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Young People – Alcohol & Sexual Risk Taking Project in the North East

Briefing for Commissioners

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Young People – Alcohol & Sexual Risk Taking

1 Background

This piece of work was commissioned by Government Office North East in November 2009 with the aim of producing a regional toolkit addressing issues surrounding young people involved in risky behaviours (specifically alcohol misuse and sexual risk taking).

Methods utilised for the project involved interviews with key stakeholders, focus groups with front-line staff, focus groups with young people in various settings (particularly those deemed to be vulnerable/at risk) and a full literature review of the academic evidence base alongside examples of evaluated and promising practice.

A regional toolkit has been developed, which is based on the academic literature review coupled with the regional qualitative work. This briefing document is one element of this regional toolkit. It is designed for local commissioners of services for young people engaged in risky behaviour (e.g. substance misuse commissioners and teenage pregnancy commissioners).

2 Purpose

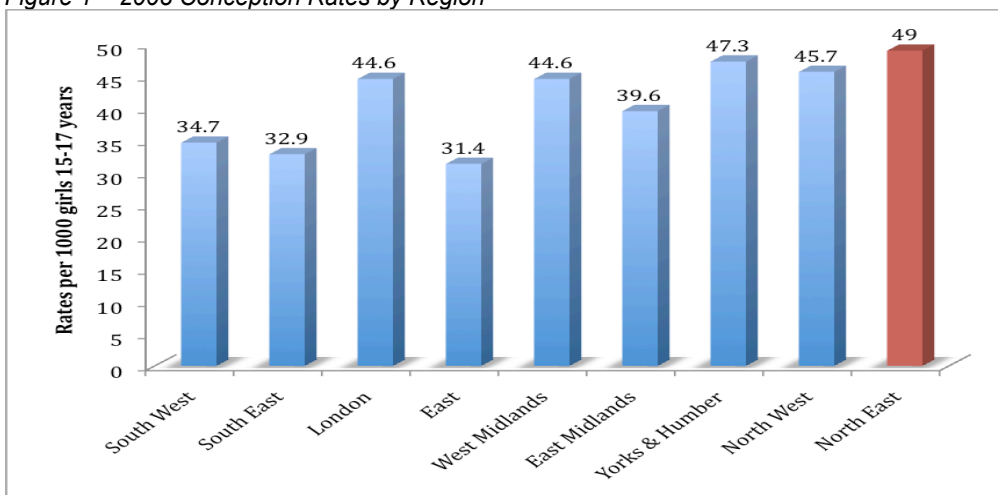
The purpose of this briefing document is to summarise the key relevant points that have arisen from the work that are likely to be of interest to commissioners. This includes an overview of risk and resilience, identified risk factors and examples of both evaluated and promising service delivery models. The evidence in terms of the link between alcohol and sexual risk taking is explored more fully in the Literature Review.

3 North East Prevalence – Alcohol & Sexual Risk Taking

The North East region has the highest levels of alcohol misuse when compared with other areas of the country and particularly high rate of alcohol misuse amongst under 18s (NWPHO, 2007).

The region also has the highest number of teenage conceptions in comparison with the UK average, the regional rate being 21% higher than the national average. This position has been static for the last 10 years, despite a commensurate reduction (across all UK regions) of 13.3%.

Figure 1 – 2008 Conception Rates by Region



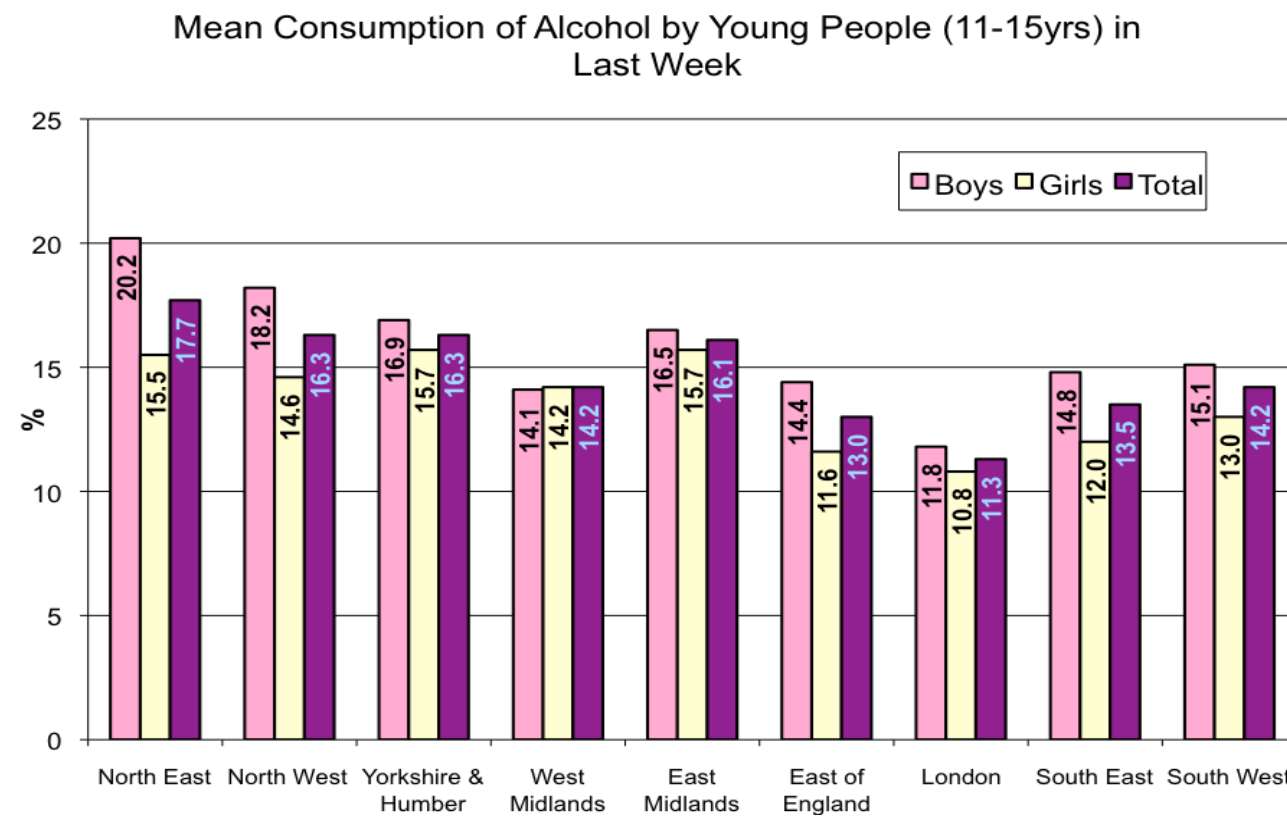
Partnership activity within the region varies significantly, with one partnership being 10% lower than the national average and another being 62% higher (in 2008 baseline). In general terms the majority of partnerships (11 out of 12) in the North East have shown a reducing trend since the 1999 national strategy. The overleaf table shows the change over the last 10 years broken down by partnership:-

Figure 2 - Change in Conception Rates between 1999-2008 by North East Partnerships

Partnership	Percentage Change between 1999 and 2008
Darlington	Reduced by 20.1%
Durham	Reduced by 10.7%
Gateshead	Reduced by 13.8%
Hartlepool	Reduced by 12.9%
Middlesbrough	Reduced by 22.1%
Newcastle	Reduced by 4.4%
North Tyneside	Reduced by 16.9%
Northumberland	Reduced by 17.4%
Redcar & Cleveland	Reduced by 18.8%
South Tyneside	Reduced by 21.7%
Stockton	Increased by 9.7%
Sunderland	Reduced by 16.4%

The below chart illustrates the prevalence of alcohol misuse amongst young people, clearly showing the North East region as the highest in comparison with other regions in the UK (NHS, 2010).

Figure 3 – Prevalence of Alcohol Consumption



4 Understanding Risk & Resilience

A number of theories have been developed to try and explain why some young people exhibit a greater propensity to risk taking than others.

Up until fairly recently the most dominant theory has been 'Problem Behaviour Theory'. This theory suggests that three aspects of a young person's make-up determine their inclination towards risk taking: the personality system, the perceived environment system and the behaviour system. It is suggested that the interaction between these three psycho-social influences determines an individual's propensity to take risks. This model has appeared to be successful in predicting risk behaviour for drug use, alcohol misuse and sexual activity in a range of empirical tests (Rayna et al, 2006)

While the term 'risk' implies the possibility of a negative outcome, young people experiencing risk factors are not inevitably on a pathway to exclusion later in life. This is because young people can develop resilience to risk through exposure to protective factors.

'Experiences in adolescence will be both positive and negative, and specific factors in young people's lives can protect them from risks they may face. Importantly, their experiences during the teenage years combine to shape their character, their personal attributes, and their level of resilience.'

(DCSF, 2007)

Research shows that many individuals who display one or more risk factors do not partake in risky behaviour and that this may be due to the strong co-presence of protective factors that effectively militate against the risk factors (Durlak, 1998).

It is now understood that protective factors do not have to be 'opposite' to particular risk factors to promote resilience. Indeed there is a shift from seeing prevention as needing to be focused on particular and/or independent problems to recognition that improving protective factors per se is effective in reducing risk (Coomber, 2004).

It is known that protective influences exist in various spheres of young people's lives – at home, at school, in the community – and in the personal characteristics which they inherit or acquire, such as intelligence, language skills, behaviour and attitudes. It is also known that the more protective influences that are in place the greater the chance of young people developing the resilience they need to avoid negative outcomes in later life (Coomber, 2004).

Definitions of risk and protective factors

- Risk factors are personal attributes or situational and/or environmental contexts that increase the likelihood of engaging in a behaviour (or the extent to which they engage in this behaviour) which adversely affects an individual.
- Protective or resilience factors are personal attributes or situational and/or environmental contexts that buffer, reduce or inhibit the behaviour in question.

5 Key Risk Groups (Alcohol & Sexual Risk Taking)

It is imperative for commissioners of services to understand the key target group for whom services are being provided. Whilst the majority of this work is, and should be, delivered as part of core universal services, there are certain 'groups' of young people who are more likely to become engaged in alcohol misuse and sexual risk taking.

By analysing various individual streams of evidence around risk factors indicating propensity towards substance misuse, teenage pregnancy, poor sexual health etc. it is possible to clearly see the most prominent risk factors which suggest young people are at higher risk of alcohol use and sexual risk taking (Kenny, 2010). There are identified as follows:-

- Young people from socially disadvantaged backgrounds
- Young women who binge drink
- Boys and young men who have disengaged from SRE
- Young people from certain BME communities
- Lesbian, gay, bi-sexual and transsexual young people
- Looked after children and young people and those leaving care
- Students
- Young people who have been sexually abused
- Young people who are excluded or have disengaged from school
- Young people who have been sexually abused
- Young people who have behavioural, mental health or social problems
- Young people who have been in contact with the criminal justice system
- Homeless young people
- Those involved in commercial sex work

6 Key Protective Factors

Using the same methods as in section 5 above the combined evidence suggests the following protective factors:-

- Positive emotional wellbeing
- Positive attitude to health, including sexual health
- High self esteem, including positive body image
- Warm supportive relationships with parents and/or other trusted adults
- Access to confidential information, advice and support
- Engagement with education, training or work
- Engagement with leisure activities involving positive peer influences
- Social and emotional literacy and life skills
- Knowledge of sexual health and contraception, including access to appropriate services

7 Teachable Moments

Commissioners have finite resources and therefore need to consider, on the basis of local need how resources are best placed. In addition to factors such as geography (e.g. targeting hotspots with limited health provision) some clear 'teachable moments (i.e. potential timely opportunities for interventions) have been identified throughout this work. The most common ones are highlighted as follows:-

- At crisis points (e.g. young people accessing A&E, emergency contraception, pregnancy terminations etc.)
- Transition from primary to secondary school
- Entering/leaving care
- After witnessing an incident (e.g. friend becomes pregnant/has alcohol overdose)
- SRE/PSHE in universal settings
- Transition from schools to colleges

8 Practice Implications & Service Delivery Models

Various models of service delivery and examples of practice have been identified which address the risks associated with the target group of young people either specifically or in a generic way (Kenny, 2010). These are primarily taken from evidence-based practice. The Literature review contains examples of service delivery within these models (both evaluated and 'promising')

Model	Key Features	Evidence Base
Comprehensive and holistic programmes of SRE linked with PSHE in schools	<p>Life skills-based education differentiates itself from skills-based health education in the content of topics that are covered. Skills-based health education focuses on health; whereas life skills-based education concentrates on a number of topics such as human rights, citizenship, and social issues such as health. Life skills education also includes communication and listening skills; negotiation and refusal skills; decision-making and problem-solving skills; and coping and self-management skills, such as increased self-esteem and the ability to manage feelings and stress. It may also include condom and contraceptive use, the ability to obtain condoms and other preventive measures from service providers, and the ability to negotiate their correct use with sexual partners.</p> <p>It has been found that effective sex and relationships education is based on a life skills approach, rather than a narrower health education approach.</p>	World Health Organisation, 2003
Positive Leisure Activities	Aiming High emphasizes the role of the youth service in providing positive leisure activities which may reduce the likelihood of risky behaviours, including alcohol misuse and risky sex.	DCSF (2007)
An active role for the Youth Service and Targeted Youth Support	<p>It is recognised that the Youth Service has an important role to play in tackling sexual health and identifying those at risk of risky sexual behaviours. The 2008/9 Teenage Pregnancy Unit Report suggested that mechanisms should be put in place to identify those at risk of teenage pregnancy, particularly within Targeted Youth Support and Integrated Youth Support services. In particular it has been suggested that:</p> <ul style="list-style-type: none"> ○ The Youth Service has a critical role in early identification of risky sexual behaviours ○ SRE and contraceptive/sexual health services could be integrated into Integrated Youth Support Services ○ Youth Support services can provide outreach and in-service support to young people's sexual health services ○ SRE and contraception outreach work can be integrated into positive activities programmes ○ <i>Targeted work with boys and young men. Research suggests that positive activities can create environments and situations where young men feel they can demonstrate masculinity in a positive way rather than through unhealthy behaviour such as binge-drinking.</i> <p>Third sector youth services can play an important role in supporting statutory services to engage more effectively with young people as they are often well placed to reach marginalised young people, often because they know their communities and have already established trust.</p>	<p>Teenage Pregnancy Unit (2009)</p> <p>DeVisser (2009)</p> <p>DCSF (2007)</p>
On site and outreach services: schools and community settings	<p>The Teenage Pregnancy Unit has recommended that contraceptive and sexual health services which provide a range of contraceptive methods and advice on sexual health, to be available to all young people through on site health services in schools and community services. Example of this kind of on-site service are given in the full Literature Review.</p> <p>A 'hub and spoke' approach to the delivery of sexual health care can provide a framework for good links and communication between the different service providers. The central mainstream 'hub' could provide the management and coordination to the other specialist services and partners ('spokes').</p>	Teenage Pregnancy Unit (2009)
On site and outreach services: further education settings	<p>As previously indicated in the last section, students are a high risk group. Further education providers therefore can play an important role in supporting young people with access to information, advice and services that can support them at this time of transition and change.</p> <p>Some further education providers are already offering sexual health services on-site, and feedback from young people, parents and governors has been positive (See</p>	Teenage Pregnancy Unit (2009)

Model	Key Features	Evidence Base
	Examples of Practice in Appendix 4). At a basic level one-site sexual health services in FE can include referral and signposting to off-site services. At a more advanced level it can include on-site drop-in clinics providing contraception and testing services. Providing access to sexual health services in further education settings is increasingly seen as an important preventative and cost effective approach.	
One-Stop Shops	A key recommendation in the National Sexual Health and HIV Strategy was the provision of more comprehensive and integrated sexual health services, including 'one stop shops' (OSS). 'One-stop shops' referred to the provision of sexual health services on a single site. There was no clear consensus on whether one provider should manage care (and who that provider should be) or whether different specialists should be housed in the same building. In 2003, the Department of Health (DH) commissioned an evaluation of three models of 'one stop shops', fuller details are contained within the Literature Review.	DoH (2001) DoH (2008)

9 Interventions for Parents/Families

Parents and families are pivotal and all commissioned services should take account of the wider family functioning as part of the 'Think Family' agenda.

Recent surveys with young people unanimously conclude that parents remain the first port of call for young people with regards to issues around sex and/or alcohol.

The 'teachable moments' identified in Section 7 can be equally applied to ensure those same opportunities for interventions with young people are actively used to promote parallel messages to parents.

Local parenting commissioners and parenting strategies are the centre point for this work and links across are essential to ensure this element forms part of a wider work programme in each partnership area for parents and families.

Commissioners may find it helpful to consider a 'tiered approach' for family support (which would, in effect mirror the wider approach for parenting support in most local partnerships). This might look as follows:-

A Tiered Approach to Commissioning Services for Parents/Families

- Tier 1 (Universal/Generic) – services within this tier would include basic advice/information/awareness to parents through school parents evenings, marketing campaigns and generic health settings
- Tier 2 (Targeted Work) – this work would focus on those parents who can be classified as 'hard to reach' and may not attend school parents evenings and are less likely to receive messages through generic/universal settings. The use of Parent Support Advisors could be utilised to work with such families along with evidence-based parenting skills programmes, parenting orders/contracts through the YOS etc.
- Tier 3 (Specialist Family Work) – This work (which may already be commissioned) would involve crisis intervention services for families most at risk.

The Department for Children, Schools & Families have recently produced non-statutory guidance (DCSF, 2010) which replaces their previous guidance (October 2006) which incorporates subsequent developments in parent and family services including the national roll-out of 'Think

Family' working between children's and adults services, and targeted parent and family intervention.

It is of particular importance to commissioners, with Chapter F being specifically dedicated to commissioning parenting support and family services.

10 Integrated Commissioning Approaches

One of the key barriers identified by stakeholders during the process of this project was the lack of integrated strategic/governance arrangements which address risk taking behaviours in a holistic way.

Whilst there are benefits in terms of achieving a *dedicated* focus to commissioning single work areas (e.g. teenage pregnancy), the consequences of this approach can sometimes lead to fragmented commissioning arrangements which become complex to join together.

Many partnerships have commissioning managers who are responsible for single work areas (e.g. substance misuse) although a few have ventured along the path of commissioning across a range of vulnerabilities.

Regardless of the commissioning setup within individual partnerships commissioners may wish to consider:-

- How does my commissioning strategy fit with other (related) commissioning strategies for young people?
- How can targets and key performance indicators be more aligned to assist front-line services to work more holistically with young people?
- Is there a way to jointly performance manage commissioned services with other (related) commissioners to send a clear message to service providers that there should be seamless integration between cross-cutting agendas (i.e. risk areas)?
- What influence can I have on universal/generic settings to ensure preventative/low threshold work with young people is fully resourced?

11 What Young People Said

As part of this work a consultation exercise was carried out with 6 different groups of young people (a total of 64 young people) including groups from the youth service, young offenders, teenage parents and young people disengaged from education and employment.

The key messages from this consultation of specific relevant to commissioners are as follows:-

- Male and female young people of all ages suggested they would talk to family or friends first if they needed sexual health advice.
- Many of the younger people felt able to trust their key worker or other support worker to give them confidential advice and support about sexual issues, for example E2E worker, a Connexions worker, a youth worker and a social worker
- Young women and younger men were more likely to seek specific advice about contraception and sexual health from a sexual health clinic than older young men who were more likely to go to a GP.
- Some older young men still looked to partners for help in accessing contraception

- Discussing alcohol use was viewed by many young people as more sensitive than sexual activity and contraception needs and there appeared to be a greater resistance to talking to family and friends about drinking than there was about sex
- A significant number of young people said they would use the internet to get information as it would be confidential.
- 'Talk to Frank' was seen as a valued first port of call in gaining information about alcohol use. It was thought that a similar model could be developed regarding sex education and the awareness of risks associated with drinking and unprotected sex.
- There is no one place designed to raise young people's awareness of the likelihood of unprotected sex after drinking alcohol, and it would depend on who the young person trusted most.
- Higher profile advertising is needed– not just 'getting the message across', but publicising information about how to access local services and in places where young people would see the information – especially those who did not attend youth clubs or projects or are not in contact with other services.
- The majority of young people didn't think there was anything that could be done to stop young people drinking and having unprotected sex, although it was important to keep raising awareness of the risks involved.
- It is important for young people to stay engaged with school and get involved in interesting things to do, that don't just involve drinking with friends.
- Schools have a responsibility to raise these issues with young people early on as part of PSHE and education programmes and these should include different kinds of contraception, where they were available, and the risks of unprotected sex including STIs and unplanned pregnancy. In terms of raising awareness, interactive teaching methods emphasising real life experience or television dramas that were part of young people's popular culture were likely to be more successful than more traditional methods.
- Discussion groups could be better (more open) in youth clubs and youth projects. Youth workers have more time to give people individual advice, support and guidance than teachers or people in sexual health clinics.
- Teachers, Connexions PAs, youth workers, social workers, GPs and parents all needed to be more aware and identify the early warning signs and risks that young people might be taking but also more ought to be done by services to help young people identify the risks for themselves. More use could be made of particular motivational and risk self assessment tools like the Rickter Board
- Older young people with experience of the issues were realistic about the possible consequences might be able to talk more effectively to young people than teachers
- Sexual health clinics should be more widely advertised at schools, colleges and employment and training schemes.
- More schools, colleges, youth projects and training schemes should provide on-site counselling, sexual health services and alcohol / drugs information and advice.

- GPs, sexual health clinics or young people's substance misuse service might help young people who were taking risks but young people would have to 'care' or be aware of the issues already or they wouldn't go to these services.
- Many young people associated unplanned teenage pregnancy with social disadvantage and the need to target work in such areas. Outreach work was important in these areas.
- Young people might play a role in supporting and advising other young people, especially if they were slightly older and had relevant life experience. However they would need to be properly trained and there was a limit to how much help other young people could be to young people with specific needs and problems.

12 Conclusions

This report summarises the key elements of the findings from the project in the North East which are most likely to be of relevance and benefit to local commissioners.

To further explore the models of service delivery and examples of actual practice, the full Literature Review should be consulted alongside this document.

Commissioning across areas of 'risk' with young people is a complex agenda. However, commissioners have a crucial role to play to ensure this agenda is strategically aligned. By doing this, services at an operational level will be able to follow-suit naturally which should consequently improve the way young people access and receive services.

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