>
<td>LACYP</td>
<td>Looked After Children and Young People</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual or Transgender</td>
</tr>
<tr>
<td>MCADD</td>
<td>Medium Chain Acyl-CoA Dehydrogenase Deficiency</td>
</tr>
<tr>
<td>MenB</td>
<td>Meningitis B vaccine</td>
</tr>
<tr>
<td>MenC</td>
<td>Meningitis C vaccine</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles, Mumps and Rubella vaccine</td>
</tr>
<tr>
<td>NAPR</td>
<td>National Academy for Parenting Research</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NRS</td>
<td>National Records of Scotland</td>
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<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OSCR</td>
<td>Office of the Scottish Charity Regulator</td>
</tr>
<tr>
<td>PAFT</td>
<td>Parents as First Teachers</td>
</tr>
<tr>
<td>PCVB</td>
<td>Pneumococcal Conjugate Vaccine Booster</td>
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| PEPAS        | Physical Education, Physical Activity and
<table>
<thead>
<tr>
<th>Terminology</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour care</td>
<td>Where people are cared for and supported throughout the day and night. This can also apply to children’s services.</td>
</tr>
<tr>
<td>advocacy and advocate</td>
<td>Advocacy means getting support from another person to help someone express their views and wishes, and to help make sure their voice is heard. Someone who helps in this way is called an advocate. In the Standards, we are referring to formal advocacy provided by an organisation to someone using care.</td>
</tr>
<tr>
<td>assessment</td>
<td>A health and/or social care assessment will find out what help and support a person needs, such as healthcare, medication, advocacy, equipment, care at home, housing support or a care home.</td>
</tr>
<tr>
<td>capacity</td>
<td>Capacity refers to an individual’s ability to make decisions about their wellbeing. This may change over time and may refer to different aspects of their life. For people who have been medically assessed as lacking capacity there is legislation to protect their wellbeing.</td>
</tr>
<tr>
<td>care home</td>
<td>A care service providing 24 hour care and support with premises, usually as someone’s permanent home.</td>
</tr>
<tr>
<td>carer</td>
<td>A carer is someone of any age who looks after or supports a family member, partner, friend or neighbour in need of help because they are ill, frail, have a disability or are vulnerable in some way. A carer does not have to live with the person being cared for and will commonly be unpaid.</td>
</tr>
<tr>
<td>communal areas</td>
<td>An area in a care service such as a living or dining room, activity room, hairdresser, library, café, garden or quiet area that everyone can use.</td>
</tr>
<tr>
<td>communication tools</td>
<td>These help people to communicate in a range of ways. For example, visual prompts, talking mats (system of simple picture symbols) or mobile phone apps.</td>
</tr>
<tr>
<td>confidentiality</td>
<td>This means that information that is kept about someone by a care provider will not be shared with anyone else unless the person gives their consent for it to be shared. Confidentiality may only be broken if it avoids or reduces the risk of harm to the person.</td>
</tr>
<tr>
<td>early years</td>
<td>Children aged up to 16 years.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>emergency or unexpected event</td>
<td>This is an incident or emergency that could require immediate action, such as the premises being evacuated.</td>
</tr>
<tr>
<td>emotionally resilient</td>
<td>Someone's ability to cope with, or adapt to, stressful situations or crises.</td>
</tr>
<tr>
<td>evidence, guidance and best practice</td>
<td>Written guidelines for agreed ways to provide care, support or carry out treatment. Often these are put together by professionals based on the best available evidence at the time. These guidelines often change so that they remain up to date.</td>
</tr>
<tr>
<td>human rights</td>
<td><em>Human rights</em> are based on the principle of respect for the individual and they are the rights and freedoms that belong to every person, at every age. They are enshrined in UK legislation under the Human Rights Act.</td>
</tr>
<tr>
<td>intimate personal care</td>
<td>This relates to activities which most people usually carry out for themselves, such as washing, going to the toilet, dressing or eating, but some people may be unable to do because of their age, an impairment or disability.</td>
</tr>
<tr>
<td>liberty is restricted by law</td>
<td>There are times when a person's choices, such as where they live, are determined by law. For instance, someone might have their liberty restricted under the Mental Health Act, as a result of a criminal conviction or decisions made by a Children's Hearing.</td>
</tr>
<tr>
<td>open-ended and natural play materials</td>
<td>Open-ended materials (also called loose parts) are play materials that can be used in numerous ways indoors and outdoors by children. They can be moved, carried, combined, and redesigned in any way the child decides.</td>
</tr>
<tr>
<td>personal plan</td>
<td>A plan of how care and support will be provided, agreed between the person using a service and the service provider.</td>
</tr>
<tr>
<td>physical intervention, sanctions or incentives</td>
<td>These are used to manage and respond to challenging behaviour. They can be constructive in reducing the risk of harm and helping people recognise that there are consequences to their actions.</td>
</tr>
<tr>
<td>planned care</td>
<td>The term used to describe care, support or treatment which is carried out as detailed in someone’s personal plan (see above).</td>
</tr>
<tr>
<td>positive risks</td>
<td>Positive risks means making balanced decisions about risks; it is the taking of calculated and reasoned risks, which recognises that there are benefits as well as potential harm from taking risks in day to day life.</td>
</tr>
<tr>
<td>premises</td>
<td>When an organisation providing care and support also provides premises, such as a nursery, hospital or care home. It does not apply when someone using a service is responsible for the premises, including housing support or care at home.</td>
</tr>
<tr>
<td>pretend play</td>
<td>Pretend play is any game or activity where children use their imagination to create their own pretend experience.</td>
</tr>
<tr>
<td>professional codes</td>
<td>These codes set out professional standards of conduct and competence, as well as the personal values, which people working in health and social care are expected to follow.</td>
</tr>
<tr>
<td>representative</td>
<td>This may include someone appointed to have power of attorney, a guardian, family member, friend, neighbour or an agreed person who can speak on the individual's behalf. A representative may be formal or not formal.</td>
</tr>
<tr>
<td>restraint</td>
<td>Restraint is used to keep someone safe or to prevent them from harming others. It might involve using physical means, changing the environment or medication.</td>
</tr>
<tr>
<td>small group living</td>
<td>Groups of approximately 6 to 10 people provided with their own lounge and dining facilities for their own group use in a homely type environment. Small group living sometimes takes place within a larger care service such as a care home or hospital.</td>
</tr>
<tr>
<td>technology and other specialist equipment</td>
<td>Specialised equipment that helps people in their day to day life, such as telecare, telehealth or telemedicine, alarm call system, remote support and advice or mobility aids.</td>
</tr>
<tr>
<td>therapy</td>
<td>A specialised treatment or intervention, such as physiotherapy, occupational therapy, speech and language therapy, counselling and talking therapies.</td>
</tr>
<tr>
<td>transition</td>
<td>Used to describe a significant change for someone, such as starting to use a new care service or a change in life stage (eg becoming an adult).</td>
</tr>
</tbody>
</table>
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