Needs Assessment for Vulnerable Young People in Kent

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Inequalities in Health Behaviours and Life Trajectories of Children and Youth: Overview

There are strong continuities between social origin and social status of destination of children and young people. Parental socio-economic circumstances remain a major determinant of young people's life chances. Factors such as parental occupation, education and income explain a far higher proportion of the variation in school performance in the UK than in western countries on average. Rather than equalising life chances, a strong class divide persists in British education. The level of education is not only strongly influenced with income level, quality of employment, housing, food, access to leisure – all of which are factors that impinge upon adult health. It also independently shapes propensity to adopt and maintain healthy lifestyles. Those with higher qualifications are less likely to smoke, more likely to control their diet and exercise than their less educated counterparts – this even after controlling for factors such as income.

Problematic risk behaviours such as smoking and drug misuse during youth are more strongly associated with social deprivation. The significance of variations in health behaviours during childhood and youth to health inequalities in adulthood should not be under-estimated. Most smokers, for example, start smoking in their teenage years. Those who are in social networks where cigarette smoking is the norm are significantly more likely to take up the habit leading to both social and neighbourhood concentration in the prevalence of smoking. A strong class gradient exists between teenagers in the lowest income groups who are the heaviest smokers and those from professional backgrounds who are the lightest smokers.

Evidence of socio-economic variations in alcohol and drug misuse varies according to the definition of substance use that is adopted. Many UK surveys suggest a positive relationship between alcohol consumption and social status, young men and women from higher income groups drinking more frequently and in larger amounts. Similarly the use of cannabis and amphetamines does not appear to be strongly associated with social deprivation although young people who leave school at 16 appear more likely to have tried drugs than those who stay on to achieve higher qualifications. Against this highly problematic drug and alcohol use appear to be strongly associated with social disadvantage.

Although sexual behaviour has consequences for current morbidity as reflected by the increasing prevalence of STIs in young people, early sexual activity can be perceived as part of a pathway leading to later adult circumstances. Children who start having sexual intercourse at an earlier age are significantly more likely to become pregnant as teenagers, to leave school early, to have poor employment prospects and to be lone mothers. There is some debate as to whether teenage pregnancy itself changes the life trajectories of young women whose adverse socio-economic outcomes are at least in part accounted for by individual and family background. However few disagree that teenage mothers are a vulnerable group whose economic prospects are significantly worse than those of women who defer motherhood.

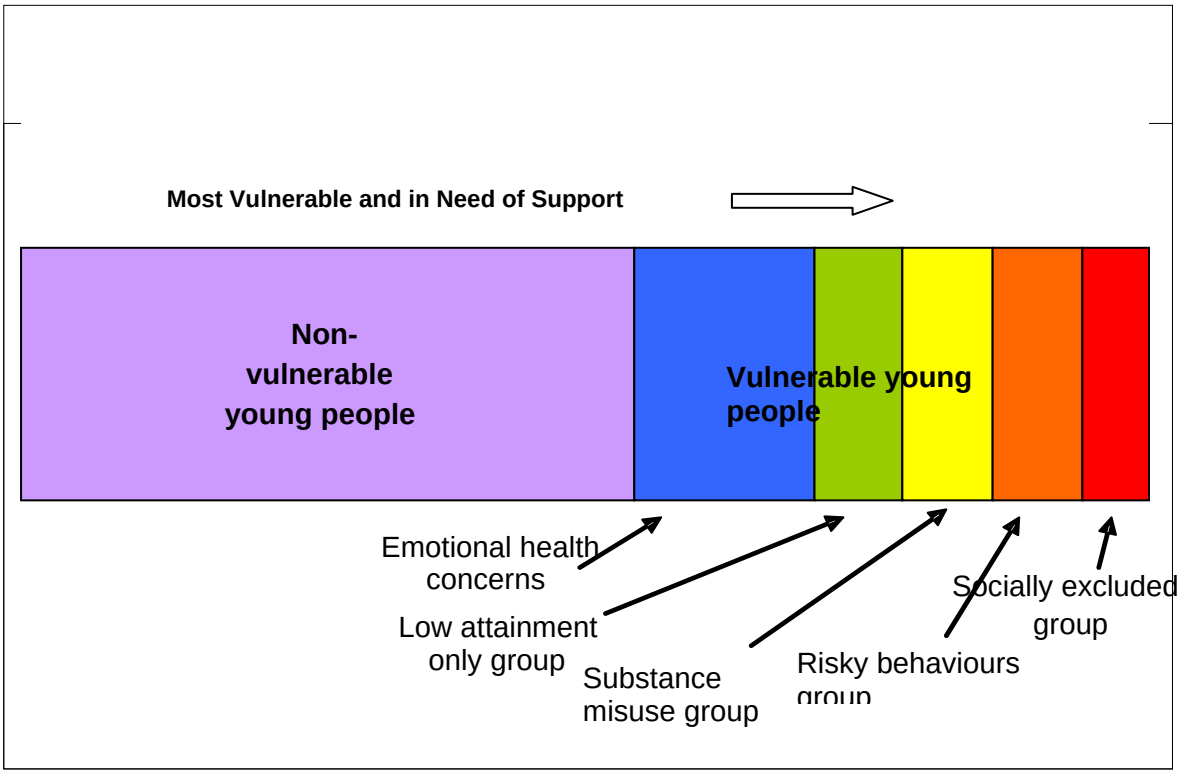
Abbreviated from Asthana and Halliday 2006

Young people's challenges in perspective

1. The majority of young people do well and will be on track to make a positive transition to adulthood. A minority of young people are more disadvantaged and in need of support.

2. Recent research by Barnes et al (2011) helps to understand the spectrum of disadvantage for young people, including the extent to which different problems can overlap and how subsequent outcomes vary for different risk groups (Figure 1.

Figure 1 - Vulnerable young people in need of support



Source: Barnes,et al (2011)

3. The research classifies young people at age 16/17 according to six areas of disadvantage: low attainment, not being in education, employment or training (NEET), teenage parenthood, emotional health concerns, criminal activity and substance misuse.

4. The analysis highlights that some young people (24%) experience one disadvantage only, specifically emotional health concerns (16%) and low attainment (8%). Young people facing these problems are more at risk of negative outcomes later in life and may require support to make a positive transition to adulthood. Eight per cent of young people experience problems with substance misuse and have a small chance of low attainment or emotional health concerns as well.

5. The young people classified in the risky behaviours (8%) and socially excluded (6%) groups are the most disadvantaged. The risky behaviours group includes young people taking part in criminal activities, a tendency for substance misuse, low attainment and emotional health concerns. The socially excluded group were NEET, tended to have low attainment, emotional health concerns and misused substances. Based on these estimates around 38,000 16 year olds are socially excluded in England. The research shows that they experience the most negative outcomes at 18/19: for example, 42% of the socially excluded group were NEET at age 18/19, compared to 5% of the non-vulnerable group.

6. Social science approaches stress the importance of the school as a context for peer selection and for the formation of social and cultural capital (Bordieu 1993) as mechanisms in which education may influence the relative vulnerability of children and young people. During school years, young people's social networks and social support systems are formed, developed and modified through their interactions with

peers (Morrow 1999). Socialising and making friends becomes important in upper primary and throughout secondary education, when children and young people's relationships outside the family environment assume greater importance (Farrell et al 2004).

7. Learning may also enhance young people's cultural and social capital which, for Bordieu consists of attainment of academic qualifications, use of language, forms of social etiquette and competence as well as degree of confidence and self-assurance, contacts and groups memberships which provide actual or potential support and access to value and resources. Through its economic value in the labour market, the form of cultural and social capital described by Bordieu can impact on young people's decisions about engaging in risky behaviour.

Educational Experience and Parental Influences

8. The most important socio-demographic family distal influences on children's attainments are parental education and income. Occupational status is also important although the effects of occupation are less clear cut. Family size is another important factor. Much studied risk factors such as teenage motherhood can have an important indirect effect if occurring in combination with other factors. However these are not in themselves major influences in the overall distribution of attainment in the population.

9. Quality pre-schooling is also important and other contexts for influences are provided by neighbourhoods. These can mitigate or offset the impact of family level factors in a substantial way. The characteristics of families have independent effects on attainment. Parental beliefs, values, aspirations and attitudes ('cognitions') are very important, as is parental wellbeing.

10. Parenting skills in terms of warmth, discipline and educational behaviours are all major factors in the formation of success at school. Parental education can also moderate the effects of risk factors and ease the effect of them on inter-actions between parents and children.

11. The transition to adulthood is changing for all young people; specifically the extension of the time taken and more diverse pathways into, secure and stable employment. Transitions have become more extended and diverse due to three elements:

    - an increase in the number of stages between compulsory schooling and stable work, as more young people study in further education and higher education, possibly interspersed with some time in work;
    - an increase in the length of time to complete some stages, such as more post graduate study and those who do enter employment taking longer to secure a stable job;
    - an interest in a broader definition of adulthood, to include housing, family formation and independent living.

12. These changes can be seen when comparing post compulsory education transitions of young men in the 1958 and 1970 cohort studies (Schoon et al 2007).

13. Thomas et al (2008) have found a range of individual risk factors associated with negative outcomes in adolescence. These factors fall into five main areas that

interact dynamically to help shape outcomes: family, school, community, individuals and peers. Typical risk factors include poor parental supervision, low income, local authority care, low achievement, school exclusion and friends involved in problem behaviours.

Table 1 - Exclusions amongst secondary school pupils 2008/09 to 2010/11

District	2010/11		2009/10		2008/09	
	Number of Fixed Exclusions 2010-11	Number of Permanent Exclusions 2010-11	Number of Fixed Exclusions 2009-10	Number of Permanent Exclusions 2009-10	Number of Fixed Exclusions 2008-09	Number of Permanent Exclusions 2008-09
Ashford	1,322	2	643	0	927	1
Canterbury	992	42	825	20	882	34
Dartford	487	2	559	5	1,270	9
Dover	1,426	17	1,001	8	1,287	15
Gravesham	693	16	721	29	651	22
Maidstone	782	28	743	27	1,033	43
Sevenoaks	206	5	436	7	696	11
Shepway	1,061	10	1,313	20	1,025	13
Swale	1,647	33	1,365	11	2,125	24
Thanet	1,230	23	1,132	21	873	19
Tonbridge and Malling	967	13	855	13	724	10
Tunbridge Wells	489	4	504	3	654	16

Excludes Academies

2006/07 Data is from the Annual Absence Return (May 2007) and the School census. Some Schools did not provide absence on either data source. 2008 to 2010 data is from the school census. Data for 2010/11 is not available yet.

14. Table 1 identifies secondary school exclusions across the County over the three year period 2008/09 to 2010/11. As regards fixed exclusions, consistently higher rates are found in Dover, Shepway and Swale schools, contrasting with reducing lower rates in Tunbridge Wells, Sevenoaks and Dartford. Permanent exclusions are matters of last resort and accordingly the numbers are far fewer. Furthermore there is less of a consistent pattern across the County. Nevertheless Canterbury schools have higher numbers of permanent exclusions in contrast to Dartford and Tunbridge Wells which have consistently low levels.

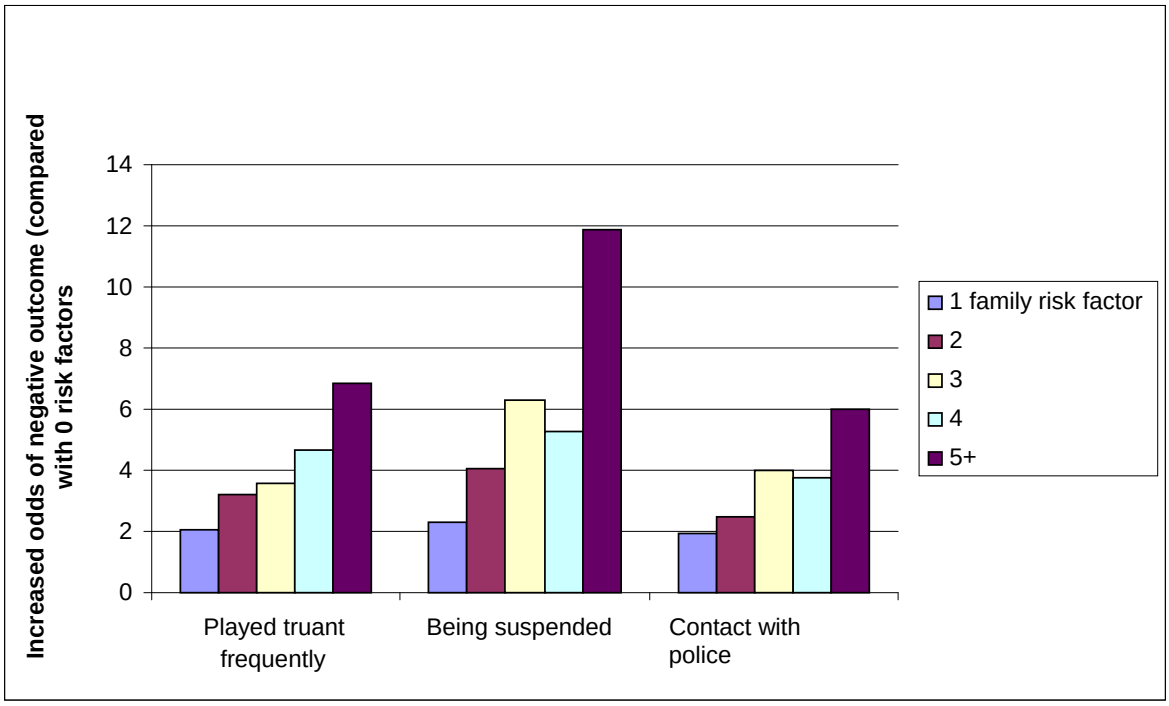
15. Barnes el al (2011) report that certain risk factors are experienced by a number of the different vulnerable groups they identify (emotional health concerns, substance misuse, low attainment, risky behaviour, socially excluded). These risk factors include being female (although boys were more likely to be in the risky behaviours group), being bullied at school, and having poor attitudes to school (including playing truant, having low aspirations and having parents who favour their children leaving the education system at 16).

16. The research on risk factors highlights its intergenerational risk: the close association between negative parental circumstances and the risk of young people experiencing negative outcomes.

17. Feinstein and Sabates (2006) investigated the link between family disadvantage and subsequent child outcomes in England. They estimated that 7% of young people, around 310,000 teenagers, were likely to experience three or more family related risk factors at any one time. These risk factors include: substance or

alcohol misuse; criminality; domestic violence; financial stress; worklessness; teenage parenthood; and overcrowding.

Figure 2 - Family disadvantage increases the risk of negative child outcomes



Source: Feinstein, L. and Sabates, R. (2006)

The case for intervening with young people

- Adolescence is a distinct and unique phase, a period of specialisation 'where what you do directly affects what you know and how you think about it' (Asmussen 2007)
- Economic evidence, brain and education research argue for a balanced approach to investment across the 0-18 age group
- Evidence from neuro-science suggests that the adolescent brain develops and re-organises during the teenage years
- Interventions during the teenage years can raise outcomes overall and close the gap in outcomes between the richest and poorest
- Some young people will develop needs for the first time during adolescence

The costs of not investing in adolescence

18. When things go wrong for young people the outcomes can be particularly damaging and costly both for them and to society. Similarly, young people who participate in risky behaviours, such as crime or substance misuse, or become pregnant early, can incur significant costs to the taxpayer:

- in 2009 the National Audit Office estimated the cost to the economy of young people aged 10-17 offending as £8.5 to £11bn (NAO 2010);
- Alcohol Concern estimate that young people under 18 attending Accident and Emergency departments cost the NHS £19m per year.
- Flint et al (2011) estimated that a young person starting to show behavioural problems when aged five and who has been through the community justice system will have cost the taxpayer £173,000 by age 16;
- DfE internal analysis (2010) estimates that the direct costs to the NHS are

£2,124 per maternity and £648 per abortion. Additional costs are also likely due to maternal mental health problems, the fact that babies born to teenage mothers are more likely to suffer health complications and possible wider costs to the public purse arising from any negative impact on the mother's educational and employment outcomes.

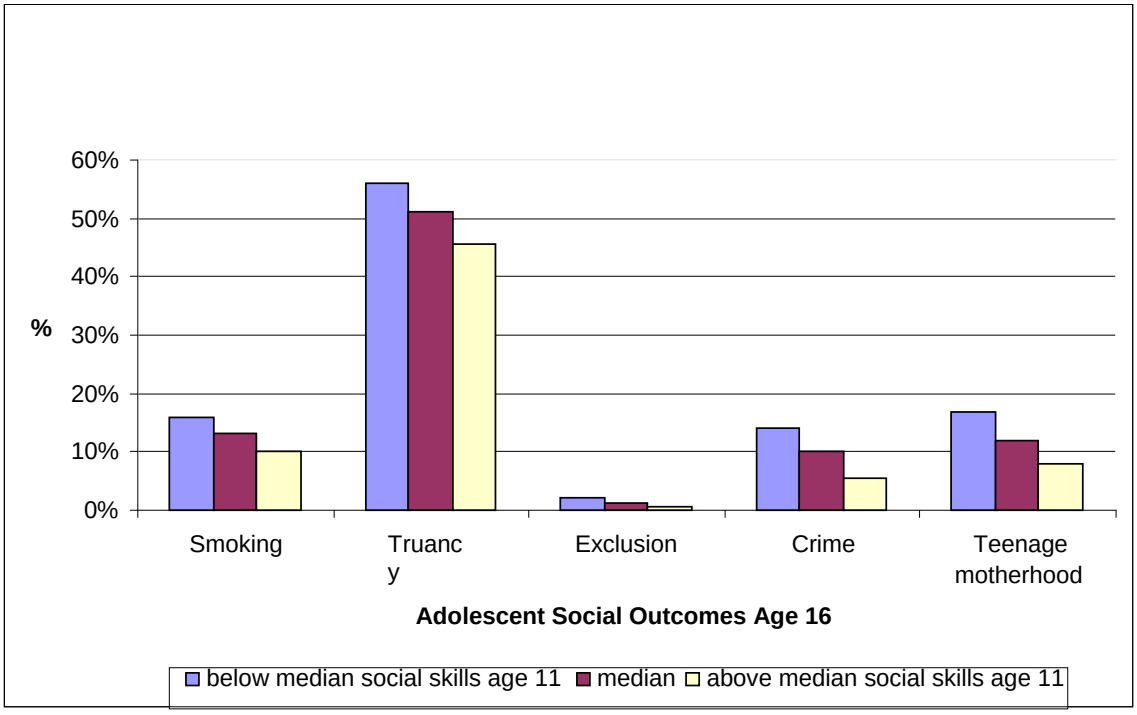
Qualifications and skills for a successful transition to adulthood

19. Qualifications and skills are essential for young people and have the strongest relationship with future employment and earnings. Those who are better educated earn more and are less likely to be unemployed (Greenwood et al 2007), are healthier and live longer (Feinstein et al 2008). As the DfE publication Case for Change (2010) notes: ''Education draws out our gifts, strengths and potential, makes life intrinsically more fulfilling, enables us to realise our goals and gives us greater control of our lives'.

20. However, research also finds that personal and social skills, such as confidence or communication skills, contribute to economic outcomes both by mediating educational attainment directly and by being associated with fewer of the risky behaviours that tend to undermine achievement. Cognitive and social skills often work together in mutually reinforcing ways to generate better outcomes for young people.

21. Research demonstrates the impact of such skills on wider health, crime and community outcomes. For example, those with below average social skills at age 11 are more likely to engage in risky teenage behaviours such as smoking, exclusion from school, engagement in criminal activity, and become a teenage mother (Figure 3).

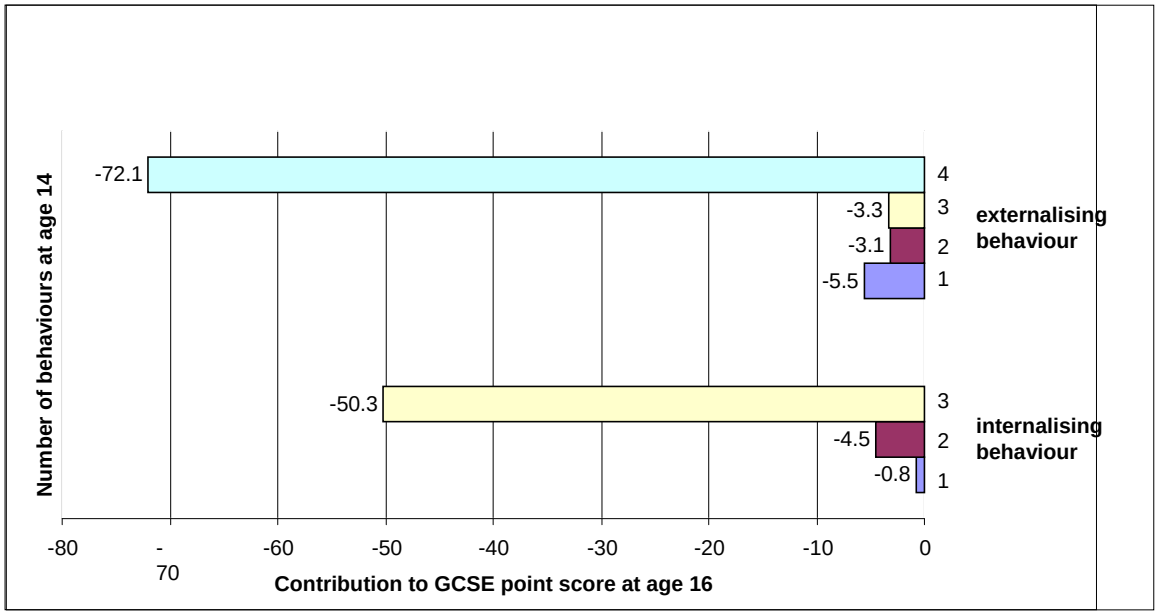
Figure 3 - Average adolescent social outcomes of those with above/median/below social skills at age 11



Source: Carneiro et al (2007)

22. Engaging in multiple risky activities is associated with impaired progress in terms of young people's educational attainment (Cebulla and Tomaszewski 2009). Building on the previous analysis, Figure 4 illustrates a clear association between the number of risky behaviours that a young person engages in at age 14 and GCSE attainment. Risky behaviours may be either internalising (ie behaviours such as smoking, truancy and drinking alcohol which are primarily harmful to the individual) or externalising (ie behaviours such as vandalism, fighting and shoplifting which primarily affect others). Engagement in multiple risky behaviours of either type is associated with up to a 20% reduction in GCSE points, or a loss of 8-12 entire GCSE grades.

Figure 4 - Relationship between number of risky behaviours at age 14 and GCSE attainment at age 16



Source: Cebulla and Tomaszewski (2009)

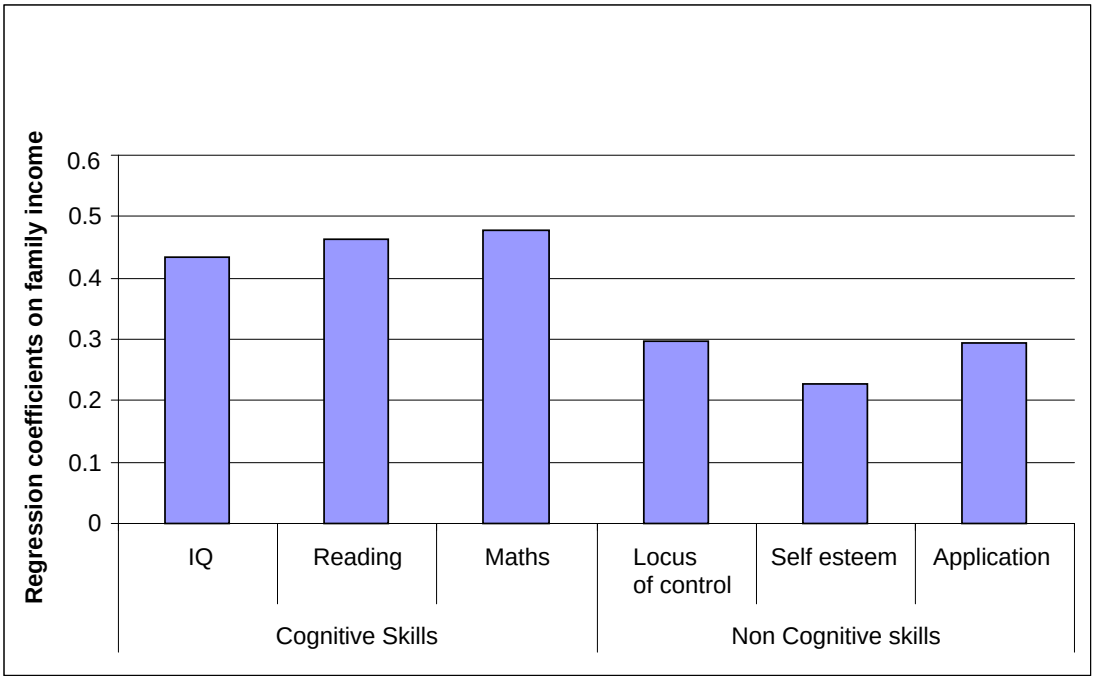
23. Many employers value personal and social skills alongside key cognitive skills such as basic literacy and numeracy. These behavioural attributes are frequently identified as the area of least satisfaction with young recruits. According to the 2010 CBI (Confederation of British Industry) education and skills survey for example, 57% of employers are unhappy with young people's self-management skills, 34% are dissatisfied with their team-working skills and 44% dissatisfied with their problem-solving skills.

24. Furthermore, evidence suggests that, 'soft skills' may be becoming increasingly important for young people's employment prospects. Analysis of multiple cohort studies by IPPR (Institute for Public Policy Research) shows that personal and social skills were 25% more important in determining the earnings of those born in 1970 than they were for those born in 1958. At the same time, cognitive skills became 20% less important (Margo and Dixon 2006).

25. Evidence from the 1970 Birth Cohort Survey points to the fact that both cognitive and non-cognitive skills at age 10 are positively related to social background (as measured either by family income or father's social class). While the correlation between family income and skills is strongest for cognitive skills, there is also a

significant relationship for non-cognitive skills, most notably locus of control and application (Figure 5) (Blanden et al 2007). The association between non-cognitive skills and parental background has become increasingly important over time; whilst a significant association was found in the 1970 cohort study between family income and non-cognitive abilities, there was not a significant relationship found for the 1958 cohort.

Figure 5 - Association between social and cognitive skills age 10 and family income



Source: Blanden et al(2007)

26. Given the role of both cognitive and non-cognitive skills in influencing young people's attainment and therefore their own future earnings, Blanden et al (2007) estimate that differences in cognitive skills account for up to 20% of the persistence of the income gap across generations whilst differences in non-cognitive skills account for up to 10%.

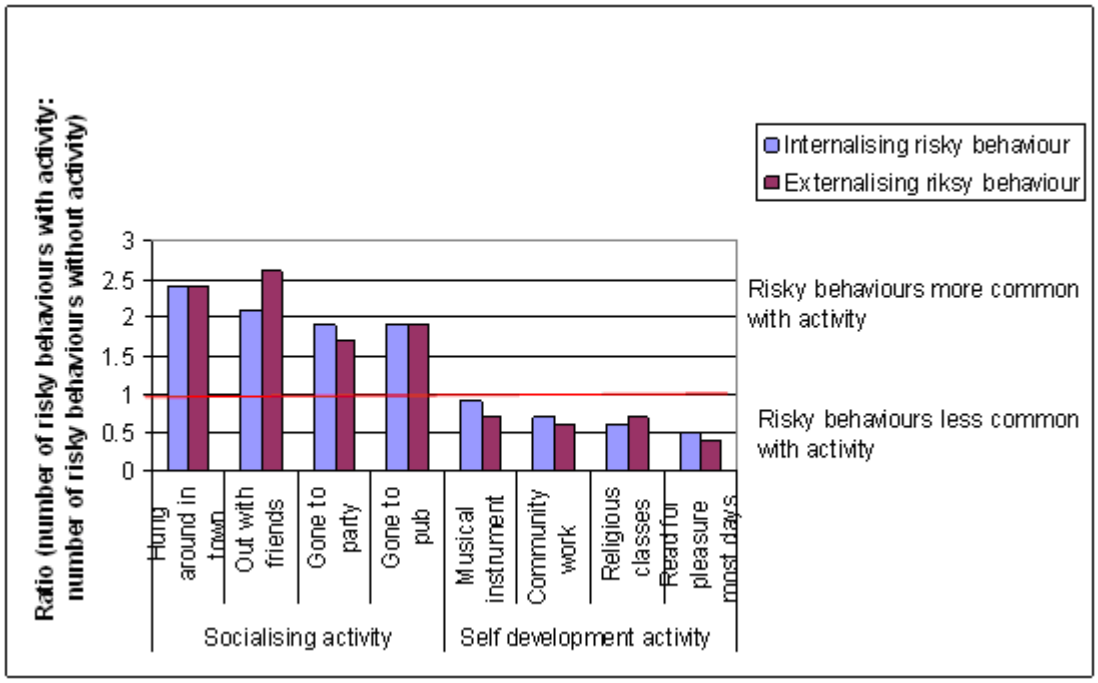
27. Carneiro et al (2007) find that the impact of increasing cognitive skills aged 11 on educational and social outcomes tends to be greatest for young people from more advantaged backgrounds. In contrast, increasing social skills appears to have at least as great an impact, if not more of an impact, on outcomes for more disadvantaged young people.

28. While schools have a major role to play in supporting the personal and social development of young people, out-of-school activities have the potential to supplement this and help those young people who need additional support.

29. Cebulla and Tomaszewski (2009) find a positive association between engaging in 'self development activities' outside lessons and adolescent outcomes. The more self development activities (attending religious classes, community work, reading for pleasure, playing a musical instrument) young people engage in the less likely they are to engage in risky behaviour. However, this positive relationship is reversed when the activities young people engage in are unstructured socialising activities such as meeting friends or hanging around in town. The more socialising activities young people engage in the more likely they are to engage in risky behaviour.

30. Figure 6 below compares the mean number of risky behaviours engaged in, depending on whether young people do or don't engage in particular activities. A ratio greater than 1 indicates that doing the activity is associated with a higher incidence of risky behaviours whilst a ratio less than 1 indicates that doing the activity is associated with a lower incidence of risky behaviours.

Figure 6 - Propensity to engage in risky behaviour by social activities engaged in



Source: Cebulla and Tomaszewski (2009)

31. However, whilst there is evidence of an association between participation in out of school activities and outcomes for young people, it is more difficult to demonstrate a causal link or to prove that particular interventions will have an impact on young people. For example, although young people who engage in self development activities are less likely to engage in risky behaviours, Cebulla and Tomaszewski (2009) find no evidence that young people who start to engage in self-development activities between the ages of 14 and 16 become less likely to engage in risky behaviours over the same period.

Adolescent Health and Vulnerable Young People

Nutrition, Exercise and Obesity in vulnerable young people

32. Whilst diet can have an immediate impact on the health of adolescents, adult susceptibility to disease can be associated with nutrition in childhood and adolescence (Cabellero 2001). It has been found that adolescents tend to consume above the recommended levels of sugar, salt and saturated fat but on the other hand there is low intake of some minerals, particularly amongst girls (Food Standards Agency 2000). On average adolescents tend to eat less than five or more portions of fruit or vegetables per day and drink quantities of soft drinks which tend to contribute to obesity.

33. Although physical activity is an important focus for health promotion, it has also been found that adolescent participation in physical activity can lead to enjoyment, feelings of competence, control and autonomy, confidence, positive attitudes (Exercise Alliance Briefing Papers – Young People).

34. Excess body weight is now the most common childhood disorder in Europe (International Obesity Taskforce and European Association for the Study of Obesity 2002) and overweight children are more likely to become overweight adults. There is also evidence to suggest that obesity and overweight can have an impact of psychological wellbeing and a low self-esteem (NHS Centre for Reviews and Dissemination 2002).

35. A decline in physical activity coinciding with an increase in sedentary activities, such as computer use and television viewing contribute to the increase in obesity (Prentice and Jebb 1995). In addition, changes in family eating patterns and the increasing use of pre-prepared meals and fast foods have contributed to increasing weight (WHO and Food and Agriculture Organisation 2003).

36. To counteract this, schools are encouraged to adopt a whole school approach to food and nutrition and in 2001 minimal nutrition standards for school lunches were re-introduced in England. In addition the Children's National Service Framework, in anticipation of Every Child Matters (DCSF 2003) and the National Healthy Weight Programme, addresses childhood obesity as part of the broader issues around promoting a healthy diet and physical activity (DH 2002).

37. Good nutritional practices and physical activity should be encouraged as early as possible in children's lives before unhealthy habits become established. Parents should be provided with good, simple information on feeding their children and adolescents need to be clear about where to seek advice around nutrition and exercise.

38. Peer-led nutrition approaches in schools to increase fruit and vegetable intake and lower the intake of fatty foods have been found to be feasible and have high acceptability (Story et al 2002).

The World Health Organisation has concluded that, for adolescents, prevention of obesity implies the need to:

- Promote an active lifestyle
- Limit television viewing
- Promote the intake of fruit and vegetables
- Restrict the intake of energy-dense, micronutrient-poor foods (eg packaged snacks)
- Restrict the intake of sugar-sweetened soft drinks

Additional measures identified included modifying the environment to:

- Enhance physical activity in schools and communities and family interactions
- Limit the exposure of young children to heavy marketing practices in respect of energy-dense, micronutrient-poor foods
- Provide the necessary information and skills to allow healthy food choices

39. In England such restrictions are not likely to be enforced by statute and the Government announced its intentions (2010) to develop a 'responsibility deal' with the manufacturers of foods which if taken to excess, have been shown to be

harmful to health. This is scheduled to be formally launched in late 2011. The 'responsibility deal' has been strongly criticised in some Public Health circles but not as yet by the Faculty of Public Health.

Nutrition, exercise and obesity can all have an impact on the health of adolescents and contribute to adult susceptibility to disease. These factors, particularly obesity, can also influence psychological wellbeing.

Adolescents in the UK are not eating optimal diets. Girls in particular fail to meet recommendations for exercise. As a result, in common with the rest of the population, overweight and obesity is increasingly prevalent among adolescents. There are socio-economic gradients in adolescent dietary habits and physical activity.

The Government is increasingly concerned with interventions in adolescent nutrition, exercise and obesity. Across the UK, measures are being introduced to educate young people about nutrition and increase access to healthy food.

Obesity is difficult to treat. Multidisciplinary teams may be able to help reduce weight and promote healthy habits among adolescents. Early intervention in children's lives is however, crucial for the promotion of good nutrition and exercise. Teaching parents, including adolescents, the importance of good early nutrition may be an effective way of promoting the health of future generations. Despite some evidence that school-based education can be effective in promoting better nutrition and exercise, there have been calls for an approach which addresses the structural and environmental causes of poor nutrition, inactivity and obesity. These include enhancing the opportunities for physical activity, increasing access to healthy foods and even limiting exposure to unhealthy food.

Smoking, drinking and drug use in vulnerable young people

40. Evidence shows that even after a relatively short smoking career young smokers have poorer respiratory health (Townsend et al 1991). The majority of smokers begin in adolescence and the younger they are when they start, the less likely to give up. However adolescent girls are more likely to smoke than boys.

41. Adolescents in the UK have one of the highest European levels of alcohol use, binge drinking and getting drunk (Alcohol Concern 2002) and there is a sharp increase in the prevalence of drinking with age. Regular heavy alcohol consumption and binge drinking are associated with physical problems, anti-social behaviour, violence, accidents, suicide, injuries and road traffic accidents and it has been found that alcohol consumption can affect school performance and crime.

42. Alcohol misuse is associated with a range of mental disorders and can exacerbate existing mental health problems and adolescents report risk taking behaviour when under the influence of alcohol.

43. Blenkinsop et al (2002) found that the use of illicit substances and the likelihood of having been offered drugs is significantly related to age. However drug taking is less common during the compulsory schooling years and rates of experimentation peak at the end of adolescence. The most likely drug to be used by adolescents is cannabis although the use of psychoactive substances to 'have fun' in nightlife settings is increasingly common (European Monitoring Centre for Drugs and Drug Addiction 2002).

44. Whilst there is a possible link between drug use and psychosis, there are links between ecstasy use and long term mental health problems including memory loss, lack of concentration and clinical depression. Frequent cannabis use in teenage

girls predicts later depression and anxiety with daily users carrying the highest risk (Patton et al 2002).

45. The use of drugs, smoking and alcohol amongst adolescents is not confined to the margins of adolescent life although there are a number of risk factors associated with smoking uptake: smoking behaviour and attitudes of parents, siblings and peers, family structure, school factors, risk behaviours, self-esteem and health concerns (Tyas and Pederson 1998). Young people are more likely to smoke if family and friends do (Schools Health Education Unit 2003).

46. Smoking prevalence was found to be highest amongst young people in social housing and lowest among those in owner-occupied accommodation (Prescott-Clarke and Primatesta 1998).

47. Factors associated with drug misuse include environmental influences such as availability, family influences including whether or not there is appropriate supervision, individual and personality factors including links with poor mental and emotional health (DrugScope and DH 2001) and educational factors (BMA 1997, Ledous et al 2002). Problematic patterns of drug use are concentrated amongst those who are worst-off (DrugScope and DH 2001).

48. Vulnerable adolescents generally start drug use from an earlier age than young people generally (DH and DrugScope 2001) and during the period following transition to secondary school they can be particularly vulnerable (DH and Drugscope 2001). At least two-thirds of young people with substance misuse disorders are likely to have co-existing psychosocial problems (Scott et al 2001).

49. Young people who start to misuse drugs under the age of 15 are referred to by professionals as early initiators. This group whilst very small in number, are vulnerable to problematic substance misuse in later life. Factors associated with drug use at such an early age are frequently in complex circumstances, experiencing family, school and other social and psychological problems. This includes parental drug and alcohol misuse, experience of sexual abuse and domestic violence. Criminal behaviour within families can also be a risk factor. (Possible reference)

50. The answers to adolescent smoking, drinking and drug use are likely to require multi-professional and multi-tiered service provision.

Adolescents in the UK are increasingly likely to experiment with smoking and use recreational drugs. Over time they have begun to drink greater quantities of alcohol and now have one of the highest levels of alcohol use and binge drinking in Europe. Smoking, drinking and drug use are all significantly related to age and their use increases throughout adolescence. There are slight gender differences; girls are more likely than boys to smoke, but drinking and drug use are slightly more common among boys. The use of addictive substances is spread across all sections of the adolescent population. However, certain social, educational, family and peer factors are associated with the use of alcohol, tobacco and drugs and problematic use if concentrated among the worst off. Many young people who misuse substances are likely to have co-existing mental health problems.

The risks of using addictive substances are well documented. Adolescents who smoke suffer increased mortality and morbidity including poorer respiratory health, lung cancer, heart disease and stroke. Heavy drinking and drug use can lead to physical, emotional, mental and social problems. All three types of substance abuse pose risks of dependence.

The Government has set targets to reduce the prevalence of smoking and drug use among adolescents and is working on interventions to tackle alcohol misuse. It is also working to provide

targeted education and co-ordinated services for adolescents and drug users.

Changes in circumstance and the acquirement of responsibility are often the most effective factors in stopping the abuse of alcohol and drugs. However, in view of the damage that these substances can inflict and their addictive nature, policy makers are bound to continue to seek effective interventions. Reducing the availability of drugs, cigarettes and alcohol may have an impact on adolescent use. In particular, there is evidence that increasing the price of cigarettes and alcohol may be an effective intervention. However, these policies can prove impractical and do nothing to tackle adolescents' attitudes. Stronger regulations of the marketing of cigarettes and alcohol may help to change attitudes and reduce abuse.

A minimum pricing policy for the sale of alcohol will be legislated for by the Scottish Government in the forthcoming parliamentary session.

Education, though an important strategy, may fail to reach the most vulnerable adolescents. If it is used, incorporating an understanding of adolescents' attitudes and an element of social skills development is likely to be important. Media strategies and multifaceted community interventions can help to reduce smoking, drinking and drug use among this age group. Harm minimisation and treatment, though not historically a focus of intervention, may become more important, particularly in helping to reduce the prevalence of smoking. Since misuse of alcohol and drugs is concentrated among the disadvantaged, targeting successful intervention is likely to be both efficient and effective.

Mental Health in vulnerable young people

51. Poor mental health can influence exercise patterns, obesity and body image, substance misuse and sexual behaviour and at any one time up to one in five children and young people experience some form of psychological problem (Mental Health Foundation 1999).

Mental disorders can include:

- Emotional disorders such as phobias, anxiety and depression
- Conduct disorders
- Hyperkinetic disorders such as attention deficit disorder
- Developmental disorders
- Habit disorders
- Eating disorders
- Post-traumatic syndromes
- Somatic disorders such as chronic fatigue syndrome
- Psychotic disorders such as schizophrenia and drug-induced psychosis (Kurtz 1996)

52. Early adolescence (11-14) is characterised by high rates of conduct and emotional disorders with adult-type depressive disorders beginning to make an appearance. Mid- and late adolescence are peak ages for the onset of depressive disorder, schizophrenia (Young Minds 2002) and other mental health disorders.

53. Conduct disorders in childhood predict many adverse developmental outcomes including educational underachievement, juvenile offending, substance misuse and dependence, anxiety, depression and suicide attempts (Scott et al 2001).

54. Deliberate self-harm is especially common in adolescent girls (Hawton et al 2002) although rates are increasing amongst males (Wilkinson et al 2002). Eating disorders such as bulimia and anorexia nervosa tend disproportionately to affect young females leading to one of the highest death rates of all psychiatric illnesses

and when not fatal leading to serious chronic medical complications (Royal College of Psychiatrists 1999).

55. Mental health issues affecting adolescents extend to suicide. The rate is low under 14 years although attempted suicide begins to occur around 11 to 12 years, increasing in frequency in the early and mid-teens. Young men aged 15-19 years are at particular risk of suicide, being less likely than girls to show their stress beforehand (Royal College of Psychiatrists 1999).

56. Age, gender and family related factors are important in explaining the mental health of adolescents. Most studies have found pronounced differences in mental health by gender. The Health Survey for England's study of four to 15 year olds found boys were more likely than girls to have conduct and hyperkinetic disorders and peer problems; girls were more likely to experience emotional symptoms.

57. For children and younger adolescents behavioural and emotional relationship difficulties increased from social class I to social class V and from higher to lower income households. Difficulties were found to be more common in lone parent households than in two parent families (Prescott-Clarke and Primatesta 1998).

Mental disorders were more common among five to 15 year olds who:

- Were children of lone parents
- Came from reconstituted families or larger households
- Came from families where parents stated that there was poor communication and low levels of support;
- Had parents who were assessed as having a neurotic disorder
- Had experienced three or more stressful life events

Risk factors for conduct, depressive and anxiety disorders include:

- Adverse temperamental characteristics in the child
- Parental mental illness, substance misuse, marital disharmony or personality disorder
- Chronic or acute stress at school, home, or in the neighbourhood
- Use of tobacco, alcohol and illicit drugs

Specific risk factors for conduct disorder include:

- Inadequate parental supervision
- Use of physical methods of punishment
- Violence in the home
- A family history of criminal behaviour
- A history of attention deficit/hyperactivity disorder (ADHD) in the child
- A delinquent peer group
- Academic under achievement
- Attendance at a 'failing' school

Some groups of adolescents are known to be at high risk of mental disorders. These include adolescents who:

- Have physical or learning disabilities
- Are in care or are care leavers
- Are excluded from school
- Are in the criminal justice system
- Are homeless
- Are young carers, especially of a parent with mental illness (Scott et al 2001)

58. Childhood and adolescent abuse can have a significant impact on mental health and adolescents who experience physical and sexual abuse as children are significantly more likely to experience moderate to severe depressive symptoms and moderate to high levels of life stress as well as regular smoking, alcohol consumption and illicit drug use (Diaz et al 2002).

59. Analysis of internationally based research from the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) demonstrates that children with a mental disorder are more likely to start drinking at a young age and have a regular cannabis use pattern. Young people with conduct problems, aggressive behaviour and a history of delinquency have a high probability of a sustained pattern of substance misuse. Much of the association between early ADHD and later substance misuse can be explained by the associations between ADHD and conduct problems. Depressive disorders have an association with alcohol abuse or dependence and of cannabis dependence. Mood disorders (including bipolar disorders – hypomania and mania) predict increased rates for cannabis use and cannabis use disorder. Child abuse, neglect and post traumatic stress disorder can also be associated with substance abuse. (Reference).

60. Anyone in contact with children and adolescents with mental health problems should take symptoms of emotional distress, behavioural difficulty and hyperactivity seriously as they impair function and development and are unlikely to be transient.

Up to one in five adolescents may experience some form of psychological problem. Adolescence is an important time in the development of mental health disorders and the likelihood of having one increases with age. There are gender differences in the mental health problems experienced by adolescents and some evidence that socio-economic variables are related to mental health disorders in early adolescence.

Family type, educational level of the mother, individual characteristics, substance misuse and educational factors are associated with the likelihood of developing a mental health problem. Some adolescents including those with disabilities, those in care, school excludees, the homeless, those in the criminal justice system and young carers are at a greater risk of developing mental health disorders.

Interventions to promote emotional wellbeing among adolescents can include education about mental health problems and the identification of those in need of help. The provision of school nurses or some sort of first line service may help to promote emotional wellbeing. Social skills training and anti-bullying policies within schools may also help to promote mental health.

There have been some recent interventions by government in adolescents' mental health disorders. Provision should be integrated with other services, especially those for substance abuse which is often linked with mental health problems. Early intervention in adolescent mental health problems is essential to try to stop the deterioration of mental health, alleviate distress and minimise the impact of mental health disorders on education and social development.

Sexual Health in vulnerable young people

There is considerable diversity in sexual experience among adolescents. Many enjoy safe, consenting sex, often as part of a steady relationship. However, there is a great deal of concern about the growing prevalence of STIs among this age group. These can cause preventable infertility, ectopic pregnancy, hospital admissions for pelvic inflammatory disease and psychological stress. Policy makers also wish to lower the rates of unwanted adolescent pregnancy, which is often associated with social disadvantage and poor mental and physical health of mother and child.

Rates of teenage pregnancy are higher in areas of socio-economic deprivation. Both STIs and teenage pregnancy are associated with early sexual initiation, sexual incompetence, lower education level and informal sources of information about sex. Certain groups of adolescents are more likely than others to experience teenage pregnancy and STIs.

Governments across the UK have developed targets and strategies for reducing STIs and unwanted pregnancies. These strategies involve multifaceted approaches including improving adolescents' social skills, providing better sex education and increasing the uptake of contraceptive services. The sexual health of adolescents does seem to be amenable to intervention. School based education can be effective, especially when linked to access to contraceptive services. Public health campaigns and community-level programmes have also proved successful in the past. Prompt diagnosis and treatment of STIs is crucial and good contraceptive services can result in lower conception rates. The services available to adolescents are therefore important for their sexual health. It is often suggested that services for adolescents are most effective when youth-oriented and geared to local needs. Adequate follow up after service use is vital to avoid unwanted pregnancy and the recurrence of STIs. Education and services for adolescents should be targeted towards those at greatest risk. In light of the social disadvantage that can follow adolescent parenthood, it is vital that young parents are well supported to avoid unnecessary psychological strain and ensure the best possible start to the lives of their children.

Pre-dispositions to criminal behaviour

61. Education is a potentially large influence on a young person's propensities to offend. Crime statistics for England indicate that crime rates are lower in areas with higher overall levels of education which are also areas of higher per capita income and contain a higher proportion of families belonging to the highest socio-economic status (Home Office 2003). Crime is more prevalent among young adults as crime rates typically increase with age during adolescence, reach a peak during teenage years and decline thereafter (Farrington 1992). Young people who become involved in crime under the age of 14 risk becoming persistent offenders (Rutter et al 1998).

62. A large body of literature has attempted to understand the process by which education is related to young adults' criminal behaviours. The human capital framework indicates that education increases human capital levels and wages derived from legal activities which raises the opportunity costs of engaging in crime (put more directly, you have more to lose if you get caught) (Freeman 1996; Farrington 2001). It also increases the opportunity costs associated with imprisonment since it increases the value of any time foregone.

63. Sabates (2008) has estimated the impact of educational attainment on juvenile conviction rates using information at the level of local education authorities in England (including Kent). This analysis uses aggregate conviction rates over time for three cohorts of young people born between 1981 and 1983 and their corresponding educational attainments, poverty indicators, time away from school etc. The results show that the increase in educational attainment between cohorts is associated with reductions in conviction rates for most offences (burglary, theft, criminal damage, drug related offences) but not for violent crime. Reductions in poverty are associated with decreasing conviction rates for violent crime, criminal damage and drug related offences. However increasing unauthorised time away from school is associated with higher convictions for theft.

Interventions in adolescent health

The way forward

Possible approaches for improving adolescent health:

- Early intervention in all areas of adolescent health should be encouraged to help prevent problems escalating;
- Interventions to improve adolescent health should be especially targeted at the most vulnerable groups of adolescents;
- Health services must be adequately funded if adolescent health is to improve. In particular, sexual health services, which are already over-stretched, should receive enough resources to minimise waiting times for assessment and treatment;
- Improving access to health services is crucial:
  - Services for adolescents should be provided in an age-appropriate environment and be seen to be user-friendly;
  - The continuity of services must be improved so that users do not fall in a gap between paediatric and adult care;
  - Adolescents must be provided with the information, support and encouragement needed to access health services independently;
  - Adolescents may need to be reassured of professional confidentiality in order to encourage use of health services.
- Prevention strategies are not sufficient to improve adolescent health. Where prevention fails, effective clinical support and treatment must be available to help adolescents adopt healthier lifestyles;
- Multifaceted approaches to intervention have the advantage of recognising the influence of and complex interaction between, individual, social and environmental factors on adolescent behaviour;
- There is a strong relationship between adolescent health and other aspects of adolescent life such as education, employment and housing. Moreover, school-based education may fail to reach the most vulnerable adolescents. Interventions in adolescent health should therefore be multi-professional and involve co-operation between health, education and social services;
- Interventions should recognise the structural and environmental influences on health behaviour:
  - Healthy, affordable food and opportunities for at least the recommended amount of physical activity should be available to all children and adolescents;
  - The media has an important role to play in forming adolescents' attitudes to nutrition, exercise and substance misuse. There is scope to harness this potential and further regulate its more harmful impact. In the light of the damaging affect alcohol has on the health of society and the rising levels of binge drinking among the young, the BMA has called for a ban on the advertising of alcohol, as there is for cigarettes. In order to protect adolescents, the BMA has also recommended that broadcasters adopt a more responsible approach towards body image and healthy eating patterns.
- Messages to adolescents about healthy behaviour should be as consistent as possible. For example, where bans on smoking exist they should be enforced. School environments must be supportive in order to reinforce health education messages on nutrition, smoking and drinking;
- Parents, children and adolescents should be made aware of the importance of good nutrition and exercise and should be equipped with the knowledge, skills and confidence necessary to integrate these into their lives;
- When education is used to address smoking, drinking and drug use, it is important to understand adolescents' attitudes and to acknowledge the perceived benefits of these behaviours. Peer education should be considered as part of health education strategies.

Mental Health in Vulnerable Young People

64. Young people in this age group face the transition to adulthood and its associated difficulties. Not only are they more prone to risky behaviour (eg drugs, risky sexual behaviour and alcohol abuse), they are also likely to experience a marked difference in the services they can access. Although CAMHS caters for children and young people from the ages of 0-18, from the ages of 16-18, young people are also using transition services that fall between adults and children's services.

65. Different diagnostic criteria are used in adult mental health services and many disorders in childhood will either go undiagnosed until the young person's symptoms are severe enough to come to the attention of adult services or re-classified under the adult diagnostic categories.

66. The diagnostic categories for mental disorders for children differ markedly from the adult categories of psychotic, neurotic and personality disorders. The adult categories are more stringent and persistent.

67. Young people's mental health problems are likely to be more acute in adolescence and psychological distress among young people is pervasive.

68. The transition from child to adult mental health services (AMHS) can therefore be difficult and these problems can further compound a young person's mental health problems. Services are not always effective at meeting the needs of young adults. While CAMHS tend to have a fairly broad remit, AMHS are more focused on severe and enduring disorders; thus many young people may be ineligible for treatment through AMHS. CAMHS also routinely work with a young person's family, which is not necessarily the case with AMHS.

69. A Young Minds mapping exercise of services for 16-25 year olds found that a comparatively low level of services are commissioned by PCTs and the needs of this age group are not being met effectively. Only 16% of CAMHS commissioners had initiatives in place to provide age-specific services to 16-25 year olds and only 9% had policies to improve access and services for this age group. A need for more formal transition protocols was also highlighted in the survey. It is important that there is a smooth transition from CAMHS to AMHS and that child and adult services work together to guarantee adequate support for all. The children's and mental health national service frameworks require local authorities and health services to ensure there is no gap in provision, something that is stressed in the 2005 consultation, Youth Matters. The DH is currently funding a two-year project which aims to improve access to age appropriate services and transition to AMHS, as well as reducing age-related inequalities.

70. In Kent, Swale, Thanet and Canterbury have the highest rates of inpatient admission for people aged under 19, Swale's admission rate being far higher then the Kent average.

Table 2 - Estimated number of young people with disorder

Estimated number of young people with disorder	16-18
Depression	27,261
Mixed anxiety and depressive disorder	18,889
Generalised anxiety disorder	5.608
Depressive episode	3,427
All phobias	2,337
Obsessive compulsive disorder	3,583
Panic disorder	1,714
Psychotic disorder	312
Probable Psychosis	623
Anti-social	298,121
Borderline	247,776
Eight or more: hazardous or harmful drinking	57,949
Any drug dependency	15,889

Source: Applying APMS to Kent population

Table 3 - Number of inpatient admissions due to a mental health disorder for those aged 19 and under for the period 2007/08 to 2009/10

Local Authority	Elective and non-elective inpatient admissions 2007/08 to 2009/10	Average crude rate per 10,000 population 19 and under
Ashford	56	6.3
Canterbury	179	16.7
Dartford	44	6.3
Dover	61	8.0
Gravesham	30	4.0
Maidstone	92	8.8
Sevenoaks	48	5.8
Shepway	55	8.0
Swale	510	50.6
Thanet	118	12.3
Tonbridge and Malling	67	7.3
Tunbridge Wells	54	6.4
NHS Eastern and Coastal Kent	979	18.2
NHS West Kent	335	6.6
Kent	1,314	12.6
Data extracted where discharge date between 01/04/2007 and 31/03/2010, primary diagnosis like F, episode sequence number = 1 and Epi start age <=19, patient classification = 1, admission method like 1 or like 2		

Source: SUS

Persistence and Incidence

71. Three years after the original ONS survey, Meltzer followed-up those he had previously questioned in order to find out if their disorders persisted or got better[1]. This found better outcomes for emotional disorders than for conduct disorders, with a quarter of children who had an emotional disorder having the disorder at follow-up, compared to 43% of children who had a persistent conduct disorder. Persistence of emotional disorders was correlated with social factors (mother's mental health, family discord, stressful life events) with 37% of those whose mothers had poor mental health having persisting disorder.

Incidence of mental disorders

72. The same follow-up study also looked at the occurrence of new cases in children who had not had a mental disorder at the time of the first study. Overall 4% of children developed new mental disorders in the three years. New emotional disorders were more common in older children than younger – 5% in 13-15 year olds compared to 3% in 5-7 year olds. New disorders were more common in children with a physical illness, with special educational needs, in families who had gone from having two parents to having one over the three years, in families with step children, in households with no working parent, where mothers had high psychological distress, and in families with two or more stressful life events. New conduct disorders were more common in boys (5% as opposed to 2% in girls), older children (11% in 11-12 year olds against 2% in 5-7 year olds), children with special educational needs, families with step children, households with no working parent, where mothers had high psychological distress, in families with two or more stressful life events and frequent use of punishment regimes.

Suicide and Para-suicide in Young People

73. Suicide is a leading cause of death in young people and many young people who die by suicide or who make serious suicide attempts have a recognisable psychiatric disorder such as depression, anxiety, conduct disorders or substance misuse, at the time of their attempt.

74. The act of suicide itself is however not classified as a mental disorder. In the UK, among 15-19 year-olds, males had higher suicide rates than females (Table 4).

[1] Meltzer's ONS survey was a cohort study following up the same interviewees after three years post their first interview.

Table 4 - Number of deaths classified as suicide or injury of undetermined event in children and young people in the UK

	0-14		15-24			
	Males	Females	Males	Age specific rate per 100,000 population	Females	Age specific rate per 100,000 population
1999	18	7	573	16	144	4
2000	19	9	588	16	155	4
2001	14	13	537	15	128	4
2002	15	14	491	13	135	4
2003	20	13	475	12	144	4
2004	14	8	463	12	134	4
2005	21	13	439	11	138	4
2006	13	10	430	10	112	3
2007	18	10	445	11	102	3
2008	16	13	473	11	119	3

Source: ONS 2010

75. Para-suicide is another important issue for young people although data on this issue is not readily available for this report. Para-suicide is deliberate self harming behaviour and is estimated to be as prevalent as between one in 12 and one in 15 (www.selfharm.org.uk) in young people aged 15-24. It is estimated that most self harming behaviour is not acute enough to be determined through hospital records although there are strong links between people who seriously and deliberately self harm and those who go on to commit suicide.

76. The ONS report into children's mental health (Meltzer 2004) reported that 21% of young people (aged 11-16) with a conduct disorder are likely to have attempted to self harm. This amounts to approximately 1,260 young people in Kent. However, deaths from suicide by young people are relatively rare compared to the over 19 year old age group in Kent and Medway. Self-harm (para-suicide) is highest among the 16-25 age group.

Risks, Resilience and Vulnerable Groups

- There are around 2,737 children in local authority care in Kent (almost half are from outside Kent).
- The majority of these children are aged 15-18 (above the national average).
- 60% of all children in care were boys although the proportion of girls is rising slightly. If applied to Kent's looked after children, this amounts to 1,192 children (based on 2010 data) with some diagnosable mental health problem.
- Thanet, Shepway and Dartford (includes figures for Sevenoaks) have the highest numbers of children in care. Dartford has the highest proportion of young people from 'out of area' placements.
- In 2007 there were 250 children in residential care in Kent (ChiMat 2011). The percentage of children having a mental disorder in residential care is 72% indicating that 180 of these young people needed psychiatric support.
- In Kent there are an estimated 41,000 lone parents with dependant children, around 8% of

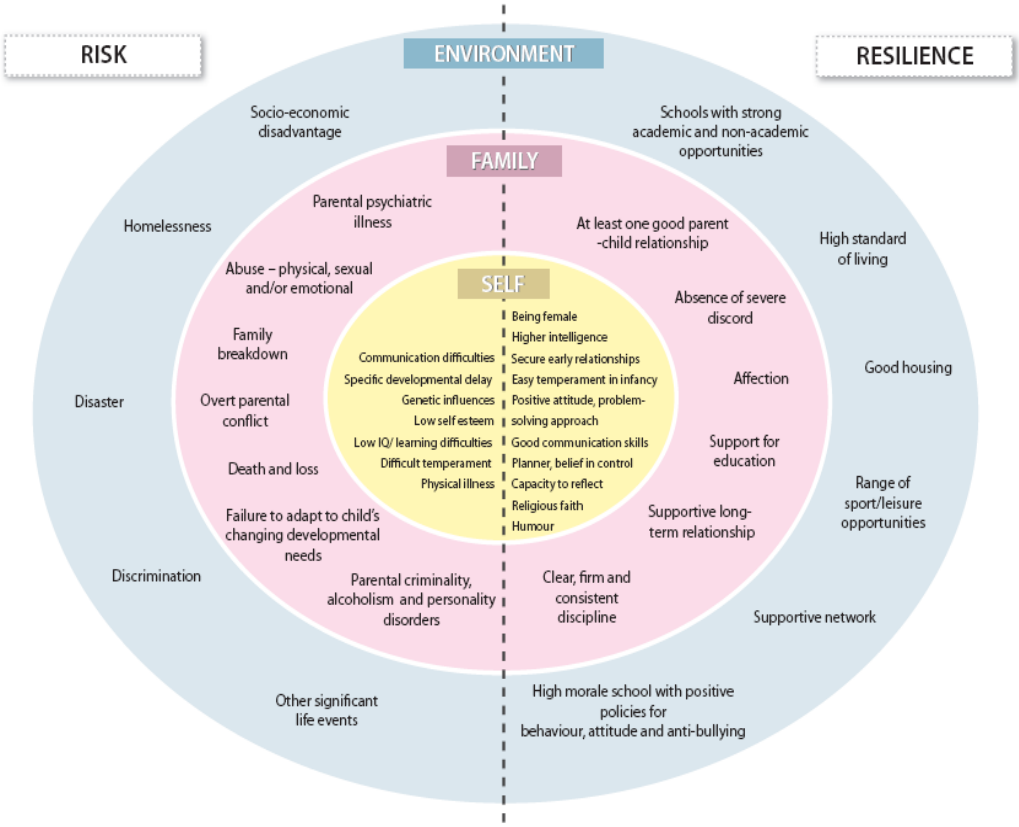
all families in Kent.

- Swale and Thanet have over 20% of children living in households claiming welfare benefits, but even in Tunbridge Wells, 10% of children are living in poverty.
- 8% of children in Kent live in overcrowded homes, over 10% in Sevenoaks, Dartford, Swale, Thanet and Gravesham.
- 1,390 children in Kent are on a child protection plan (KCC activity data 2010).
- 225 new children were classified as unattended asylum seekers in 2010 and there are an estimated 850 in Kent (Ofsted 2010).
- Children with a special education needs (SEN) statement in Kent are six times at risk of mental health problems then other children.
- 2,425 children in Kent with a SEN statement will require some mental health service.
- The proportion of BME children in Kent is small, however being black gives young people (particularly boys) six times higher risk of psychosis.
- 70% of offenders have been in local authority care and young offenders have three times the risk, compared to non offenders, of having psychosis. Almost 2,000 young offenders will have a conduct disorder and 149 will have psychosis in Kent.
- 200 children in Kent aged from 8-12 are providing over 50 hours of care a week to either parents or siblings.
- 3,024 children live with a parent with a mental health problem and of these 1,192 need CAMHS.
- Being a male in a lone parent family, living in social housing where a parent is on welfare benefits and there are more then three children living in the property increases the risk of an emotional or behaviour problem threefold. If his parent has a mental health or alcohol problem the risks are even higher. If taken into care, his life chances diminish and he will have a 50-60% chance of developing a mental health problem in adulthood.

77. The diagram (Figure 7) below describes the factors in the environment, family and individual that create risks and resilience to mental health distress in young people.

- Risk: any factor or combination of factors that increases the chance of an undesirable outcome affecting a person;
- Vulnerability: a feature that renders a person more susceptible to a threat;
- Protective factors: the circumstances that moderate the effects of risk;
- Resilience: positive adaptation in the face of severe adversities.

Figure 7 - Factors in the environment, family and individual that crate risks and resilience to mental health distress in young people



Source: NCH Resilience Study 2007 (thebridge@nch.org.uk)

78. There are five independent factors significantly associated with the persistence of mental disorder in childhood:

- Being male;
- Being in an older age group;
- Having one parent rather than two parents;
- Having unemployed parents;
- Being part of a larger family than a smaller family.

Table 5 - Factors Affecting Risks and Resilience in Young People's Mental Health

Risks: There are some factors which are well established as increasing children's vulnerability to mental health problems, such as:	Resilience: There are also factors which protect against the development of a mental health problem. These include:
• a learning disability of any kind; • enduring physical ill health such as epilepsy; • physical or sexual abuse; • witnessing domestic violence; • a child whose parent has a serious mental health difficulty.	• attributes, such as an adaptable nature or good self esteem; • a range of relationship factors, including peer and family relationships; • the consistent availability of a person whom they can trust.

Key issues in adolescent health: The general part

Teenage Pregnancy

79. The national teenage pregnancy programme was set up to reduce the rates in the UK which are amongst the highest in Europe and the programme finished in 2011. Ministers of the Coalition Government continue to stress the importance of managing down teenage pregnancy incidence through local prioritised initiatives. The programme will continue in Kent.

80. Evaluation of the national programme has shown overall success in managing down the rate, notwithstanding that this is substantially higher than the projected national target. Successful local programmes are characterised by:

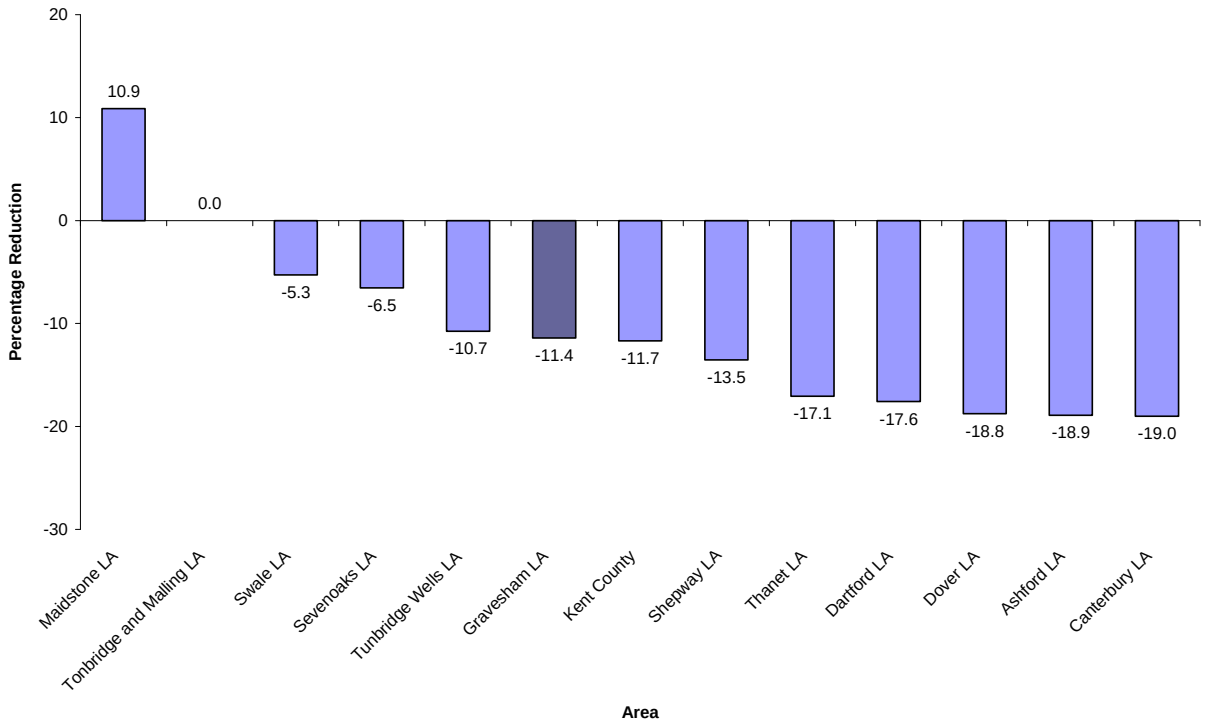
- Active engagement of the key mainstream delivery partners who have a role in reducing teenage pregnancy; health, education, children's services, youth services, voluntary sector;
- A strong local champion;
- Availability of well publicised young people centred contraceptive and sexual health advice services and strong remit to undertake health promotion work as well as delivering reactive services;
- A high priority given to Personal, Social and Health Education (PSHE) in all schools with support from the local authority to develop a comprehensive programme of Sex and Relationship Education (SRE) in all schools;
- A strong focus on targeted intervention with young people at greatest risk of teenage pregnancy, especially looked after children;
- The availability (and consistent take-up) of SRE training for professionals in partner organisations such as Connexions Personal Advisors, youth workers and social workers working with the most vulnerable young people;
- A well resourced youth service providing things to do and places to go for young people with a clear focus on addressing social issues affecting young people such as sexual health and substance misuse.

81. The local Kent programme has been subject to a recent KCC scrutiny committee (2007) which has made 18 specific recommendations as to how the Kent programme can be strengthened; highlighting in particular the responsibility that schools have in this issue. Teenage pregnancy is not simply a public health issue. There are risk factors associated with pregnancy at an early age but these factors have more to do with socio-economic position than age.

82. A study commissioned by the Kent Teenage Pregnancy Partnership undertaken by the University of Kent, has now been published; the final outcome of an intensive survey of Kent children and of greater survey power than any nation-wide study. The survey should provide further insight into how the Kent programme can be further managed both at county and local level.

83. Over the period of the teenage pregnancy programme, there has been a modest decline in the rate of teenage pregnancy in Kent. Nevertheless a significant number of children are living with a teenage mother.

Figure 8 - Percentage reduction in under 18 conception rates between 1998/2000 and 2007/2009



Source: Kent Teenage Pregnancy Unit

84. Throughout the periods monitored, the rate in Kent has been lower than the England and Wales average. Notable reductions have been achieved in Canterbury, Shepway and Dover, whilst the pattern in the west of the county has reduced at a lesser rate. The Maidstone rate has increased. However the rates in Swale appear to be commencing a downward trend. The rates are calculated on three year rolling averages.

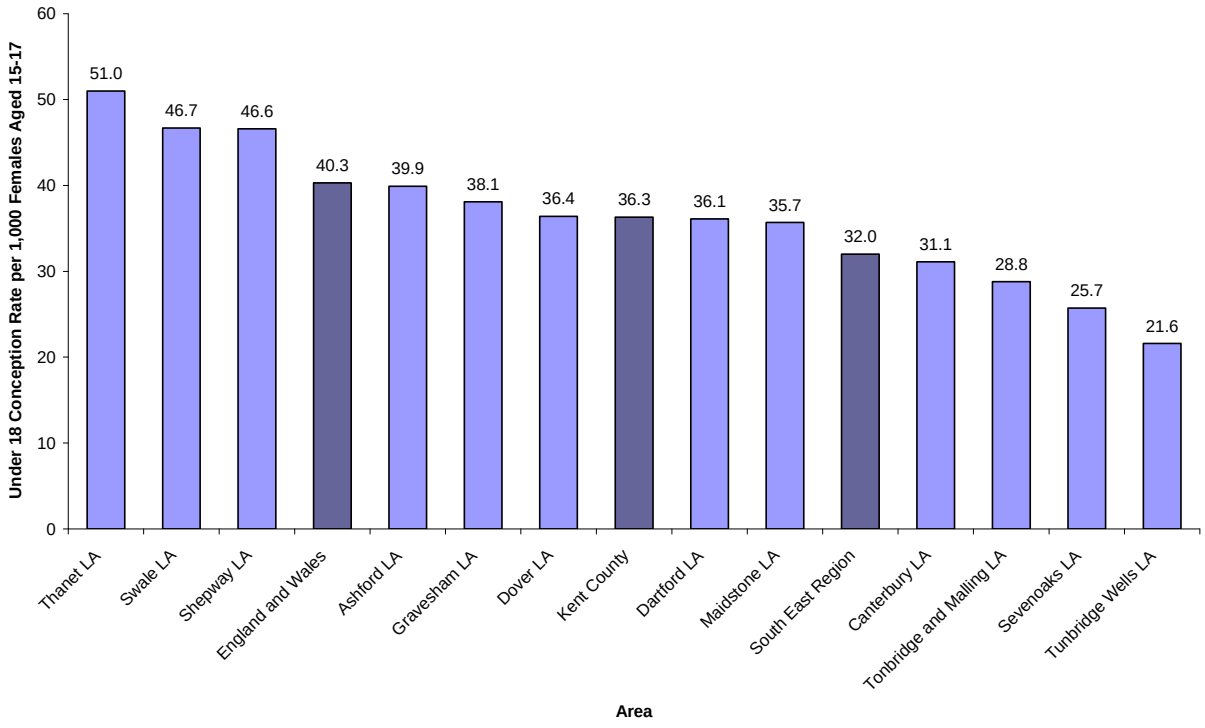
85. The nature of the challenge to reduce teenage pregnancy is characterised by regular fluctuation in rates year on year.

Table 6 - Under 18 conceptions in Kent districts 1998/00 to 2007/09 and 2010 target rates

	Under 18 Conception Rate per 1,000 Females Aged 15-17										
	1998/00	1999/01	2000/02	2001/03	2002/04	2003/05	2004/06	2005/07	2006/08	2007/09	2010 Target Rate
Ashford LA	49.2	48.7	46.3	41.5	40.2	41.8	44.1	43.7	40.9	39.9	25.6
Canterbury LA	38.4	36.5	38.1	33.3	31.9	29.6	28.9	29.3	29.8	31.1	19.8
Dartford LA	43.8	46.1	48.6	47.3	45.0	41.3	40.5	40.7	38.0	36.1	19.6
Dover LA	44.8	41.4	38.9	34.6	39.1	38.1	41.3	37.2	38.1	36.4	23.6
Gravesham LA	43.0	39.8	38.4	34.9	38.4	40.7	38.4	35.8	38.7	38.1	21.6
Maidstone LA	32.2	33.8	35.9	34.9	36.2	36.0	38.2	36.8	37.9	35.7	15.6
Sevenoaks LA	27.5	23.5	22.6	22.4	23.2	23.2	23.2	26.4	26.6	25.7	15.7
Shepway LA	53.9	54.2	52.6	52.8	46.0	45.2	41.7	43.4	44.9	46.6	31.5
Swale LA	49.3	51.2	48.8	45.3	42.2	45.0	47.9	50.2	48.6	46.7	22.5
Thanet LA	61.5	59.7	57.5	50.0	48.0	53.0	55.4	56.1	53.5	51.0	29.6
Tonbridge and Malling LA	28.8	27.0	26.0	26.2	28.3	30.0	29.8	28.4	27.0	28.8	16.6
Tunbridge Wells LA	24.2	23.4	26.6	27.8	27.2	25.3	23.7	23.1	23.2	21.6	14.4
Kent County	**41.1**	**40.2**	**39.8**	**37.3**	**37.0**	**37.7**	**37.6**	**37.4**	**37.1**	**36.3**	**21.0**
South East Region	**36.6**	**35.6**	**35.1**	**34.1**	**33.6**	**33.6**	**33.5**	**33.3**	**33.0**	**32.0**	**18.9**
England and Wales	**45.4**	**43.9**	**43.1**	**42.6**	**42.3**	**41.7**	**41.4**	**41.4**	**41.1**	**40.3**	**23.3**

Source: Teenage Pregnancy Unit

Figure 9 - Under 18 conception rates in Kent districts, 2007-2009



Source: Teenage Pregnancy Unit

86. Overall there are higher rates of termination in west Kent. Easy access to termination services continues to be a challenge, especially for some parts of east

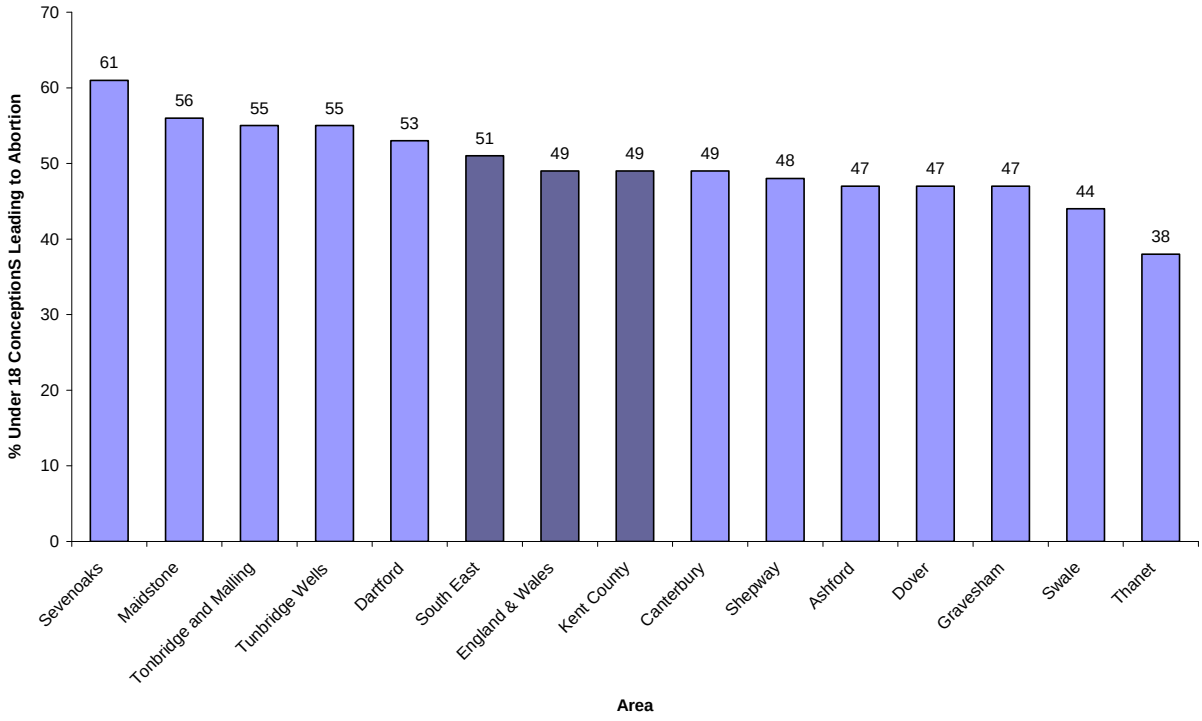
Kent. Teenage pregnancy is strongly associated with disadvantage. A significant proportion of the conceptions are less likely to be resolved in termination; in contrast to counterparts in wealthier areas. Pregnancy can be a calamity for those expected to become better educated, better skilled and to pursue a career. By contrast, motherhood can represent a rational and meaningful life option for young women with poor expectations.

Table 7 - Percentage of under 18 Conceptions Leading to Abortion in Kent Districts, 2001-03 to 2007-09

Area	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09
Ashford LA	40	40	46	47	51	49	47
Canterbury LA	47	45	46	49	51	52	49
Dartford LA	49	47	46	44	47	48	53
Dover LA	44	41	39	36	40	42	47
Gravesham LA	48	47	47	46	45	48	47
Maidstone LA	47	46	50	50	55	56	56
Sevenoaks LA	58	61	60	63	62	64	61
Shepway LA	40	41	43	48	46	47	48
Swale LA	37	36	42	42	43	42	44
Thanet LA	35	35	38	39	40	38	38
Tonbridge and Malling LA	54	53	54	52	57	53	55
Tunbridge Wells LA	56	52	52	49	57	54	55
Kent County	**45**	**44**	**46**	**46**	**48**	**48**	**49**
South East Region	**48**	**48**	**49**	**50**	**51**	**52**	**51**
England and Wales	**46**	**46**	**46**	**48**	**48**	**49**	**49**

Source: Teenage Pregnancy Unit

Figure 10 - Under 18 conceptions leading to abortion in Kent districts, 2007-2009



Source: Teenage Pregnancy Unit

Conceptions in Under 16 Year Olds

87. Whilst the main focus of the reduction strategy is primarily upon the 15-17 year old group, it is important to highlight early conception rates since in the 13-15 year range the issue should be regarded as much as a child health issue as a matter of 'teenage pregnancy'. Incidence is often related to complex social circumstances.

88. A recent study on pregnancies amongst 16 year old young women and younger (Allen et al 2007) suggests, notwithstanding the small numbers in the study, that relationships with parents, with the school as well as expectations for the future may have important influences on teenage pregnancies amongst this younger age group. Hosie's (2007) qualitative study further demonstrates linkages between a dislike of school, pregnancy and disengagement with education.

89. Relative to England and Wales, the Kent rate has been consistently lower and there is a welcome downward trend which is greater than the somewhat marginal decline from an England and Wales perspective. There is a marginal reduction within the area served by NHS West Kent. Overall, the pattern in NHS Eastern and Coastal Kent is static (increases counter balanced by decreases between districts). The rates are unacceptably high, notwithstanding that the incidence is low relative to the totality of young people.

Table 8 - Under 16 conception rates 2004-06 to 2006-08

	Under 16 Conception Rate per 1,000 Females Aged 13-15		
	2004-06	**2005-07**	**2006-08**
Area	Rate	Rate	Rate
Ashford CD	7.4	7.5	7.3
Canterbury CD	5.4	5.6	5.6
Dartford CD	6.2	7.2	5.9
Dover CD	6.4	6.7	7.4
Gravesham CD	7.0	6.8	6.6
Maidstone CD	6.6	5.7	6.5
Sevenoaks CD	4.9	5.8	5.0
Shepway CD	8.8	8.1	7.2
Swale CD	8.9	9.8	9.1
Thanet CD	8.6	9.9	9.6
Tonbridge and Malling CD	5.4	5.2	3.9
Tunbridge Wells CD	4.6	4.6	4.8
Kent County	**6.7**	**6.9**	**6.6**
SOUTH EAST	**6.1**	**6.3**	**6.3**
England	**7.7**	**7.9**	**7.9**
England and Wales	**7.7**	**8.0**	**8.0**

Source: Teenage Pregnancy Unit

Terminations

90. The table below analyses the trends relating to termination amongst conceptions in under 16 year olds. The rate within Kent County is less than the England and Wales rate. The figures as regards both PCTs appear to be consistent throughout the period 2001-2004.

91. Higher rates of termination are noted in Dartford, Maidstone and Sevenoaks. There is a much lower percentage in Ashford, Canterbury, Dover and Thanet which may reflect poorer geographical access to termination facilities. In Canterbury there has been a notable fall in terminations between 2005/07 and 2006/08 – but a constant rate of under 16 conceptions over the last six years. This is a sign of some success with the local programme.

Table 9 - Under 16 Conceptions Leading to Termination, 2004-06 to 2006-08

LA Area	2004-06	2005-07	2006-08
	% leading to abortion	% leading to abortion	% leading to abortion
Ashford CD	57.1%	58.0%	51.0
Canterbury CD	50.0%	52.3%	47.7
Dartford CD	66.7%	76.3%	71.0
Dover CD	40.0%	40.4%	50.0
Gravesham CD	54.8%	58.5%	60.0
Maidstone CD	54.9%	63.6%	68.0
Sevenoaks CD	63.6%	69.2%	73.5
Shepway CD	56.0%	55.6%	59.0
Swale CD	62.9%	64.9%	61.1
Thanet CD	53.7%	62.3%	56.0
Tonbridge and Malling CD	70.3%	72.2%	63.0
Tunbridge Wells CD	55.6%	61.1%	64.9
Kent County	**56.7%**	**61.0%**	**59.5**
SOUTH EAST	**61.3%**	**62.1%**	**63.2**
England	**58.4%**	**59.9%**	**61.4**
England and Wales	**58.0%**	**59.5%**	**60.9**

Source: Teenage Pregnancy Unit

Sexual Health

Sources of sexual health information among young people

92. A University of Edinburgh Study (2010) on the sources of sexual health information among young people demonstrates that almost half of boys and a third of girls reporting school as the main source of information on sexual matters. This has changed since the 1998 and 2002 surveys, where friends were previously reported as the primary source of information on sexual matters.

93. Boys who report school as their main source of information are less likely to have had sex than those who report friends or parents. Girls who report school or

parents as their main source of information are less likely to have had sex than those who report friends.

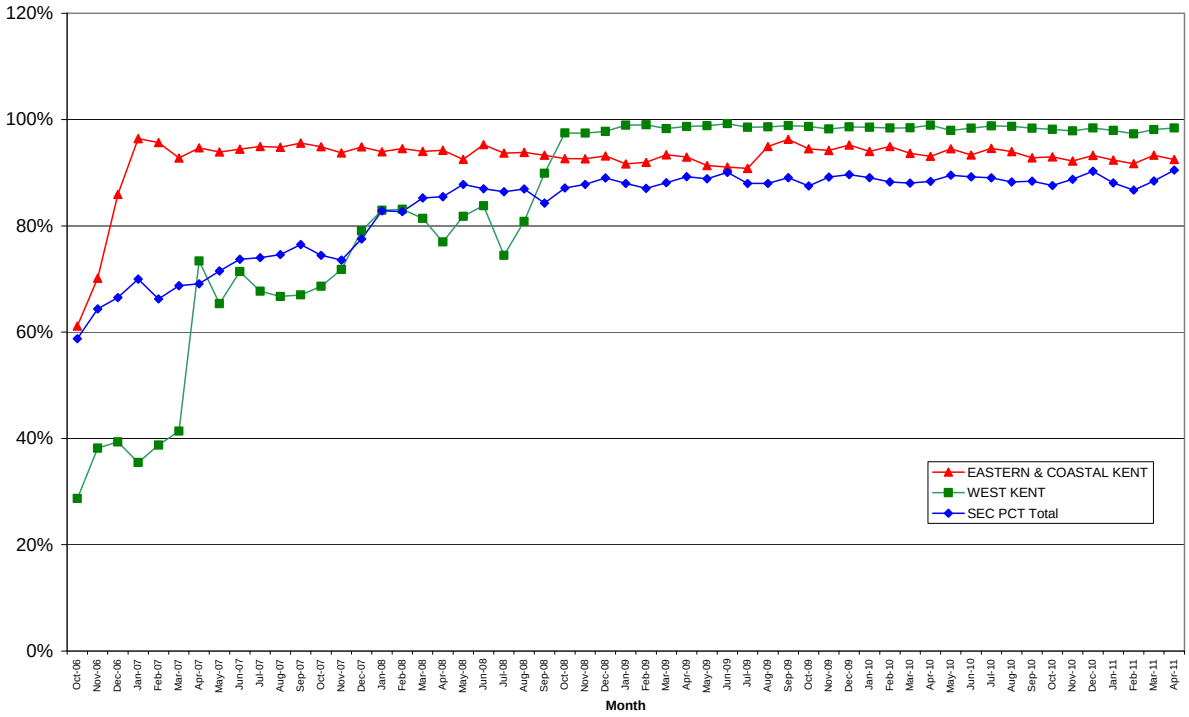
94. Pupils report friends as being the easiest people to discuss personal and sexual matters with, the proportion of girls doing so being significantly higher than boys.

95. Regardless of where young people get their primary information about sexual matters, the majority report friends as being the easiest person to talk to about personal and sexual matters, with few reporting teachers as being the easiest to talk to. Pupils who report parents as their main source of information are more likely to find it easy to discuss sexual matters with their parents than those who get their information from friends or school.

96. Young people generally have a higher number of sexual partners, a greater number of concurrent partnerships and change partners more often than older age groups (HPA et al, 2003). As a result they are more vulnerable to acquiring a sexually transmitted infection (STI). Sexual health has deteriorated in recent years – surveillance data indicated a rise in the prevalence of acute STIs since 1999, with a particularly steep increase being noted for those aged 24 years and under. Between 1997 and 2002, diagnoses of chlamydia, gonorrhoea and new HIV infections have doubled and new diagnoses of syphilis have increased ninefold (data derived from the Health Protection Agency).

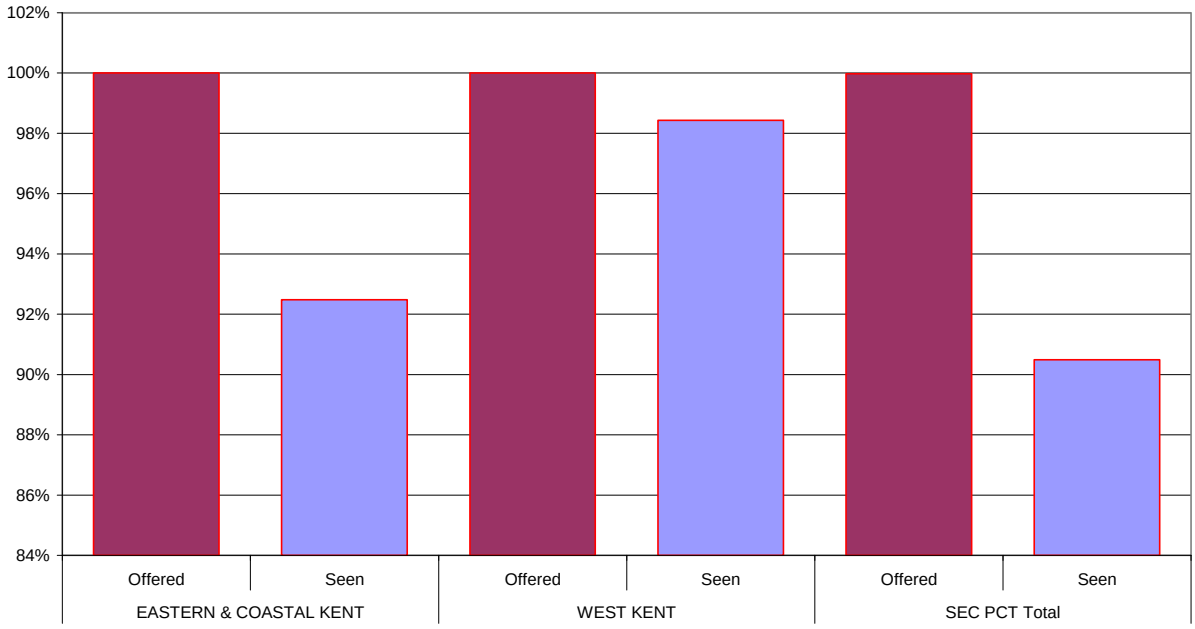
97. Comprehensive monitoring of the 'Offered' target has not been possible until very recently due to the gradual upgrading of antiquated patient administration systems. As a proxy measure, the Health Protection Agency introduced a patient survey to report the percentage of patients seen within 48 hours.

Figure 11 - Percentage of first attendances seen within 48 hours of contacting a service



Source: Monthly GUM Access Monthly Monitoring (GUMAMM) Returns of UNIFY2

Figure 12 - GUM clinic access - percentage of patients SEEN versus those OFFERED appointments to be seen within 48 hours of contacting a service April 2011



Source: Monthly GUM Access Monthly Monitoring (GUMAMM) Returns of UNIFY2

98. Table 9 summarises the percentage of the population aged 15-24 screened for chlamydia. Whilst screening rates are below the England average (but not the SHA), coverage across all parts of Kent demonstrates a welcome increase. Crucially the rate of positive result shows a reduction from last year in all parts of Kent.

Table 10 - Percentage of population aged 15-24 screened for Chlamydia. Data for the period 1st April 2010 - 31st March 2011

PCT name	PERSONS								
	Number of tests			percentage of population tested			Percent positive		
	Age group (years)			Age group (years)			Age group (years)		
	15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
Medway	4,824	3,571	8,395	26.9	20.1	23.5	5.2	5.5	5.3
West Kent	12,309	6,695	19,004	28.2	19.7	24.5	3.1	4.8	3.7
Eastern and Coastal Kent	11,540	9,098	20,638	22.7	18.5	20.6	5.1	6.1	5.6
ENGLAND	**920,105**	**813,166**	**1,733,271**	**28.2**	**22.6**	**25.2**	**5.0**	**5.5**	**5.2**

PCT name	MALE								
	Number of tests			percentage of population tested			Percent positive		
	Age group (years)			Age group (years)			Age group (years)		
	15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
Medway	1,618	1,091	2,709	17.4	11.9	14.7	4.3	7.3	5.5
West Kent	4,284	1,522	5,806	19.2	8.8	14.7	1.6	4.7	2.4
Eastern and Coastal Kent	3,123	2,195	5,318	11.9	8.8	10.4	3.9	8.2	5.7
ENGLAND	**342,005**	**255,460**	**597,465**	**20.3**	**13.8**	**16.9**	**3.4**	**6.2**	**4.6**

PCT name	FEMALE								
	Number of tests			percentage of population tested			Percent positive		
	Age group (years)			Age group (years)			Age group (years)		
	15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
Medway	3,206	2,480	5,686	37.2	29.0	33.1	5.6	4.8	5.3
West Kent	8,025	5,173	13,198	37.8	30.8	34.7	3.9	4.8	4.2
Eastern and Coastal Kent	8,417	6,903	15,320	34.1	28.5	31.3	5.6	5.4	5.5
ENGLAND	**575,008**	**554,027**	**1,129,035**	**36.3**	**31.6**	**33.8**	**5.9**	**5.2**	**5.6**

Footnotes:
1. Data as of 25.05.2011 and may not reflect all screens/tests performed. **Data are based on NCSP and non-GUM, non-NCSP tests within the VSI criteria.**

2. Tests with unknown / unspecified sex have been excluded from the 'Male' and 'Female' columns but included in the 'Total' column.
3. Data presented is number of tests and not number of people tested. Please note that number of tests as collected through the NCSP programme will be used as a proxy for the number of people tested.
4. Data presented is based on tests with confirmed positive and negative results only. Tests with equivocal, inhibitory and insufficient results have been excluded as most people with these results are retested.

5. England total excludes those resident outside of England.

Source: Monthly GUM Access Monthly Monitoring (GUMAMM) Returns of UNIFY2

99. Table 11 summarises the trends in STIs for 16-19 year olds in 2008 and 2009. Overall rates are broadly stable and in some instances demonstrate a small decline in incidence.

Table 11 - Number of new episodes of STIs recorded at GUM clinics in Kent by sex and year for <16 and 16-19 year olds - Kent residents (Sum of NHS West Kent and NHS Eastern and Coastal Kent)

	Gender	Age	2008	2009	2010
Infectious Syphilis *	Male	<16	0	0	0
		16-19	0	0	0
	Female	<16	0	0	0
		16-19	0	SUPPRESSED	0
Gonorrhoea †	Male	<16	0	0	0
		16-19	12	7	SUPPRESSED
	Female	<16	0	SUPPRESSED	0
		16-19	6	13	9
Chlamydia ‡	Male	<16	SUPPRESSED	SUPPRESSED	SUPPRESSED
		16-19	133	98	79
	Female	<16	15	14	8
		16-19	284	236	139
Anogenital Herpes §	Male	<16	0	0	0
		16-19	9	11	10
	Female	<16	5	SUPPRESSED	SUPPRESSED
		16-19	46	42	34
Anogenital Warts **	Male	<16	SUPPRESSED	SUPPRESSED	SUPPRESSED
		16-19	96	101	55
	Female	<16	7	10	10
		16-19	247	230	126

Source: Data from the Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

Table 12 - What works - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Sexual Health

Sexual Health	Source
There is good evidence to support school-based sex education; education linked to contraceptive services alongside the community-based delivery of education, development and contraceptive services; youth development programmes; and family outreach (but this is not supported by RCTs)	Review of reviews
STI campaigns increase condom use and can delay initiation and reduce the frequency of sex, potentially reducing unintended pregnancy as well	Review of reviews
Programmes that offer educational support or improve job prospects may motivate young people to avoid pregnancy	Overview/Cochrane Review
Parenting programmes and ante-natal care programmes may be effective in improving outcomes for both teenage mothers and their infants	Cochrane review
Lack of review-level evidence	
Early fatherhood	
Upstream interventions versus poverty and disadvantage	
Interventions relating to the UK	

Smoking

100. In UK surveys, the following definitions of smoking prevalence in children are used:

- Regular smokers – usually smoke at least one cigarette a week;
- Occasional smokers – usually smoke less than one cigarette a week;
- Current smokers – all regular and occasional smokers.

101. There is some evidence that young people who smoke may under-report their usual smoking behaviour (National Statistics and NHS Information Centre 2006). This survey of 11-15 year olds did not measure initiation ages as such but identified the length of time respondents had been regular cigarette smokers (Figure 13 - Length of time as a regular smoker (aged 11 to 15) in England 1988 to 2006
102. below).

103. 61% had been smoking for more than one year, 16% for 6-12 months, 10% for 3-6 months and 13% for less than three months. The data on smoking prevalence and initiation age show that young people are a major sector of the tobacco market. Most smokers start before they are 18 years old and virtually all do by the age of 25, making this group a key target for tobacco industry marketing as well as tobacco control.

Risk factors associated with youth smoking:

- Parental smoking
- Peer influence from older siblings and friends
- Low socio-economic status
- Female – the creation of an adult social identity; peer valued as ‘cool’, ‘popular’
- Low parental education
- Living in a single parent household
- Poor academic performance
- Participation in risk taking activities
- Exposure to tobacco marketing activities
- Television and films
- Mental illness

Source: National Statistics and NHS Information Centre (2006)

104. Tobacco marketing in all its forms is a central influence on the initiation and continuance of youth smoking. In particular, evocative tobacco brands appeal to young people. The entertainment media are full of images that normalise smoking, making it appear both more common and acceptable than it really is. In this way, it influences how young people perceive and attribute meaning to their own and others smoking. It also reinforces the idea that cigarettes have social and cultural significance (BMA 2008).

Different forms of tobacco marketing

- Sponsorship of sport and the arts
- Point-of-sale: promotional material in shops such as branded gantries, clocks, signage, staff clothing and product display
- Merchandising: giving away or discounting low cost items such as T-shirts, baseball hats and key rings
- Free samples: the distribution of free products
- Loyalty schemes: promotional mail and coupons designed to encourage continued purchase

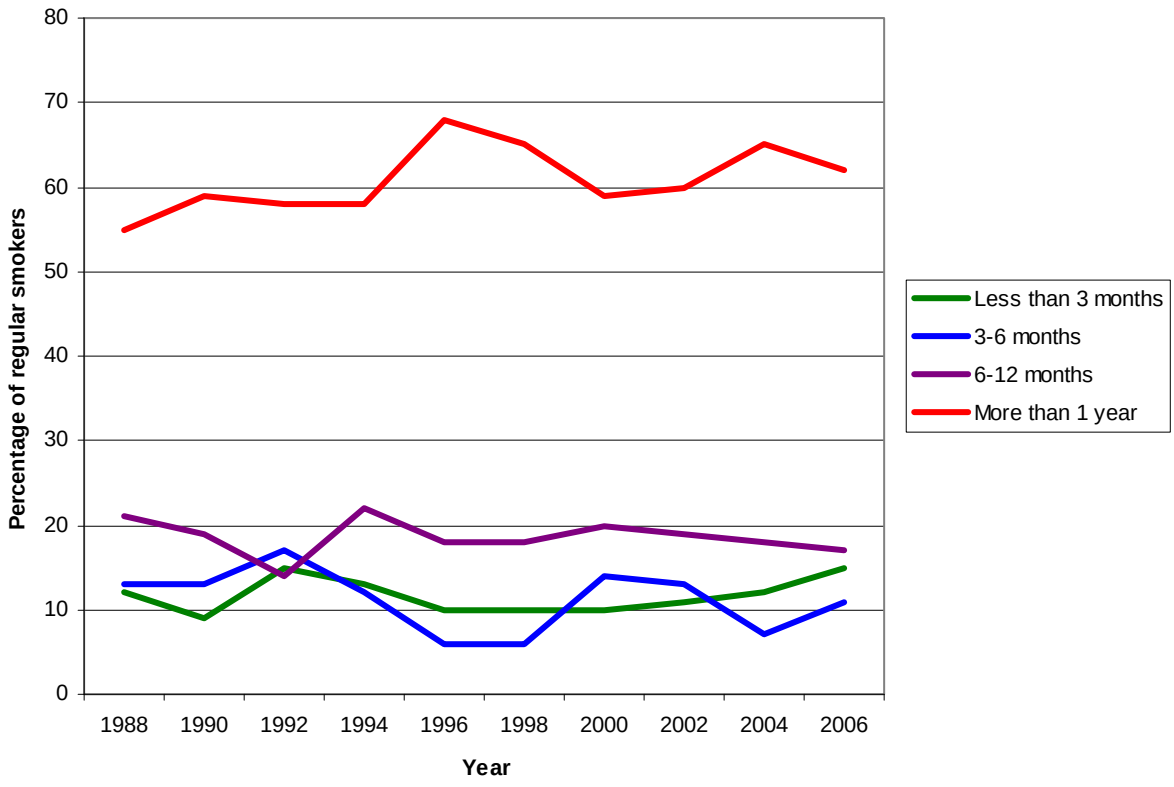
• Brand stretching: non-tobacco products with tobacco branding such as Marlboro Classic Clothes • Pack designed to communicate brand image and to add value • Internet sites: websites promoting tobacco companies, cigarette brands or smoking • Product placement: paid-for placement of cigarette brands in films or television

Source: Based on MacFadyen et al (2001)

105. Parental attitudes to smoking have been established as a major risk factor for smoking initiation, with permissive attitudes towards smoking increasing the risk. In England, 10% of children who smoke regularly report that they have been given cigarettes by their parents. Children of parents who smoke are nearly three times more likely to smoke than those who come from non-smoking homes.

106. Smokers who begin to smoke at a young age are less likely to give up than those who start later in life. One study has shown that those who start before the age of 16 are more than twice as likely to continue smoking than those who begin later in life (Khuder et al 1999).

Figure 13 - Length of time as a regular smoker (aged 11 to 15) in England 1988 to 2006



Source: Information Centre for Health and Social Care 2007

Table 13 - What works - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Tobacco

Tobacco	Source
Smoking	
There is a lack of high-quality evidence about the effectiveness of combinations of social influences and social competence approaches in	Cochrane Review

school	
Enforcement of the law relating to cigarette sales to under-age youth can have an effect on retailer behaviour, but the impact on smoking behaviour is likely to be small	Cochrane Review
There is some support for the effectiveness of community-wide interventions in helping to prevent the uptake of smoking in young people based again on social learning theory/the social influences approach	Cochrane Review
There is some evidence that the mass media can be effective in preventing the uptake of smoking in young people in conjunction with other interventions	Cochrane Review
There is review-level evidence that increasing the price of cigarettes reduces tobacco use among both adolescents and young adults	Review of reviews

107. Nicotine replacement therapy (NRT) is now licensed for use for young people over the age of 12 years. Recent research raises questions as to whether NRT will be effective in this regard (Platt et al 2006, Grimshaw et al 2006). Grimshaw et al (op cit) reviewing adolescent cessation programmes including 15 trials involving more than 3,500 smokers under the age of 20, concluded that more evidence is needed to elucidate effective measures to support young people to stop smoking. Amos et al (2006) found that many young people often express a desire to give up, but that their views are characterised by ambivalence. Many see quitting as a project for the future rather than short term.

Alcohol

108. Whilst the evidence base for policy and practice in relation to substance misuse focuses on the misuse of drugs there is little in the way of an evidence base with respect to alcohol. This is as much a response to social attitudes with a general acceptance of sensible alcohol use as opposed to a concern for abstinence. The acceptance of links to social exclusion also means that alcohol misuse is increasingly seen as an integral part of the larger youth agenda and in conjunction with vulnerable groups such as the homeless, care leavers and youth offenders. There is little in the way of an evidence base in respect to alcohol misuse amongst adolescents as such.

Alcohol Use

109. Nationally, alcohol use overall amongst 11-15 year olds appears to have fallen but use amongst 11-13 year olds is increasing. An overall fall in prevalence has also been accompanied with an increase in consumption. Those who do consume alcohol are doing so more regularly and consuming higher levels of alcohol. These higher levels of alcohol consumption are associated with high risk behaviours including unprotected sex and offending (Home Office 2008).

110. Alcohol use is disproportionately concentrated in areas of high deprivation. In the most deprived areas, alcohol related death rates amongst women are three times higher than those women in the least deprived areas, for men they are five times higher (ibid).

111. The health consequences of increased consumption at an early age are manifest in the increase in liver cirrhosis in the 25-34 year old age group. Early initiation before the age of 14 is strongly associated with dependency in later life.

112. A recent study (Viner and Taylor 2007) of 11,622 subjects from the 1970 British Birth Cohort Study, surveyed at aged 16 years (1986) and aged 30 years (2000) showed that binge drinking was reported in 17.7% of the cohort. It was associated with increased risk of drug/alcohol dependence, excessive regular consumption, illicit drug use, psychiatric morbidity, homelessness, convictions, school exclusions, lack of qualifications and lower adult social class. In short, adolescent binge drinking was a risk behaviour associated with significant later adversity and social exclusion and may contribute to the development of health and social inequalities during the transition from adolescence to adulthood.

Alcohol misuse, sexual risk behaviour and adverse sexual health outcomes

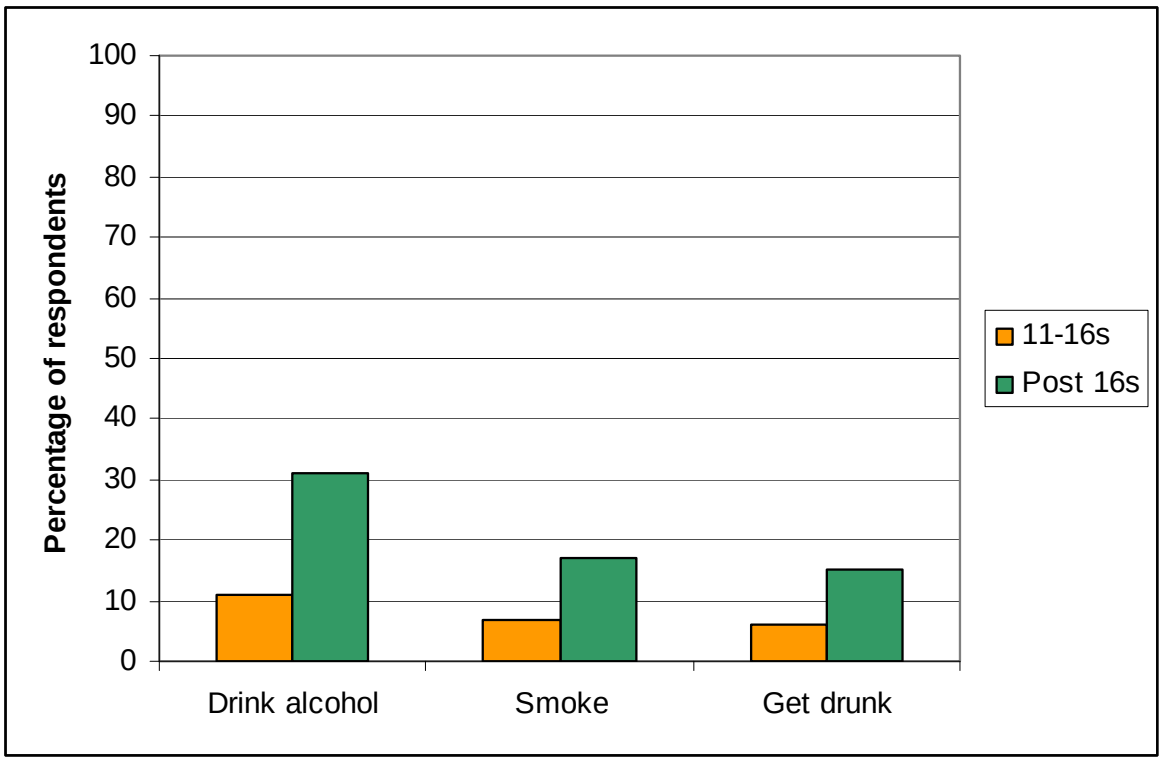
113. Based on probability surveys conducted in 1990/91 and followed up in 2000/01 involving interviews with British residents aged 16-44, the proportion reporting being drunk as their main reason for first heterosexual intercourse increased from 2.5% amongst those born in 1946-49 to 6.4% of those born in 1980-84. These respondents were more likely to report intercourse before 16 and without the use of contraception. Notwithstanding that alcohol purchase at the age of 16 has remained illegal, usual alcohol consumption in excess of recommended limits 'heavy drinkers' was more common amongst those reporting larger partner numbers and unprotected sex with two or more partners, but not with STD clinic attendance/diagnosis. Male heavy drinkers were more likely to report sexual function problems and female heavy drinkers using emergency contraception. Therefore sexual risk behaviours and some adverse sexual health outcomes continue to be associated with excess alcohol consumption (Aiken, Nardone and Mercer 2010).

Attitudes and behaviours related to drinking and smoking from KCC commissioned survey of children and young people in Kent

114. Only 1% of children (7-11 years) thought it was healthy to be around people who smoked and 1% thought it was healthy to smoke.

115. Most young people felt that smoking caused health problems (93% of the 11-16s and 95% of the post 16s agreed or strongly agreed) and that getting drunk could be dangerous (84% of the 11-16s and 85% of the post 16s agreed or strongly agreed). However as Figure 14 illustrates, a small minority of young people, in particular the post 16s, reported that they regularly (most days or once or twice a week) drank alcohol and slightly smaller proportions said that they smoked and got drunk.

Figure 14 - Percentage of young people (11-19 years) who smoke regularly (most days or once or twice a week) smoke, drink and get drunk



Source: NFER Survey 2009

116. These findings suggest levels of underage drinking have reduced over the past year in Kent. The proportion of 11-16 years olds who said that they drank alcohol has decreased by four percentage points and the proportion of post 16s who said that they drank alcohol has also decreased.

117. The Smoking, Drinking and Drugs survey of children and young people in England in 2008[2] indicates that 6% of 11-15 year olds smoked regularly (at least once a week). This is similar to the proportion of 11-16s in the Kent survey who reported that they smoked regularly (7%). Just under a fifth (18%) of young people participating in the Smoking, Drinking and Drugs survey said they had drunk alcohol in the last week, compared to 11% of 11-16s in the Kent survey who indicated that they did drink alcohol most days or once or twice a week. Although the questions are measuring slightly different behaviours, they can be broadly compared and suggest that a slightly lower proportion of young people in Kent get drunk regularly.

What characteristics are young people who have healthy attitudes and behaviours related to drinking and smoking likely to have?

118. Further analysis (multilevel modelling) was undertaken to explore which groups of young people scored higher and lower than average on the measure of healthy attitudes and behaviours related to drinking and smoking when other measurable factors were taken into account[3]. The findings (

[2] For further details on survey please see: http://www.ic.nhs.uk/pubs/sdd08fullreport
[3] It is worth noting that some of the different SEN variables included in this model are closely correlated and this may affect some of the findings relating to SEN status at pupil level and school level

Figure 15) showed that there was a stronger association between a higher score on the healthy attitudes related to drinking and smoking measure and:

- Being of Asian British, Black British, Dual Heritage/Mixed or any other ethnic origin;
- Having a statement of SEN (Special Educational Needs);
- Being gifted and talented;
- Attending a grammar school;
- Attending a school with an above average percentage of pupils with statements of SEN.

119. The findings showed that there was a stronger association between a lower score on the healthy attitudes related to drinking and smoking measure and:

- Being year eight and above;
- Attending a special school/PRU (pupil referral unit);
- Attending a boys' school (compared to attending a mixed school);
- Being recognised for school action or school action plus on the register of SEN;
- Being eligible for free school meals.

120. In this case, attending a grammar school is associated with higher scores on this measure whereas attending boys' schools has lower scores of association. This association of grammar schools mitigates the lower scores association of boys' schools. This suggests boys who are from mixed grammar schools will tend to have higher scores on healthy attitudes related to drinking and smoking compared to those from boys' grammar schools. Those from boys' grammar schools will tend to have similar scores to those from mixed secondary modern schools and those from boys' grammar schools will tend to have higher scores compared to those from boys' secondary modern schools.

Figure 15 - Young people (11-19 years) scoring above and below average on the healthy attitudes relating to drinking and smoking[4]

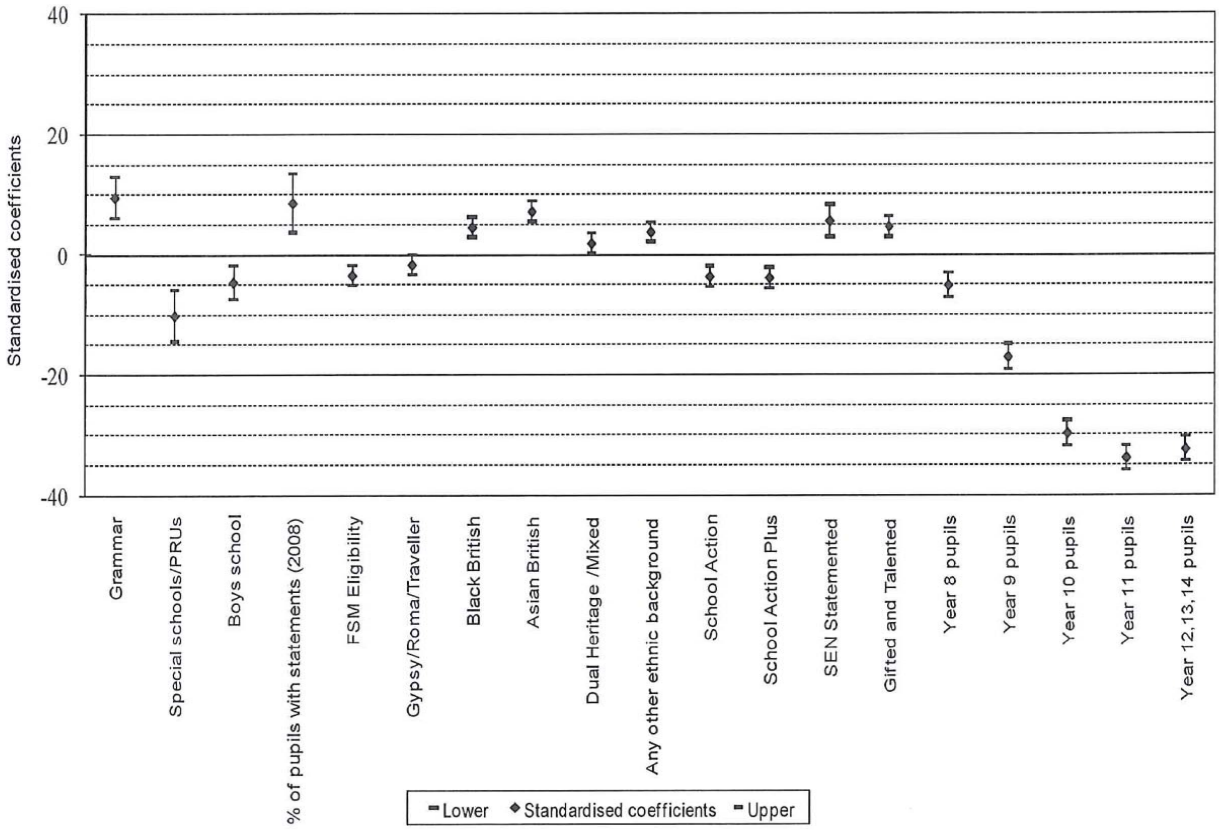


Table 14 - What works - Interventions during childhood and adolescence: summary of the evidence base relating to health behaviours – Alcohol

Alcohol	Source
No firm conclusions about the effectiveness of psychosocial and educational interventions aimed at the primary prevention of alcohol misuse for those aged under 25 in the short and medium term are possible	Cochrane review
There is some evidence for effectiveness of peer-led prevention programmes and interactive programmes that foster the development of interpersonal skills. This also applies to smoking	Review of reviews
Minimum legal drinking age laws prevent alcohol-related crashes, supported by lower blood alcohol concentration laws	Review of reviews
Drugs	
Very little is known about treatment outcomes for young people	Overview
Family therapy appears to be superior to other treatment modalities in reducing substance misuse	Overview

[4] Being of Gypsy/Roma/Traveller origin is included in the analysis as it is important that this variable is controlled for, along with others. However, although being from this ethic group emerged as significant it is not reported in the commentary because the result may be significant due to the small sample size.

Lack of review-level evidence	
Effectiveness of community programmes	
Interventions that focus on youth	
Initiatives to prevent progression to harder drugs and minimise harm from problematic drug use	

Gambling

121. Adolescent gambling is a cause for concern in the UK and is related to other delinquent behaviours. For instance, in one study of over 4,500 adolescents, gambling was highly correlated with other potentially addictive activities such as illicit drug taking and alcohol abuse (Griffiths and Sutherland, 1998). Another study by Yeoman and Griffiths (1996) demonstrated that around 4% of all juvenile crime in one UK city was slot machine-related, based on over 1,850 arrests in a one year period. It has also been noted that adolescents may be more susceptible to problem gambling than adults.

122. A typical finding of many adolescent gambling studies has been that problem gambling appears to be a primarily male phenomenon. It also appears that adults may to some extent be fostering adolescent gambling. For example, a strong correlation has been found between adolescent gambling and parent gambling (Wood and Griffiths, 1998). Other factors that have been linked with adolescent problem gambling include working class youth culture, delinquency, alcohol and substance abuse, poor school performance, theft and truancy (Griffiths 1995; Yeoman and Griffiths 1996; Griffiths and Sutherland 1998).

123. A MORI survey also found that:

- 17% of adolescents are regular fruit machine players (playing at least once a week);
- 3.5% of adolescents are probably pathological gamblers and/or have severe gambling related difficulties.

124. All studies have reported that boys play on fruit machines more than girls and that as fruit machine playing becomes more regular, it is more likely to be a predominantly male activity. Research suggests that irregular ('social') gamblers play for different reasons than the excessive ('pathological') gamblers. Social gamblers usually play for fun and entertainment (as a form of play), because their friends or parents do (ie it is a social activity), for the possibility of winning money, because it provides a challenge, because of ease of availability and there is little else to do and/or for excitement (the 'buzz').

125. Pathological gamblers appear to play for other reasons such as mood modification and as a means of escape. Like other potentially addictive behaviours, fruit machine addiction causes the individual to engage in negative behaviours. This includes truanting in order to play the machines, stealing to fund machine playing, getting into trouble with teachers and/or parents over their machine playing, borrowing or the using of lunch money to play the machines, poor schoolwork and in some cases aggressive behaviour (Griffiths 2003). Fruit machine addicts also display bona fide signs of addiction including withdrawal effects, tolerance, mood modification, conflict and relapse.

126. It is clear that for some adolescents, gambling can cause many negative detrimental effects in their life. Education can be severely affected and they may acquire a criminal record as most problem gamblers have to resort to illegal behaviour to feed their addiction.

127. Whilst amusement arcades can be found in every town, they are a particular feature of coastal towns in Kent and it is likely that here the highest risks and incidence of adolescent gambling will be found. Further work needs to be done to analyse the local problem. Licensing authorities need to be made aware of the risks to children and young people.

Crime

128. Collective responsibility to prevent youth offending, shared between a range of public voluntary agencies and also the wider community, is established national policy. Youth Offending Teams (YOTs) are responsible for preventing offending and re-offending by young people. Community Safety Partnerships (CSPs) are responsible for cutting down overall crime levels, a significant proportion of which involve young people either as victims or offenders.

129. The work of YOTs tends to be dominated by courts and pre-court work, CSPs focus on prevention, situational measures and civil orders such as Anti Social Behaviour Orders (ASBOs). The goal of reducing young people's involvement in crime needs CSPs to influence work with the most prolific offenders and YOTs need to be involved in preventive measures ranging from targeted provision, such as intensive mentoring to impact on universal services – education, housing, employment and health, which make a critical difference to offending patterns in the long term.

130. Health and mental health services have crucial roles to play in meeting the wide needs of young offenders and a need to involve schools directly (Audit Commission 2004). Every Child Matters (DfES 2003) argues for the co-location of front line staff in children's centres, extended schools and health settings to increase the opportunities for the early identification of risk.

Youth Offenders

131. It is well established that young offenders are a vulnerable group, with complex psychosocial, physical and mental health needs. 40% of young offenders have a diagnosable mental health disorder.

132. Many of these young people suffer from conduct disorders, problems with social understanding and disorders on the autistic spectrum.

133. Despite the high incidence of mental health problems in this group, only a small proportion of young offenders with mental health problems are receiving help from specialist child and adolescent mental health services (CAMHS). The National CAMHS Mapping Exercise in 2004 showed of the total caseload of CAMHS, only 5% were young offenders.

Youth Offending

Table 15 - First Time entrants (FTEs) to the Youth Justice System (based on Ministry of Justice published figures):

	2007/08		2008/09		2009/10	
	Number of FTEs	Rate per 100,000 population	Number of FTEs	Rate per 100,000 population	Number of FTEs	Rate per 100,000 population
Kent	2,573	1.2	2,446	1.6	2,075	1.4
National	94,361	1.8	74,588	1.4	57,291	1.2

Source: Ministry of Justice Statistics Bulletin 14 October 2010 – Youth Crime: Young people aged 10-17 receiving their first reprimand, warning or conviction, 2000-01 to 2009-10

134. The trend for the county and nationally in the number of first time entrants to the youth justice system continues to be downwards, both in terms of the actual numbers and in the number per 100,000 of the population. The Kent figure for the number per 100,000 was lower than the national figure in 2007/08 but in the last two financial years it has been significantly higher.

Table 16 - First Time Entrants known to Kent Youth Offending Service/Medway Youth Offending Team (based on individual notifications received from Police)

BCU	District	2009/10	2010/11 Total to date*	2010/11 Rate to date per 100,000 pop*
North Kent	Dartford	130	68	0.72
	Gravesham	159	131	1.25
North Kent BCU		289	199	1.00
West Kent	Sevenoaks	105	66	0.57
	Tonbridge and Malling	142	130	1.00
	Tunbridge Wells	99	89	0.71
West Kent BCU		346	285	0.77
Mid Kent	Maidstone	197	96	0.68
	Swale	248	173	1.23
Mid Kent BCU		445	269	0.95
East Kent	Canterbury	119	122	0.85
	Thanet	214	173	1.24
East Kent BCU		333	295	1.04
South Kent	Ashford	143	101	0.84
	Dover	187	142	1.25
	Shepway	176	142	1.46
South Kent BCU		506	385	1.16
Unknown/No fixed abode		5	6	n/a
Kent total		1,924	1,439	982

135. The table above shows that during 2010/11 there were 1,439 first time entrants (NB this is still a provisional figure) compared with 2,075 during 2009/10; a fall of 30.7%.

136. With the exception of Canterbury (+3) there has been a recorded fall in first time entrants in each of the districts. The most significant decreases were seen in Maidstone (101, -51.3%) and Dartford (62, -47.7%) and Swale (75, -30.2%).

Table 17 - BME proportionality of Kent clients (April 2009-March 2010)

BME Proportionality	White	Mixed	Asian/ Asian British	Black/ Black British	Chinese or Other	All Groups	Not Known
Number of young offenders committing an offence that resulted in a Substantive Outcome between 1.1.2009 and 31.12.2009	3,236	96	52	95	14	3,590	97
% of total	90.14%	2.67%	1.45%	2.65%	0.39%	100.00%	2.70%
Population numbers (mid 2007 ONS population estimates)	137,302	1,954	3,635	2,122	1,502	146,515	
Population representation	93.71%	1.33%	2.48%	1.45%	1.03%	100.00%	
Difference	-3.57%	1.34%	-1.03%	1.20%	-0.64%		

Table 18 - BME Proportionality of Kent clients (April 2010 to March 2011)

BME Proportionality	White	Mixed	Asian/ Asian British	Black/ Black British	Chinese or Other	All Groups	Not Known
Number of young offenders committing an offence that resulted in a Substantive Outcome between 1.1.2010 and 31.12.2010	2,603	81	37	77	24	2,917	95
% of total	89.24%	2.78%	1.27%	2.64%	0.82%	100.00%	3.26%
Population numbers (mid 2007 ONS population estimates)	137,302	1,954	3,635	2,122	1,502	146,515	
Population representation	93.71%	1.33%	2.48%	1.45%	1.03%	100.00%	
Difference	-4.48%	1.44%	-1.21%	1.19%	-0.20%		

137. There continues to be concern at the ongoing disproportionate representation, even if it is small, of Black/Black British and Mixed Race young people within the Kent Youth Justice System.

Table 19 - Offender profile by district and gender

	April 2009 to March 2010			April 2010 to March 2011			
District	Female	Male	All	Female	Male	All	% change
Ashford	71	177	248	44	136	180	-27.40%
Canterbury	55	158	213	52	144	196	-7.98%
Dartford	48	152	200	36	122	158	-21.00%
Dover	96	214	310	73	172	245	-20.97%
Gravesham	68	175	243	46	185	231	-4.94%
Maidstone	101	220	321	46	182	228	-28.97%
Sevenoaks	43	116	159	26	78	104	-34.59%
Shepway	93	193	286	62	180	242	-15.38%
Swale	126	264	390	75	200	275	-39.49%
Thanet	112	299	411	60	275	335	-18.49%
Tonbridge and Malling	65	142	207	53	149	202	-2.42%
Tunbridge Wells	41	106	147	38	111	149	1.36%
No Fixed Abode	0	4	4	1	6	7	n/a
Out of County	123	327	450	95	268	363	-19.33%
Unknown	0	1	1	1	1	2	n/a
Total	1,042	2,548	3,590	708	2,209	2,917	-18.75%

138. The table above identifies a downward trend in the youth offending population across each of the districts with the exception of Tunbridge Wells, which recorded a small numerical and percentage increase of two children/young people (1.4%).

139. The downward shift varies significantly between districts ranging between 34.6% (Sevenoaks) and 2.4% (Tonbridge and Malling).

140. Significant downward shifts were recorded in Swale (29.5%), Maidstone (29.0%), Ashford (27.4%), Dartford (21.0%) and Dover (20.7%).

141. With respect to the number of offenders by district:

- Thanet had the highest (335);
- The districts with the five next highest were Swale (275), Dover (245), Shepway (242), Gravesham (231) and Maidstone (228) – so for the most part similar with a differential of 47 between the highest and lowest within this group.
- The three districts with the lowest numbers are all in the west of the county: Dartford (158), Tunbridge Wells (149) and Sevenoaks (104).

Table 20 - Whether children and young people in Kent feel safe - Survey 2009

	% of those surveyed		
	7-11 year old Yes	**11-16 year old Most of the time**	**Post-16 year old Most of the time**
In school/college	70	72	85
In the area they live	70	70	70
Getting to and from school/college	79	70	79
Survey included 28,417 7-11 year olds, 10,199 11-16 year olds and 1,117 post-16 year olds			

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

142. Table 21 demonstrates a range of issues that cause children and young people concern and potentially give rise to insecurity.

Table 21 - Things making children and young people in Kent feel unsafe where they live - Survey 2009

7-11 year olds	
Worry about the following	**% of those surveyed**
Broken glass on ground	66
People hanging around	69
Busy roads/speeding traffic	60
Being on a bus or train	38

11-19 year olds	% of those surveyed	
Feel unsafe most/some of the time due to the following	**11-16**	**Post-16**
People carrying knives	33	19
People on drugs	24	12
People damaging property or cars*	21	14
Groups of people hanging around	22	15
Dark or unlit places	21	19
People drinking/being drunk	18	9
Busy roads/speeding traffic	11	9
Broken glass or syringes lying around	11	5
Being on a bus or train	7	5
Survey included 10,199 11-16 year olds and 1,117 post-16 year olds		

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

Youth Homelessness

Statutory Homelessness

143. Individual applicants are accepted as statutorily homeless and are thus owed a housing duty, if they are proven to be unintentionally homeless and in priority need due to particular vulnerabilities. Priority categories are households with dependent children or containing a pregnant woman, aged 16 and 17, having been in care and aged 18-20.

144. Table 22 demonstrates that the statutory acceptances of individuals under those priorities is rising when compared with the total of acceptances. However, the total of statutory acceptances across Kent has fallen.

Table 22 - Statutory Homelessness Acceptances 2005-06 to 2009-10

	2005-06		2006-07		2006-07		2007-08		2009-10	
	Priority categories		Priority categories		Priority categories		Priority categories		Priority categories	
Local Authority	Aged 16-17	Aged 18-20 (having been in care)	Aged 16-17	Aged 18-20 (having been in care)	Aged 16-17	Aged 18-20 (having been in care)	Aged 16-17	Aged 18-20 (having been in care)	Aged 16-17	Aged 18-20 (having been in care)
Ashford	12	0	7	0	2	0	5	3	15	6
Canterbury	6	0	0	0	1	0	1	0	1	0
Dartford	14	1	16	0	14	0	17	0	5	0
Dover	15	0	21	0	19	2	18	0	16	1
Gravesham	16	0	23	3	25	1	12	3	23	0
Maidstone	21	3	14	0	6	0	9	2	3	0
Sevenoaks	20	2	5	2	5	2	7	2	3	1
Shepway	16	1	23	2	8	0	21	0	22	0
Swale	4	0	2	0	1	1	7	1	3	0
Thanet	20	2	11	8	14	2	9	2	5	1
Tonbridge and Malling	1	0	2	0	5	1	1	1	2	0
Tunbridge Wells	9	0	10	3	6	1	7	2	3	1
Total number of Kent acceptances	1,829		1,422		1,260		973		795	
Number of priority acceptances aged 16 and 17 (having been in care) as a % of all Kent acceptances	8.9		10.7		9.2		13.3		14.0	

Source: Client Records - Kent Supporting People Team - KCC

145. Not all homeless applicants are accepted as statutory homeless. Large numbers of applications are rejected on the grounds that applicants have made themselves homeless, do not meet priority status or are not homeless under the Homelessness Act.

146. According to anecdotal evidence, applications from some young people are refused because they are deemed to have made themselves homeless by ‘walking out’ of family homes, or because their behaviours caused family breakdown and parents evicted them from family homes. Some of those young people as well as those accepted as statutory homeless can access supported housing.

147. The following table provides a breakdown of homeless applications and illustrates how relatively few applicants are successful:

Table 23 - Homeless Applications made to Local Housing Authorities in Kent April 2009-March 2010

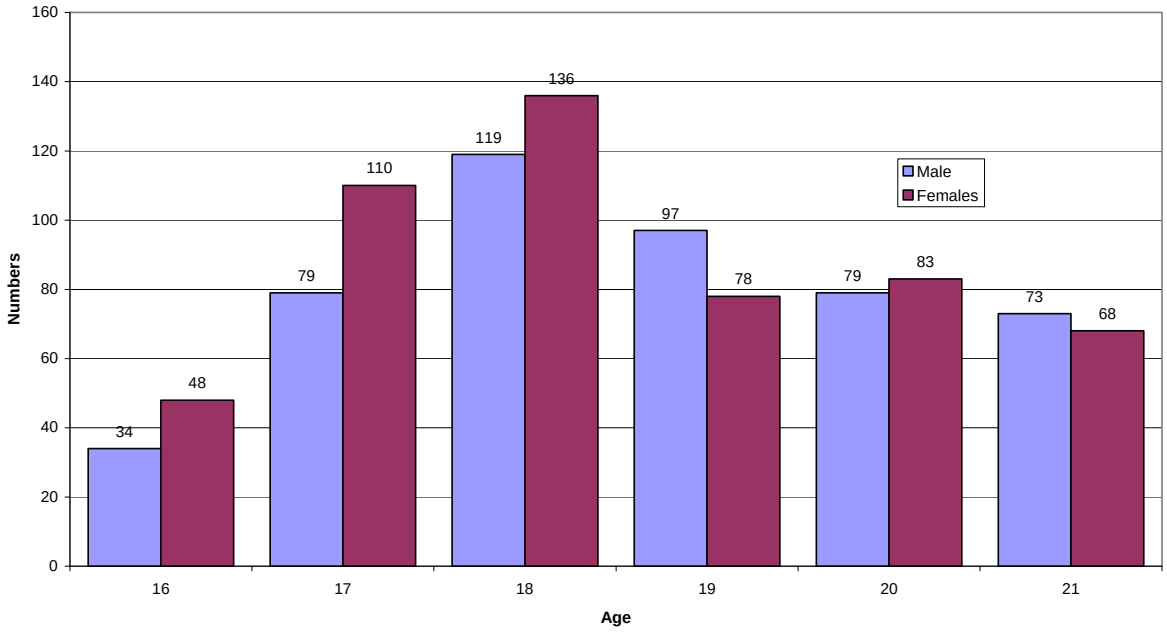
	IMD	Eligible, unintentionally homeless and in priority need	Eligible, homeless and in priority need but intentionally so	Eligible, homeless but not in priority need	Eligible but not homeless	Ineligible households	TOTAL DECISIONS
Ashford	227	178	19	5	45	1	248
Canterbury	198	47	13	155	13	1	229
Dartford	186	100	15	17	16	3	151
Dover	153	62	4	3	52	0	121
Gravesham	142	73	35	8	24	2	142
Maidstone	248	7	5	7	38	0	57
Sevenoaks	295	50	4	4	15	0	73
Shepway	123	80	30	19	29	0	158
Swale	116	59	3	1	30	0	93
Thanet	65	63	8	5	56	0	132
Tonbridge and Malling	281	32	15	22	27	2	98
Tunbridge Wells	273	44	3	13	24	2	86
Total		795	154	259	369	11	1,588

Source:Client Records - Kent Supporting People Team - KCC

New Clients in Supporting People funded services, 2006-07.

148. The following figure shows the distribution of male and female new clients by age:

Figure 16 – New clients aged 16-21 accessing services April 2010-March 2011 by gender – All client groups



Source: KCC Supporting People Programme

Table 24 - Client Group Classification of New Clients aged 16-21 April 2010-March 2011

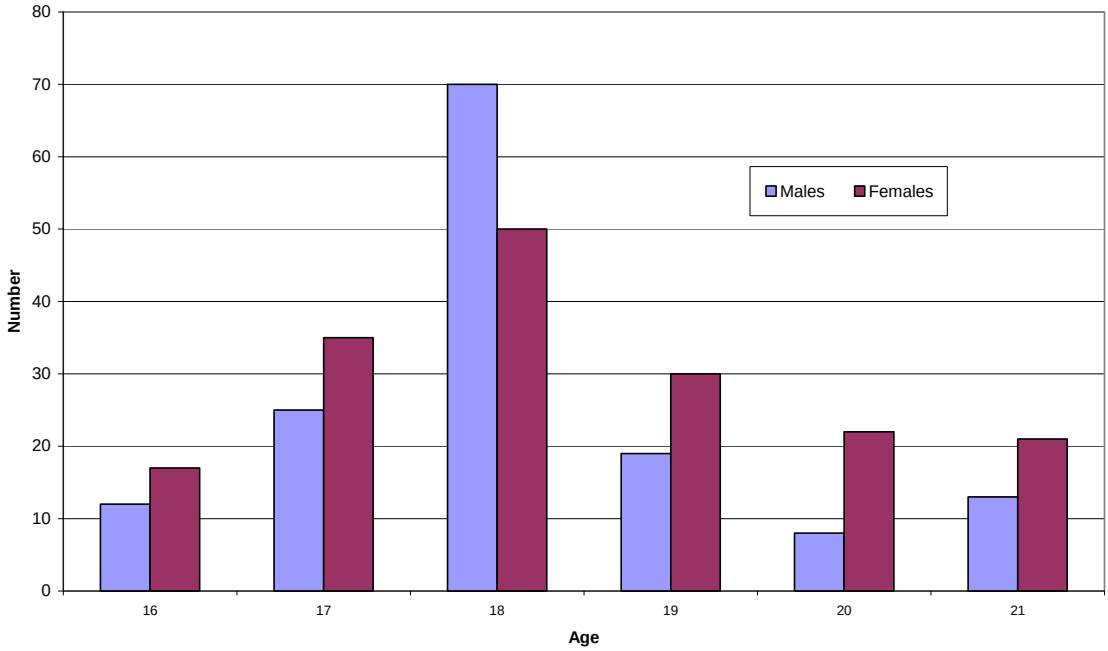
Primary Client Group	Aged 16	Aged 17	Aged 18	Aged 19	Aged 20	Aged 21	Total
Homeless families with support needs		2	3	1	5	1	12
Offenders	3	2	4	2	4	5	20
People fleeing domestic abuse	3	1	9	7	11	16	47
Single homeless	25	89	89	62	46	48	359
Rough sleepers	3	4	14	10	17	8	56
Teenage parents	10	22	27	18	18		95
Young people at risk	36	62	49	39	30	31	247
Young people leaving care	2	2	42	7	6		59
People with mental health problems		2	5	6	9	11	33
People with learning disabilities			3	10	2	2	17
People with drug problems		2	1		1	3	7
People with alcohol problems				1		1	2
Gneric/complex needs		1	5	10	12	14	42
People with physical/sensory disabilities			3	2	1		6
People with HIV/Aids			1				1
Refugee						1	1
Total	**82**	**189**	**255**	**175**	**162**	**141**	**1,004**

Source: Kent Supporting People Team

149. As Table 24 shows the vast majority of new clients aged 16-21 were classified as client groups other than 'Young People at Risk' and many accessed supported housing not specific to young people such as homeless hostels.

150. Looking specifically at the two client groups of 'Young People at Risk' and 'Young People Leaving Care', the majority of cases demonstrate a higher female to male ratio with the exception of age 18.

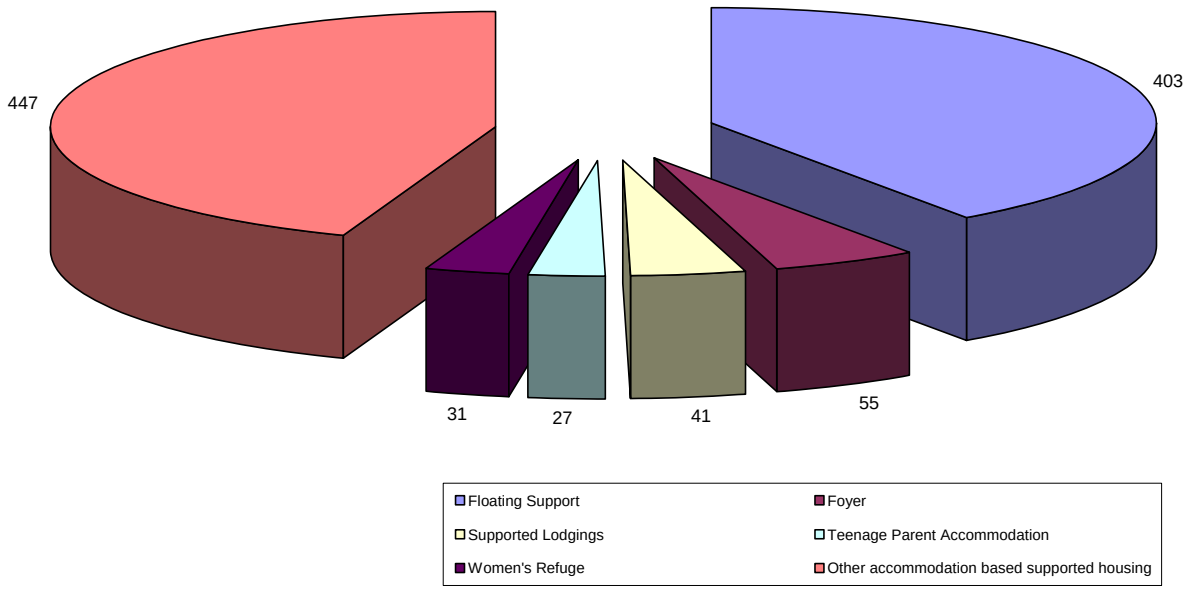
Figure 17 - New service users by age and gender - April 2009 to March 2010 - Client groups young people at risk and young people leaving care



Source: Client Records - Kent Supporting People Team - KCC

151. Figure 17 shows the distribution of the client groups 'Young People at Risk' and 'Young People Leaving Care' by the type of supported housing they entered. It should be noted that these 321 people represent a small proportion of the total single homeless identified in Kent and to focus on these specific interventions alone under represents demand and need for single housing within that age group.

Table 25 - New Clients aged 16-21 accessing services, Apri1 2010-March 2011 by type of supported accommodation



Source: Kent Supporting People Team – KCC

152. Children's Social Services have a duty under Section 20 (3) of the Children Act 1989 to accommodate any child in need aged 16 and 17, whose welfare is likely to be seriously prejudiced without the provision of accommodation. The circumstances in which a child is owed a Section 20 duty requires an assessment to be carried out by Children's Social Services, prior to whether housing services can determine if any child has a priority need. This clarification of the law has been determined by a House of Lords judgement in 2009 (R v London Borough of Southwark).

153. In consequence, in August 2010 through the work of the Kent Joint Planning and Policy Board for Health and Housing, an agreed protocol to address the needs of homeless young people aged 16-21 in the County has been agreed. The protocol seeks to clarify the statutory duties and responsibilities of partner agencies and to establish a system to ensure a seamless service to vulnerable young people irrespective of which agency they present to first or which district in Kent they live in. Finally the protocol seeks to ensure that through methods such as mediation, reconciliation between young people and their families/carers is achieved wherever possible.

Evidence of Wellbeing - Making a Positive Contribution Amongst Children and Young People

Table 26 - Whether children (aged 7-11) engage with the community - Survey 2009

Whether children	Yes %	Not sure %	No %	No response %
Would tell an adult if they saw someone being bullied	83	12	4	1
Help other people	82	14	2	2
Help collect money for charity	48	29	21	2
Survey included 10,199 11-16 year olds and 1,117 post-16 year olds				

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

154. The majority of children (about four fifths) indicated that they would tell an adult if they saw someone being bullied and a similar proportion indicated that they helped other people. A lower proportion (just over two fifths) indicated that they help collect money for charity, although a further 29% were unsure if they did.

155. Younger children were more likely to say that they would tell an adult if they saw someone being bullied than older children (88% of year three compared to 76% of year six). Younger children were more likely to report that they help collect money for charity compared to older children (53% of year three compared to 39% of year six).

Table 27 - Whether children and young people (aged 11-19) engage with the community - Survey 2009

	I do already%		I would like to do%		No I wouldn't do this%		No response%	
Do/would children and young people:	**11-16**	**Post 16**	**11-16**	**Post 16**	**11-16**	**Post 16**	**11-16**	**Post 16**
Help someone who is being bullied	31	27	52	58	11	10	6	5
Raise money for charity	25	26	49	51	20	18	6	5
Help a neighbour	34	30	42	49	18	16	6	5
Do voluntary work	15	22	42	41	36	32	7	5
Vote in a school/college election	20	18	32	32	41	45	6	5
Join in a school/collect council	13	15	23	18	57	62	6	5
Survey included 10,199 11-16 year olds and 1,117 post-16 year olds								

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

156. About a quarter of young people in both age groups (11-16 and post-16) reported that they already helped their neighbours (34% and 30% respectively), raised money for charity (25% and 26% respectively) and helped people who were being bullied (31% and 27% respectively). More than half said they would like to help someone who was being bullied (52% and 58% respectively), raise money for charity (49% and 51% respectively) and help a neighbour (42% and 49% respectively).

157. About 40% of young people would like to do voluntary work, about 30% would like to vote in a school or college election and about 20% would like to join a school or college council. The proportions of young people already participating in these activities were between 15% and 22%.

Table 28 - Whether children (aged 7-11) support the environment - Survey 2009

Do children	Yes %	Not sure %	No %	No response %
Always put litter in the bin	80	13	6	1
Recycle	77	14	8	1
Survey included 10,199 11-16 year olds and 1,117 post-16 year olds				

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

158. Over three quarters of children indicated that they always put litter in the bin and over two thirds said that they recycled. 6% of children admitted to not putting litter in the bin and 8% said they did not recycle.

Table 29 - Whether children (aged 11-19) support the environment - Survey 2009

	They do already %		They would like to do %		No %		No response %	
Do children	**11-16**	**Post 16**	**11-16**	**Post 16**	**11-16**	**Post 16**	**11-16**	**Post 16**
Recycling	67	75	14	13	13	8	6	5
Survey included 10,199 11-16 year olds and 1,117 post-16 year olds								

Source: KCC Children and young people survey 2009 - National Federation for Educational Research (NFER) 11-19 year old survey 2009

159. About three fifths of young people (67% of 11-16s and 75% of post-16s) indicated that they already recycled. Less than a quarter (14% of 11-16s and 13% of post-16s) reported that they would like to recycle.

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