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A Health Needs Assessment for children and young people in Liverpool (0-19 years)

Stage 4: Young people aged 16-19 years

Public Health Institute, Liverpool John Moores University

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A Health Needs Assessment for children and young people in Liverpool - Stage 4: Young people aged 16-19 years

Public Health Institute, Liverpool John Moores University

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1.Introduction

The public health white paper 'Healthy Lives, Healthy People' (DH, 2010) emphasises the importance of giving all children a healthy start to life; in particular it highlights improving maternal health and children's health and development in order to improve a range of health and wellbeing related outcomes such as educational attainment, risk of mental illness, unhealthy lifestyles, road traffic deaths, hospital admissions and tooth decay (DH, 2010). Children and young people under the age of 20 make up 22.2% of the population of Liverpool and the health and wellbeing of children in the city is generally worse than the national average including higher levels of child poverty and obesity (PHE, 2015).

Liverpool city council commissioned a health needs assessment (HNA) to inform the redesign of their public health provision for children and young people aged 0 to 19 years (currently covered by the Health Visiting, School Nursing and Family Partnership services). Liverpool City council identified four stages of childhood/adolescence as the focus of the needs assessment:

- Stage 1: Conception to the first 1,000 days
- Stage 2: Readiness for early learning and school
- Stage 3: Pre-adolescence
- Stage 4: Young people aged 16-19 years

Aims & Objectives

The HNA aims to inform the development of a 0-19 years public health programme for Liverpool by comprehensively assessing the health needs of children in Liverpool focusing on four key life stages. The main objectives of the needs assessment are to:

- Identify children's health needs;
- Examine demand for services
- Map current service provision;
- Identify existing assets which lie outside this service provision;
- Assess the gaps between these factors
- Explore different models of service provision for the 0-19 programme

Four separate HNAs have been undertaken for each of the population groups identified above. In addition to individual reports, the findings from the four needs assessments have been triangulated to create a summary of key needs and priorities for children and young people in Liverpool across the life course. This fourth report of four focuses on stage four of the health needs assessment: Young people aged 16-19 years

2.Methodology

A five step methodology based on the National Institute for Healthcare Excellence (NICE, 2005) guide to health needs assessment was used (figure 1). HNA is a cyclical process but many of the elements can be conducted concurrently. The methodology will be the same for each of the four needs assessments and further details and considerations for each of the life stages are outlined below.

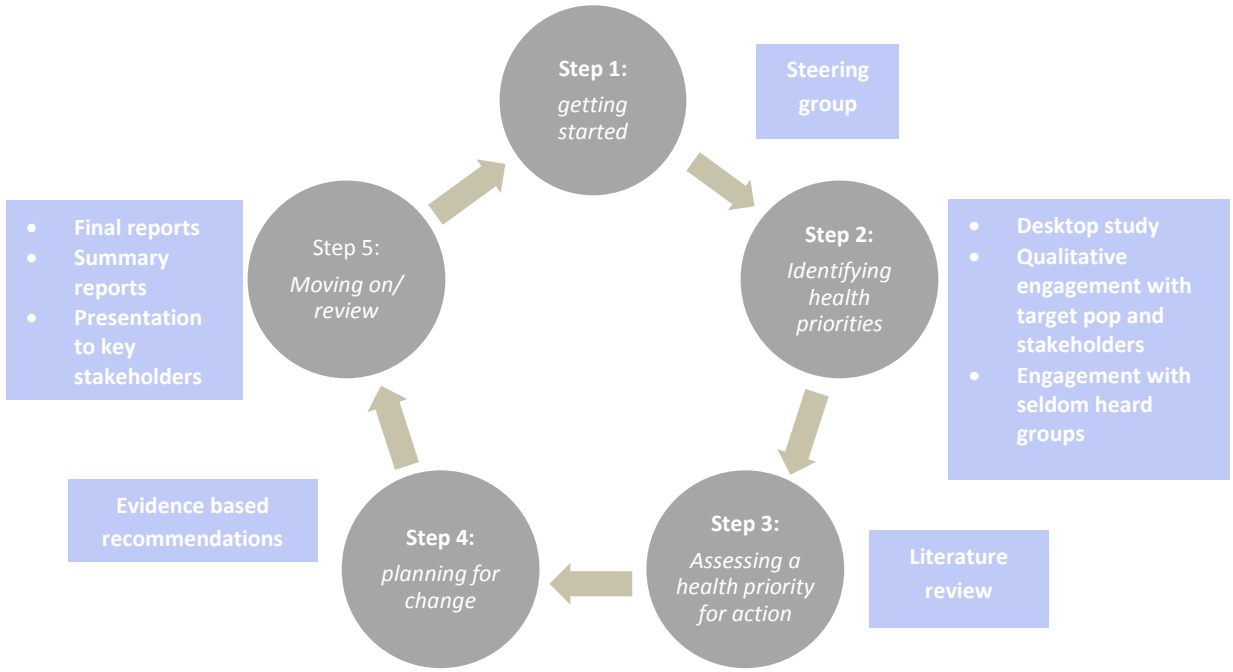


Figure 1. The five steps of health needs assessment (NICE, 2005)

A project steering group was established and included representation from the research team, commissioners at Liverpool City Council and key stakeholders involved in the commissioning and provision of children's services across Liverpool. The research team had regular contact with the steering group throughout the HNA. An internal advisory group was developed at Liverpool John Moores University and included key members of staff from Nursing and Allied Health for expert support and advice. The two groups provided advice and support around recruitment, interview materials and provided feedback on draft reports.

All LJMU research is designed and delivered in compliance with rigorous ethical standards. Ethical approval for the research was granted by the LJMU Research Ethics Committee prior to the commencement of the evaluation (reference 16/CPH/020).

Identifying health priorities

Desktop study – Quantitative methods and analysis

Analysts from Liverpool City Council led on the analysis of data for the desktop study with direction from commissioners and the research team, which was then written up by the research team at LJMU. Data on children and young people was collated from a range of published and unpublished sources to assess local need, map service provision and identify gaps in service provision and areas of unmet need.

The desktop study includes the following:

- Demographic data on children, young people and their parents/carers
- Health and wellbeing indicators for children and young people including disease prevalence, mortality, lifestyle factors, risk behaviours and uptake of health checks, vaccinations and screening
- Socio-economic profile data including poverty, housing status, education and employment
- Mapping of local service provision
- Provider and performance data from local service providers

Engagement with target population – Qualitative methods and analysis

Service user engagement

Three focus groups (n=12) were conducted with young people. This included one group in an area of higher socio-economic deprivation and one group in an area of lower socio-economic deprivation. The research team also aimed to conduct a further focus group with young parents. All recruitment routes were explored including working with schools, colleges and services for young people and young parents, however due to limited recruitment uptake, this was unfortunately not possible. Therefore additional stakeholder interviews were undertaken to explore health issues for this group. Recruitment was supported by gatekeepers and held at youth clubs and schools. All participants received a participant information sheet and gave written consent to take part (parental consent was also gained for children under 16 years of age) and all participants received a £5 shopping voucher to thank them for their time. Focus groups and interview questions were informed by the literature and evidence, and focused on the young person's perceptions of their health needs.

Table 1. Focus groups

Focus Group	Number of participants
Youth club (lower SES)	3 males, 2 females (16-19)
Secondary school (higher SES)	7 females (16-18)

Stakeholder engagement

Across the four stages for the HNA, 23 interviews were undertaken with key stakeholders involved in the delivery of children's services across Liverpool. This included stakeholders from a range of services including Children's Services, midwifery services, health visiting, children's centres, substance use services, sexual health services, youth club, young person's advisory services and health projects, mental health services and general practice. Stakeholders were asked about service provision, health needs priorities and barriers to accessing healthcare. Stakeholders who were asked about provision in relation to young people aged 16-19 years included:

Table 2. Stakeholder interviews

No.	Service and organisation
1	Children's Family Support & Residential Services, Liverpool City Council
2	Family Nurse Partnership, Liverpool Community Health
3	Perinatal Mental Health Service, Mersey Care
4	Babies & Mums Breastfeeding Information and Support, Liverpool City Council
5	Children's Centre, Liverpool City Council
6	Midwifery, Liverpool Women's Hospital
7	Academic specialising in women seeking asylum
8	Substance use service, Young Addaction
9	Sexual health service, Brook
10	Youth Club
11	Young person's advisory service, Gay Youth R Out (GYRO), YPAS
12	Post Natal Depression Service, Person Shaped Support
13	Health Visiting, Liverpool Community Health
14	Young people's health group, Health Line Project, Merseyside Youth Association
15	Learning Support Secondary School, Secondary School
16	Young person's mental health service, Child and Adolescent Mental Health Services, NHS
17	Young person's mental health service (college), YPAS
18	GP, NHS

The focus group and telephone interviews were transcribed and analysed using thematic analysis to identify key themes for young people aged 16-19 years health needs and health services provided to support them.

Assessing a health priority for action

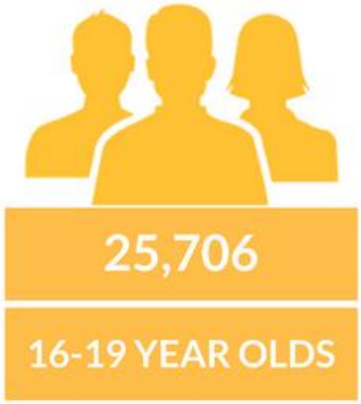
A comprehensive review of all relevant literature was conducted including academic peer reviewed journals, grey literature such as national and local policy and independent research. The review summarised the available evidence on interventions to address the priority health needs of the target population including an overview of key health priorities in comparison to the local context. The quantitative, qualitative analysis and literature review were then triangulated to develop evidence based recommendations to help inform the redesign of public health provision for 0-19 year olds in Liverpool.

3.Findings

3.1 Identifying health priorities

Desktop study – Quantitative analysis

16-19 YEAR OLDS IN NUMBERS[1]



There are an estimated 25,706 young people aged 16-19 years in Liverpool representing just under a quarter (24.1%) of the 0-19 population. Overall, 16-19 year olds account for 5.4% of the Liverpool population.

Key indicators

Data from a range of indicators from Public Health England profiles (including Health Profiles, the Public Health Outcomes Framework and Child and Maternal Profiles) were compared to identify areas which were worse and better than the national average. Each of these areas will be considered in greater detail below.

[1] *Unless otherwise stated the data in this section were provided by Liverpool City Council intelligence team.*

Indicators significantly worse than the national average

Hospital admissions

In 2015/16, there were 6,713 emergency hospital admissions among Liverpool residents aged 0-19 years. This was a 6.4% increase on the number of admissions seen five years previously (2012/13). Speke-Garston was the ward with the highest number of emergency admissions (n=406). There were 2,237 emergency admissions among 13-19 year olds, a rate of 56.9 per 1,000 population. This included 827 in 15-17 year olds (rate 54.8 per 1,000). Everton had the highest rate of admissions for this age group (111.1 per 1,000). Among 18-19 year olds, there were 1,013 admissions; a rate of 67.2 per 1,000. Central ward had the highest rate of admissions for this age group (386.7 per 1,000).

The rates of hospital admissions in Liverpool were significantly higher than the England average for unintentional injuries (111.5 per 10,000 vs 104.2 per 10,000) and asthma (302.3 per 10,000 vs 202.4 per 10,000). Injuries are a leading cause of hospitalisation among children and are a major source of premature mortality and morbidity. They are also a source of long-term health issues including mental health related to injury experiences (PHE, 2016a; PHE, 2016b). There is also a strong link between unintentional injury and social deprivation with children from the most disadvantaged families more likely to be killed or seriously injured (PHE, 2016b). In 2015/16, the rate of hospital admissions caused by injuries in 15-24 year olds in Liverpool (161.0 per 10,000 resident population)wasis significantly higher than the national average (134.1 per 10,000 resident population). Between April 2013 and March 2016, there were 118,826 attendances at North West A&Es for injuries among 16-19 year old Liverpool residents. The majority attended either Aintree (45%) or the Royal Liverpool (41%) NHS Hospital Trusts. Just over one in five (21%) arrived by ambulance.

Self Harm

Self-harm is defined as an intentional act of self-injury or self-poisoning irrespective of motivation or suicidal intent (PHE, 2015). The incidence of self-harm in the UK has continued to rise over the past 20 years and self-harm among young people in the UK is the highest in Europe (RCPsych, 2014). Self-harm is one of the top five causes of acute medical admissions; those who are admitted for self-harm have a one in six chance of repeat A&E attendance in the same year (PHE, 2015) and are at heightened risk of suicide (Hawton et al, 2003). Self-harm is also poorly understood in society and as a consequence people who self-harm are subject to stigma (PHE, 2015). Young people remain at greater risk of self-harm with 10-13% of 15 to 16 year olds having self-harmed in their lifetime (DH, 2011).

The age standardised rate of hospital stays for self-harm in Liverpool in 2015/16 was 266.1 per 100,000 population which was significantly higher than the national average (196.5 per 100,000). In 2015/16, there were 290 admissions for self-harm in Liverpool residents aged 0-19 years; a rate of 2.8 per 1,000 population. Central ward had the highest rate of admissions for self-harm at 5.7 per 1,000.

Alcohol and substance misuse related hospital admissions

Alcohol-related hospital admissions are largely avoidable and alcohol-related harms continue to be the leading cause of death among men and women aged 15-49 years in the UK. The rate of hospital admissions for alcohol-related harm in Liverpool in 2015/16 (969 per 100,000 population) is significantly higher than the national average (647 per 100,000 population). The rate of admissions for alcohol-specific conditions among under 18s in 2015/16 was 40.6 per 100,000 population; this

did not differ significantly from the national average (36.6 per 100,000). The rate of hospital admissions among 15-24 year olds related to substance misuse in Liverpool (119.6 per 100,000) was also significantly higher than the national average (95.4 per 100,000).

Sexual health

The majority of young people start forming relationships and become sexually active between the ages of 16 and 24 years. Young people in this age group have significantly higher rates of poor sexual health including sexually transmitted infections (STI) diagnoses and abortions (DH, 2013). During consultation for the Government's "Positive for Youth" young people's strategy, young people said that removing the stigma from asking for sexual health advice was seen as key to helping them take responsibility and make informed decisions relating to their sexual health (DoE, 2011a).

The overall rate of new sexually transmitted infections (STIs) for Liverpool residents in 2016 was 1,141 per 100,000 population which was significantly higher than the national average (750 per 100,000 population) (PHE, 2016b). The highest rates of STI infections remain among those aged between 15 and 24 years.

The rate of conceptions under 18 years nationally is now at the lowest level since these statistics were first produced in 1969. Office for National Statistics (ONS) suggest several reasons for this decline including: the sex and relationship education, contraception access and publicity programmes invested in by successive governments, a shift in aspirations towards education by young women and the perception of stigma associated with being a teenage mother (ONS, 2015). However, despite these declines, the rate of teenage conceptions in Liverpool still remains significantly higher than the national average.

In 2015, there were 234 under 18 conceptions in Liverpool; a rate of 32.1 per 1,000 conceptions. This was higher than both the North West (24.7) and England (20.8) averages. Seven wards in Liverpool had a teenage conception rate that was significantly higher than the Liverpool average (Clubmoor, County, Everton, Kirkdale, Norris Green, Picton and Speke-Garston).

There were 2,408 terminations in Liverpool in 2015; a rate of 22.6 per 1,000 women (this is higher than the England average 16.7 per 1,000). The rate of abortion for under 18s was 16.9 per 1,000 women (England average 9.9) and for 18-19 year olds the rate was 32.5 per 1,000 women (England average 24.2).

Not in education, employment or training (NEET)

Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes including poorer health, early parenthood and depression. Young people with a number of characteristics are at increased risk of being NEET including: those with no GCSE qualifications, those with a disability, those who are eligible for free school meals, those who have been excluded or suspended from school and those with their own child (Mirza-Davies and Brown, 2016). According to the Longitudinal Study of Young People in England, at least a quarter of NEET young people in each of these groups were NEET for over a year (DoE, 2011b). In 2015, 6.3% of 16-18 year olds in Liverpool were not in education, employment or training; this was significantly higher than the national average (4.2%).

Lower educational attainment is associated with becoming NEET with young people who have achieved five of more GCSEs A-C significantly less likely to be NEET. Nationally around 25% of 16-24

year old without any qualifications are NEET compared with 10% of those qualified to GCSE level and above (Mirza-Davies and Brown, 2016). In total, 3,155 Liverpool students were entered for a level 3 qualification between 2014/15 and 89% of students achieved at least 2 substantial level 2 qualifications (slightly lower than the national average; 91.4%). The average point score per student (692.9) is lower than the national average (717.8). The average score for girls (702.8) is higher than for boys (681.3). This included 2,030 young people who were entered for at least one A level of which 12.3% achieved AAB grades or better (this is lower than the national average, 19.2%). The proportion of boys achieving AAB grades (14.9%) was higher than for girls (10.3%).

3.2 Engagement with target population – Qualitative analysis

Service user engagement

What does "being healthy" mean

For both groups their first comments about being healthy related to a healthy diet. For the youth group they discussed healthy eating and appropriate diet for your activity levels; young people felt that people who were 'sporty' needed more protein and carbohydrates within their diet, and people who were sedentary needed fewer calories.

Both groups discussed mental health. For the school group this related to everything from low level stress and emotional issues to higher level serious mental health disorders such as schizophrenia and suicide. Young people felt the low level mental health was an issue for many of their peers as they were very stressed with exams and school pressure. The school group viewed mental health as a continuum and felt that their generation had a better awareness and understanding of mental health than their parents.

"You see when I say mental health to my mum and dad or an older generation they see it as like a really big problem. They see it as like a general thing, they see it as, like if I say my mental health is not good they see it as something that is really wrong, if you say your mental health is not well you could just be having a little tiny issue, so I don't think that it is exposed and I don't think people realise the spectrum for it being a little tiny issue" (Female aged 17/18)

The youth group also felt sleeping well and good mental health were important and that poor mental health affected physical health. This group discussed how people deal with challenging situations differently, where some people are able to cope with distress and unpleasant situations but for others this can have an impact on mental health.

"It depends on how people react and stuff like that because some people can sit there and feel sorry for themselves and someone else could do something about it" (Male, aged 17)

The school group also discussed relationships and sexual health as an important part of a healthy lifestyle, making sure their relationships are happy and healthy. This particular group felt this was talked about a lot more because they went to an all-girls school; they felt they had received good Personal Social and Health Education (PSHE) and felt that not having classes with boys made this easier and people were more likely to be open.

"But like they do end up coming to help, so we have sexual health clinics coming in like the Brook and they do workshops and you are just like…even if you never end up in that situation you knowledge around sexual health is just like expanded and you know where to go to if anything should go wrong or anything like that" (Female aged 17/18)

Health was very important to the youth group who were described their lifestyles as physically active, with an interest variety of activities including football, gymnastics and going to the gym. This group discussed how they felt that not all their peers wee as interested in sport, health or nutrition as they were. They also felt having aspirations and goals in life was important and encouraged people to stay healthy.

Influences on health and wellbeing

Negative influences

Both the school and youth club groups felt their health could be influenced by friends and who they choose to spend their time with. The behaviour of the people around them was thought to have an impact, both in terms of lifestyle factors and risk taking (i.e. smoking and antisocial behaviour) and outlook on life, aspirations and ambitions. Some friends were viewed as a positive, protective influence and some friend as negative. The groups agreed this could have a strong influence.

"When you're older your friends do determine a lot of things you do, like I know I have good friends who wouldn't influence me to do bad things… but some people don't like…some people don't have good friends who would say 'no that is a bad choice don't do that'" (Female aged 17/18)

"Like say you are all out on a night out and you got offered like drugs or something like you know your friends would say like 'what you are doing, don't do that!' But some people don't have that, their friends would be like 'ah yeah that would be dead fun'" (Female aged 17/18)

" Maybe the other people that you are with as well they have an influence on you, the people that you are around, like if they smoke and stuff then obviously that is going into your system and that is probably going to make you, you might not do it you know what I mean but if you are around people who are positive and have the same goals as you then that will make you want to achieve and achieve more…but if I am around people that were getting into all sorts of mischief then I am likely to probably do that wouldn't I?" (Male aged 17)

Behaviour and social norms were thought to change as they aged. The school group (all lower sixth) felt that the behaviour of them and their peers had changed since they entered sixth form and alcohol use and drunkenness was now more common.

"I think when people like us get to sixth form a lot of us actually start drinking and doing things like that and when you are younger you sort of think like 'oh yeah adults do that', but it's people our age now doing it, so sometimes I think it is like the opposite of stigma sometimes I think like it's 'oh it's cool'" (Female aged 17/18)

"Definitely, nowadays it has gone like properly ridiculous. Problems like a few years ago you would have thought wow they are massive, now it's like seen as the norm to do it like" (Female aged 17/18)

The school group also felt family background had an influence on health and behaviour and on health service use. The youth group described how the way in which people react to situations can influence health and stress levels; this groupfelt a positive mental attitude and resilience was good for you and it was important to find ways to cope with pressure and stress.

Both groups mentioned specific situations that were 'bad for their mental health'; particularly stresses caused by exams and problems at home.

"[Stress] just exams and stuff or things that are going on at home and stuff" (Male aged 17)

"Especially in like a school environment everyone is like stressed and stuff, there is exam stress, so you do see like an impact on mental health" (Female aged 17/18)

"I think for a lot of us it is exams and stress and the pressure of that and for a lot of us it is when you go into sixth form it is completely new, like you are starting to grow up and you know what your GCSE's are and why you need your GCSE's and then you kind of go into you're a levels and it is a big step up. You are looking around at different universities; you need different grades for different universities" (Female aged 17/18)

The young people felt that physical health was also thought to impact on mental health and problems were exacerbated when they had no one to speak to.

"With stress also, other kids might also have problems at home and stuff. And they might not have no one to speak about it to and might not know how to deal with it" (Male aged 17)

For the school group they felt lack of free time stopped them and their peers from doing regular physical activity.

"I think as well it is like time, like yeah you might make time to go to the gym, but if you are like dedicated to a sport you have got to go to that like most days and it is like with the stress of school and like you want to do things with your friends, it is like fitting it all in" (Female aged 17/18)

Positive influences

The school group discussed how physical activity keeps them healthy this group explained that they used to do PE every week up until GCSEs but in sixth form they don't do any. This group said that very few of their peers do any physical activity outside of school. For those members of of school group who did participate in sport, they explained that they found sport and playing in a team very good for their mental health, describing this as 'a good way to not think about everything'.

Both groups discussed what kinds of activities they enjoyed doing and how this kept them happy and healthy. For the youth club group this included playing sport, shopping, spending time with animals and eating good food. The young people also discussed using physical exercise to help reduce exam stress.

"I think it [being a young person and undertaking exams] is quite overwhelming because it literally feels like you have got one shot and if you miss it that is it. Because with AS [level] you could see where you were going and that, and with this you sort of got nothing to fall back on now. But like in terms of improving it, a few of us here are on sports teams and I think that helps. It is sort of an outlet whether you are angry or upset or something, it makes you feel better being in a team" (Female aged 17/18)

For the young people in the school focus group who weren't interested in sport they believed it was good to spend time with their friends and enjoy themselves. They thought it helped their mental health to think about different topics away from the pressure of school.

"I think like going out with your friends and things and having a good time like, doing something completely different from school, like you might be with the same people you are with in school but you are not in the same kind of environment you are not doing the same kind of things, you are doing things that you enjoy, like that is like sports like you enjoy it so it like takes your mind off to like a different topic" (Female aged 17/18)

Accessing advice and support

Schools and colleges

The school group discussed the wide selection of support that they felt was easily available to them in their school; this included an inclusion team, a guidance counsellor and a school nurse. The group felt these people were very supportive and explained that they would be happy to see then for advice and support. The young people thought the system worked well in their school well, describing how the nurse and wellbeing teams were based in a separate part of the building and this gave them confidence that they could obtain this supportconfidentially.

"Guidance counsellors, we have got like a school nurse, we have got a lot and although they are part of the school community they are very much part of their separate part of the building, I think that they are people you trust that you know, we have also got a pastoral office, we have got a sixth form" (Female aged 17/18)

"They not going to go around telling anything like about guess what they have been up to" (Female aged 17/18)

"You are completely out of the way, you are just in a room with them, no one else knows" (Female aged 17/18)

The school group also felt the school based services were particularly useful if people needed help immediately as they were available during the school day and they didn't have to wait until later or travel anywhere. However, some of the school focus group felt they would prefer to speak to people out of school due to embarrassment and the stigma associated with mental health. Overall they felt that their school provided a lot of support and they explained they were lucky to have the services, wellbeing days and support staff. They were aware that family and friends in other schools did not have as much support for their wellbeing.

"My sister goes to a different school and I think that shows that contrast a lot more, and I always say this to her our school they do really care about your grades, and they really do and they want you to do well and leave with all A and all that…but they care about your wellbeing a lot a lot more. And I think that is different now, like obviously like, it is different like because she goes to a private school but I spoke to other people and they do feel a lot more pressure from their school so we are very lucky with the school we have and it does , and it is upsetting that other people don't have the support system we have in this school and like in the community, but like I think the more people like talk about it and the more people talk about different ideas then more schools might implement things like wellbeing day and things like that" (Female aged 17/18)*

The school group felt that even if they don't use the support available at school they knew it was there as a safety net.

"Because even if you don't use it, it is a bit of a safety net, it's like if something was to go wrong, at least it is there. But I think family is my first thing I would turn to" (Female aged 17/18)

One of the members of the youth service focus group discussed the support available at their college. They felt college was even more supportive than school and they were more able to talk to students and tutors. This participant felt that some younger people were reluctant to talk to teachers but may be more likely to do so at college because of a more equal relationship between students and tutors.

"Well some people will go and talk to their friends and stuff like, I don't know there are some teachers and stuff but there are people like that you feel you can't really speak to about stuff like that. I mean I had problems when I was at home and I had no one to speak to and when I started going to college I met a few more people, but like I learned to handle it more and started reading, that kind of like helped me" (Male aged 17)

"Don't think there is that relationship with teachers to be honest with you. In like college, I don't know the environment is just different, teachers are like, I don't know it is just different. …. But it is like they are not teachers, they help us and stuff but they are not like teachers. We get along with them like the students as well" (Male aged 17)

GP or NHS services

In terms of health service use, most participants said they would use NHS services if they knew where to go.

"I would yeah [go to a doctor], if I knew how to. Like obviously if I had mental health issues, didn't know where to go or who to speak to I would just be sitting there with my problems, but if I knew how to and who to contact then I would do it and it would help me" (Male aged 17)

The school group (all 16 and 17) felt like they should be able to go to the doctors on their own but they were still nervous and didn't always feel confident enough to make an appointment or attend an appointment alone. The group discussed how they still relied on their parents (usually mothers) to go with them.

"I feel like there is quite a lot of pressure now at like 16, nearly 17, I should be able to just like go to the doctors meself but I still feel like I need me mum there. I know it sounds silly but me mum will be like ring up the doctors yourself and I am like no that is what you do, you know what mean but like I should be at the point where like that is my own health care that I should be taking responsibility for myself and I think I will have to soon" (Female aged 17/18)

All participants in both groups were aware of Brook and how to access it, and some had attended with friends. Some of the youth group talked positively about the Bitesize Brook events they had in their schools and liked the format of these events in terms of moving around and working in small groups. However, when asked, the young people couldn't remember what else they had learnt on these days.

Other organisations

Young people at the youth group were aware of Fag Ends and Addaction for support with cigarettes, drugs and alcohol. They talked positively about the session they had with Addaction using beer goggles but they had to be reminded about this by the youth worker (who was present at the focus group). Awareness raising sessions at youth clubs were thought to be a good idea, but young people highlighted that these would need to be offered on a relatively frequent basis, or rolling programme, as people may forget the information they are given at sessions.

Both groups also discussed the external agencies who had attended their school to deliver health promotion; this included Brook Bitesize events, Addaction and the school group discussed a play about Child Sexual Exploitation (CSE) called 'Sophie's Choice'. The school group felt the Addaction activities were particularly effective as they met a service user who had experienced drug abuse; the young people described how this felt more relevant, relatable, powerful and useful that a teacher telling them the information.

"I think it was very beneficial as well because I think things around cases such as drugs abuse and alcohol abuse there is a lot of stigma, like scruffs, or people that are like, you know some people bring class into it, so to see them come in and it was like men who were like you know 'I was coming to work in the office every day and I was having like 12 pints', obviously not 12 pints but you know what I mean…it was relatable. Obviously we are not in an office and we are not men but do you know what I mean! But it is different, because if it was like the teachers, I think it is even more of like a barrier between the students and teachers because of the fact that like sometimes you actually forget like they [teachers] are real people" (Female aged 17/18)

The school focus group also felt that there was a difference in the information they received in school compared to from external agencies; here, school was thought to give the message 'never drink' whereas external organisations recognised that young people would experiment with risk-taking behaviours and promoted safety, moderation and healthy balance.

"…in a school environment it is very much 'no you shouldn't drink you should do this...' but whereas external it is they are sort of like 'no you are fine to it is just in moderation' it is the learning, the education about I" (Female aged 17/18)

"Measures and control" (Female aged 17/18)

The group at the youth club discussed how they would be happy to talk to youth workers about their health and if they just needed some low level (for example they discussed exam stress and general worries) mental health support. However, this group explained that they would not speak to youth workers about sexual health, being more likely to access a service such as Brook.

Friends and peers

Both the school and youth groups said they would seek out friends and peers they knew who were knowledgeable about topics; examples given here were people at the gym or in sports teams who would be able to give advice about diet and exercise and friends and classmates who were sexually active who would be able to advise about sexual health.

"It doesn't matter what background you come from we all try and have the best reputation for ourselves, like sort of like a lady and things like that. With me I have like older parents so there is absolutely no way I would ever in my life ever talk about things like that, but I think that there is people in the year…it sounds really horrible but if they have got like a certain reputation or they …like you know that they have experienced things that my friends wouldn't have then I think I would feel more comfortable talking to them than I would immediate friends. You sort of draw on people' s experience" (Female aged 17/18)

"You can just ask people you know….Like your friends and stuff because people in my school do sport and stuff like that" (Female aged 16)

Information available online

The youth club participants liked the anonymity of sites that offer counselling and online support. The researchers asked if they were referring to an organisation such as Kooth but the group were not able to remember the name of any particular organisations.

"People like to talk anonymously, like I seen a video where it's like when you can't go to anyone you go online and it is like, I can't remember the website but like you talk like your problems but it is anonymously. And like people online, who are on the website, try and help" (Male aged 19)

For advice regarding healthy eating and exercise, the youth group members accessed websites, particularly regarding a healthy diet for athletes. Some of the young people described using apps with specific 30-day diet or exercise regimes, however these young people explained that they were aware that some of the information online was very unreliable and some of the diets and weight loss advice were 'too good to be true'. Young people described that they felt it wasn't always easy to know what information was reliable. They also felt a lot of the information on the television about health was unreliable and explained that they were more likely to search for information online.

The participants in the school focus group explained that they would also go online for information about specific health conditions and felt that it was difficult to establish which information was reliable; this group talked about how it was easy to 'scare when looking up symptoms. The group explained that they tried to use NHS sites and not focus on more unreliable Google search results or forums and chatrooms. However, they felt when they were worried or panicking it wasn't always possible for people to differentiate between reliable and false information. They did think the NHS sites were particularly helpful and gave the example of a NHS BMI calculator.

"Like I went online when I had an issue and I like, I really …oh I will just say it…I had a lump in my breast but it wasn't, like I got it tested, it wasn't breast cancer, I Googled it online and that obviously is the first thing that comes up and it is the first thing you know as a woman and you kind of like, you panic, but there is no really other options so you have to scroll down go further down …" (Female aged 17/18)

"But I think a lot of the times if people are resorting to online sites they sort of, they are in quiet a serious situation, you are not going to like stub your toe and then google it, you obviously have worries anyway so if you google it and then unreliable information comes up, automatically just as a human instinct you are going to believe it because you are in a panic situation anyway so I don't think you can always differentiate what is reliable or not, you sort of going to just believe whatever fits the description" (Female aged 17/18)

"I actually know a lot of people who do that you know, so …being girls a lot of us do talk about…I know it is a stereotypical thing but we talk about weight, so like we are all different heights, different sizes, and a lot of my friends will say like oh yeah but it is because you are tall, and that really irritates me because I am like it doesn't matter that I am tall if I am putting on weight I am putting on weight. But like NHS have like a BMI chart and I find that so helpful because that is not telling you like whether you are fat or thin that is telling you if you are healthy" (Female aged 17/18)

Health Education

Both groups felt schools and colleges were a good place to obtain information about where to access help for physical and mental health. Both groups felt mental health and sexual health promotion

needed to be delivered in smaller groups with facilitated discussions, rather than in a large assembly setting, as people 'stop listening'. The young people felt more comfortable in groups with external organisations (for example at Bitesize Brook events) because they were with fewer people and there weren't teachers listening. Asking questions in an anonymous setting by putting questions in a box was thought to be a less intimidating way to ask questions of teachers and other organisations. The school group felt that learning in an informal setting with interaction was particularly effective, they particularly liked learning from the experiences of people with whom they could identify.

"Yeah I think in the casual environment, it's just…and hearing from people who have been through it…because…it's just like, you hear people go 'oh they grown up like that they from'…but they not, they just speaking about it from a completely what seems normal background doing a normal day routine, so that makes it just more… makes you a bit more aware and you think hang on you need to be a bit more careful and everyone…it can happen to anyone" (Female aged 17/18)

Drama was mentioned as a powerful tool that allowed the young people to put themselves in the shoes of the characters and led to them talking with friends about the issues for days after. However the school group also felt that sometimes they needed simple information about science (for example how contraceptive pills work) to be delivered in a simple educational way.

"Detail and level of information you are going to go into and then once you and your friends have had a little giggle then you can all sort of, and then, like the play wasn't really that informal, we sat in our lunch, but it was delivered in a way where …like if we had a lesson now, we are not going to go and talk about the lesson or two hours after really, but when we seen the play, it was like 'oh do you remember in the play, and he gave that to her, what if that happened in real life' and it sort of, it opens discussion up then" (Female aged 17/18)

Barriers to accessing advice and support services

Not knowing where to go

Both groups felt knowing where to go for advice and support stops young people accessing services, explaining that if they don't know where to go they will try to deal with it on their own.

"Like obviously if I had mental health issues, didn't know where to go or who to speak to I would just be sitting there with my problems, but if I knew how to and who to contact then I would do it and it would help me" (Male aged 17)

The school group felt that awareness of where to go for mental health support was generally low, especially amongst older generations. This group compared the availability and ease of access for physical health treatment to how difficult they found it to access mental health support.

"Sort of like the most extreme bracket and even those people don't all have a place to go. But like sort of when, I just don't think it is as accessible as, like if I broke my arm or something like that we'd all know where to go and everyone would see it and notice the severity of it whereas if I was like oh I have had a bad day someone would say ok, what do you want me to do about it?" (Female aged 17/18)

The youth centre focus group suggested there is information around the youth centre but they hadn't really noticed it; they didn't think young people look at posters around a youth centre but

may seek it out if they need it. They also could not really remember what they learnt in school regarding support that is available for mental health.

Embarrassment and fear of judgment.

All participants in both groups were aware of Brook and the services available there. However they were all scared to be seen going into the Brook clinic for fear of judgement.

"The fear of being caught in there [Brook]" (Male aged 17)

"You would be there and like obviously they just jump to conclusion like 'ah he has got Chlamydia'" (Male, aged 17)

The girls in the school group explained that they felt particularly embarrassed and scared of being judged, and most wouldn't feel they could even tell their friends if they needed to go to Brook. In their school they felt they had to uphold a 'good reputation' and they didn't want to be 'judged and get a bad reputation'; this was through to be caused by the type of school (a girls only school). Embarrassment, pride and ego were thought to be a barrier which would stop the participants in the school group from talking to their friends or the school about a health problem, especially mental health.

"Because when we were…doing drama again… we were looking into mental health because of the issues and like it was the biggest killer of men. Like out of anything, any diseases and we were saying like females are always more open like they will go and talk to their female friend or they are fine to be upset and the men are kind of like perceived to have to be like, as you said, hard and strong and not get upset and then they keep it in and don't talk and then it can just escalate to that point" (Female aged 17/18)

"What I think, in Liverpool particularly, I do think there needs to be more mental health services, because it just...because there wasn't that many to being with and now funding has been cut and stuff like that and then the waiting lists just get longer and longer , and I think a lot of people with mental health they need help immediately, it is not a case of oh like you can come back and you can get help, they sort of like need it now so if you don't have it" (Female aged 17/18)

"Or you are overthinking it, because I know that none of my friends, because I know that they are the nicest people ever, I know they wouldn't be like 'oh my God sick' I know they wouldn't do anything like that, but it is the fact that I know I would over think it and be like 'oh my God she is going to think that everyone time I go out that this or that'" (Female aged 17/18)

Confidentiality

Some young people at the youth club had a nurse at their school who held weekly clinics, however they felt that students were reluctant to use the service as they were unsure if the information was confidential.

"At our school they actually run a Friday every few weeks but nobody pays attention. No one goes and sees them. Because it is in school and I don't know they might go and tell teachers and stuff…Because you don't know who they are going to tell… teachers, whether they are going to find out sort of thing" (Female aged 16)

Stigma about mental health

The school group discussed the stigma around mental health and how they felt it was something that people were scared to talk about, especially younger groups and parents. They were concerned about the way mental illness is portrayed in the media.

"Mental health isn't spoke about as openly as obviously physical health, I think it is a bit of a taboo subject really" (Female aged 17/18)

"Like I think mental health has definitely got a lot to do with the media and how they sort of cover it up in a way and also how they desensitize the issue, so basically all they did was just label them 'they mentally ill' because of that quick judgment and label, they were but there was a lot more to it that than, but I think because there is such a wide range of saying if someone is mentally ill , like the spectrum is so large and they could be so innocent or so large and the fact that that was all they labelled them and anyone who has like really low down in the scale… I think it will always be difficult but I think more awareness will eradicate it" (Female aged 17/18)

Although the school group felt they had staff in school they could talk to about issues if they needed, and many did, some would not want to. Some of the school group felt embarrassed to talk to teachers, especially about mental health and would not want to see the teacher every day; they liked the anonymity and one-off contact with external services.

"Also if you have a problem and you tell a teacher and it is one of the teachers you have every day and it is a problem you don't want to have to like face every single day you don't want to have to go in and speak to them. But if you go to someone outside of school like say you go to the Brook or something, you never have to see them again or speak to them again" (Female aged 17/18)

"But then I think I would rather go and see someone else that is not at school because I think as much as I know they wouldn't talk about me, I would feel, like if you ever see them in school that would embarrass me, like even if it was about mental health because I think that has got a negative stigma about it and I think that would, I wouldn't feel comfortable talking to someone about it, do you know what I mean, I would feel better talking to…like when you go to see a doctor, you don't know that doctor so you feel like you can tell them whatever really" (Female aged 17/18)

Lack of access to mental health services

The school focus group were aware of Child and Adolescent Mental Health Service (CAMHS) but weren't sure how to get a referral. They were also concerned that there were long waiting lists and problems with funding that meant that CAMHS services were very difficult to see, especially for lower level mental health issues. They expected that the delay in being able to access mental health services was a problem as people would only become more unwell the longer they waited. The group described how they felt this was going to have a negative impact on the mental health of their generation.

"Yeah I know sometimes you have to be referred [to CAMHS]. And I know some people, I know a lot of people who have suffered from bad mental health and wanted to go there and there is a long waiting list and obviously funding has cut a lot on Liverpool mental health services, and I think that is something that puts a strain on our age particularly, because like everyone will suffer, I think, some sort of bad mental health whether it is through exams or like through family or something. I don't think it is that easy to just find somewhere to go. I think people feel more comfortable if they feel they have got extreme bad mental health, but sometimes if you are having an off moment or an off day I don't think it is like somewhere you can just go and speak to…" (Female aged 17/18)

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The school group felt seeking help for mental health was more difficult for boys; they all felt there was more stigma about boys asking for help with their mental health. They felt that boys had more pressure to appear strong and did not want to be seen to cry or show weakness, whereas they felt that girls found it easier to ask for help and talk to their friends.

"I think it is easier for girls than boys, but I think that is like…and I understand and I am quite like an open person but I understand not every girl is like that, but then I think like there is like status connected, like I think boys are meant to be like quite hard and like not show much emotion. So when it comes to mental health boys will think like that is never going to happen to me, like you know boys have an argument they just have a fight about it and it is like over and done with like that is the way it is, but with girls like, they can cry like and it is ok, do you know what I mean, it is like girls are allowed to get upset and be like oh I have actually got this issue and actually talk about it than boys are, and I think it is like harder for them" (Female aged 17/18)

Location of services

The school focus group felt that travelling to services could be a barrier, describing how they were often 'difficult to get to', especially for young people. Linking in with embarrassment and stigma, the location was also thought to be a barrier, especially for sexual health and mental health services because young people did not want to be seen accessing these services. Services in the centre of town were felt to put people off because any of their friends might see them,

"Travel, sometimes it is not always as close to you as you think. Sometimes you have got to make a trip somewhere, or sometime it's in like a public place, so we spoke about stigma, so with em, sort of mental health and sexual health are the two that scream out to me, if that is in the centre of town I am not going to walk in there because I know I am going to get seen by people, so that is a big thing, it sounds like a really small issue…but they say they are a discrete service or whatever but if I am walking in the middle of town or whatever and I see me friends and then I walk in there, that is not discreet" (Female aged 17/18)

Barriers to accessing support

Some young people wrere unsure whether there was a cost to access some health services and had limited knowledge around this. To promote access to free services, this information needs to be provided through leaflets and adverts around young people and information in school. This information needs to be easily available and not have to involve time researching information about specific services.

The school focus group were concerned that some support and health services were expensive and felt that this stopped a lot of people being able to access them. They also felt that even if most services were free the perception that they may cost discouraged people from attending.

"I think as like a young person as well, if you wanted to say something without people knowing, so whoever friends, family, if you wanted to find a service , like quite a lot of them do charge so it's cost as well, especially as like a young person, because we are lucky here we have got free people we can go and speak to and go and see, but if we didn't and you are outside of school, and like all the things were full and you are on a waiting list and you wanted to see someone…quite a lot of it you have to pay for and most people don't have that money, and it is quite expensive" (Female aged 17/18)

"It is more like you don't want to be scrolling through someone's website to see prices, it should be snappy information, like quick, like if I am doing something on a whim and looking at something, I am not going to want to scroll through websites, as I say it should be like one place that you can go, maybe like, I don't know, just a health page, there is the NHS one obviously, but something that just tells you short snappy points that you need to know" (Female aged 17/18)

Members of both groups expressed concern about long waiting times at walk-in centre or at drop in appointments in Brook. However, despite the long wait to be seen many of the youth group said they preferred the walk-in centre to the GP as it was it was very difficult to get an appointment to see their GP. The school focus group discussed how some young people will put off going to the GP because they know the waiting time for an appointment is so long and you may not be seen for two weeks; they explained that they had obtained this information from parents and grandparents.

A minority of the youth club group had some comments on the Lifestyles Centres; they felt the staff needed to be more friendly and wanted steam room and sauna facilities in all Lifestyles gyms.

"Well the staff at the Lifestyles but you can improve that can you. Because I work around a lot of them people and they just look like they don't enjoy their job and don't want to be there (Male aged 17)

The school focus group felt that young people needed to have access to free first aid training, some had received first aid training through Duke of Edinburgh, sports clubs or National Citizenship Awards but they felt it was important for young people to know the basics of first aid.

"It is National Citizen Service, it is a government run programme, and they come into school and get people to do it and at the end you get a first aid certificate. So I think that is so beneficial because I think that is something we should all know anyway like I don't think you should have to go on that and so yeah…that was really good" (Female aged 17/18)

Stakeholder engagement

Mental Health and Emotional Wellbeing

Mental health was highlighted by many of the stakeholders as being one of the key health concerns for this age group. The Educational Psychologist discussed the transition from primary to secondary school and how they felt there needs to be more mental health support for young people that are making this transition. They noted that there are assessments available to identify learning disorders, but that schools often lacked resources to help young people with issues such as general anxiety and depression.

"The fourteen to nineteen cohort I'd say the gap [in service provision] is very much related to mental health interventions and I want to quantify that it is more around therapeutic interventions or mental health support and not assessments" (Educational Psychologist)

The stakeholders who were involved in mental health services discussed concerns around self-harm. It was noted by the School Nurse that the increasing openness about self-harm can create problems as young people are more aware of it which can potentially lead to some young people copying others:

"There is definite increases in self-harm, I think a lot of it was previously hidden, and now it's a bit more in the open, but sometimes it's a bit too open. We get copying and things like that" (School Nurse)

The School Nurse discussed how they sometimes experienced problems referring young people to CAMHS because of the strict criteria.

The LGBT Advice and Support Worker discussed how their service provides specific support relating to gender and sexuality. The main issues relate to anxiety and depression:

"Generally for our LGBT young people they can come with presentations, not all of the young people have emotional or mental health issues some just need and require that safe space. For those young people who are maybe facing emotional and mental health difficulties – particularly we see a lot of young people who are struggling with anxiety (that could be general anxiety, social anxiety) a lot of family and relationship difficulties, issues around perceived or actual hate crimes in the community, not feeling social acceptance within their community (this can be perceived but this can also be actual) – that isolation and that feeling of not belonging can have a number of detrimental effects on LGBT young people and their emotional wellbeing" (LGBT Advice and Support Worker)

The Sexual Health Worker also discussed the importance of providing specialist LGBT services for young people in order to create awareness of diversity and deliver anti-bullying interventions.

The Merseyside Youth Associateion (MYA) worker spoke about how the adolescent brain starts to develop between the ages of 16 and 25 and so this period of an individuals like may see them engaging in sensation seeking behaviour which could include sex and substance use. They felt that this was one of the main health needs for this age group.

"One of the things that we emphasise with mental health is about the adolescent brain development which starts between the ages of 16 and 25… they're working from a different part of the brain, the amygdala which is a very emotion, sensation seeking. So within that young people will have a lot more risk because that's the part of the brain that is feeding that sensation seeking experience …they might do that whether it be through fast cars, it could be able sex, it could be about substance use, it could be alcohol substances or legal highs" (MYA)

Alcohol and Substance Use

The Substance Use Support Worker discussed how their service has been developing a better relationship with schools and that they felt schools are now more pro-active in making referrals to substance misuse services. Their service provided educational and drop in sessions with schools as well as taking referrals for young people that have a substance misuse problem. They also had

sessions with parents to help increase awareness, but noted that these are usually attended by mothers and they have less engagement with fathers.

The Substance Use Support Worker did discuss increasing dual diagnosis referrals and had some concerns that the right support wasn't always available in these cases and that additional training for staff was required.

Sexual Health

The Sexual Health Worker discussed how their service provided clinical services (such as pregnancy testing, STI testing, referrals for terminations, etc.) as well as educational sessions and outreach work with schools and colleges as well as more specialist environments such as care homes and youth offending services. They emphasised the importance of promoting confidence and self-esteem with young people in order to help them develop their own personal awareness.

The School Nurse discussed how, in their experience, young people would often access Brook as opposed to their school nurse to discuss any sexual health related issues because they were concerned about confidentiality as staff often had to escort them to appointments. They felt that steps needed to be taken to reassure young people that confidentiality would be maintained and to raise the profile of school nurse drop in services within schools so that more young people are aware of the help and support on offer. Additionally, the Sexual Health Worker also discussed issues around confidentiality and stressed the importantance of information and guidance being available online. They hoped that by doing this, young people could be more familiar with their service and how it works which would make them more confident in accessing the service.

Teenage Parents

It was noted by some stakeholders that the number of teenage pregnancies was reducing. The Enhanced Midwife who provides individualised care for pregnant women that have mental health issues, drug/alcohol issues or are known to social services discussed how teenage pregnancies would often fit under their remit because they often fell under one of those categories.

The Enhanced Midwife noted that, similarly to the general population, teenage mums will often take influence from what their mum did when it comes to breastfeeding. They discussed how it is therefore important for professionals like themselves to discuss the benefits and provide support to encourage more teenage mums to breastfeed. Similarly, the Family Nurse also recognised breastfeeding as having a low uptake by this group, and their service would also work with young mums to encourage breastfeeding and offer support as well as making referrals to BAMBIS. Both the Family Nurse and Babies and Mums Breastfeeding Information and Support (BAMBIS) Support Worker also noted that family had a significant influence on whether a young mum would breastfeed and that, in Liverpool, older female family members will often have a significant role in raising the baby and as a result the young mum may be discouraged from breastfeeding:

"It [breastfeeding] is a very contentious subject. It is sewn into our programme, so we are very pro breastfeeding, but we also recognise choice...sometimes it is their families that are the barrier" (Family Nurse)

"We have high proportions of teenage mums who will listen to family members and their own mums who possibly bottle fed, or their mums – the grandmas – will think they're helping the teenagers by giving them a bottle so the mums can have a rest" (BAMBIS Support Worker)

The Family Nurse discussed the stigma that is often associated with young mothers and how this could lead to potential mental health issues, for example anxiety about whether or not they are a good parent. They also stated that social media has further increased these issues:

"One of the biggest challenges for us is managing social media. We try to do a lot of protection work around that because that impacts mental health...It's awful the things that they share with us that are written on Facebook about their parenting skills" (Family Nurse)

Teenage mothers were reported to often feel pressured to return to education, training or work. It is important that there should be choice, as some young women are happy to stay at home and be a full-time parent, which is particularly important in terms of building attachment and promoting bonding between mother and baby.

"…when we speak to our psychology colleagues, they say it's important to start and build that bond with the baby. It's a contentious subject" (Family Nurse Partnership)

It was also reported that young parents often have transient and volatile relationships with higher levels of domestic abuse and violence being reported by this cohort, requiring a referral to the Multi-Agency Risk Assessment Conference (MARAC). The general vulnerability of young parents, particularly young mothers, was noted by several participants. It was suggested that a specialist young persons' social worker, to work exclusively with young parents, would be a valuable addition to the services available in Liverpool.

"It's usually young mums, but not always, that are vulnerable and might not consider health needs as a priority, they prioritise other areas of their lives" (Family Support)

"I think we come across a lot of mental health issues, which can be low mood, anxiety, depression self-harm" (Family Nurse Partnership)

The stakeholders also discussed very little with regards to young fathers which suggests that the majority of services available to teenage parents are aimed at mothers. The Family Nurse did note that she tended to have more contact with males than females that were engaged in the criminal justice system and that there were high levels of domestic abuse amongst young parents.

Multiagency Working

The Educational Psychologist discussed how multiagency working can often be successful, as long as all of the services involved are equally committed. They did state that facilitating multiagency work is often easier in regards to younger children compared to teenagers when it can be difficult to get all of those concerned to attend meetings due to limited resources. They also discussed how multiagency working can be difficult to facilitate when the young person has challenging behaviour because it can be difficult to determine which criteria they meet and who should have the primary responsibility for working with them.

It was also noted by some stakeholders that because parents and families play an important role in their child's health and wellbeing that they are also a key stakeholder and they should be included in any key decisions, providing their involvement is appropriate.

"We work with the families too because we can't do anything for a young person without consent from the parents" (School Nurse)

However, the LGBT Worker did also discuss how some young people were concerned about their confidentially being broken and as a result were less likely to access services such as their local GP because of this.

The Residential Worker, LGBT Worker and School Nurse cited examples of multiagency working with Brook and Addaction and all had positive experiences of working with these specialist organisations. Furthermore, the Sexual Health Worker discussed how they successfully delivered educational sessions for young parents alongside the delivery of antenatal services. They also discussed referrals to YPAS, smoking cessation and drug and alcohol services and felt very positive about multi-agency working as it meant a sharing of skills and knowledge.

Funding cuts and restraints were recognised as having implications across all of the different types of services.

"Our main challenge is funding. We are a commissioned service so obviously we have got our targets that we have to meet" (Sexual Health Worker)

One stakeholder also spoke about how communication between agencies has changed and that it is not harder to have simple conversations.

"Whereas one time you could pick up the phone and discuss things and now you might be pushed to have to go through a referral process which could take longer. One time you could just have those informal conversations which would be effective. I suppose there's a lack of opportunity to have those" (MYA)

The stakeholders discussed how multiagency working was key in dealing with some of the limitations created by these cuts as it allowed different services to pool resources.

"With the council there are restructures all the time and there's another so many million that has to be saved next year so it's funding cuts. So sometimes you have to think outside of the box a little bit and be a bit creative. Maybe do things that you would normally pass on because that agency isn't there and you have to try and manage it" (Family Support Worker)

Accessing health care

One stakeholder felt that the main health need for young people is the accessibility to health services. It was felt that although there are a number of services within the city for young people to access, they do not all provide an accessible service to young people.

So a lot of health care settings within Liverpool, as they are throughout the country, are not necessarily young people friendly… their health needs tend to be a bit more neglected because people don't know how to access or who to access or may not have a GP.(MYA)

3.3 Assessing a health priority for action

Putting the findings into context: A review of the literature

In order to make effective recommendations for practice, it is important to consider the desktop study and qualitative findings within the wider policy context. The following presents a review of key literature relating to the priority health needs of the target population. This wider evidence builds on findings from the desktop study and qualitative work, and addresses any gaps identified through this process.

Young people Not in education, employment or training (NEET)

As detailed in the quantitative findings, in 2015/16 there were significantly higher levels of young people not in education, employment or training (NEET) in Liverpool compared to the national average. There is a cyclical relationship between health, housing and NEET (McCoy et al., 2015). Those who are NEET are more likely to be at risk of poor physical health, anxiety and depression, social isolation, alcohol and substance misuse and increased risk of suicide ideation (Children & Young People Now, 2015; Goldman-Mellor et al., 2015; Power et al., 2015; Scottish Government, 2015). Males who are NEET are more likely to hold a criminal record than those who are not (PHE, 2014b).

Interventions in the earlier years, especially around supporting education and parental engagement, can lead to reduced levels of young people being NEET and a reduction in anti-social behaviour (McCoy et al., 2015; Menzies and Baars, 2015; Nelson and O'Donnell, 2012; PHE, 2014b). These interventions have been discussed in the literature reviews for the earlier stages of the needs assessment.

The offer of a varied and flexible curriculum, different to school and developed in partnership with young people is important in helping to keep young people engaged with education (Nelson and O'Donnell, 2012; PHE, 2014b). Also important are approaches to ease school-to-work transition. These would include structured and systematic work experience, careers fairs and company visits, entrepreneurship education, vocational training, apprenticeships, volunteering programmes and greater involvement from employers in schools (Nelson and O'Donnell, 2012). Professional advice and guidance should be at the heart of the strategy to engage young people(Nelson and O'Donnell, 2012).

Lack of aspiration, motivation or relevant skills are a factor in the problem of youth unemployment (Naylor, 2015). Employment enhancement programmes (Seddon et al., 2013) and projects such as Talent Match aim to address these issues. Talent Match is a service for young people who are currently NEET, providing personalised support through the use of intensive mentors. Whilst on the Talent Match programme, young people have access to a variety of support including counselling, placements, courses, support in finding and writing job applications and mentor support. The project is currently being evaluated by Liverpool John Moores University.

In addition to raising aspirations and improving skills of young people, it is perhaps more important to promote the role of employers and other agencies in working together to provide good quality opportunities and meaningful career development prospects for young people (PHE, 2014b;

Simmons and Thompson, 2014). 'Youth Resolution' is a proposal for Kite Marked partnership between local authorities, employers and education institutions which would benefit businesses, give young people fair opportunities and help tackle youth unemployment and drive local growth (Simmons and Smyth, 2016; Simmons and Thompson, 2014).

Any developments in policies to reduce the NEET population need to be based on reliable data about the size and composition of this very varied group (Maguire, 2015; PHE, 2014b; Russell, 2013).

Sexual health

In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region and North America for condom use among sexually active young people (DH, 2013). Compared to the total population, young people between the ages of 16 and 24 have significantly higher rates of poor sexual health, including STIs and abortions. Data show that young people in Liverpool have higher rates than the national average for both.

During consultation for the Government's "Positive for Youth" young people's strategy, young people said that removing the stigma from asking for sexual health advice was seen as key to helping them take responsibility and make informed decisions relating to their sexual health (DE, 2011a; DH, 2013). The importance of good quality universal sex and relationships education and youth friendly contraceptive services are noted in the following section on Teenage Parents. Services should follow the government's 'You're Welcome' quality criteria for being young people friendly (DH, 2011; PHE, 2014a). STI testing, in particular for chlamydia, should be offered to young people routinely.

It is recommended that local areas should focus on embedding chlamydia screening for 15 to 24 year olds into a variety of non-specialist sexual health clinics and community-based settings. The focus should be on those which serve the populations with the highest need, based on positive test results. They should also emphasise the need for repeat screening annually and on change of sexual partner; as well as the need for re-testing after a positive diagnosis within three months of initial diagnosis (PHI LJMU, 2016b).

Targeted services are necessary for high risk and vulnerable groups. Opportunities for risk assessment relating to STIs may arise during contraception, pregnancy testing and abortion consultations, when offering an STI test, during routine care and when a new patient registers (CPH LJMU, 2006). Health professionals in general practice, community health, voluntary sector and genito-urinary medicine (GUM) services should identify individuals at high risk of STIs, and provide or arrange one to one sexual health counselling (CPH LJMU, 2006; NICE, 2007c).

Vulnerable groups requiring targeted interventions include care leavers, young people with learning disabilities, young asylum seekers and young homeless people. For example homeless young people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money (DH, 2013). The FPA 'Sleepin' Safe, Sexin' Safe' project aims to increase and improve homeless young people's knowledge of sexual health, working in partnership with the youth homelessness charity Centrepoint and other youth homelessness organisations (DH, 2013; FPA, online).

Teenage parents

Teenage parents and their children are at greater risk of poor health outcomes, for example teenage mothers are more likely to have poor mental health, to be smokers, have low breastfeeding rates and live in poor housing. Their children are more likely to live in poverty and have a low birth weight and higher rates of infant mortality (PHE, 2016). Young fathers are twice as likely to be unemployed, even when accounting for levels of deprivation (PHE, 2015b). Teenage mothers and young fathers are also much less likely than older parents to attend antenatal education (PHE, 2015a).

Over the last 15 years, there has been progress, as the under-18 conception rate has more than halved, to the lowest level since 1969 (PHE, 2016). However, rates in Liverpool are significantly higher than the national average and teenage abortion rates are also high. Further progress is needed narrow the variation in rates between, and within local areas, and improve the outcomes for young parents and their children (PHE, 2016).

It is important to point out that teenage pregnancy and parenthood is not a problem in itself; it is unplanned teenage pregnancies and the negative health outcomes discussed above that can be difficult for young parents to cope with. Interviews with young mothers in a deprived north west area found that they felt motherhood was a positive experience, which provided them with a valued social role (Anwar and Stanistreet, 2015).

Various whole-school health interventions, discussed in the Stage 1-3 HNA reports, are effective in ensuring young people are equipped to choose to prevent teenage pregnancy, in addition to preventing smoking, and bullying and other risky behaviour (Shackleton et al., 2016). Such universal approaches are more effective than targeted approaches to tackle teenage pregnancy (Bonell et al., 2014; Kneale et al., 2013). In addition to high quality sex and relationships education, there is a need for easy access to effective contraception with youth friendly schemes, early access to free pregnancy testing, unbiased advice on pregnancy options and prompt referral to abortion or early antenatal care (NICE, 2014; PHE, 2016).

Research with teenage parents found they valued being recognised as being a *'first-time parent, not just a young parent'* and emphasised the importance of health professionals using techniques such as active listening and building rapport (Norman et al., 2016). Holistic support programmes providing specialist support for young parents, such as the Family Nurse Partnership and Sure Start Plus programmes, appear to improve outcomes for young mothers and their children (Anwar and Stanistreet, 2015; DCSF, 2008; PHE, 2015a; PHE, 2016). These programmes use trusted staff members to assess individual need and provide support for health, benefits, housing, education and employment opportunities. They will also support young parents in preventing further unplanned pregnancies, with one to one sessions, as described under 'sexual health' above (CPH LJMU, 2006; NICE, 2007c; PHE, 2015a; PHE, 2016). All support needs to be provided early, be sustained, involve multi-agency working co-ordinated by a lead professional and needs to be trusted by young parents (PHE, 2016). Staff need to be trained to work with young people and services should be easily accessible and welcoming, with a positive attitude to young fathers (PHE, 2015a). Although improving outcomes for teenage parents saves money in the long term (PHE, 2016), programmes are at risk due to cutbacks in services such as Sure Start children's centres (Anwar and Stanistreet, 2015).

In addition, it is important to tackle wider issues such as financial hardship, lack of appropriate housing or childcare (Anwar and Stanistreet, 2015; PHE, 2016). The availability of good flexible childcare is important to assist young parents to make choices in education and training. Russell

(2015) noted that lack of childcare support and sometimes lack of acceptance that some young mothers choose to stay at home seemed to trigger disrupted educational and employment pathways (Russell, 2015). This was also a comment in the stakeholder interviews for this needs assessment; it is often presumed that young mothers would not want to stay at home with their babies. It is important that there should be choice, as some young women are happy to stay at home and be a full-time parent, which is particularly important in terms of building attachment and promoting bonding between mother and baby (see Stage 1 & 2 stakeholder analysis).

Alcohol, substance misuse and smoking

In Liverpool, hospital admissions for substance misuse amongst 15-24 year olds in 2015/16 were significantly worse than the national average. For alcohol-related harm, although the overall rate of hospital admissions in Liverpool was significantly higher than the national average, the rate for those aged under-18 was similar. The importance of partnership working in reducing alcohol harm has long been recognised in Liverpool (Liverpool City Council, 2011). A recent multiagency focus has been to develop a good working relationship with local licensees and other local partners to encourage the responsible retailing of alcohol to young people and to bring about a reduction in binge drinking (Champs, 2016).

For those young people accessing specialist drug and alcohol interventions, most have problems with alcohol (37%) and cannabis (53%). Most will require psychosocial, harm reduction and family interventions, rather than treatment for addiction, which is usually for adults (NTA, 2017).

Preventive population interventions*:* Prevention approaches for young people are usually not drug, alcohol or tobacco specific but are focused more on reducing risks and increasing resilience (PHE, 2015d). Evidence shows that physical and mental wellbeing, and good social relationships and support are all protective factors (PHE, 2015d). Approaches that build resilience and ensure informed decision making are deemed to be most effective (PHE, 2015d). Young people need to understand basic information about alcohol and other substances and their effects. Harm reduction messages (drinking less, getting home safely etc.) are also important. However, it should not be assumed that all young people drink; around a third of 16-24 year olds do not drink or drink lightly (Mentor, 2013). Education setting interventions are detailed in NICE recommendations and cover further education colleges and sixth form colleges (NICE, 2007a; NICE, 2010b; NICE, 2012; NICE, 2015).

Several important risk and protective factors relate to a young person's family environment. Parents can be helped to deal with alcohol and other issues through simple leaflets and courses focussing on parenting skills (Mentor, 2013).

Community Alcohol Partnerships involve a range of interventions that have had success in reducing underage public drinking by local education and health authorities working together with police, retailers and trading standards (CAP, 2017; Mentor, 2013). Working in such partnerships, local authorities can take a lead on preventive action in the areas of pricing, availability, marketing and licencing review (NICE, 2010a). Pricing interventions are particularly effective, as they have a disproportionate effect on younger drinkers (Loring, 2014).

On preventing the uptake of smoking, local authorities can ensure retailers are aware of legislation prohibiting under-age tobacco sales using various measures, including providing training and guidance on how to avoid illegal sales (NICE, 2008, updated 2014).

Information-only interventions can be just as effective as one-to-one brief interventions in reducing alcohol and cannabis use in adolescents in general (Carney et al., 2016). For young people whose drinking may already cause concern, 'brief interventions' may be a cost-effective way of getting them to rethink risky behaviour (Jensen et al., 2011; Mentor, 2013). However, more research on their effectiveness with adolescents is necessary (Merz et al., 2015). Family-based prevention approaches have been found to be more than twice as effective as approaches that are solely child focused (for example schools-based, peer-based or individual-based)(JRF, 2009). A combination of family- and child-focused approaches is recommended.

Screening should be undertaken by health and social care, criminal justice and community and voluntary professionals in both NHS and non-NHS settings who regularly come into contact with this group (NICE, 2010a). Brief interventions can take place in primary care settings, schools and colleges, or be delivered by youth workers, or they may be triggered through alcohol-related attendance at A&E, which Mentor describe as an 'alarm bell moment' (NICE, 2007d; NICE, 2010a). The particular needs of groups according to gender, ethnicity and other vulnerable groups should always be considered (PHE, 2015d).

For young people identified as having alcohol use disorders or at high risk of substance misuse, more extensive interventions are required, such a cognitive behavioural therapy and family or systems therapy, with family-based, structured support (NICE, 2007b; NICE, 2007d; NICE, 2011a).

Injuries, intentional and unintentional

Road traffic accidents are the most significant cause of unintentional injury for young people. Alcohol use is a significant risk factor for both unintentional and intentional injuries in young people. It is estimated that around 40% of all injuries are attributed to alcohol consumption, in particular among males (EuroSafe, 2010). In Liverpool, the rate of hospital admissions caused by unintentional injuries in 15-24 year olds is significantly higher than the national average.

Examples of effective actions for reducing injury risks for young people include lowering speed limits, promotions of cycle helmets, sports and workplace safety measures, and life skill development programmes in schools and colleges (as described under the above alcohol heading) (EuroSafe, 2010). Public Health England suggest steps for improving safety for young and novice drivers and riders. However they point out that travel independence of young people can be supported by local authorities through creating safe environments, with the provision of safe cycling and walking facilities, and improved access to public transport, including travel passes (PHE, 2014c). Children and young people who live in more deprived areas are at a much greater risk of injury than those from the most affluent areas (PHE, 2014c). It is important to support action on child poverty, as outlined in the Liverpool City Region Child Poverty Strategy (Liverpool City Region, 2011). The provision of

good housing in safe neighbourhoods with access to green spaces will help to reduce injury risks for children and young people.

Intentional injuries include self-harm and interpersonal violence (EuroSafe, 2010). Self-harm is a growing problem amongst young people in the UK, with hospital admissions due to self-harm increasing by 68% between 2000 and 2010 (YoungMinds, 2011). For the prevention of self-harm and suicide, school and college-based programmes can improve knowledge, attitudes and help-seeking behaviours and help the development of coping skills (CPH LJMU, 2010). Training for 'gatekeepers' in contact with at-risk groups and supporting and treating those at risk have been shown to be effective. For suicide prevention, community interventions such as the use of safety fencing and signposting to support in hotspot areas, and media guidelines, can also be effective in helping to reduce suicide rates (CPH LJMU, 2010). NICE guidance on self-harm covers psychological interventions and harm-reduction approaches (NICE, 2011b).

Emotional health and wellbeing

Young people aged 16-19 are a group undergoing major life transitions such as leaving home, entering the world of college, university or work, or suffering from an uncertain employment situation (ACEVO, 2015; PHE, 2015c). Many in this age group will have the stress of undergoing exams. These factors can lead to depression, anxiety, sleep problems and in extreme cases, self-harm, as discussed under the previous heading. Related to self-harm issues are young people's concerns with sexual orientation, gender identity and body image, which have been discussed in the literature review for Stage 3 of this HNA.

Promoting and strengthening young people's resilience and ability to cope are just as important as delivering services that deal with problems once they have arisen (PHE, 2014a). Schools and colleges should ensure that they provide an emotionally secure environment that provides help and support for children and young people (NICE, 2009; PHE, 2014a). It is important to empower young people in educational settings by giving them the skills they need to develop healthy relationships, for example, by providing opportunities within the curriculum to teach relationship skills (PHE, 2014a). Children should feel that they can easily access someone to turn to when they need support, which can help to prevent small problems developing into more serious ones which become more difficult to deal with.

Social isolation: Relationships with friends, family and a sense of belonging are central to young people's health and wellbeing (PHE, 2014a). Loneliness is a recognised problem among the elderly, but studies have overlooked the loneliness epidemic among younger adults (the guardian, 2014). A Mental Health Foundation survey found that 57% of 18-34 year olds said they felt lonely often or sometimes, compared to 35% of those aged 55 plus (MHF, 2010). The major life transitions experienced by those aged 16-19 can lead to isolation and involve added stress for some groups, for example the families of those in the armed forces may be particularly affected by multiple moves (DH, 2015). The risk factors for social isolation among young people can be from life events or socially ascribed identities, such as those related to gender, ethnicity, sexuality, physical appearance or socioeconomic status (PHE, 2015c), with the fear of ostracism often acute amongst this group

(MHF, 2010). Social media and the internet can be a boon and a problem and for some, comparing friends' seemingly perfect lives with their own can lead them to withdraw socially (the guardian, 2014). Those especially at risk of social isolation include immigrants, the unemployed or NEET, lone parents, those with long-term mental health problems and disabilities, carers, teenage parents and people living in poverty (Children & Young People Now, 2015; MHF, 2010; PHE, 2015c). Social isolation and loneliness can have harmful effects on physical and mental health. If related to social exclusion, it can also lead to aggressive behaviour and phenomena such as gang crime and extremism (ACEVO, 2015).

It is important to develop and use methods to engage local communities in developing interventions to strengthen mental wellbeing (UCLAN, 2010). A recent report into loneliness amongst young people noted the need for initiatives to build young people's resilience, self-esteem and social skills, to prevent them from entering into anti-social, destructive patterns of thinking and behaviour (ACEVO, 2015). It was recommended that local authorities ensure that loneliness among all age groups features in their Joint Health and Wellbeing Strategy (JHWS) and Joint Strategic Needs Assessments (JSNA). They also need to adopt a long-term approach to young people's commissioning, taking into account the savings to be made through preventative youth work. It is also important to incorporate loneliness prevention and alleviation strategies into Public Health services and built environment strategies, ensuring that young people have places to go where they feel safe and included (ACEVO, 2015).

There are numerous examples of voluntary sector schemes that are helpful in equipping individuals and communities to combat loneliness, both through alleviating loneliness and providing the skills to prevent it (ACEVO, 2015). Community-based approaches to tackling loneliness involving peer to peer support are particularly effective. Local authorities can better support the voluntary sector to deliver the help needed through more long-term commissioning. Helplines and counselling can help in many cases (ACEVO, 2015). Interventions with 'at-risk' groups include those targeting young offenders, for example the St Giles Trust 's SOS project, which "aims to re-integrate into social networks isolated individuals who are ex-offenders or who are at risk of offending, through provision of personalised, holistic support across areas such as housing, education and training according to the particular needs and aspirations of the individuals" (PHE, 2015c).

Homeless Youth

Changes to the welfare system, poorer access to affordable and supported housing and cuts to support and youth services have all adversely affected young people. Without early intervention or support, homelessness can impact on education, employment and health and wellbeing (Homeless Link, 2015). It is important to take steps to ensure these services are not further cut. The most effective preventive approaches are education and mediation. Schools colleges and youth services should aim to increase resilience with the provision of life skills training, including budgeting, cooking, tenancy training and sexual health knowledge (FPA, online; Homeless Link, 2015). Homeless Link set out a Positive Pathway approach which has been used by several local authorities. The Positive Pathway sets out a clear framework for statutory and voluntary sector organisations to provide support for young people to prevent homelessness and provide a range of suitable housing options and support. Joint working between housing and children's services is encouraged and every local authority should have a local strategy outlining how they will provide accommodation for

young people at risk. In addition to housing related support, this would include provision of low cost move-on accommodation and schemes to assist this including rent deposit and bond schemes. There should be financial support to assist young people to travel to work, education and training destinations (Homeless Link, 2015).

Young carers

Liverpool has significantly higher levels of young people providing unpaid care aged 16-24 than nationally (PHI LJMU, 2016a). Young carers are those who care for family members to such a level that their emotional and physical responsibilities negatively impact on their own development. Being a young carer can have detrimental effects on young people, including problems at school, health problems, emotional difficulties, isolation and lack of time for leisure (Frank and McLarnon, 2008). It is important to intervene early, working in a multi-disciplinary way with schools and organisations already in touch with the family, using a whole-family approach that takes into account both the needs of the adult requiring care and the child (BLF, 2013; The Children's Society, 2012). Services should provide an opportunity for young carers to be themselves, focussing on them as young people and not as young carers (BLF, 2013). Young carers projects or similar direct services made available through local targeted youth support are effective (Frank and McLarnon, 2008). Local authority commissioners can link with the voluntary sector organisations that work to provide support for young carers (including Action for Children, Barnado's, Carers UK, and the Children's Society). As with other young people in transition to adult services, transition planning is important for young carers as they become adults, to ensure that they continue receiving support (as outlined under 'Transitions' below) (NICE, 2016).

Transitions

It is important to ensure that vulnerable young people do not become disengaged from support services as they move from children's to adult services (NICE, 2016). Those at risk include care leavers, young offenders, young carers and young people with mental and physical health problems. For example a local study on transitional care to adult Attention Deficitit Hyperactivity Disorder (ADHD) services in the Liverpool area found that as many as 73% (almost three quarters) of patients eligible for transition to adult services were either discharged or lost to follow-up (Ogundele, 2013).

The risk of disengagement can be reduced by carrying out transition planning, ensuring that it is tailored to the young person, addresses any lifestyle changes, involves their GP and includes information and signposting to non-statutory services (NICE, 2016). Transitions can be improved by:

- planning early, involving all related agencies,
- involving young people in equal partnership, and their families where appropriate,
- providing appropriate and accessible information,
- providing a more holistically focussed, 'young people friendly' adult services,
- using a transition co-ordinator and
- using joint commissioning

(LPHO, 2015; NICE, 2016) (PHE, 2014a)

A gap analysis would help to identify continuing needs, as described in recent NICE guidance (NICE, 2016).

In mental health, rather than the usual transition at the age of 18, it has been suggested that commissioners should consider approaches which view young people aged 16-25 as having distinct needs, providing holistic care to meet mental and physical health needs and support around relationships, education and employment (MHF, 2014). These services should be based on the model adopted by many UK Early Intervention in Psychosis Teams and some general mental health teams and voluntary counselling agencies, which offer a distinct service for young people up to the age of 25 (LPHO, 2015; McGorry P. et al., 2013; YoungMinds, online).

4.Discussion & Recommendations

Young people aged 16-19 can experience major life transitions during their late teens including leaving school. entering college, university or work and leaving home (ACEVO, 2015; PHE, 2015c). Understanding the experiences and outcomes for young people is essential in ensuring that vulnerable young people do not become disengaged from support services as they move from children's to adult services (NICE, 2016).

The focus groups with young people generated discussions regarding understandings of their health needs and knowledge of where to access healthcare. In general the young people had a good awareness of where to seek different types of healthcare support including school and college (inclusion team, a guidance counsellor and a school nurse), youth club, sexual health services, mental health services, substance use support, GP and other health services. They also discussed services working together, with specialist services providing education and support in schools and colleges. Stakeholders also acknowledged the good multiagency working that is currently being undertaken in Liverpool, but recognised that facilitating multiagency work can be difficult due to limited resources, and when working with young people with challenging behaviour to ensure one service takes the lead responsibility for their care.

In general, stigma, fear of judgement, travel, waiting times and confidentiality were seen as barriers to not accessing healthcare, especially when seeking support for mental health and sexual healthcare. Whilst stakeholders agreed that there are a number of services to support young people, accessibility was still an issue for some young people. School was seen as important place for immediate support; however young people did have concerns around confidentiality and stigma attached to discussing anything around mental health. Both groups felt schools and colleges were a good place to get the information across about where to access help for physical and mental health, and felt that health promotion around mental health and sexual health needs to be delivered in smaller groups with information around real life experiences and interactive options to suit different learning styles. The young people liked the anonymity of websites that offer counselling and support online, but did have concerns around using reliable information.

Young people aged 16-19 are a group undergoing major life transitions including exam stress, leaving home, entering college, university or work, or suffering from an uncertain employment situation (ACEVO, 2015; PHE, 2015c). Mental health was a prominent discussion during the focus groups with young people and highlighted as a key health concern for this age group by stakeholders. The young people talked about experiencing exam stress and problems at home which they felt could impact negatively on their mental health. The young people did think whilst there is still a stigma attached to mental health, especially though media portrayal, they did believe that their generation had better awareness through education and talking about mental health.

Guidance highlights the importance of early intervention and young people having someone to talk to before smaller problems become more serious and more difficult to deal with (PHE, 2014a). The young people had a good knowledge of where to seek support and talked about the importance of having someone to share your concerns with and the impact of not having a support network. The young people had good awareness of support services available to them and they discussed specialist services such as CAMHS, they did however voice concerns over waiting lists and thought that such services were difficult to access for low level mental health issues. The young people

acknowledged that this was a concern as mental health can deteriorate. The stakeholders shared these concerns.

Evidence recommends promoting resilience in young people to help build protective factors (PHE, 2014a) with the young people at the focus group supporting this notion, and agreeing that they felt better equipped to deal with challenging situations if they had a good positive mental attitude. Schools and colleges should ensure that they provide an emotionally secure environment that provides help and support for children and young people (NICE, 2009; PHE, 2014a). The stakeholder interviews demonstrated the link between mental health support and educations, with CAMHS providing support to schools and the YPAS having a designated mental health worker for college students. However the young people at the focus groups were less likely to seek support through school due to embarrassment of sharing their problems with teachers.

Relationships with friends, family and a sense of belonging are central to young people's health and wellbeing (PHE, 2014a). The major life transitions experienced by those aged 16-19 can lead to isolation and involve added stress for some groups (DH, 2015). Both the school and youth groups said they would seek out friends and peers they knew who were knowledgeable about topics, with examples given of people at the gym or in sports teams who would be able to give advice about diet and exercise and friends and classmates who were sexually active who would be able to advise about sexual health. Both the school and youth club groups felt their health can be influenced by friends and who they choose to spend their time with. The behaviour of the people around them was thought to have an impact – both in terms of lifestyle factors and risk taking (i.e. smoking and antisocial behaviour) and outlook on life, aspirations and ambitions. Some friends were viewed as a positive, protective influence and some friend as negative. The whole group agreed this could have a strong influence. It is important to develop and use methods to engage local communities in developing interventions to strengthen mental wellbeing (UCLAN, 2010). A recent report into loneliness amongst young people noted the need for initiatives to build young people's resilience, self-esteem and social skills, to prevent them from entering into anti-social, destructive patterns of thinking and behaviour (ACEVO, 2015).

Young people aged 16-24 are more at risk of poor sexual health, and Liverpool has higher rates than the national average for sexually transmitted infections. The young people at the focus groups recognised that healthy relationships and good sexual health are an important aspect of a healthy lifestyle. Policy recommends good quality universal sex and relationships education that reduces stigma and promotes informed choice (DE, 2011a; DH, 2013). Stakeholder interviews discussed the provision of sexual healthcare including clinical services and educational sessions, and the importance of promoting confidence and resilience for young people to develop their own personal awareness. The focus group facilitated at an all-girls school felt that sexual health was frequently discussed through good quality PSHE lessons and sexual health education events at school. All young people had good awareness and knowledge of young person specific sexual health services and how to access sexual healthcare. However it was felt that school nurse healthcare provision for sexual health support should be more positively promoted to encourage young people to seek advice at school.

The importance of partnership working in reducing alcohol harm has long been recognised in Liverpool (Liverpool City Council, 2011). Prevention approaches recommend education and support to reduce risk and strengthen resilience through the promotion of good physical health, mental

wellbeing and social relationships (PHE, 2015d). Substance use specific support is provided through supporting schools in Liverpool, to deliver education and provide support for young people. The stakeholder interviews demonstrated that substance misuse services and schools have developed relationships and schools are becoming more proactive in making referrals for students. Support is also provided via substance misuse services through school for the young people's parents, which fits in line with recommendations around reducing risk and promoting protective factors for young people through family based approaches that also support parents to improve their parenting skills (Mentor, 2013). The young people discussed the support available to them through services providing education at school.

This section of the HNA also looked at young parents as a seldom heard group and health priority group. Teenage parents and their children are at greater risk of poor health outcomes, for example teenage mothers are more likely to have poor mental health, to be smokers, have low breastfeeding rates and live in poor housing. Evidence suggests that the children of teenage parents are more likely to live in poverty and have a low birth weight and higher rates of infant mortality (PHE, 2016). Over the last 15 years, the under-18 conception rate has more than halved, to the lowest level since 1969 (PHE, 2016). However, rates in Liverpool are significantly higher than the national average and teenage abortion rates are also high. Evidence suggests that in addition to high quality sex and relationships education, there is a need for easy access to effective contraception with youth friendly schemes, early access to free pregnancy testing, unbiased advice on pregnancy options and prompt referral to abortion or early antenatal care (NICE, 2014; PHE, 2016).

Althought attempted, it was not possible to speak with any young parents during the focus groups, however stakeholders discussed the targeted interventions provided in Liverpool for young parents including enhanced midwifery services for young vulnerable mothers and the Family Nurse Partnership for providing parenting support. Research with teenage parents found they valued being recognised as being a 'first-time parent, not just a young parent' and emphasised the importance of health professionals using techniques such as active listening and building rapport (Norman et al., 2016). Similarly to findings in report 1 (conception to first 1,000 days), low uptake of breastfeeding was seen as a high priority for this age group, and the importance of discussing the benefits of breastfeeding with young people was seen as a priority. Again, corresponding to report 1, mental health was seen as the other key issue for young mothers. Stigma of becoming a young parent, alongside anxieties of becoming a new parent, and underlying issues such as existing mental health conditions and substance misuse were seen as having a negative impact of expectant and new mothers. Stakeholders also felt that young mothers can feel pressured to return to education or employment and whilst this is encouraged, the option of being a 'stay at home mum' should not be discouraged. The stakeholders also discussed very little with regards to young dads which suggests that the majority of services available to teenage parents are aimed at mothers.

Recommendations

- Transition from children to adult's services was highlighted as a potential risk through this research. Potential young people who may be most vulnerable from becoming disengaged with services include care leavers, young offenders, young carers and young people with mental and physical health problems. A gap analysis could be undertaken to identify the extent to which young people are supported through transitions across key services.

- Whilst young people described their knowledge of where to access healthcare, many felt there were a range of perceived barriers. Issues such as travel, location, cost and waiting times were specific issues raised here. Public health programmes should ensure that access to services is equitable, in terms of location and cost, with awareness-raising and education programmes addressing these issues. Stigma, judgement and waiting times for mental health and sexual health support were seen as barriers to service access for some young people; whilst it may not be feasible to increase capacity within existing services, the role of community organisations should be explored and maximised here, particularly for young people requiring low-level mental health support. Sexual health education should continue to reinforce messages to ensure young people feel reassured that they will not be judged when they arrive for support.
- As with the findings from Stage 3 of this HNA, mental health was highlighted as a key concern for this age group, although the contributors to poor mental wellbeing were slightly different for this age group than for the younger age group. Exams and problems at home were highlighted as key causes of stress and anxiety for the young people in this stage of the research. Young people and stakeholders expressed concerns around provision for low level mental health issues including stress. Mental health provision for early intervention and lower level mental health concerns does appear to be limited. The young people also described a stigma attached to mental health problems. It is important for schools and colleges to work with external services and community organisations to improve identification and early intervention support for mental health, and it is vital that parents are included within this. More awareness of school nurses and guidance counsellors needs to promoted within schools, with the reassurance that support is free and confidential. Development of sessions to help build the resilience to promote protective factors and decrease risk is also recommended, for example improved confidence and self-esteem. PSHE sessions were highlighted as a good source of education and could provide further education and support.
- Similar to recommendations in Stage 3, a holistic approach to mental health should be encouraged, with a focus on understanding the role of community organisations in supporting resilience, confidence building, self-esteem and coping strategies, particularly where resources are limited amongst existing CAMHS arrangements.
- This research highlights the role of friendships and social support, citing community groups (including youth groups and sports) as central to this. Stakeholders should work holistically to ensure that local community groups are available and accessible to young people, and that young people are aware of their existence.
- The use of community groups as settings in which to develop and deliver interventions should be maximised. Local stakeholders (including public health organisations, voluntary groups and other relevant organisations) should work to understand the assets available within their local areas and work with stakeholders to develop and deliver interventions within such settings.
- Peer support has been highlighted as central to providing mental health support, particularly regarding social isolation. Local authorities should work collaboratively with voluntary groups to identify opportunities to engage young people in delivering and engaging with peer support.
- Levels of homelessness are a clear issue within Liverpool, affected by changes to the welfare system, and poorer access to affordable housing. Early prevention measures should be put

in place to protect young people from these issues, including joint working between housing and children's services, and support to assist young people to travel to work, education and training destinations.

- As with stage 3, young carers were identified as a priority population group for Liverpool. Evidence has suggested that many young carers can remain hidden. Organisations should work to understand and identify the extent of young carers in Liverpool. Work with community groups could help identify young carers and the types of support they need. Work should be joined with statutory support, schools and community organisations to ensure that appropriate support is given to young carers.
- The young people praised the education workshops from external services including sexual health and substance use support. However, they did express a need for smaller group work and a focus on alternative delivery techniques to suit different learning styles. Interactive novel sessions, group work and talks from people with real life experiences were all suggested. Young people appeared to forget information conveyed in health promotion sessions, so it is important that sessions are repeated on a regular basis
- Whilst the majority of young people used the Internet for information, they had concerns around reliable information and mixed messages. Further education on how to differentiate between reliable and unreliable online information is recommended, alongside signposting to local and national support websites. This should be delivered alongside any interventions delivered in setting such as the school and the community.
- When working with young parents it is important that they feel listened to as new parents. The holistic services providing parenting support were praised, however further support for young fathers may be needed. Further research with this group would help understand additional needs. Wider issues such as financial hardship, housing and employment should also be tackled.

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