



The WiSHing Project

Wirral Sexual Health, Health and Wellbeing Needs Assessment of Young People

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The Centre for Public Health in collaboration with Wirral Brook

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1 Executive Summary

Background

Adolescent sexual health has become a public health priority in the UK. Nationally a quarter of young people reported sexual debut before the age of 16. The risk of sexually transmitted infections (STIs) doubles with early sexual debut. UK teenage pregnancy rates are the highest in Europe and relate to poor parental supervision, deprivation, city living, low educational expectations, and poor access to services. Rates of STIs have risen dramatically in the UK since 1997, with a high burden in young people 16 to 24 years old. Young people account for half of all STIs diagnosed in genitourinary medical (GUM) clinics, but constitute only 12% of the population. Attendances and diagnoses in the youngest age groups are predominantly female. A North West study found half of males (>16 years) would not attend a GUM due to embarrassment, 43% because they did not know where it was, and a quarter for fear someone would hear they had attended. Only 13% knew the location of their local GUM clinic.

Adolescent health and wellbeing has also become a priority with young people demonstrating vulnerability in many contexts. UNICEF placed the UK last in a league table on child wellbeing in the 21 richest countries, based on data gathered on 40 indicators including poverty, family relationships, and health. The death rate of 15-19 year olds in the UK is now higher than in the under 5's. One fifth of adolescents have mental health problems, with serious problems occurring in one in eight boys and one in five girls aged 11-15 years. A youGov poll, reported by the Prince's Trust in January 2009, found half of 2000 teens questioned regularly felt stressed, a quarter were often down or depressed and one in ten felt life was meaningless.

The Wirral Sexual Health, Health and Wellbeing Project (WiSHing) was therefore commissioned by NHS Wirral at the start of 2009 to examine the health of under-19s in their area. The results of the study will inform and guide NHS Wirral to develop effective partnerships, services and support to ensure that the young people in Wirral receive information and services that meet their sexual health, health and wellbeing (SHHW) needs.

Aims

1. To provide an insight into young people's attitudes, experiences, and behaviours; as well as their real-life challenges, opportunities and perceived barriers in dealing with their own sexual health, health, and wellbeing needs.
2. Within this context, to explore met and unmet needs not only in young people in general but also in particular subgroups who may be more vulnerable to problems with sexual health: ie looked after, homeless, disabled (ie learning disabilities and physical disabilities), abused and exploited, black and ethnic minorities, excluded from school, those not engaged in education employment or training, young teen parents, young carers, young gay lesbian bisexual transgender people, chronically ill, and those with low attainment.
3. To utilise the data to describe health seeking and barriers to sexual health services, and identify changes that could be made to encourage uptake and use leading to improved health and wellbeing of 11-19 year olds in Wirral.

Methodology

Observational (ie non-interventional) descriptive studies using qualitative and quantitative methodologies were used to capture attitudes, experiences, and behaviours of young people 11-19 years of age. Questions explored their real-life challenges, opportunities and perceived barriers in dealing with their own sexual health, health, and wellbeing needs. Wirral Brook was identified by NHS Wirral to be the key community partner to facilitate project activities, particularly with regard to engagement of young people outside of schools. In addition, surveys of service users and providers were conducted in the sexual health services to generate views on the strengths and weaknesses of current services and patterns of utilisation.

Key Findings

Access to services

Opening hours of services were found to vary by service and within services, creating confusion for young people who are not sure when a place is open or closed. Effective advertising is needed to inform young people when services are open. Accurate online information should be easily accessible. Only Brook and Harm Reduction offer consistent and long opening hours. Young people in focus groups wanted services to be open after school and college hours and at some point over the weekend.

- Service providers believed that contraceptive services are 'patchy', in terms of geography, opening times and services offered, however free condoms and comprehensive information is widely available.
- Reasons for not attending sexual health services were fairly constant and included; embarrassment, worries about confidentiality, fear that friends and family (or even the general public) would see them and not knowing where to go.
- Young people want friendly, non-judgemental services that welcome young people. Current services, excluding Brook, are not perceived as such and more focus should be placed on implementing the 'You're Welcome' criteria.
- Wirral Brook was the most frequently mentioned service by young people (separate and unrelated to their involvement in this project). Most questionnaire respondents cited Brook, followed by their GP to resolve a diverse range of general health and sexual health problems, suggesting young people are not fully aware of the variety of services available. Wirral Brook were also mentioned by a number of NHS staff as offering a high quality and important sexual health service to young people.
- Wirral Brook play an important central role in educating and supporting young people throughout Wirral and their mode of operation and procedures could be used as a model to enhance other services. Younger service users tend to use Brook reflecting the preferential use of Brook for younger people. Brook was described as confidential and anonymous, which were thought of as key requirements for a sexual health service. When asked how sexual health services could be improved there was a consistency in response that more services like Brook, or similar to Brook were needed across the Wirral.
- Fewer young people access Wirral Sexual Health Service and GUM services in comparison to Brook. NHS services need to ensure they are continuing to build on successes from 'You're Welcome', further developing young people friendly services, effectively advertising and opening at appropriate times.
- The majority of both the male and female population were recruited at Brook. The participants from GUM were older and none usually attend school or college. This suggests Brook is providing a service that is attractive and accessible to younger teenagers, while older young people (school-leavers) choose to access GUM.
- Some organisations have difficulty advertising, especially in some schools, which is reflected in the lack of awareness in young people of services other than Brook. Most people accessing services had heard about Brook through friends or school and GUM/SH services were usually heard about through GPs and schools/colleges. All services need to ensure they advertise in a wide range of places to ensure young people know about all services available. Young people suggested billboards, posters at bus stops or on the internet using Bebo or Facebook as a good way to advertise.
- Young people in general thought they would visit either their GP or Brook if they had alcohol or drug problems, or emotional wellbeing issues; few were aware of other varied specialist services such as CAMHS or Response. These services were highly regarded by young people who had accessed

them, suggesting that the reason they were seldom mentioned by young people was lack of awareness rather than lack of effectiveness. Such services need to raise their profile, particularly among school-aged population, to ensure greater awareness and accessibility for young people.

- The term 'confidentiality' was repeatedly mentioned in various focus groups, questionnaires and samples. Young people view this as vital to any service they attend and lack of, or perceived lack of confidentiality seriously deters young people from accessing services. Promotion of services and signposting should ensure it clearly states 'confidential' on all materials.
- When questioned on what services they would like, schoolchildren stated they wanted services close to town centres, open as one stop shops, or close to their GP; they did not want a school service to refer them back to their family GP. Other young people questioned through online counselling or counselling programmes, felt they needed more respect and more time given to talk, that services needed to be more warm and friendly towards young people.

Unmet Needs

- The most striking barrier to services for young people was lack of knowledge about the various services that exist and what they offer. The majority of young people were only aware of Brook, some mentioned the names of other services but did not know what they offered but most had not heard of any other services. This information is an important need of young people.
- Attendance at all services is much lower in males than females. Needs of a large proportion of young men are not being met by current services. Further effort is required to better understand why young men are not fully aware of the available services and/or do not wish to access them. Services need to ensure they are welcoming and accessible to young men.
- Vulnerable young people accessing support services such as Connexions, CAMHS, and Response indicated they did not find GPs very approachable for support with depression, wellbeing or substance abuse problems. However, other respondents amongst the general population of young people surveyed often suggested GPs were one of the top choices to go to for various wellbeing problems. This may thus suggest that 'high risk' groups feel somewhat ostracised from the standard system of care, requiring additional support, to encourage them to make use of all types of health facilities available.
- Knowledge of STIs other than chlamydia and gonorrhoea was low. Young people did not consider HIV to be a risk. Although young people were aware of Chlamydia and gonorrhoea they did not know where they could get tested.

Risky behaviours

- Young people in focus groups reported risky sexual behaviour amongst their peers, particularly in relation to not using condoms. They thought condoms are used if available, but at night and in unplanned sexual encounters a lack of condoms would not deter young people from having sex. More readily available and cheaper condoms in areas young people meet (for example bars) were recommended.
- Although a lot of young people keep condoms in the house girls who carry them were generally viewed as 'up for it' or 'easy'. This perceived attitude affected girls who were unwilling to 'be prepared' in a sexual encounter for fear they would be considered 'looking for sex' or 'easy'. Ways to promote condom carrying as socially acceptable need to be explored as a priority.
- An overlap between frequent alcohol use and sexual health suggests a strong relationship; there is thus an opportunity to link and integrate policies and services for both public health issues for young people. Young people in focus groups acknowledged that alcohol could be, and was, obtained under-age and that it was strongly linked to unprotected sex. Signposting of support services for the two require particular attention.

- Similarly, drugs (marijuana mainly) were easily available and used by young people on the Wirral. However, the link between drug use and unprotected sex was not as clearly vocalised (as for alcohol) by young people.
- Awareness of chlamydia and gonorrhoea was high but knowledge of other STIs (including HIV) was sparse. Following education sessions from Brook, many young people indicated they would consider being screened for STIs. Prior to this they had little information on where they could be tested and what this involved. Lack of information, coupled with misinformation (e.g. the umbrella test) acted as a barrier, as did embarrassment. Suggestions that screening could be offered through schools and colleges were made in many of the focus groups.

Sources of information

- Sex education and SRE were described as sub-standard or nonexistent by almost all participants in focus groups. The young people identified; lack of information about STIs, education being provided too late, and substandard teaching by their PSHE or form tutor. They wanted education to be more holistic and not just about pregnancy, be taught by an external expert, use more explicit information about STIs and more up to date and relevant materials. Younger sexual debut was linked to risky behaviour by participants of focus groups and it was suggested this could be addressed through the provision of SRE at a younger age.
- Schools and teachers were cited by a large proportion of young people as barriers, because teachers were difficult to talk to about health and sexual health matters. Improvements to SRE and general sex education in school would provide an opportunity to build trust with young people about such issues and encourage them to approach teachers for support on health issues.
- Misinformation about sexual health issues was common (including over a third of girls who thought they could not get pregnant whilst having their period), and seeking information from online sources was common. There are many high quality sexual health resources for young people available but a third of boys in the SRE evaluation (subset of Wirral participants in a larger NW study to evaluate standardised sex and relationships education materials) stated they got information about sex and relationships from online pornography and girls got it from fictional films and magazines. These sources will not give young people an accurate or realistic impression of sex and relationships.
- Very few young people knew about long acting reversible contraception suggesting there needs to be further promotion of this method for young people. SRE lessons would be a good opportunity to inform young people about LARC.

Wellbeing

- Wellbeing in young people varied between the different samples. General wellbeing scores were reasonable high but young people indicated high levels of stress, depression, loss of control/anger, lack of confidence, high levels of alcohol consumption and many concerns about body image.
- Considering the emotional wellbeing issues experienced by a high proportion of young people in the study we suggest greater emphasis needs to be placed on highlighting and promoting the use of CAMHS and similar services. Awareness of CAMHS, Response and Connexions was relatively low and a high proportion of young people indicated they would access Brook for emotional wellbeing issues. Brook could, nevertheless, further address wellbeing through triage, by general signposting of services, and through referrals.
- Use of the Brook model, including giving talks in schools, could be adopted by counsellors from CAMHS to raise their profile.

Vulnerable Young People

- Very similar general concerns and needs were mentioned by all the vulnerable groups and by the less vulnerable groups; this included availability and easy access to services, opening times, strict confidentiality and availability of free condoms.

Additional issues for vulnerable groups included;

- Young teen mothers were particularly stigmatised by giving their date of birth and feeling others (including peers, the general public and health professionals) judged them for having children when they were teenagers. They were confident to access Brook and services in hospitals, maybe because of familiarity with hospitals through antenatal care.
- Black and minority ethnic groups stated it was especially hard for them to access services as they were worried about being seen and judged by other people from their community. This was especially important for Muslim girls as their religion and culture stipulates sex should only be within marriage. They suggested sexual health services should be housed under an umbrella service that offered other support so it wasn't obvious they were attending for issues related to sexual health.
- Persons surveyed through the online counselling service kooth.com, who are more likely to have emotional wellbeing issues felt it was particularly important for services to be private, warm and friendly and with lots of time to talk. They found adults (teachers, parents, GPs, pharmacist) especially difficult to talk to about emotional and sexual issues.
- Gay, lesbian, transgender groups felt they were also stigmatised and disadvantaged, particularly during school sex lessons, when nothing was discussed about healthy homosexual relationships, and no opportunities given to discuss their health needs. They did not want separate services but wanted more welcoming services open to all irrespective of sexuality.
- Harm Reduction and CAS provided foreign language leaflets but other services had limited information available on sexual health for persons of ethnic minority groups who struggle with English

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2 Introduction

2.1 Background

2.1.1 Health and wellbeing of young people

The health of adolescents is a growing concern in developed countries, particularly the United Kingdom (UK). The death rate of 15-19 year olds in the UK is now higher than in the under 5's.¹ Health risks are associated with alcohol/drug abuse, social disruption, depression and stress. A fifth of adolescents have mental health problems with serious problems in one in eight boys and one in five girls aged 11-15 years.¹ UNICEF placed the UK last in a league table on child wellbeing in the 21 richest countries, based on data gathered on 40 indicators including poverty, family relationships, and health.² A youGov poll, reported by the Prince's Trust in January 2009, found half of 2000 teens questioned regularly felt stressed, a quarter were often down or depressed and one in ten felt life was meaningless.³ Bullying, including sexual bullying, is now endemic in the UK.⁴ The national Tellus3 survey found nearly half of children reported bullying at school and over 40% felt it was not dealt with appropriately.⁵ Engaging in two or more health-risk behaviours such as smoking, alcohol, drugs, and risky sexual behaviour predicts psychological distress and depressive symptoms.⁶ Adolescent binge drinking causes significant current and long term harm, and correlates with violence, sexual risk-taking, and sexual victimization.^{7,8,9,10}

Adolescent sexual health is of particular concern. Earlier onset of puberty results in uninformed risk-seeking behaviour and increased vulnerability at ever younger ages.¹¹ Nationally a quarter of young people report sexual debut before the age of 16 with the median debut age of 16 years.¹² The risk of sexually transmitted infections (STIs) doubles with early sexual debut,¹³ with a higher risk if first infection occurs before 16 years.¹⁴ Use of a condom at first intercourse is lower the earlier the sexual debut (ref 12). UK teen pregnancy rates are the highest in Europe and relate to poor parental supervision, deprivation, city living, low educational expectations, and poor access to services. Girls having sex under-16 are three times more likely to become pregnant than those beginning after 16, and more likely to be early school leavers with no qualifications.¹⁵ In 2006, 7.8 and 40.9 per 1,000 13-15 and 15-19 year olds, respectively, became pregnant in England and Wales.¹⁶ In the past decade conceptions rose 9% in 15-19 year olds (from 94,900 to 103,100) while dropping 12% in 13-15 year olds (8,900 to 7,800) and 4% in 15-17 year olds (43,500 to 41,800).¹⁷ Under-18 (15-17 year olds) pregnancy rates per 1000 in England and Wales, North West England, and Wirral were 40.9, 44.2 and 47.8 respectively. In the most vulnerable groups, one in three girls will become a teen mother by age 20.¹⁸ Pregnancy prevention, including abortion, is crucial because of the poor health and wellbeing outcomes (including a 60% higher infant mortality rate) associated with teen pregnancies.¹⁸ The choice to abort is highest in the younger age groups (65% at 14, 49% at 16, and 39% at 18).¹⁶ The proportion of under-18's who undergo abortions are the same nationally, regionally and locally (48%).¹⁶

Rates of STIs have risen dramatically in the UK since 1997, with a high burden in young people 16 to 24 years old.^{19,20,21} Young people account for half of all STIs diagnosed in genitourinary medical (GUM) clinics, while representing only 12% of the population.^{19, 21} Data from national and North West England GUM clinics indicate diagnosis is proportionately higher in young females compared with males.^{21,22} In the North West, a local study found nearly half of males 16 years and older would not go to a GUM clinic because of embarrassment, 43% because they did not know where it was, and a quarter because they feared someone would find out they had been.²³ When questioned specifically, only 13% knew where their local GUM clinic was.

In the UK, risky behaviour tends to refer to drug, alcohol and tobacco use, as well as underage sex and any unprotected sexual activity. Risks additionally involve behaviours such as criminal activity, carrying weapons, gang membership, bullying, running away, obsessive study leading to stress, contact sports, sedentary lifestyles, excessive 'screen watching', over- and under-eating. Alcohol use and pervasive bingeing (5 or more per session) have become entrenched within youth culture, creating one of the greatest challenges to UK public health in recent years.^{24,25,26} Adolescents in the UK aged 15-16 years were ranked in the top 5 of 30 countries for most measures of alcohol misuse.²⁷ A national study reported 52% of 11-15 year olds have drunk alcohol in 2008, including 16% of 11 year olds.²⁸ While this is a drop

from 61% in 2003, between 2007 and 2008 consumption in those drinking rose 15% to 14.6 units with the greatest rise in 11-13 year old girls (63%). North West England represents an area of the UK with heavy drinking and high levels of alcohol-related harm.²⁹ Surveys report a third of 15-16 year olds binge drink weekly,^{30, 31} whilst alcohol-related hospital admissions are the highest in the country.²⁹ Evidence is accumulating, particularly from American studies, of a strong association between alcohol abuse in young people and poor sexual behaviour.³² These studies suggest early regular consumption is associated with early onset of sexual activity, and any drinking is associated with being sexually active.^{32,33} Few peer reviewed studies are available from the UK, and most reports are anecdotal, or based on local area data.³⁴ A North West regional survey did find, however, a 2-fold higher risk of regretted sex in 15-16 year olds who had been binge drinking.⁹ Exploration of associations between alcohol abuse and sexual behaviour in adolescents in the UK is thus required to inform integrated strategies at local regional and national level.

2.1.2 Sexual health, health and wellbeing (SHHW) services for Young People

A bold whole-system approach, with a broad set of integrated policies to enhance wellbeing, is required to counteract risks to health and wellbeing in young people in the UK. Good quality sex and relationships education (SRE) is required to ensure young people acquire the knowledge and skills needed to stay healthy and achieve sexual health.^{35,36,37,38} Five key factors needed for sexual health are: compulsory SRE in schools, access to local services, meeting women's needs in relation to abortion, building contraceptive services, and prevention of STIs.³⁹ The reshaping of children and young people's services, through *Every Child Matters* and *Youth Matters* programmes (Box 1), aim to prevent poor outcomes, target the underlying risk factors linked to teenage pregnancy, and give young people the chance to make positive choices and achieve their potential.⁴⁰ Stigma and barriers to health seeking by young people are being tackled by locating services in places where children and young people go.^{41, 42}

Box 1 Choosing Health and Every Child Matters⁴⁰ guidance

The *Choosing Health White Paper* had a specific focus on young people, in line with the *Every Child Matters* recommendations, and recognises that 'emotional well-being underpins good physical health and reduces the likelihood that children and young people will take inappropriate risks'⁴⁰. To this end the White Paper states that:

- extended schools can also provide, for example, One Stop Shops and multi-agency health centres located on a school site, which will enable health professionals to work alongside education and social care professionals;
- personal health guides (PHG) will encourage young people to build health into the way they live their lives;
- general information, advice and support about health issues, as well as emotional wellbeing, puberty, sexual health and access to further help and advice will be provided, for example, through a confidential email service;
- learning about health choices and managing risk will be supported, for example, through incentive schemes using reward points.

DH (2004) *Choosing Health: making healthy choices easier*
DfES (2003) *Every Child Matters*

Local authorities (LA) and primary care trusts (PCT) are required to take young peoples' needs into account, applying criteria to services to become young people friendly. The Department of Health thus now provides '*You're Welcome*' quality criteria (2007)⁴³ to aid in the promotion of young people (under-20) friendly services. The criteria cover many areas including accessibility, publicity, confidentiality, environment, staff training, joined up working, monitoring and evaluation, health issues, sexual and reproductive health, and mental health services.

The Department of Health has prioritized sexual health as a key public health issue in the UK. It defines the need to reduce the prevalence of STIs, reduce unintended pregnancies (particularly in teenagers), and to improve the range, access to and quality of service provision. Their National Strategy for Sexual Health and human immunodeficiency virus (HIV), developed in 2001, has several specific aims (Box 2).

Box 2 The National Strategy for Sexual Health and HIV

In 2001, the Government published the National Sexual Health Strategy, which aimed to:

- reduce the transmission of HIV and STIs
- reduce the prevalence of undiagnosed HIV and STIs
- reduce the rates of unintended pregnancies
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs

The Government hoped to achieve these aims through, for example, the provision of clear information; ensuring there is a sound evidence base for effective local HIV/STI prevention; setting a target to reduce the number of newly acquired HIV infections; developing managed networks for HIV and sexual health services; evaluating the benefits of more integrated sexual health services⁴⁴, including pilots of one-stop clinics; beginning a programme of chlamydia screening; stressing the importance of open access to GUM clinics and ensuring that a comprehensive range of contraceptive services are available to those who need them.⁴⁵ Specific government targets were defined in the White Paper *Choosing Health: making healthier choices easier* (Box 3).

Box 3 Choosing Health guidance

In 2004 the public health White Paper, *Choosing Health: Making Healthier Choices Easier*³⁶, called for action to improve sexual health in the UK, through a £300 million investment over three years. The subsequent action plan reinforced earlier public service agreements. Clear targets were set in the paper and incorporated:

- A reduction of 50% in the rate (from 1998) of under-18 conceptions by 2010.
- All patients attending a GUM clinic to be offered an appointment within 48 hours by 2008.
- A decrease in the rate of new gonorrhoea diagnoses by 2008.
- An increase in the uptake of chlamydia screening for people between 15 and 24 years by 2008.

Through government investment GUM clinics across the UK have worked towards improving patient waiting times. The 48-hour waiting time audit was established and has been in place since 2004 recording the progress of clinic waiting times. With the increased emphasis on sexual health from the Department of Health there are high-profile targets to be achieved, including the 48 hour appointment target.³⁶ The improvement of sexual health was one of the top six priorities for the NHS in 2006/07 and continued to be the case for 2007/2008. To help ensure these targets are met it is essential that comprehensive monitoring of services and service users is in place to further focus resources where they are needed most.

Government investment also produced a national campaign to promote condom use. '*Condom Essential Wear*' was launched and has been running since December 2006 along with the sexual health campaign for young people, *RU Thinking*. Both campaigns also have websites providing information and advice. Community services have been set up to provide sexual health screening for chlamydia and to provide local and specific sexual health services for young people, such as one stop shops and C-card distribution schemes. Targets were set to address acute needs, for example, the National Chlamydia Screening Programme's aim to control genital chlamydia among the under-25s through early detection and treatment, with a target to screen 15% of the eligible population (15-24 years) in 2007/2008.⁴⁶ Recent guidance outlined in '*vital signs*' reassesses the target for 2009/10 and suggested PCTs plan to screen 17% of the eligible population in 2009/2010 as part of tier two national priorities.⁴⁷

One of the key targets from the White Paper (see Box 3) is to reduce the under-18 conception rate in line with the 1999 Teenage Pregnancy Strategy.³⁶ However, there continues to be a high number of teenage conceptions in the UK, a high proportion of which lead to abortion.⁴⁸ In addition, the UK has the highest rates of teenage births in Europe. UNICEF have rated the UK as bottom of 21 higher income countries with regard to general child health, and also reports that more UK children have had sex by the age of 15 than any other country in the survey.⁴⁹ Research suggests that not only can teenage pregnancy have a

negative impact on a young woman's employment, earning potential, mental health, living conditions and academic achievement; it can also have a negative impact on the child. The child of a teenage mother is more likely to belong to a one-parent family, be a low academic achiever, experience abuse, be involved in crime, misuse drugs and alcohol, and become a teenage parent, thereby perpetuating the cycle.⁵⁰

The Government has set contraceptive services as a high priority within sexual health. It is recognised that access to sexual health services varies across the country. The Government stated in the *National Strategy for Sexual Health and HIV* that they would ensure a range of contraceptive services are provided for those who need them and promised an audit of contraceptive service provision in its White Paper, *Choosing Health*.³⁶ Contraceptive services are cost effective and are estimated to save £11 for every £1 spent; and the prevention of unplanned pregnancies by NHS contraceptive services saves the NHS over £2.5 billion per annum.⁵¹ The average spending on community contraceptive services (which include primary care prescriptions and emergency contraception) is £11.67 per female aged 15-49 per annum. Good quality contraceptive services are important in the achievement of the public service agreement for reducing under-18 conceptions by 50% by 2010 and also, more broadly, the improvement of sexual health.⁵¹ It is important that patient choice in terms of choosing a method of contraception is a priority and that those requesting contraception should be given the advantages, disadvantages and failure rates of each method. As recommended by NICE, this should also include information on long-acting reversible contraception (LARC) methods.^{51,52} It is estimated that 30% of pregnancies are unplanned and, in order to reduce the rate of unplanned and unwanted pregnancies, the National Institute for Health and Clinical Excellence (NICE) has produced guidelines to promote LARC to women.⁵² The guidance promotes the use of the contraceptive injection, contraceptive implant and intra-uterine methods, which do not need to be remembered daily and are less susceptible to incorrect usage. The most popular methods of contraception for women in 2006-07 were the pill and condoms (46% and 28% respectively), with 21% of women using LARC.⁵³

NICE also aims to improve the deficit in guidance and training available to healthcare workers in order to enable women to make informed contraceptive choices.⁵² An issue with the promotion of LARC, or any method of hormonal contraception, is that it could potentially reduce the number of women using barrier method contraceptives and could contribute to the risk of STIs. However, LARC has the potential to effectively reduce the rate of contraceptive failure, the average cost of which is approximately £1500 which includes ectopic pregnancy, maternity (live births), abortion, and miscarriage services. Further, it is estimated that for every £1 spent on contraceptive services, £11 is saved.⁵⁴

Sexual ill health costs the NHS more than £700 million a year.⁵⁵ Appropriate investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of STIs including HIV. The direct cost of treating STIs (not including HIV) is approximately £165 million a year, which would increase if the cost of treating sequelae were included.⁵⁴ There is a strong correlation between STIs, sexual behaviour, and substance abuse (including alcohol). The implications for young people engaging in risky sexual behaviour are that they are at greater risk of contracting an STI; becoming young parents; failing at school; building up longer-term physical and mental health problems; and becoming addicted to alcohol and drugs. The most at risk young people^a are those:

- socio-economically the most disadvantaged;
- who are homeless;
- whose parents have no aspirations or expectations of educational attainment for them;
- not attending school regularly;
- who have no self-worth;
- who were a child of a teenage mother;
- classified as looked-after children;
- who have no-one to discuss intimate issues with.

Recent guidance on 'one to one interventions'⁵⁶ published by NICE determines good practice for preventing STIs and reducing under-18 conceptions. They recommend health professionals in general practice, community health, voluntary sector and genito-urinary medicine (GUM) services should identify

^a This most at risk list is taken from 'Sex, Drugs, Alcohol and Young People'. Published June 2007 by the Independent Advisory Group on Sexual Health and HIV.

individuals at high risk of STIs, using the client's sexual history. Further, GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one-to-one sexual health advice.

Improving the sexual health of school-aged children, their ability to negotiate safe sex and opportunities for them to access services is recognised to be a significant public health challenge. In July 2008, the Teenage Pregnancy Independent Advisory group (TPIAG) defined five key things we need in place to improve sexual health in the UK: compulsory SRE in schools, access to local services, meeting women's needs in relation to abortion, building contraceptive services, and prevention of STIs including HIV. The 'You're Welcome' criteria should be viewed as essential requirements for all Primary Care/NHS Trusts, regarding sexual health services, due to the pressing need to improve the sexual health of young people.

Box 4 Sexual Health Services for Young People

Local areas need to ensure:

- All contraception and sexual health services for young people are commissioned and provided against the 'You're Welcome' Quality Criteria²
- The full range of contraception methods, including long acting reversible contraception (LARC), are available to all young people at convenient times and in convenient places
- Young people's services are widely publicised through universal services (e.g. schools, colleges and Integrated Youth Support Services) and through targeted services (e.g. Targeted Youth Support, Positive Activities, CAMHS workers and social workers/foster carers)
- Contraception and sexual health services for all young people are located in accessible settings³, (e.g. schools, colleges, outreach services and other youth settings)
- Testing and treatment for STIs is provided where possible with contraception as this is an effective way for local areas to meet both chlamydia screening and teenage pregnancy targets
- There should be strong links and sign-posting between all sexual health services (including condom distribution schemes, pregnancy testing and NHS pharmacy emergency hormonal contraception schemes)
- Abortion providers are funded to supply the full range of contraception methods in line with new NHS contract requirements to ensure that young women receive immediate and continuing contraception post-abortion. This is an essential part of reducing repeat abortions in young people, which are as high as 20% in some areas
- Contraception is accompanied by well planned and effective SRE in schools and colleges and other relevant settings and support for parents in talking to their children about relationships, contraception and sexual health

Evidence suggests that young people with disabilities (learning and physical) or chronic conditions are a sexually active group,^{57,58} and have similar expressions of sexuality, and if not similar levels of sexual experience in comparison to able bodied peers, then at least a substantial prevalence of sexual activity.^{59,60,61} However it must be acknowledged that there are variations between these groups of young people,⁶² young people with cerebral palsy have been found to have less sexual experience than their able bodied peers, whilst other studies have reported either that sexual activity begins earlier,⁶³ or there is a higher rate of sexual activity in comparison with the typical adolescent.⁶⁴ It is likely these differences are a function of the degree of incapacity of the groups studied.

There are however, areas relating to sexual health that show some consistent differences between young people with or without a disability. One issue noted in several studies relates to the difficulty that young people with a learning or physical disability or chronic condition report in developing intimate relationships.^{62,65} Other studies point to the lack of adequate sex education, specifically contraception and sexually transmitted diseases.^{59, 65, 66} It is widely believed that this is in order to 'protect' the young person from exposure to sexually explicit facts. Thus, young people with disabilities participate in sexual relationships without knowledge and skills to keep them healthy, safe, and satisfied, and are at greater risk

of abuse.⁶⁷ Consequently, a number of studies have also found that they are more at risk of sexual abuse than their peers.^{60, 63, 68}

3 Methodology

3.1 Scope of WiSHing Project: NHS Wirral Call

The Sexual Health, Health and Wellbeing (SHHW) needs assessment is fundamental in ensuring that services meet the need of young people in Wirral and in reducing health inequalities. Through this work, new services may be developed and existing ones may be further enhanced.

On the whole, the SHHW needs assessment is a step forward in NHS Wirral's commitment to support the development of health services in schools and other youth settings in Wirral as set out in The Health & Wellbeing Charter for Children and Young People. It will contribute to the priorities for improvement in the new local area agreement (LAA) developed by the Wirral Strategic Partnership in which NHS Wirral plays a pivotal role.

3.1.1 Aims

To carry out a Sexual Health, Health, and Wellbeing Needs Assessment of Young People aged 13 –19 years of age, across Wirral, North West England.

3.1.2 Objectives

For the Needs Assessment service provider to:

1. Develop and propose a validated needs assessment process using reliable tools which will produce comprehensive and credible outputs, outcomes, conclusions and recommendations.
2. Conduct reviews of relevant national, regional and local research studies and statistical analysis data to use as baseline information.
3. Consult with young people and relevant professionals from a range of organisations to identify existing and possible gaps in sexual services for young people in Wirral.
4. Provide an insight into the young people's attitudes, opinions, real-life challenges, experiences and opportunities in dealing with their own sexual health, health and wellbeing needs.
5. To collect contextual data on the young people.
6. Work closely with the established and appropriate Expert Panel in Wirral.
7. Carry out and complete the Needs Assessment.
8. Analyse results and produce interim and final reports.
9. Present the reports to the Expert Panel and other highly relevant stakeholders.

1. To provide an insight into young people's attitudes, experiences, and behaviours; as well as their real-life challenges, opportunities and perceived barriers in dealing with their own sexual health, health, and wellbeing needs.

2. Within this context, to explore met and unmet needs not only in young people in general but also in particular subgroups who may be vulnerable to problems with sexual health: i.e. looked after homeless, disabled (learning disabilities and physical disabilities), abused and exploited, excluded from school, those not engaged in education employment or training, chronically ill, and those with low attainment, young teen parents, young carers, young black and ethnic minorities (BME), and young gay lesbian bisexual and 'unsure' people (LGBU).

3. To utilise the data to describe health seeking and barriers to sexual health services, and identify changes that could be made to encourage uptake and use leading to improved health and wellbeing of 11-19 year olds in Wirral.

Box 5 Outcomes and Impact of WiSHing Project

The results of the study will inform and guide NHS Wirral to develop effective partnerships, services and support to ensure that the young people in Wirral receive information and services that meet their SHHW needs. This will:

1. Provide an awareness of what young people perceived as risks to their sexual health, health and wellbeing.
2. Provide knowledge of young people's awareness of SHHW services available to them locally.
3. Develop understanding of the perceived and actual SHHW needs as confirmed by young people and professionals across Wirral.
4. Enable NHS Wirral to identify services that can better support young people to achieve healthy lifestyles and remove health-related barriers to their successful progression in education or into work.
5. Enable NHS Wirral to identify and invest on new and innovative SHHW approaches and services that can deliver healthcare savings through prevention and reduction measures.
6. Enable NHS Wirral to prioritise and allocate resources effectively and efficiently to best meet the needs of the young people.
7. Reduce health inequalities among young people in Wirral.
8. Gain information on the services available to young people with regard to accessibility (transport and opening times), safety, systems and procedures, awareness/promotional materials used and how they address diversity and equal opportunity.
9. Stimulate involvement of service staff, practitioners, end-users and community stakeholders.

3.1.3 Scope

The project will be conducted within the geographical boundary of Wirral Local Area District only.

Depth and type of work:

- Engage the end users/potential end users/non-users in the needs assessment.
- Engage the relevant professionals and specialists in the needs assessment.
- Identify 'gatekeepers' for the specific groups of young people as listed above and involve them in the needs assessment.
- Gather and analyse quantitative and qualitative data.
- Visits to existing SHHW services and support for young people in Wirral.
- Work closely with the established Expert Panel / Steering Group.

3.1.4 Population under study

End users, potential end users and non-users:

- Young people aged 11-19 years old living in Wirral;
- Young people aged 11-19 years old who are using the SHHW services;
- Young people aged 11-19 years who have used but stopped using SHHW services;
- Young people aged 11-19 years who have never used SHHW services;
- Young people aged 11-19 years from a range of backgrounds including:
 - Looked after young people (and those who were looked after young people)
 - Young offenders
 - Young homeless people
 - Young disabled people (including mobility, sensory impairment, learning disabilities, ill-health)
 - Abused and sexually exploited young people
 - Those excluded from school
 - Not engaging in education, employment and training (NEET)
 - Those with low educational attainment
 - Young teenage parents

- Young carers
 - Young Black and ethnic minorities (BME)
 - Young Lesbian, Gay, Bisexual and Transgender (LGBT)* people
- *'Transgender' was reclassified to 'Unsure' to fit in with Wirral Brook activities

3.1.5 Out of scope

- Mapping of relevant services in Wirral including their locations, accessibility, safety, settings, services being provided, outputs and outcomes / impacts of the services and usage and age of clients accessing the services. (Information to be provided by the NHS Wirral).
- The information on the population demographics will be provided by the NHS Wirral.

3.2 Project Methods

3.2.1 Protocol development

A preliminary meeting at NHS Wirral confirmed (i) intelligence from this project should include primary research gathered through NHS providers and users, necessitating an ethics submission to the National Research Ethics Committee (NREC); (ii) the project should be conducted in close collaboration with Wirral Brook; (iii) generation of information on vulnerable groups within the community is essential; (iv) the age range of 11-19 years is necessary to provide intelligence for service development. The relatively short timelines proposed (completion by June 2009) was recognised to be dependent on methodological demands, e.g. NHS ethical and local research and development approvals.

The research protocol underwent a number of changes before final approval was granted. The project initially proposed to distribute a core questionnaire to 2000 young people during their PSHE lessons in secondary schools in Wirral. Data generated would have provided intelligence on young peoples' met and unmet sexual health, health, and wellbeing needs (including knowledge and behaviours). This was included in the initial ethical and protocol submission to NHS Ethics (NREC), Liverpool (January, 2009). However, prospective gathering of information with young people in state schools became untenable due to decisions made by the Director of Children's Services regarding child protection. The revised protocol which subsequently received full NHS ethical approval thus excluded primary research in school-based populations. Nevertheless, recently completed and contemporaneous studies in this age group, conducted through other allied projects, were sought to bridge knowledge gaps. Findings from these allied studies, including analysis specifically for the Wirral WiSHing Project, are presented in this report as allied sub-studies. For example, the LJMU evaluation of Sex and Relationships Education (SRE) conducted through Government Office North West throughout North West England included one Wirral school. Wirral-specific data have been separately analysed and are presented in this report. In addition, a regional teen study on alcohol, wellbeing, and sexual health conducted by LJMU throughout NW England includes Further Education Colleges and sampling from independent schools in Wirral; data generated on over 2000 young people will be published as an addendum to the WiSHing Project to augment intelligence on the met and unmet sexual health, health, and wellbeing needs of young people in Wirral.

3.2.2 Wirral Brook

Wirral Brook are part of a national organization of 17 Brook Centers across the UK who provide free and confidential sexual health and advice services to young people. Brook is an independent registered charity who provides services commissioned usually by local authority and PCTs. In Wirral, as well as running an LGBT group, a young women's group and a young men's group, Brook also run a drop in clinic six days a week that provides counseling, contraception, pregnancy testing, referral for abortion, Chlamydia and gonorrhea screening, and free condoms. There is also an education and outreach team within Wirral Brook who provide a number of different types of education in school, colleges and other organisations. One of these courses is a 5 day personal development programme called All Different, All Beautiful which focuses on confidence building, negotiation skills, sexual health education, gender and relationships. Wirral Brook also provide *Bitesize Brook*, training sessions in a variety of schools, colleges, youth groups and other groups that usually consist of a 2 hour session discussing sexually transmitted infections and various methods of contraception. These are delivered by professional youth workers and, along with All Different, All Beautiful, engage young people in an interesting and interactive way encouraging debate and

memorable information (for example graphic pictures of STIs and allowing them to look at and feel various contraceptives).

NHS Wirral asked Liverpool John Moores University (LJMU) to work with Wirral Brook as they have excellent relationships with many partners throughout Wirral, are highly respected, and have access to many groups of young people who may have been inaccessible to LJMU alone. Brook have provided invaluable connections to a number of organizations and worked with LJMU researchers to facilitate the majority of the focus groups. A close collaborative working relationship has been established during this project, providing both parties with opportunities to develop their skills and knowledge base. Focus group sessions were facilitated through the Education Manager and members of the education and outreach team, as well as with a number of youth workers who deliver the All Different, All Beautiful programmes and one-off sessions that have formed the basis of the focus group studies. Furthermore, Brook provided the forum for conducting an NHS Wirral Health Audit in schools, enabling young people to be surveyed during their Bitesize Brook session.

3.2.3 Ethical approval

Ethical approval for the WiSHing Project was sought and granted from the Liverpool Children's Research Ethics Committee (NREC reference: 09/H1002/17). The initial protocol and NREC application was submitted on 29th January 2009. The ethics panel meeting, held on February 19th, was attended by Dr Penelope Phillips-Howard, Principle Investigator, LJMU, Ms Hannah Madden, Researcher, LJMU, Ms Deborah Williams, Sexual Health Lead, NHS Wirral, and Ms Sue Drew, Director Public Health, NHS Wirral. Issues raised by the panel and subsequent correspondence from the NREC included the young age of the participants (as young as 11) given the nature of some of the questions, the consent methodology proposed in schools (parental opt-out), and issues relating to potential disclosure of young people during the focus groups.

The final revised NREC ethics forms and protocol was submitted on 8th April 2009. LJMU submitted a synopsis on research related to parental consent in addition to amendments requested by NREC. Focus group procedures were changed to ensure that a 'gate keeper' would take responsibility for preventing personal disclosures during discussions. Withdrawal of the school-aged sample (see above) eased NREC concerns about questioning of 11-13 year olds in schools on their sexual activity. NREC approval was granted on 28th April 2009 and authorised submission for local Research Governance. Documentation was fast-tracked for immediate submission to NHS Wirral for Research Governance approval. Materials were reviewed and external auditing (by NHS Halton and St Helen's PCT Research and Development) provided final local NHS Governance approval on 9th June 2009, authorising that participant recruitment and data collection could begin.

Ethical approval was independently sought for allied (supplementary) projects which collected primary research data on the knowledge, attitudes, and behaviours of young people. This included:

- The evaluation of Sex and Relationships Education package delivered by Government Office North West in North West England (Ethical approval by Liverpool John Moores Ethical Committee August 2008).
- Parents and children's perception of alcohol use (Ethical approval by Liverpool John Moores Ethical Committee June 2008).
- North West Teen Study: Collaborative study throughout North West England (Ethical approval by Liverpool John Moores Ethical Committee July 2009).

3.2.4 WiSHing Project Study Timelines.

	Jan09	Feb09	Mar09	Apr09	May09	Jun09	Jul09	Aug09	Sept09	Oct09	Nov09	Dec09
Preparation												
Study design, and collaborations	⌚											
Design questionnaires, other tools	⌚											
Team /Brook/NHS meetings	⌚											
NHS Ethics, local R&D												
Develop logistic framework; roles												
Recruitment and training												
Prep data entry, syntax, analytic plan												
Desktop studies												
Research studies (published/grey)												
NWPH Observatory data												
Observational studies												
Focus groups												
Service Providers												
Service Users												
Community surveys												
Supplementary studies												
NW Teen study												
Aggregation of findings/outcomes												
Data entry												
Data analyses												
Draft /final Report												
Feedback Collaborators, Stakeholders, Schools, Community												
Prep scientific manuscripts												⌚

Green – activity. Red - key meetings with NHS Wirral

3.2.5 WiShing Project Study Population

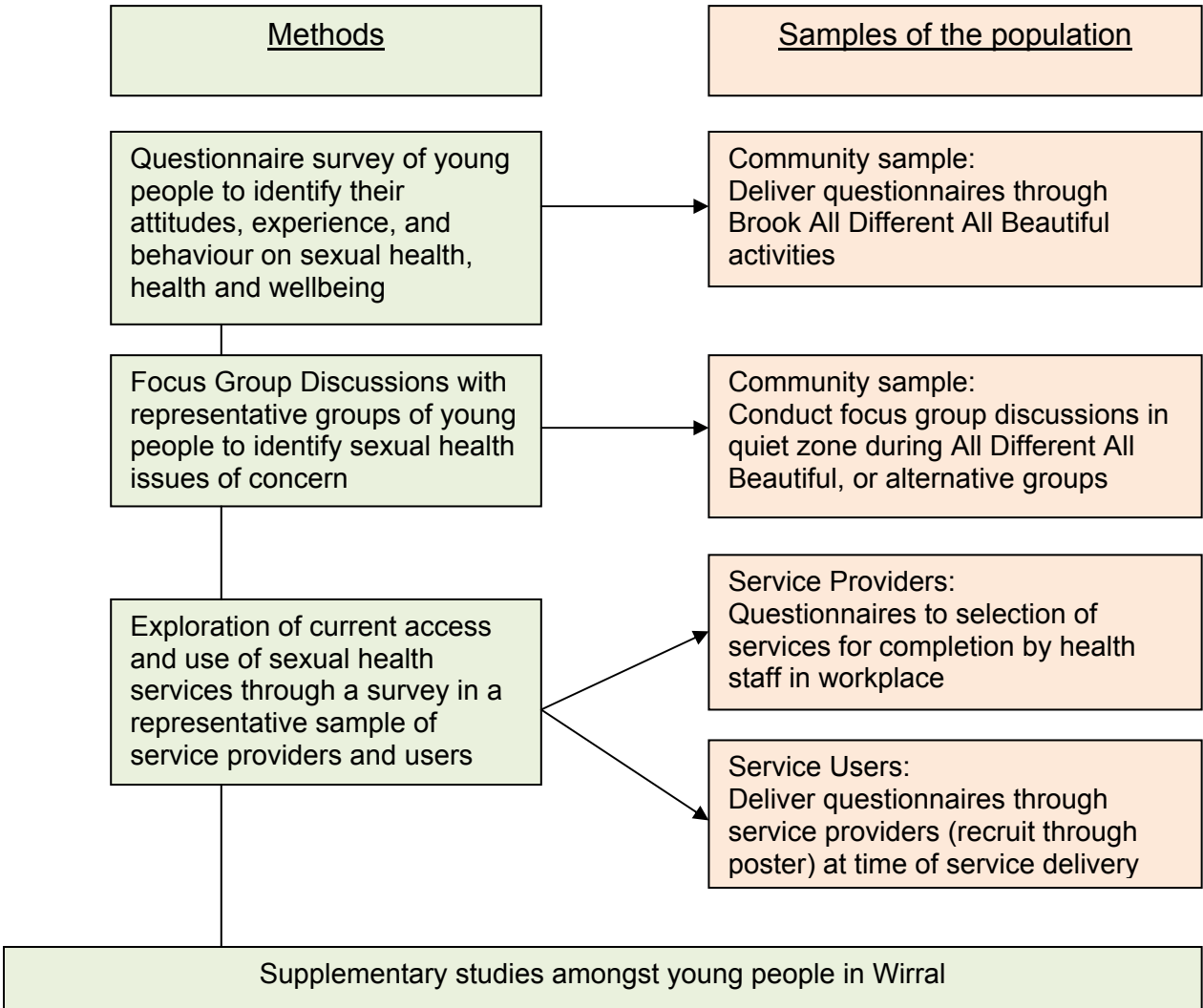
3.2.5.1 Study population

The study population for each sub-study is described separately below in each methodological section. In the ethics protocol, the inclusion and exclusion criteria were defined as follows:

<p>Inclusion criteria:</p> <ul style="list-style-type: none">• Aged 11–19 years old• Resident in Wirral (NW England)• Provide own written consent• Parents have not withdrawn their consent• Not severely impaired mentally or physically	<p>Exclusion criteria:</p> <ul style="list-style-type: none">• Outside the age range• Not resident in Wirral• Terminally ill• Severely impaired either physically or mentally• In prison• Parental consent withdrawn• Student consent refused• Non-English speaking
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3.2.5.2 Overview of study activities

The following flow diagram briefly illustrates the methods used and the population sampled. Further details are provided in each methodological section.



3.2.5.3 Study tools and materials

A number of tools and materials were prepared for this project. Each of these are itemised below within the study methodology sections. They include:

1. Core Questionnaire
2. Questionnaire for Service Users
3. Questionnaire for Service Providers
4. Participant Information sheet (community, service user)
5. Focus group Participant Information Sheet
6. Focus group guideline tools (worksheets)
7. Non-Consent Parents
8. Consent Focus Group Participant
9. Consent Service Users
10. Consent Community Core Questionnaire
11. Poster for clinics
12. Health Audit Form

3.2.6 Data generation methodology: Sexual Health Services

To establish how effective, accessible and appropriate current services are, data was obtained from users and providers of sexual health services in Wirral. Contact with service providers and service users were orchestrated in close collaboration with the managers of each service.

3.2.6.1 Service Providers

Design: Cross-sectional survey of service providers using confidential and semi anonymous self completed questionnaires. The questionnaire asked for job title and contained a code indicating place of work so questionnaires could not be fully anonymous. Further, as responses remained sparse additional information was gathered by completing a telephone interview (using the same questionnaire as a structure for interview) with persons from some services.

Tools: A questionnaire was designed in two parts; the first part was to be completed by a manager or senior member of staff and included questions about how the service was provided, any young person specific services, where the service is advertised, the opening hours and staff employed. A second questionnaire was designed for clinical staff (nurses, health advisors, and doctors) and asked about the services they personally provided including number of young people they see, waiting and appointment time and personal opinion of how good the service is generally. The questions were a mix of forced choice and free text answers.

Sampling and recruitment: Providers of Sexual Health services were identified by NHS Wirral and senior managers who were then contacted directly. The services were Wirral Sexual Health Services based at St Catherine's, the genitourinary medicine (GUM) clinic at Arrowe Park Hospital, Wirral Brook in Birkenhead, Wirral Chlamydia screening service, the Confidential Advice Service in New Brighton, Harm Reduction at St Catherine's, and the health service at Wirral Metropolitan College. Once contact had been made with the manager or the service lead, questionnaire batches were sent to the lead for them to disseminate at their service. Telephone interviews were then conducted with any services that had not been able to provide comprehensive information.

Participants: Participants consisted of staff working at the service who agreed to complete the questionnaire between June and October 2009.

Procedure: Questionnaire packs contained an invitation letter from researchers and NHS Wirral sexual health lead, a participant information sheet, a consent form and a prepaid addressed envelope. Participants returned the completed questionnaire in the envelope to LJMU. As noted above, data was augmented through telephone interviews with services. Participants were told about the study, invited to participate and provided with an opportunity to decline the telephone interview. Those wishing to proceed were then asked the questions in the same order as on the question form.

Analysis: The data was entered manually into the statistical analysis package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. However, because of the small number of providers, some analysis was conducted thematically, tabulating the responses of individual providers.

3.2.6.2 Service users

Design: Cross-sectional survey of service users of sexual health services in Wirral.

Tools: The core questionnaire developed for use in the community was distributed to young people attending sexual health services. In addition, a service-users specific questionnaire form was provided to glean service users' opinions on the services they were visiting, why they were attending and waiting times. The main questionnaire was to be completed in the waiting room while awaiting their appointment with three questions completed after the appointment to investigate how satisfied young people were with the service.

Sampling and recruitment: Questionnaires were distributed at the main sexual health services in Wirral - Wirral Sexual Health Services based at St Catherine's and at their satellite clinics around Wirral, the GUM clinic at Arrowe Park Hospital and Brook in Birkenhead. This intended to capture as large a sample as possible. A poster was displayed in the waiting room and the receptionists asked young people if they would like to fill in the questionnaire.

Participants: Young people aged between 11-19 years who attended sexual health services in Wirral between June and October 2009.

Procedure: All young people under 20 were asked by reception staff if they would like to complete a questionnaire. Any young people showing interest were given a questionnaire pack containing a participant information sheet, consent form and prepaid addressed envelope. Young people completed all but the final three questions whilst waiting for their appointment. Following the appointment the young people spent a couple of minutes finishing the final questions, sealing it in the envelope and then handed it back to reception.

Analysis: The data was entered manually into the statistical analysis package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. Using syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essential when determining the correct denominator for multiple response questions. These tables were then exported to Microsoft Excel, where the data were graphically displayed. Chi-squared tests were used to determine whether there was a statistically significant association between two non-constant categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less).

3.2.7 Data generation methodology: Community

To develop a thorough understanding of the needs of young people in Wirral this assessment must include those who are most at risk of sexual ill-health and attempt to gain opinions of these young people who are the least likely to be included in a school or college sample. Vulnerable groups were defined by NHS Wirral and attempts were made to set up focus groups with these young people.

3.2.7.1 Qualitative (focus groups, workshops)

Design: Qualitative methods using focus groups of between four and ten participants

Tools: The focus group guide developed by Ingham & Stone⁶⁹ was used as the basis for the group interviews. The guide provided a list of topic headings and prompts for use within these. The key topics initially selected for use with all groups were: Awareness of services, Use of services and Risk behaviour and Condom use. Key topics for each specific group were identified for further exploration. Some topics emerged through local knowledge e.g. Brook identified high occurrence of partner swapping and subsequent STI infection among those living in hostels, whilst other topics emerged from the literature e.g. the lack of sex education generally provided for young people with special educational needs (SEN). These key topics were added to the list for use with the appropriate group.

Sampling and recruitment: The majority of focus group sessions were organised through groups that Wirral Brook were running. Focus groups were held as part of the 5 day personal development programme All Different, All Beautiful. These programmes are held regularly by Wirral Brook with different groups around the Wirral, particularly with more vulnerable young people and those on vocational training courses outside of mainstream education. Most programmes run one day a week for five weeks. Some of the focus groups were done in one off sexual health education training sessions and usually happened in the second hour of these two hour sessions. Other groups were arranged directly through a specific organisation i.e. Connexions (Connect Uz) and Wirral Metropolitan College, and the focus group set up as a one off arrangement. A number of other vulnerable groups were identified through statutory services and agreement (in principle) was reached for us to conduct focus groups with them. However, due to logistical or other difficulties, despite numerous requests and reminders, arrangements were not made for the groups to be conducted, so we were unable to reach all groups that had been anticipated.

Box 6 Focus Group Details

Participant Group	Date held	Facilitator	Composition of group	Age	Gender make up	Participants who took part/refused
1 LGBU group	11/06/09	Brook	'Lesbian, Gay, Bisexual and Unsure' youth group who meet once a week	15-18	mixed	4/0
2 Young mothers and pregnant teens	12/06/09	Brook	Support/education group who meet every week	16-19	Female	5/0
3 Special Educational Needs	15/06/09	Brook	One class in SEN school. Focus group after sexual health education session	16-17	mixed	5/2
4 1 st Mixed group	01/07/09	Connexions	Youth group who meet once a week	16-19	mixed	5/0
5 NEETS	04/08/09	Brook	Group on a basic skills course. Day 2 of 5 day personal development course	16-17	mixed	9/0
6 1 st Young men group	12/08/09	Brook	Group on a vocational training course. Day 2 of 5 day personal development course	16-17	males	5/1
7 Hostel housing	20/08/09	Brook	Group who live in same accommodation centre. Day 2 of 5 day personal development course	18/19	mixed	7/0
8 2 nd Young men group	24/08/09	Brook	Group on engineering course. Day 1 of 5 day personal development course	16-18	males	9/0
9 Young women	26/08/09	Brook	Group on hair & beauty course. FG after one-off SH education session	16-17	females	8/1
10 2 nd Mixed group 2	27/08/09	Brook	Group on training course. Day 1 of 5 day personal development course	16-17	mixed	6/0
11 BME men	14/10/09	Wirral Change	Group recruited through Wirral Change. All Bangladeshi males aged 14-16	14-16	males	7/0
12 BME Women	30/10/09	Wirral Change	Group recruited through Wirral Change. Mainly Muslim women aged 14-19	14-19	Females	6/1

Procedure: Young people were informed about the focus group at the start of the programme or the week before the session, provided with information sheets and asked if they wanted to participate. Before the focus group started, the project was explained again and any questions answered by the researchers. Consent forms were signed then handed to the research team and any young people who did not wish to take part were allowed to go to a different area. Before the focus group started participants were asked to set some ground

rules for the group and were prompted to include respecting others views, not interrupting and confidentiality. Participants were also reminded that researchers did not want to know about their own sexual experience but rather those and the views of their peers in general. Sessions were recorded on a digital dictaphone with participant consent.

The initial four groups were run using the topic guide and prompts. However, after consideration it was felt that this approach did not yield as much discussion as required. The topic 'Use of services' was amended as few participants seemed able or willing to discuss this, (probably as their own use of sexual health services was limited) instead the topic of 'ideal' sexual health services for young people was introduced, which gave them the opportunity to suggest what a young peoples' service should include, and how it should be run. Sex education was also included as a topic as the initial group discussions suggested there was a lack of information provided to young people on sexual health and relationships. A further change was introduced into the format. Instead of simply introducing the topic and asking the core questions in the topic guide, a selection of statements made by participants in previous groups were presented to them (e.g. 'Most people I know have unprotected sex'). Participants were asked to choose one of the following responses 'Agree', 'Disagree' or 'Unsure' and explain the reasons for their choice. Other members of the group were then asked to offer any other opinions. This method generated more in depth discussion than previously.

No names or locations were included in the transcripts and all quotes given were checked to ensure anonymity. Participants were informed of this. Following the session the recordings were transcribed verbatim and checked by a researcher who was present at the session whilst simultaneously listening to the recording.

Analysis: Transcripts were analysed using content analysis. Each transcript was reread to gain a sense of the main issues emerging from the data, irrespective of the topic guide. Notes were made before returning back to the individual transcripts. The key themes were noted for each transcript, and within these, sub themes were identified. This process was adopted for all the initial interviews, 8 in total. A list of the key and subthemes was drawn up as a master list. The list was then used alongside each of the transcripts in order to code the data. Once coded, the analysis was written up within a thematic framework, with quotes used to illustrate the text. The later transcripts were used as a consistency check. This involved checking for any new themes, which were added to the framework, again with illustrative quotes. They were then considered in light of the overall framework. Where they corresponded to the findings thus far, they were seen as corroborating the data. Where they contradicted the findings the raw data was revisited to ensure the initial interpretation was appropriate. If not, this was re-analysed and written up in light of the new findings. If the analysis showed inconsistencies with the raw data presented previously, this was taken to be a reflection of the view of that specific group, and incorporated as a new finding. As a final check, the initial notes were reviewed and any contradictions with the narrative explored further.

3.2.7.2 Quantitative (surveys)

Design: Cross sectional survey using structured questionnaires in subgroups of young people in Wirral.

Tools: A standard core questionnaire, amalgamating similar questionnaires used in sexual health and wellbeing studies, was used to investigate behaviours of young people. Questionnaires in the public domain successfully utilised for previous studies, that informed the amalgamated questionnaires were: (a) Young Peoples Development Programme, London;⁷⁰ (b) Rochdale Teen Pregnancy Unit;⁷¹ (c) NAZ-TSA, London;⁷² (d) Tellus3;⁵ (e) Canadian Youth Survey;⁷³ and (e) a Government Office North West sponsored study 'Evaluation of sex and relationships education in schools in NW England' (Phillips-Howard PA and colleagues, ongoing). The questionnaire was reviewed by young people in the community (via Brook) prior to study commencement and was altered slightly. The questionnaire pack included participant information sheet, consent form and questionnaire in a prepaid addressed envelope.

Sampling and recruitment: Opportunistic sampling of individuals in the community through facilitating organisations including Brook, Connexions, Youth Service and Wirral Change.

Participants: Young people aged between 11 and 19 years who attended community services in Wirral between June and October 2009 who agreed to participate and complete a core questionnaire:

- Connexions: Bebington Connexions Connect Uz
- Brook – All Different, All Beautiful: Morthyng Training; Cornerstone Training; The Vocational College; Forum Housing; Maritime Engineering College
- Brook – one off sessions: Michael John Training; LGBU Group
- Tranmere Community Project
- West Kirby SEN School
- Wirral Change

Procedure: Young people were informed of the study by a group leader or receptionist. They were asked if they would like to take part in the study and then given a questionnaire pack. Once they had read the participant information sheet they completed the consent form and questionnaire and sealed it in the prepaid envelope. In most cases these were then handed back to the facilitator or receptionist but occasionally they were posted back to LJMU by the participant themselves.

Analysis: The data were entered manually into a spreadsheet for the statistical analysis programme package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. Use of syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essential when determining the correct denominator for multiple response questions. These tables were then exported to Microsoft Excel, where the data were graphically displayed. Chi-squared tests were used to determine whether there was a statistically significant association between two non-constant categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less).

Datasets from the Service users, WiSHing Core (community) participants, and students completing the pilot questionnaire for the NW Teen Study were also merged together using SPSS's command syntax language, allowing a direct comparison between the three groups across numerous variables common in each of the questionnaires.

3.2.8 Data generation methodology: allied (supplementary) studies

Supplementary research and audit studies that have been conducted in parallel with the WiSHing Project, by the researchers were identified and explored for added value. Sources were included in this project if they were identified to provide unique additional information on the sexual health, health, and wellbeing of young people in Wirral, or provide the opinions and experiences of young people who had not been adequately sourced directly through the WiSHing Project. These subpopulations do not overlap with the service or community-based studies and thus broaden the intelligence base of the study. A component of each of the studies involved the LJMU researchers who are part of the WiSHing Project team, and no permission was required; however, permission was obtained from any collaborators.

3.2.8.1 Healthy Schools Initiative: Health Services

Background: NHS Wirral is involved with the development of school-based health services throughout Wirral. In preparation for this, the views of young people, in terms of where they would like services, for particular health-related issues, is required. Wirral Brook routinely visits schools in Wirral to provide health and wellbeing guidance for young people in their Brook Bitesize programme.

Aim of Health Services Audit: Gather the views and opinions of young people on the types of health services they believe young people would prefer in Wirral.

Methodology: A short health service audit questionnaire was developed by NHS Wirral with assistance from researchers at LJMU. Three schools were identified to undergo Brook Bitesize during the summer term (June-July) 2009. At the start of the Bitesize session, Brook invited participants (Year 9 students, aged 13-14 years of age) to complete a simple 2 page health audit form (taking ~15 minutes), which was anonymous. They were reminded their participation was voluntary and any views expressed would remain confidential. No personal questions were asked. Audit forms were forwarded to LJMU for analysis.

3.2.8.2 GONW Sex and Relationship Education pilot study

Background: In December 2007 Government Office North West (GONW) contacted directors of Children's Services in 11 areas of the North West and invited them to participate in developing a benchmark for Key Stage 3 for schools across the region. Prior to this, GONW had consulted with young people, the North West regional network of Teenage Pregnancy co-ordinators, and Healthy Schools co-ordinators. The Sex and Relationship Education (SRE) study aimed to develop a curriculum resource that built on existing good practice and to establish a regional benchmark for the minimum quality of SRE. As part of this, the SRE intervention would be piloted in 22 schools across 11 authorities in the North West in order to understand and document the barriers and facilitators affecting the implementation of effective SRE in schools, and respond to the recommendations. Ethical approval was obtained from Liverpool John Moores Ethics Committee, and GONW obtained agreement and support from the Regional Safeguarding Office.

Aim of SRE evaluation study: The primary goal of the research conducted by LJMU was to determine whether standardised SRE lessons in schools lead to higher and more consistent knowledge about sexual health, along with more healthy attitudes and behaviours. The project also sought to gather evidence on factors affecting the delivery and effectiveness of SRE in schools such as the effect of school ethos and whether schools differ by deprivation in the level of increase in knowledge/change in attitudes.

Study population: Twenty two schools were recruited by GONW to participate in the teacher training and dissemination of the pilot SRE package. Two were located in Wirral, one of which withdrew while the other completed the SRE pilot. The target population for the survey was students 11 to 14 years of age in year groups 7 to 9 who would participate in the pilot SRE programme. Students outside the age range, not resident in North West England, terminally ill or severely incapacitated, did not speak English, had a signed withdrawal from consent by a parent or carer, or who personally did not consent were excluded from the survey.

Methodology: Prior to survey, letters informing about the study and parental withdrawal forms (non-consent) were sent to the homes of children in classes selected to be part of the SRE pilot. On the day of the survey, teachers informed school children about the survey, provided an information sheet about the project, and distributed consent forms. After signed consent, an anonymous self-completed questionnaire was administered to students estimated to take 15 minutes to complete. Both students and teachers were informed that the questionnaires were confidential, that completion was voluntary, and students were free to stop answering the questionnaire at any time. Teachers were told not to vet, monitor, or validate answers given freely by the students. Completed questionnaires were folded so that teachers could not review answers given by a specific student.

Tools: The questionnaire sought information on students' knowledge, behaviour and attitudes towards sex and relationships. Specific questions on SRE related to the exact content of the SRE programme. Other questions (by request of GONW) were involved with broader themes of wellbeing and included related issues such as alcohol use (such questions have been used in many questionnaires for children – i.e. TellUs3). Questions were age appropriate (by year group), and structured around the proposed intervention content for each year. Knowledge questions varied in complexity, allowing students of different ages and abilities to express their knowledge. Behaviour and attitude questions were also tailored appropriately. For example, questions about behavioural intention were more appropriate among younger age groups, while sexual behaviour questions were possible for older students. As noted above, sexual debut before 16 years of age occurs in a third to a quarter of the population, thus it was essential to categorise adolescents by level of sexual experience.

Analysis: The data was entered manually into the statistical analysis package SPSS 17. SPSS programme command syntax language was developed to analyse the data. Using syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essentially when determining the correct denominator for multiple response questions. These tables were then exported to Microsoft Excel, where the data could be graphically displayed.

Data generated from the baseline survey was abstracted for the Wirral school and reanalyzed separately. Analysis consisted of frequency distribution and cross-tabulations by gender and age, or by year group. Student characteristics of interest concerned wellbeing, school ethos (generated as ranked scores using a 5-point Likert Scale ranging from strongly agree to strongly disagree), activities outside school, bullying, use of

alcohol (categorical measure of 'have you ever drunk alcohol, yes/no) and frequency of alcohol use ranging from never, very occasionally (less than once/month), occasionally (about once or twice/month), once/twice a week (regularly), three or more times a week, or every day. Data were graphically displayed with gender-wise layering of populations subdivided by binary variables relating to questions regarding bullying. Multiple response questions regarding seeking of information on sex and relationships, what matters regarding sexual relationships the students try to engage with their parents and vice versa, were converted to binary variables using the command syntax language. These were displayed as horizontal bar charts. Frequency distribution of knowledge and use of services was computed. The sexual indicators in the Year 9 population (including whether the respondent has had a sexual relationship, and what form of sexual activities this involved) were displayed graphically after converting the multiple response variables to binary variables, when necessary. The results were separated and compared by demographical variables, namely year group and gender. Where feasible, chi-squared tests were used to determine whether there was a statistically significant association between two non-constant categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less). Due to the small sample size more complicated analytic investigations were not feasible.

3.2.8.3 kooth.com

Background: kooth.com is a free online support and counseling service for young people available in 11 local authorities in England and Wales. Information pages, message boards and live online counseling is offered on a variety of wellbeing issues including sexual health, relationships, family life, bullying, drugs and alcohol, stress, anxiety and mental health issues. More information on the service they offer can be found at www.kooth.com.

Aim of kooth.com study: The aim of the study through the kooth website was to access the opinions of young people who turn to kooth for advice and support and to gather the views and opinions of these young people on the types of health services they believe young people would prefer to use in Wirral. This group is likely to be highly vulnerable and may not access mainstream services. The questionnaire was very similar to the Healthy School initiative health services audit detailed in this report – 5.2.5.3

Methodology: A short health service audit questionnaire was developed by NHS Wirral with assistance from researchers at LJMU. When users registered on kooth who are resident in Wirral logged on to kooth.com a link to a survey was presented on the homepage. This linked to an online questionnaire version of the survey which asked about views and opinions of young people on health services in Wirral. The simple page health audit form took approximately 15 minutes to complete and was anonymous. They were reminded their participation was voluntary and any views expressed would remain confidential. No personal questions were asked and responses were anonymous.

Analysis: Output data from the questionnaire were forwarded to LJMU for analysis. Due to the small number of variables, analysis was performed using the Microsoft Excel spreadsheet. Analysis consisted of frequency distributions and cross-tabulations of variables of interest against age and gender. Small numbers also precluded geographical analysis to avoid accidental disclosure of individuals using kooth counseling services.

3.2.8.4 National Children's Bureau study on young people: depression and GP services

Background: The National Children's Bureau (NCB) are involved with a variety of activities related to the health and wellbeing of young people in the UK. One such study involves partnerships with NHS Trusts and PCTs to further understand the needs of young people with emotional wellbeing (mental health) issues, and in particular how they perceive health services (with specific reference to GPs) to support their needs. NCB met with Response, Connexions, Wirral Drug and Alcohol Action Team (DAAT), Youth Service, Children and Adolescent Mental Health Services (CAMHS) to plan activities and amongst these was a request to conduct an informal survey with a small number of young people to understand their views on GP and health service support for substance abusers who suffered depression.

Methodology: An NCB one page questionnaire was sent to Response, Youth Offending Service, Connexions and CAMHS requesting they ask a small pilot sample (~10 young people each). Each group conducted the survey during routine counseling activities, by asking young people whether they would be willing to answer 5 open-ended questions. These were conducted in private and face to face questioning was transcribed onto the form by the counselor. Completed forms, without names, were forwarded to LJMU for analysis.

Analysis: Themes were abstracted from the question forms for each answer and were entered onto a spreadsheet. Frequencies were calculated for each question and main themes arising. Quotes were then abstracted to best describe the range of opinions of young people, to portray their own voices.

3.2.8.5 Parents and children's perception of alcohol use

Background: LJMU designed a study to explore the perceptions of both parents and their children on use of alcohol to determine if there was any association between the amount drunk by children and by their parents. Within the study, designed as a questionnaire survey to be conducted in schools in Wirral (academic year 2008/09), children were asked if they suffered any emotional wellbeing problems.

Methodology: Parents and children attending parents evening in three schools in Wirral were invited to complete a 2 page questionnaire about their use of alcohol. Parents and students were told about the study and provided with an information sheet and a consent form to complete if they were willing for themselves and their children to participate. Children were aged between 11 and 17 years of age. The survey was conducted between September 2008 and June 2009.

Analysis: Data were entered manually onto an SPSS spreadsheet. For the purpose of WiSHing, information reported by children only were explored. Data variables of interest included age and gender, and children's reported health or wellbeing issues, activities outside of school, and their alcohol use. No questions were asked about childrens' sexual behavior or health seeking.

3.2.8.6 Pilot study for NW teen project: Sexual attitudes and behaviors of young people, alcohol and teenage conceptions

Background: A collaborative partnership between Government Office NW, NHS NW, the three Sexual Health Networks, and local authorities and NHS Trusts and PCTs was established to bring together persons interested to explore young people's sexual health experiences, with a particular interest in their other risk taking behaviour, including alcohol use, drugs, and risk of teenage conception, and their emotional wellbeing. Based on work conducted for NHS Wirral, and the GONW pilot of the SRE programme, a questionnaire and tools were developed which would be used to survey a very large sample of young people (~15,000) throughout the NW region. Data generated locally will provide an insight into behaviour of college aged students; combined data from the region will provide definitive information for the UK on the inter-relationships between wellbeing, alcohol use (and other risk factors) and sexual behaviour.

Methodology: Birkenhead 6th Form College, Birkenhead agreed to pilot the questionnaire and tools in June 2009. Questionnaires, information sheets, and consents were forwarded to the college, who implemented the survey during class time. Completed questionnaires were forwarded to LJMU for evaluation of the quality of answers, if any questions were poorly understood, missing answers, with particular care to determine if the 8 page questionnaire was too long (e.g. if students would get questionnaire fatigue). Open ended questions were evaluated to determine frequent responses that could then be included in the final North West Teen Study questionnaire. In addition, frequency distributions were made for questions of interest to the Wirral WiSHing Project, and are reported below.

Note, although Wirral Met was unable to participate with the pilot, Mr Paul Little (Tutorial and Enrichment Manager) and colleagues from the college provided invaluable advice and suggestions to improve the quality of the questionnaire to ensure it fully captured views and opinions of young people, and characteristics of risk associated with the most vulnerable in Wirral. Their college will participate in the full study early in 2010, with results being made available also to NHS Wirral.

Box 7 Objectives of the NW Teen Study

- To characterise and define which subgroups of the school/college aged population (aged 13-19 years) are sexually active, and are exposed to the risk of conception and other risky sexual outcomes;
- To quantify use of alcohol, and analyse what impact alcohol (and other such risk factors) has on age of sexual debut, use of condoms during debut, use of emergency contraception, frequency of partners, use of condoms during their most recent sexual activity, number of pregnancies, number of abortions, and live births. This would be explored for boys as well as for girls;
- To determine teenagers' sexual health seeking behaviour, and identify patterns of utilisation of pregnancy prevention and/or abortion services;
- To explore socio/geo-demographical and economic factors which influence risks of poor sexual behaviour, alcohol use, and conception risk;
- To define other factors that enhance or mitigate risk (e.g. sexual attitudes, parent/carers collusion, structured sex and relationship lessons, information seeking from media, wellbeing indicators, schooling, religion, parent/carers employment, and other socio-economic and geo-demographic indicators, positioning of Sexual Health Clinics in or near schools/colleges);
- To characterise the frequency of, and differences between, girls who take emergency contraception, those who elect to abort, against those who decide to take their pregnancy to term;
- To prepare data for local authority drug and alcohol action programmes as above to assist with integrated policy reviews on teenage alcohol use and poor sexual health, pregnancy, and other negative outcomes.

Analysis: An SPSS spreadsheet was formulated in preparation for data entry. Data entry was conducted by hand (the main study will scan questionnaires). Syntax was written to transform data variables to account for missing data, and to re-categorise bivariate, scaled (Likert scale), and continuous variables. Cleaning was conducted on a sample of questionnaires. Characteristics of young people were analysed and described by age, gender, socio/geo-demographic parameters, religion, school ethos, wellbeing characteristics, parental collusion, and vulnerable risk factors. Alcohol and drug use were characterised by use, and frequency of use. Analysis consisted of frequency distributions, cross-tabulations and statistical tests of data. Using syntax resulted in ease of reproducibility of analytic outputs and the correct treatment of missing values, the latter of which is essentially when determining the correct denominator for multiple response questions. These tables were then exported to Microsoft Excel, where the data were graphically displayed. Chi-squared tests were used to determine whether there was a statistically significant association between two non-constant categorical variables. Statistical associations were significant at the 95% level (e.g. $p = 0.05$ or less).

In the North West Teen Study, alcohol-related indices will be defined including age first consumed alcohol, age first got drunk, attendance at accident and emergency for alcohol-related harm, other harms associated with alcohol (and drugs), alcohol units drunk at usual drinking session, and alcohol drunk at specific sexual events (sexual debut, recent sex). The sample in the pilot study was not sufficient to break down into each of the relevant categories, however, limiting data analysis and interpretation. Similarly, sexual indicators were defined including the age of sexual debut, use of condoms and/or emergency contraception during debut and recent sex; frequency of partners, number of conceptions, whether alcohol was drunk by self or partner, number of abortions, and live births. Sexual health seeking behaviour was determined by listing the types of services used and reasons given for not wanting to use specific services.

Datasets from the Service users, WiSHing Core (community) participants, and students completing the pilot questionnaire for the NW Teen Study were also merged together using SPSS's command syntax language, allowing a direct comparison between the three groups across numerous variables common in each of the questionnaires.

4 Results

4.1 Demographics of young people in Wirral

Wirral, located in the north west of England, is a peninsula geographically separated from Liverpool and North Wales by the rivers Mersey and Dee. Chester is situated in Cheshire, juxtaposing Wirral on its southern border. Wirral Compendium of Statistics (2008) provides up to date data on the status of its residents.⁷⁴ The population of Wirral is currently estimated to be 312,400, spread over 22 wards. The majority of residents are classified as 'White British' (95.5%), with a further 1.1% 'Other white', and 0.9% 'Irish'. All other ethnic groups comprise less than 0.5% of the population. Currently there are 41,928 young people aged between 10-19 years of age, 51.4% (21,554) of whom are males. The number of people in this age group is predicted to fall by 9% by 2011, with a continuing downward trend until 2026.

Male life expectancy is 74.7 years (range by wards; 68.3 Birkenhead to 79.9 Heswall) and for females 79.7 years (range by wards; 75.3 Birkenhead to 84.9 Bebington), roughly similar to other areas of the North West but lower than England. The Index of Multiple Deprivation IMD classification (a score which varies from least deprived zero to most deprived 85) suggests mixture of wealth and deprivation, ranging between 10.3 in west Wirral (Heswall) to 78.9 in north Wirral (Birkenhead). Nearly a third (30.0%) of children aged 0-15 years are living in low income households (2001) which is higher than the North West (25.3%) and England (21.3%).⁷⁵ There are 670 'looked after' children (0-17 years of age) in this category (including 62 from out of the borough), giving a rate of 97 per 10,000, higher than the average for the North West (69) and England (55); the range again varies between wards. Wirral has a higher rate of under-18 year olds (35.2 per 10,000) who were the subject of a Child Protection Plan, compared with the North West (23.6 per 10,000) and England (25.3 per 10,000).⁷⁵

There are 24 secondary schools and nine 'special' schools in the area; the latter include both hospital schools and facilities for those with a learning and/or physical disability. In 2007, data indicated 2.2% of secondary school pupils are statemented for special educational needs, which is comparable with the North West (2.3%) and with England (2.13%). Data from schools suggest Wirral has a higher percentage (12.4%) of children given a fixed period exclusion (2005-6), compared with the North West (10.7%) and England (10.4%), although the permanent exclusion rate was lower (0.17%) in comparison (0.24%, 0.24% respectively). Approaching 12% of young people aged 16-18 years are not in education, employment or training (NEETs), compared with the North West (10.8%) and England (8.6%). There is a huge disparity between the wealthiest (i.e. Heswall: <1%) and the most impoverished (Birkenhead and Tranmere: 25%) areas. Academic achievements (A*-C grades at GCSE) correspond with the national average but vary by ward.

The under-18 (aged 15-17) conception rate in Wirral has shown small fluctuations over the last 10 year period, and showed a downward shift between 2007 and 2008 (from 47.4 to 40.0 per 1,000; based on provisional figures).⁷⁶ In 2008, the under-18 pregnancy rates in England and Wales, North West England, and Wirral were 40.6, 45.7 and 40.0 per 1,000 respectively. In Wirral, six 'hotspot' wards, with rates among the highest 20% in England, account for half of under-18 conceptions.⁷⁷ The abortion rate for the under-18's in Wirral now stands at 18 per 1,000 which is comparable to figures for the North West (18) and England (18.3).⁷⁸ Nationally, one in three girls in the most vulnerable subcategories become a teen mother by the age of 20.⁷⁹ In Wirral 80% of teen mothers are lone parents (compared with 61% for England), and a third of lone parents with dependent children are under 18 year olds,⁷⁵ with the percentage of lone mothers over 40% in deprived wards.

Hospital admissions in children under-18 are two and a half fold higher in Wirral than the national average,⁷⁵ and alcohol-related admissions in males are double the North West average, and triple the national average.⁷⁵ Obesity is also a public health priority: it is estimated a quarter of adolescents will be obese in 25 years.⁸⁰ In Wirral, 20% of children starting secondary education are obese, compared with the North West average of 17%.⁸¹ Eating disorders have similarly increased: anorexia, precipitated as a coping mechanism against stress and conflict, is the third most common chronic condition in adolescent girls in Britain.⁸²

4.1.1 NWPHO compilation of demographic information on young people in Wirral

Box 8 Summary of Key Young Peoples Indicators for Wirral

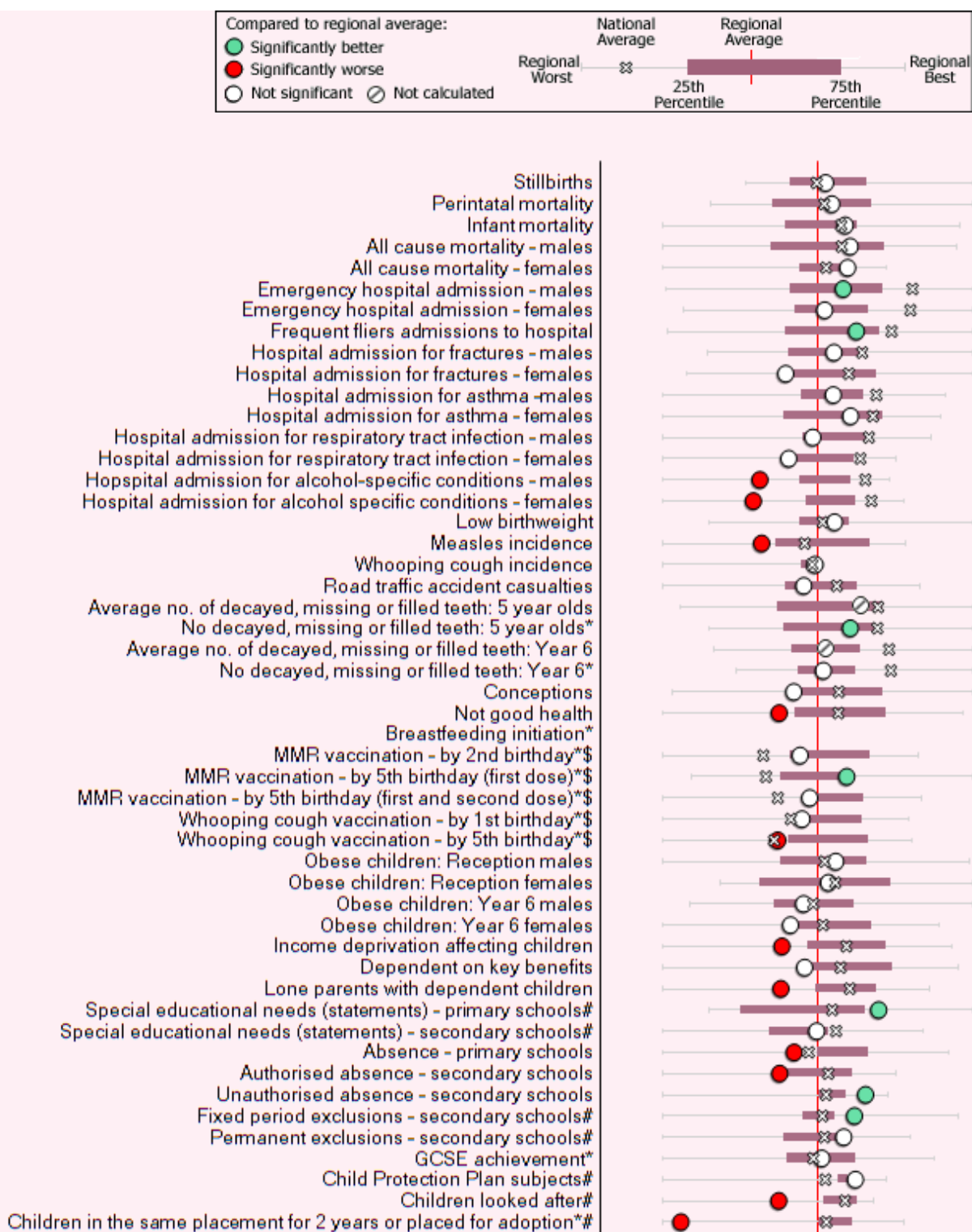
(Children and Young People's Health Indicators, North West Public Health Observatory*)

Of the 43 local authorities in the North West, Wirral was ranked:

1. 41 of 43 for alcohol admissions for boys (0-17 years) with 158.33 per 100,000 (NW average and national average 106.37 and 61.85 per 100,000 respectively).
2. 41 of 43 for alcohol admissions for girls (0-17 years) with 190.49 per 100,000 (NW average and national average 130.29 and 78.23 per 100,000 respectively).
3. 27 of 43 for deaths/serious road traffic injuries for children (0-15 years) with 0.39 per 1,000 (NW average and national average 0.34 and 0.28 per 1,000 respectively).
4. 32 of 43 for under 18 conceptions for teenage (15-17 years) girls in 2006 with 47.78 per 100,000 (NW average and national average 44.18 and 40.70 per 1000 respectively); update for 2007 is Wirral 47.1, NW England 47.0, England 41.7 per 1000.
5. 27 of 43 for obese males in Year 6 in 2008 with 20.4% (NW average and national average 19.8% and 20% respectively).
6. 32 of 43 for obese females in Year 6 in 2008 with 17.8% (NW average and national average 16.8% and 16.6% respectively).
7. 37 of 43 for percent of children 0-15 years in families receiving income support/tax credits with 29.9% (NW average and national average 25.3% and 21.3% respectively).
8. 32 of 43 for percent of children 0-15 years in families receiving key benefits in 2007 with 23.4% (NW average and national average 22.0% and 19.2% respectively).
9. 38 of 43 for percent of lone parents with dependent children under-18 years in all families with dependent children in 2001 census with 33.1% (NW average and national average 29.0% and 25.2% respectively).
10. 18 of 43 for percent of secondary school pupils with statements of special education needs (SEN) in 2008 with 2.2% (NW average and national average 2.2% and 2.0% respectively).
11. 33 of 43 for percent of pupil half days missed due to authorised absence in maintained secondary schools (2006/7) with 6.7% (NW average and national average 6.5% and 6.4% respectively).
12. 4 of 43 for percent of pupil half days missed due to unauthorised absence in maintained secondary schools (2006/7) with 1.1% (NW average and national average 1.6% and 1.5% respectively).
13. 8 of 43 for percent of fixed period exclusions in maintained secondary schools (2006/7) as percent school population with 9.5% (NW average and national average 11.1% and 10.8% respectively).
14. 13 of 43 for percent of permanent exclusions in maintained secondary schools (2006/7) as percent school population with 0.17% (NW average and national average 0.24% and 0.22% respectively).
15. 26 of 43 for percent of pupils at end of Key Stage 4 achieving 5 or more GCSEs at grades A*-C in 2006/7 with 65.8% (NW average and national average 65.2% and 64.8% respectively).
16. 9 of 43 for children and young people subject to Child Protection Plan in 2008 with 24 per 10,000 children under 18 years (NW average and national average 33 and 31 per 10,000 respectively).
17. 39 of 43 for looked after children in 2008 with 89 per 10,000 children under 18 years (NW average and national average 69 and 54 per 10,000 respectively).
18. 2 of 43 for percent of children under 16 years who have been looked after for two or more years or placed for adoption in 2008 with 52% (NW average and national average 66% and 67% respectively).

Accessed for WiSHing Project Report 24 October 2009 via www.nwpho.org.uk

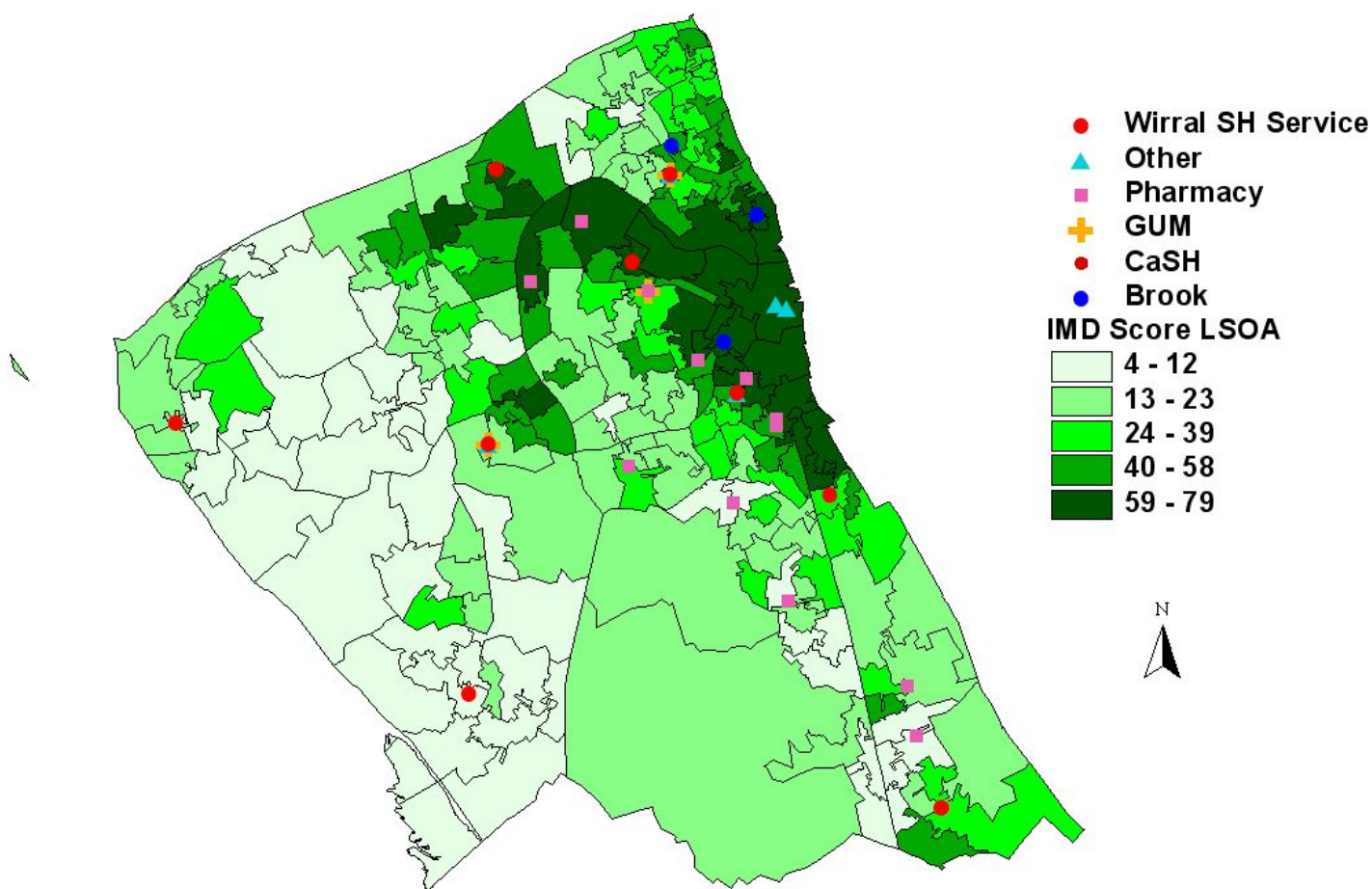
Children and Young People's Health Indicators, North West Public Health Observatory Comparison between Wirral, North West and England averages



Significantly better for emergency hospital admissions males, frequent flier admissions, no decayed missing filled teen by 5 years, MMR 1st dose by 5th birthday, special education needs at primary schools, unauthorized absences secondary schools, fixed period exclusions.

Significantly worse for alcohol related hospital admission; not good health, income deprivation affecting children, lone parents with dependent children, absence from primary schools and secondary schools, looked after children, and children in the same placement for 2 years or placed for adoption.

4.1.2 Location of services



Map 1. Locations of services and levels of deprivation

Index of Multiple Deprivation (IMD) scores are presented by lower super output area (LSOA; a geographically steady area with approximately 1,500 people in each LSOA). Sexual health services are mainly located in areas of higher deprivation around Birkenhead and Wallasey. The majority of the services are on the east of the peninsula with only one service (the Wirral SH Service service at West Kirby Health Centre) in Hoylake or West Kirby. ‘Other’ includes specialist services (Harm Reduction, Terrence Higgins Trust, and Response) and Walk-in Centres.

4.2 Findings

4.2.1 Sexual Health Service Providers: Services available and provider opinions

Box 9 Sexual health services on Wirral - services available and service provider opinions.

- Questionnaires and telephone interviews were conducted with staff employed at the key sexual health services on Wirral to determine the sexual health services provided, gaps in provision and the opinion of staff who work on the front line caring for young people.
- There are some sexual health services available at all times during week days, some evenings and Saturday day time. Young people must attend Walk-in clinic centres for sexual health help on a Sunday. Poor awareness of the sexual health services available at Walk-in centres may delay treatment, this is especially important if emergency hormonal contraception is needed.
- Opening hours are limited and at the majority of services are at different times each day which leads to confusion and difficulty for some young people. Effective advertising needs to be in place to ensure young people know when services are open. Only Wirral Brook offers consistent and long opening hours.
- Out of hours services are provided by Wirral Brook, The Confidential Advice Service (CAS), Wirral Sexual Health Service and two satellite GUM clinics.
- Provision of contraception is widespread and information comprehensive.
- Contraceptive services were thought to be 'patchy', in terms of geography, opening times and services offered. More consistent services that offer free condoms are widely available
- Availability of intra-uterine devices are limited.
- Chlamydia and gonorrhoea testing is available in a wide variety of settings, as well as in community services and GPs, through the screening programme.
- Wirral Brook were mentioned by a number of NHS staff as offering a high quality and important sexual health service to young people. Only Brook offers consistent and long opening hours and their service is highly regarded by both Brook staff and staff based at PCT services.
- The number of young people attending services varies week to week. Wirral Brook appears to see the highest number of young people, while relatively fewer young people are recorded to access general GUM clinics and Wirral Sexual Health services.
- Attendance is much lower in males at all services (except for in Harm Reduction). This may be because young men do not wish to access services, or do not know about the services – services need to ensure they are welcoming and accessible to young men.
- Some organisations have difficulty advertising, especially in some schools.
- Young people don't seem to access Wirral Sexual Health and GUM services as much as Brook. PCT services need to ensure they are young people friendly, effectively advertised and open at appropriate times. Adherence with You're Welcome criteria will enhance this.
- Education and outreach is provided in school by a dedicated education team at Brook, Wirral Sexual Health Service and occasionally in assemblies by CAS. The chlamydia screening service does a lot of outreach and publicity work especially in areas where young people often congregate. Outreach work with sex workers and drug users is offered by Harm Reduction.
- All services are wheelchair accessible.
- Only Harm Reduction and CAS can provide information in a language other than English though interpreters are available.
- Only 'Harm Reduction' can provide post-exposure prophylaxis for HIV.
- A number of services were unsure how many young people they see and if any of them are categorised as being particularly vulnerable groups.

Access to existing services (Table 1)

Generally individuals felt that services are well advertised and covered a number of areas (table 1). Wirral Chlamydia Screening Programme advertises the widest and promotes their service in more obscure locations such as the Territorial Army and army bases, at local events. Efforts are being made to promote chlamydia screening in areas that young men access such as local industry that employ lots of young men, at Tranmere Rovers matches and in Sunday league football changing rooms. Wirral Brook and CAS noted difficulty promoting their services in some schools, especially faith schools. It was also mentioned that services who mainly advertise in schools (like CAS) do not publicise themselves to young people not in mainstream education and these are the young people more likely to be at risk of poor sexual health. CAS also report difficulty advertising their services. They need young people to know about them but do not want to advertise too publically and risk discouraging young people from attending because of common knowledge that they offer sexual health services. They have difficulty tailoring their advertisement so not to compromise the confidential nature of the service. The chlamydia screening service has so far been unable promote their services in any special educational needs school. Harm Reduction in St Catherine's Hospital do not advertise their sexual health service widely and find most of their patients come through word of mouth or through referrals from drug services.

Harm Reduction and CAS are able to provide information in languages other than English. They are able to do this through their computer system that can translate all text into a variety of languages.

The majority of services provide a drop-in or a drop-in combined with an appointment service so young people can usually see a nurse within a few days. Most services have limited, short opening hours or are open at different times everyday which could lead to confusion for young people wishing to attend; especially if the service is not well advertised. Only Wirral Brook and Harm Reduction have consistent long opening hours. The GUM service at Cloughton Medical Centre, Victoria Central Hospital, Wirral Sexual Health Service, CAS and Brook are also open out of hours. All days of the week are covered between the services but on Sundays, for example, only NHS Walk-in centres are open. Reduction mentioned they see a lot of young people towards the end of the day as they come from school and believe young people are happy to visit their service as it is within a hospital so not as obvious as to where they are going. Opening times and locations of Wirral Sexual Health Service are presented in table 3.

All services have wheelchair access. Outreach services are provided at the syringe exchange by GUM, in schools by Brook, CAS and Wirral Sexual Health Service and with street sex workers and in massage parlours by Harm reduction.

Services Provided (Table 2)

The majority of services included provide pregnancy testing, free condoms, screening for STIs (or at least chlamydia and gonorrhoea) and a range of contraception. All services offer free condoms. Only Harm Reduction are able to provide post exposure prophylaxis for HIV but most others stated they can signpost to other services. There are also a few places that can offer IUCD fitting though again most indicated they can refer or signpost to other services. Only CAS can provide HPV vaccination. No services offer a 24 hour helpline or information line though websites are available. A number of phone lines are available nationally (ie sexline, childline etc) but these do not contain local information.

CAS also reported that they provide a range of additional services that relate to sexual health including discussion around drugs and alcohol. Harm reduction also provide treatment and support relating to substance use. Chlamydia screening is available at over 200 sites across Wirral including in all GPs and Wirral SH Service. Actual screening is not available in pharmacies but most distribute postal kits and information cards.

Contraceptive services (Table 4) Contraception is the most common sexual health service provided in the organisations we surveyed. All centres that provide contraception also offer full information about choice, effectiveness and instructions for each method. Although the only contraception that the chlamydia screening programme can provide is free condoms they are located within the main Wirral Sexual Health service at St Catherine so can escort young people next door for other contraceptive needs. Harm Reduction mentioned they offer a range of LARC that suits some of their client group (especially sex workers and substance users) as it is more appropriate for a chaotic lifestyle.

Clients attending services (Table 5)

Services were asked to estimate how many of each age group attended their service in an average week. Information about attendees was not available for every service. This, in itself, is of concern when it comes to planning provision as it means that a number of staff on the front line are not aware of how many young people they see. For the majority of services the number of patients varied substantially each week/session.

The number of young people attending general services (such as Wirral Sexual Health Service and GUM) was very low, especially in the younger age groups. CAS, for example, see between 2 and 18 young people per two hour session and it varies dramatically from week to week. Wirral Brook sees the highest number of young people - over 200 per week. Brook was able to provide data averaged over the year that indicated the majority of their attendees were female and mainly from the older age group. The majority of GUM clients were over 19. Wirral chlamydia screening programme sees a large number of young people. The service was part of the original screening pilot so has been established for 10 years. Harm reduction indicated they see approximately 15 young people each week. The majority of these are male steroid users and they also try to encourage under-16 year olds to attend Brook.

In most services far fewer males than females attend. In some services, for example Wirral Sexual Health Service, the type of service provided and history of family planning may account for this. Overall Harm Reduction see the highest proportion of males and most of these are under 19 and are steroid injectors. GUM sees a large proportion of males in the 16-19 year old group. Most services reported that males usually come in with their female partners.

Vulnerable groups attending services (Table 6)

All services indicated that they see young people with learning disabilities, behavioural problems, those living in hostels, looked after children, temporarily and permanently excluded, and young carers. Harm reduction see a number of substance users and sex workers. A number of respondents indicated they did not know if they had any clients from vulnerable groups and are thus unaware of any increased risks for the patients.

Staff opinions

Participants were asked what they thought of the service their organisation provides and about the provision of sexual health services for young people on Wirral. Answers fell into three main categories: strengths, problems and barriers to access and suggested improvements.

Strengths and Successes

Generally staff believed the service they offer is a good quality, comprehensive and friendly service. A number of people stated they believed the various services in Wirral work well in partnership with good networks set up. Harm reduction believe their location is especially good for young people and Brook were mentioned by a number of services as providing high quality specialised service to young people

Box 10. Strengths and successes - Exemplar Quotes from Service Providers

'Good within constraints of clinic and time'

"[we offer a] Good service"

"feel we develop good relationships and give a good quality of service"

"good service which YP trust"

" good non judgemental service"

"young people like our service [Harm Reduction] because it is flexible. It isn't as obvious as Brook and they can come in on their way to school. It is less obvious to come here [as it is in the hospital] than a lot of the other services"

"We find it easier to promote the [CAS] service in schools as we are a broad health service and don't just focus on sexual health. This means parents and schools are more accepting, including some faith schools."

"[our service is] generally a good service – staff are non judgemental and nurses have embraced STI testing/treating with enthusiasm"

"Brook provides an excellent service which works in a complementary way with PCT service"
(Wirral Sexual Health Service staff)

"A clinic everyday is provided on the Wirral"

"Brook are fabulous – they really attract young people. The staff are friendly and the services fantastic" (Wirral Sexual Health Service staff)

"we have good joint working between GUM, family planning and us [Harm Reduction] and GUM and family planning know they can send people over here if they are not open"

"Brook is the saving grace of Wirral" (Wirral Sexual Health Service staff)

"[provision of services is] very good in the area we have womens, CAS and Brook".

"Services are a lot better and there are good networks set up." (CAS)

"Things are changing, people are listening and beginning to modernise services. They are changing them for the better and improving them for the young people"

Problems and barriers to services

A number of problems and barriers to services were stated by a variety of service provider participants. The difficulty in promoting services, specifically to young people was stated by a number of participants. CAS finds advertising a challenge. They want to make young people aware of the services but conversely do not want the stigma of it being known widely as a sexual health service which may deter potential users. Services were also mentioned to be 'patchy' (both geographically and in opening times) and not always young person friendly. A couple of service provider participants noted that the term 'family planning' tended to put young people off attending, especially the males.

Box 11. Problems/barrier to services- Exemplar Quotes from Service Providers

"could be promoted more"

"limitations as we can only test for chlamydia and gonorrhoea"

"we seem unable to get YP to attend"

"YP find it difficult to trust services especially as they are on a main road" (Brook)

"Long waits, especially at evening [Wirral Sexual Health Service] clinics are problematic and sometimes young people leave without being seen"

"there are geographical 'black spots' in Wirral for young people regarding sexual health provision. Other 'black spots' include post TOP counselling."

"SH services are patchy - YP perceive they aren't approachable and so don't attend".

"they are very well provided for if only they would make full use of our services - some YP do, some don't."

"It will be interesting to see how the school nurses get on as young people are often reluctant to attend services in school as they see nurses as employed by the school and worry information will be passed on to the teachers"

"I personally have reservations about the value of school based services – the peak demand is weekend/half terms/school holidays when school services would not be open. But they do have a place, albeit limited"

"there are no weekend or late evening clinics for young people"

"the term family planning puts some young people off – they all think it is about women and pregnancy"

"there is no CaSH service open during the day on Monday – surely this is a peak time for them to provide the morning after pill after the weekend"

Suggested improvements to services

A number of service provider participants mentioned various improvements that could be made, including widening opening hours or opening at more convenient and appropriate times, particularly a Monday morning for EHC. Participants mentioned modernising and 'funking' up services as well as introducing up to date technology as a way to increase attendance of young people.

Box 12. Improvements – Exemplar quotes from service providers

"Clinics open all day or attached to walk-in centre"

"train up the existing walk-in nurses in family planning and some sexual health problems"

"need a clinic on Monday AM for post coital contraception. It is difficult to get an appointment for GPs on a busy Monday morning."

"open access facilities over the weekend"

"we need to modernise services and introduce new technology to attract young people – like swipe card registration or using texts more"

"we are quite well staffed but need to reorganise provision to allow 'quick stream' which would fix this [young people leaving without being seen]"

"there is a need for a specialist young persons clinic for those with physical/learning disabilities etc"

"[services] need funk up to attract the young, all at one stop would be good away from healthcare may be attached to internet cafe as easily accessible of train/bus"

"If CAS services are going to be rolled out across all of Wirral I hope all of the clinics it will be managed by one central team. Funding should be used to employ front line nurses and not on coordinators."

"we need to modernise the term family planning"

"we need to make the services more friendly to young men"

Table 1. Access to services

	Genito Urinary Medicine - Arrowe Park Hospital	GUM satellite clinic - Claughton Medical Centre	GUM satellite clinic - Victoria Central Hospital	Brook, Birkenhead	Wirral Sexual Health Service	Chlamydia screening Service	Wirral Metropolitan College	Confidential Advice Service New Brighton (CAS)	Harm reduction
Advertising	Local papers and leaflets in GP surgeries	Local papers and leaflets in GP surgeries	Local papers and leaflets in GP surgeries	College/Schools, Internet, GPs Radio/TV Letters through post	Clinic times in all GP surgeries Flyers Word of Mouth Signposting Actively trying to increase advertising	Local papers, schools/colleges/ GP services, letters through post (all YP registered at GP get invitation letter on 19 th birthday), in shops (sunbed salons, hairdressers, travel agents), beer mats in pubs/clubs, internet, pharmacies, TA and army barracks, big employers in region (Vauxhall, police), gyms, Tranmere Rovers games	Within colleges	Schools/ Colleges, GP Services, shops, internet, youth clubs, n assemblies at schools.	Leaflets at syringe exchange sites, drug service, leaflets in Wirral SH Service. Take referrals from other services and drop in.
Leaflets in other languages	No but they can get an interpreter	No but they can get an interpreter	No but they can get an interpreter	No	No, interpreter available	No	No	Yes – all text can be converted into other languages by practice computer system	All information can be translated using computer programme
No. YP sessions per week	0	0	0	15+	0	n/a	Probably 1	2	0

Drop in or appointment system	Drop in	Drop in	Drop in	Appointments and Drop-in	Appointment and Drop-in	CT screening office is drop-in for tests but appointment for treatment	will be appointment	Drop in	Drop in and appointments
How long for appointment	No wait - drop in	No wait - drop in	No wait - drop in	No wait – drop in	No wait – drop in	No wait – drop in		No wait – drop in	No wait – drop in
Wheelchair access	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Opening hours	Monday 9-11 Thursday 2-4 Friday 10-12	Wednesday 5.30-7.30	Tuesday 5.30-7.30	Clinic open weekdays 3-6.30 Tues 9.30-12 Saturday 1-3 Male session Friday 3.45-5.45	See table below	Office offers drop-in testing 9.30-4.50 on weekdays. Many screening site (pharmacies, GPs, walk-in centres) offer screening out of hours.	Will hopefully be 4 hours on a Thursday afternoon	Tuesday 4-6pm Thursday 4-6pm	Monday-Thursday 8.30-6.30 Friday 8.30 – 4.30?
Any outreach	Quarterly clinic at Harm Reduction. syringe exchange	Quarterly clinic at Harm Reduction/ syringe exchange	Quarterly clinic at Harm Reduction/syringe exchange	Counselling, a full time education team, education in schools, and 3 SH community clinics	Offer education sessions and SH training in school, colleges and 6 th forms. Stall at health events. CT screening in colleges and 6 th forms.	Outreach in a variety of settings – FE colleges/6 th form college, TA base. Do leafleting and information/advice campaigns at Wirral Show, football games, schools.	Nurse does SH tutorials, free condoms, "Health Bite" on intranet that pops up SH info on college computers	Stands at Wirral show, open days, assemblies giving information in schools	With sex workers and in massage parlours – condoms, contraception support CT/GC screening, smears. Hep B vaccination

Table 2. Services Provided

	Genito Urinary Medicine - Arrowe Park Hospital	GUM satellite clinic - Claughton Medical Centre	GUM satellite clinic - Victoria Central Hospital	Brook, Birkenhead	Wirral Sexual Health Service	Chlamydia screening Service	Wirral Metropolitan College	Confidential Advice Service New Brighton (CAS)	Harm reduction
Informed confidential	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pregnancy testing	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Cervical smears	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
STI Testing	Yes	Yes	Yes	yes	Chlamydia & gonorrhoea only	Chlamydia & gonorrhoea only	CT &GC screening	Yes – test for all STIs	Chlamydia, gonorrhoea, BV, TV, Hep B, Hep C & HIV
STI Treatment	Yes	Yes	Yes	Yes	Chlamydia only (gonorrhoea must be treated in GUM)	Chlamydia only(gonorrhoea must be treated in GUM)	No	Yes – need to refer more complex cases	Direct care pathways set up for quick treatment with consultants in GUM
IUCD Fitting	No	No	No	Yes	Yes	No	No	No	No
Post exposure prophylaxis	No	No	No	No	No	No	No	No	Yes
Oral contraceptives	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Injectable contraception	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Free condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HPV vaccine	No	No	No	No	No	No	No	Yes	No
counselling	No	No	No	Yes	Yes	No	Yes	Yes	No
contract tracing	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No
24hr helpline	No - 24 hour answer phone with some information	No - 24 hour answer phone with some information	No - 24 hour answer phone with some information	No	No	No. Answer phone directs YP to website which gives information, can request a	No	No	

						postal test and points YP to a testing sites			No
other					referral for termination of pregnancy and psychosexual counselling	Chlamydia screening office is based within central Wirral SH Service so any other issues are referred to sister clinic		Provide information about alcohol, drugs, smoking cessation as well – not just a sexual health service	General advice and harm reduction work

Table 3. Opening times of Wirral Sexual Health Services.

	AM	PM
Monday	9.30 -11 St Caths	6.30 - 8 Eastham Clinic
		6.30 - 8 VCH
Tuesday	9.30 -11.30 Leasowe Primary Care Centre	1 - 3 New Ferry Parkfield Medical Centre
		1.30 - 3.30 VCH.
		6 - 7 Antenatal Clinic APH
Wednesday	9.30 -11.30 St Caths	6.30-8 VCH
	9.30 -11.30 Eastham Clinic	
Thursday	9.30-3 St Caths	
		5-7 St Caths
		6.30-8 Heswall Clinic
		6.30-8.30 Eastham Clinic
Friday	9.30 -11.30 Miriam Health Centre	
	9.30 -11.30 West Kirby Health Centre	

Table 4. Contraceptive services

	Genito Urinary Medicine - Arrowe Park Hospital	GUM satellite clinic - Claughton Medical Centre	GUM satellite clinic - Victoria Central Hospital	Brook, Birkenhead	Wirral Sexual Health Service	Chlamydia screening Service	Wirral Metropolitan College	Confidential Advice Service New Brighton (CAS)	Harm reduction
methods of contraception offered	All except implant and coil. Can only offer some types of oral contraception	All except implant and coil. Can only offer some types of oral contraception	All except implant and coil. Can only offer some types of oral contraception	All: oral, implant injection, coil, condoms	All: oral, implant injection, coil, condoms	None. Refer to Wirral SH Service	None	All except coil. There is a GP in surgery next door so the nurses can always consult for more complex cases.	Combination pill. POP, injections patch
Information provided about contraception	Effectiveness, side effects and instruction. Info provided verbally and written	Effectiveness, side effects and instruction. Info provided verbally and written	Effectiveness, side effects and instruction. Info provided verbally and written	Effectiveness, side effects and instruction. Info provided verbally and written	Effectiveness, side effects and instruction. Info provided verbally and written	None. Refer to Wirral SH Service	Do not provide any contraception apart from condoms. Can signpost and offer advice	Effectiveness, side effects & instruction. Also always discuss effects of alcohol and issues around choice of contraception if they drink a lot.	Effectiveness, side effects and instruction. Info provided verbally and written
opinion of contraceptive service	Limited - hoping to set up more PGDs so they can provide more.	Limited - hoping to set up more PGDs so they can provide more.	Limited - hoping to set up more PGDs so they can provide more.	Excellent - thorough and in depth		Being located within Wirral SH Service at St Catherine's Hospital means that referral is easy and YP can just be taken next door to see a FP nurse.	Hoping to do a family planning course so nurse can provide more than just condoms	Would like contraception services to be used more by young people	Good to be able to offer a range of LARC which is appropriate for some of the clients with chaotic lifestyles.

Table 5. Clients attending services

	Genito Urinary Medicine - Arrowe Park Hospital	GUM satellite clinic - Claughton Medical Centre	GUM satellite clinic - Victoria Central Hospital	Brook, Birkenhead	Wirral Sexual Health Service	Chlamydia screening Service	Wirral Metropolitan College	Confidential Advice Service New Brighton (CAS)	Harm reduction
No. all clients per week	~250	25-50 (avg 30-40)	25-50 (avg 30-40)	200+	200+	~250 screens per week	Service not running yet	4-36 in YP sessions per	Avg ~50
No YP person week	Varies	Varies	Varies	200+	~50		Service not running yet	4-36 in YP sessions	~15
no. 11-13 per week	Very few	Very few	Very few	<15 ~11 per week	<25	Screens in 15 and over	All clients 16 and over	Rarely see under 13 but don't turn anyone away	None. Do not see under 16s
no. 14-16 per week	Very few	Very few	Very few	15-16 ~26 per week	<25		All clients 16 and over	2-15	None. Do not see under 16s
no. 17-19 per week	Very few	Very few	Very few	17-19 ~42 per week	<25		All clients 16 and over	5-20	~15
Young People attending each service	*Across all GUM Services quarterly data Apr-Jun 2009 (total seen in quarter : females 2059, males 1897) under 15 yrs: 1 female 15yrs: 1 female, 3 males 16-19 yrs: 17 females, 38 males			Under 15yrs: 71% female, 28% male 15-16yrs 85% female, 15% male 17-19yrs: 84% females, 16% male	11-13yrs 80% female, 20% male 14-16yrs 90-99% female, 1-10% male 17-19yrs 90-95% female 5-10% male	Brook do 1/4 - 1/3 of all screen in Wirral and are mainly in younger groups. CAS screens a large number of school aged young people. GPs often screen the slightly older age groups in 20s.	All over 16. More females than males.	The vast majority are female. Do get some regular male attendees and some who come with their girlfriends	Majority of young people are male steroid users. ≤19 80% male

*GUM data for quarter Apr-Jun 09; Brook data weekly average from yearly figures

Table 6. Vulnerable groups attending

		Genito Urinary Medicine - Arrove Park Hospital	GUM satellite clinic - Claughton Medical Centre	GUM satellite clinic - Victoria Central Hospital	Brook, Birkenhead	Wirral Sexual Health Service	Chlamydia screening Service	Wirral Metropolitan College	Confidential Advice Service New Brighton (CAS)	Harm reduction
Does your service see young people with...	Learning disabilities	Yes	Yes	Yes	Yes	Yes	Not often. Aware they need to expand on services to this group.	Yes	Yes	no
	Phys disabilities	NK	NK	NK	Yes	Yes	Yes	Yes	Yes	Yes
	Chronic health problems	NK	NK	NK	NK	Yes	Yes	Yes	Yes	Yes
	Behavioural problems	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Does your service see young people who are...	homeless	NK	NK	NK	Yes	Yes	Yes	Yes	Yes	No – would refer to Response
	hostel	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	LAC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Temp Excluded	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	Perm Excluded	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
	NEETs	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NK
	Young carer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Refuse to see anyone	No	No	No	No	No	No	No	No	No

Box 13 Sexual health Providers services on Wirral – Conclusions

- Service Providers were extremely helpful in the completion of this evaluation, providing data and their opinions for the benefit of improving services for young people.
- While there are some sexual health services available at all times during week days and some evenings and Saturday day time, no services are available on a Sunday. Young people must attend Walk-in centres for services on a Sunday. Our data suggest young people are not aware of the sexual health services available at Walk-in centres (see service users) so delay treatment, this is especially important if they need EHC.
- While provision of contraception appears to be widespread, with free condoms widely available and comprehensive information, discussion with service providers suggests in reality the contraceptive services are 'patchy', in terms of geography, opening times and services offered.
- Opening hours of services vary by service and within services creating confusion for young people who will not be sure when a place is open or closed. Effective advertising is needed to inform young people when services are open. Only Brook and Harm Reduction offer consistent and long opening hours.
- The chlamydia screening service conducts outreach and publicity work especially in areas where young people often assemble. Chlamydia and gonorrhoea testing is available in a wide variety of settings, as well as in community services and GPs, through the screening programme.
- Wirral Brook were mentioned by a number of NHS staff as offering a high quality and important sexual health service to young people.
- The number of young people attending services varies week to week, with some services being rather unsure of exact numbers. Brook sees the highest number of young people and very few young people access general GUM and Wirral SH Service. Attendance by males is much lower at all services. Further effort is required to better understand why young men do not wish to access services, some information has been gleaned through service users surveys (see later sections), suggesting they do not need the services, however it is likely they are also not fully aware of available services and services are not advertised widely. Services need to ensure they are welcoming and accessible to young men.
- Young people don't seem to access Wirral SH Service and GUM services as much as Brook. NHS services need to ensure they are continuing to build on successes from You're Welcome, further developing young people friendly services, effectively advertised and open at appropriate times.
- Education and outreach is provided in school by a dedicated education team at Brook and occasionally in assemblies by CAS. Some organisations have difficulty advertising, especially in some schools. Wirral Brook play a very central role in informing young people throughout Wirral and their mode of operation and procedures could be used as a model to enhance other services.

4.2.2 Service Users survey

Box 14 Service users survey – main findings

- A questionnaire was completed by 83 young people attending sexual health services on Wirral.
- The majority of respondents were female (86.2%) aged between 17-18 years. Over half of females were recruited whilst attending Wirral Sexual Health Service (53.5%) while most males came from the GUM clinic.
- Younger participants tended to come from Brook and older service users from Wirral Sexual Health Service reflecting the makeup of service users.
- The most common reason for attending Brook or Wirral Sexual Health Service was to get hormonal contraception (the Pill; 45% and 36% respectively). Eighty-three percent of those attending the GUM did so for an STI check.
- The majority of young people recruited at Brook were attending school or college
- The majority of females (56.3%) reported having been to Brook before whereas three quarters of males were attending for the first time.
- The majority of males (75%) and females (56.3%) indicated they had heard about Brook through a friend. Half of females also indicated they had heard about it through their school or college, only 6.3% of females indicated they found out about the service through their GP.
- None of the young people attending these services sought relationships advice or counselling.
- The majority of males and females, regardless of age, were attending the GUM clinic for an STI check or for Chlamydia screening. All but one male and 58% of females had never been to the GUM clinic before.
- The most common reason for attending Wirral Sexual Health service was to get the pill and condoms, a pregnancy or STI test.
- One in 5 young females stated they had gone further sexually than they had planned or intended; identification of reasons for this, and attention to improving advice to reduce this risk is required.
- The majority of persons attending Wirral Sexual Health Service had heard about the service through friends or their GP.

Demographics

A questionnaire was completed by 83 young people attending sexual health services on Wirral. The majority of respondents were female (86.2%) aged between 17-18 years. Over half of females were recruited whilst attending Wirral Sexual Health Service (53.5%) whereas most males came from the GUM clinic (figure 1). Those attending Brook were predominantly between the ages of 15 and 18 years old. Respondents aged 19 and over came mainly from the Wirral Sexual Health service (Figure 2). Respondents that attended GUM clinic were more likely to be between the ages of 16-19.

Figure 1. Gender of respondents by service

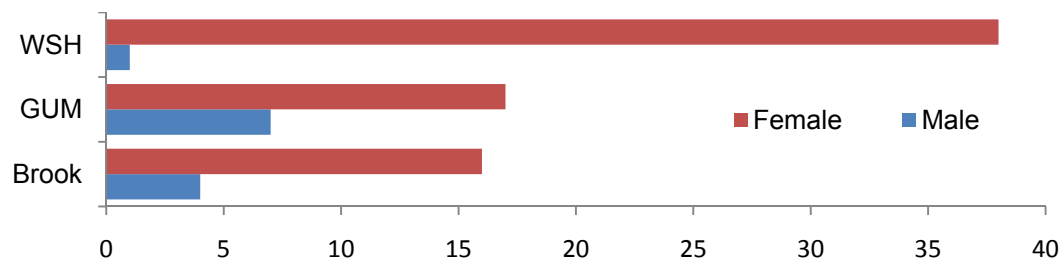


Figure 2. Age of respondents by service

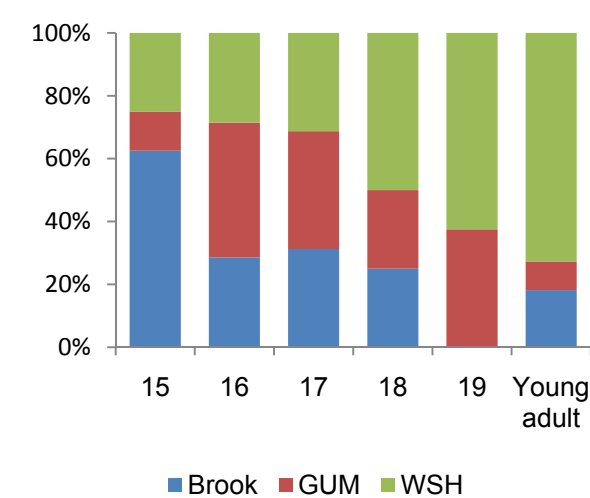
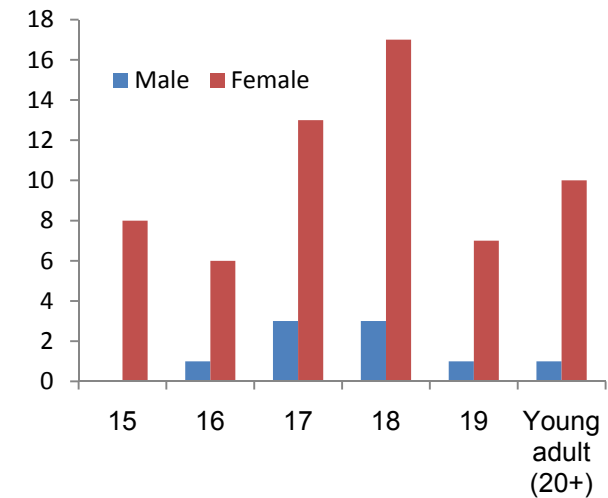


Figure 3. Population by age



The majority of respondents attending services who were able to complete a questionnaire are white, particularly white British (figure 4), and the majority of respondents described themselves as atheist (figure 5)

Figure 4. Ethnicity of respondents by service

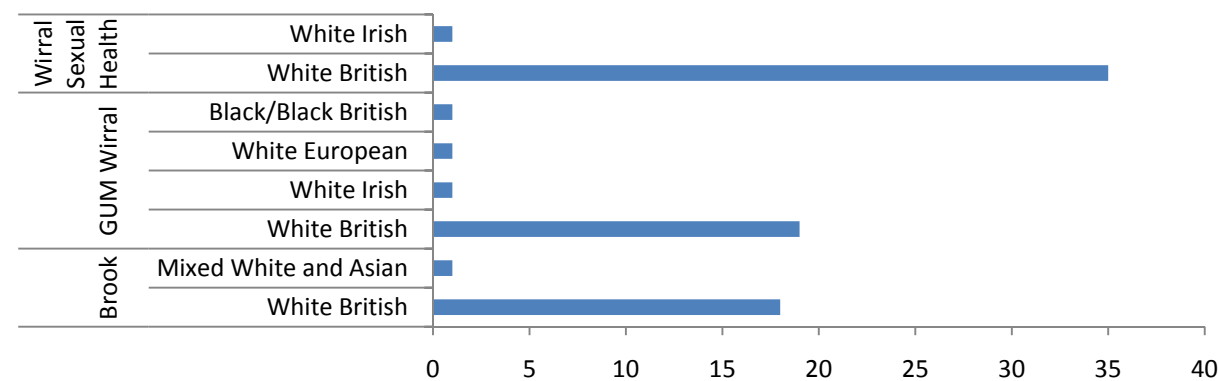
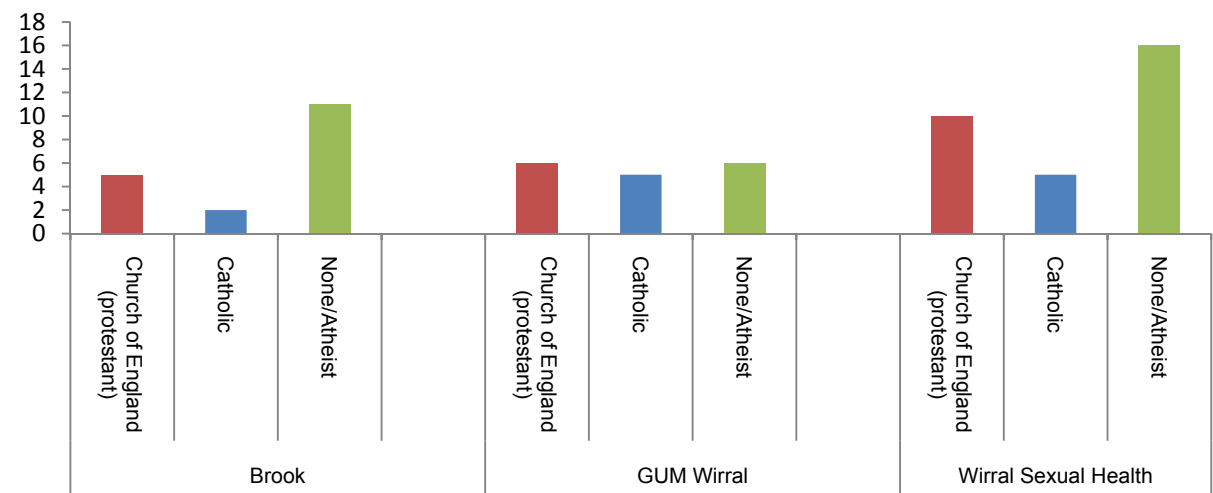


Figure 5. Religion of respondents by service

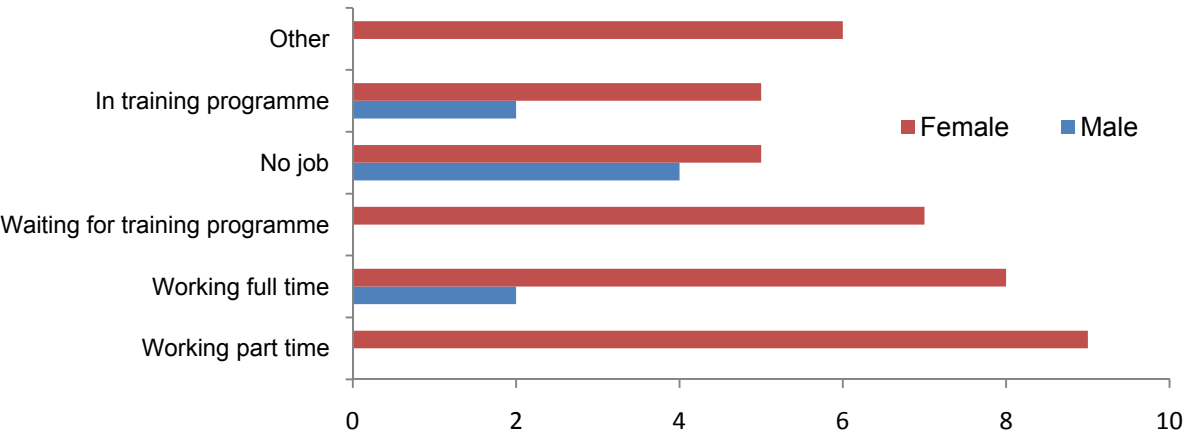


The majority of service users lived with their mother (66%) and/or father (40.4%) in the family home (78.7%). None of the respondents indicated they were a young carer, five females indicated they have a disability or special educational need including dyslexia (3), dyspraxia (1) and one young person with learning difficulties.

Seventeen females and two males indicated they have a long-term physical or mental health condition; of the respondents who gave details this included Crohn's disease, epilepsy, diabetes, long-term mental health problems (e.g. schizophrenia), hernia and hypermobility syndrome.

A similar proportion of females visiting services were attending school or college (40.7%) to those that don't (41.9%). Only 15% of the male sample attended school compared to 84.6% that did not. Of those that had stopped school or college the majority of both males (88.8%) and females (94.1%) did so because they had finished year 11 or 13 (figure 6). One female indicated she no longer attended school or college because she had a baby, and two females indicated they had been permanently excluded. Other reasons for not attending school or college were 'dropped out' 'family issues' and 'intimidating people'. Exactly half of the female population work either part or full time, and 20.5% are currently waiting for a training programme. The majority of males (44.4%) in this sample have no job. Six females indicated that they no longer attended school or college and that they were waiting to go to university.

Figure 6. Population who don't attend school/college



Reasons for attending services

The majority of young people attending Brook, including half of the females and a quarter of males, did so to get hormonal contraception (the pill). An equal number (20%) were attending either to obtain the morning after pill and/or condoms. None of the young people at Brook, who took part in this survey, were there to get advice on sex, relationships, a pregnancy or an STI test (figure 7).

Figure 7. Brook: reason for attendance

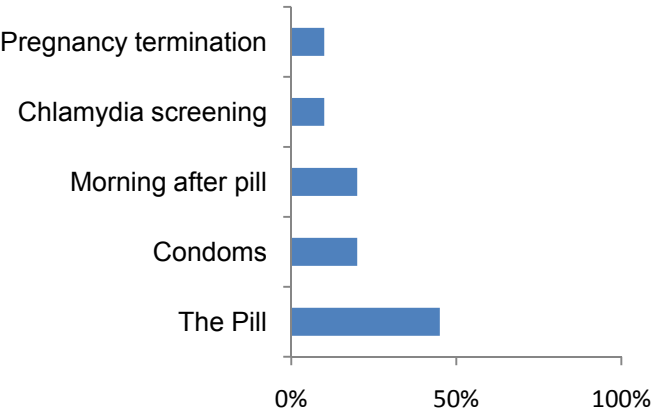
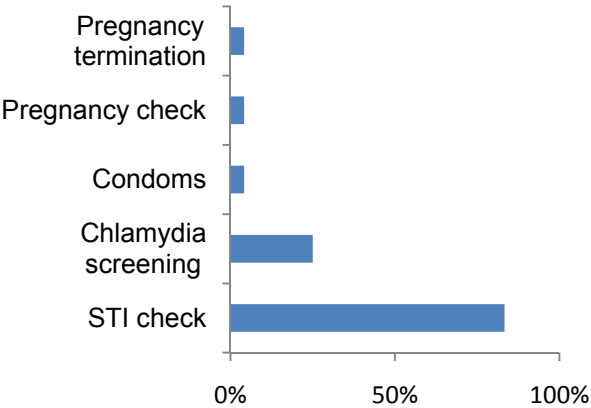
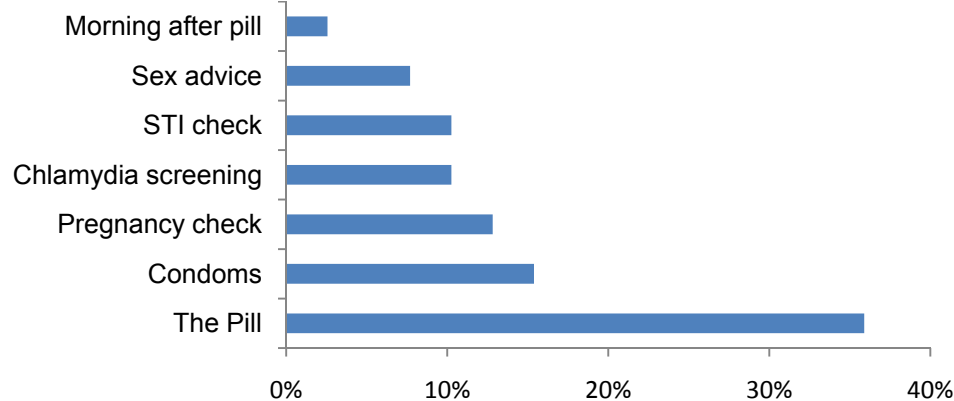


Figure 8. GUM: reason for attendance



Over 80% of the population who attended Wirral GUM clinic did so to get tested for a sexually transmitted infection (figure 8). This included 30% of all males and 82% of all females. The next most common reason was for a Chlamydia screening. None of the young people at GUM were there to get the Pill or the morning after pill, or to get sex or relationship advice. The reasons given for attending the Wirral Sexual Health service were more varied (figure 9). The majority (35.9%) were attending to get the Pill followed by condoms (15.4%) and for a pregnancy check (12.8%). The only individuals who reported attending a service for advice on sex were at Wirral Sexual Health Service.

Figure 9. Wirral Sexual Health Service: reason for attendance



Overall the most cited reason for attending a sexual health service was to get checked for an STI with 28% of respondents giving this answer (Figure 10). However, most of these individuals were from GUM and no young person attended Wirral Brook for STI screening. The pill was also a common reason for attendance across all the services. It is interesting to note that none of the young people who completed this questionnaire were attending a service to get advice or counselling on relationships. It may be that the service users are not aware of all the services available to them and therefore cannot take advantage of them.

Figure 10. Reasons for attending- all services

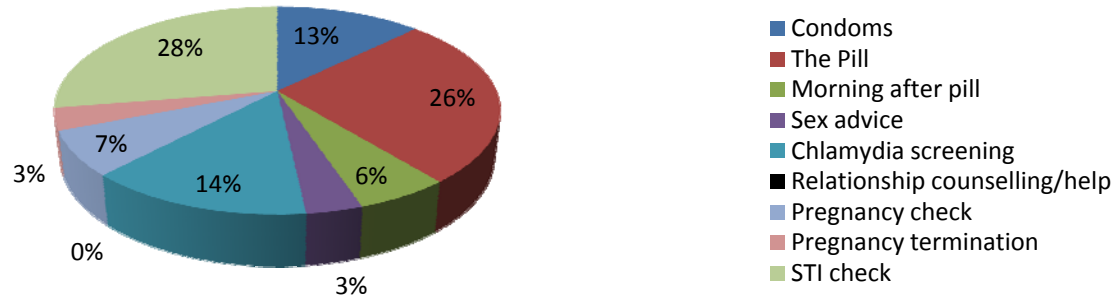
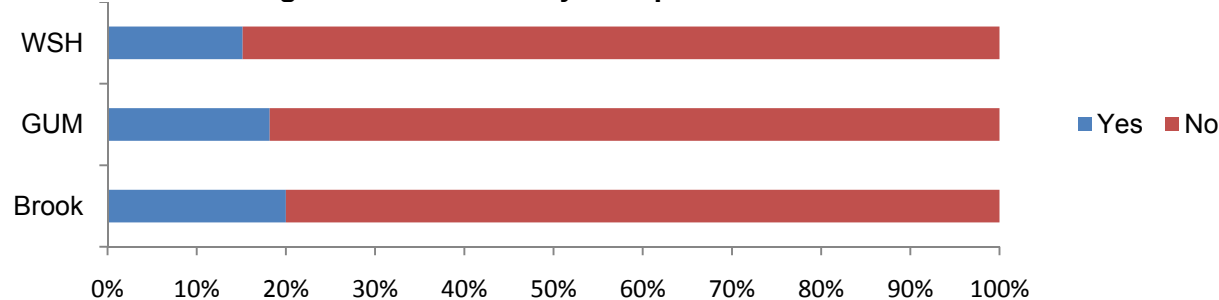
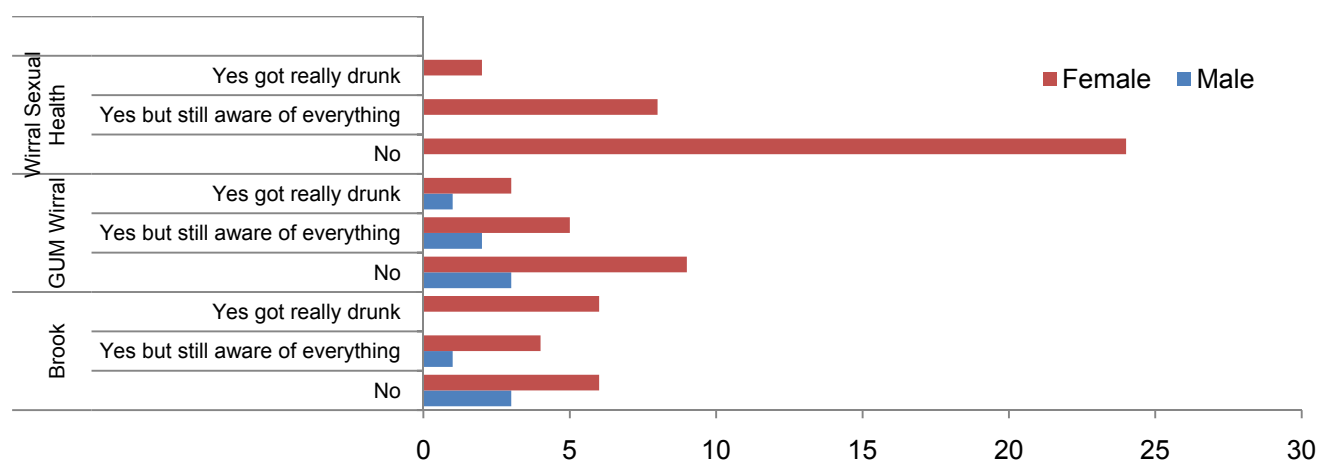


Figure 11. Females ‘ever gone further sexually then planned’



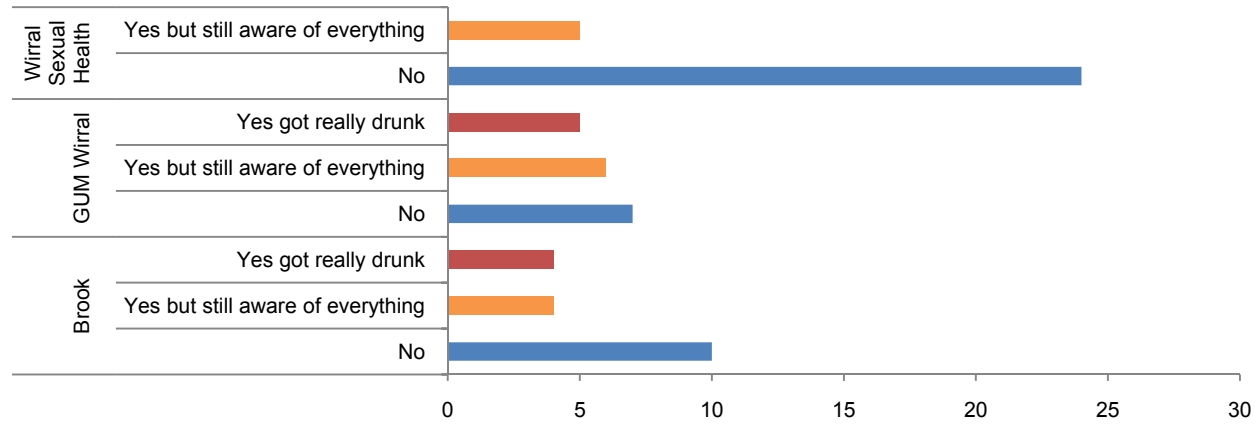
When questioned if they had ever gone further sexually than planned or wanted, ~80% of young females seeking advice stated no. Thus, 1 in 5 of this small sample stated they had gone further than they had intended, the largest proportion stating this had attended Brook (figure 11). Reasons for this need to be further explored by Brook in order to better inform and protect young females.

Figure 12. Alcohol consumption at first sexual experience



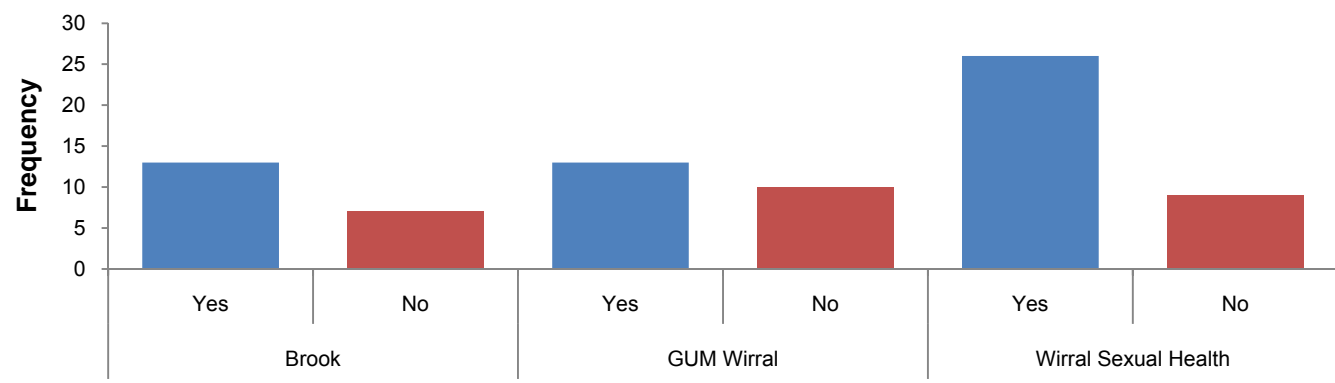
When questioned on most recent sexual activity, both Brook and GUM clinic attendees indicated they had been ‘really drunk’ at the time, however this was not the case for those attending Wirral Sexual Health Service (figure 13). Small sample size prevents further analysis but data suggest Brook and GUM clinic have an opportunity to integrate public health messages to young people, and discuss alcohol misuse.

Figure 13. Alcohol consumption at most recent sexual experience



Those attending Wirral Sexual Health service were more likely to have used a condom at first sex (as well as being less likely to drink) which suggests those attending this service may have planned their first sexual experience and decided ahead of time what contraception to use.

Figure 14. Use of condom at first sex



Wirral Brook

The majority of the male and female population recruited at Brook attend school or college (figure 15). Of those no longer at school or college, their age of leaving varied between 14 and 18, with a higher proportion of young females having left school before the age of 18 (of those that had stopped school, 57% of girls stopped at age 15).

Figure 15. Males that are usually at school/college

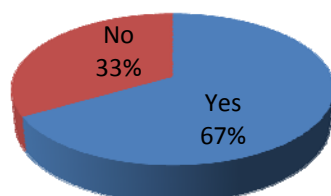


Figure 16. Females that are usually at school/college

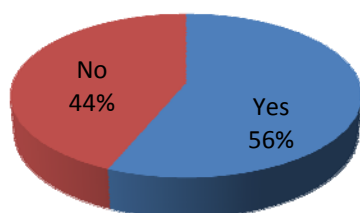


Figure 17 Males current employment status

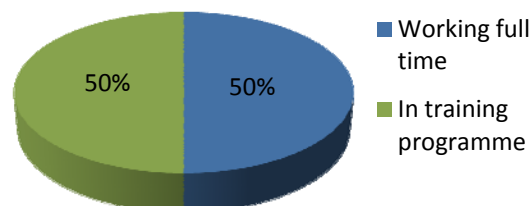
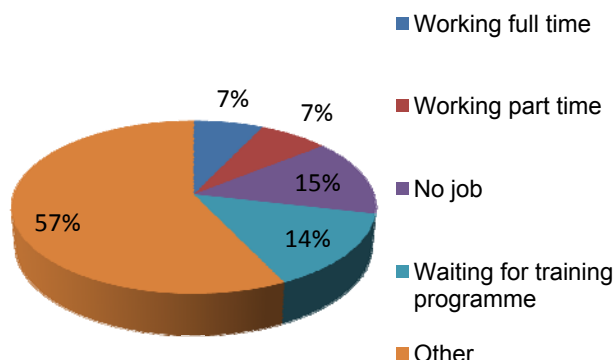


Figure 18. Females current employment status



Half of males responding at Brook were in full time work and half were in training programmes (figure 17). Female respondents were much more varied and 15% reported to not be in education, employment and/or training (figure 18). The majority (57%) reported their current status to be 'other'. Only 14% reported to be in full or part time work and 14% to be waiting for training opportunities (figure 18).

Most females were attending Brook to get The Pill, other reasons included to get condoms, the morning after pill, Chlamydia screening and for referral for pregnancy termination (Figure 20). The data suggests that the main reason males were at Brook was with their girlfriend (figure 19). Other reasons for attending Brook were to get some form of LARC and to accompany a friend or girlfriend

Figure 19. Males Reason for attending service

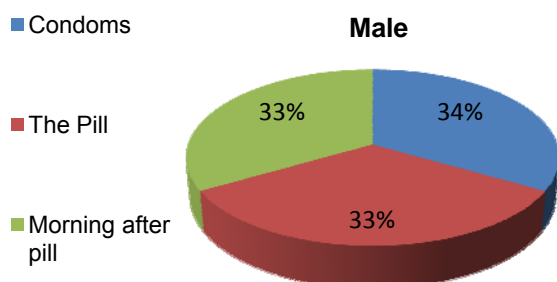


Figure 20. Females Reason for attending service

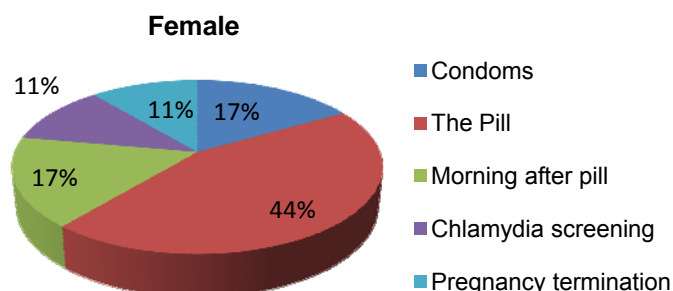
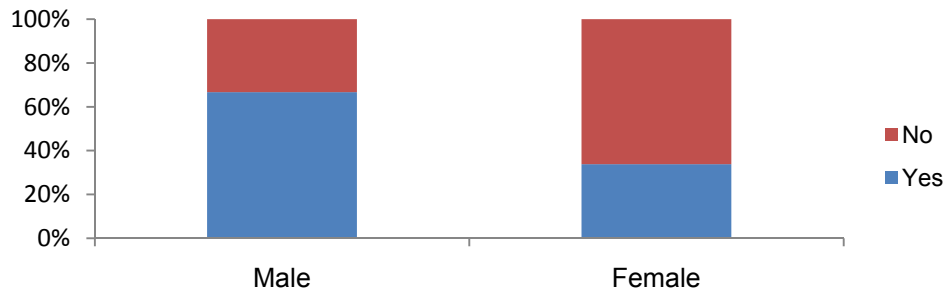


Figure 21. First time attending service



The majority of females (56.3%) reported having been to Brook previously whereas three quarters of males were attending for the first time (figure 21). The majority of males (75%) and females (56.3%) indicated they had heard about Brook through a friend. Half of females also indicated they had heard about it through their school or college, only 6.3% of females indicated they found out about the service through their GP. One individual wrote in the free text box that they had found out about Brook by walking past.

Genitourinary Medicine Clinic

None of the males who attended the GUM clinic attend school with the most cited reason being that they had finished year 11 or 13. A slightly lower percentage of females attend school compared to those that don't (figure 22). One female indicated this was because she had a baby but the majority (61.5%) of respondents had finished year 11 or 13 (see figure 12).

Figure 22. Females in education at time of response

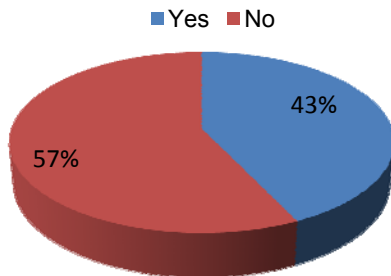
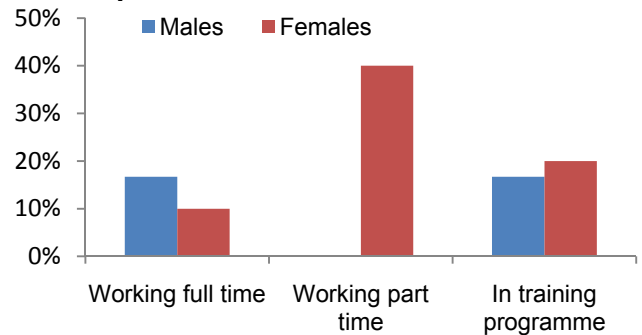


Figure 23. Current work/education status of Brook respondents



The majority of females (40%) attending GUM clinics who no longer go to school are currently in part time work (figure 24). More females (20%) than males (16.7%) are in a training programme and more males (16.7%) than females (10%) are in full time employment (figure 23).

Figure 24. Males reason for GUM clinic attendance

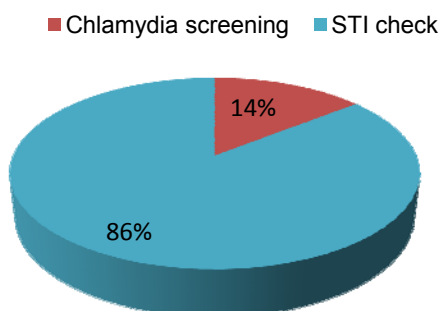
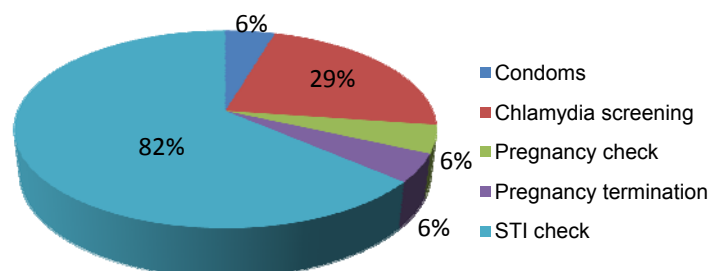
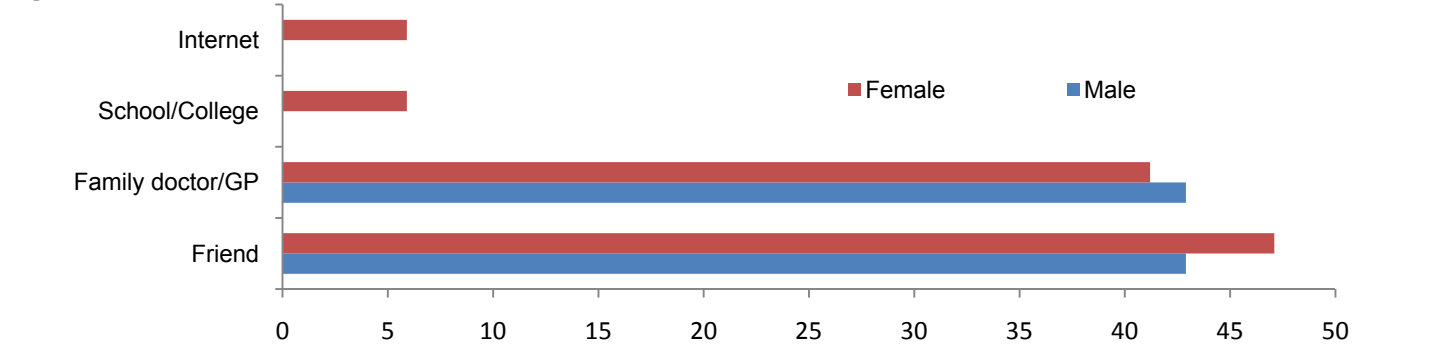


Figure 25. Females reason for GUM clinic attendance



The majority of both males and females, regardless of age, were attending the GUM clinic for an STI check or for Chlamydia screening (figure 24 and 25). Only females reported coming to collect condoms. Females also used the service for referral for pregnancy termination and for a pregnancy test (figure 25).

Figure 26. How did they find out about the GUM service



Males said they found out about the service from their GP or from a friend (figure 26). Females reported finding out about services from a variety of sources, predominantly from their GP or from friends, but also from the internet or from school/college.

Wirral Sexual Health Service

Only one male attending the Sexual Health Service completed a questionnaire, thus, all information concerning service users is based on responses from female attendees. Of the females almost half attended school or college and half did not.

Figure 27. Females age that stopped school

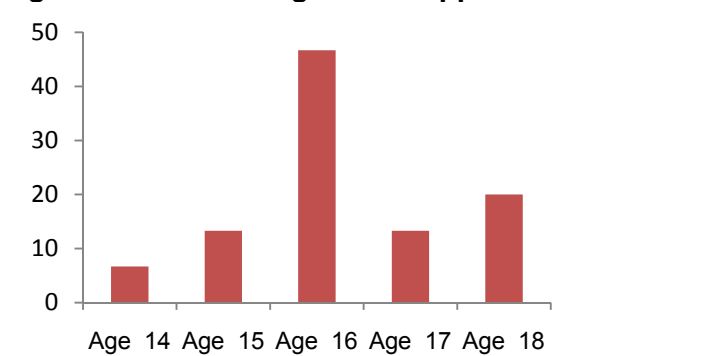
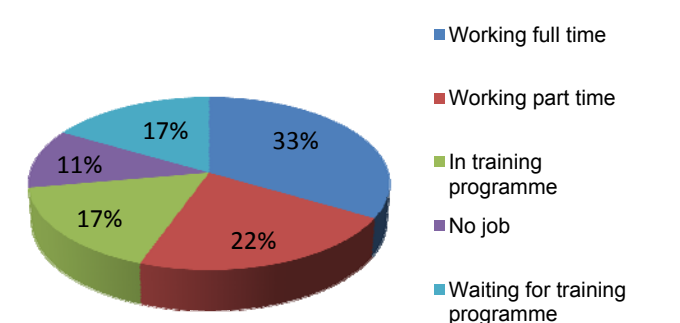


Figure 28. Females current work or education status



The majority of respondents finished school/college when they were 16 indicating that they stopped attending after year 11 (figure 27). Just over a third of respondents were in full time work and just over a fifth in part time whilst 11% were not in employment. A significant proportion were in or waiting to start a training programme (34%; figure 28).

The majority of females attended clinic for the ‘Pill’ (43%) followed by 18% attending for condoms and 15% for a pregnancy check. A very small proportion attended for the morning after pill (figure 29). The majority of females found out about the service through friends. The second most common way was through their GP. A small proportion reported they found out from the internet or kooth.com (figure 30).

Figure 29. Female reason for clinic attendance

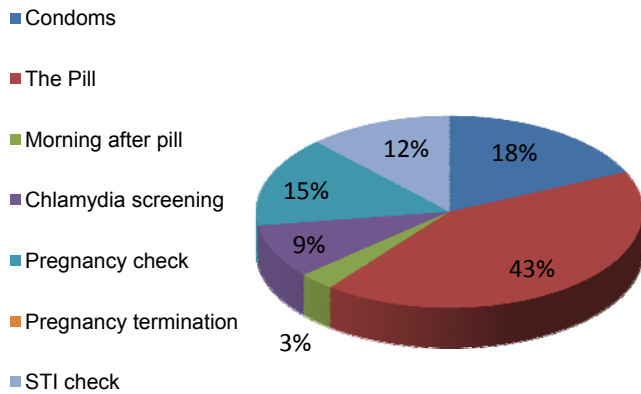
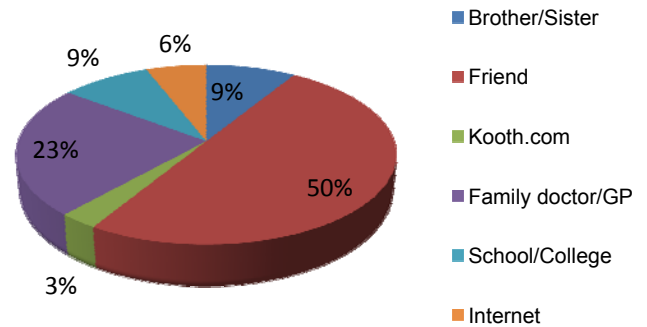


Figure 30. How did they find out about the service



Box 15 Conclusions from the Service User Survey

- Younger participants tended to come from Brook and older SUs from Wirral Sexual Health Service reflecting the preferential use of Brook for younger people.
- The majority of both the male and female population recruited at Brook although none from GUM usually attend school or college. This suggests Brook is providing a service that is attractive and accessible to younger teenagers, while older young people (school-leavers) choose to access GUM.
- The most common reason for attending Brook and Sexual Health service was to get The Pill (45% and 36% respectively) which suggests responsible planning for protected sexual activity in the future. Eighty-three percent of those attending the GUM did so for an STI test suggesting absence or improper use of contraception.
- The majority of females (56.3%) reported having been to Brook before whereas three quarters of males were attending for the first time. This suggests that Brook services are especially friendly to young women and encourage repeat attendance.
- The majority of males (75%) and females (56.3%) indicated they had heard about Brook through a friend. Half of females also indicated they had heard about it through their school or college, only 6.3% of females indicated they found out about the service through their GP. Brook need to be promoted and advertised in GP services, especially as it is so accessible to young people.
- None of the males and very few of the females who completed the questionnaire in GUM attended school.
- The majority of males and females, regardless of age, were attending the GUM clinic for an STI check or for Chlamydia screening. All but one male and 58% of females had never been to the GUM clinic before.
- The most common reasons for attending Wirral Sexual Health service was to get the pill, condoms, checking for pregnancy and STIs was also common.
- The most common way to hear about Wirral Sexual Health Service is through friends and GP. Further promotion of services could be done in schools and colleges.
- None of the young people who completed this questionnaire were attending a service to get advice or counselling on relationships. It may be that the service users are not aware of all the services available to them and therefore cannot take advantage of them.

4.2.3 Young People's experiences of SHHW Services: main quantitative findings

Box 16 Young peoples' experiences of SHHW Services: main quantitative findings

- A total of 374 young people completed the questionnaire survey of whom 162 (43.9%) were male and 207 female (5 not stated). The sample population were aged between 10-28 years with 42.3% aged 16-18 years of age. Young people completed the questionnaire in the community (64), at sexual health services (83), and in an FE college (227). The majority of respondents were white (>80%).
- The majority of those surveyed lived at home with a parent or carer; 32%, 40% and 50% of respondents in the community, service user and college, respectively, lived with both parents, and 90% lived in the family home with 7% of community participants living in B&B/hotel accommodation.
- A very high proportion of survey respondents considered themselves to have some form of long-term health problem: 18.8% of the community and 22.9% of the service user sample indicated they have a long-term physical or mental health condition. The college pilot population were not asked this question.
- One in 10 of the community sample and 2.6% of those in college reported themselves to be young carers; and 12% of community sample and 5% of service users were permanently excluded from school.
- A third of young people at college and in the community, and 15% of service users never or rarely drink alcohol; with 86% of service users, 65% community and 69% of college students drinking once a month or more. Over 50% of young people in community or service users, and 30% of college students smoke. 10-15% of young people in college and the community took drugs once a week or more.
- Young people would primarily visit their GP for advice on drug or alcohol issues. The second most frequent service was Wirral Brook (samples for college and service users not recruited via Brook). The least likely place was CAMHS. The community sample also recognised Connexions and Response.
- The sample showed evidence of poor emotional wellbeing in the past 3 months, with over 60% of college students and 40% of service users saying they were very stressed. College students also frequently ticked loss of anger/control, and feeling very depressed. Nearly 40% of college and service users thought themselves too fat. An equal proportion of all young people (~10%) stated they had tried to self-harm, and ~15% of college and service users claimed they were suicidal.
- Young people stated they would seek help for emotional wellbeing issues from the same services as for drug and alcohol issues; such as their GP/doctor, and failed to recognise the importance of CAMHS.
- A very high proportion of girls knew where the sexual health services were: ranging from 70% of college students to 90% of service users; 50% of male college students knew. When requested to state where, the most cited place for both males and females was Brook, other places included Connexions, Eastham clinic, GUM, Litherland, Mill Lane and Field Road.
- Reasons females in the community sample gave for not getting help when they wanted it were; they were too embarrassed, worried their parents would find out, fearful of meeting someone they knew, and their friends finding out. A smaller proportion of young females from college or the services considered these problems. This highlights the need to support young vulnerable females to feel more comfortable, since they did not state other perceived practical barriers preventing their attendance.
- When asked where help could be accessed for individual problems, ranging from relationships issues, to pregnancy termination, most cited Brook, followed by their GP, few other services were mentioned.
- A higher proportion of females had accessed the various services than males, predominantly Brook.
- When asked in a free text question where they would go to get a number of services (including the pill, condoms, EHC and counselling) nearly all answered 'Brook' showing high awareness of their services. Other suggestions were limited showing a need for more advertising of other local sexual health services.
- Young people believe Brook is the best place to attend for STI screening although only gonorrhoea and chlamydia testing is available through Brook. Information about other possible STIs including screening needs to be promoted amongst young people.
- Knowledge of sexual health clinic location was high in young people who drank alcohol.
- Only respondents who had drunk alcohol in the last three months had visited a sexual health clinic in the same time period. Thirty-seven percent of those drinking frequently had been to a sexual health clinic. Those who drank the most attend sexual health clinics were more likely to have sexual health problems, suggesting integrated strategies on alcohol and sexual health could be adopted in sexual health clinics.

Demographics: A total of 374 young people aged between 10 and 28 years of age completed the core questionnaire. These young people comprised three different sample survey populations in Wirral; young people who completed the survey while visiting community services (64), those who filled in the questionnaire while visiting a sexual health service (83), and young people who were students at a local FE College (227). The overall sample consists of 162 (43.9%) males and 207 females. As such the majority of young people participating were aged between 16 and 18 years (61%; figure 31). An equal proportion of males and females completed the questionnaire from the 6th Form college; the majority of service users responding were female (85.5%), while the community sample consisted predominantly of males (71.8%).

Figure 31. Population by age and gender

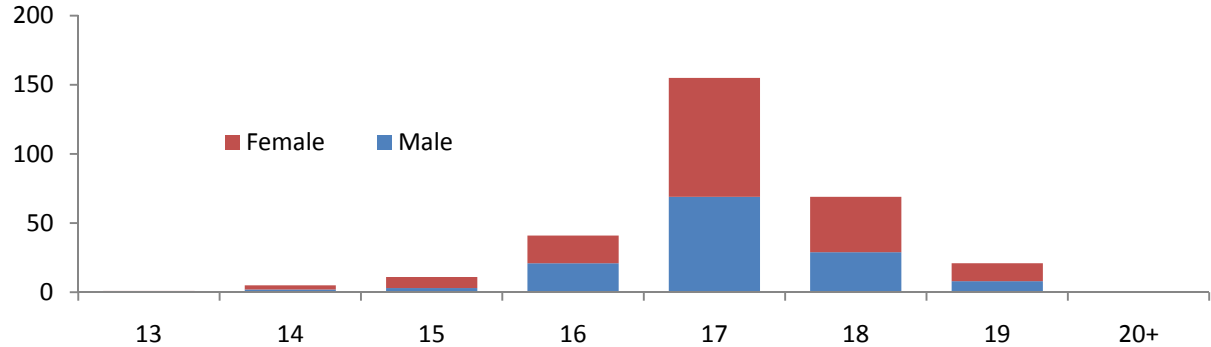
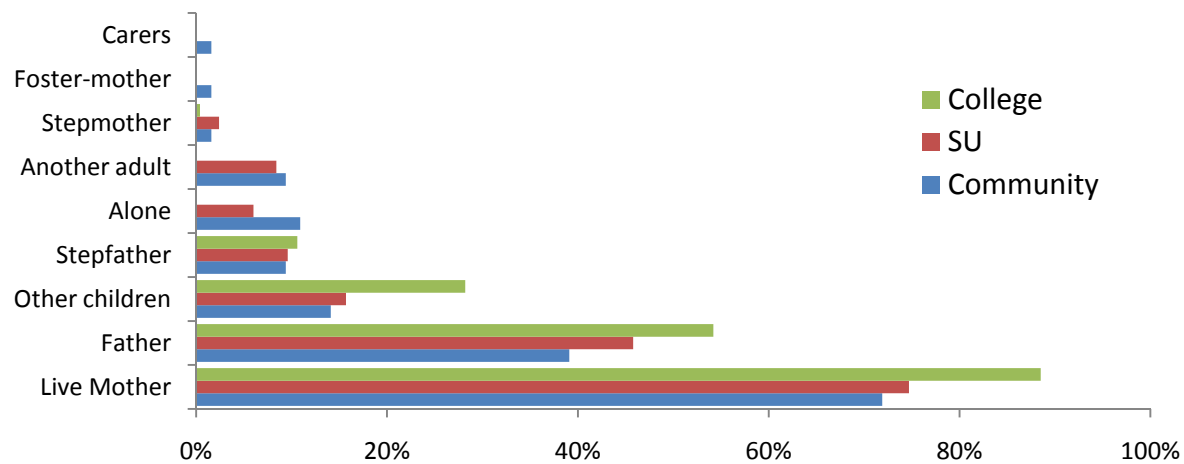
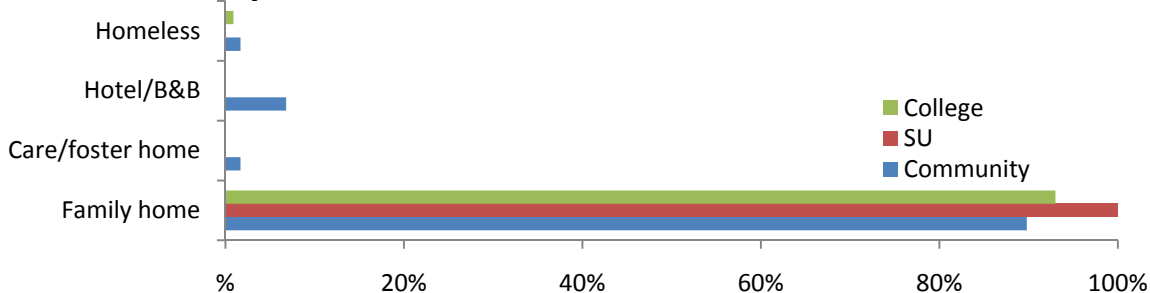


Figure 32. Who do young people live with



Information about who the young people lived with revealed that the majority of respondents from each sample live with their mother and/or their father. In total, 32%, 40% and 50% of respondents lived with both parents in the community, service user and college sample respectively (figure 32). All of the service users, 90% of the community respondents, and 93% of the college students lived in the family home. One respondent from the community sample indicated they lived in a foster or care home and another indicated they were homeless. Seven percent of community sample lived in B&B/hotel accommodation (figure 33)

Figure 33. Place of resident by service use



A small number of the community (9.4%) and the college (2.6%) samples indicated they were a young carer. A total of 17.2% and 6% of the community and service user samples respectively responded ‘yes’ to having a disability or special educational need. Of the community sample, 18.8% indicated they have a long-term physical or mental health condition as did 22.9% of the service user sample (figure 34). Details of the disabilities or SEN included two individuals with ADHD, one who is deaf, six individuals with dyslexia, one with dyspraxia, one with hypothyroidism and one respondent with a speech impediment. Those with a long-term physical or mental health condition included one respondent with asthma, one with Crohn’s disease, four young people with diabetes, one with epilepsy and one with IBS. The college sample pilot questionnaire did not include a question on disability or a long-term physical or mental health condition. One in 10 in the community and 2.6% of college students reported they were young carers.

Figure 34. Disability or SEN/ long term physical or mental health condition or Young Carers

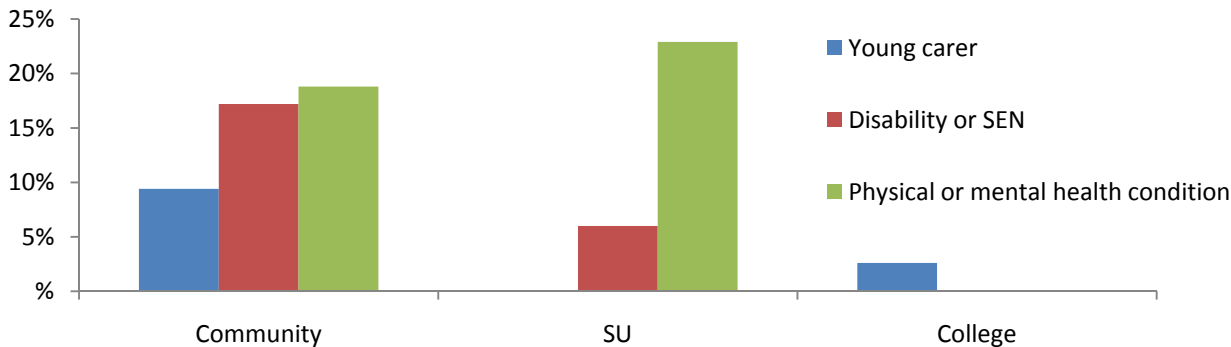


Figure 35. Usually at school/college

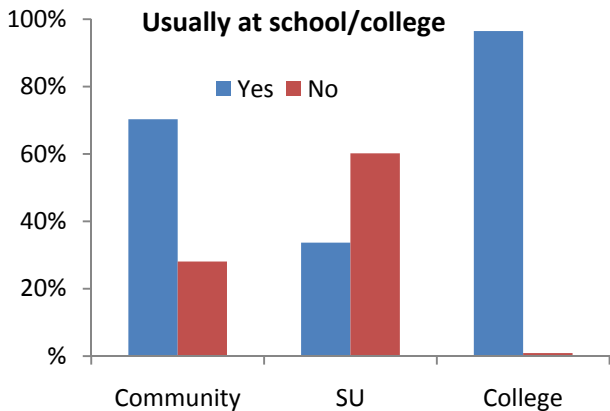
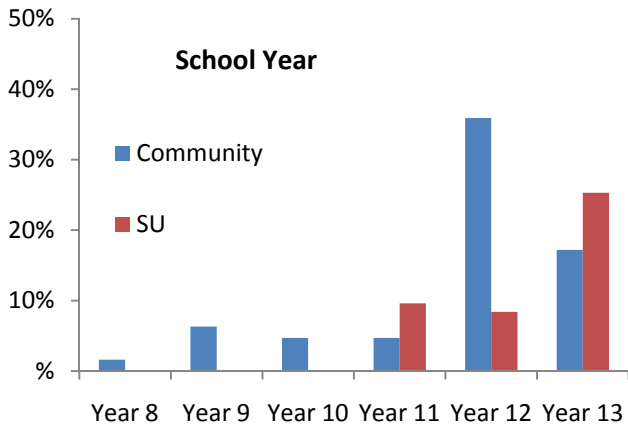


Figure 36. School Year



Young people were questioned if they attended school or college. As expected, persons from college indicated yes; over 70% of the community sample was usually at school or college while over 60% of the service users were not (figure 35). The majority of respondents in the community and the service user sample were in year 12 and 13 of school or college. Within the college sample, over 90% were in their first year (year 12; figure 37).

Figure 37. College sample: Year in College

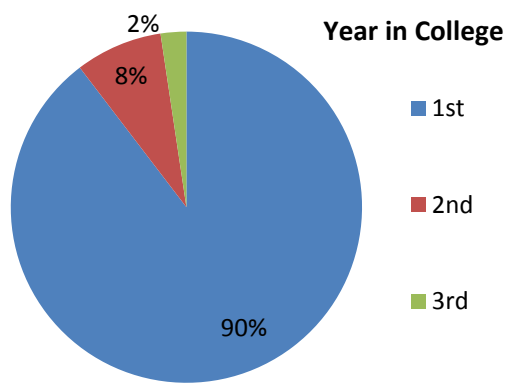
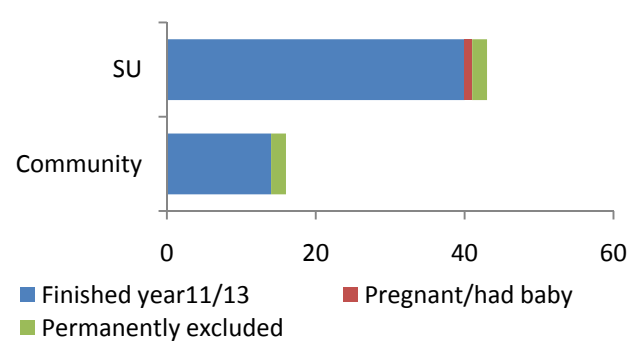
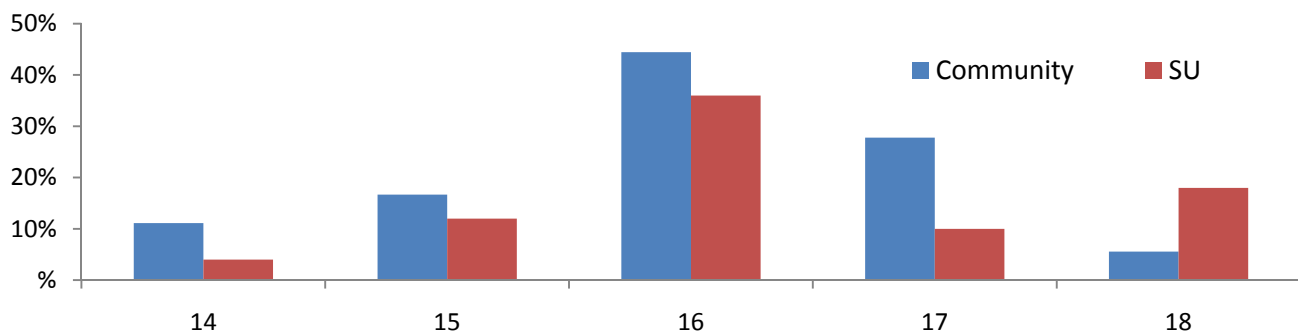


Figure 38. Reasons Young people had left school/college



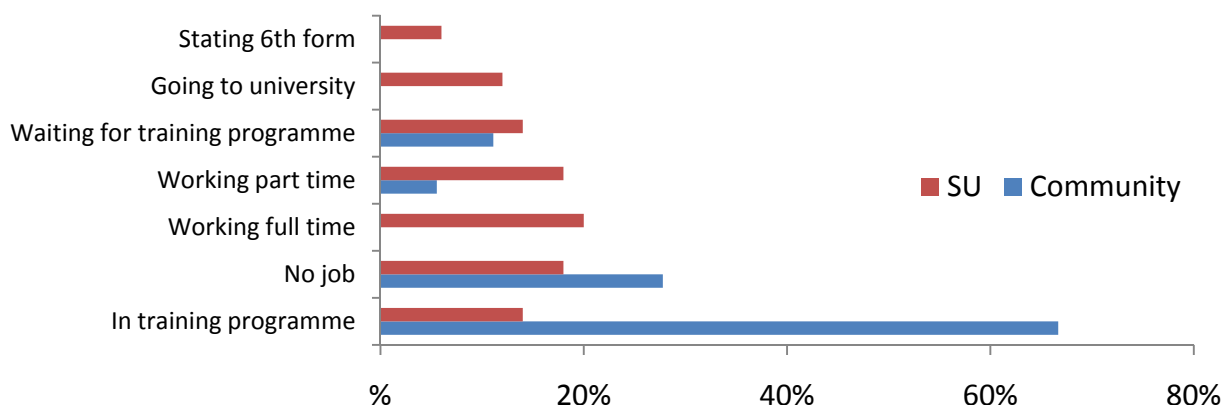
The majority of persons finished school or college because they completed their education. A minority recorded they had left, including one 17 year old, due to pregnancy and another who ‘dropped out’ of school (figure 38). One young person indicated they left school/college due to lack of support. Two of 16 (12.5%) of the community sample and 2 of 43 (5%) of the service users had been permanently excluded. Young people who had left school or college provided us with an approximate age of leaving education. A quarter of young people from the community gave up education before the age of 16, compared with 16% of service users (figure 39).

Figure 39. Age when stopped attending school/college



The majority of young people within the community sample, who no longer attended school or college, were in a training programme (66.7%), 11% were waiting for a training programme and nearly 30% did not have a job. Within the service users 20% were working full time, 18% were working part time and 18% had no job. A number of individuals in this sample indicated they are waiting to go to university (12%; figure 41).

Figure 40. Current Occupation of young people not at school or college



The young people completing the survey were mainly white British (>80%; figure 41), with mixed religions. A high proportion of the college group was Catholic, and half the service users were atheist (figure 42).

Figure 41. Ethnicity of respondents

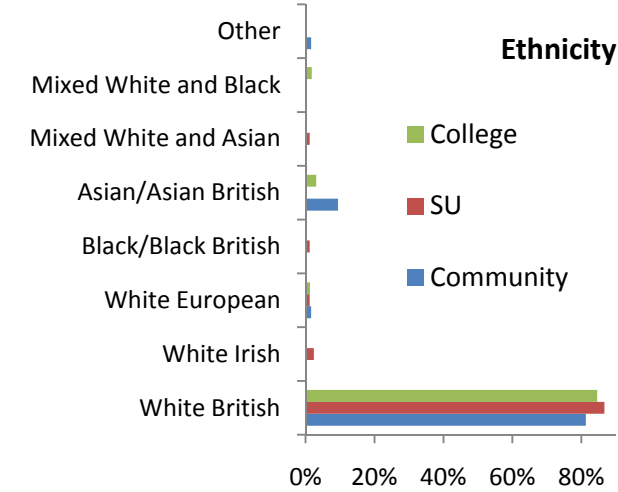
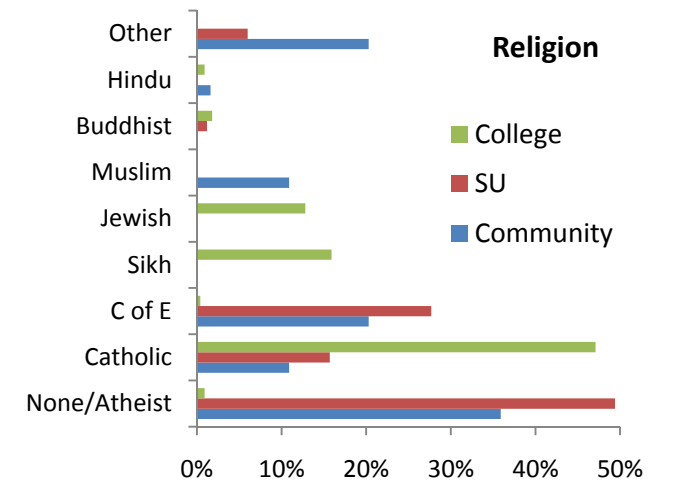


Figure 42. Religion of respondents



Before detailing the sexual health and health seeking of these young people, the figures below briefly illustrate some other risky behaviours amongst the groups responding to the questionnaire. Skipping school or college was most common in those from the college group (figure 43). Over half (51%) of respondents in the community sample had been excluded from school either permanently or temporarily. This was less common in the service user group and those in college were least likely to have been excluded (10%; figure 44).

Figure 43. Skipped school/college in the past 3 months

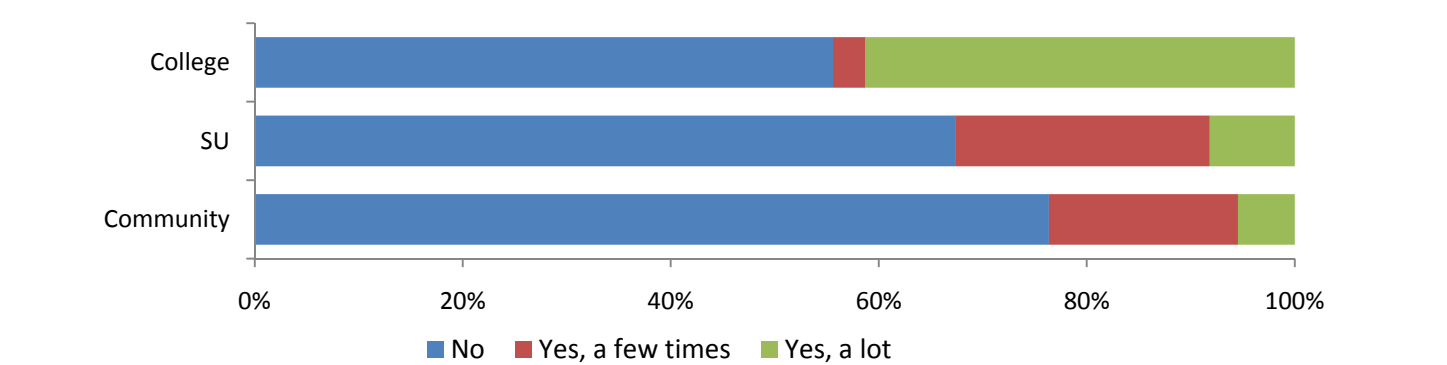
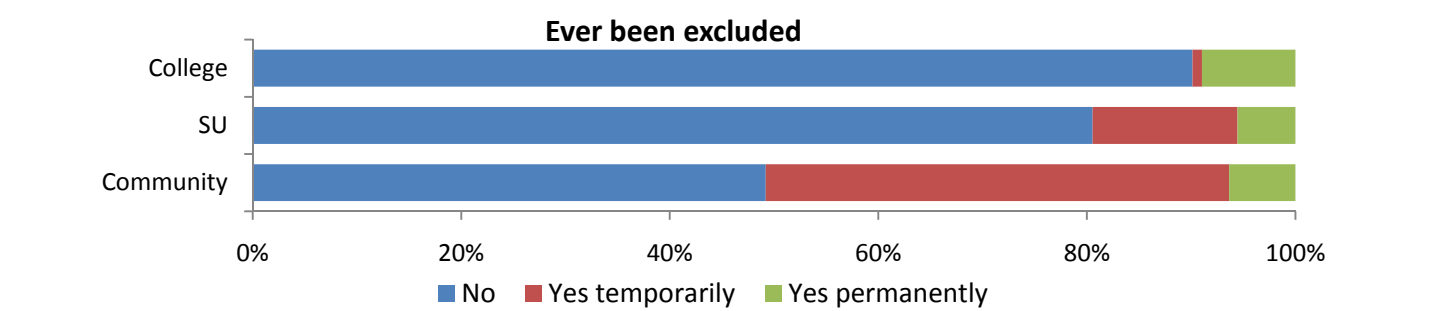


Figure 44. Ever been excluded



Alcohol, smoking and drug use

Young people in all groups were asked how frequently they had drunk alcohol, smoked or had taken drugs in the past three months. Approximately a third of young people at college and in the community, and 15% of

service users never or rarely drink alcohol (figure 45). In the service user (SU) group 86% drink once a month or more compared to 65% community and 69% of school. Drinking more than once a week was also the most common response in the service user sample. Nearly 70% of college students indicated they never smoked, while about half of all and community sample smoked once a week or more. This question polarised people with very few in each group only smoking occasionally (figure 46). The majority of young people stated they did not take drugs. This abstinence was highest in college students (75%) and lowest in service users (62%), however 10% of college students did take drugs more than once a week. The majority of young people in all groups had not taken any drugs in the last 3 months (table 47).

Figure 45. Frequency of drinking in the past 3 months

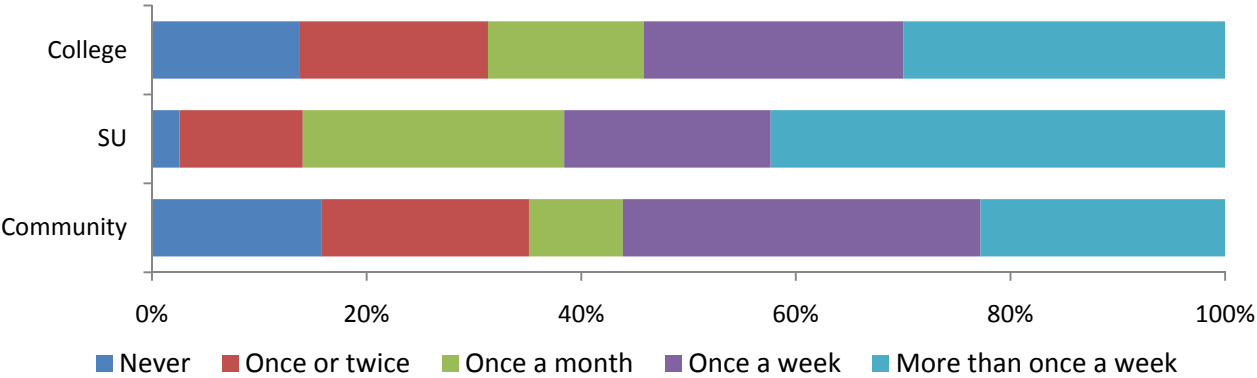


Figure 46. Frequency of smoking cigarettes in the past 3 months

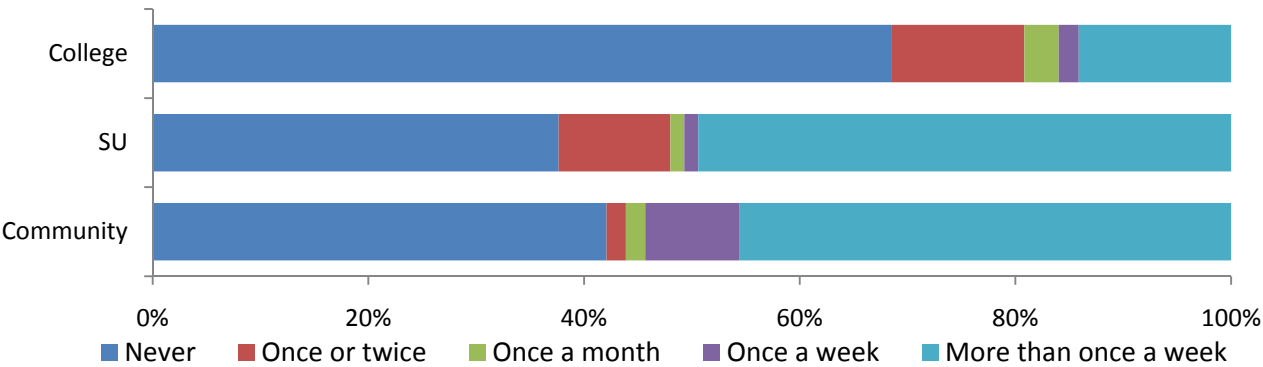
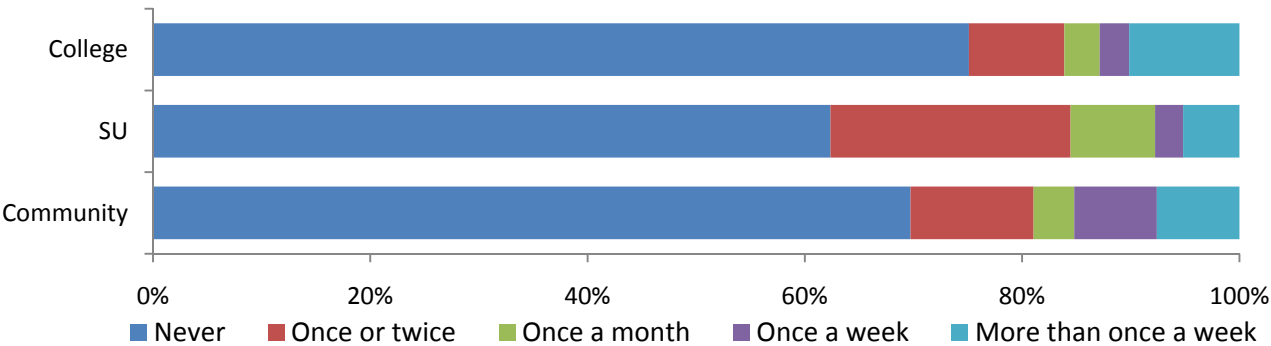
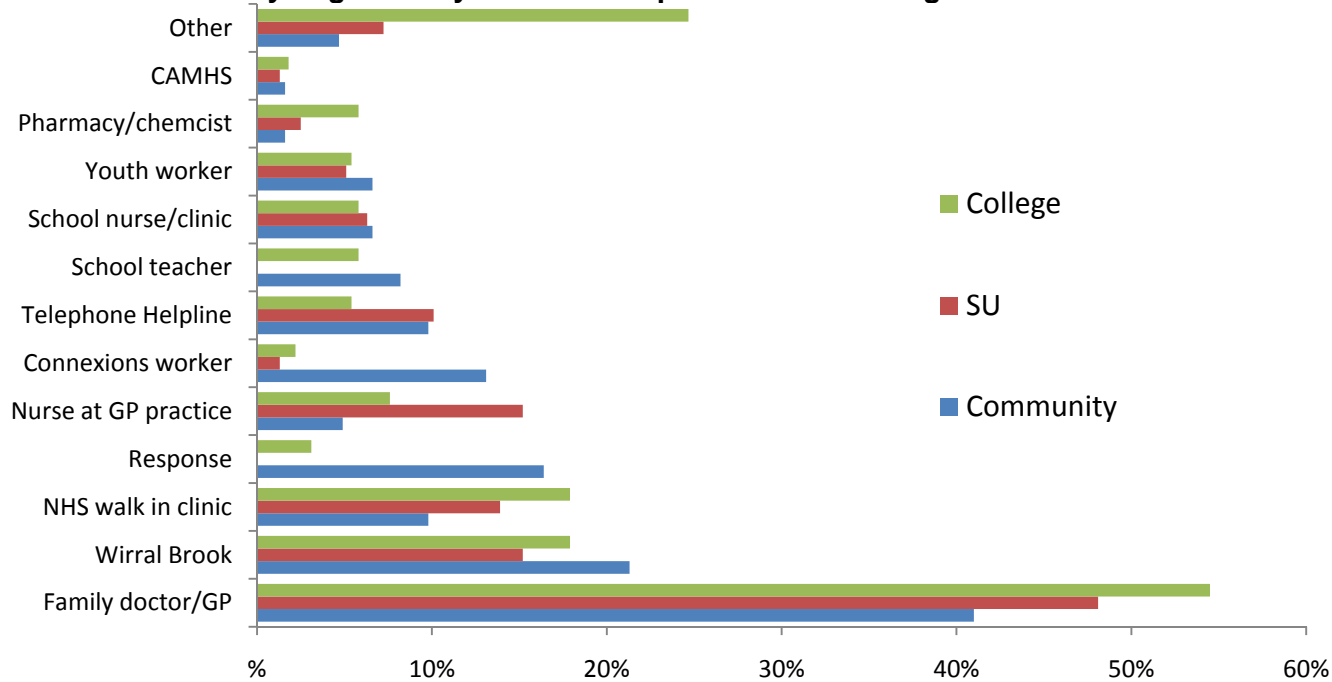


Figure 47. Frequency of drug use in the past 3 months



Young people were questioned on where they would go to get further advice on drug or alcohol use issues. Half of college students and service users, and 41% of young people from the community would go to their GP (figure 48). The second service young people would opt to visit was Wirral Brook. Amongst the samples, while the community may have been biased towards Brook (due to sample recruitment), the service users and college sample were not recruited through Brook. The lowest frequency was CAMHS, which was ticked by 1-2% from each sample. Community samples better recognised other services such as Connexions and Response.

Figure 48. Where would you go for any advice or help on alcohol or drugs



Emotional Wellbeing issues in young people in college, community, and service users

Young people answering the questionnaire were asked to tick a list of problems and issues (mostly emotional wellbeing issues) to record if they felt they suffered from any of them in the past three months. Over 40% of young people in the community, and a third of those in services did not consider they suffered any of the problems listed. Figure 49 shows that a high proportion of young people consider themselves to be under stress. College students particularly felt this (60%), although the survey was taken at the end of the college year after exams were completed. College students also frequently ticked loss of anger/control, and feeling very depressed. Nearly 40% of college and service users thought themselves too fat. An equal proportion of all young people (~10%) stated they had tried to self-harm, and ~15% of college and service users claimed they were suicidal.

Figure 49. In the past 3 months have you had any emotional wellbeing issues

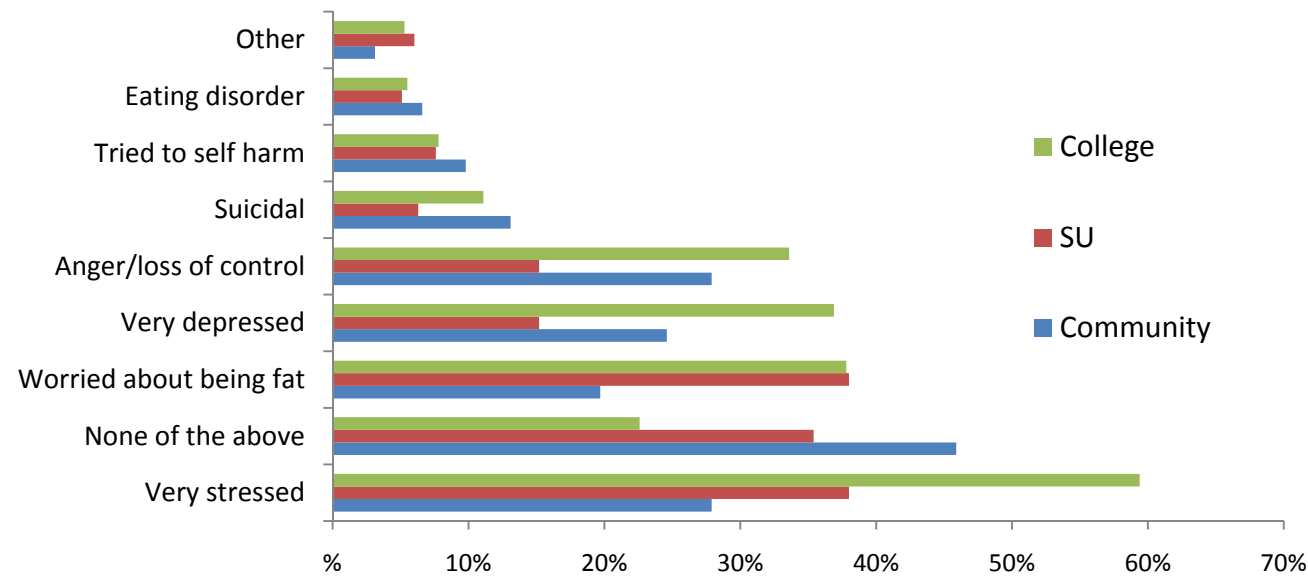


Figure 50. Where would you go for any advice or help for any emotional well being issues

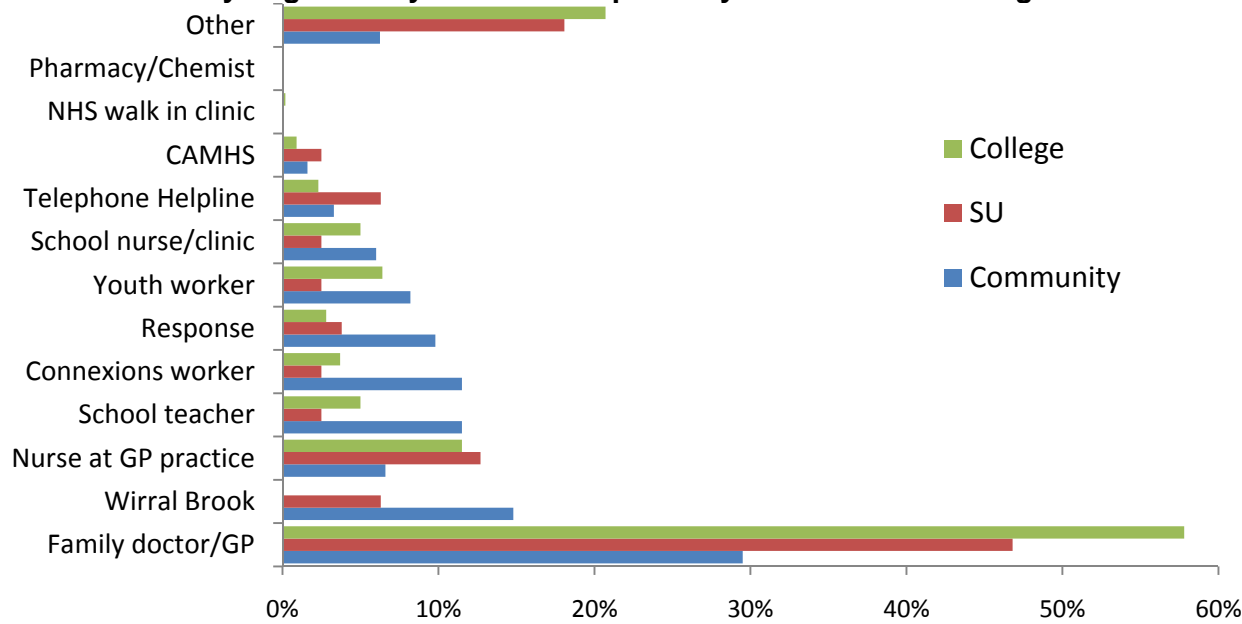
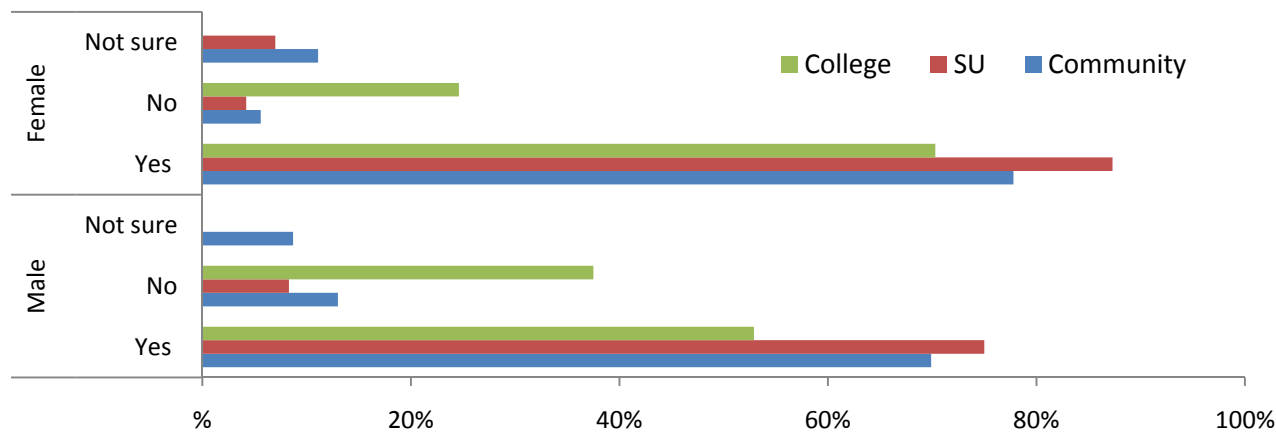


Figure 50 shows where young people state they would seek help for emotional wellbeing issues. It is noted that they in general have opted for the same services as for drug and alcohol issues, suggesting difficulty in their ability to differentiate which services are useful for particular problems. Notably, young people fail to recognise the importance of CAMHS for emotional wellbeing issues.

Issues related to Sexual Health of Young People in Wirral

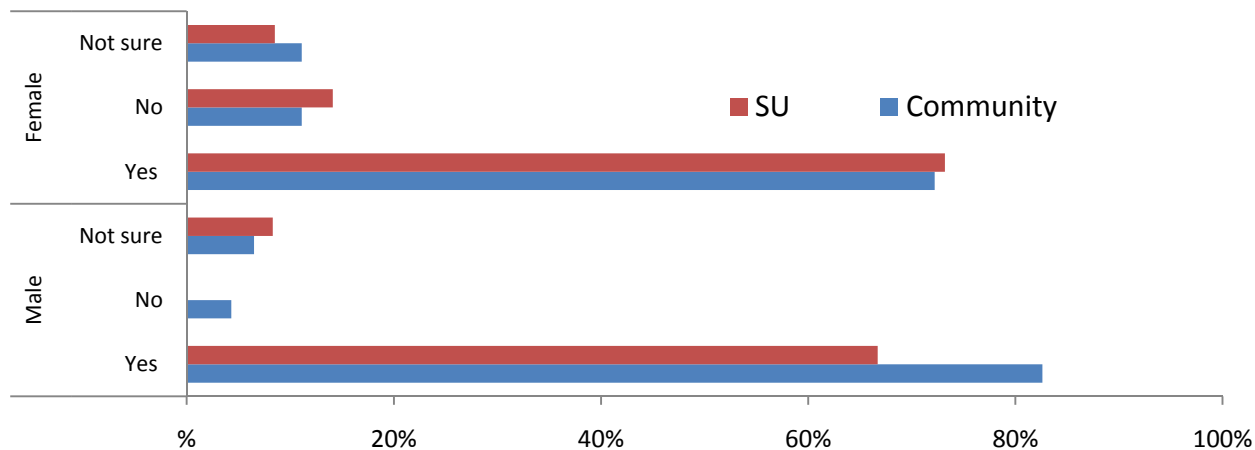
Young people answering the questionnaire from the three different locations were asked if they knew where their local sexual health clinic was. While we assumed this would be clearly biased towards service users, a high proportion of girls from all groups stated yes (70% to 90%). In general the least knowledgeable were college students. For males about 50% of college students stated yes (figure 51). When requested to state where was this, the most cited place for both males and females was Brook, other places included Connexions, Eastham clinic, GUM, Litherland, Mill Lane and Field Road.

Figure 51. Do you know where your local sexual health clinic is?



We also asked the young people if they would be prepared to attend a sexual health clinic on their own. The majority of respondents indicated that they could attend their local sexual health clinic on their own (figure 52).. (Note, this question was not asked on the pilot college survey form).

Figure 52. Could you go to a sexual health clinic on your own



Sexual Health and unmet needs: young people not attending services

All young people surveyed were asked if they had wanted, but had not accessed, help for sexual health issues, to identify unmet need. A higher proportion of females compared with males stated ‘Yes’, with 28% of females in the community sample (representing more vulnerable groups) stating they wanted help but had not accessed it (figure 53). The community group gave many more reasons for not attending services. Females were mainly too embarrassed, worried their parents or their friends would find out and were fearful of meeting someone they knew. A much smaller proportion of young females from college or the services considered these to be problems (figure 54). This particularly highlights the need to help support young vulnerable people feel comfortable. It was noteworthy that physical accessibility was not a barrier to their attendance.

Figure 53. Proportion who wanted to get help but didn't

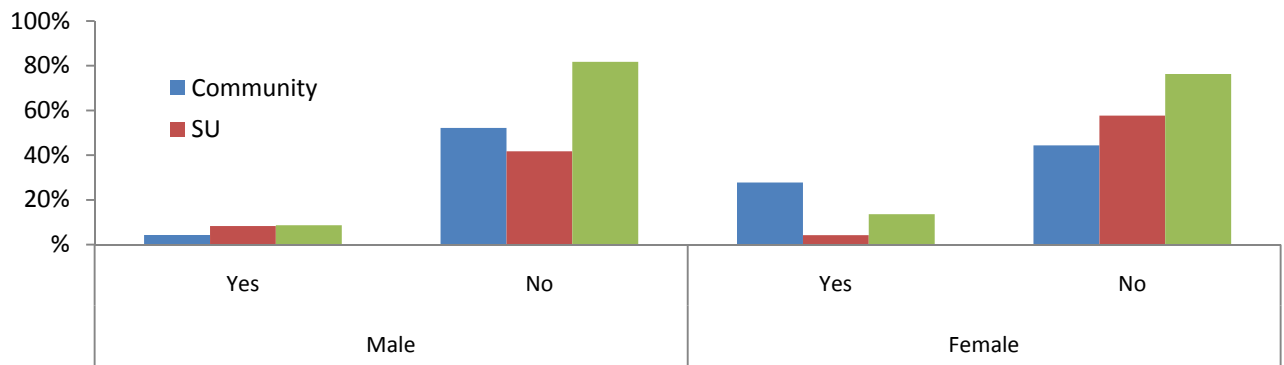


Figure 54. Females: reasons for not getting sexual help or advice

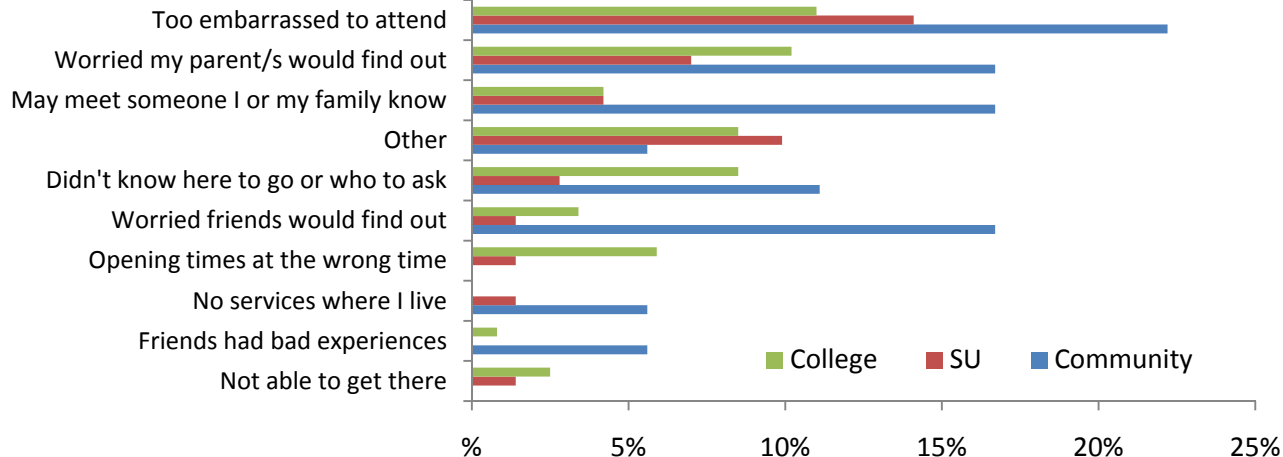
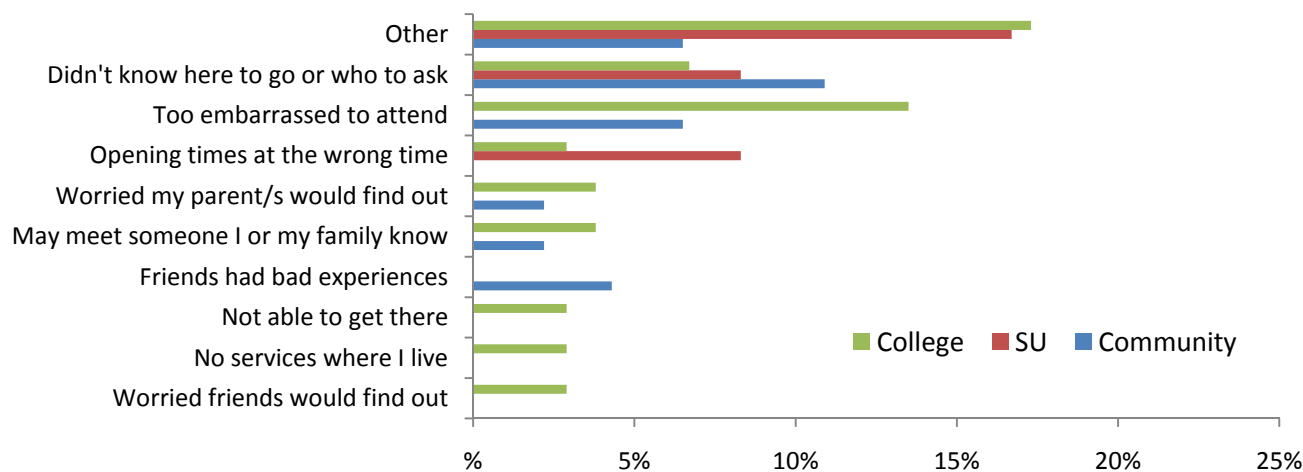


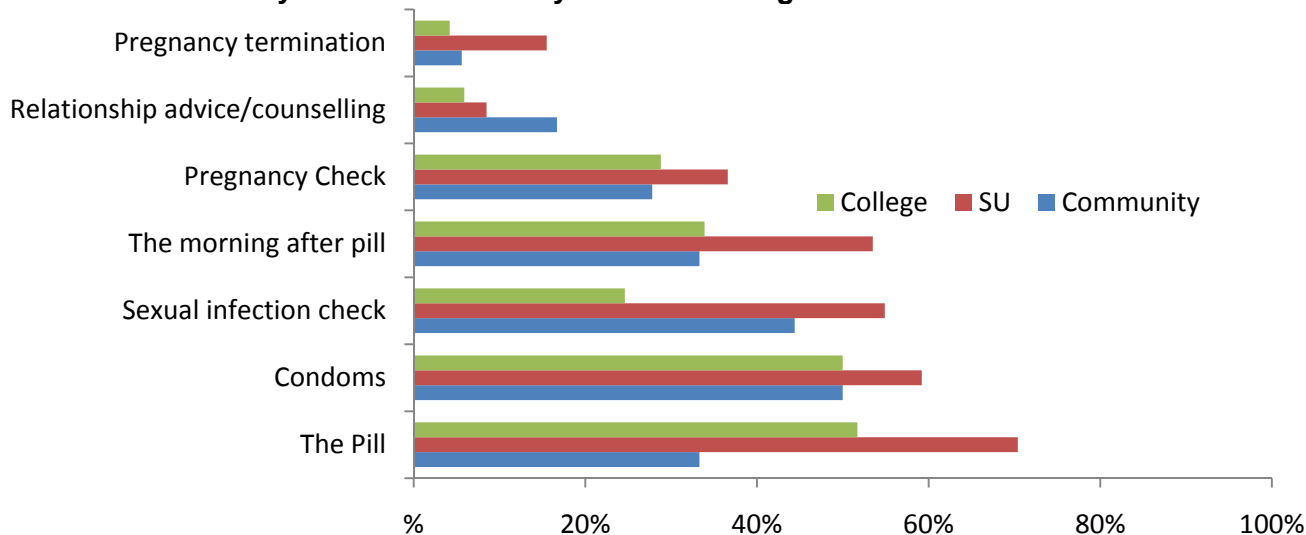
Figure 55. Males: reason for not getting sexual health help or advice



Reasons for males not attending were very different from that of females (figure 55). When asked why they had not gone for advice or help when they wanted it, the most common answer was ‘other’. This open field box was populated by answers from males saying ‘don’t need to; know everything already’. The second most common reason was that they did not know who to ask or where to go. This was the most common answer for the community sample and service users. Young men in college were less affected which may reflect good advertising of services in their college. This suggests wider community promotion of services to young men. A high proportion of the men in the college and the community sample indicated they were too embarrassed to attend. Opening times at the wrong time was a problem for those in the service user sample.

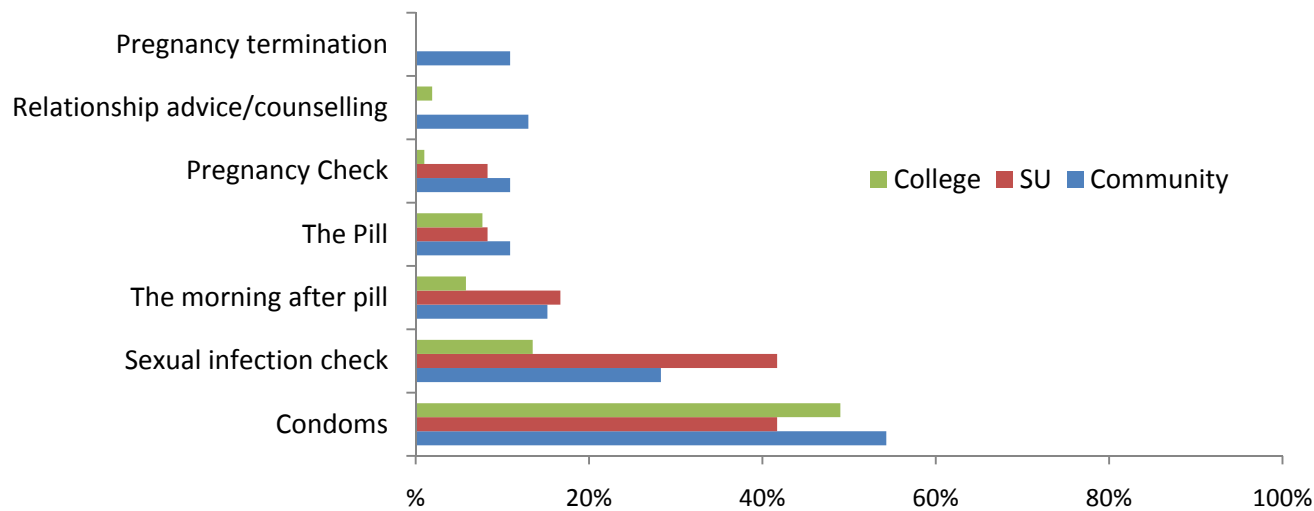
Uptake and utilization of Sexual Health Services by Young People

Figure 56. Females: have you ever been to any of the following...



Service users, as expected, had accessed more of all the sexual health services, with over 70% having sought the pill and ~60% having a test for STIs (figure 56). Condoms and the pill were also frequent reasons for attendance. Few of the females in the college sample had attended for an STI test or sought help for termination of a pregnancy. Fewer males sought services compared with females (figure 57). The most common service young men had attended for was condoms; this was especially high in the community group. Service users were more likely to have attended for an STI test. A lower proportion of the males in college had attended for an STI test. Very few males indicated they had ever attended for relationship advice/counselling or pregnancy termination.

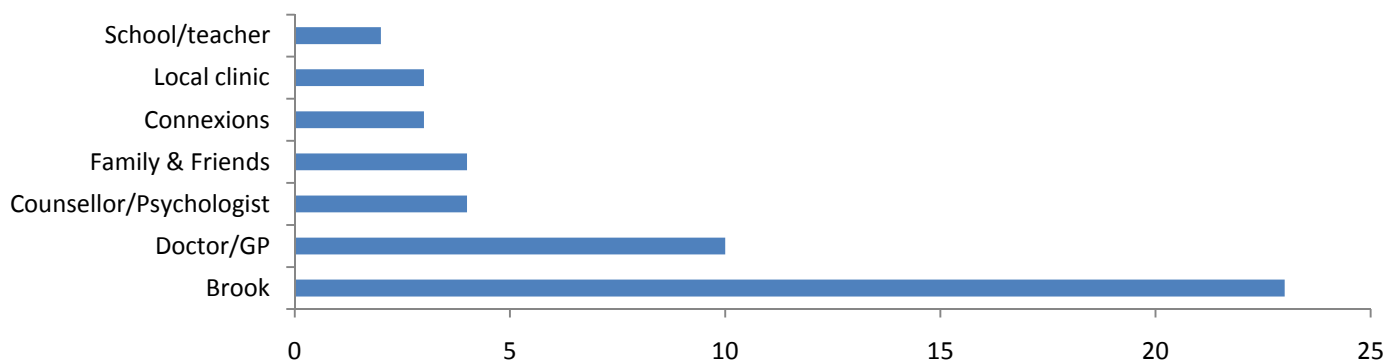
Figure 57. Males: have have you ever been to any of the following...



Knowledge of services

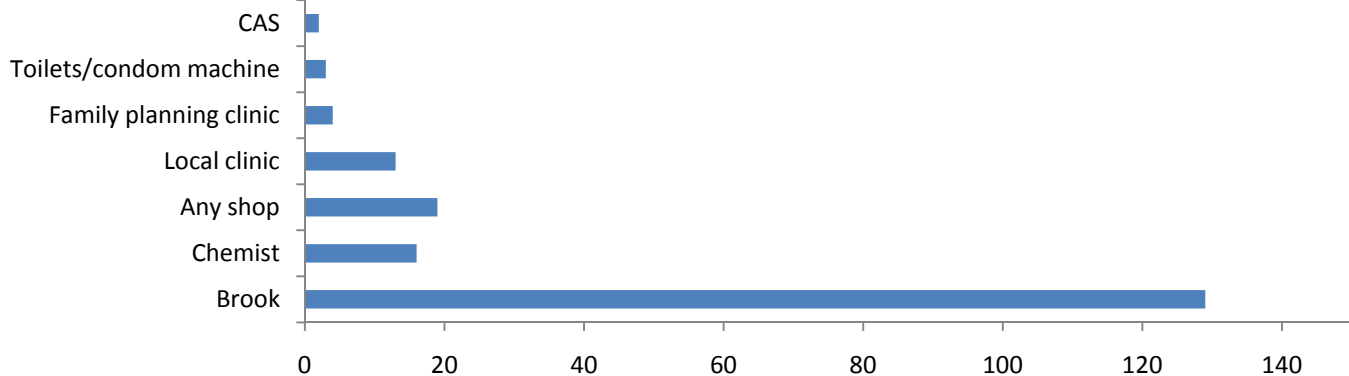
Young people were asked where they thought would be a good place to access a number of services. A free text box was provided for their answers. Responses were grouped into main categories and graphs are presented as frequency of young people who indicated each category. Response rates are out of the 374 young people answering the questionnaire and responses to this question were low.

Figure 58. Service choice for relationship advice/counselling



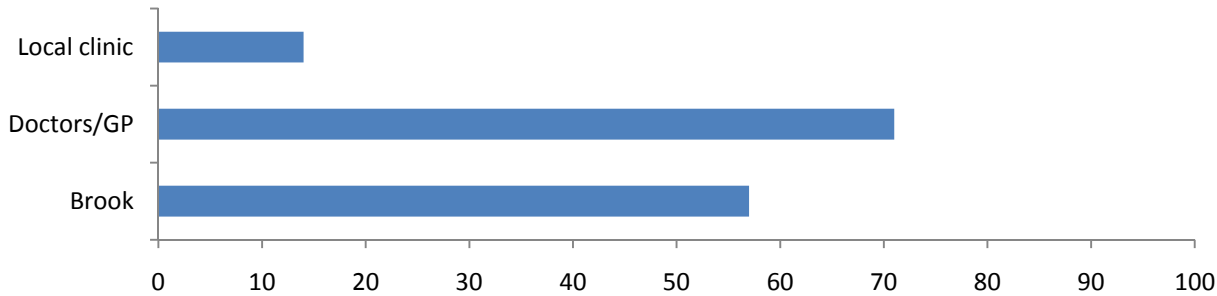
Respondents most frequently considered Brook and the GP as the places to go to get relationship advice and counselling, with school and teachers the least frequent answer (figure 58). The low number of responses to this question may indicate that young people do not know where to get help with relationships and counselling.

Figure 59. Service choice for condoms



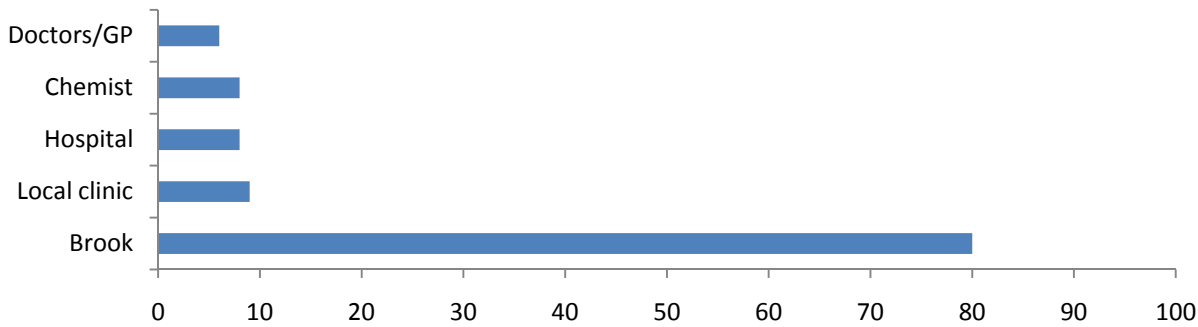
Awareness of where condoms are available was high in young people with over half of respondents completing this answer (figure 59). By far the most common place to access condoms was Brook with 129 people indicating this. Shops were also a common place to get condoms.

Figure 60. Service choice for the pill



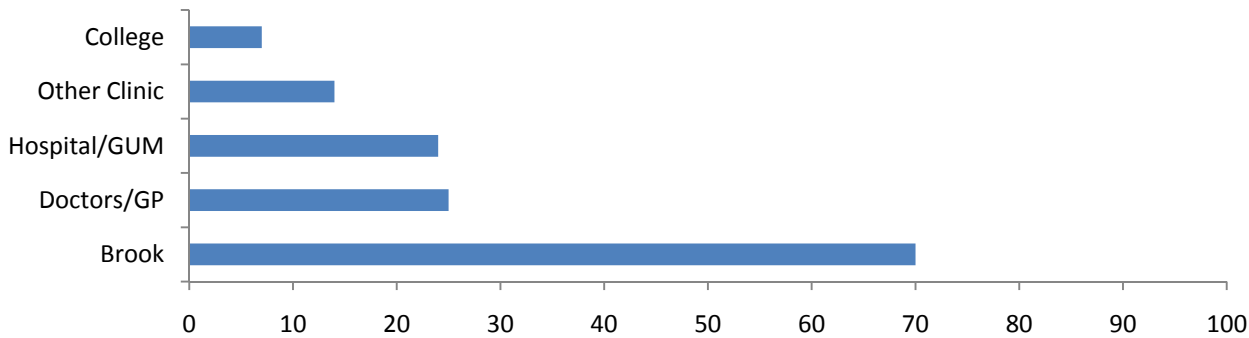
The GP was most frequently mentioned as the place to get the contraceptive pill, with Brook also commonly cited. The category of local clinics (for example by name or just ‘clinic’) was also a popular choice (figure 60).

Figure 61. Service choice for emergency contraception



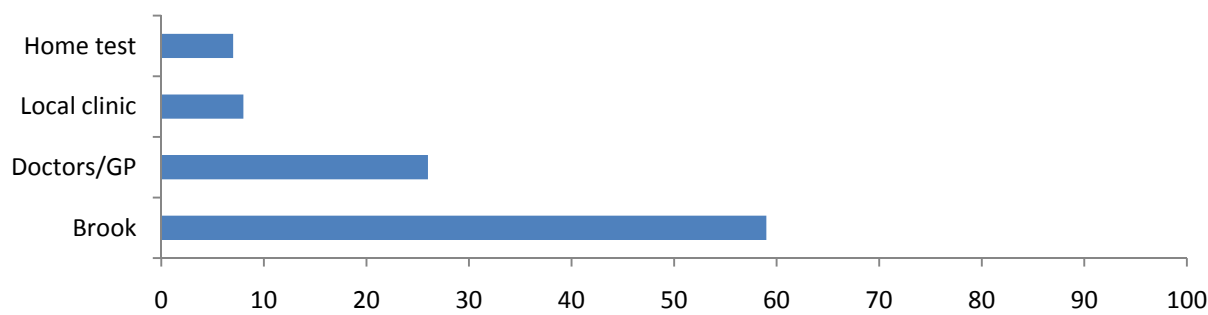
The most common place suggested to get emergency contraception was Brook with 80 individuals writing this response (figure 61). Other clinics, hospitals, chemists and GPs were also mentioned but only by a few individuals.

Figure 62. Service choice for STI screening



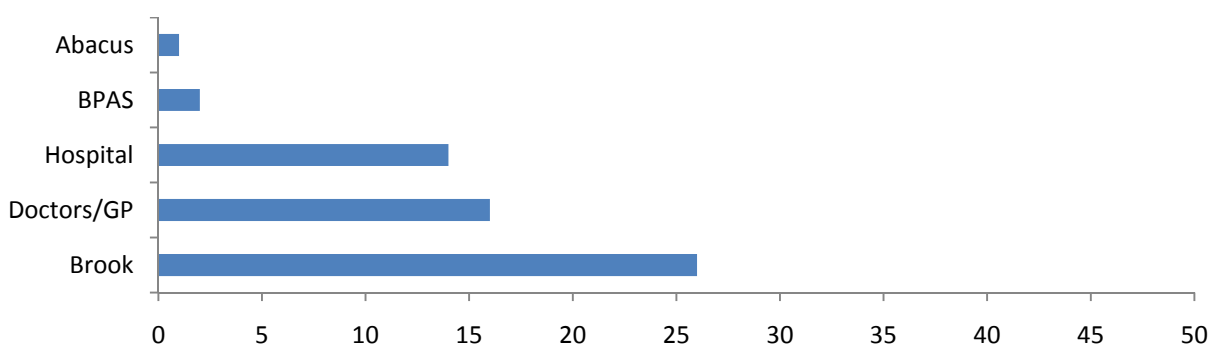
The most common place suggested for STI screening was Brook (70 individuals). Other places were the GP, hospital or GUM (figure 62). Other clinics were mentioned by name (e.g. ‘Eastham clinic’ or general terms such as ‘clinic’ or ‘family planning’). In reality, full STI screening is only available at GUM and other hospital services.

Figure 63. Service choice for pregnancy check



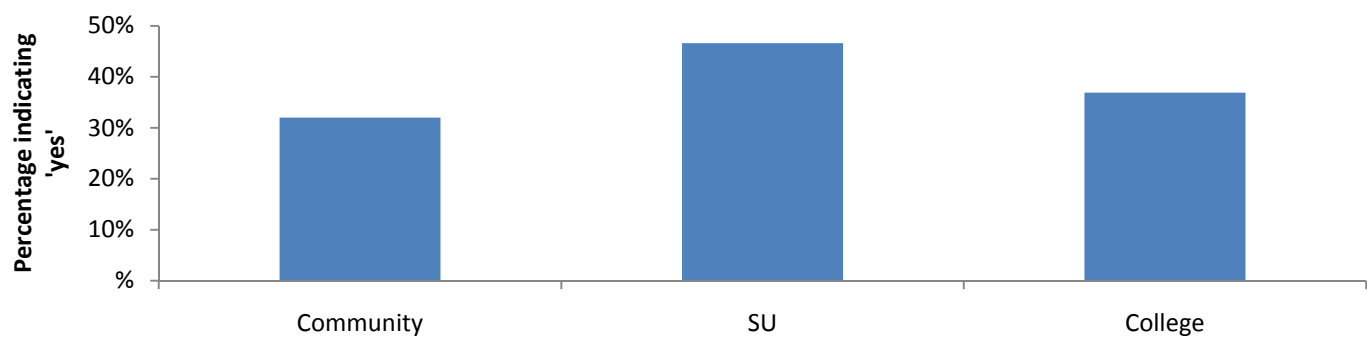
Brook was the place most cited to get a pregnancy test, followed by GP, local clinic, and home tests (figure 63).

Figure 64. Service choice for pregnancy termination



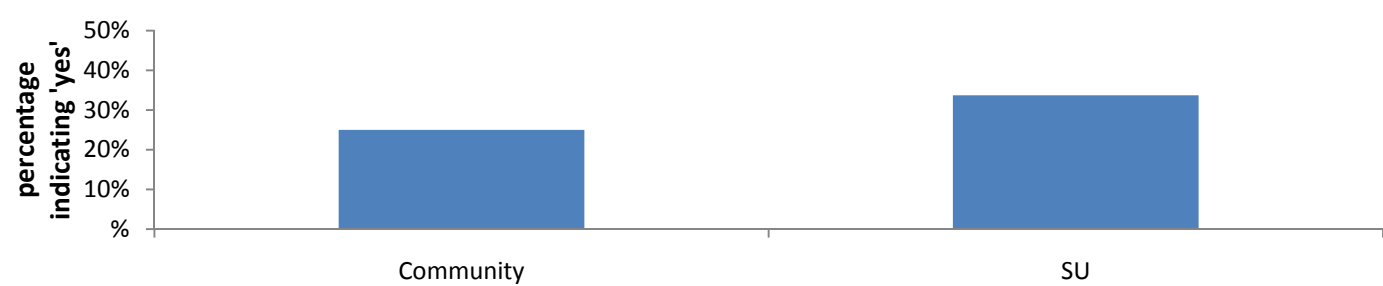
Brook was also most cited as the place to get help for pregnancy termination, followed by the GP, or hospital. Abacus and BPAS in Liverpool were cited by three individuals (figure 64)

Figure 65. Have you been to any of these services in the past 3 months?



Participants were asked if they had attended any of the places they had cited above (for condoms, the pill, EHC etc) in the last three months (figure 65). As expected more of the service user population indicated they had. Attendance was low in the more vulnerable community sample. When asked which of the services they had attended responses were mainly 'Brook', 'Chemist', 'Clinic' and 'GUM'. The most cited source of knowledge of these places was school/college followed by friends.

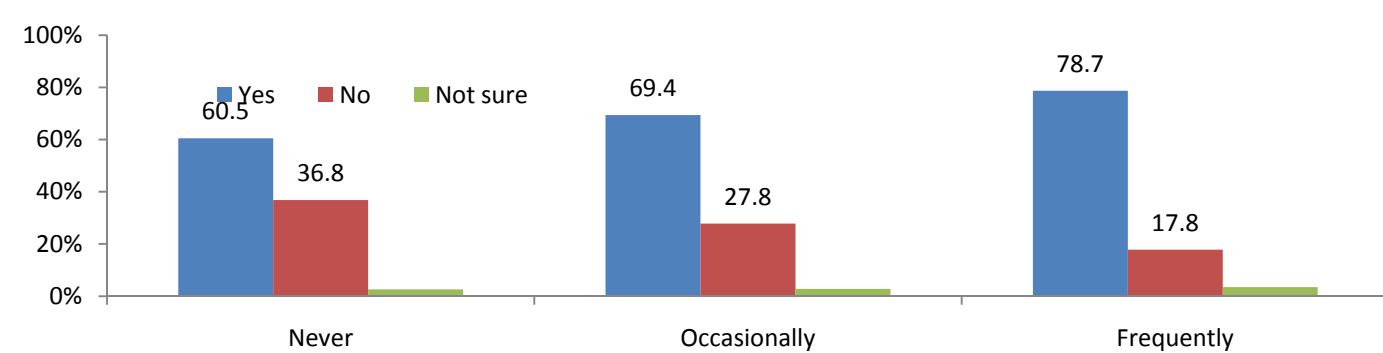
Figure 66. Have you been to a sexual health clinic in the past 3 months?



The community and SU group were asked if they had been to a sexual health clinic in the past three months. Only 34% of young people in the service user sample indicated they had attended a sexual health service (figure 66). The most cited response as to where they had attended were Brook, followed by hospitals including Arrowe Park and The Countess of Chester. One individual responded they had been to the GUM clinic. The individuals found out about these places in similar ways mainly through friends and school or college.

Alcohol use and attendance at services

Figure 67. Knowledge of sexual health clinics by frequency of alcohol drinking



In all groups the majority of young people knew where their local sexual health clinic was located. Those who had never drunk alcohol or who only drank occasionally were less likely to know where the sexual health clinic was (figure 67). Seventy-nine percent of those who drank frequently knew where their local sexual health clinic was. This in part suggests those drinking frequently find themselves in greater need of sexual health services, although older aged people may be accessing services as well as drinking more (limited data prevented more detailed analyses).

Figure 68. Have you been to a sexual health clinic in the past 3 months?

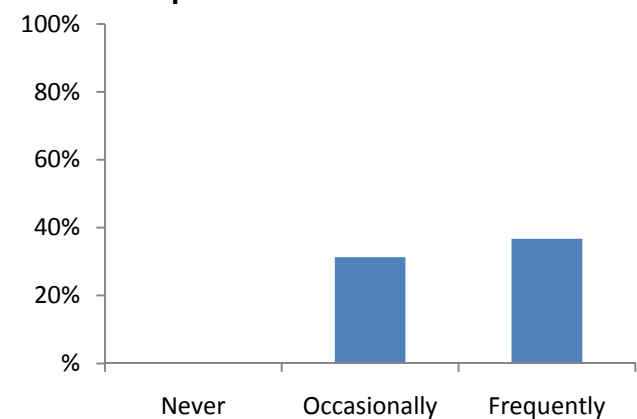
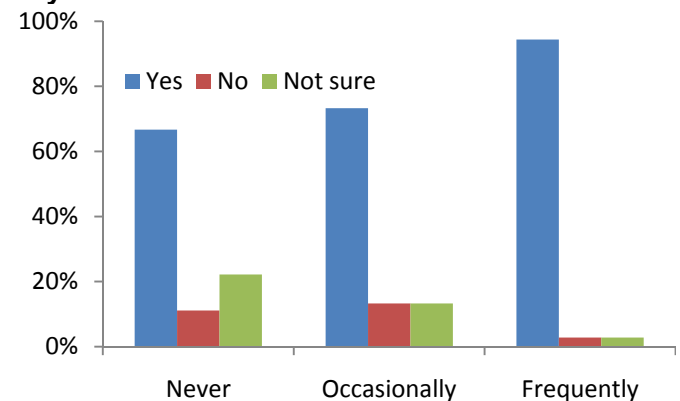


Figure 69. Could you go to a sexual health clinic on your own?



No respondents who stated they had never drunk alcohol in the last three months had visited a sexual health clinic in the same time period (figure 68). Thirty-seven percent of those that said they drank frequently had been to a sexual health clinic. This suggests the heaviest drinkers are the individuals attending sexual health clinics but have more sexual health problems. The majority of young people indicated they could attend a sexual health clinic on their own. This proportion was highest in the group who drank frequently (94%) showing more of a willingness to visit sexual health services in those most in need (figure 69).

Box 17 Conclusions for Young People's experiences of SHHW Services

- Although this was not a true random sample of young people in Wirral, the many and varied answers relating to young people's sexual health, health and wellbeing provide some highly relevant public health findings regarding this group in Wirral. Little information was gleaned about the views of non-white populations (see qualitative findings).
- Between a third and a half of respondents lived with both parents; while 90% lived in the family home, a minority living in temporary accommodation.
- Young people questioned appeared to have a high frequency of emotional wellbeing issues and long-term health problems. One in 10 of the community sample self reported to be young carers, 12% of the community sample and 5% of service users were permanently excluded from school.
- Young people in general thought they would visit either their GP or doctor, or Brook if they had alcohol or drug problems, or emotional wellbeing issues; few were aware of other varied specialist services such as CAMHS.
- Knowledge about where sexual health services were was very good, even amongst young men (50%).
- Amongst the total sample, young people from the community sample indicated they would have a problem attending sexual health services despite needing them. Females in the community sample gave reasons associated with personal fear or confidentiality rather than lack of awareness of where services were, highlighting the need to support young vulnerable females to attend.
- Most respondents cited Brook, followed by their GP, to resolve the diverse range of sexual health problems, suggesting young people are not fully aware of the range of services available.
- An overlap between frequent alcohol use and sexual health seeking suggests there is an opportunity to link and integrate services for both public health issues for young people.

4.2.4 Focus Groups (Qualitative)

4.2.4.1 Sex and Relationship Education

Box 18 SRE and sexual health services – Focus Groups

- Many participants had little or poor sex education and consequently had scant knowledge of STIs generally and in particular of HIV and AIDS.
- They identified a need for sex education to be provided at an earlier age, before young people engage in sexual activity.
- Criticisms of sex education include being taught by a teacher rather than an expert, having mixed gender classes, and out-dated materials.
- Participants identified a need for more information on STIs and particularly the use of graphic images such as the type used by Brook, which were recognised as a deterrent to unprotected sex.
- Most participants were familiar with Brook and identified them as the one sexual health service that they would (or did) use. Other sexual health services were far less well known.
- Brook were viewed as a confidential service, confidentiality and anonymity were key requirements that young people identified as important, in any sexual health service.
- The location of Wirral Brook was seen as problematic, despite being in a central location and generally accessible. Clients were concerned about being visible to traffic and passersby on the main road as they entered and left the building.
- Preference was expressed for sexual health services to be sited in a less visible location, (to prevent the 'walk of shame') preferably within an umbrella services, such as Connexions.
- Sexual health services for young people need to be open after school and college hours and at times over the weekend.
- Advertising of sexual health services could be done in schools and colleges, through billboards or posters at bus stops, or on the internet using Facebook or Bebo.
- When asked how sexual health services could be improved there was a consistency in response that more Brook clinics (or similar facilities) were needed across the Wirral.

There was overwhelming opinion from most participants when asked, that the sex education they had received in school had been poor. This was reflected in a number of derogatory comments made in response to our questioning. Some felt it had been nonexistent '*We didn't get it in High School*' (Mixed group 2 P4) or at least insignificant enough for them not to remember anything about it '*don't even remember mine*' (Male 2 P2). Others remembered it simply because of the poor quality. One noteworthy exception to the view regarding the lack of sex education came from group 2, the teenage mothers. They were of the opinion that they had received a lot, if not too much, information on sex education.

'But I'm not saying never taught us not to do that cause we had the Brook and we had loads of them health things didn't we' (P3)

'Yeah, like that's what I was saying beforehand how many talks do we need on bloody the Brook and sex education honestly! We have so many' (P5)

We've had loads' (P1) All young mothers

In general, criticisms were made about both content and presentation by participants irrespective of the group they participated in and therefore reflect the experiences and views from a number of schools across the Wirral. Scathing comments were made in relation to media presentations used, particularly cartoons or 'dated' videos with the following comments being typical.

'They're crap in school for sex education....watched some cartoon porn and basically that's it. They didn't tell us anything about STIs or nothing like that' (Male 1 P3)

'Like the videos are not up to date, they show people from the 80s and you're concentrated on what clothes they wear and you laugh at them, you just go ha ha' (P1 Mixed 1)

'and the voice is always dodgy, it just needs to be modern and updated' (Mixed 1 P2)

Another criticism made was that it came too late and needed to be introduced before young people start having sex. Many of the participants were in agreement with this.

'I was in year 10 or 9 so it was too old anyway, cause most people were having sex at that age anyway' (Hostel P3)

Hence, the first information young people often received about sex was *'from the streets, from me mates.....it was all lads stuff, myths and that'* (Mixed 2 P5)

There was much discussion within these groups regarding the ideal age or year group that sex education should be provided, with consensus not reached in any. There was some acknowledgement that as the age of sexual debut was getting lower, this should be recognised. Whilst two participants in separate groups believed that sex education should be introduced in primary school, in both groups this suggestion was rebuffed by other members who felt that this was too young, unless relating only to information about puberty.

Having teachers lead the sex education lessons was clearly another issue for young people, sometimes even where this occurred as part of the personal and social education lesson. One reason was that some pupils thought teachers didn't have the expert knowledge required, hence participants requested they were taught by *'people who know what they're actually talking about'* (Hostel P2). Many observed that the teachers themselves appeared uncomfortable or embarrassed with their role, and in turn this was reflected back onto the pupils themselves.

'A really old embarrassing teacher and at the end they go 'have you any questions?' and everyone just sits there' (LGBU P3)

Furthermore the sex education lesson was not seen in isolation but part of the ongoing relationship the teacher has with his/her pupils. As a result, conversations, questions or any disclosure that arose in the lesson might remain in the teacher's consciousness outside of the sex education lesson. Some participants however, did feel that being taught by the PSE teacher was not a problem primarily because it was part of their teaching role. Many though, did suggest that sex education could be taught by independent staff and specialists such as Brook. (Indeed those who had an education session from Brook prior to the focus group felt that that this type of session would be ideal as a format for sex education in schools). Another suggestion, though made only by one group, was that peer education would be an effective way of teaching about issues such as STIs and pregnancy.

Mixed Group 1 came to the consensus that they had a preference to be taught by someone of their own gender, although this view didn't emerge from any of the other group discussions.

'I wouldn't mind for the general knowledge but when it's the kind of serious stuff you don't want a girl telling you how to do a man's job' (Mixed 1 P2)

In contrast, the gender of pupils participating in sex education classes was discussed more widely. Although not unanimous, most felt that sex education should be taught in single sex groups. Mixed groups engendered an atmosphere of embarrassment and led to some pupils *'showing off'*. In contrast, single sex lessons were more likely to be conducted in a more conducive atmosphere. However, a couple of the males from the Young Men Group 2 suggested that as sex was a consensual act both genders should be present at the same time to receive identical information.

A specific issue raised by LGBU Group 2 concerned teaching of only heterosexual sex and relationships in schools sex education. The group members unanimously agreed that homosexual relationships should be incorporated into the school curricula, in order to normalise same sex relationships, which in turn would help prevent bullying and abuse.

'They just tell you about straight and when people are confused and don't know what to choose it wouldn't help them in a way would it?' (LGBU P2)

'That would make people think they're weird, different or wrong. Or they're thinking the wrong thing' (LGBU P1)

One subject that didn't seem to be addressed well, if at all, in sex education lessons, was that of STIs. Numerous participants reflected on the education lesson they had just received from Brook, and reported that the information was new to them, but would have been useful to have received sooner. Indeed participants suggested that this information would act as a deterrent to risk taking, both for themselves and for their peers.

'It might shock you but it makes you think' (Hostel P1)

Generally praised as good sources of sex education were the programmes 'Embarrassing Bodies' and 'The Sex Education Show', both shown on Channel 4 television. They were seen as factual and relevant as well as being interesting, and that they used real people for examples and discussion was also seen as a bonus. The following dialogue illustrates this view.

'They told you interesting facts and stuff, not just showed you a book and pictures' P2

'They talk more like talking with you, not just talking at you' P3

'Yeah, and they treat you like adults on that programme' P1

'Cause it's quite patronising the way people will talk to you at school, some of the teachers, they were really quite patronising and didn't help at all' P4 (all Mixed group 1)

Additionally other important means of targeting sexual health messages to young people through the media were via television soaps such as Hollyoaks and Skins, which are targeted specifically at young people, also mentioned but to a lesser extent was Eastenders.

4.2.4.2 Sexual Health Services

Brook

Wirral Brook was unique in that it was the only sexual health service that the majority of participants were familiar with. We acknowledge that our sample was biased as most of the focus groups were organised and in some cases run in conjunction with Brook. Notwithstanding, the group run aside from Brook were very similar in their positive responses i.e. their familiarity and attitudes towards Brook. Furthermore, many participants demonstrated knowledge of their services, describing their own experiences in visiting them.

Overall four key areas of recognition of Brook services were evident. Participants were highly conversant with their name, that they offered services specifically for young people, and that they gave out free condoms. Most importantly, and this was a key theme throughout the interviews, they were seen, and praised, as having a confidential service. (Indeed confidentiality recurred as an important theme throughout many of the focus group interviews).

'It's confidential and that, isn't it, isn't it so nothing to worry about when you go and that' (Mixed group 1 P3)

'Yeah, I reckon, you don't want all people knowing you've got Chlamydia or something do you' (Mixed group 1 P1)

Although many were familiar with the location of the Brook clinic, not all were. There was however some concern over its location. Whilst some praised it for being central and easily accessible, many others felt that its visibility was a drawback as clients were clearly visible to the general public, particularly those in passing cars and on buses, hence the comment:

'I like to wait until most of the cars have gone' (Young women P2)

The following excerpt illustrates some further concerns over location.

'I think people hold back because' P3...

'In Birkenhead on a busy road' P1

'Loads of traffic especially if the lights are on red' P2

'There's a massive sign saying 'The Brook' I know that's to help people see where it is but then if you're just like going in its not as if people think you're going in for housing or to sign' P5 (all Young women)

This particular group came to the conclusion that the entrance should be around the back, and thus not visible to passersby. However, an argument against having a sexual health service in a private location was put forward by group 4, one of whom stated:

'If it was more private you would feel more weird going in cause if it weren't so bad, why does it have to be private?' P1

Furthermore, *'and everyone goes so you feel normal going' P2 (both mixed group 1)*

The word *'normal'* was used in subsequent groups in the same context, the premise being that if visiting a sexual health clinic was a common activity then more young people would be encouraged to visit without the fear of stigma.

Despite Brooks' popularity as a service there was much confusion around opening times, with few knowing when the service was open. This invariably led to some discussion about what would be the ideal opening hours for any young person's sexual health service. Whilst 24/7 or 9-5 on weekdays tended to be the initial suggestions offered, the impracticalities of these times were generally pointed out by other members of the group. As a result the discussion usually ended with some consensus that opening hours should include out of school hours, with additional weekend opening, for those who needed EHC.

Many participants came to the conclusion that sexual health services could be improved simply by having more services like Brook, or more actual Brook centres located throughout the Wirral.

Other sexual health service provision

Other sexual health services in the Wirral were far less familiar to young people. When asked to name any sexual health services on the Wirral, few participants mentioned services other than Brook. The following quote was a typical response.

'No, apart from the Brook there isn't much. I don't know anything anyway' (Male group 1 P1)

There was some recognition of the GUM service at Arrowe Park hospital, although there was some question as to what service this provides (and some lack of understanding for what GUM stood for). Whilst group 2 felt a hospital was a good place to locate a sexual health clinic because it was anonymous, this view was not in accordance with those from the other groups. It is likely that this was a reflection of group 2 having (in general) more contact with hospital services through their pregnancy, and thus being more familiar and comfortable accessing them.

Single participants in the young mothers, and mixed group 2 mentioned a family planning centre in the local hospital without naming it (this is assumed to be St Catherine's), whilst four participants in different groups acknowledged the GP could be a source of sexual health information and services, although just one of these specifically said that he would visit his GP for this service, whilst another pointed out that *'the doctor's a pain in the arse getting an appointment isn't he'* (hostel P2).

One member of the hostel group spoke of a CAS clinic in her college at Conway Park, but this acted as a barrier to her because of visibility to her fellow students if she attended. Another in the young mothers group spoke of another clinic in Rock Ferry, which surprised other members of the group, who were aware of its existence, without realising that it provided sexual health services. As with the GUM clinic at Arrowe Park Hospital it was generally felt that locating a service within a wider service acted as a screen so that the public were unaware who was accessing sexual health services. For this reason participants in the young women's group came to the conclusion that a good place to site a sexual health clinic would be as part of the Connexions building in Birkenhead so that it would look to passersby as though clients were going in to

Connexions and anonymity could be maintained. Members of the BME male group also suggested this as a solution.

Young people would only visit services they believed to be confidential; hence they would talk to staff at Brook rather than a counsellor/nurse/teacher in other services. However, even within Brook clinic issues of anonymity were raised as a concern. Disclosure of personal details i.e. name and age, as well as the reason for attending clinic, made some participants embarrassed and uncomfortable, this also included having staff call out their name when it was their turn to be attended to.

'I remember thinking the worst is telling them your date of birth' (young mothers P3)

Hence the young mothers suggestion that a numbering system could be adopted instead of using names. Girls from the young women's group also made a similar suggestion but furthermore added that they shouldn't have to say out loud why there were attending. One suggestion to rectify this would be to simply state the type of service provider they wished to see.

'so it's like you're saying I need to see a counsellor, I need to see a doctor, that sort of thing' (young women P3)

Continuing the overarching themes of anonymity and confidentiality, service providers themselves were required to be trustworthy and discreet. Friendliness and approachability were also qualities the young people wanted in staff. Furthermore, they also wanted to be attended by staff who were not going to 'judge' them irrespective of who they were, or how they behaved. Some participants thought that very young staff were more likely to judge them, so whilst they didn't want an 'old' member of staff, they felt that middle age or maturity was a positive attribute. Not all groups agreed with this however, the girls from the young women's group found it easier to talk to younger people, and felt that someone who was nearer their own age would have more of an understanding of the issues that were important to them.

Gender/Sexuality

Generally it was agreed that the services should be provided simultaneously for both genders, and it was not necessary to have separate clinics or clinic times, however it was preferable to have a choice of seeing a member of staff of either gender. Whilst many participants, although not all, stated that they had no preference themselves, they did feel that the option should be available to them.

Participants from the LGBU group were unanimous in their opinion that services should not be separated for LGBU young people, as this would create more of a barrier between them and their heterosexual peers. However, they felt that within the service they should have access to staff who understood their needs, preferably those who were LGBU themselves as they would have more understanding of the experiences they were going through. In contrast the girls from the young women's group suggested that a separate service could be held to protect them because:

'I know like gay boys wouldn't want to go with straight boys, cos straight hard boys probably take the mickey at them' (young women P2)

The LGBU group also felt that assumptions should not be made by staff about their sexuality, but that either they should be asked directly or the questions should be framed around their relationship with 'a partner' rather than a 'boyfriend /girlfriend'.

Advertising

Suggestions for advertising sexual health services included: posters to be displayed in colleges and schools, billboards or bus stops – indeed *'put it where you'll get bored so you'll have to read it'* (Mixed group 1 P4)

'Free and confidential, that's all you need on a poster' (Mixed group 1 P3)

Advertisements could also be placed on the internet on sites such as Facebook or Bebo, as well as on local radio including times when local football commentary was on. Wider advertising could be put on the television during programmes aimed at young people such as Hollyoaks, and Skins.

4.2.4.3 Behaviour - Risk Taking

Box 19 Behaviour / risk taking – Main Findings from Focus Groups

- Young people were aware that risk taking occurred amongst their peers. Whilst there was a core of young people who did not use condoms for protection, many young people would use them if they had access to them at the time. However if not available, this would not deter them from having unprotected sex.
- Whilst young people were easily able to obtain condoms, the problem occurred at night time if sex was unanticipated. Another barrier to access was that of cost. However, free availability of condoms in vending machines etc would be wasted.
- There was some evidence of negative attitudes towards girls who carry condoms on their person. This had the compounding effect of preventing girls from carrying them, although they did keep them at home.
- Participants had some awareness of chlamydia and gonorrhoea, but were largely ignorant about HIV and AIDs, believing generally that they were not at risk of contracting the virus.
- Following an education session from Brook, many participants speculated they would now consider being screened for STIs. Prior to this they had little information of where they could be tested and what this involved. Lack of information, coupled with misinformation (e.g. the umbrella test) acted as a barrier, as did embarrassment.
- Suggestions that screening could be offered through schools and colleges were made in many of the focus groups.
- There was acknowledgement that alcohol could be, and was obtained under-age, and that it was strongly linked to unprotected sex.
- Similarly drugs (marijuana mainly) were easily available and used by young people on the Wirral. However, it was less clear to participants that this was linked to unprotected sex.
- Some groups suggested that pregnancy was an easy way to obtain access to housing and monetary benefits, and that was why some girls deliberately chose to get pregnant.
- Participants believed that there was a trend towards sexual debut occurring at a younger age and that this was linked to risk behaviour, and needed to be redressed through provision of sex education at an earlier age.

Much of the discussions centred around opportunistic sex or one night stands rather than within more stable relationships. Whilst it is likely this is a result of the topics being introduced into the discussion, it was evident that the former were a familiar concept to these young people, whether part of their own lifestyle or those of their peers. The discussion statement *'young people take risks with their sexual health'* drew agreement from all but one group, where this was discussed. However, even within this group there was not unanimous agreement. Participants clearly identified risks taken through the non use of contraception. Some felt this practice was very common among their peers, others less so, but all seemed to know of friends or peers who engaged regularly in unprotected sex.

The most common reason for unprotected sex was that of alcohol consumption (discussed in more detail below), also important was the lack of protection available during opportunistic sex. It was also suggested that young people rarely think about STIs, and thus do not envisage that they will be infected. One solution put forward by a number of groups to reduce this was to show pictures of STIs to young people. The comment *'that might put them off altogether'* (hostel p1) was typical of the belief that graphic evidence of the effects of an STI would act as a shock tactic.

Additional reasons given for risk taking, though less important were: that girls could take the EHC afterwards to protect themselves from pregnancy, and as succinctly put from one male from male group 1 *'they'd rather get their numbers up and take that risk'* (P1).

It is apparent that there is a core group of young people who would use a condom if one was available at the time. However, if they or their partner didn't have one then it would not prevent them from having sex. The immediate gratification far outweighed any fear of future ill effect.

'When you're there though, I think it's hard to turn it down me, can't just like, no I haven't got a condom, you go for it don't you?' (Male group 2 P1)

There was an element of dissociation with regard to STIs and this was particularly displayed through the dialogue of the young mothers group. That is, despite having knowledge that unprotected sex can lead to pregnancy, at the time of intercourse this doesn't register. The following quotes illustrate this common belief:

*'Like even though you know sex produces a baby you just don't think about that, and that sounds dead thick like, but you don't think about it? You know when you're just going to have sex you don't think oh f*** hell me life, I'm going to have this massive baby, you just don't think that way but you should'* (young mother P4)

'But I think with your boyfriend you don't, I didn't think it, like I used to have unprotected sex with him all the time and I never ever thought oh can I be pregnant now' (young mother P5)

Young people clearly knew where to get condoms listing sources such as the Brook clinic, condom machines in pubs and 'Tesco' toilets, or purchasing off the shelf in supermarkets and chemists. However, it was frequently suggested they should be given out free at colleges and also schools. Participants acknowledged that they could access them without difficulty – provided they planned ahead. However, if sex was opportunistic this led to difficulty obtaining condoms at times, particularly at night. Whilst acknowledging that they could be bought in pub vending machines, a clear barrier was cost as they are '*terribly expensive*' (young women P2). This view was evident in many of the focus groups, and clearly an issue for young people. As one young lad said:

'They've got them in the pub like, but you don't want to spend the money do you? They charge you £3 or something' (male group 1 P4)

A particularly strong opinion came from another group of lads, male group 2 who felt it was a '*waste of money*' to buy condoms.

'Buy some more beer and risk it' (male group 2 P5)

'Paid that money for that and it splits' (male group 2 P3)

As stated, this issue of expense arose in several groups, and invariably led to discussion in some of the groups about the price of condoms, and the acknowledgement that if they were complimentary in vending machines they would all get taken and wasted, mainly just '*to shove on their head and stuff*' (male group 1 P4). One solution put forward by the young women's group was to keep them at a low price but to put more in the box.

Some groups were asked whether the boy or girl should carry the condom. Invariably the initial answer was '*both*'. However, with some further discussion and prompting, although some felt that it meant '*she's safe*' (mixed group 2 P5), negative perceptions about girls who carried condoms became evident. That a girl might anticipate having opportunistic sex meant to some that she was a '*slag*' (or acknowledgement that others might think this). This is illustrated in the following quotes:

'People might look at 'oh look at her the little slag she's equipped' (mixed group 2 P3)

'In a good way, yeah I'd say in a good way because she's like careful. But then I think I'd see her in like a different way as she's like expecting to get it anytime' (NEETs P2)

This opinion was further illustrated in the male group 2. When asked how they would react if a girl produced a condom one response was '*shock*'. Further dialogue is provided below:

'But why would she carry one around with her all the time' P3

'She's a slag' P1

'Exactly that's what you'd think and then you'd start thinking about STIs and shit like that' P3 (all male group 2)

As a result of these prevalent attitudes some girls stated they would not carry around condoms, although admitted that they might keep them in the house for use there. A solution put forward by the girls in the young women's group was for a trinket box or similar to be promoted as a fashion accessory to keep condoms in. They felt that this might be seen as a 'cool' thing to have. This would help to lessen the problem associated with 'expectation' as they would be carried around constantly as one might do with a lipstick or sanitary towel. As a result:

'I think the boys would get over it and think well they're, we're both being protective so....' (young women P3)

In line with the negative perception of girls who had opportunistic sex, male group 2 voiced the opinion that whilst they didn't know of any lads who had an STI (primarily because the lads '*couldn't be bothered to get tested*'), they did know girls who had but:

'they're just not bothered, they're just a walking STD machine like' (male group 2 P3)

The views portrayed by this particularly misogynistic group, were that they could protect themselves by not having sex with 'slags'.

As a general rule girls in the groups were more concerned about pregnancy than catching an STI. This was evident not just from responses to a specific question but also in relation to general discussion about condom use. Condoms were regarded as a source of contraception rather than a way of protecting from STIs. Generally however, girls felt that the boys were more concerned about STIs than pregnancy.

'I think boys don't care about pregnancy to the same degree. They say "it's your mess", they all say "it's your mess now so deal with it" and that type of thing' (young women P2)

'They can just say "it's not mine" (young women P3)

Yet despite this opinion most, though not all, of the young lads that were asked, were more apprehensive of impregnating a girl. There was some acknowledgement that having a child is a lifelong commitment, whereas an STI could be treated.

'the right STI you can get rid of them the next day, some of them with a course of pills and that, but pregnancy's like a life commitment isn't it. Its shit scary pregnancy' (male group 2 P3)

That STIs could be treated however, meant that some young people displayed a casual attitude to the possibility of becoming infected.

'I wouldn't even be arsed if I got that mate, get rid of that after tablets' (mixed group 2 P3)

A few other males, albeit a minority, felt getting an STI was more of an issue than getting a girl pregnant.

'I wouldn't be as panicky if me girlfriend was pregnant than if someone told me you've got an STI I'd be flapping mate. Proper shitting it' (mixed group 2 P4)

HIV/AIDS

When the participants spoke of STIs they generally only mentioned chlamydia and gonorrhoea, and didn't mention HIV/AIDS until specifically asked. On questioning, the consensus lay in the belief that they weren't really at risk of becoming infected.

'They just think it won't happen to me, let's do it' (mixed group 1 P2)

'It's more of a joke with some people' (mixed group 1 P4)

A reason for this detachment was due, to some extent, as it being viewed as a condition that affects homosexuals rather than heterosexuals.

'I reckon it's not really known that well that straight people can actually get it. It's more known for gay people to get it' (mixed group 1 P3)

Another evident fallacy was that HIV/AIDS was not likely to be contracted by anyone living on the Wirral. One young lad illustrated this with the following quote:

'I knew I could catch it like but I wouldn't think anybody local would have it...unless they slept with someone far' (male group 1 P4)

This quote was used later in an agree/disagree format for subsequent focus groups, and although the majority disagreed, there was some concurrence with the sentiment.

'there's not HIV or anything like that around here it's all Africa and things like that' (male group 2 P4)

Further lack of knowledge was demonstrated by some of the questions that arose, including:

'Can you get HIV off having sex with someone, unprotected sex like with girls on their periods?...I've been told you can get AIDS if you have sex with someone who's on her period. You can just get it' (mixed group 2 P3)
'what if a mozzie flew over and I got bitten?' (mixed group 2 P4)

Overall, although researchers did not concentrate specifically on this topic, it was evident that there was lack of knowledge, and much misinformation around the subject.

Screening

Screening for STIs was seen as a positive step and one that many speculated that they would participate in, now that they knew (following a Brook education session) where they could get tested, how easy it was, and that it did not involve painful testing or treatment. Indeed both a male group (2) and a female group (young mothers) spoke of the 'umbrella test', *'I heard I heard something like they put an umbrella down ... And they wonder why people don't want to go and get checked'* (young mother P2). A number of participants were only aware of screening programmes and available treatment due to the education session from Brook that they received prior to the focus group. Indeed some did state that having acquired this knowledge they would go for screening in future.

'A lot of young people don't think you can get rid of Chlamydia and gonorrhoea as easy as you can, that why most people won't even go to a clinic, if, cause I knew that's all it was, some antibiotics I would have had that test ages ago. Just the fear though of like, don't know' (Male group 1 P3)

Embarrassment, fear of the unknown, and a belief that the treatment was painful or ineffective acted as a barrier to getting both tested and treated for an STI, as did lack of knowledge regarding where screening services were provided.

'If it's more difficult to treat it I think you're more reluctant to seek help' (Male group 1 P1)
'They don't really tell us where it is to go and get checked out' (male group 2 P1)

The suggestion was made that Brook (or a similar service) could go around to the colleges and schools offering information and screening. It was thought uptake rate would be high. Another suggestion was that screening should be made a routine task like having a dental check up, and could be done through the GP.

'You do go to the dentist when you go and get checked up don't you? Well I do anyway, so like if they put it in that frame of mind so when you get checked up at the doctors, they just do it. I wouldn't mind getting checked out when I went for a check up' (male group 2 P4)

However, it must be noted that this comment did not lead to any agreement or disagreement within the group.

Alcohol

There was consensus within all groups questioned, that alcohol was easily obtained for consumption by young people in the Wirral. Although some shopkeepers would not sell it to underage youths, it was easy to persuade someone else to buy it for them. There was also recognition that alcohol consumption was associated with a likelihood of young people having sex both by lowering of inhibitions and by increasing of libido.

'There are those out there, they'll drink to have sex, so their confidence is a bit up' (NEETs P4)

There was overwhelming acknowledgement that being drunk led to unprotected sex. All groups that were questioned about this were both explicit and vehement in their response.

'Well most of the time young people having sex are fuelled by alcohol so they're not really thinking about condoms and stuff like that, they don't know where they are most of the time' (NEETs P1)

'yeah cos when you're drunk you're just like, oh forget it, it doesn't matter [using a condom]. Not me personally like but..' (young women P5)

'Oh yeah, I'd regret that way. Like if I'd had a drink like – I done it plenty of times, had a drink and had sex and not used nothing, and I thought shit, like, I regretted it' (Young mothers P7)

Drugs

Like alcohol, drugs were seen as easily available to young people, with two of the groups specifying that some drugs were easier to get hold of than alcohol, although more expensive to purchase.

'It's easier to get hold of weed than it is to get hold of liquor' (mixed group 2 P5)

'you can get a bottle of cider for £3.30 yeah and be off head, whereas if you're going to get a bag of drugs you're looking at the £20 mark do you know what I mean? Now if anything, people with money issues..' (mixed group 2 P2)

The expense thus had some influence on whether young people chose to take drugs or drink alcohol.

'You get a better buzz from drugs, but it is more expensive' (hostel P5)

However, there was no clear pattern identified as to whether drug use or alcohol use was more important in this population. Some groups felt that young people were more likely to take drugs than drink alcohol, whilst some had the opposite view others still thought it was a fifty/fifty split. Mixed group 2 did identify that alcohol was more of an issue amongst girls, whereas drug use was more prevalent among boys.

'Most girls don't even take any drugs at all. More the lads who take the drugs isn't it? And the girls just, they'll be drinking' (mixed group P1)

However, this was not raised in any of the other groups. The drug use spoken of within the focus groups seemed to relate mainly to cannabis and to a lesser extent ecstasy, rather than other forms of drugs. Other forms of drug taking was not really identified with amongst participants in the groups, rather they saw drug users as 'smack heads' or 'bag heads' making rather derogatory remarks about them.

'If you went to the park on like a Friday you'd see pure people like that 'aaaahhhh' – twisted' (mixed group P3)

There was some acknowledgement that alcohol was more likely to make people do something that they would regret as opposed to smoking cannabis where *'you are still in control'*. One participant said about experiences whilst drinking alcohol *'I've ended up in strange beds and busy cells'* (hostel P1). In contrast, the relaxing and soporific effect of cannabis *'doesn't lead to sex'* (hostel P1) *'no you're just asleep'* (hostel P2). Hence the conclusion:

'You just legalise drugs and make alcohol illegal' (hostel P5)

However, as one participant in mixed group 2 pointed out there were risks associated with drug use.
*'If you're smashed you're not going to be arsed getting up and getting a condom, like f*** that'* (mixed group P3)

Therefore there was a general agreement, where discussed, that it would be useful to be informed about the effects of taking drugs, as well as alcohol.

Pregnancy

When the young mothers were questioned as to how many of their peers had babies or were pregnant, there was a chorus of exclamations to the effect that this was a very common occurrence.

'Oh my God. Wait there. The whole school. Everyone...' (P1)

'most of our year's pregnant' (P3)

'Yeah, same year group. Us three are, us four' (P1)

This perception was also echoed in one of the other groups, although not specifically questioned about it.
'How come most of the Wirral have got pregnant or got kids? There's only about four of my mates that haven't got kids' (mixed group 2 P2)

When asked whether their peers tended to plan their pregnancies, the group felt that whilst some did, others did not. Furthermore, without specifically being asked, it appeared through a variety of comments that most of the members of this group may have had unplanned pregnancies. At least two of these mentioned that they were on the pill when they became pregnant. Forgetting to take it and being on antibiotics were reasons put forward for its failure. Another girl mentioned that although she took it every day, it was at irregular hours.

A few groups raised the issue of young girls getting pregnant so that they could get access to housing and benefits. They firmly believed that this occurred amongst their peers.

'I know people who've had babies just so they can get a house. They use that baby as, like a key to get a house and get all money for nothing' (young mothers P1)

It had the effect that others went on to judge them, believing that they had become pregnant for the same reasons.

'we're all stereotyped aren't we?.....I had these lovely midwives but then I had one that was horrible and I knew why. It was because of me age like everyone just assumes that we don't work and like me boyfriend doesn't work and that we get our house paid for, but for their information we don't get anything paid for, it's all really expensive' (young mothers P3)

Younger age at sexual debut

It was interesting to note that four of the groups (young mothers, mixed 1, hostel and BME females) although not specifically questioned, voiced the opinion that age of sexual debut was getting younger. Some participants were concerned about this, whilst others were disapproving.

'I reckon the biggest risk now is people are starting a lot too early cause they think we're in a relationship that's what they have to do' (mixed group 1 P1)

'There's loads of little slags in like year 10 year 8 isn't there?' (male group 2 P2)

The general opinion amongst these participants was that younger people take more risks than people of their own age, and that this was an issue that needed tackling particularly, through provision of sex education at an early age, before they became sexually active.

Box 20 Recommendations from Focus Groups

Sex Education

- To be provided at a young age reflecting the age at sexual debut
- To be taught by 'experts' rather than teachers, in single sex classes
- To use modern, informative media reflecting 'real people' rather than graphics or cartoons
- To include information about sexual health services on Wirral; including information on location, opening times and services offered
- To include factual information on same sex relationships as well as gender identity
- To include information on sexually transmitted infections – covering the different types, ways of transmission, effects, screening and treatment, with illustrations showing the different infections
- To specifically include information as above on HIV/AIDS and including local information on its prevalence in the Wirral
- To include information on the effect of alcohol and drug consumption in relation to sex

Sexual Health Services

- To dramatically increase promotion of all NHS and non statutory services to young people, with information on services provided, opening hours and location – including screening services for STIs, what this involves, and forms of treatment
- To promote the confidentiality of the services provided
- To consider issues of anonymity for clients when they present to reception and are called into clinic
- Consideration of location for any new services – including accessibility and visibility
- For providers of the contraceptive pill to make certain that clients understand how and when the pill is effective, and circumstances when it is not
- For the PCT to continue to work with and fund Brook to provide high quality services to young people on Wirral

Reduction of Risk

- To promote condom carrying in girls, with promotion strategies targeting attitudes of males as well as females.
- To promote condoms to reduce STIs as well as a method of contraception
- To consider ways of reducing costs of condoms, or making more available at the same cost
- To consider means of making condoms easily accessible to young people during evening times and in locations young people drink alcohol
- To increase awareness of HIV and STIs and attempt to promote and normalise screening

Further research

- To investigate in more depth the negative attitudes that some individuals/groups have towards the LGBT population
- To investigate in more depth the negative attitudes that some individuals/groups have towards girls who carry condoms on their person
- To investigate ways to challenge misconceptions about the type of person who becomes infected with STIs

4.2.4.4 Specific issues faced by vulnerable groups – findings from the focus groups

By targeting specific vulnerable groups we were aware that issues unique to each may emerge. However, for the most part, the themes that arose were common to all, although the following exceptions are outlined below.

Box 21 Lesbian, Gay, Bisexual and Unsure Young People (LGBU)

This group consisted of 4 participants who meet as part of a wider group on a weekly basis. They were aged 15 – 18. As part of a support network they were conversant and able to express their opinions clearly. Homophobia and bullying emerged as a huge concern to members of this group, as did the lack of acknowledgement of same sex relationships, and information on sexual health and services for LGBU youth. Whilst much of their opinions of the sex education they had received mirrored those from the other groups, their specific differences and thus needs they felt were, for the most part, ignored by educators and service providers. By not providing information or even acknowledging differences in sexuality at education level, this had the effect of making them feel *'different'* or *'wrong'*. One participant stated:

'I think it goes back to the education thing doesn't it, cause if our sexuality isn't even important enough to be talked about at school then why should people give a crap about it on the street, or why should the police care about it, you know' (P5)

Failure to acknowledge differences in sexuality encouraged, or at least did not discourage, negative beliefs about homosexuality, yet it was agreed acknowledging homosexuality as normal leads to acceptance.

'Cause if you grow, if you grow up with it then its normal, you accept it' (P3)

Participants wanted sex education in schools to acknowledge same sex relationships, rather than to pretend that they don't exist. On the whole, they felt that information on sex for young LGBU youth was non-existent or inappropriate, being too overtly sexual. When discussing a safer sex guide for gay men published by the Lesbian and Gay Foundation in Manchester they felt *'the wording in it is really really crude'* (P1) and *'aggressive'* (P3) and it was noted that there was *'no mention of the word love is there?'* (P4). The consensus was that this format of information assumes that LGBU couples are not in a loving relationship but rather are just having sex. It was noted that this type of information would not be provided to heterosexual couples. The lack of sex education geared toward LGBU youth also led to ignorance about risk behaviours, particularly for lesbians.

Examples of being bullied at school because of their sexual orientation were provided by members of the group, and it appeared they had not been supported by the staff.

'I got told by one of my teachers, like, just ignore him, don't go near him – as if I went and hunted him down. I was like, I hide from him all the time, it's not like I'm going out of my way to walk past him and say "look here bully me"' (P3)

'They're like that with me in [name of school] cause I went in there and came out as gay in there. Every day I got picked on so when I went to the other school I just didn't say anything. I just kept it to myself' (P2)

Bullying and homophobia was not just present in schools, but also in society in general, in the Wirral area. The following were just two of the many examples that were given: *'I used to get abuse all the time and its only been the last 2 months that I haven't been getting that much abuse as I used to. I mean I used to walk down the street and I'd be called a faggot or something stupid like that....some of it by most of the people that I didn't even know'* (P4)

'I got spat at...called me a queen and spat at me. And then all down me jacket' (P3)

As a result, the group acknowledged that their lives were difficult, with their mental and physical health affected negatively.

Box 22 Young People Living In Hostel Accommodation

This group consisted of 7 participants, 3 male, 4 female. The group knew each other well and thus were happy to discuss and disagree amongst themselves. For the main part the issues described by this group were very similar to those from the other groups. No differences from the overall group findings were evident. However, having been informed by service providers (Brook) that STIs were a specific issue amongst young people living in hostel accommodation as they are more likely to have sex with the same partners, we specifically delved into this issue. Interestingly, the participants themselves did not identify with this problem but did believe this was an issue amongst the younger residents of the hostel, hence the following:

'when you see the little young ones that we live with and they're all running around sleeping with each other using nothing....I think the older ones of us know to keep it safe whereas the young ones are little hooligans aren't they...and the 16-18 year olds like, they're little loose cannons aren't they. They just run round wild, and the older ones are more settled and more not sleeping round.....and the younger ones just seem to have each other every 2 seconds like cannibals aren't they? It's hereditary you know when you live in a place like this' (P3)

However, despite the reference to hostel living, when asked whether this issue was specific to residents in hostels, the opinion was that it was not, but rather a reflection on the attitudes and behaviour of young people in general. It is interesting that these participants distinguished between themselves and 'young people' despite perhaps only one or two years difference in age.

Box 23 Young People with Special Educational Needs / Learning disabilities

A specific SEN focus group was set up as part of a Brook Education session, however two other groups included participants who had SEN. One who took part in group 4 (mixed youth group), remained virtually silent for the whole session, although attempts were made to solicit his views. Two other participants in the NEETs group had SEN, one made no attempt to join the discussion, whilst the other contributed very little. Thus we are unable to add any views from these participants to the overall body of evidence.

The SEN group were part of a group that had taken part in an education session. Initially participants were of mixed ability. However, a number of potential participants chose not to participate, whilst a couple of others left during the session due to time constraints. Thus the group were left with just three participants for whom it was deemed inappropriate to ask the usual questions. We therefore asked specifically about the sex education that they had received and their views on it. Whilst it was clear that they had received sex education on more than one occasion from Brook, and were familiar with some forms of contraception and STIs, they had very little to say about the quality of the education (apart from good) and how it could be improved.

Box 24 Black and Minority Ethnic Young Men

The group was run specifically for our research purpose by a male facilitator from Wirral Change, no females were present. However, Brook provided an education session as part of the package. This group comprised 7 Bangladeshi males aged 14 – 18 however, the recording/transcript indicated that the group were quiet, reserved and not particularly forthcoming with their views.

This group had mixed views of sex education at school. Despite being young men, they had been happy to have it delivered by a woman (a teacher in one case, and a school nurse in another). In contrast to other groups they were happy that it had been provided by a teacher. The negative comments evident in the other groups were not displayed. A preference was displayed for the group receiving the sex education to be all males rather than mixed, as it would allow them to talk more openly.

Participants were positive about the session that they had just received from Brook because *'like you explained it and we got involved in by doing things, acting the part'* (P3). They were particularly struck by the graphic images that Brook provided of the STIs.

'I think it's better to see the worst things, cause you know that, like, you know that's the worst thing and you should definitely get it treated' (P4)

Along with the other groups they were also thought the *'majority'* of young people have unprotected sex. *'Most people I know have unprotected sex'* (P3)

(We are not in a position to know whether this refers to their Asian peers or to all young people). With regard to contraception, there was acknowledgement that they would use a condom if one were available, however, not having a condom or having one that split would not stop them from having sex. *'No, say if you had a partner and you only had one, you'd like what I said if you was split or something you'd just throw it away but you'd still do it wouldn't you. You wouldn't stop yourself because you didn't have one'* (P3)

Interestingly, although the opinion was that both the male and female should be responsible for bringing a condom, one of the participants felt that in reality the woman tended to take responsibility. (Unfortunately this point was not discussed further with the group, and we are unclear whether these comments relate to Asian women or any young women). Interestingly, three members of the group spoke of the girl not wishing to use a condom *'for more pleasure'* (P1).

As with other groups, alcohol was an issue with this group in relation to sex. *'because you don't know what you're doing'* (P2) Pressure to drink came from both friends of the same culture and their wider set of peers.

Barriers to using services were the same as for all groups – embarrassment was the biggest factor. However, it was acknowledged that girls of the Bangladeshi and Muslim community *'wouldn't have no chance of coming into a Brook'* (P1); this is because a girl *'Cannot expect to have engaged in sexual activity before you're married'* (P1). When asked whether it would be a problem for the male if their marriage partner had had sex previously, it seemed that as long as they did not actually know this it would not be an issue, *'be a mystery'* (P3). However, *'It would be an issue if you knew'* (P3).

It was acknowledged that sex was never discussed with parents, this was both a generational factor and also dependent upon *'how traditional you are'* (P3). It appeared that this group felt they would behave differently when they were parents, and be more open by discussing issues around sex, which suggests that they themselves might have liked a more open relationship with their parents in regard to sexual health.

The group were asked whether they had experienced any discrimination in relation to health services. They reported that they had not, but the facilitator noted their body language and facial expressions suggested that this was not necessarily true. Despite encouragement, this was clearly not an issue that the group wanted to discuss openly.

Box 25 Black and minority ethnic young women

The group consisted of six females aged between 14-19 years. Although all spoke, three of the older members of the group did most of the talking. One of the main issues that arose from this group discussion related to sex education. Within the group they appeared to have had different experiences of this, some had frequent sex education, whilst others had a one off. However, all seemed to have been subject to a message that they felt related more to other groups of females than inclusive of their own culture. The participants were very clear in their understanding that girls of their own culture should not have sex before marriage, yet the information they received related to the likelihood of their having early sex with multiple sexual partners.

'It felt like they were pushing you, well not pushing but like it was ok to sleep around.....as long as you have a condom it's ok, but with our religion it doesn't really apply' (P1)

'They just gave information to girls who were going to sleep around' (P2)

Within this group their beliefs dictate that when they do have sex, it will be within marriage, and hence with just one partner. As a result they felt *'cut off'* from much of the information that they were getting. However they did acknowledge that information would be useful if it were in a different format i.e. if a wider view is presented, without the assumption made that all girls will have sex at a young age and with multiple partners. They felt sex education that told them about long term contraceptive methods would be useful to prepare them for marriage. They did not, however feel that they needed to be taught specifically by someone of their culture, as this would *'isolate'* them and just serve to highlight differences between them and their peers, as well as make them feel like they were being judged.

Like most groups they felt that it was better to have sex education provided by *'experts'* rather than teachers. *'Like someone from the Brook, they have more knowledge'* (P3)

However, they did suggest it would be better to have single sexed lessons.

This group found it difficult to discuss some of the topics raised as they had little knowledge or experience of sexual health services. However, they did feel that pregnancy would be more of an issue amongst their peers than STIs. Following the education session by Brook, this had made them more aware of STIs.

'How easy it is to get...how severe it is' (P1)

And like most other groups they felt that the use of the graphic photographs of the various STIs would act as a deterrent to unprotected sex, as would giving figures of how prevalent they are. In relation to condom use, the comment was made that:

'If you're old enough to have sex, you're old enough to protect yourself' (P1)

However, although they felt it didn't apply to them, they thought that carrying a condom would give a girl a bad name. *'They might think she's easy, up for it, might prey on you'* (P2)

One of the main themes that came out of this focus group related to their being judged by members of their community. They felt that being seen to access sexual health services would be frowned upon, thus using services such as Brook was not an option. Instead they felt it would be more likely that their peers would access their GP as they could be seeking advice or treatment for anything. And although they acknowledged that their GP provided a confidential service, accessing the GP was described as *'more of a hassle'* because of the need to have an appointment which may take some time. They also suggested housing a sexual health service within another context or umbrella service would make them more likely to access it.

Black and minority ethnic young women...continued

In relation to staff providing a sexual health service, they did not feel it necessary to be seen by someone from their own culture, but rather someone who was open minded about all cultures. Indeed being advised or treated by someone from their own culture made them:

'More scared in case they judge you' (P5)

Whilst it was important that they were given the option to see a female member of staff, it did not matter what age the staff were.

Like all groups they suggested advertising of sexual health services could be done through schools and colleges, on local radio and via the internet (Facebook). The message to send out would be that the service was confidential and free.

Box 26 Young people not in Education, Employment or Training (NEETs)

This group consisted of 9 members, 7 male and 2 female, most of whom had no qualifications, and were attending a 2 week basic skills course. The group were fairly quiet with most of the interaction from 3 participants (2 male and 1 female). For the most part this group appeared to have similar views to the core body of young people from all of the focus groups. However, they found it quite difficult to discuss their views of sexual health services, because they had little experience of using them. Indeed, Brook seemed to be the only service that they were familiar with. They were aware that many of their peers took risks in relation to their own sexual health by non use of protection during sex, and it seemed that STIs were not something that their peers were particularly concerned about.

'I don't really think they care about diseases, they just think its sex at the end of the day' (P5)

'Probably think its cause chlamydia and gonorrhoea are more common and they're curable that it wouldn't be that bad if they got them as much as it would be if they got HIV really cause its incurable' (P4)

Indeed, HIV and AIDS were seen as a 'rarity', *'They always think we're not going to catch it' (P2)*

Furthermore alcohol and drug use increased this risky behaviour. This group thought that it was easier to get hold of drugs than alcohol. Overall, they felt that the main issue facing their peers was that of pregnancy.

'You don't think about it when you're about to have sex, the risks really. You just go into it really...I'm going to get an STI, get this girl pregnant you know, "let's leave it for now". You just have it and then afterwards like now's the problem' (P1)

Discussing this further, whilst one participant reported *'Sometimes they just want a baby so they've got someone to love don't they' (P2)*, her peer added *'and sometimes they didn't think what they were doing at the time' (P1)*. This group did believe that some of their peers had children because of the support that was offered.

'Benefits as well. They have a baby so they can get housing benefits' (P2)

'If a girl just like goes out on the dole and says I'm pregnant, there's a house and everything now. She'll just get the house and that. They've got it easy, they'll just claim for years, just to sit in a house' (P5)

It is possible this view might be a specific reflection of the peers of those who are NEETs. It may well be more likely that those who leave school without qualifications or a job to go to, do have children earlier as a consequence. However, we can only speculate on this, and demonstrate that this was a view held by members of our NEETs group.

Box 27 Young Mothers

This group consisted of 5 participants. There was one girl with twins, two girls with a young child each, and two girls who were pregnant. This group meet on a weekly basis at a support group. As they knew each other well, they were very relaxed and open, although this meant that it was difficult to keep them on a topic at times.

There was a mix amongst the group as to whether their pregnancy was planned or not. Three participants reported that they were on the pill at the time of conception; two had taken antibiotics, whilst another had forgotten to take it on one occasion. Two participants thought their experience was fairly typical.

'I used to have unprotected sex with him, not like everyone but with [boyfriend] all the time and I never ever thought oh can I be pregnant now? Never used to think it because like there is loads of people like me and [participant] who thought we couldn't have kids cause we were in a relationship and we had loads, well you know, not that much, sex, yeah we didn't use the pill or anything and like we just didn't get pregnant' (P5)

Consequently one of the participants reported that she had used the 'morning after pill' about five times.

Where the pregnancy was not planned it was kept hidden to some extent from immediate family (mothers). One mother realised due to her daughter having morning sickness, whilst another mother only realised when her daughter was five months pregnant. Two other participants chose to tell their mother but not face to face, preferring to do this by telephone or text. Two participants reported that their mothers initially reacted very badly to the news.

'I didn't see me mother for six weeks. She dropped all me stuff off and everything at me boyfriends – chest of drawers by the gate' (P2)

One participant reported that she knew of 'people whose mums have forced them to have an abortion' (P1). This did not surprise the other members of the group, and indeed one spoke of her father having tried to pressure her into having a termination. Another felt that she had disappointed her mother:

'She was disappointed because she wanted me to do something with me life, but I'm going to do something with me life anyway' (P1)

This particular participant had a supportive family and partner, was enrolled at college and intended to go to university.

This group felt that their experiences were generally typical of their peers, and that many of their friends and schoolmates were either pregnant or had already had children, naming many examples to illustrate this. They concluded that:

'so everyone in our school really is pregnant' (P5)

'or on the way to getting pregnant' (P1)

Despite this, contrary to the core group of participants, this group felt that they had received plenty of sex education at school, including sessions from Brook as the following excerpt shows

'but I'm not saying [school] never taught us not to do that cause we had The Brook and we had loads of them health things didn't we' (P3)

'So you think it's not because no one's kind of explained contraception to you' (Facilitator)

'No, it's not that' (P1)

'No, we've had loads' (P2)

Young Mothers...continued

.....the conclusion was that *'I think we sort of assume it will never happen to us'* (P3)

'Like even though you know sex produces a baby you just don't think about that' (P4)

There was some acknowledgment that having a baby was a natural instinct for some of their peers who chose to get pregnant. However, others wanted a child so that they could get access to housing and benefits.

'They use that baby as, like a key to get a house, and get all money for nothing' (P1)

Some of the group felt that having a child hadn't altered their ambitions, two were attending college, and one of these intended to go to university in the near future. The whole group felt that having a child had made them more conscientious, in that they had to achieve more in order to give their child a good life.

'Like when I used to think about getting a job I used to think, oh I can't be arsed, I'll stay in bed, I haven't got to go to school so I'll stay in bed. But now if you think about it, you think I've got a baby to feed, I've got rent to pay and thinks like that. So it does give you more get up and go, if you've got a baby or someone else to look after' (P5)

However, they did concede that not all of their friends or peers had this attitude, with perhaps half of their peers staying at home in order to protect their benefits.

One of the key topics that this focus group discussed was the different methods of contraception. They had negative views about 'the injection' which *'messes up your insides'* (this, or a similar phrase was used by three participants), the implant and the coil were used by members of the group who were satisfied with these, when asked about being put off by having it fitted internally, one reported that having had kids she had already *'lost our dignity'* (P1). Another participant used the 'patch' but felt that it was not attractive physically and:

'you don't want people seeing it cause it can look as though you're smoking or something' (P3)

Other members of the group asked a number of questions of her, as they had little awareness of this form of contraception. All members of the group expressed a strong dislike of using condoms, for reasons including; the smell, the feel on your hands, the feel of it during intercourse, also:

'the fact that you're in the mood and then you have to stop just to put a condom on' (P1)

'you always think it's going to fall off, you're like checking and checking' (P3)

'that's my worst nightmare, having to go to Arrowe Park and say I've got a condom stuck up me, can you get it out' (P5)

Overall, this group had similar knowledge and views on sexual health services as the main core of the participants, although they were more open to using sexual health services in a hospital setting – possibly as they had more experience of using hospital services. As with other groups, they were put off accessing services they knew little about.

'I know where they are but I'd never think of going 'cause I don't know what they're like' (P4)

However, they reported having been tested for STIs during pregnancy, but this was not seen as an issue as it was part of the routine care they received at this time. Despite their experience within the health care system, they were similar to the main group, in their need for anonymity and confidentiality, and their dislike of giving personal information (name and date of birth) to sexual health service staff, for fear of staff disapproval.

Box 28 Young Women

This consisted of a group of 9 young women on a vocational training course, 8 of whom agreed to take part, the remaining participant did not want to leave but remained silent throughout the discussion. Five girls contributed much to the discussion, with two others making occasional comments, the 8th participant did not contribute. The group interacted well and were quite happy to disagree with each other but this occurred in a non confrontational way. We assume from this that many of the views were accurate portrayals rather than to fit in with group opinion.

This group felt very strongly that males were less concerned about pregnancy than they were, and that whilst they were equally responsible, *'they say 'it's your mess', they all say 'it's your mess now so deal with it'(P2).*

There was a strong sense that they believed girls were judged by their sexual behaviour, and this had the effect of stopping them and their peers from carrying around condoms for example. They were aware that some males made excuses as to why they couldn't use condoms including being too tight, allergies, or 'it's not as good'. (This is in contrast to the young mothers group who themselves had reasons as to why they did not like using them). These young women also had different views to the young mothers regarding young motherhood

'Yeah, like people I speak to like my age, 15, 14 just say to me 'I want to have a baby' and you're like 'why?' it's ridiculous' (P4).

This group also believed that some girls had a child to get more money, or access to housing, whilst others did it because they were bored

'they're not in college or anything so they have a baby' (P1).

Something to do isn't it, keeps you busy' (P4).

Indeed many of the comments did centre around the boredom factor, and it appeared that they felt it was a contributory factor to teenage pregnancy.

As with most groups, these young women acknowledged that alcohol consumption was rife amongst their peers, usually at parties, and did lead to unprotected sex, yet it is easy to get older people to buy alcohol on their behalf. In contrast, to some of the other groups, they did feel that drug use was not as common as alcohol consumption amongst their peers.

In relation to sexual health services, this group demonstrated very similar views and behaviour to that of the overall group. Key issues were confidentiality and anonymity, although in contrast to others, they preferred staff in these services to be younger as

'they understand what kids like teenagers nowadays go through, cos it was not that long when they were a teenager or something'. (P3).

Typically though, they felt that the services provided (i.e. Brook) were fine but

'there just needs to be a bit more of them' (P2).

Box 29 Young Men

Two focus groups were held with young men. Group 1 consisted of 5 participants aged 16-17 who were on an engineering course, and appeared to know each other quite well. Group 2 consisted of 6 males aged 16-17 who were on day 1 of a 5 day personal development course. Although many of the views were broadly similar, there were members of Group 2 who displayed some very extreme views, particularly in relation to girls. Girls who had sex were 'slags' and this term was used frequently throughout the group discussion. It is quite possible however, that these particularly macho views were displayed in order to impress their fellow students, rather than being extreme for real. Certainly these extreme comments were not echoed in the first all male group.

Both groups were clear in their views that sexual health services should be confidential, and this was one of the reasons that they identified Brook as a good place to go. Whilst some preferred to see a male member of staff, others did not mind, although they thought it would be good to have a choice. However, unlike the all female group, they preferred to see someone older, rather than someone close to their own ages.

In agreement with the core group they felt that sexual health services could be improved simply by having more services available, and not just central to Birkenhead. The male groups were equally concerned about being seen entering a sexual health service by passersby. Three members of this group specifically reported that they would not visit their GP on matters related to sexual health, a fourth would but only if he knew him better.

Whilst there was some acknowledgement that they and their peers may take risks in relation to STIs, members of both groups were more concerned about pregnancy. So, the pattern appeared to be with group 1 that they would have sex without using a condom, if the girl was on the pill. In contrast members of group 2 spoke of girls having the emergency oral contraceptive pill, rather than the daily oral contraceptive pill, as

'some girls don't care. They just think I'll get up in the morning, take the pill' (Group 2 P1).

So, whilst STI's were generally not so much of a concern

'you can cure most of them anyway, can't you, so I don't see what the big problem is like' (Group 2 P2).

Specifically HIV and AIDs were not considered at all. Members of group 1 admitted that they never thought about the possibility of catching this. Some members of group 2 also *appeared* to believe that they would know if they had slept with a girl who had an STI

'You'll hear about them anyway, hear about them, the girl like, meant to be riddled so people will start saying stuff to you anyway' (Group 2 P1).

Indeed the way to prevent catching an STI was *'just know who the slags are'* (Group 2 P4).

There was no evidence that males in Group 1 thought negatively of girls who carried condoms, however just one person answered this question, and possibly with more in depth probing, views visible in other groups may have emerged. In contrast, whilst the initial reaction from members of group 2 was *'I'd be well happy f I didn't have one'* (P1), this view changed quickly....

'You'd think that but why would she carry one around with her all the time?' (Group 2 P3).

'She's a slag' (Group 2 P1).

Both groups confirmed that it was easy to obtain condoms, but group 2 were very negative in relation to paying money for them.

'I'd rather spend me money on something else like, I'm not wasting me money on that' (Group 2 P4).

Members from both groups confirmed that it was easy to get hold of alcohol, if they were underage there was always someone else who would get it for them. However, they did believe that drug use was more of an issue for males than females but that unlike alcohol it had less effect on sexual risk taking.

4.2.5 Supplementary studies

4.2.5.1 Findings from a Health Service Audit in Schools in Wirral

Box 30 Summary of Findings from a Health Service Audit in Schools in Wirral

- Bitesize Brook surveyed 348 Year 9 students (aged 13-14 years) during their Brook event in three high schools in Wirral to elicit the opinions of young people on local health services.
- The most important element of a health service for YP was rooms where they could talk in private, 'treating young people', and 'warm and friendly'. More boys than girls opted for free condoms.
- YP did not specify one particular location for accessing health services; just under half indicated a doctor or GP clinic health building; more girls indicated they would like a mobile bus, close to shops, in youth centres and at school or college than boys.
- YP thought Wirral Brook was the easiest / best service to talk to. Girls also chose their friends, and in general chose more people / organisations to talk to about health issues. Few boys chose 'connexions worker', 'school teacher' and 'CAMHS'; few girls chose 'pharmacy/chemist', 'school teacher' and 'CAMHS'. School nurse / clinic was midway on list of preferred options.
- The majority of YP found 'parents / carer' most difficult to talk to, along with 'school teacher' and 'brothers or sisters', and 1:3 boys compared with 1:10 girls, had difficulty talking to friends.
- Few YP ticked 'CAMHS' for any questions, suggesting they are not acquainted with this service.
- Two thirds of girls and boys thought services were friendly and helpful but only 18% of boys and 27% of girls thought services were well advertised.
- Helpful services for particular health issues were identified in this school-based population for (i) *depression*: family GP/doctor, Wirral Brook were considered most helpful, while CAMHS and Connexions were least; (ii) *eating disorders*: family GP/doctor, 'nurse at GPs', 'NHS walk-in clinic' and 'school nurse', with 'Connexions', 'CAMHS' and 'Response' least helpful; (iii) *alcohol and drug-related problems*: this population thought Wirral Brook and family GP/doctor were most helpful with 'Connexions', 'CAMHS' and 'Response' least helpful; (iv) *contraception*: 80% thought Wirral Brook was the most helpful place followed by 'family GP/Doctor', 'NHS walk in centre' and 'nurse at GPs'; (v) *problem with relationships-bullying*: the most helpful service was youth workers, followed by 'school nurse' (39% of girls) and Wirral Brook (30% of boys); (vi) *Giving up smoking*: 'NHS Walk in clinic' and 'family GP/doctor' were the most common choices for both boys and girls, followed by 'school nurse' (34% of girls), and 'Wirral Brook' (34% of boys); (vii) *check for sexual infection*: 'Wirral Brook' was most common for girls (68%) and boys (65%), followed by 'family GP/doctor', 'NHS Walk in clinic' and 'Nurse at GPs'.
- YP stated if a school health service was opened the most popular opening times are 'all day' but not during lessons.
- YP had a variety of deep-seated worries about school based health services. The main worries were friends or peers finding out or seeing them go in, embarrassment or fear (especially for boys) including the clinical actions taking place, the word 'confidentially' was explicitly mentioned by many. Girls were worried their parents would find out.
- Referrals were preferred to YP-specific services, and GP services close to the school, and the worst place would be to the family GP and doctor (indicating again fear of loss of confidentiality).

A total of 348 young people, from three schools, completed a health audit form as part of a Bitesize Brook event. A similar number of audit forms were completed at Woodchurch High (a mixed sex school; 130) and Caldy Grange Grammar School (a boys school; 139). Fewer participants were from Prenton High School for Girls (79; 23%). This is reflected in the sex of the respondents (62% boys and 38% girls). The majority of the respondents were 14 years of age (89%); this is likely to be due to the questionnaires being distributed in the final term, in Year 9 (table 1).

Table 7. Descriptive Statistics of participants recruited at school-based Bitesize Brook event

		Frequency	Percent
Sex	Male	216	62.1
	Female	131	37.6
	Unknown	1	0.3
School	Calday Grange Grammar	139	39.9
	Prenton High School	79	22.7
	Woodchurch High	130	37.4
Age	13	38	10.9
	14	308	88.5
	Unknown	2	0.6
Year Group	9	345	99.1
	10	1	0.3
	Unknown	2	0.6
Total		348	100.0

Respondents were asked a number of questions about what they thought of current health services and how they would prefer any new health services for young people to be like. Graphs are presented to represent the percentage of each gender who indicated a preference on a 'tick any that apply' basis.

Figure 70. What is important for a health service for young people?

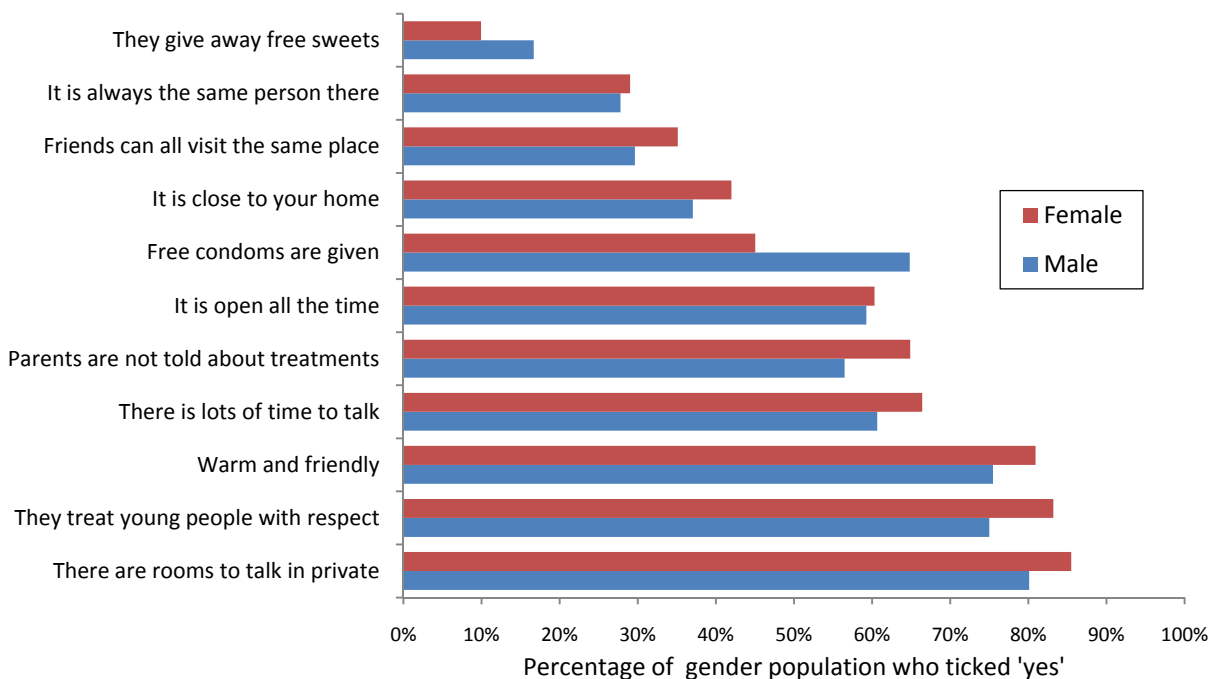
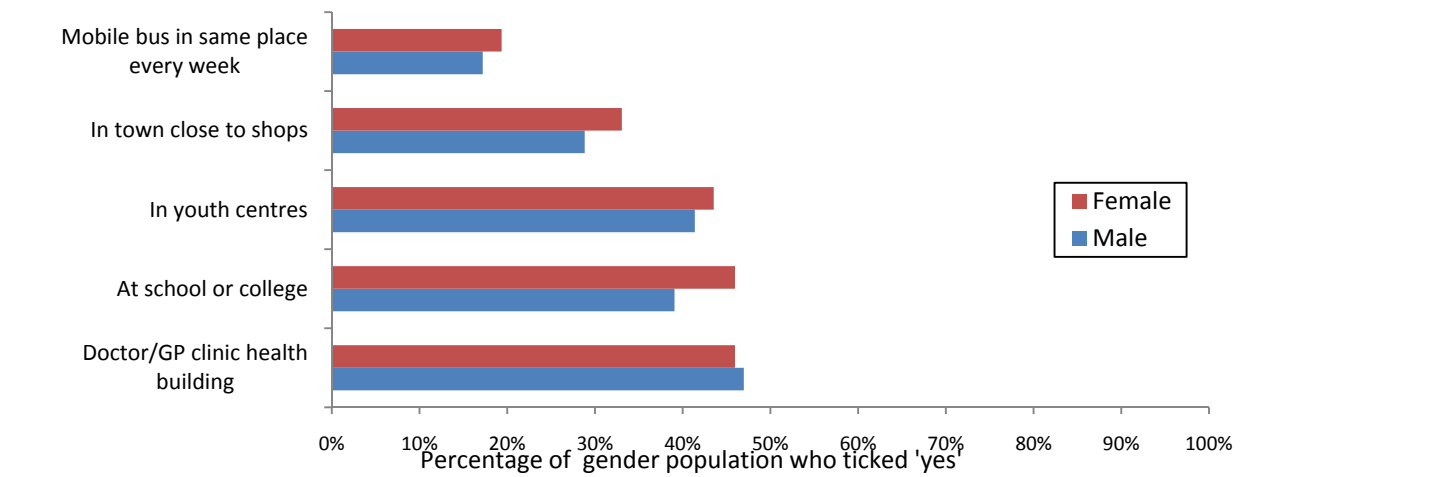


Figure 70 shows that girls and boys had similar opinions about what was important in a health service for YP. The most important element was rooms where they could talk in private and this was indicated by 80% of boys and 85% of girls who answered the question. 'Treating young people with respect' and 'warm and friendly'

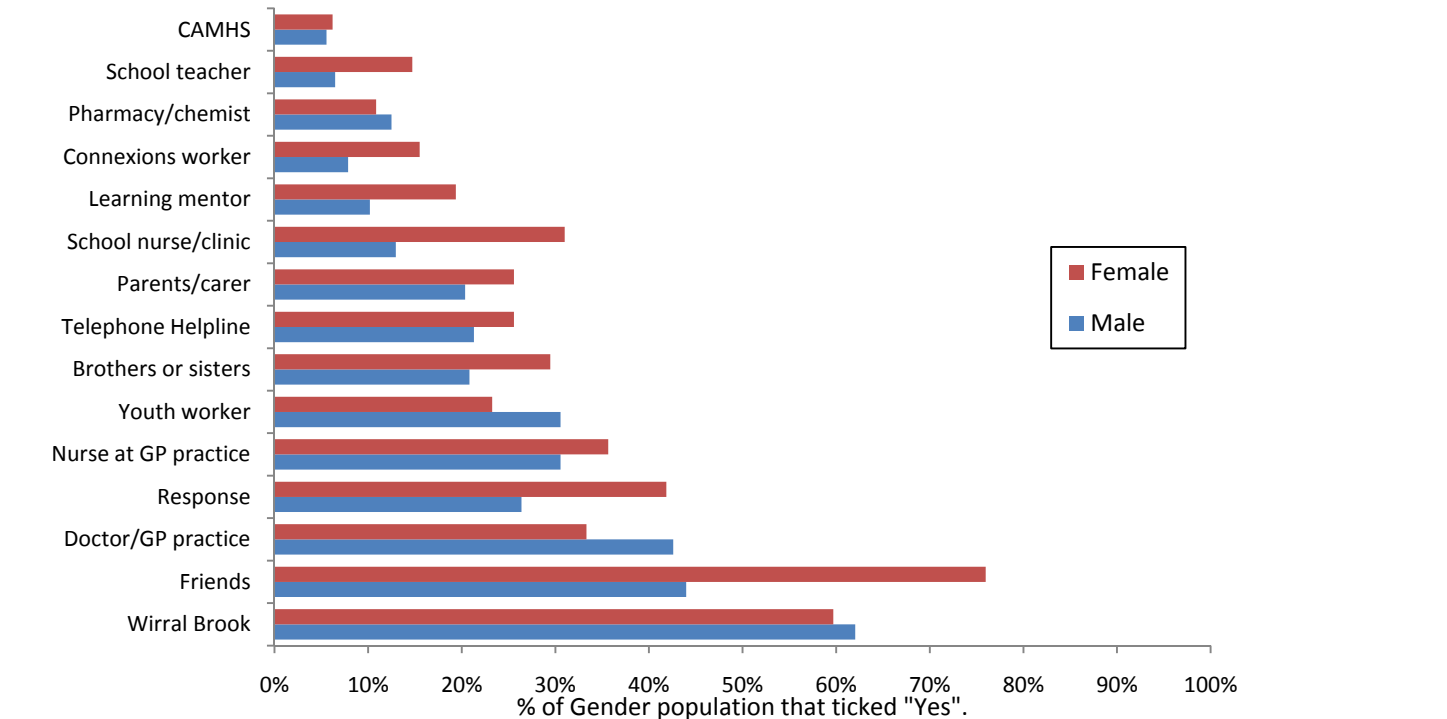
were also things that YP thought were important. Overall more girls indicated preference for each element apart from free condoms which males thought were more important (65% of males, 45% of females). Giving away free sweets was not prioritised by many individuals.

Figure 71. Where do young people want their health service/clinic to be?



Fewer young people expressed any one specific opinion on location of health services (figure 71). More girls indicated they would like a mobile bus, close to shops, in youth centres and at school of college than boys. A slightly higher proportion of boys indicated they would like it in a most popular location, a doctor or GP clinic health building (47% of boys and 46% of girls).

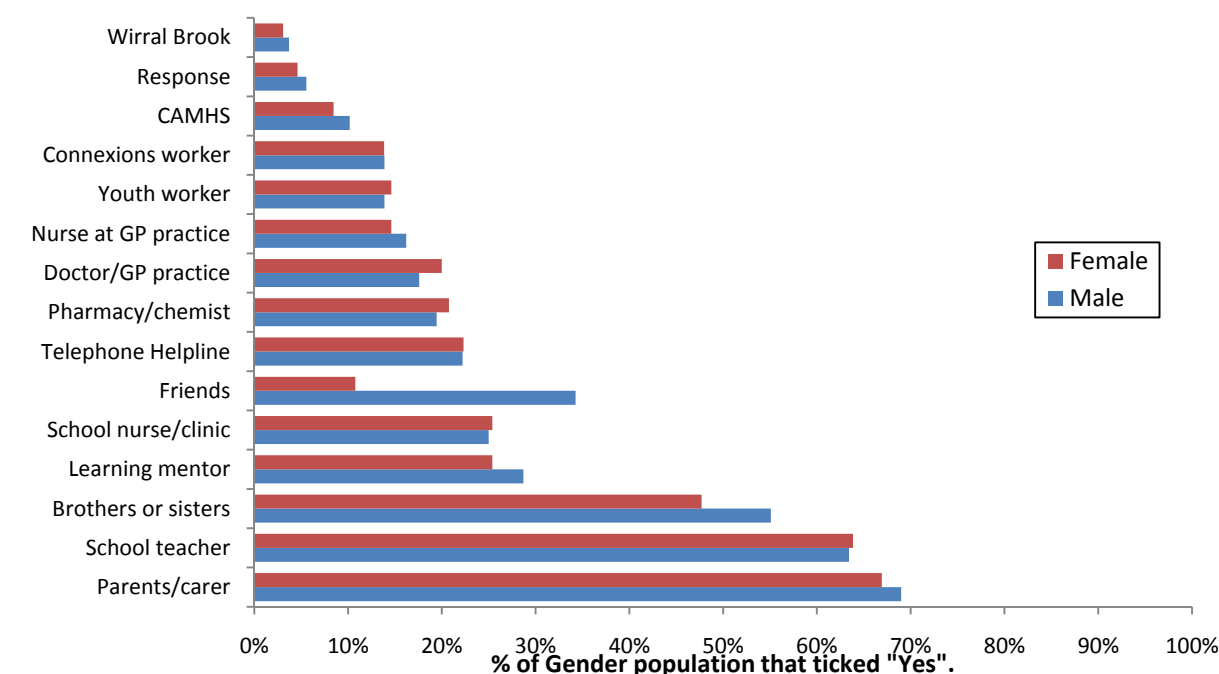
Figure 72. Who do young people find it easy to talk to about health issues?



Young people were asked to indicate all people/services who they thought it was easy to talk to about health issues (figure 72). The most popular service overall, and most popular for boys, was Wirral Brook. This may have been influenced by Brook leading the session the questionnaires were delivered in. Girls' most popular choice was 'Friends' (76% of females who answered the question indicated they thought friends were easy to talk to)--a much higher proportion than boys (44%). Overall girls indicated there were more people/organisations that were easy to talk to about health issues than for boys. The least popular choices for boys were 'connexions worker', 'school teacher' and 'CAMHS', and for girls were 'pharmacy/chemist', 'school

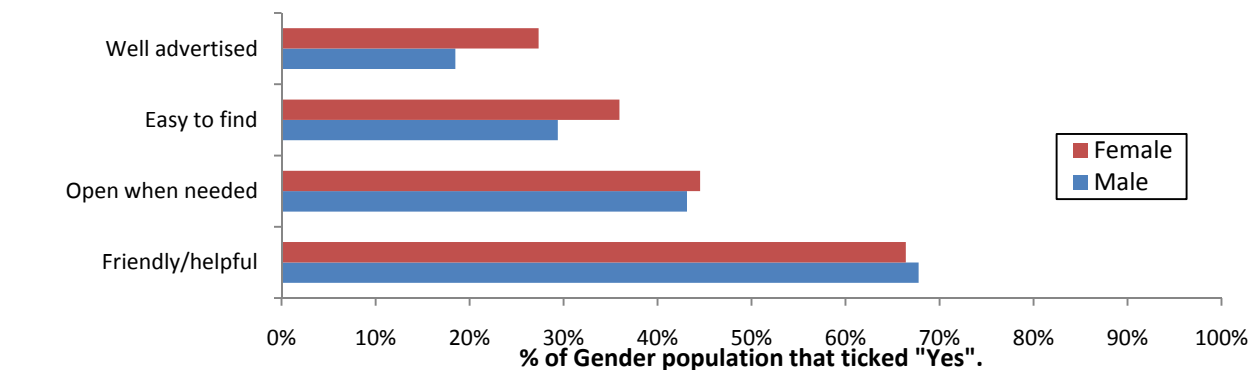
teacher’ and ‘CAMHS’. School nurse/clinic was about half way down list of preferred options, with more girls than boys choosing this.

Figure 73. Who is it difficult to talk to about health issues?



In figure 73 YP were asked which people/organisations were difficult to talk to about health issues. The most common answer for both boys (69%) and girls (67%) was ‘parents/carers’. YP also indicated it was difficult to talk to ‘school teacher’ and ‘brothers or sisters’. A third of boys indicated that they found it difficult to talk to friends about health issues (34%) compared to only 11% of girls. ‘Wirral Brook’ were ticked least, showing they were rated as easy to talk to (see previous question), ‘Response’ and ‘CAMHS’ were also ticked by very few males or females. The low rates of people ticking ‘CAMHS’ for this question as well as low rate of ticking for ‘easy to talk to’ in previous question may indicate YP do not know about these services and therefore have no opinion.

Figure 74 Are health services for young people in Wirral at the moment...



YP were asked their opinions on existing health services for young people in the region (figure 74). Two thirds (65% of girls and 67% of boys) thought services were friendly and helpful. Only 18% of boys and 27% of girls thought the services were well advertised.

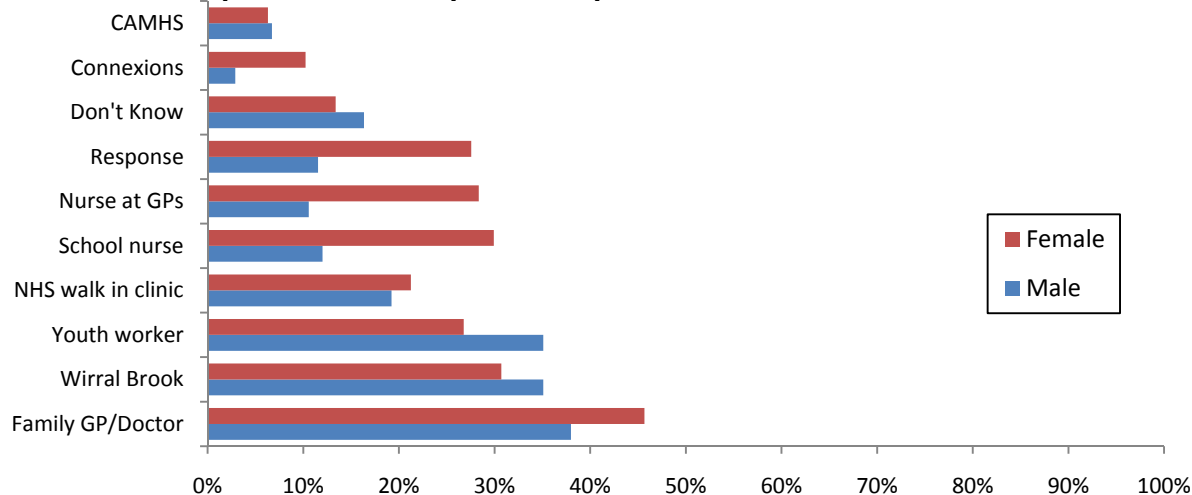
Health services which are helpful to young people

YP were asked their opinion on how helpful all of the different health services were for a series of health-related issues: depression, eating disorders, alcohol or drug-related problems, problem with relationships like bullying, where they would get contraceptives (nested amongst other questions), need to give up smoking, and

need to check for sexual infection. These questions were designed to investigate which services YP are aware of and which they would prefer to use without asking if they have used them.

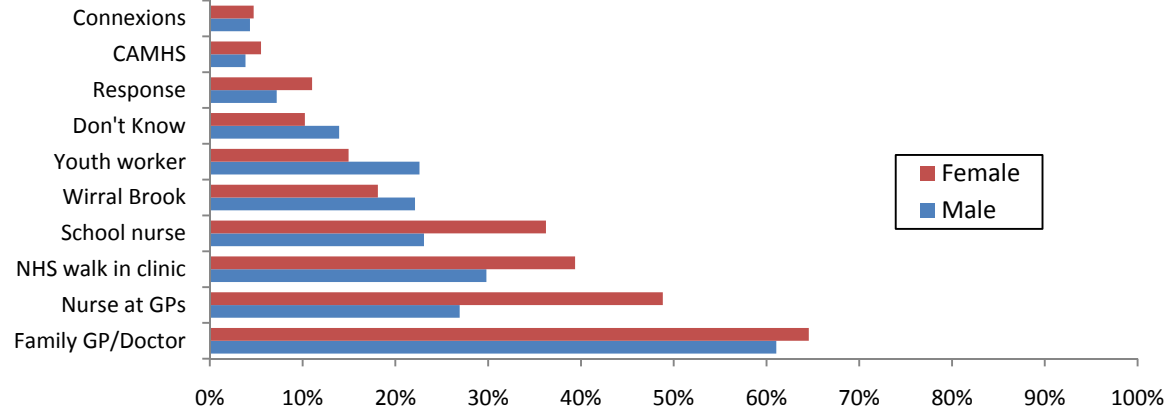
Responses to the question about which services were helpful for depression were low (figure 75). The most common answer was ‘family GP/doctor’. Wirral Brook’ and ‘youth worker’ were common choices for boys and ‘Wirral Brook’, ‘Response’, ‘nurse at GPs’, and ‘school nurse’ for girls. The least common choice for boys was ‘Connexions’ and ‘CAMHS’; and ‘CAMHS’ for girls. The few people choosing CAMHS to help with depression is discouraging as this is one of the most appropriate options given. It is unknown if this is due to poor awareness of the service in this school-based population, or not understanding the acronym, as opposed to any particular basis for considering it least helpful.

Figure 75. Services perceived as helpful for depression



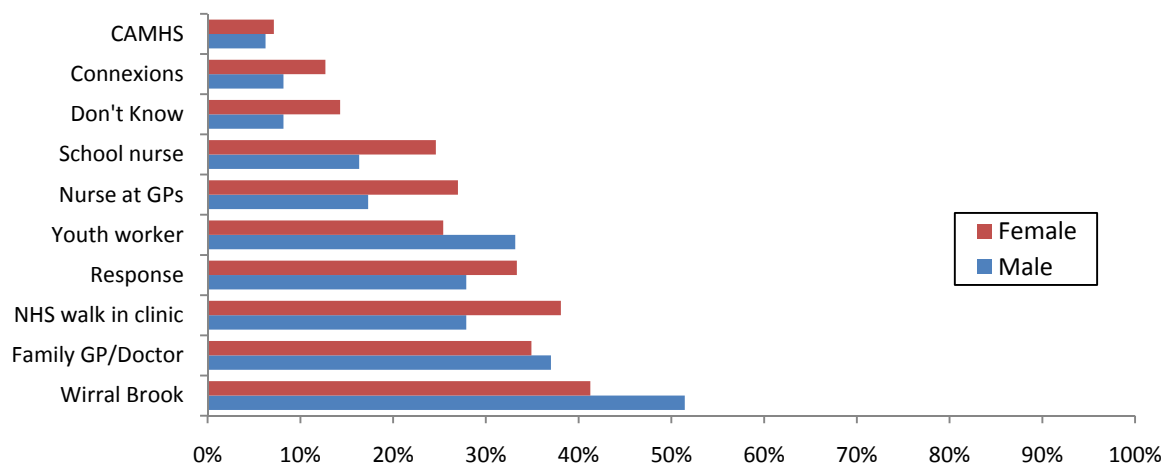
Again the most common option chosen by YP for eating disorders was ‘family GP/Doctor’ (65% of females and 61% of males; figure 76). Girls also indicated they thought ‘nurse at GPs’, ‘NHS walk-in clinic’ and ‘school nurse’ would be helpful. Boys also indicated these as their preferred options but to a lesser degree. The services YP thought would be least helpful were ‘Connexions’, ‘CAMHS’ and ‘Response’.

Figure 76. Services perceived as helpful for eating disorders



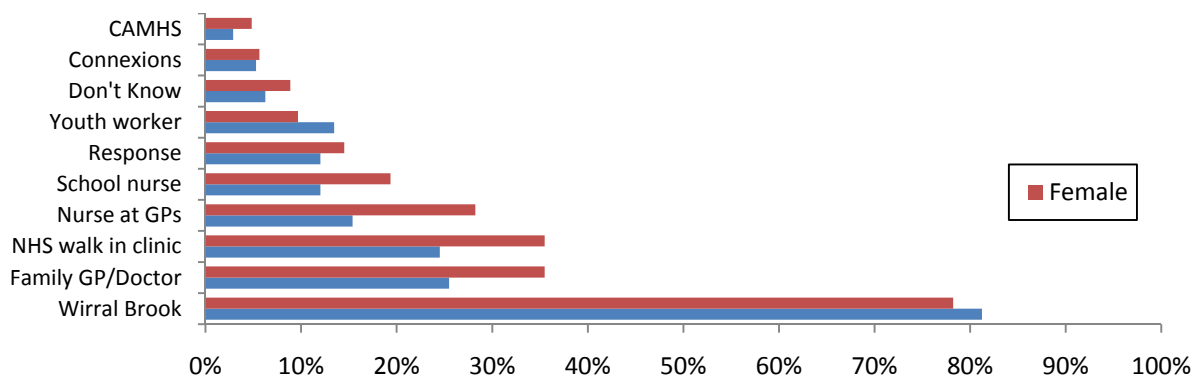
The service that both males and females thought would be most helpful for alcohol or drug related health problems was Wirral Brook (51% of boys and 41% of girls; figure 77). ‘Family GP/doctor’ was also popular with both sexes and least common answers were ‘CAMHS’ and ‘Connexions’. Again this may be because YP are unaware of the services that these organisations offer.

Figure 77. Services perceived as helpful for Alcohol or drug related problems



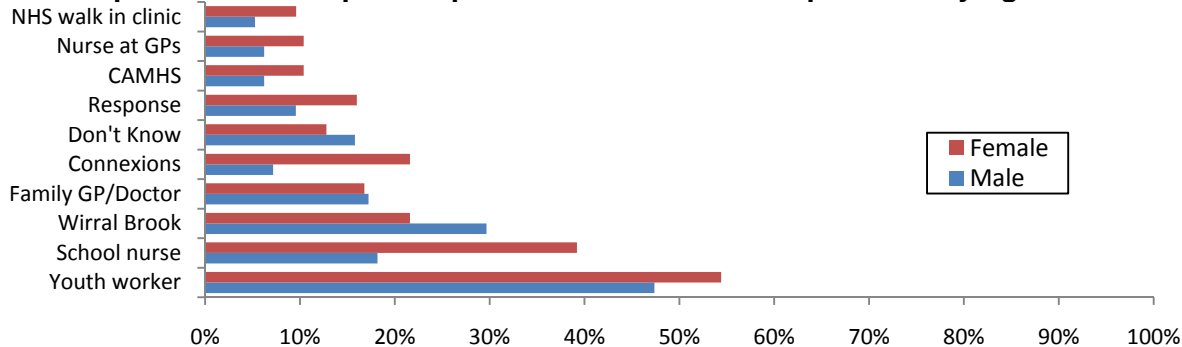
From figure 78 it can be seen that Wirral Brook was the most helpful place YP chose to get contraceptives (81% boys and 78% of girls); thus, 20% of YP taking part in a Bitesize Brook lesson did not choose Brook, indicating they were not aware of the service or that they did not find Brook ‘helpful’. Girls also indicated ‘family GP/Doctor’, ‘NHS walk in centre’ and ‘nurse at GPs’ were also helpful places to get contraceptives. Boys prioritised these options although less so. ‘CAMHS’ and ‘Connexions’ were the least common choices.

Figure 78. Services perceived as helpful for contraceptives



For the non-clinical health problem of bullying, YP overall believed the most helpful person would be a youth worker (54% of girls and 47% of boys; figure 79). Girls also indicated the school nurse would be helpful (39% of females) while boys thought Wirral Brook would be helpful (30% of males). YP appropriately indicated that that ‘NHS walk in centre’, ‘nurse at GPs’ and ‘CAMHS’ would not be helpful if they were being bullied.

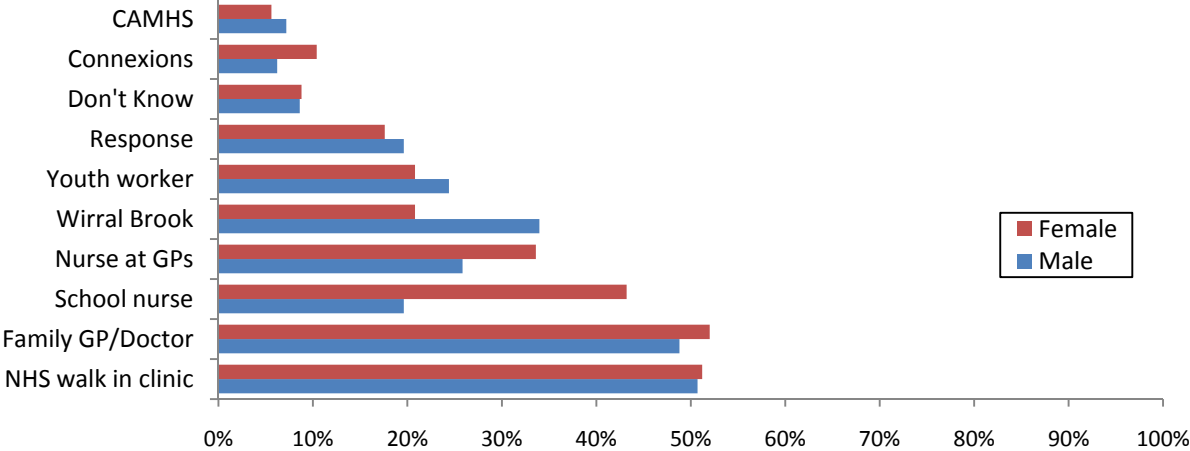
Figure 79. Services perceived as helpful for problems with relationships like bullying



‘NHS Walk in clinic’ and ‘family GP/doctor’ were the most common choices for both boys and girls for giving up smoking as shown in figure 80. Twice as many girls (43%) as boys (20%) indicated that the school nurse

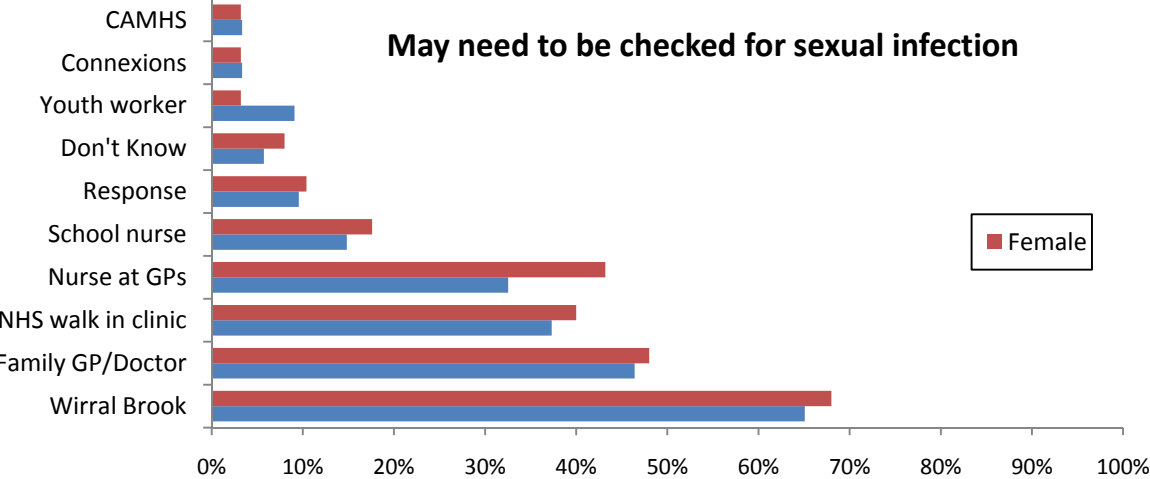
would be helpful while more boys (34%) than girls (21%) thought Wirral Brook would be helpful. 'CAMHS' and 'Connexions' were the least common choices.

Figure 80. Services perceived as helpful for giving up smoking



The final question of this section, shown in figure 81, asked which service YP thought would be helpful if they needed to be checked for a sexual infection. The most common answer was 'Wirral Brook' (68% of girls and 65% of boys) which is encouraging as this is the most appropriate service on the list. Other common responses were 'family GP/doctor', 'NHS Walk in and 'Nurse at GPs' –more frequently indicated by girls than boys.

Figure 81. Services perceived as helpful for checking for sexually transmitted infections

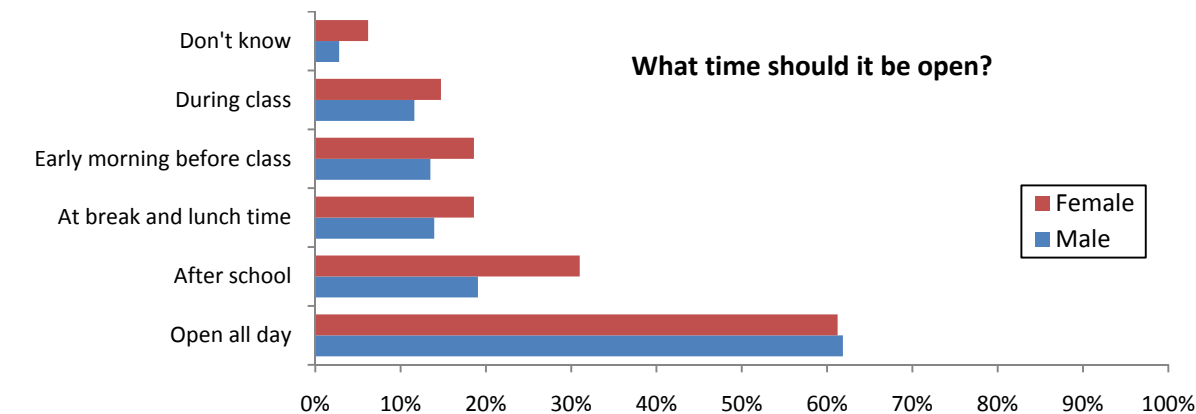


Having a health clinic/service in schools

Young people were asked their opinions of how a school based health service should be developed in terms of the time the clinic should be open, what would worry YP about having a clinic in school (open opportunity to respond), and if the school health clinic advised a young person to get extra help where would be the best and the worst place to be sent.

Two thirds of boys and girls stated they would like clinic opening times to be 'open all day' (figure 82). A third of girls and less than one in five boys indicated that the clinic should be open after school. The least favoured time for opening was during class.

Figure 82. What time should a school health service/clinic be open.

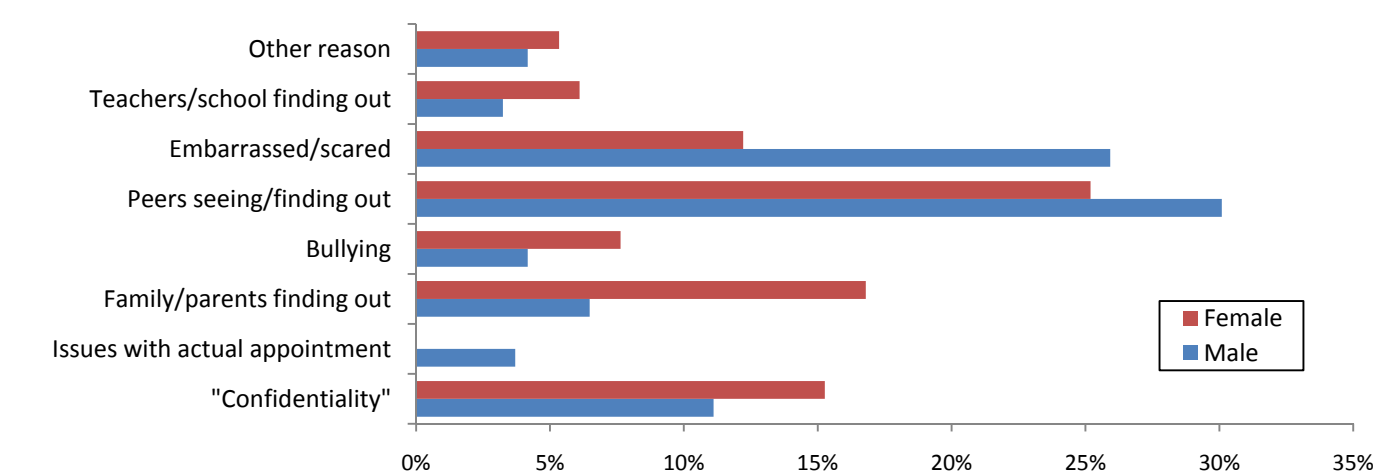


YP were asked “What worries could young people have about going to the school clinic...” and given a space to answer with no predefined possibilities. The responses were categorised into eight types of concerns based on the frequent use of single words and phrases. Some YP suggested more than one reason and the results include all these answers.

The most frequently suggested worry YP would have is that they would be seen by friends or other pupils, or that these others would find out (30% of boys and 25% of girls stated this). Examples of responses that indicate this included “friends knowing about you going into the clinic, wondering why”, “friends may see them”, and “people will catch on“. Boys were embarrassed or scared about going (26% of males and 12% of females suggested this), responses included “embarrassment, worrying of having an infection”, “nervousness and embarrassment too” and “if they are ashamed“. Girls were more concerned about family and parents finding out (17%, “parents getting told” and “they might phone home”).

The word “confidentially” was explicitly mentioned by many (15% of girls and 11% of boys) indicating how important this issue is to YP and how important it will be to promote any school-based service as ‘confidential’. Some boys also suggested particular worries about embarrassing activities required during the appointment (e.g. 4% of males mentioned “whipping it out” and “getting it out”). All of these concerns will need to be alleviated when promoting a service if it is to encourage YP to attend.

Figure 83. What worries could young people have about going to the school clinic?



YP were asked if the school health clinic advised a student to get extra help where would be the best and the worst place to be sent (figure 84 and 85). Both boys and girls indicated the best place to be sent would be to a special clinic for young people or a GP/doctor close to school. Young people thought the worst place to be referred to would be the family GP or doctor or to a hospital.

Figure 84. If you needed to be referred this would be the best place to be sent

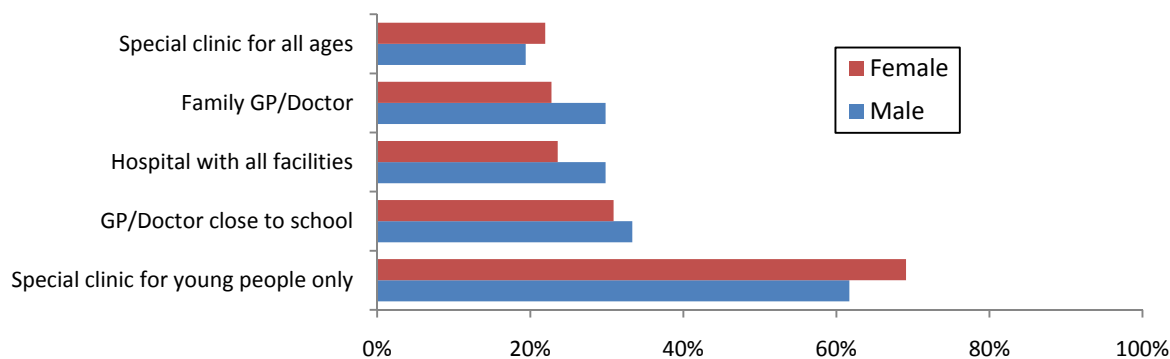
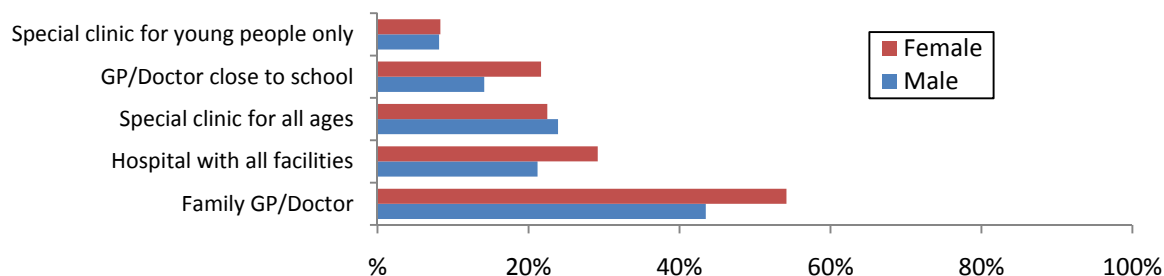


Figure 85. If you needed to be referred which would be the worst place to be sent?



Box 31 Conclusions from Health Audit in School-aged Young People

- This school-aged population represent three schools in different areas of Wirral. While they in general thought current health services were friendly, their responses suggested they are not well advertised, easy to find or open at the right times, implying signposting could be improved.
- Young people preferred warm and friendly services, but did not perceive health services generally to be accessible to YP suggesting attention is required to strengthen the ‘You’re Welcome’ strategy.
- Young people (especially girls) can talk to their friends and Brook but are less happy talking to parents, teachers or most official organisations. Guidance on how to talk to young people, even amongst parents, may provide valuable assistance particularly for interactions with boys.
- For different health related problems, YP predominantly chose Wirral Brook, or their family GP/doctor as the place to go. They were not able to differentiate different services for different health problems, and there was a particular lack of reporting CAHMS, Connexions, or Response (even for emotional problems). This suggests young people are not acquainted with such services and highlights a need to strengthen signposting.
- YP appear to like the presence of a school health service open all day. They have a variety of deep-seated worries about school based health services, including friends or peers finding out or seeing them go in, embarrassment or fear (especially boys) including the clinical actions taking place. Confidentiality was explicitly mentioned by many and girls feared their parents would find out.
- Provision of school-based health services may not resolve all the issues facing YP but barriers to use, including confidentiality, need to be taken very seriously to ensure such services are well utilised.
- Referrals were preferred to YP-specific services, and GP services close to the school, and the worst place would be to the family GP and doctor (indicating again fear of loss of confidentiality). This further highlights the need to strengthen ‘You’re Welcome’ strategy in family GP practices, as well as improve signposting and transport facilities to preferred services.

4.2.5.2 Findings from a Sex and Relationships Education Pilot in Wirral

Box 32 Summary of Findings from a Sex and Relationships Education (SRE) Pilot in Wirral

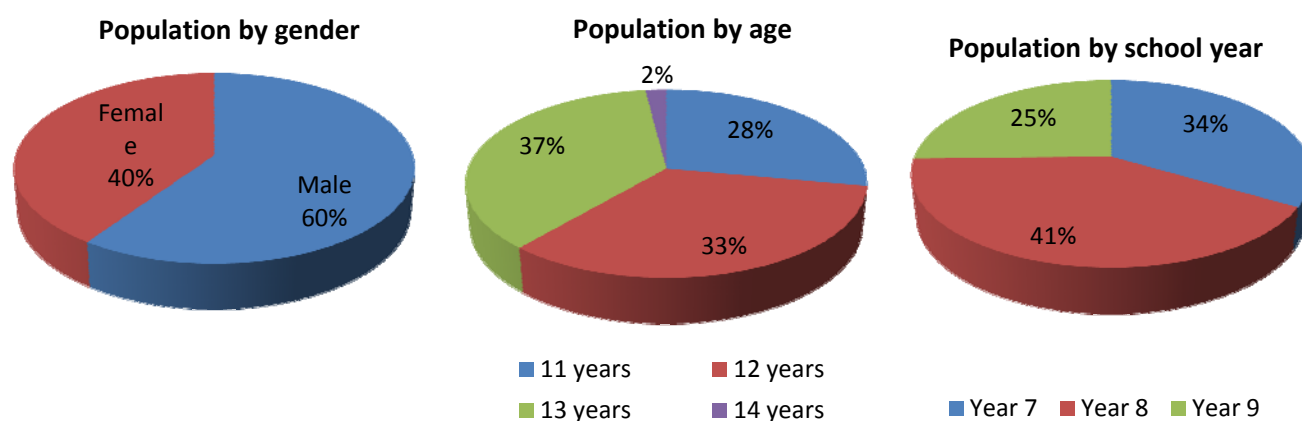
- A total of 209 young people attending the SRE pilot school completed a pre-intervention baseline survey questionnaire during school time.
- Findings from the Centre for Public Health evaluation of the Government Office North West pilot SRE package were analysed for one school in Wirral (209 students, 11-14 years). While findings do not represent all young people in Wirral schools it provides insights into the sexual health, health, and wellbeing of this age group.
- YP at the sampled school generally have good wellbeing: with 4 in 5 agreeing they have a happy home life, three-quarters of boys and half of girls reported they were self-confident, but a high proportion of girls wanted to change the way they look. Girls could talk to parents about problems more than boys. Half of students could not assert their views with boy/girlfriends although more (and particularly amongst girls) were able to assert their views with their friends.
- Love, trust, good friendship, and able to be yourself were identified as the most important features of a 'relationship'. Safe sex ranked around 7th of 20 factors. Parental approval was ranked low.
- YP at the sampled school are generally positive about school and their teachers. A higher proportion of boys agreed their teachers expected too much of them. Students were generally not sure if they play a part in making school rules.
- As in other parts of NW England, perceived bullying in the Wirral school is highly prevalent with 1 in 3 indicating they had been bullied in the past 3 months. One in five reported sexual jokes or comments made about them.
- Half of YP have drunk alcohol, including 60% of girls and 46% of boys; by Year 9 (13-14 year olds). This mirrors NW regional findings. Weekly drinking occurred in 8% and 10% of boys and girls in Year 9. Alcohol use was associated with all types of bullying particularly amongst girls. The SRE regional data link alcohol use with school connectedness, wellbeing factors, and sexual behaviour.
- YP seek information on sex and relationships primarily from their parents, their school, and friends their own age. Few reported accessing information from external sources such as youth workers. About 20% in each year indicated accessing their GP or doctor for information. YP would prefer to get more information from their parents and their school (particularly the younger age group).
- Accessing information from media, including online is particularly prevalent, and rises in older aged students. One in 3 boys accesses pornography as a source of information. A main source for girls is fictional films, books, and magazines.
- 50% of girls talk to parents about body changes/puberty and bullying, compared with 33% of boys, but <20% of either gender talked to parents about pregnancy, sexual activity or contraception. Few Year 9's talked to parents about emotional health compared with younger age groups.
- Parents were more likely to talk to girls than boys with 3-fold higher proportion of girls reporting parents want to talk to them about pregnancy and conception. A lower proportion of students in Year 7 recorded their parents talked about pregnancy and sexual activity compared with older students.
- Students reported mostly learning about puberty and the body at school. Girls reported they were taught more on self-esteem/confidence, learning how to say no, parenting, and sexual health services; while boys reported more about using a condom, emergency contraception, and risky behaviour. Younger years reported they were taught about puberty and the body. Students in Year 9 did not record being taught about emergency contraception and <20% recorded learning about pregnancy, sexual infections, or parenting in school.
- Younger age groups wanted to know more about body changes, improving self-confidence and how to say no. A third of students wanted more information on contraception. Older age groups wanted more information on STI prevention. Boys wanted more information on how to use condoms, but only 20% of older girls ticked this.
- 70% of boys in Year 9 agreed they could buy condoms compared with 25% of girls. Boys were also more confident than girls in asking their partner to use a condom. ~80% of girls considered they were or would be able to say no to unwanted sex or sexual actions, compared with 65% of boys (~10% of

boys strongly disagreed). Over 40% of girls did not know if they would be comfortable accessing emergency contraception.

- 83% of boys and 63% of girls thought condoms were the most reliable form of contraception. Nearly half ticked the hormonal pill, and over half of boys and 40% of girls ticked not having sex during a girls' period. A very small proportion of girls ticked LARC (injections), and none ticked implants suggesting young people in school have a poor knowledge on effective methods of contraception.
- A small proportion of Year 9 boys stated they have had intercourse or oral sex but no girls reported this. All Year 9 students recorded petting. Reasons for having a sexual relationship were predominantly being 'In love', rather than 'lonely' or 'wanting to impress friends'. Only boys cited being drunk and only girls cited wanting to keep their boyfriend.
- Boys reasons for not yet having a sexual relationship were because they are too young and did not want to, but not due to parental disapproval or fearing pregnancy. Too young was the most cited reason with girls, followed by not wanting to/not having met the right person/not being ready. Girls cited parental disapproval and fearing pregnancy, but not fear of a sexual disease.

Evaluation of the Government Office North West piloting of a Sex and Relationships Education (SRE) package was planned in two Wirral schools. Of these, one school took part during the autumn term of 2008. Prior to SRE implementation, school children were surveyed to better understand their wellbeing, school connectedness, their relationships and attitudes and behaviours towards alcohol and sex. These data are shared with the WiSHing Project to help define characteristics of the school-aged population in Wirral.

Figure 86. Population by gender, age and school year



Demographics

A total of 209 young people attending the SRE pilot school completed a pre-intervention baseline survey questionnaire during school time. The respondents came from years 7, 8 and 9 aged between 11-14 years old with a mean age of 12.13 years (SD of .84). Just over half (59%) the survey population were male, with a higher proportion in year 8 and aged 1 years (see figure 86). The younger population had a higher proportion of males and there were proportionally more females in the older years (figure 87 and 88)

Figure 87. Population but gender and school year

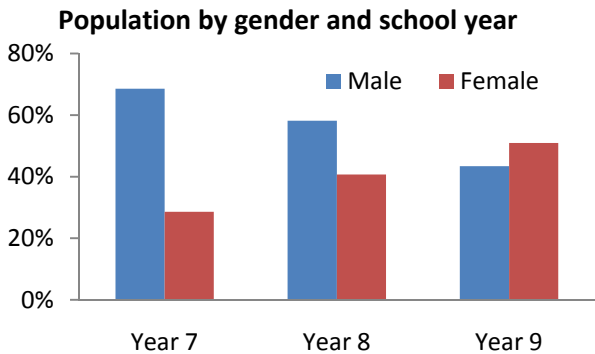
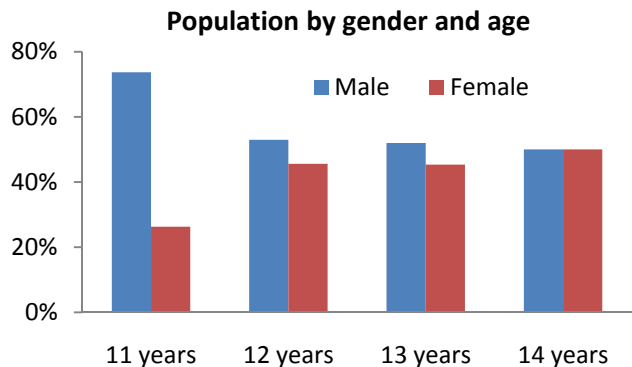


Figure 88. Population by gender and age



Wellbeing and confidence

Students were presented with a series of statements about their life, compiled as indicators to record their confidence and wellbeing. They were asked to respond by scoring their answer according to the Likert Scale (strongly agree, SA; agree, A; disagree, D; strongly disagree, SD; with don't know DK used to categorise ambivalence/no opinion).

Students' perceive themselves to have a happy home life, for both genders, with close to 60% strongly agreeing; only 6% of boys and 5% of girls either disagreeing or strongly disagreeing (figure 89).; this mirrored data generated in schools around the North West There was a significant difference between the responses given for boys and girls ($p < .01$) for wanting to change the way they look (figure 90). The highest percentage of boys strongly disagreed while the majority of girls strongly agreed. Three quarters of boys and two-thirds of girls had confidence in themselves (figure 91). More girls than boys considered they could talk to their parents about problems ($p = 0.05$), and a higher proportion of boys opted for 'don't know' (figure 92).

Figure 89. You have a happy home life

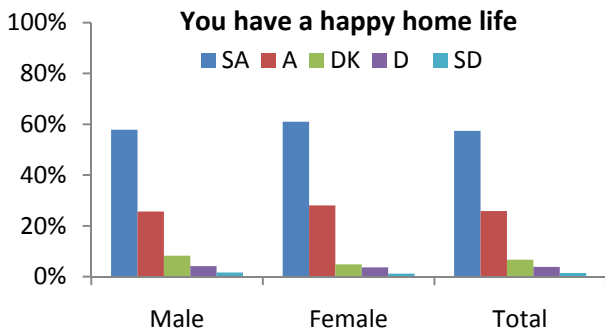


Figure 90. You would like to change the way you look

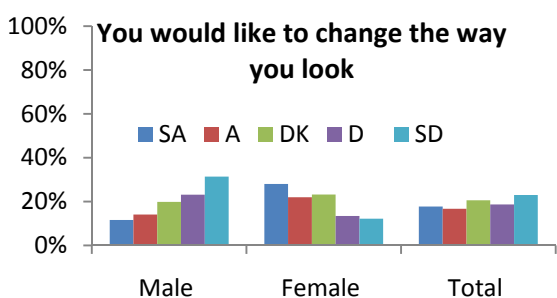


Figure 91. You have confidence with yourself

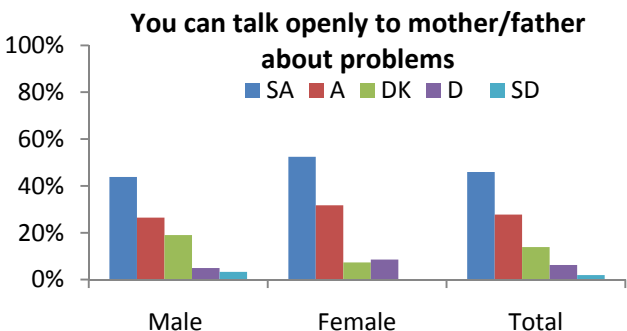
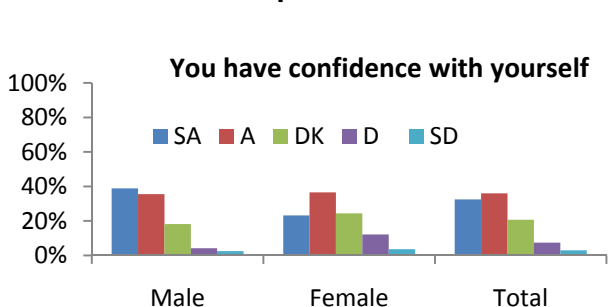


Figure 92. You can talk openly to your mother/father about problems



Young people were much less confident about being able to assert their views among their boy/girlfriends than they were among their friends. While 82% of girls and 64% of boys either agreed or strongly agreed they were able to assert their view among their friends, only 48% and 50% respectively stated they could assert their views with their boy/girlfriend (see figures 93 and 95 respectively). The 'don't know' responses were also the highest for this wellbeing indicator with 31% of the total indicating this. Girls were significantly more likely to often be sorry for things they had done, with two thirds (67%) saying they agreed or strongly agreed, compared with 58% of boys ($p < 0.01$) (figure 94). From figure 96 it can be seen that girls more often disagreed that they had a hard time saying no.

Figure 93. You are able to assert your views among your friends

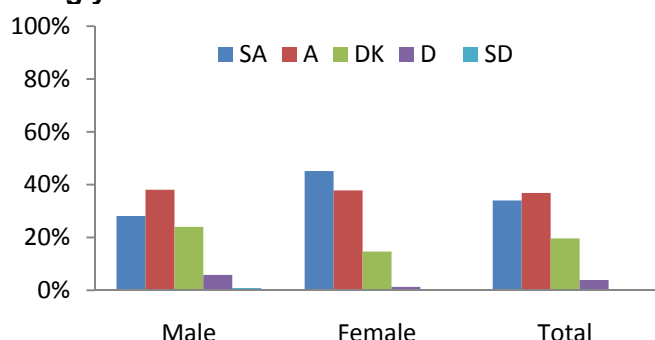


Figure 94. You are able to assert your views with your boy/girlfriend

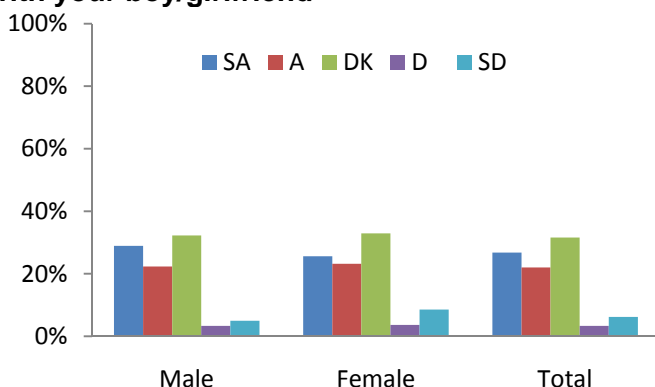


Figure 95. You are often sorry for the things you do

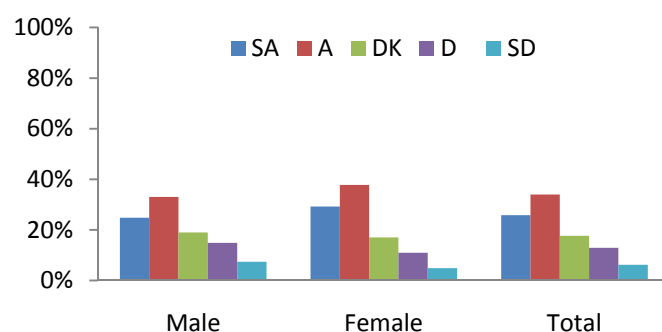
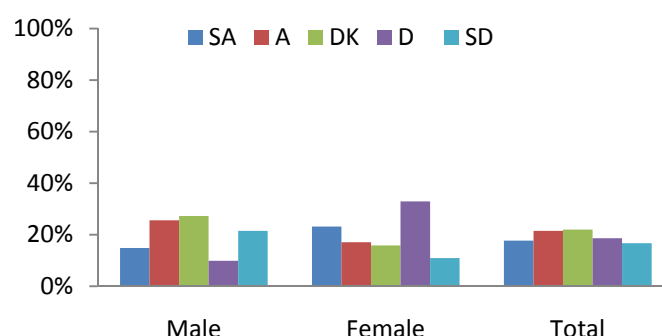


Figure 96. You often have a hard time saying no



What young people in school think about relationships

Young people were asked what they think are the important things in a relationship with a boy/girlfriend. The circle below, figure 97, shows the range of views expressed by young people by gender (boys views inner circle, girls views outer circle). Information given suggests, in these young teens, that both boys and girls have relatively similar views. While views differed very slightly by age; love, trust, good friendship, and being able to be yourself predominated in all age groups. Safe sex ranked between 6th and 8th, for the different year groups. Parental approval of the relationship was ranked low by all groups.

Perception of School Connectedness

Students were presented with five statements about their school and how they felt they were treated, compiled as indicators to record their perceptions of school life ethos. They were asked to respond by scoring their answer according to the Likert Scale (strongly agree, agree, disagree, strongly disagree; with don't know used to categorise ambivalence/no opinion).

**Boys: inside
Girls: outside**

Reason	Percentage
Future plans	7%
Good friendship	10%
Love	11%
Safe sex	5%
No strings attached	5%
Wealthy	10%
Have fun	7%
Experimentation	3%
Faithfulness	5%
Respect	8%
Good communication	5%
Things in common	4%
Parents approval	3%
Similar friends	7%
Trust	3%

Gender	SA	A	DK	D	SD
Male	22%	50%	19%	3%	3%
Female	26%	57%	13%	2%	0%
Total	24%	53%	16%	3%	2%

A bar chart showing the percentage of respondents by gender (Male, Female, Total) and age group (SA, A, DK, D, SD) for the statement 'I am a good person'. The Y-axis represents the percentage from 0% to 100% in increments of 20%. The legend indicates: SA (blue), A (red), DK (green), D (purple), and SD (cyan).

Gender	SA	A	DK	D	SD
Male	35%	58%	3%	1%	1%
Female	23%	61%	13%	3%	0%
Total	30%	59%	7%	2%	1%

111

Figure 100. The students are treated to strictly in your school

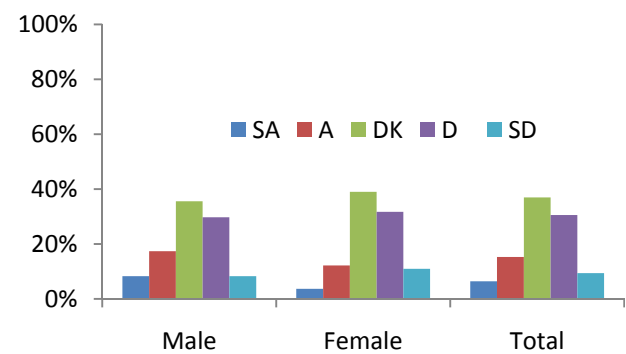


Figure 101. Teachers expect too much of you

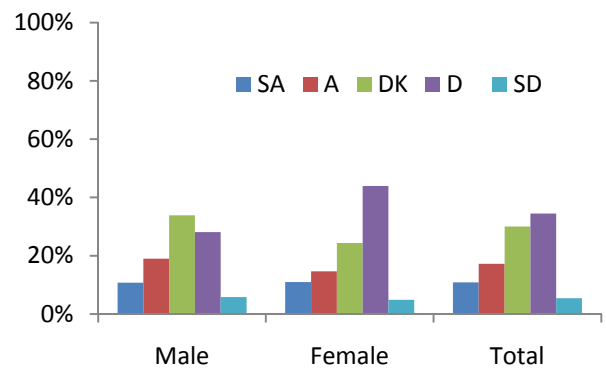
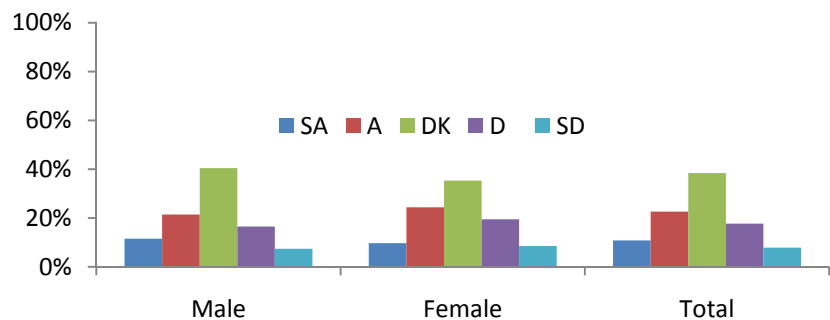


Figure 102. In your school students take part in making the rules



Bullying

From figure 103 it can be seen that nearly a third of students indicated they had been bullied by another student, with more boys (33%) than girls (23%). Over a third (36%) indicated that they had experienced rumours or lies being spread about them in the previous 3 months, with more girls responding yes (40%). One in five reported having had sexual jokes or comments made about them in the previous 3 months (figure 104). Slightly more girls admitted bullying another student in the previous 3 months than males (16%, 11% respectively; figure 106) but over 82% of respondents indicated they had not.

Figure 103. You have been bullied by another student

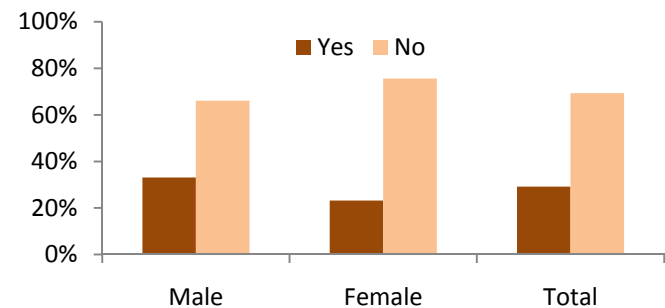


Figure 104. Sexual jokes/comments made about you

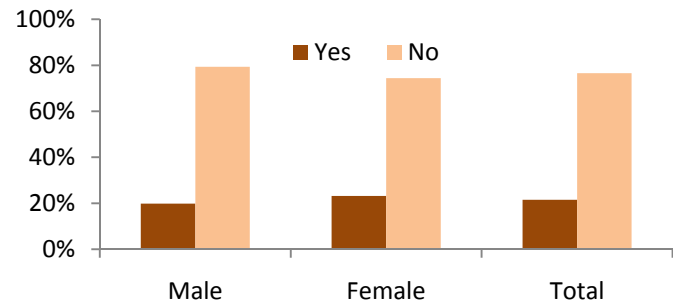


Figure 105. Rumours or lies were spread about you

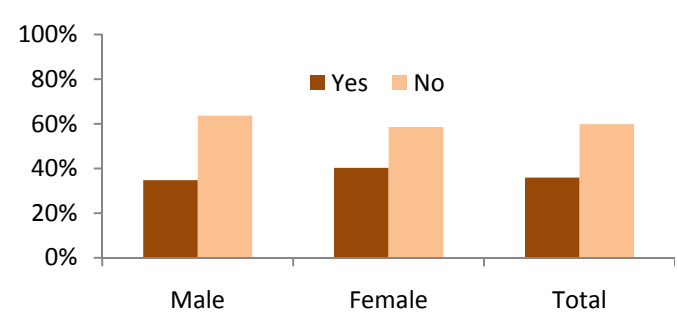
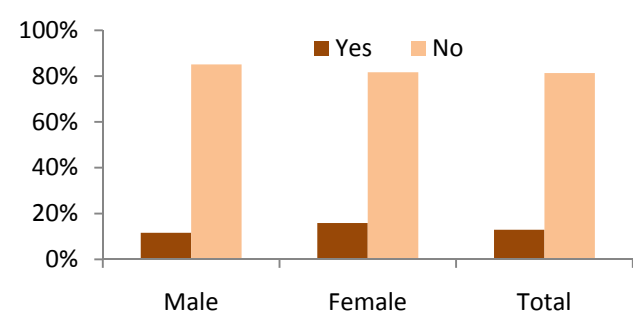


Figure 106. You have bullied another student



Alcohol use by students at school

We used the opportunity of questioning school students about their use of alcohol. Although this was a young population, more than half admitted drinking alcohol (a proper drink not just a sip) with more girls (60%) than boys (46%; figure 107). The proportion who had drunk alcohol increased by year rising from a third in Year 7 to two-thirds in Year 9 ($p<0.01$; figure 108). Drinking frequency increased by year. Weekly drinking was reported in 5% of all boys, with it reported in 8% and 10% of Year 9 boys and girls, respectively (figures 109 and 110).

Figure 107. Have you ever drunk alcohol by sex

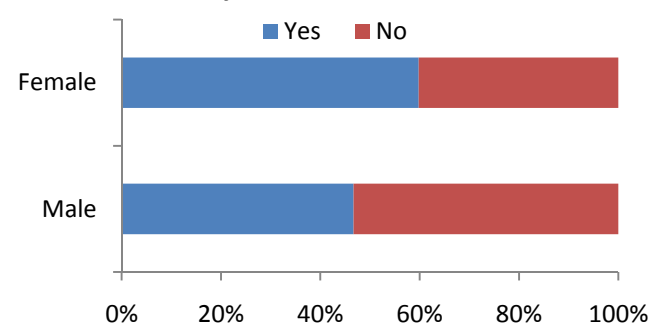


Figure 109. Frequency of alcohol drinking by school year – males

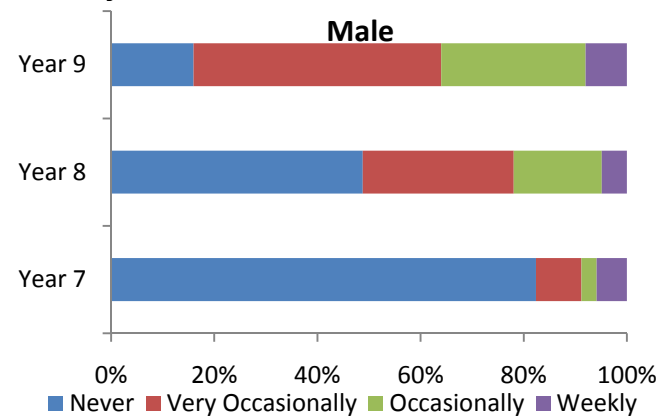


Figure 108. Have you ever drunk alcohol by school year

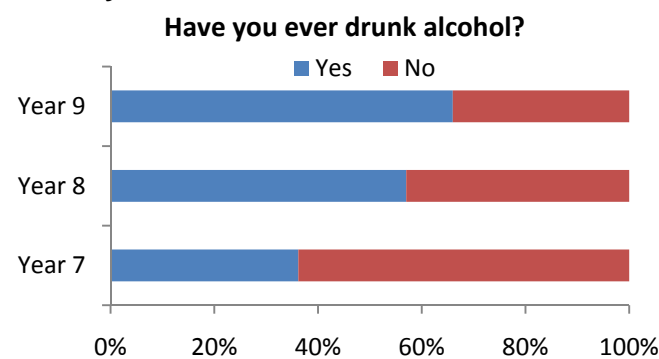
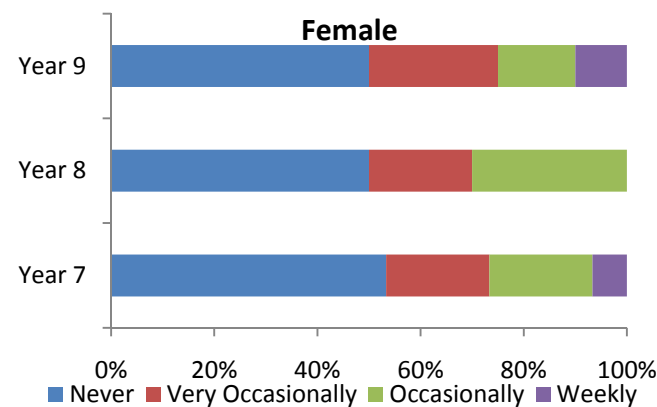


Figure 110. Frequency of alcohol drinking by school year – females



Alcohol and bullying

We looked at the relationship between bullying in the previous three months and whether the student had drunk alcohol. The findings show a higher proportion of school children that have drunk alcohol complain of bullying, particularly for sexual bullying in girls. Proportionately girls that report bullying others are more likely to drink alcohol (figure 118).

Figure 111. Rumour or lies spread about you by alcohol consumption - Boys

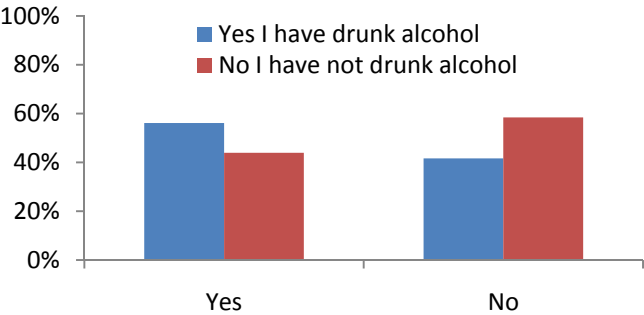


Figure 115. Rumour or lies spread about you by alcohol consumption - Girls

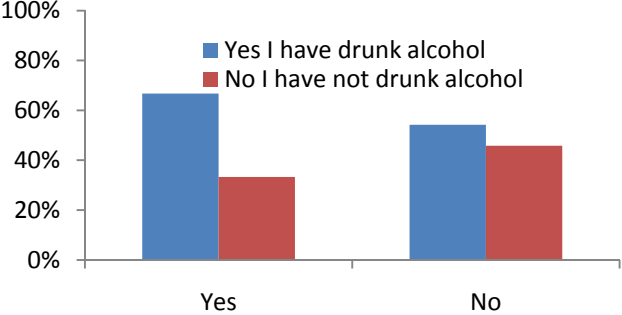


Figure 112. Have been bullied by alcohol consumption – Boys

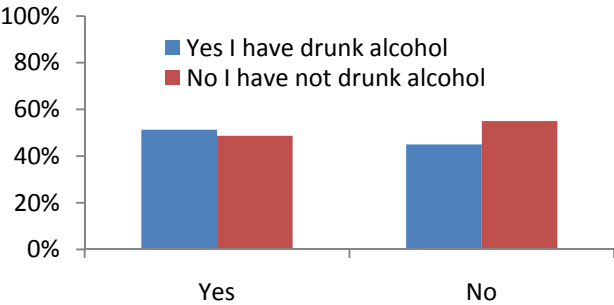


Figure 116. Have been bullied by alcohol consumption – Girls

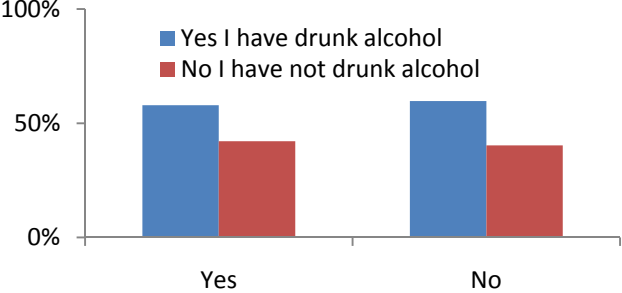


Figure 113. Sexual jokes or comments made about you by alcohol consumption - Boys

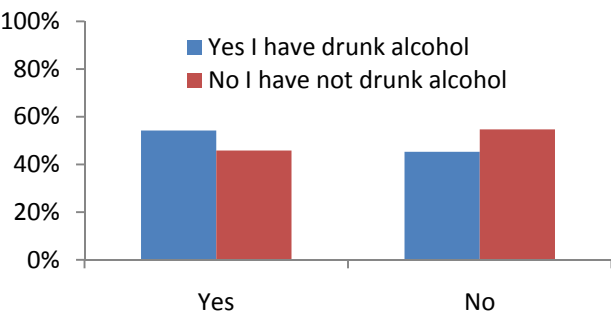


Figure 117. Sexual jokes or comments made about you by alcohol consumption - Girls

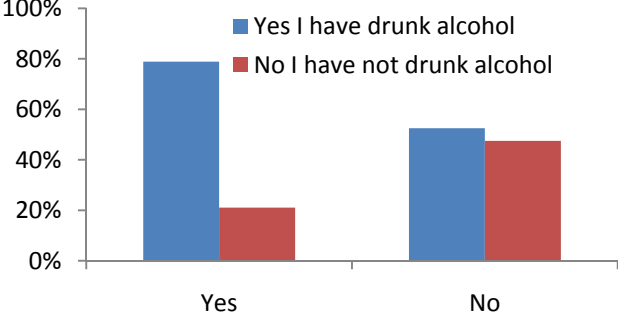


Figure 114. Bullied another person by alcohol consumption – Boys

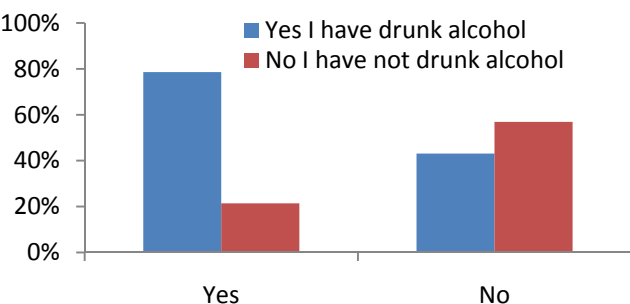
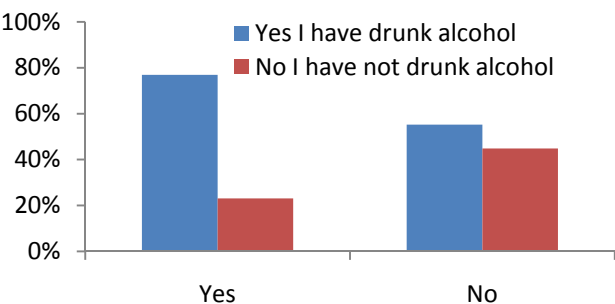


Figure 118. Bullied another person by alcohol consumption – Girls



Associations between alcohol and sexual health, health and wellbeing

Although outside the mandate of this project, and thus not presented in this report, findings from the SRE pilot study at regional level show statistically significant correlations between alcohol use and the sexual behaviour of young people in NW England, their school connectedness, and certain wellbeing indicators. Persons interested are invited to read the separate report of the SRE pilot study due to be published through the Centre for Public Health website www.cph.org.uk

Where do young teenagers get their information about sex and relationships from?

School students were asked where they get information about sex and relationships from. Because of the nature of the SRE intervention pilot, and its regional nature, types of questions asked were oriented towards home, school, and media. No specific reference was made to Wirral Brook, limiting the opportunity of YP to specifically pick this service as an option.

The majority of boys (52.9%) and girls (62.2%) indicated that they get information from their parents, their school, and friends their own age (figure 119). Few reported accessing information from external sources such as youth workers. About 20% in each year accessed their GP or doctor for information (figure 120). Over 50% of boys and 65% of girls recorded they would prefer to get more information on sex and relationships from their parents whereas only around 30% said they would prefer to get it from their school (figure 121 and 122).

Figure 119. Where do young people get sex and relationship information from by sex

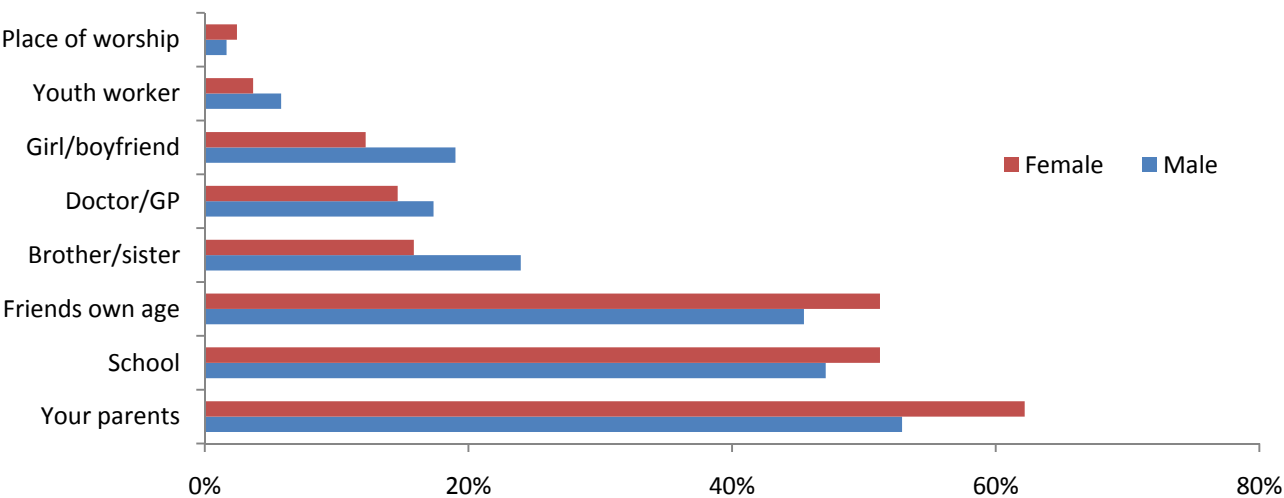


Figure 120. Where do young people get sex and relationship information from by school year

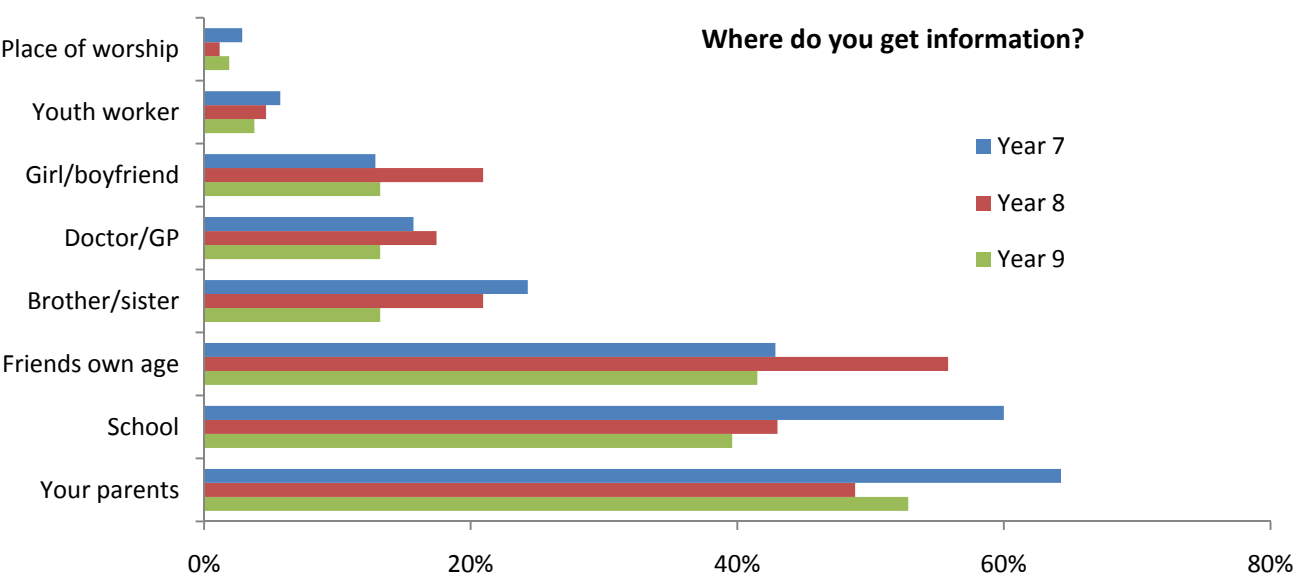


Figure 121. Where would you like to get more sex and relationship information by sex

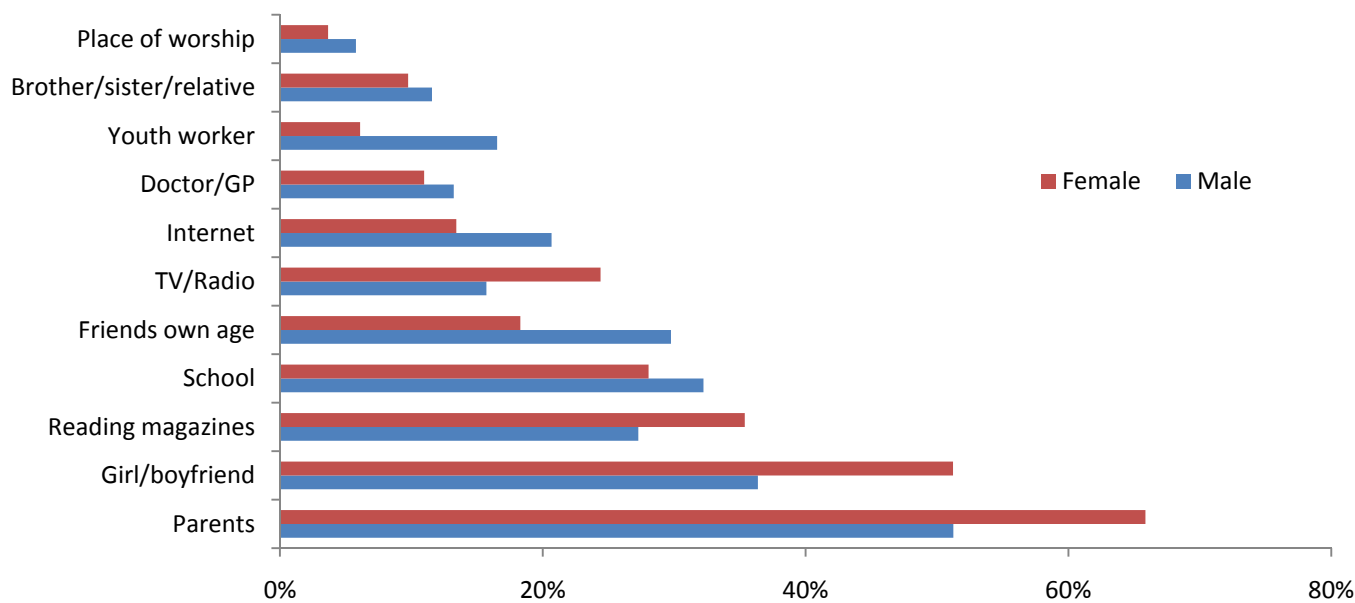
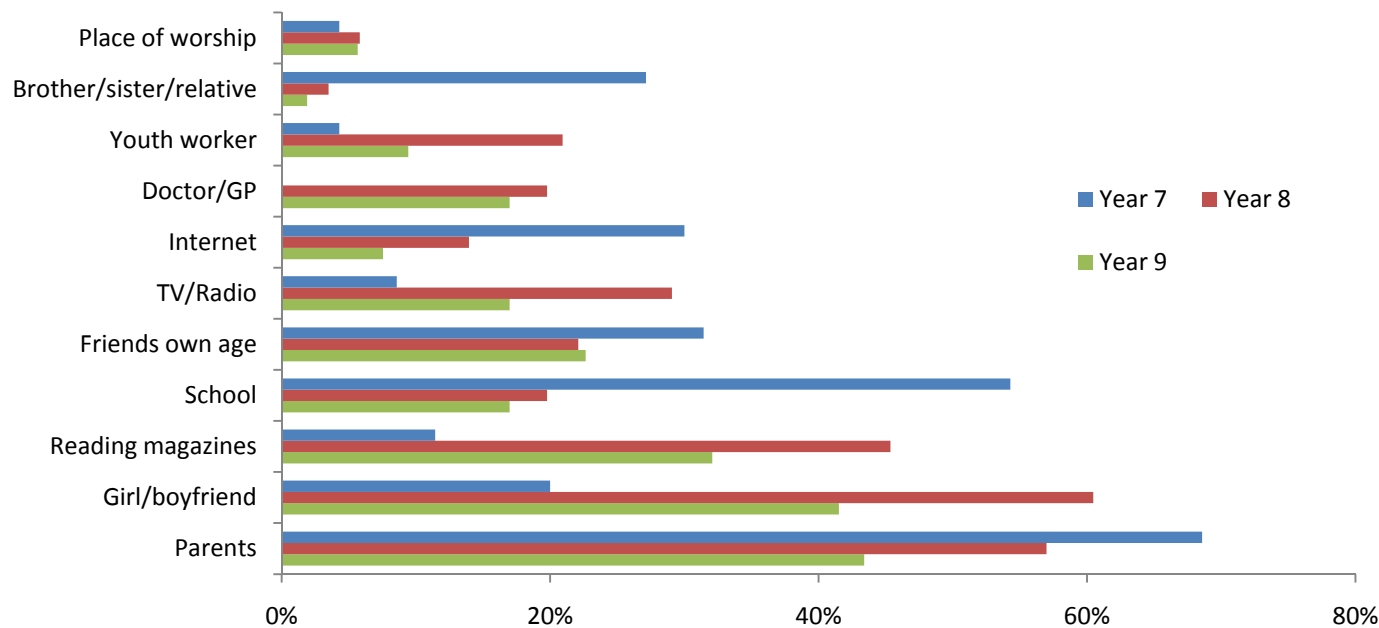


Figure 122. Where would you like to get more sex and relationship information by school year



In addition to getting information from parents and school, students were asked whether they also get information from other sources, relating particularly from different forms of the media, as below. Over two thirds of girls (67.1%) reported gaining information from TV Soaps, compared with 37.2% of boys, while boys ticked pornography (in every media type) as one of their main sources of information (Figure 123-128). Separate analysis (not shown) indicate that pornography use increases by age, except for internet pornography which Year 7 boys reported accessing as frequently as Year 9 students. Girls also disproportionately report they acquire knowledge from fictional films and books (figure 124 and 126).

Sourcing information on sex and relationships from the media

Figure 123. Sex and relationships information from media – Magazines

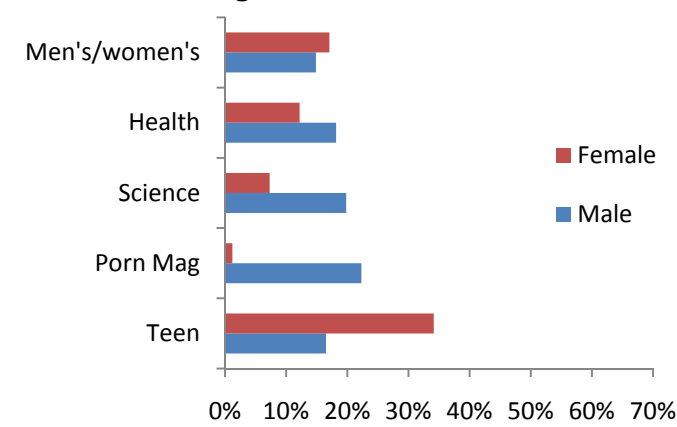


Figure 126 Sex and relationships information from media - Films

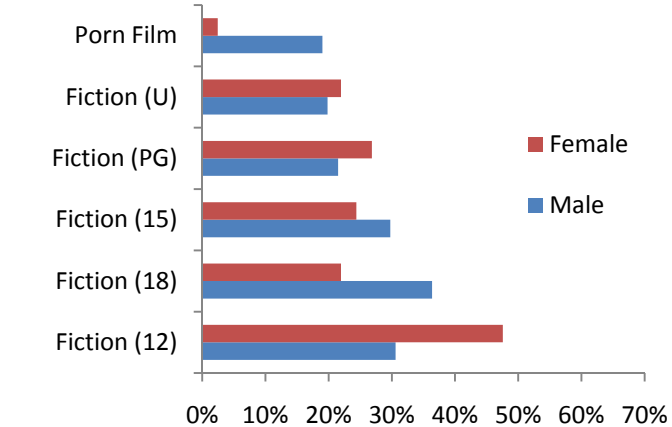


Figure 124 Sex and relationships information from media - Books

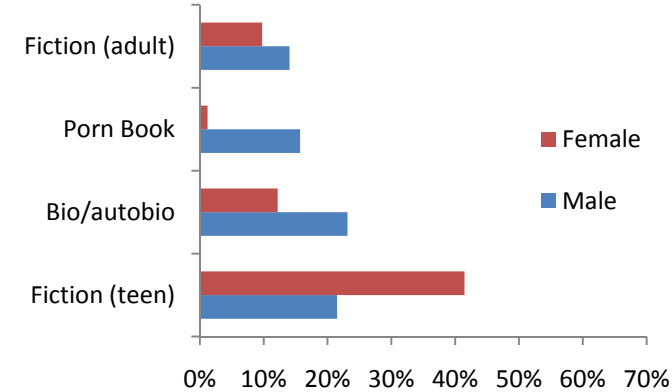


Figure 127 Sex and relationships information from media – Internet

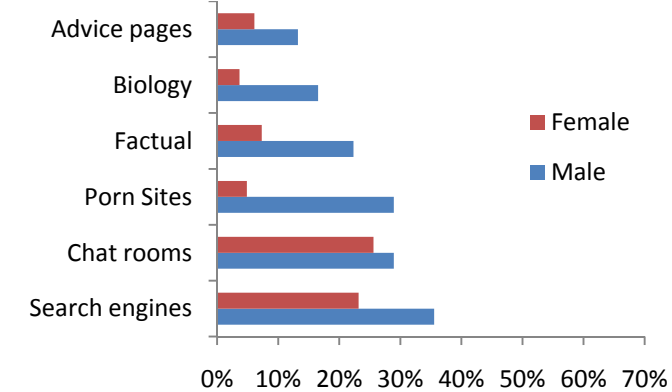


Figure 125 Sex and relationships information from media – Television

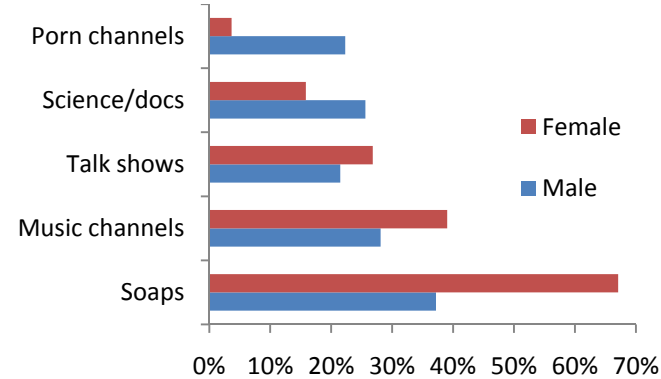
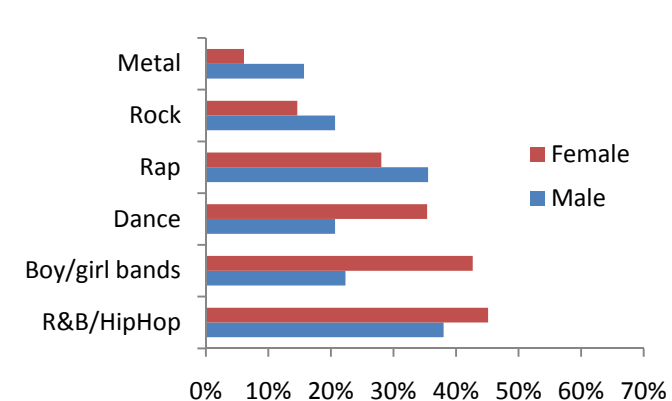


Figure 128 Sex and relationships information from media - Music



Combining all media sources together highlights to determine the ten most frequently indicated sources shows differences between boys and girls (figure 129 and 130). It is also noted that proportionately fewer boys seek any information through the media compared with girls.

Figure 129. Top ten sources of sexual health information – Males

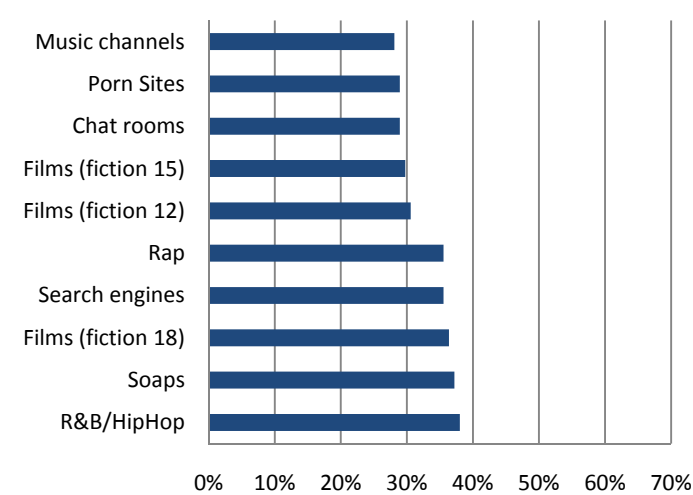
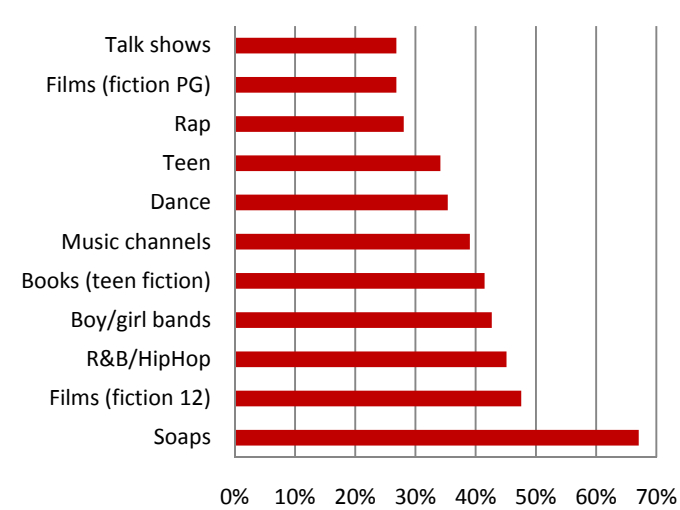


Figure 130. Top ten sources of sexual health information - Females



Sourcing information on sex and relationships from parents and school

In young teenagers we were interested to know what information they acquire from their parents and from their school, and what other information they would like to discuss, either from parents or from other sources. Findings indicate girls talk to their parents about issues more than boys, with over 50% of the girls sampled talking about body changes/puberty and bullying, compared with 33% among boys (figure 131). The least talked about subjects reported by girls or boys were pregnancy, sexual activity and contraception. Less than 10% of Year 7's reported talking to parents about these issues. It is noted that proportionately fewer Year 9's wish to talk to parents about emotional health issues compared with younger age groups (figure 132).

Figure 131. Issues young people discuss with their parents by sex

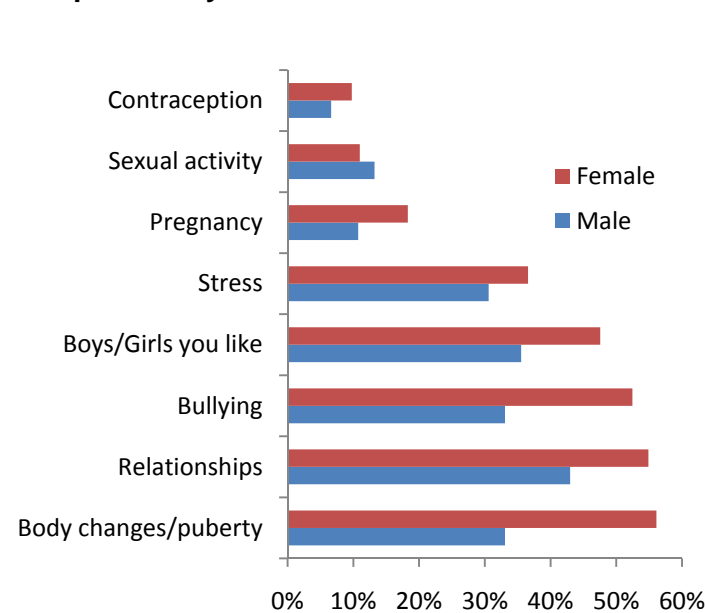
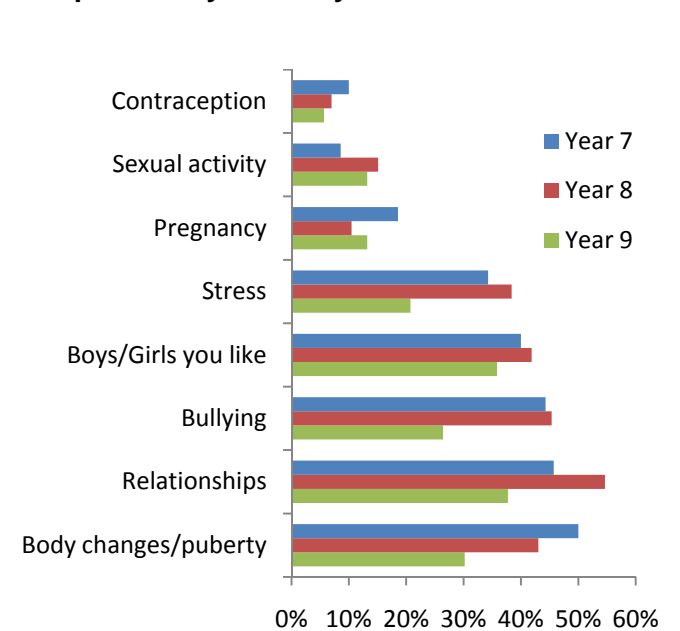


Figure 132. Issues young people discuss with their parents by school year



A separate question was asked about what parents (or guardians) try to talk to their sons and daughters about. The below graphs illustrate what students report parents do attempt to talk to them about. More girls reported their parents talk to them about all of the issues, compared with boys (except stress, which was equal). There was a 3-fold differential between boys and girls regarding parents talking about pregnancy and contraception (figure 133). By year group, a lower proportion of students in Year 7 recorded their parents talked about pregnancy and sexual activity compared with older students (figure 134).

Figure 133. What do your parents try to talk to you about by sex

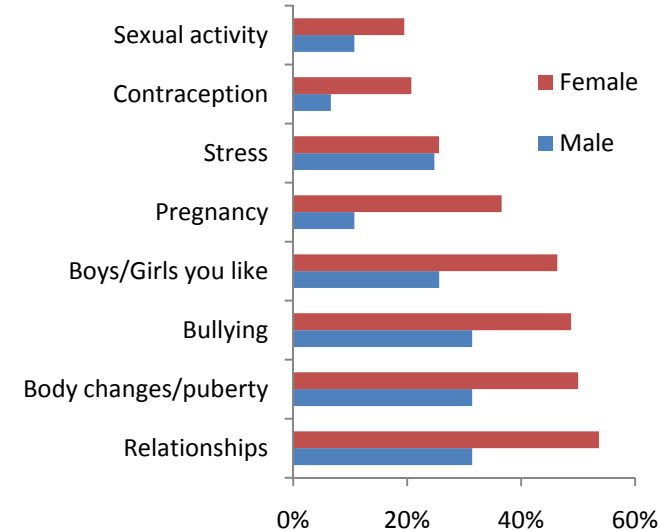
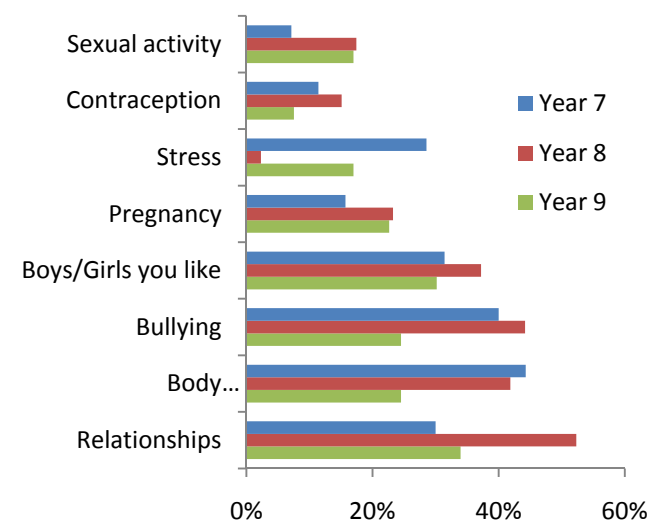


Figure 134. What do your parents try to talk to you about by school year



Students were asked what issues associated with sex and relationships they had learnt about through school. This is, as above, was reported by gender and again by age to differentiate if there are any gaps in learning in particular groups. Few differences were reported by boys and girls in what they have learnt about sex and relationships at school (as opposed to question regarding parental discussions). In general they reported they were most informed about puberty and the body. Girls reported more information taught on self-esteem/confidence, learning how to say no, parenting, and sexual health services; while boys reported more about using a condom, emergency contraception, and risky behaviour. More students in the younger years reported they were taught about puberty and the body. Students in Year 9 did not record being taught about emergency contraception and <20% recorded learning about pregnancy, sexual infections, or parenting.

Figure 135. What would young teenagers at school like to know more about – Year 7

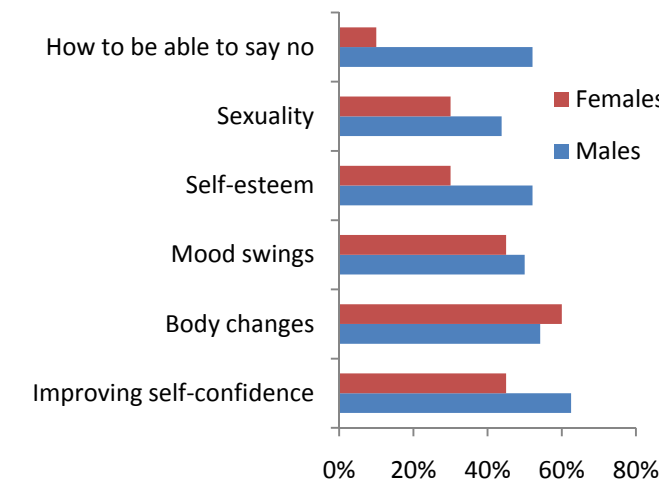
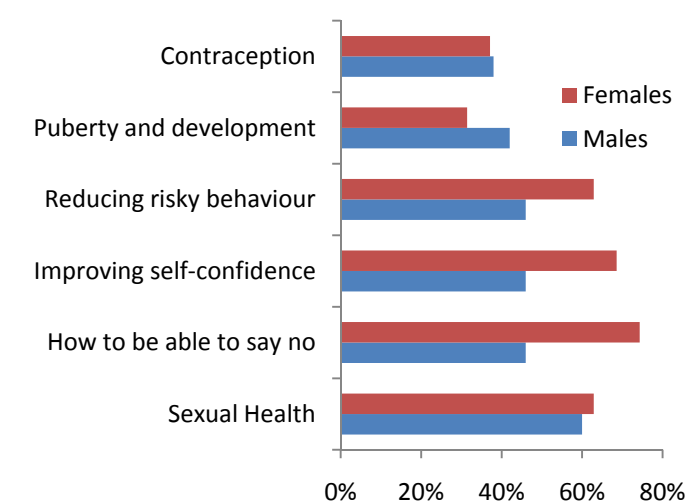
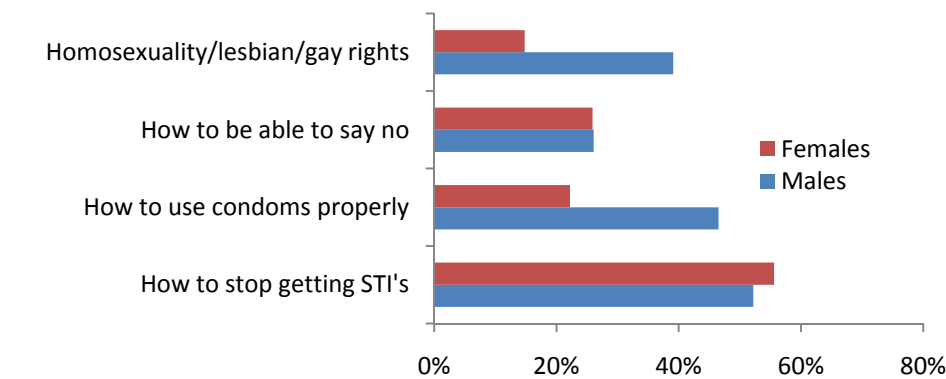


Figure 136. What would young teenagers at school like to know more about – Year 8



In year 7 (figure 135) more boys than girls responded ‘yes’ to each statement. Both boys and girls wanted to know more about body changes. Improving self-confidence and how to say no received most ticks by boys, while girls asked for more information about body changes. In Year 8 (figure 136), girls requested more information than boys on all topics, particularly on how to say no (75%), improving self-confidence and reducing risky behaviours. A third of students wanted more information on contraception. In Year 9 (13-14 year olds; figure 137), over half of both boys and girls requested more information on how to stop getting STI’s. A relatively small proportion of both boys and girls asked for more information on how to say no, and few girls wanted to know more about ‘homosexuality/lesbian/gay rights’ compared with boys. Further, boys wanted more information on how to use condoms, but only 20% of girls ticked this.

Figure 137. What would young teenagers at school like to know more about – Year 9



Sexual confidence of young teenagers (Year 9, 13-14 year olds only)

Year 9 students were asked to rank (strongly agree to strongly disagree) whether they are or would be able to buy condoms. Boys were more confident than girls about buying condoms, with nearly 70% agreeing or strongly agreeing they can do this. Half of the girls responding said they did not know, a quarter agreed or strongly agreed and 17% disagreed/strongly disagreed. Boys were more confident than girls about ticking they would be comfortable asking their partner to use a condom, with few girls strongly agreeing.

Year 9 Confidence about accessing condoms

Figure 138. You are or would be able to buy condoms

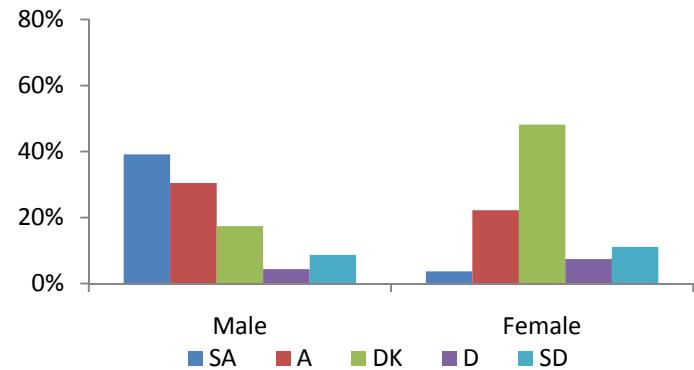
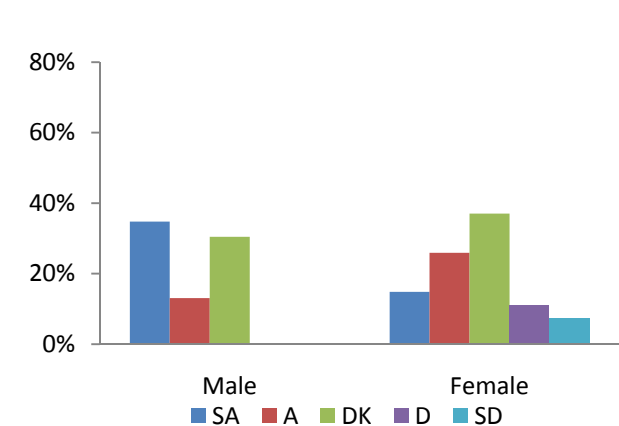


Figure 139. You are or would be comfortable asking a partner to use a condom



Nearly 80% of girls considered they were or would be able to say no to unwanted sex or sexual actions, compared with 65% of boys (figure 140). About 20% of both genders did not know, and ~10% of boys strongly disagreed. The majority of boys and girls did not know about accessing emergency contraception. It is likely the 1 in 3 boys who strongly agreed may not have understood the question (figure 141).

Figure 140. You are or would be comfortable saying no to sex/sexual actions you don't want.

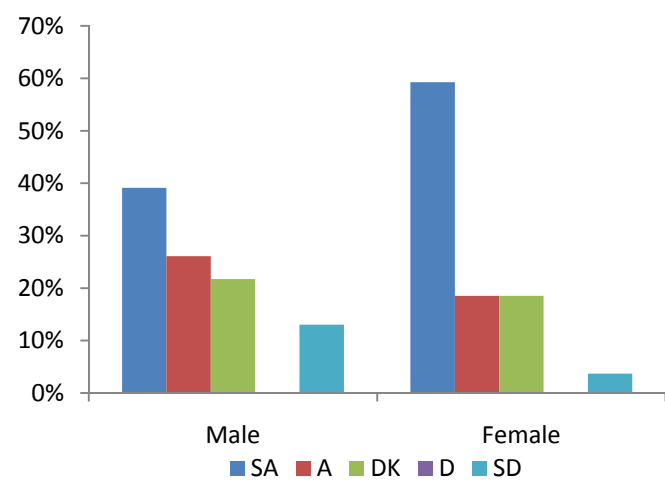
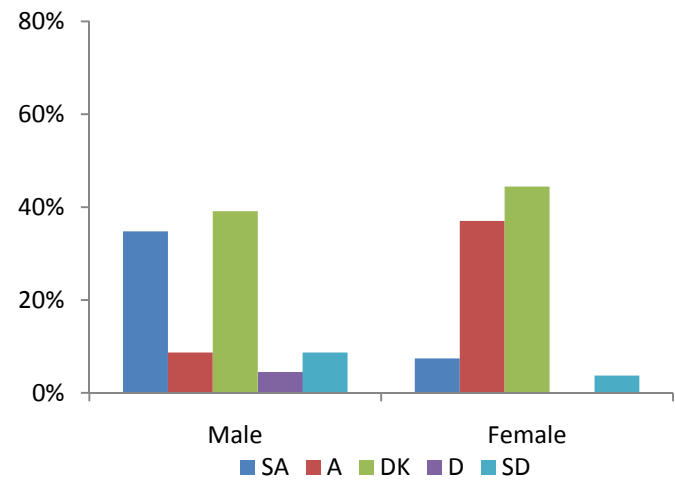
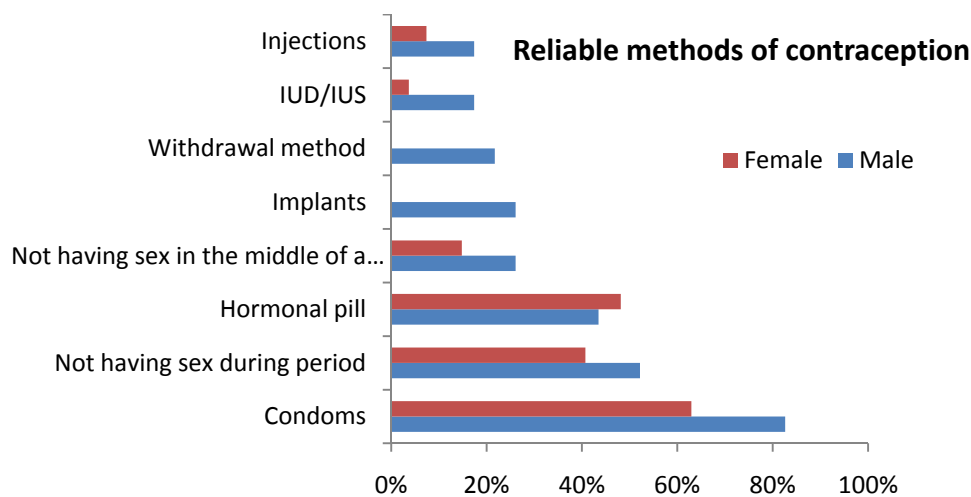


Figure 141. You are or would be comfortable accessing emergency contraception if needed.



When asked what were the most reliable forms of contraception both boys (82.6%) and girls (63%) mainly ticked condoms (figure 142),. Nearly half ticked the hormonal pill, and over half of boys and 40% of girls ticked not having sex during a girls' period. A very small proportion of girls indicated that examples of LARC (injections) were reliable forms of contraception, and none said implants were. Interestingly more boys identified these as reliable methods. This result suggests that students at school have poor knowledge of effective contraception, and little is understood about LARC or implants.

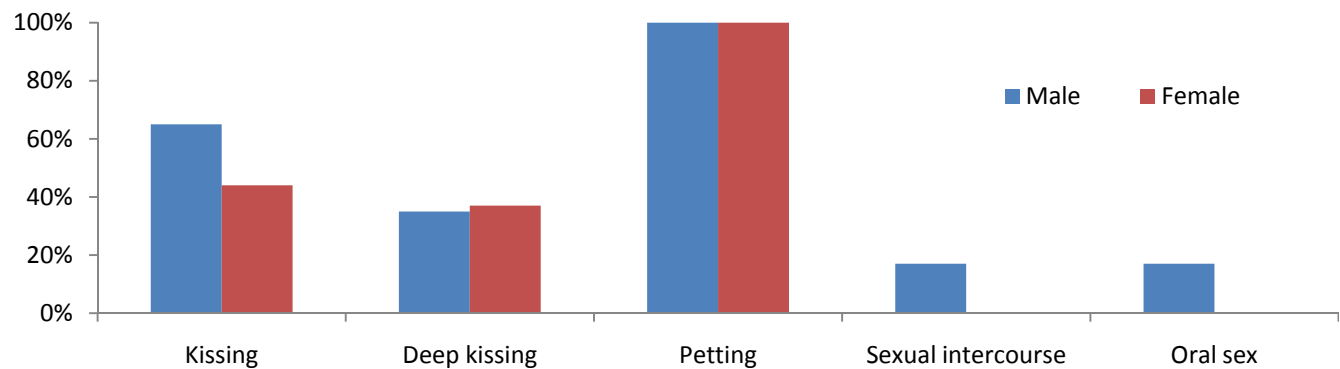
Figure 142. What do you think is a reliable method of contraception?



Sexual Relationships in Year 9 Students

Year 9 students were asked if they had had a sexual relationship (broadly defined as kissing, deep kissing, petting, oral sex and sexual intercourse). No females responded that they had sexual intercourse or oral sex compared to ~ 17% of boys for each. All students reported petting (defined as touching private parts; figure 143) but fewer had kissing or deep kissing.

Figure 143. Sexual experience of year 9 respondents



Students were asked reasons why they had a sexual relationship. Neither boys nor girls indicated being ‘lonely’ or ‘wanting to impress friends’ was a reason. Being ‘In love’ was the most cited reason with 77% of boys and 45% of girls indicating this (figure 144 and 146). In this small sample, only boys cited being drunk and only girls cited wanting to keep their boyfriend. Graphs are presented by sex and those who have had and who have not had a sexual relationship (including kissing, deep kissing, petting sexual intercourse and oral sex; figure 144 – 147))

Figure 144. Boys who have had sexual relationship – reasons given

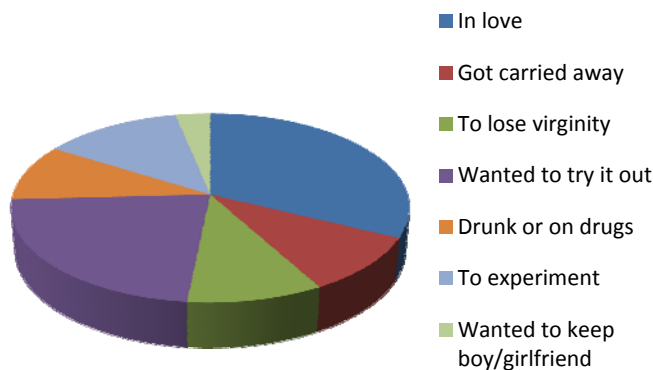


Figure 146. Girls who have had a sexual relationship – reasons given

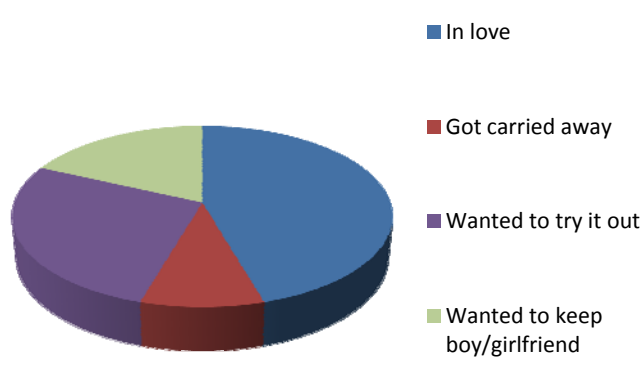


Figure 145. Boys who have not had a sexual relationship – reasons given

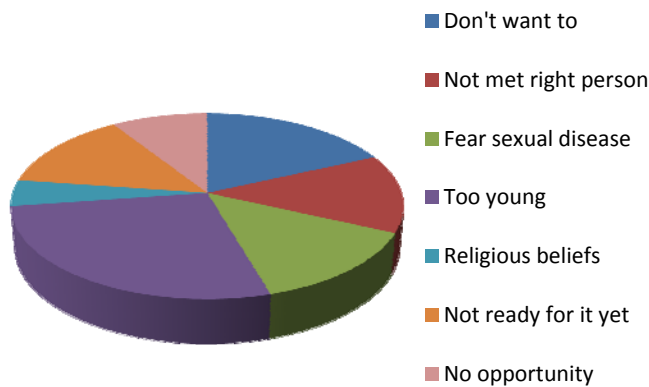
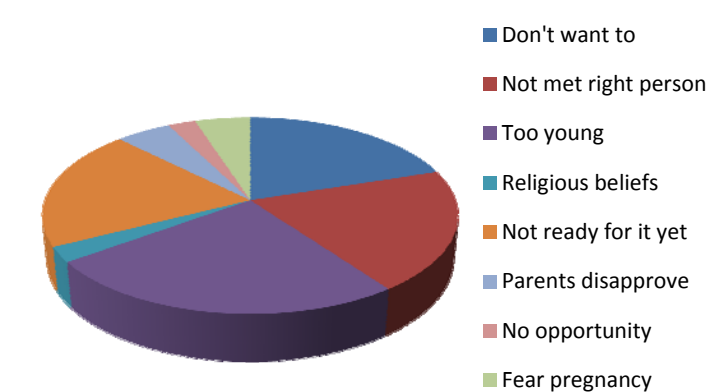


Figure 147. Girls who have not had a sexual relationship - reasons given



Believing that they are too young and not wanting to were the most cited reasons for boys not having a sexual relationship. No boys indicated parental disapproval or fearing pregnancy as a reason (figure 145). Too young was the most cited reason with girls, followed by not wanting to/not having met the right person/not being ready (figure 147). Unlike boys, girls did cite parental disapproval and fearing pregnancy, but no girls indicated fearing sexual disease as a reason.

Box 33 Conclusions from a Sex and Relationships Education (SRE) Pilot in Wirral

- YP in the sampled school have good wellbeing and were generally positive about school-life however certain questions revealed lack of self-esteem and an inability to assert themselves, ask questions to parents, or seek advice as needed. Development of wellbeing indicators in schools would be useful to evaluate the effect of statutory SRE and monitor the prevalence of bullying.
- YP start drinking alcohol at an earlier age than national figures suggest with frequency increasing by age. National and local efforts to curb this social norm are required. Alcohol use was associated with bullying and other wellbeing measures. More is required in schools to tackle alcohol use and all types of bullying.
- YP did not recognise CAMHS or other types of services, which indicates the need for improved signposting of types of services available for YP in Wirral.
- Parents, school, and friends are the main sources of information on sex and relationships; with few accessing GP services. Information from the media, including pornography by boys, is common. Better signposting of alternative sources of quality information for YP in Wirral is suggested.
- The high proportion of YP wanting access to information through magazines highlights an opportunity to develop specific YP-focused sex and relationships materials.
- Parental advice appears sporadic and varies by age and gender of students, suggesting that parents require further guidance and advice on helping their children negotiate teenage years.
- Girls appear to have little confidence with condom use, and do not have adequate knowledge on methods of contraception, particularly regarding long acting contraception or the morning after pill, or where to get further advice.
- The data suggest young people in school do not have adequate access to services, and do not fully understand what contraceptives are available. While superficial wellbeing and school-ethos suggest YP are confident and happy, their responses suggest they are under-informed and unable to access sufficient advice and support from parents, school, or other essential external services.
- Wirral Brook appear to be playing a valuable role in providing information to school-aged YP.
- The proportion of YP having full sexual experiences by age 13-14 was very small, and YP were able to cite many reasons for not yet starting a sexual relationship. However, the regional dataset linked alcohol and sexual behaviour, strongly supporting the need to integrate policies on alcohol and sexual health for young people.

4.2.5.3 Findings from a Health Audit of young people through kooth.com in Wirral

Box 34 Summary of Findings from a Health Audit through kooth.com in Wirral

- Young people seeking counselling from kooth.com are thought to represent more vulnerable YP who seek confidential advice and guidance from an online service. Between June and September 2009, 802 users logged on to the kooth service; of these 55% were female and 45% were male. Frequency of use of the service was calculated showing--on average--females accessed the service 8.9 times during the 13 weeks, while males accessed it 3.2 times. However, frequency of use varied substantially rising to over 100 times in 1% of users.
- 52 (6.5%) completed an online survey about health services in Wirral; the majority were 12 to 17 years old. Voluntary participation was achieved by 10.8% of females but only 1.7% of males.
- YP in this sample considered the most important elements of a health service for young people was a private room (89%) and adequate time to talk (83%), and a warm and friendly service (83%). Few wanted the service close to their home, or that their friends could also attend. Over half thought it should be located in town close to shops, by the school or at the GP surgery.
- In this sample seeking counselling, YP thought 'friends' and 'online counselling services/Kooth' easiest to talk to about health issues (67%), and then their doctor/GP. Parents/carers, the pharmacy/chemist and CAMHS were considered the least easy to talk to. When asked who was the most difficult to talk to, the majority cited parents/carers, along with their teachers, GP/doctor, nurse at the practice, and pharmacies. Thus, all adult persons well known to the YP appeared difficult to talk to. Wirral Brook, Response, and online services (kooth.com) were least difficult.
- The main source of sex and relationship information was friends their own age (57%), school and through parents or siblings. Some 5% put Brook or kooth.com in the free text box. Most could not talk openly about sexual matters to adults at school (87%), fathers (89%), or mothers (68%).
- About half of the respondents knew where their sexual health clinic was located but over half of all those surveyed would not go on their own due to embarrassment, and fear their family would find out. Three out of four have not tried to go to a clinic, of whom approximately a third wanted to go but did not due to embarrassment or because they feared their family would find out.
- Over half of respondents wanted more information on how to be able to say no to sex (59%) and how to stop STIs (50%). Few were concerned about using condoms or LGBT issues.

Overall use of kooth.com online counselling site

An audit questionnaire was posted on the Wirral section of kooth.com between 11th June and 16th September 2009. During that time period, 802 users logged into the site 5,071 times. Among users, 444 (55%) were female, who logged on 3,933 times (mean average 8.9) and 358 (45%) were male who logged on 1,138 times (mean average 3.2). Thus, during this time period, females more frequently used the service and among these individual females, on average, accessed the counselling service nearly three times more frequently than males. While the majority of the users accessed the site 10 times or fewer, 94 logged in between 11 and 100 times during the time period. A very small number (8) logged in over 100 times (max 259). YP accessing the service were clustered from a few areas with few coming from the most deprived areas of Wirral.

Due to the confidential nature of the service, data were not available to determine the reasons for contacting Kooth counsellors, although it is recognised to be predominantly related to emotional wellbeing.

Survey respondents

Among the 802 users, 52 (6.5%) young people voluntarily participated in completing the survey. The majority (48; 89%) were female and the most common years of birth were 1992-1996 indicating respondents were mostly 12 to 17 years of age. Thus the spontaneous involvement of young female participation was 10.8% (48/444), and for young males was 1.7% (6/358). Respondents represented areas of residence throughout the Wirral. There was no evidence of clustering in respondents from particular areas, linked with a high Index of Multiple Deprivation.

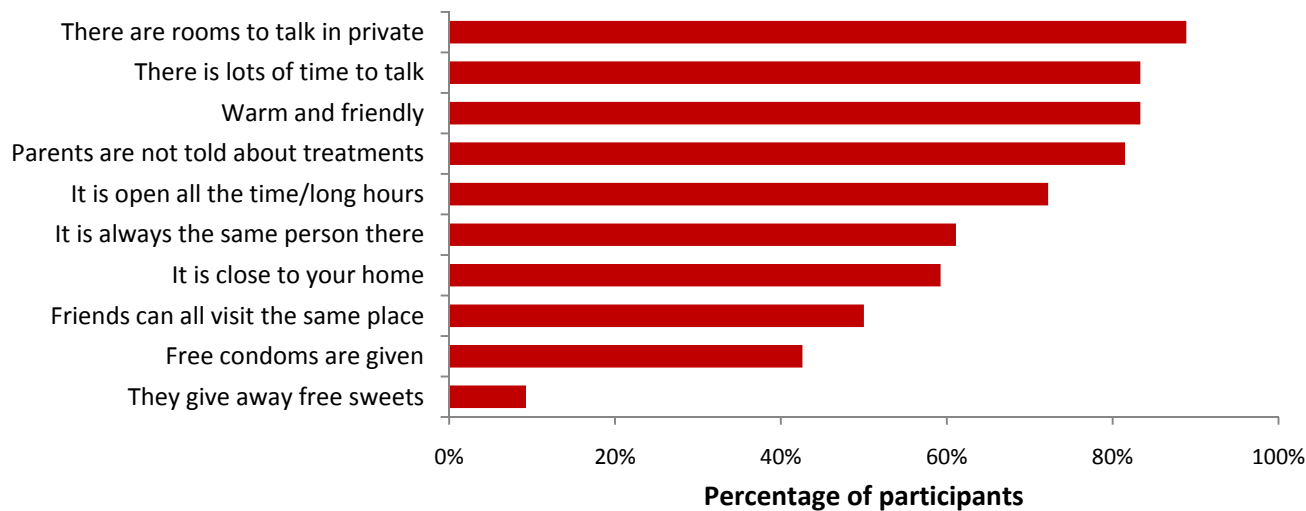
Table 8. Demographic characteristics of health audit survey respondents

		Frequency	Percent
Sex	Female	48	88.9
	Male	6	11.1
Year of Birth	1984	1	1.9
	1985	1	1.9
	1987	1	1.9
	1990	2	3.7
	1991	5	9.3
	1992	7	13.0
	1993	8	14.8
	1994	8	14.8
	1995	8	14.8
	1996	6	11.1
	1997	5	9.3
	1998	2	3.7
Place of residence	Bebington	6	11.1
	Wallasey	5	9.3
	West Kirby	5	9.3
	Hoylake	4	7.4
	New Brighton	4	7.4
	Seacombe	4	7.4
	Birkenhead	3	5.6
	Irby	3	5.6
	Pensby	3	5.6
	Heswall	2	3.7
	Liscard	2	3.7
	Moreton	2	3.7
	Prenton	2	3.7
	Barnston	1	1.9
	Bidston	1	1.9
	Bromborough	1	1.9
	Caldy	1	1.9
	Poulton	1	1.9
	Rock Ferry	1	1.9
	Thingwall	1	1.9
	Tranmere	1	1.9
	Woodchurch	1	1.9
Total		54	100

Opinions about health services for young people

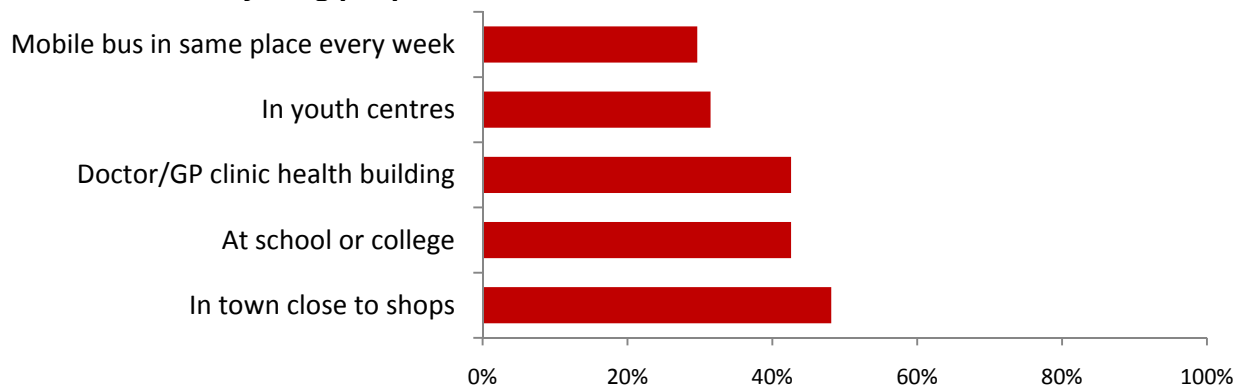
Young people were asked what they thought was important for a health service for young people and asked to tick all that apply. The majority of respondents wanted rooms to talk in private (89%), being given adequate time to talk (83%) and a warm and friendly service (83%). Being given free sweets or free condoms was least important. Fewer YP ticked that they wanted the service close to their home, or that their friends could also attend (figure 148).

Figure 148. What is important for a health service for young people?



YP were asked where they would like their health services to be located. The largest proportion (48%) indicated they would like a health service or clinic to be in town close to shops. This was closely followed by school or at the GP surgery (42%). Around 30% thought it could be located in youth centres or be a mobile clinic located in the same place each week (figure 149).

Figure 149. Where do young people want health service/clinic to be?



YP were asked who they found it most easy to talk to about health issues. Two thirds indicated they found ‘friends’ and ‘online counselling services/kooth’ easy to talk to about health issues (67%; figure 150). Their doctor or GP practice was the third highest option. All other options were chosen by less than a third of people. The least easy to talk to were ‘parents or carers’, the ‘pharmacy or chemist’ and ‘CAMHS’. Wirral Brook was included within this survey and was chosen as an option by less than 20%, with nurses, teachers, and learning mentors ranking higher.

The reverse question, who do you find it difficult to talk to, almost mirrored the reverse of the previous question (Figure 151). While the majority (83%) of YP indicated parents or carers (and siblings) were difficult to talk, they also thought teachers, their GP or doctor, nurse at the practice, and pharmacy were equally unapproachable. In this instance Wirral Brook, Response, and online services such as kooth were least difficult to talk to.

Figure 150. Who do young people find it is EASY to talk to about health issues?

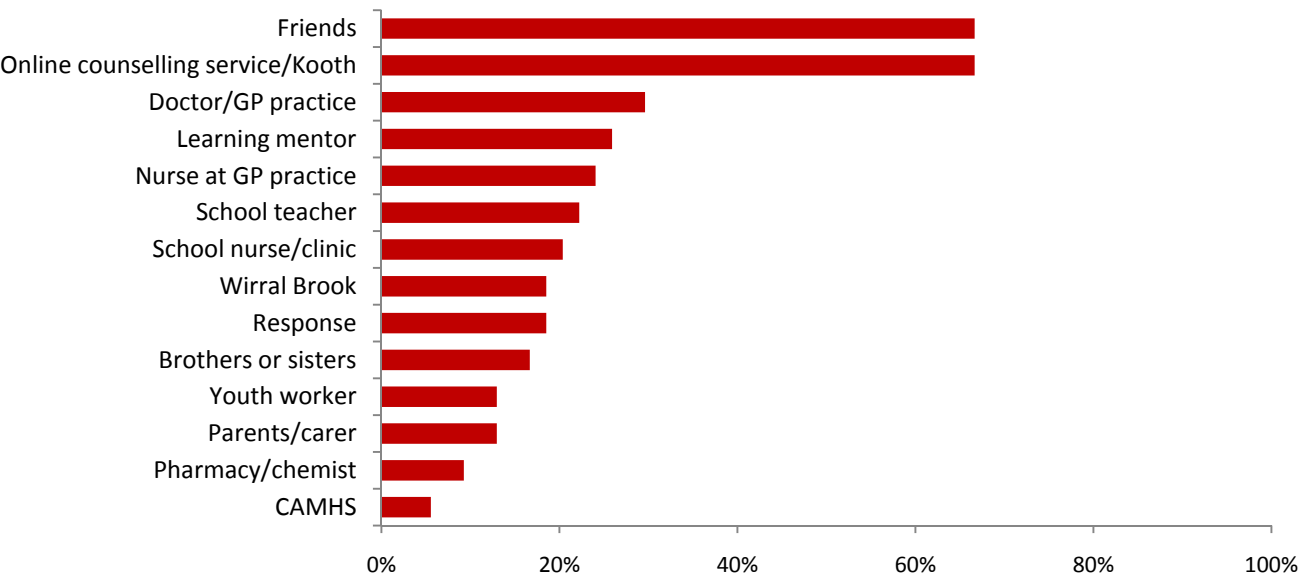


Figure 151. Who is it DIFFICULT to talk to about health issues?

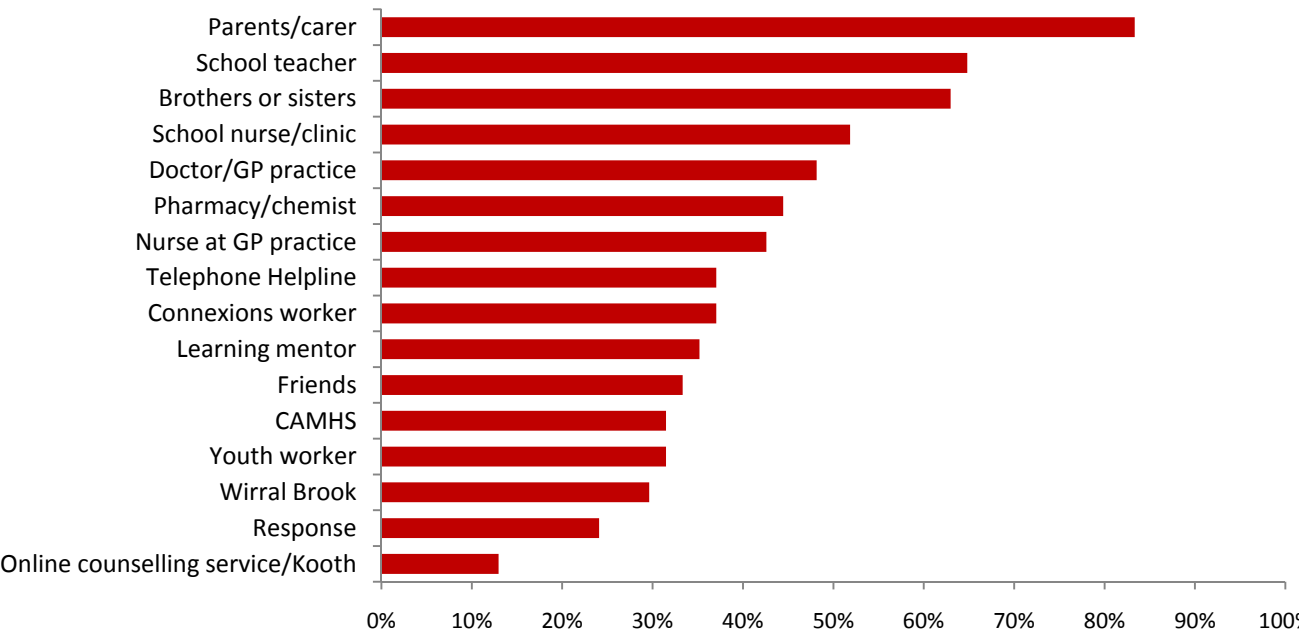
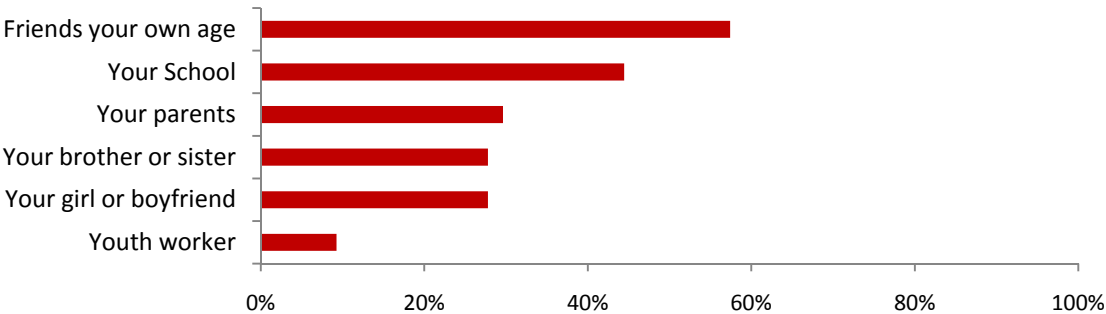
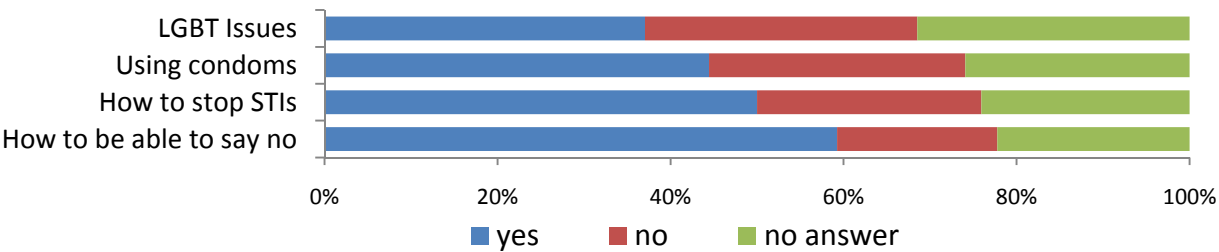


Figure 152. Where do you go to get information on sex and relationships?



YP most frequently recorded that they get their information about sex and relationship from friends their own age (57%; figure 152). About half stated they got information from school and a third through parents or siblings. A free box for other was seldom completed, this included ~ 5% spontaneously stating Wirral Brook, and a similar proportion stated kooth.com, and 'none'.

Figure 153. What of the following do you want to know more about...



Young people indicated they would like to know more about how to be able to say no to sex (59%) and how to stop STIs (50%). Fewer people were concerned about using condoms or LGBT issues (figure 153). The majority of YP said they could not talk openly about sexual matters to adults at school (87%) or to their fathers (89%). More young people indicated they could talk openly to their mothers about sexual matters (30%), with 68% stating they could not (figure 154).

Figure 154. Can you talk openly to about sexual matters

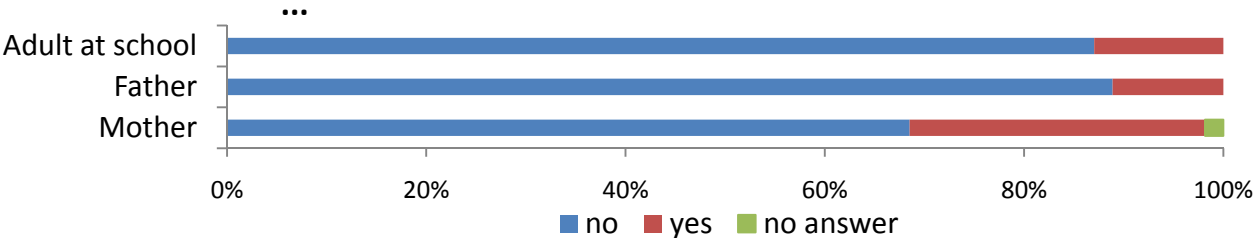


Figure 155. Do you know where your local sexual health clinic is

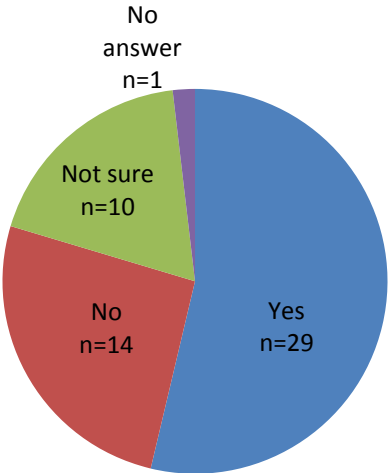
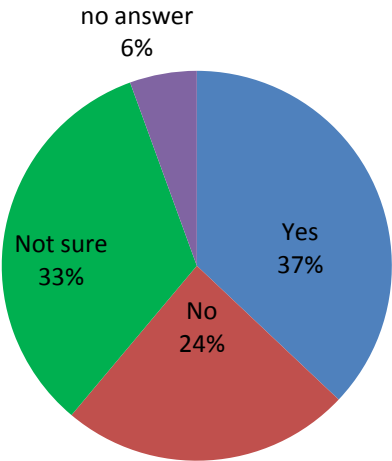


Figure 156. Could you go there on your own



More than half of the YP knew where their local sexual health clinic is (54%) while 44% did not know or were not sure (figure 155). Over half (57%) of the YP indicated they could not go to the service on their own, or were not sure if they could (figure 156). When asked why they could not go on their own a third of the sample gave a reason in the free text box. Of these, a third said it was embarrassing or awkward, just over a quarter said they

would need support, and a smaller proportion were scared their family/parents would find out amongst other reasons given. The majority of respondents (72%) never tried to get help or advice on sex and 13 (24%) had tried. Of those wanting to get help 30% had not (figure 157).

Figure 157. Have you ever tried to get help/advice on sex?

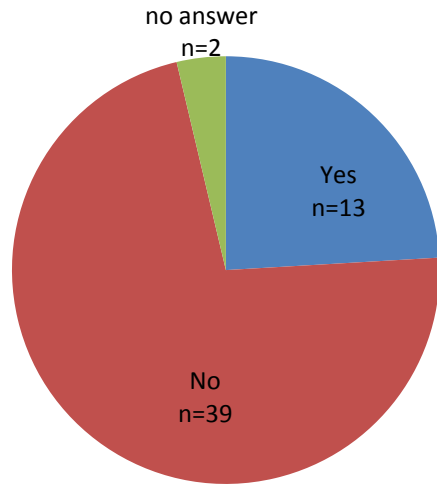
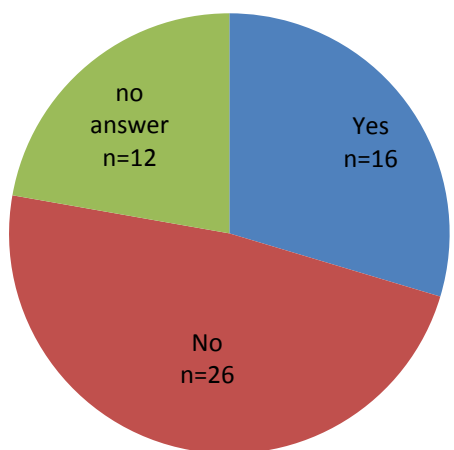
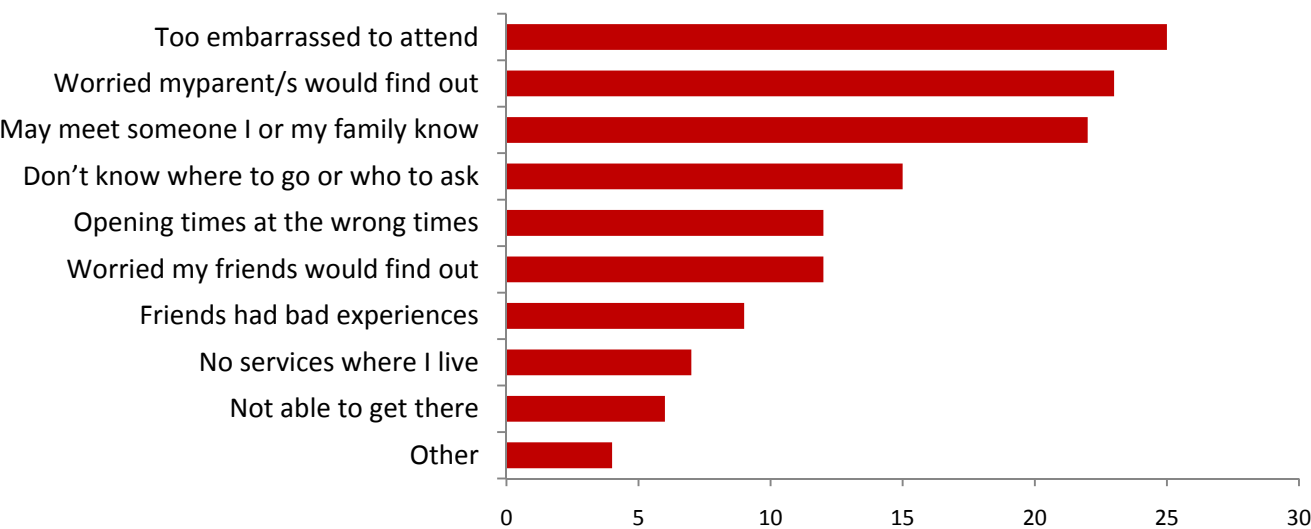


Figure 158. Have you ever wanted to get help/advice on sex but not wanted to?



Participants were asked if they did not get help or advice what stopped them (figure 158 and 159). Not all of the individuals who answered this question had indicated they had wanted to attend but did not. Overall 34 individuals indicated they has a worry that would stop them going to a service for help or advice. The graph below, figure 159) shows frequencies as a reliable demoniator was not available. The most common reasons for not going for help or advice about sex were embarassment, worry that parents would find out or that they would meet someone they knew. Poor access, for example not able to get there or no services in their area, was the least frequent answer.

Figure 159. If you did not go to get help/advice why not...



Box 35 Conclusions from Health Audit of online kooth.com in Wirral

- Young people seeking counselling from kooth.com represent more vulnerable youth, seeking private advice. While the sample represents a small overall population their views and experiences add to the overall knowledge base on the met and unmet needs of this diverse population. Although the total number of users is marginally more females, amongst users, females appear to repeatedly access Kooth services more frequently than males.
- Data suggest this population are not comfortable accessing information from parents, school teachers, and other adult members of the community and thus Kooth offers an important counselling role. Evidence from the data also suggests they are also reticent to seek sexual health advice from available services.
- For such vulnerable young people, they prefer services to be located away from their home, preferring places in town, by the school or at the GP surgery.
- YP preferred Wirral Brook, Response, and online services to CAMHS in terms of being easy to talk to; again this may reflect lack of awareness and inadequate signposting rather than considering it not a preferable service.
- This population do not appear to be able to talk openly to their mothers, fathers, or school about sex and relationships, citing their friends as their main source of information.
- There appears to be substantial reticence to visit a sexual health clinic; in this population, this did not appear to be because they were unaware where it was; embarrassment at being identified or family finding out was the biggest barrier to use.
- Evidence of lack of self esteem is suggested with respondents asking for more information on how to be able to say no to sex (59%) and how to stop STIs (50%), while how to use condoms did not rank as a major concern.

4.2.5.4 NCB study: Young people with emotional wellbeing issues and role of GPs

Box 36 Summary of findings on emotional wellbeing (National Children's Bureau)

- A National Children's Bureau pilot study surveyed 41 YP (age range 10-21 years) attending youth services (Connexions, CAMHS, Response and Wirral Youth Offending service) in Wirral by face to face interview using an open questionnaire to gather opinions on depression, substance /alcohol misuse, GP's and health services.
- The majority of YP perceived depression to be a state of sadness and of feeling low. There was an understanding that depression could lead to young people wanting to hurt themselves or resort to alcohol, crime and violence.
- YP felt that having 'more to do' in the evenings and weekends would be a good way to combat drug taking or bingeing, as well as having 'better access to education', and more accessible young people's clubs.
- Both males and females felt family and friends could help stop drug taking and/or bingeing, followed by counsellors and YP's service providers; better policing was also mentioned.
- YP had generally not attended their GP for some years. Attitudes towards GP services were broad, ranging from those who were happy with their GP to others who felt GPs to be unapproachable, did not respect them, and were unskilled at knowing how to talk to young people. Their attitude suggested a reluctance to attend GP services.
- YP felt being depressed was not a reason to go to the GP as they were too embarrassed and felt GPs would prefer to treat with medication rather than spend time listening to problems.
- The majority would like to see GP services as being more approachable, better placement in schools and in the community, with more advertising, informal, better opening and access times, and more about care and listening rather than just about medication.

Background: As part of the National Children's Bureau (NCB) 'Young people, drugs and depression' project, young people attending youth services in Wirral (Connexions, Response, Children's and Adolescent Mental Health Services (CAMHS) and Youth Offending Service) were consulted. The NCB study aims nationally to identify key issues regarding emotional wellbeing of young people, inform primary care services in recognising and supporting young people with such problems, and share good practice. This sub-study offered the opportunity to better identify the role of GPs for YP struggling with emotional wellbeing issues, and from their perspective, what makes a good service. The study was organised locally by Terry White (DAAT, Wirral) and colleagues from the different youth services. Liverpool John Moores, as a good-will gesture, offered to analyse and interpret the data.

Questions for young people

1. What do you think being depressed means to young people?
2. What do you think would stop young people from taking drugs/binge drinking?
3. Who/what kind of services would young people turn to if they felt depressed or had a substance misuse problem?
4. What do you think about GPs and why?
5. How could GPs and other professionals improve the service they provide to young people to help them with their mental health and/or substance misuse problem?

Methodology: NCB developed a one page questionnaire with five open ended questions. The purpose of the questionnaire was to assess who YP would turn to if they had substance misuse and/or emotional problems, and identify whether GPs and other health services meet their needs regarding substance misuse and depression. Staff from the youth services invited attending YP if they would like to respond to some questions in a face to face (informal) interview and their responses were written down on the form. No names were written down. It was ensured that the YP were comfortable to discuss the issues in a supportive, non-judgemental and friendly environment, encouraging them to participate openly and share their opinions.

Demographics: Forty-one YP agreed to participate. Participants attended Response (17), CAMHS (5), Connexions (9), and Wirral Youth Offending (10). The majority of respondents (46%) were aged 17-18, followed by those aged 14-16 (37%). Very few (5%) 10-13 year olds were questioned, all of whom were consulted through the Wirral Young Offending Service. The majority of 17-18 year olds were questioned at Response and Connexions, with 14-16 year olds equally distributed among the four services. Of the 41 respondents, 22 (54%) were females. More males than females were consulted through Wirral Youth Offending Service, 4 of 5 responses from CAMHS were female. Response and Connexions consulted with both genders.

Young people’s perceptions of depression

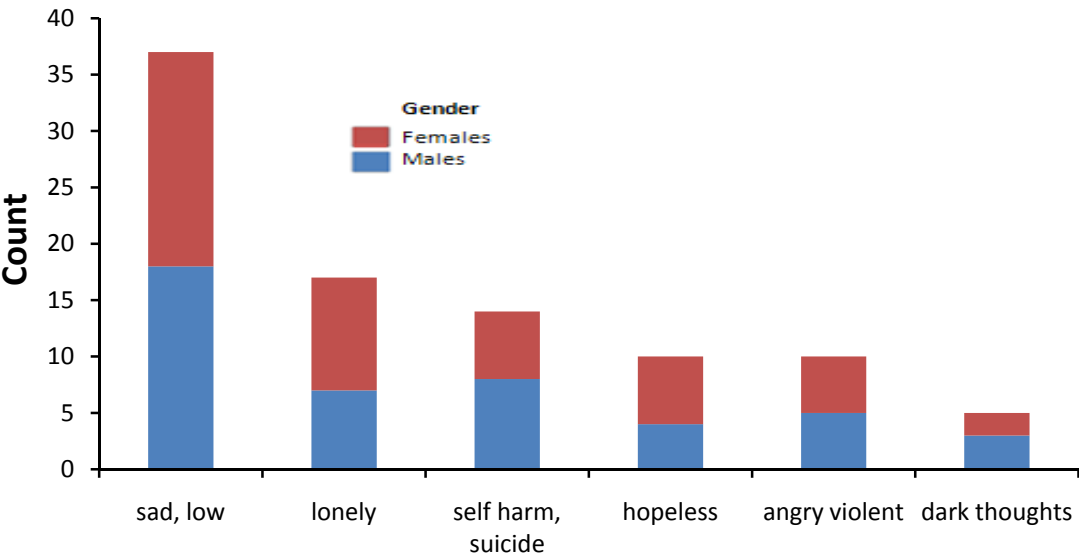
The majority perceived depression to be a state of sadness and feeling low. A slighter higher proportion of females described depression as feeling lonely. Less young people thought depression involved feelings of hopelessness, described more by females than males.

‘Stressed and unhappy. If things are not going well in the family it could lead to drinking and crime. Also young people could kill themselves or self harm. Young people feel isolated with nobody to listen or understand them.’ (Male 15)

‘When people on a downer want to hurt themselves or go out and do something stupid. Hurt someone or themselves, can’t control feelings, smash something up.’ (Female 16)

There was an understanding by both males and females that depression could lead to a person wanting to hurt themselves, or resort to alcohol, crime and violence (figure 160).. More males described depression as leading to self-harm and/or suicide. Older age groups (17 years and older) described a feeling of hopelessness

Figure 160. Young people’s perception of depression by gender



What would stop young people taking drugs and/or bingeing?

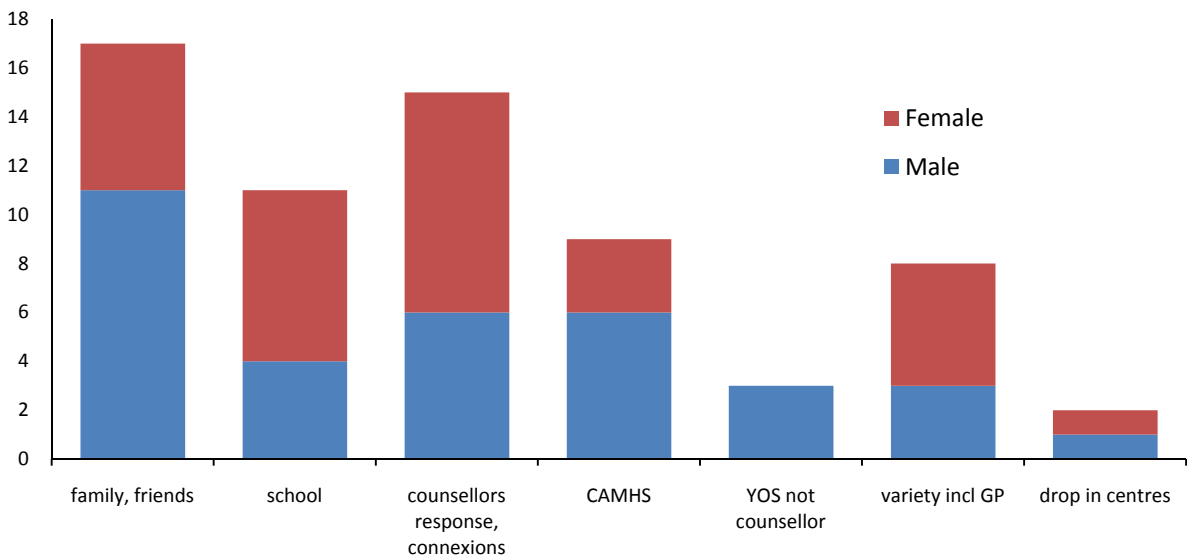
Two-thirds of YP questioned felt having ‘more to do’ would help deter young people from taking drugs and/pr bingeing. However, less than half gave any indication where they would like to go, with most responses generalising on going out, more activities on weekends, more things to do which do not require money, and stop being with people taking drugs. Older females (17-18) felt that making changes to their lives to ‘stop being sad’ would be an effective way of combating drug use and bingeing, and younger (14-16) YP felt that to stop hanging out with people who take drugs would help. Only 20% suggested specific places they would like to go to help stop or combat depression or substance use. Amongst these, YP suggested ‘better access to education’ and ‘clubs including older young people’s clubs’.

“possibly more police on patrol speaking to young people...giving YP something to do and somewhere to go, most of the time they go to parks as there’s nothing else to do” (Male 19, Response)

“Giving advice/information in schools earlier even primary schools to teach dangers at an early age” (Male 20, Response)

Both males and females felt family and friends can be the strongest deterrent to taking drugs or bingeing, followed by counsellors and young people’s service providers (figure 161). More females than males felt school could be an influence whereas more males thought CAMHS would be. Since only males from youth offender services were asked, only males responded saying this was a positive influence. GP services were considered to be the fifth out of seven strongest influences on taking drugs or bingeing.

Figure 161. What would stop young people taking drugs/bingeing?



Responses from YP suggested half would not willingly chose to visit their GP and a third were unsure. This was equally distributed across both genders, however, stratification by age showed older ages were least willing to attend (17 years and above; figure 162). Half of those aged 14-16 years reported issues with their GP suggesting they would be reticent to visit, while all those aged 10-13 years implied they would attend (figure 163).

“I haven’t been to the GP for ages. They’re OK. I would feel embarrassed talking to them if I were depressed”. (F 14, Connexions)

‘My GP is OK, don’t know if I could trust them with drugs and drinking ...wouldn’t go for depression, I’d be embarrassed’ (Male 15, Response)

Figure 162. Would you attend your GP?

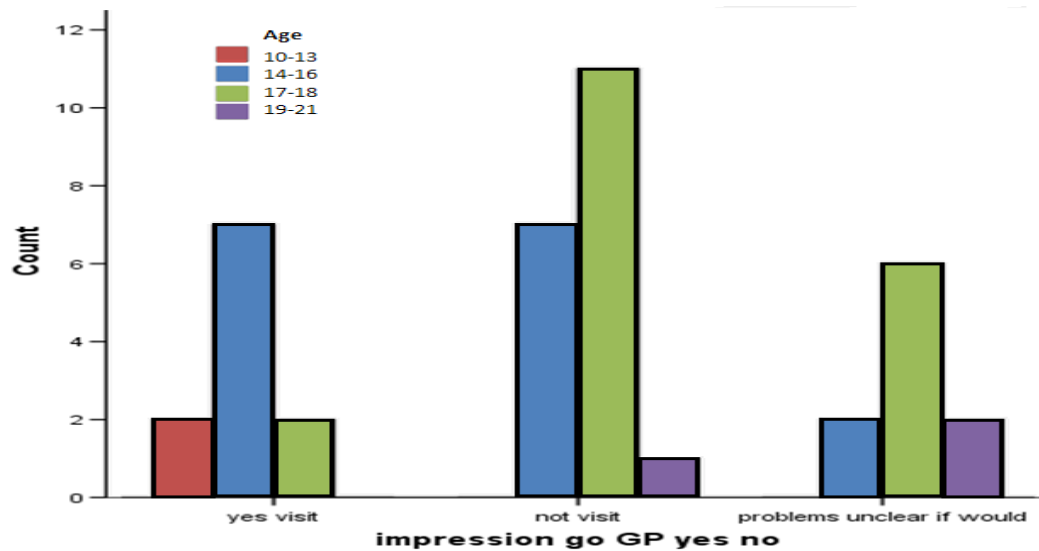
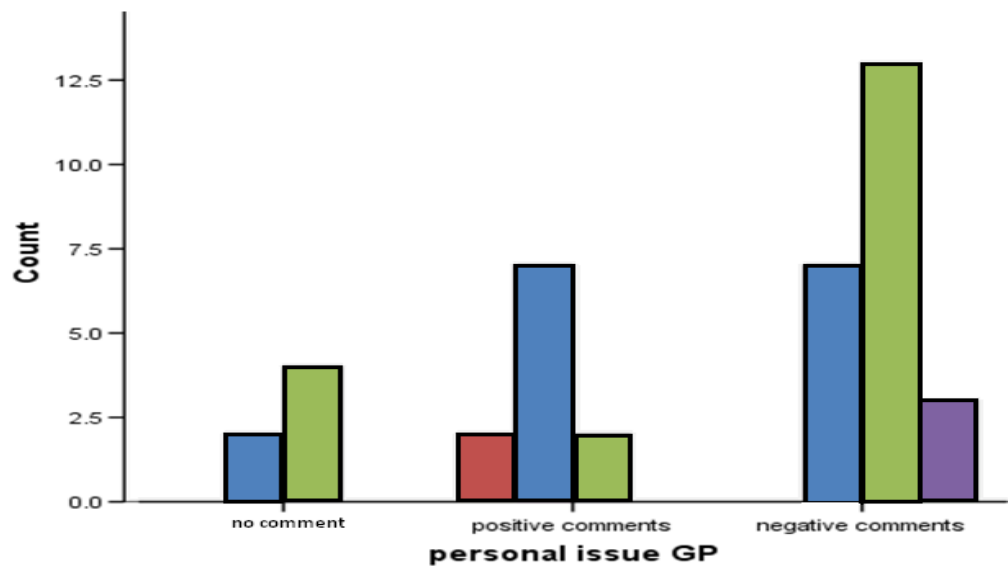


Figure 163. Impressions of GP



Box 37 Some negative opinions young people expressed about their GPs

“Cold, grumpy, snobby, horrible, scary” (different words used by 10 young people)
“Haven’t been to GP for years” (8 young people)
“GPs don’t listen” (6 young people)
“OK with physical but not for young people with depression or substance abuse issues.....just want to give drugs/medication/prescriptions” (6 young people)
“Don’t dress in a suit it puts people off” (Female 16)

The numbers of positive, negative and no comments were similar to the levels of those that said they would, would not, or did not know if they would attend. This suggests that the young people’s attitudes toward GP services affected where they would or would not attend. Positive responses about their GP show that a portion

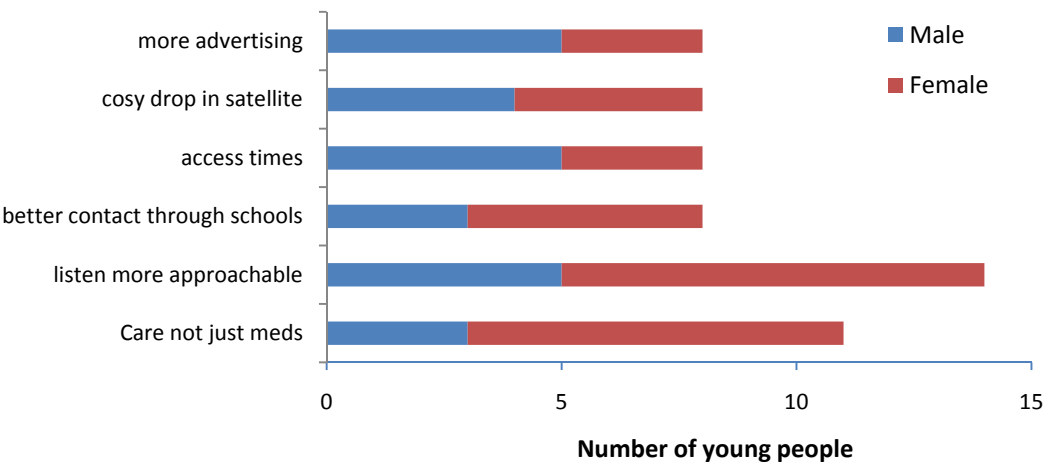
of young people do have a good relationship with their GP, particularly when there is a physical rather than mental health issue.

Box 38 Some positive opinions young people expressed about their GPs

“Helpful and caring” (7 young people)
‘I think GPs are OK they help you when you are ill and give you medicine’ (Male 16, Youth Offending Service)
‘Mine are quite good. I was referred into treatment’ (Female 17, Connexions)

YP were questioned on what GP services need to do to improve their service for young people. Of those questioned, the majority responded they would like to see GP’s listen more, followed by their concern that GPs provide drugs (medication) and they should try to care by listening more (figure 164). Most of these comments were made by females. More males suggested better advertising and opining/access times. Improving contact through schools was also mentioned.

Figure 164. How can GP services improve for young people



Some of the opinions given are reported below:

Advertise other reasons for coming to doctors not just illness; create awareness in schools; less snobby looking, more friendly.” (Female 16)
“Try to talk to them (YP) on same level but without patronising them, try to create a comfortable, friendly environment; special clinics for young people with specially trained staff and specific times for young people.” (Male 18)

This open questionnaire produced remarkably similar views and opinions from many of the YP. The majority thought GP services should be more approachable, and have GPs that are trained to understand, and listen more to young people’s concerns; this was particularly noted by YP in the older age groups (figure 165). All groups felt that GP services should not just be about medication. Those aged 10-13 years of age thought that more advertising was required to better understand what services are available for YP as well as the concern about medications. Those over the age of 18 thought that a cosy drop in satellite, better access times and not just caring about medication were important. Those aged between 14-18 years thought better contact through school would be helpful.

“GP’s could be more sympathetic and shouldn’t just try and prescribe everyone with antidepressants” (Female 17)

“No waiting lists, flexible times, satellite clinics in YP services” (Female 20)

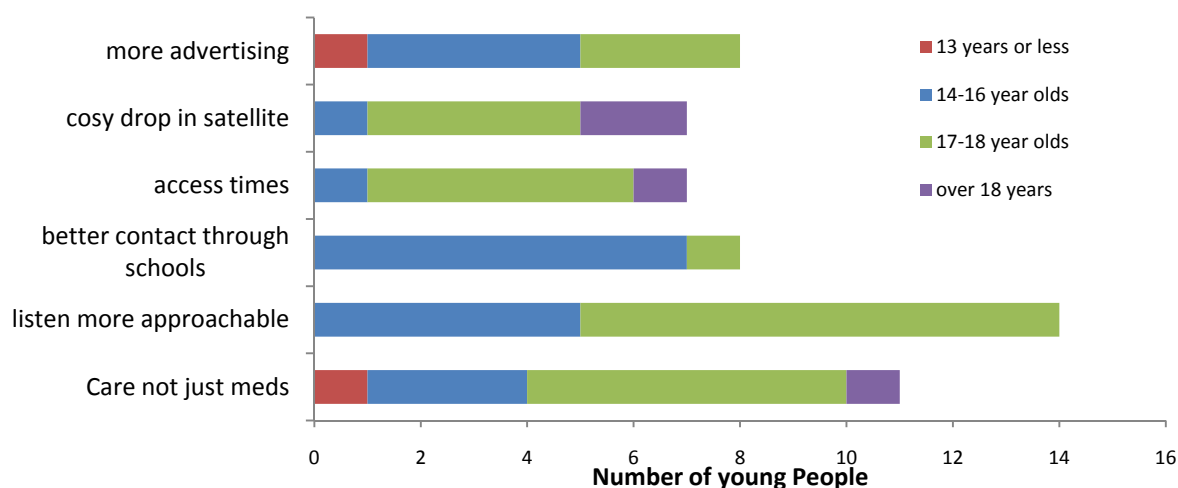
“If they were more friendly and caring and you knew you could trust them and that they were real and not patronising.” (Female 15)

“Come into schools and tell other children what is out there” (Male 14)

“Time...make more time when you see the doctor” (Female 17)

“More information, later opening times” (Male 16)

Figure 165. How can GP and other services improve for young people?



Box 39 Conclusions on emotional wellbeing (National Children’s Bureau) and GPs

- Although this study was small and in a non-representative sample of vulnerable YP, it highlights a number of critical concerns of young people may be more likely to suffer from substance abuse issues and have a tendency towards depression, and their interactions with GPs and health services.
- YP stated they had not been to their GP for many years. Overall signposting and finding ways to improve access for this age group is clearly sought to counter unmet need.
- The experience of YP indicates that their GPs are not easily accessible for their problems; either because it is many years since they last visited, the GP appears to be rather aloof and unapproachable, or that treatment tends to be more drug-related therapy, with little time available for informal friendly chatting about problems.
- These issues, relating to teen accessibility to health services, are carefully considered under the ‘You’re Welcome’ commitment. It appears that YP with emotional wellbeing issues and substance abuse may be a subsection of the population that need particular attention, and could be a useful marker of success of the You’re Welcome programme.
- YP suggest GPs be made more accessible, through making clinics more cosy, informal, with longer opening hours and easy access. Such views can help to inform the health service agenda, and may be linked with putting health clinics in or close to schools.
- For YP not attending schools, however, further thought is needed on how to advertise GP services for vulnerable YP in need.

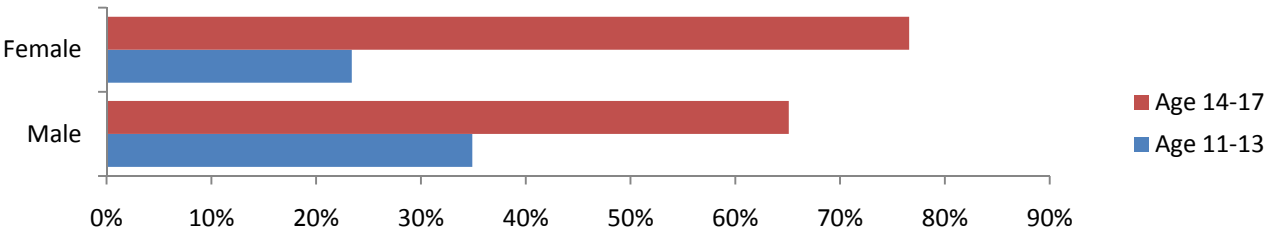
4.2.5.5 Parent and children’s perceptions of alcohol use

Box 40 Family alcohol study- Main findings

- A total of 281 students from three schools in Wirral completed a questionnaire about alcohol use.
- The most common problem amongst the population was stress with 6% of respondents indicating they suffer from stress.
- Individual’s suffering from dyslexia, attention deficit hyperactivity disorder (ADHD), Asperger’s syndrome, autism and learning disabilities were all males. In addition males were the only ones to indicate suffering from depression and suicidal feelings. However, this is a very small percentage of the whole population with one and three males respectively suffering from these problems.
- A larger proportion of females indicated they suffer from anger problems or losing control than males, and all three respondents with an eating disorder were female.
- More individuals aged 11-13 years indicated suffering from stress, anger/loss of control, ADHD and/or a learning disability than those aged 14-17 years.
- Sport was the most common activity participated in with nearly three quarters of the population playing once a week or more.
- With regards to problems experienced in the previous 6 months 20% of males and 18% of females reported losing or changing friends. Just under 20% of females indicated they had not had much money in the previous 6 months. Not doing well at school was the third largest problem for males with 17% of all males indicating this.
- None of the sample indicated they had used illegal drugs or caught an STI in the previous 6 months.
- A much larger proportion of 11-13 year olds had problems with their weight, and had experienced family relationship problems in the previous 6 months than the 14-17 year olds.

This sample was collected from three schools in Wirral. The majority of respondents were female (206) aged 14-17 years (151; figure 166). The ages ranged from 11 years to 17 years.

Figure 166. Population by age and gender



Wellbeing

As can be seen from the percentages in figure 167 in bold 6% of the overall population indicated they suffer from stress. Within gender 3.9% of females indicated they were stressed compared to 7.1% of the male population. Dyslexia, anger/loss of control and ADHD were the next most cited problems with slightly more males (7.1%) than females (3.4%) reporting having dyslexia, slightly more females (3.2%) than males (2.9%) suffering from anger problems, and a higher proportion of males (8.6%) than females (5.3%) suffering from ADHD. Interestingly although being the smaller sample the only individuals who suffered from Asperger’s Syndrome, Autism or learning difficulties were male. In addition males were the only individuals to suffer from depression and suicidal feelings, and females were the only ones to report having an eating disorder (see figure 167).

Figure 167. Wellbeing issues experienced by sex

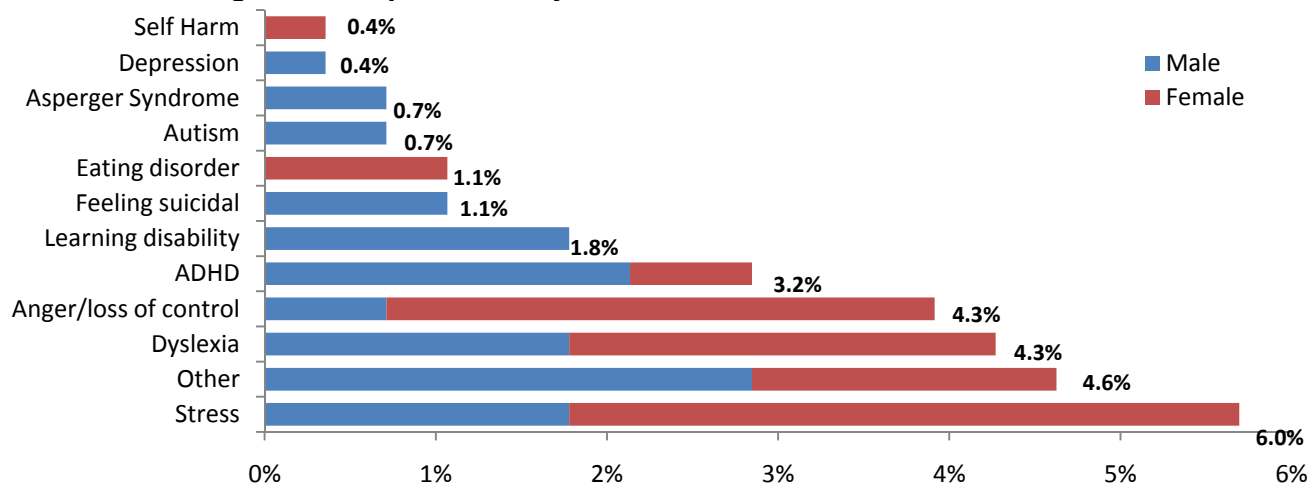
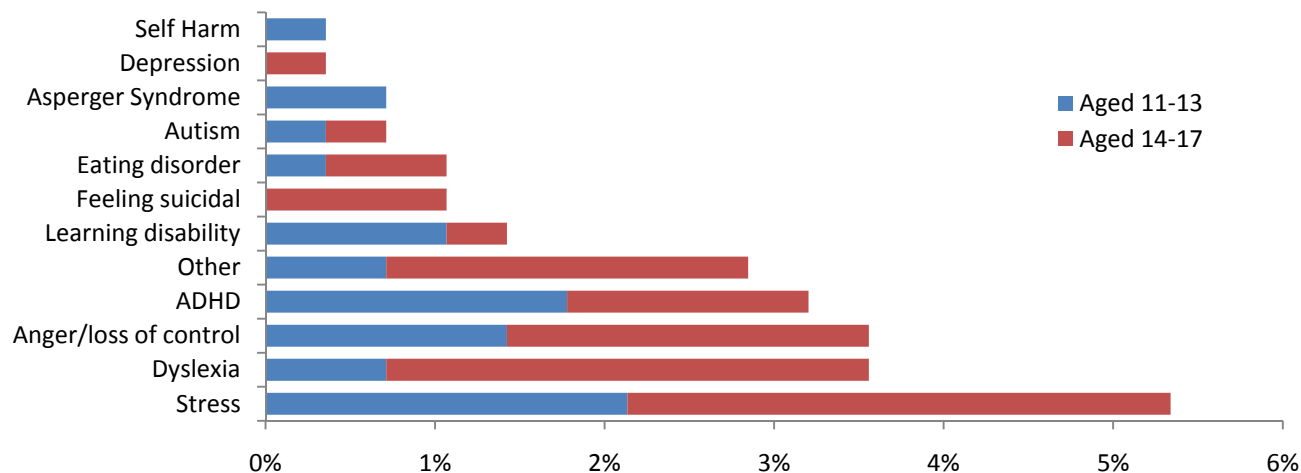


Figure 168. Wellbeing issues experienced by age



Within age, almost double the percentage of 11-13 year olds (8.7%) indicated they suffer from stress than 14-17 year olds (4.6% figure 168). A higher percentage of 11-13 year olds also suffer from anger or loss of control (5.8%), ADHD (7.2%) and learning disabilities (4.3%) than 14-17 year olds (3.1%, 2.1% and 0.5% respectively). A higher percentage of 14-17 year olds suffer from dyslexia in this sample and the older age group contain the only individuals who have suicidal feelings or suffer from depression. A number of individuals also reported they suffer from asthma, eczema, dyspraxia and another physical disability.

Figure 169. Activities/hobbies participated in once a week or more by sex

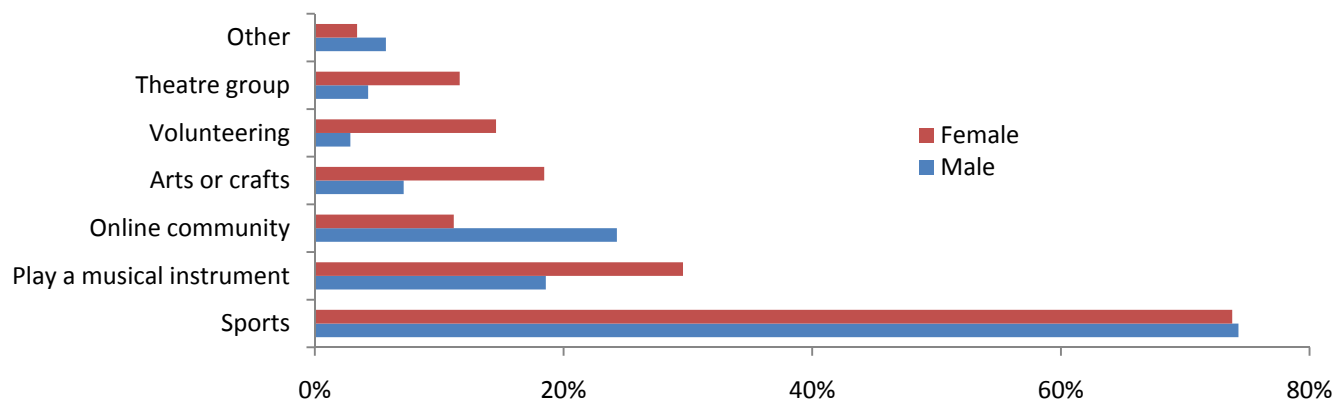
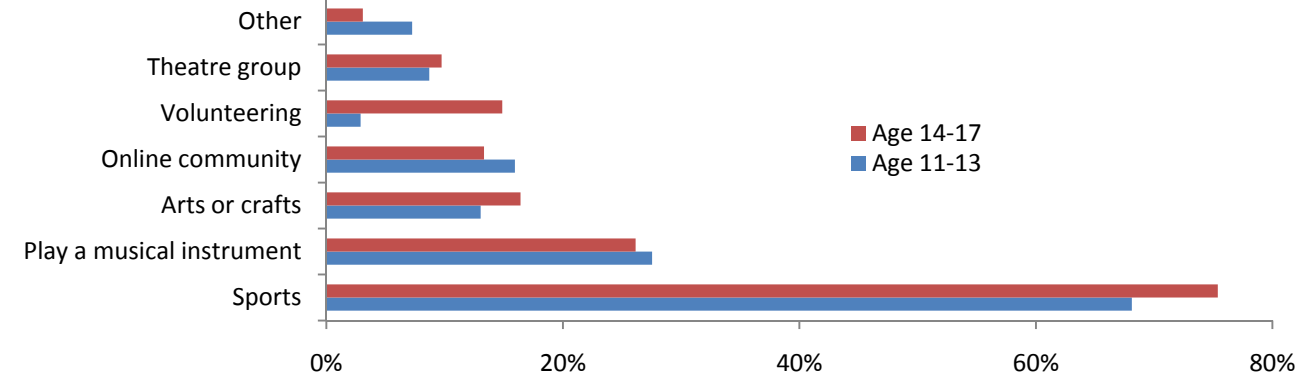


Figure 170. Activities/hobbies participated in once a week or more by age



Participating in sports at least once a week was the most common activity amongst both genders and age groups, with nearly three quarters (74%) of the entire population playing once a week or more. Around 10% more females than males play a musical instrument, and over 10% more males are part of an online community. The age split between these activities is relatively even. A much larger proportion of females (14.6%) and those ages 14-17 (14.9%) do volunteering at least once a week than males (2.9%) or the younger age group (2.9%). Under ‘other’ the activities include bike riding, cadets, choir, dance, guides, horse riding and attending a youth club (see figure 169 and 170).

Figure 171. Percentage of population who experienced problems in previous 6 months by sex

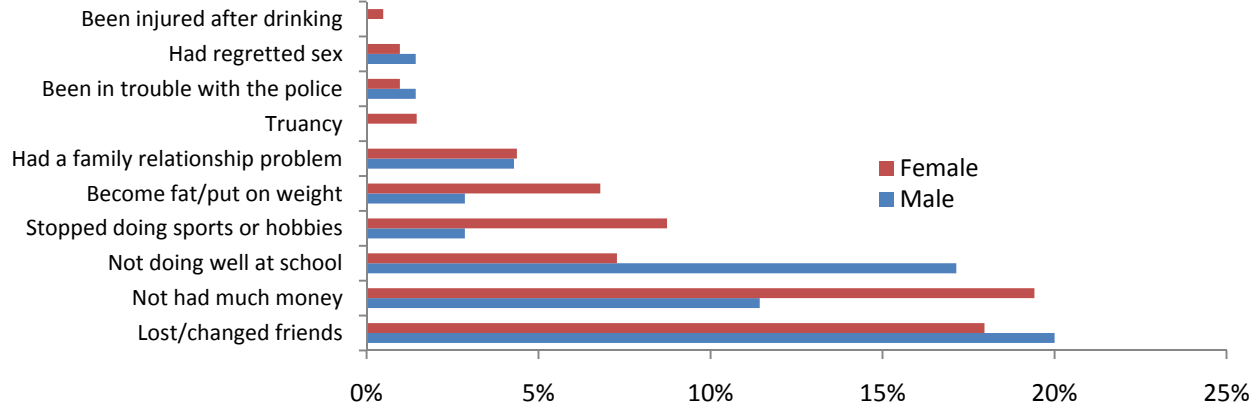
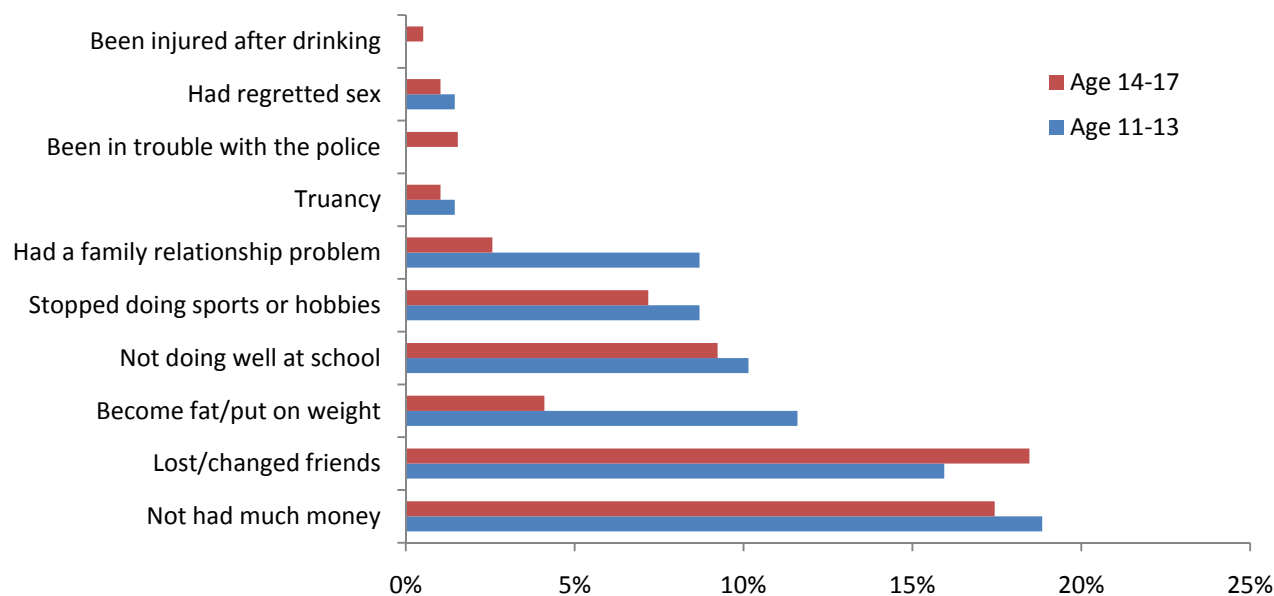


Figure 171 and 172 show the most highly cited problems experienced in the previous 6 months were losing or changing friends and not having much money; around 18% of the overall population indicated experiencing these. A much larger proportion of males (17.1%) reported not doing well at school than females (7.3%), whereas considerably more females had stopped doing sports or hobbies (8.7%) and reported having put on weight or become fat (6.8%). A positive finding is that none of the sample reported having used illegal drugs or having caught a sexually transmitted infection, and only 1% of the entire population indicated having had regretted sex. Less positive is the much larger proportion of 11-13 year olds who reported having problems with their weight (11.6%) and family problems (8.7%) compared to the older sample (4.1% and 2.6% respectively).

Figure 172. Percentage of population experiencing problems in previous 6 months by age



Box 41 Conclusions from the Family alcohol study

- Stress was the most commonly cited problem but overall only 17 individuals indicated they suffered from this. However, within age a much larger proportion of 11-13 year olds indicated they suffered from wellbeing issues than 14-17 year olds, including stress, anger and learning disabilities.
- More females reported suffering from anger/loss of control problems than males and more males reported feeling suicidal and depressed. These again were very small numbers and this indicates that the sample as a whole have good levels of emotional and mental wellbeing.
- The young people in this sample seem active and engaging as nearly 75% of both the male and the female sample play sport at least once a week. In addition, over a quarter play a musical instrument and nearly 15% participate in arts and crafts and/or belong to an online community.
- The majority of the young people in this sample had experienced none of the problems mentioned in the questionnaire, however, 'losing or changing friends' and 'not having much money' were the most highly cited problems of those experienced.
- A positive finding is that none of the sample had used illegal drugs or caught and STI but a very small number of individuals admitted to having regretted sex, to getting in trouble with the police and/or being injured after drinking alcohol.
- Overall, the majority of the sample have few, if any, emotional wellbeing problems, they are generally an active group and the biggest problems they had experienced over the previous 6 months were changing or losing friends and not having enough money; problems most young people aged 11-17 may experience regularly.

4.2.5.6 North West Teen collaborative study pilot in Wirral*

Box 42 College Pilot Study- Main findings

- A total of 227 students from Birkenhead 6th Form College completed a pilot survey.
- Magazines were the most cited source for information on sex or relationships for females, and various porn outlets were the most cited for males.
- More females than males reported wanting to get help or advice on sex and not doing so.
- More females than males had been to a sexual health service in the previous 3 months with Brook the most visited place.
- A large proportion of both males (53%) and females (70%) have knowledge of where their local sexual health and family planning clinic is. However, Brook is either the first or only service that the majority of the sample thought of. Fifty-one percent of young people had been to Brook in the past three months indicating a willingness and comfort with this service. Twelve percent had been to a family planning service in the last three months.
- Both males and females in this sample are drinking regularly with around 30% having drunk more than once a week over the previous 3 months. Smoking is less prevalent in this sample with 61.5% of males and 73.7% of females having never smoked.
- The majority of this sample had had sexual intercourse (60% males and 68% females).
- Condoms were the most popular form of contraception at the first time after which their use diminished. Female's use of the pill increased at subsequent times with 40% using it at the most recent time.
- There was no relationship found between lack of contraception at first time and prior alcohol intake. However, all males who did not use any form of contraception at most recent time had been drinking alcohol beforehand.
- Experiencing alcohol related problems was positively related to frequency of drinking over the previous 3 months as well as amount of alcohol drunk in a usual session and number of times drunk. Not being able to remember what happened was the most frequently cited problem.
- Overall the sample responded positively to the wellbeing indicators with upwards of 70% indicating positive feelings.
- Of those that had had rumours or sexual jokes and comments made about them in the previous 3 months the majority were heavy drinkers, drinking more than once a week.

Demographics

A total of 227 students from Birkenhead 6th Form College completed the pilot survey questionnaire in July 2009. The age of respondents ranged from 16.8 years to 19.8 years (mean age 17.7, SD 0.64). Of 222 students recording gender, just over half (53%) were female (figure 174).

Figure 173. Frequency of respondents by age and gender

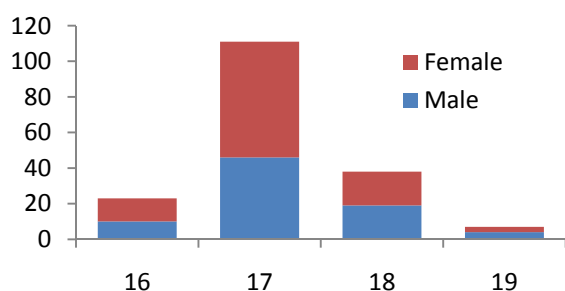
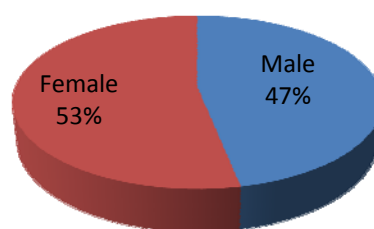


Figure 174. Student population by gender



*Separate short report on Birkenhead 6th form college survey has been completed and is available at www.cph.org.uk

Where do young people look for information on sex or relationships?

Students were given a tick list of all the places they could look for information independently. Females predominantly sought information from magazines whereas males sought information from porn (figure 175) The main source of information for females is teenage magazines and for males it is internet advice sites and TV documentaries. A much higher proportion of males use internet porn sites (19%) and porn movies (14%) compared to females (0% and 2% respectively). There is little difference between the source of information between ages apart from internet porn sites and porn movies which a much larger proportion of 18 year olds use (figure 176)..

Figure 175. Where do you get information about sex and relationships by sex

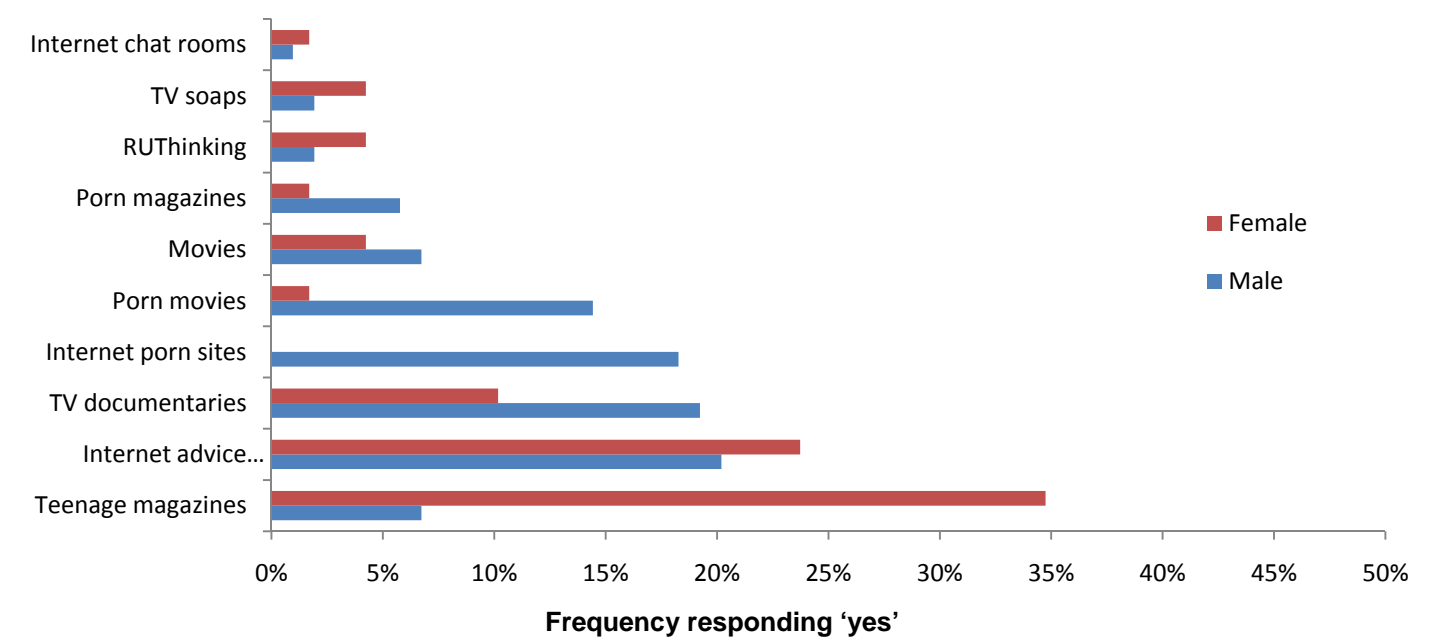


Figure 176. Where do you get information on sex and relationships by age

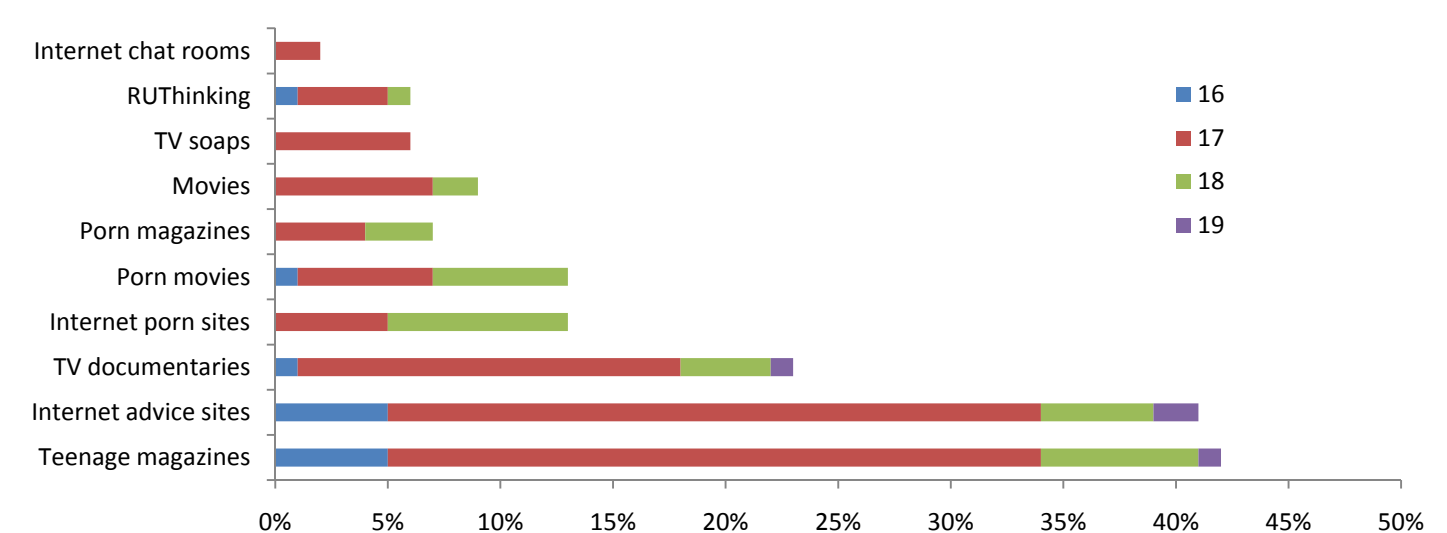


Figure 177. Have you ever wanted to get help/advice on sex but did not by sex

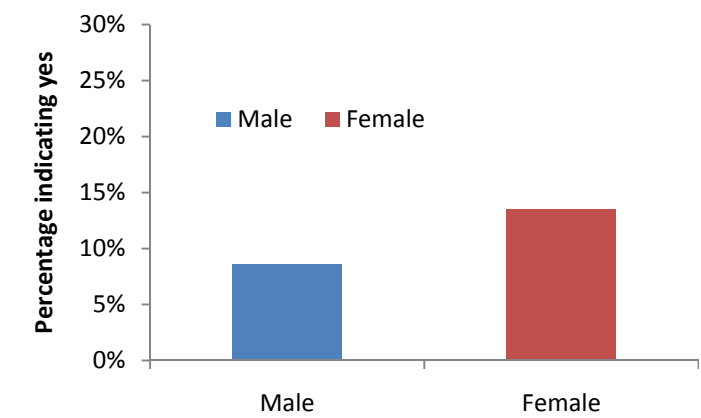
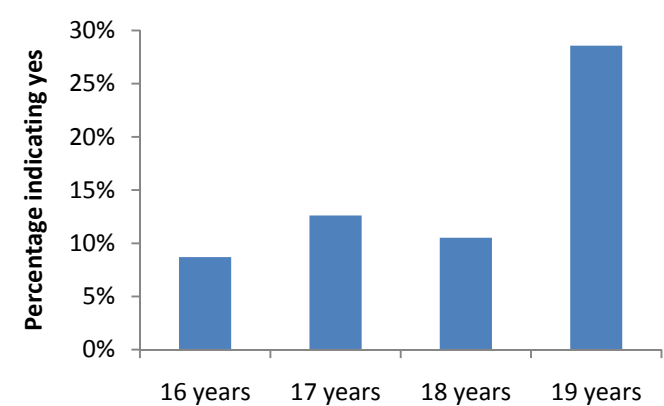


Figure 178. Have you ever wanted to get help/advice on sex but did not by age



More females (14%) than males (9%) reported having wanted to get help or advice on sex but not having done so (figure 177). Among seven 19 year olds, 19% (figure 178) reported not getting help when they wanted to.

Figure 179. Places young people had been in the previous 3 months

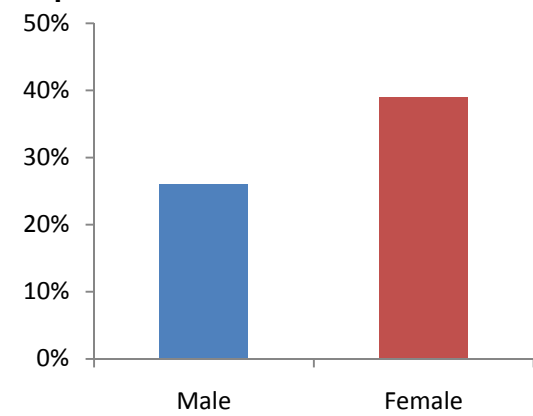
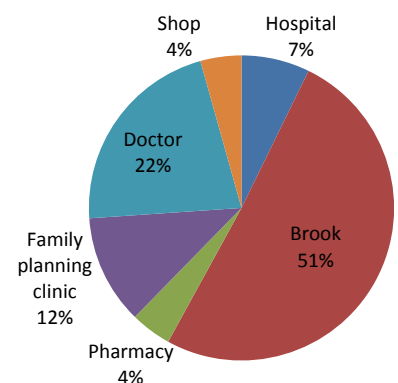


Figure 180. Percentage of population who had been to services previous 3 months



A high proportion of the sample had attended services in the previous 3 months including 26% of males and 30% of females (figure 179). The majority of these visits were to Brook (figure 180; 51%).

Figure 181. No. of young people attending each service by gender

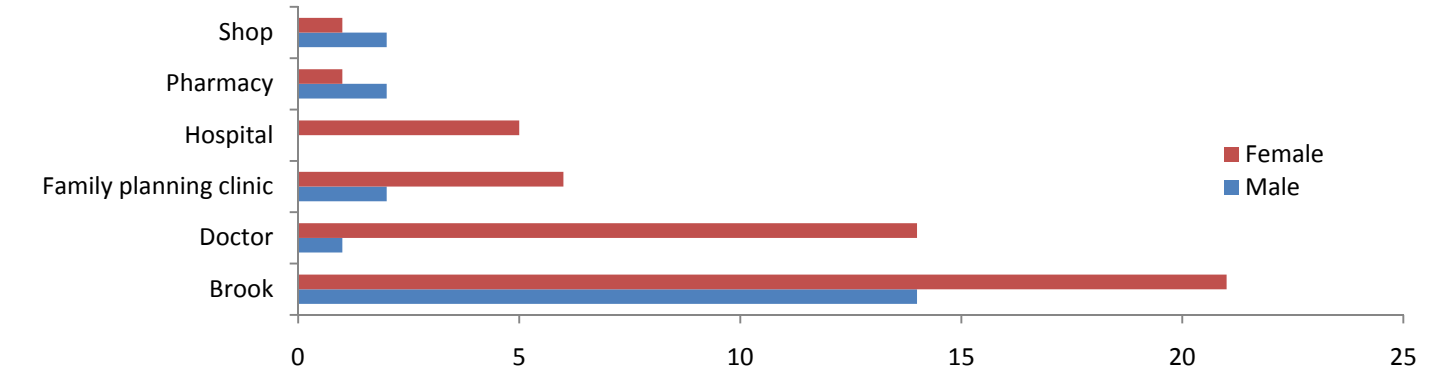


Figure 182. Do young people know where their local STI testing clinic is by sex

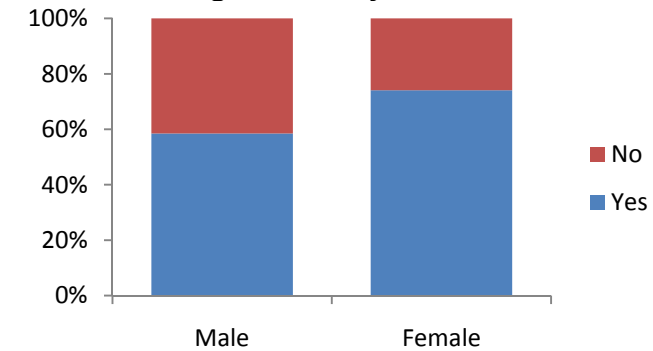
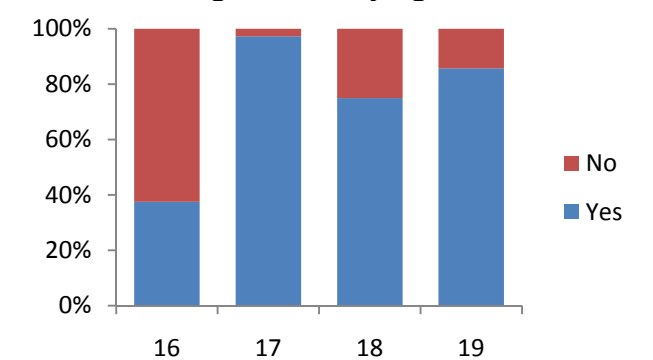


Figure 183. Do young people know where their local STI testing clinic is by age



Figures 181 to 183 show that the majority of males (53%) and females (70%) do know where their local STI testing clinic is. Females have more knowledge than males and more 17 year olds (65%) do than other ages. There is a similar balance of knowledge about family planning services within our sample with again more females (85%) than males (55%) knowing the location (figure 184)

Figure 184. Do young people know where their local family planning services are by sex

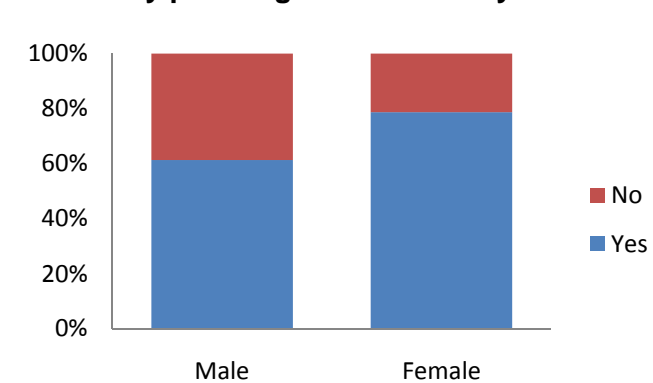


Figure 185. Do young people know where their local family planning services are by age

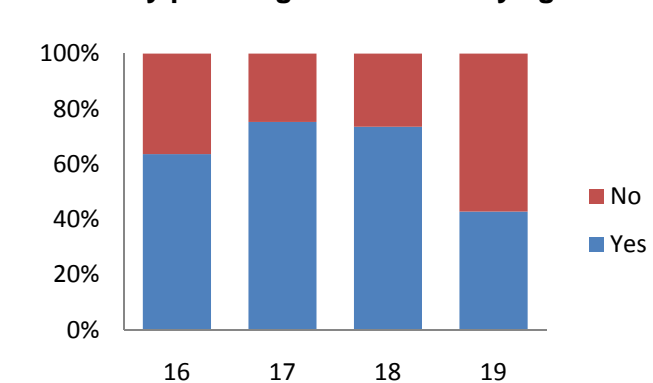


Figure 186. Where do young people think their local STI testing centre is

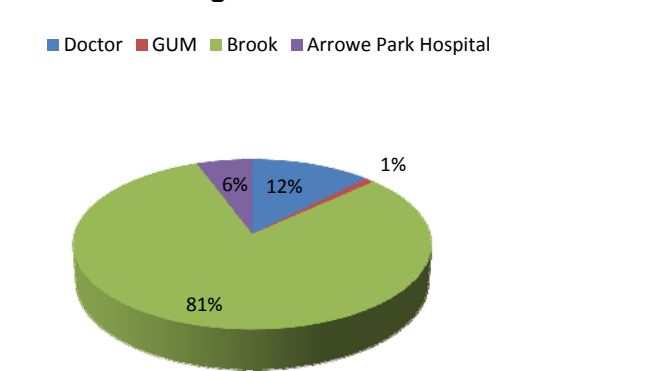
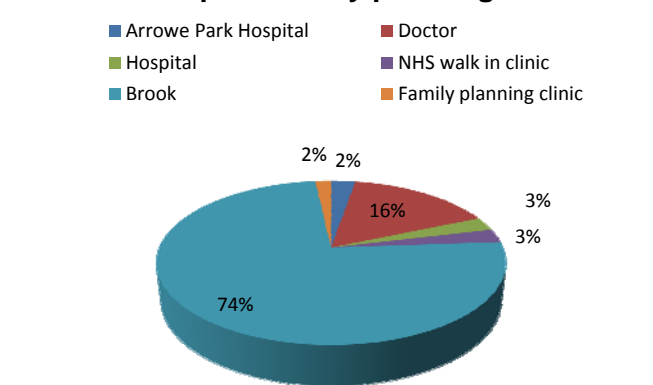


Figure 187. Where do young people think their local contraception/family planning services are



Although some individuals within our sample have knowledge of a range of sexual health services in their local area, Brook is the service that most young people will think of and maybe the only service some young people in Wirral have knowledge of (figure186 and 187).

Frequency of alcohol and cigarette use in previous 3 months

Frequency of drinking is high with 30% of both males and females drinking more than once a week (figure 189). Within these regular drinkers 17.4% are 16 years of age and 33% are 17 years old, meaning almost half of those who have drunk more than once a week in the previous 3 months are under the legal drinking age (figure 189).

Figure 188. Frequency of having drunk alcohol in the previous 3 months by gender

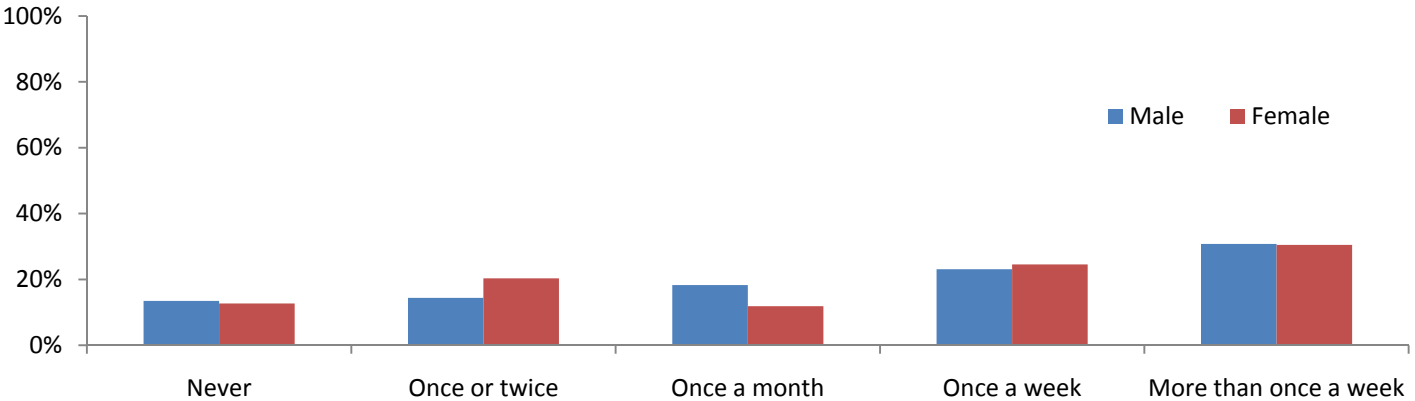


Figure 189. Frequency of having drunk alcohol in the previous 3 months by age

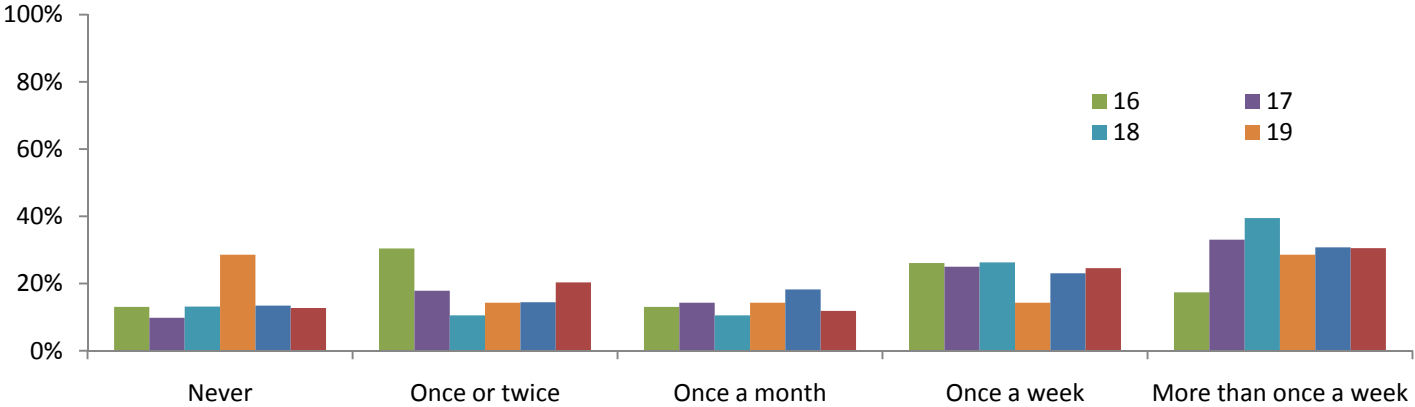


Figure 190 Frequency of having smoked cigarettes in the previous 3 months by gender

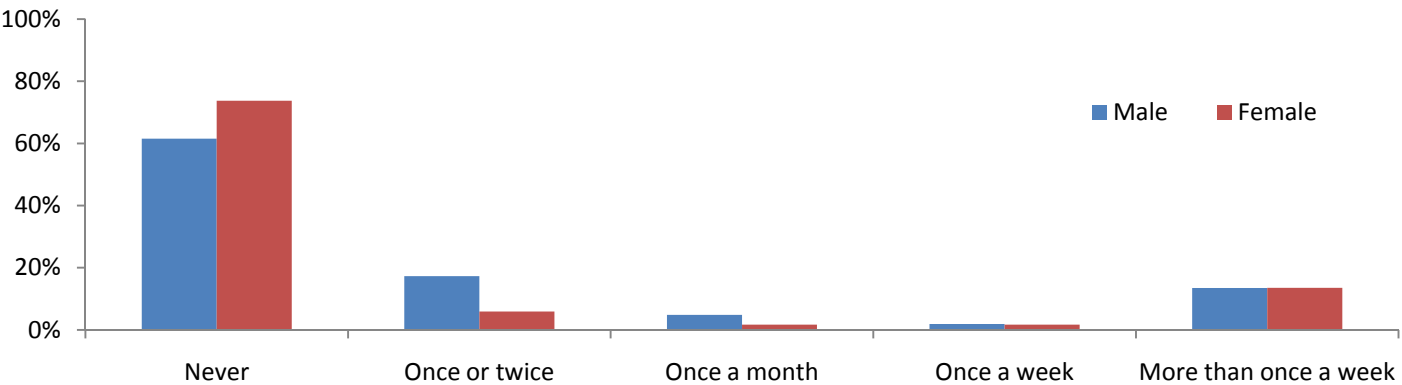
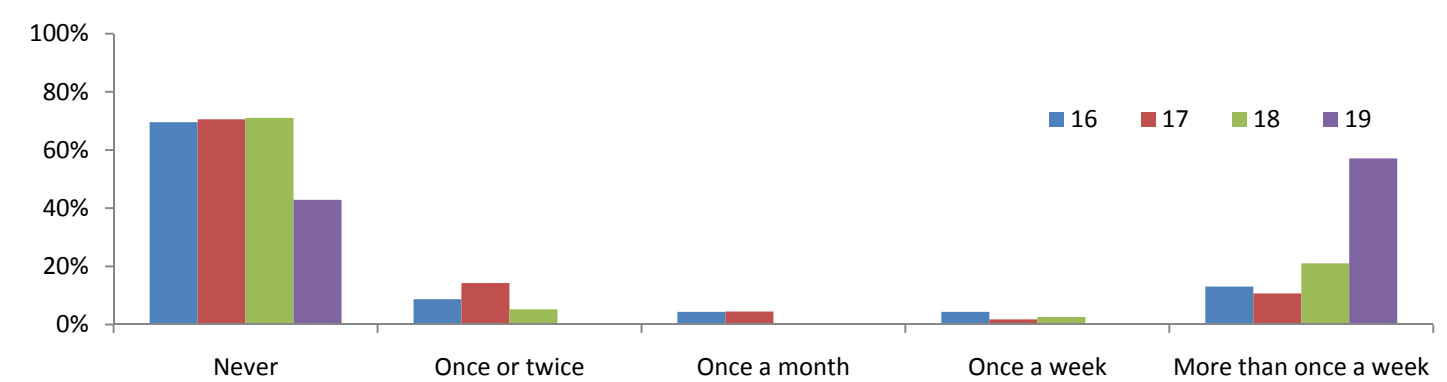


Figure 191. Frequency of having smoked cigarettes in the previous 3 months by age



Smoking is less prevalent than drinking with 61.5% of males and 73.7% of females reporting not smoking during the previous 3 months (figure 190). However, 13% of both males and females are smoking more than once a week including almost 60% of all 19 year olds (figure 191).

Sexual Behaviour amongst young persons surveyed (pilot) at college

Figure 192. Have you ever had sexual intercourse by sex

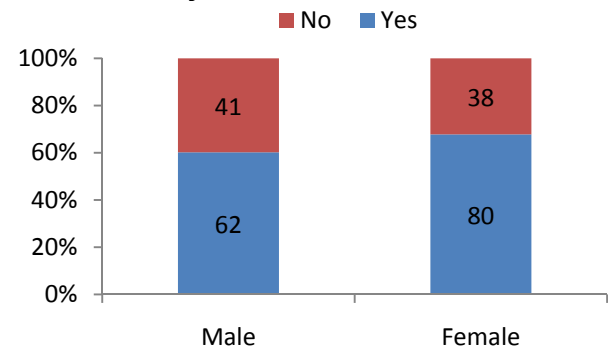
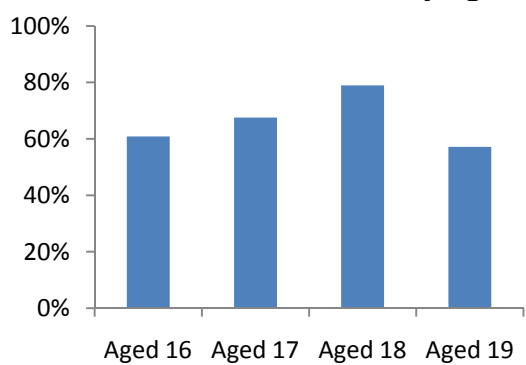


Figure 193. Proportion indicating 'yes' they have had sexual intercourse by age



More males than females reported having had sexual intercourse (figure 192). Over 60% of 16 year olds reported having had sex (figure 193). The majority of those reporting having had sex used protection both the first time and the most recent time with condoms (77% and 57% respectively). Condom use appears to diminish after the first sexual intercourse. Females are more likely to report using the Pill instead of or as well as condoms, at subsequent times (figure 194).

Figure 194. Contraception use among those who have had sex. Use at first sex

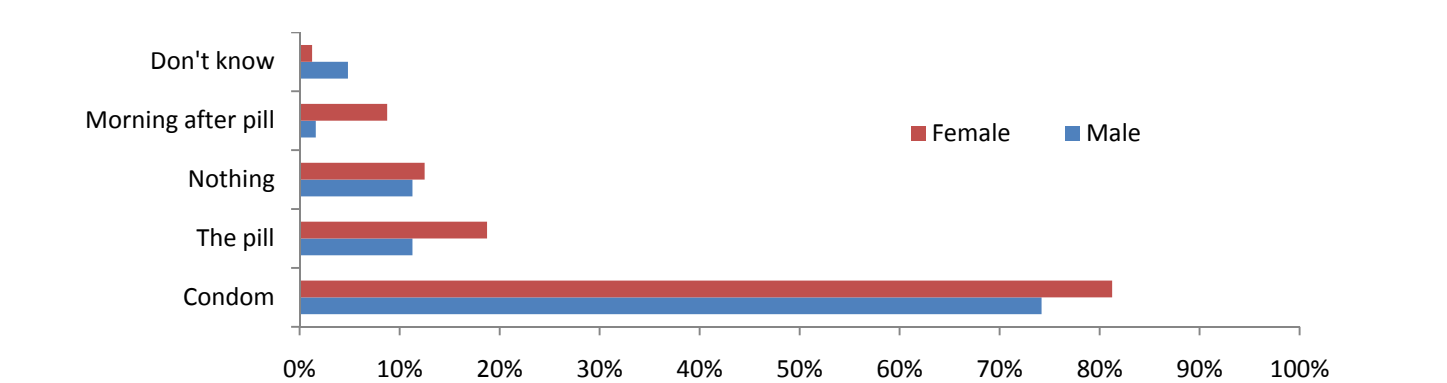


Figure 195. Contraception use among those who have had sex. Use at most recent sex

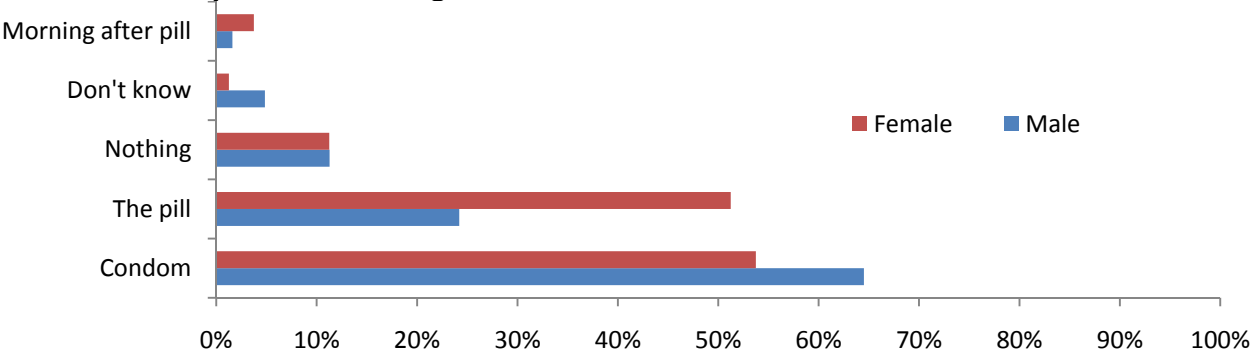


Figure 196. Percentage of respondents reporting using no contraception and their prior alcohol intake – at first sex



Figure 197. Percentage of respondents reporting using no contraception and their prior alcohol intake – at most recent sex

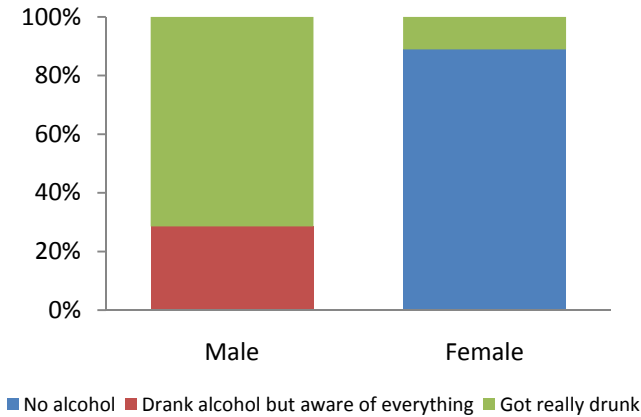


Figure 196 shows that over 50% of both males and females who used no contraception when they had sex the first time had not been drinking any alcohol. At the most recent time all of the males who reported not using any contraception had drunk alcohol prior to the event whereas most females who used nothing had not been drinking any alcohol (figure 197).

Emotional wellbeing and alcohol use

Figure 198. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and frequency of drinking. Males

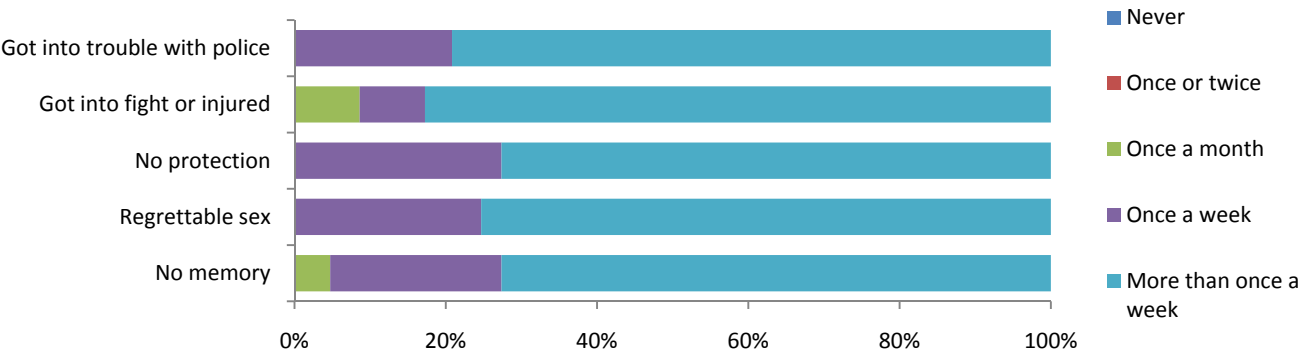
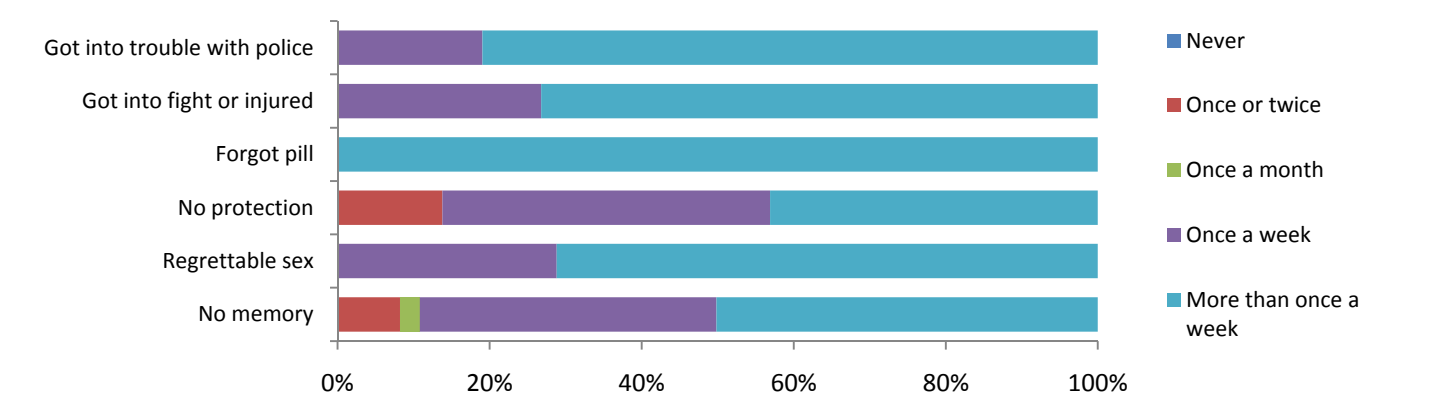
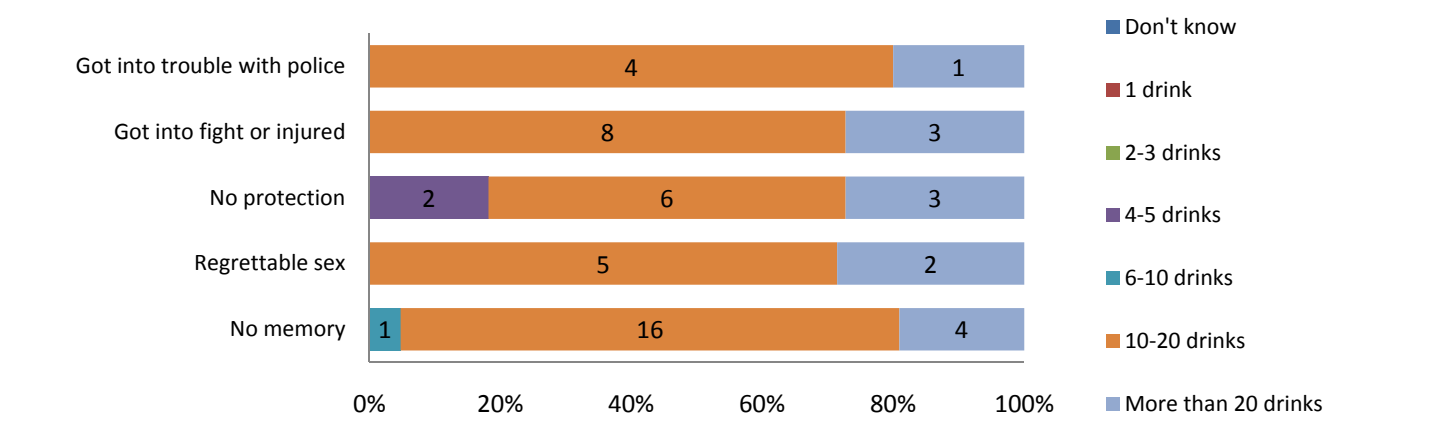


Figure 199. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and frequency of drinking. Females



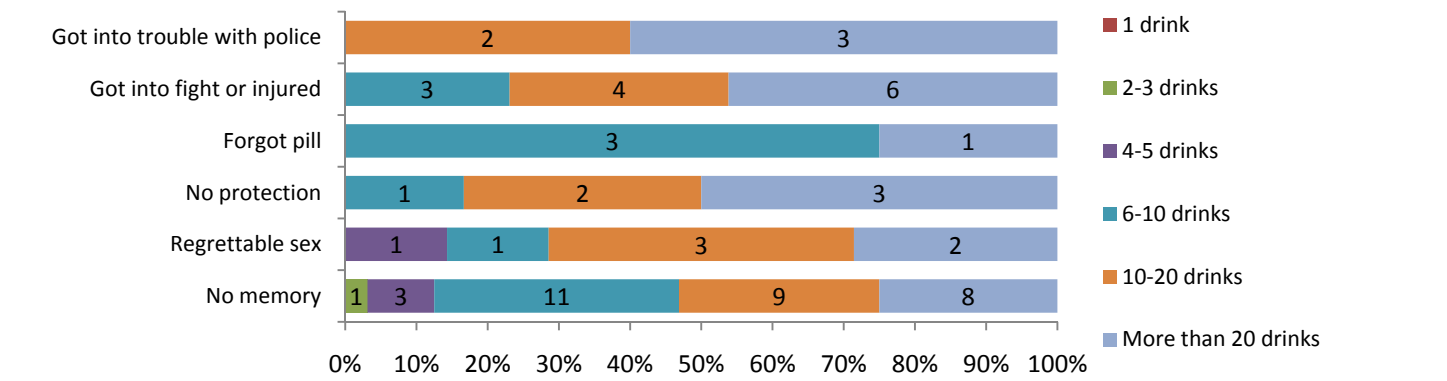
The proportion of individuals indicating they had experienced alcohol related problems, both males and females, are by majority those who drink alcohol more than once a week (figure 198 and 199). Suffering from loss of memory after drinking was the most common problem with 15% of both males and females reporting experiencing this in the previous 3 months. More males (7.7%) than females (2.5%) reported having had unprotected sex due to alcohol. Similar proportions of both genders reported regrettable sex (~5%), getting into a fight or getting injured (~9%) and getting in trouble with the police (~3%).

Figure 200. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and how much they drink in a single usual session. Males.



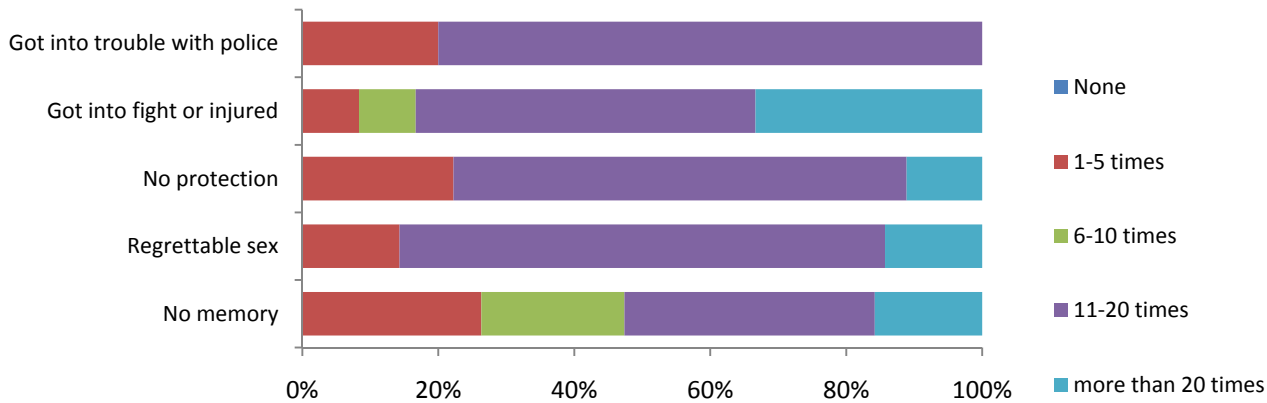
The amount of alcohol consumed on a usual drinking session shows individual experience problems (figures 200, 201), with females drinking more drinks in one session than males. All of the males, apart from 3, who reported these problems in the previous 3 months drink at least 10 drinks during a usual session.

Figure 201. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and how much they drink in a single usual session. Females



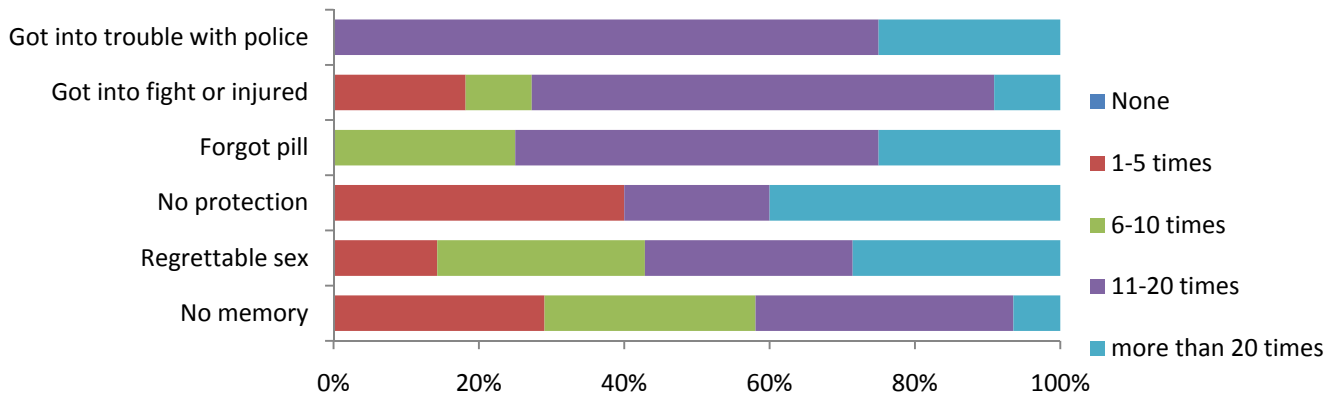
The female data in figure 201 show those females who get into fights and get in trouble with the police are most likely to drink more than 20 drinks in a usual session. The government suggests that the tolerable weekly alcohol allowance for adult men is 21 units and for adult women is 14 units, these young males and females are far exceeding this recommendation and it is causing a large proportion of them problems.

Figure 202. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and how many times they had been drunk. Males



In addition to the high levels of alcohol intake in a usual session the majority of both males and females who had experienced problems are getting drunk regularly. Over 60% of males who reported having had regretted sex in the previous 3 months had been drunk at least 11 times, which is on a near weekly basis (figure 202). This is also true for over 50% of males who had used no protection, 50% of males who got into a fight whilst drinking and 80% of those who had got in trouble with the police. All of the male individuals who had been drunk more than 20 times reported getting into a fight whilst drinking.

Figure 203. Percentage of population who responded ‘yes’ to having had alcohol related problems in the previous 3 months and how many times they had been drunk. Females



In figure 203 nearly 60% of females who had been drunk 11-20 times admitted having problems with memory loss after drinking and 50% admitted to forgetting or being unable to take the pill the day after getting drunk. Of those that got into a fight whilst drinking 50% had been drunk 11-20 times, and the only females to have been in trouble with the police due to drink had been drunk at least 11 times in the previous 3 months.

Frequency of drinking in the previous 3 months and well-being and bullying indicators

Figure 204. Frequency of drinking in the previous 3 months and confidence in yourself. Males

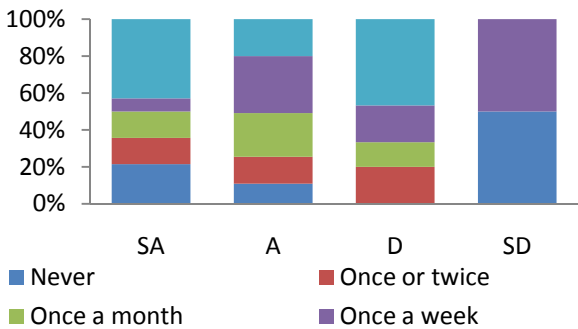
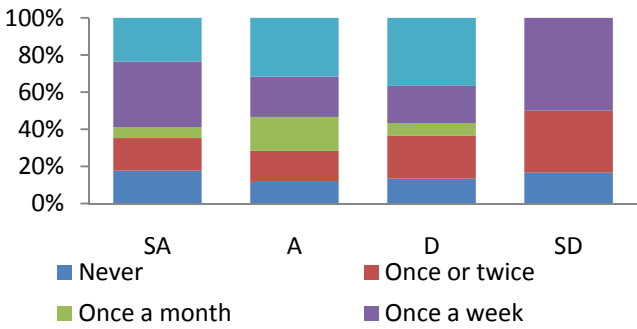


Figure 205. Frequency of drinking in the previous 3 months and confidence in yourself. Females



A positive finding from these results is that the majority of both males and females either strongly agreed (28% and 15% respectively) or agreed (55% and 53% respectively) with the statement ‘I have confidence with myself’. There is no clear relationship with frequency of drinking as 40% of males who strongly agreed and disagreed reported drinking more than once a week (figure 204). However, 50% of both the males and females who strongly disagreed with this statement had been drinking once a week over the previous 3 months (figure 205).

Figure 206. Frequency of drinking in previous 3 months and ability to state views with friends. Males

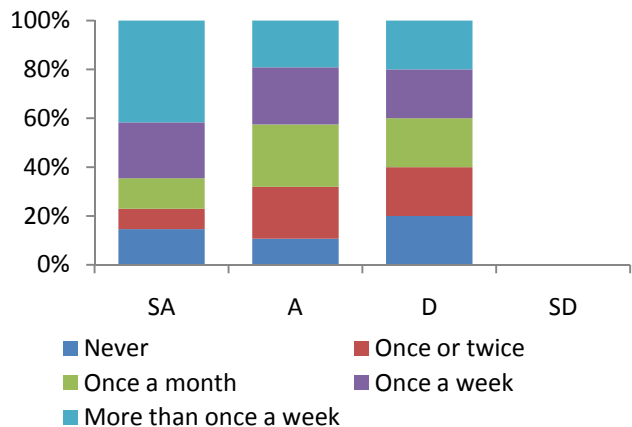
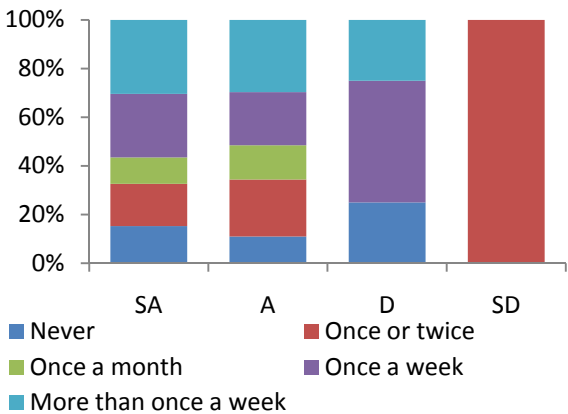


Figure 207. Frequency of drinking in previous 3 months and ability to state views with friends. Females



These graphs show that no males and only one female strongly disagreed with being able to state their own views with their friends (figure 206 and 207). Around 95% of both males and females agreed or strongly agreed with this statement. Of the males that strongly agreed over 40% indicated drinking more than once a week. Of the females that either agreed or strongly agreed around 30% had also been drinking more than once a week over the previous 3 months.

Figure 208. Frequency of drinking in previous 3 months and ability to state views with boy/girlfriend. Males

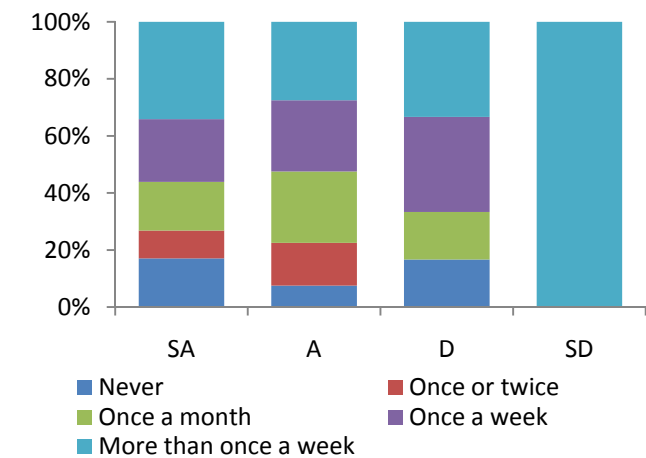
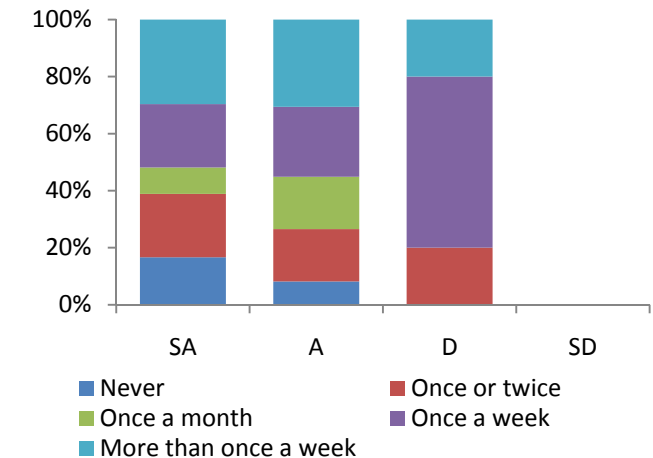


Figure 209. Frequency of drinking in previous 3 months and ability to state views with boy/girlfriend. Females



Figures 208 and 209 show results were also positive with 90% of males and 95% of females either strongly agreeing or agreeing with the statement ‘I can state my own views to my girl/boyfriend’. In relation to drinking 100% of the males that strongly disagreed reported drinking more than once a week, and 60% of females that disagreed reported drinking once a week. The majority of those who agreed or strongly agreed with this statement reported drinking more than once a week (~30% of both males and females), compared to around 15% who strongly agreed and around 8% who agreed and never drank.

Figure 210. Frequency of drinking in previous 3 months and happy home life. Males

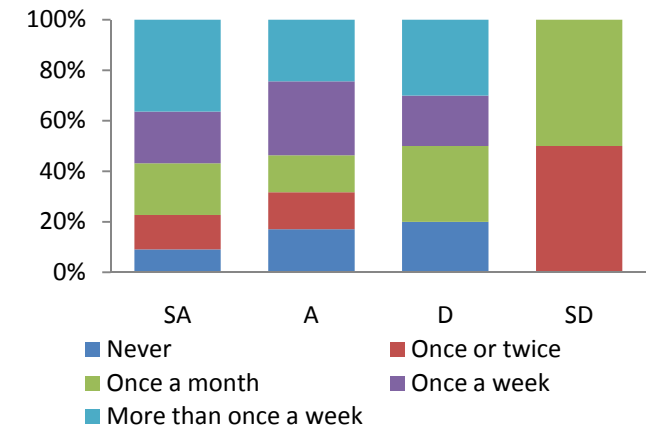


Figure 211. Frequency of drinking in previous 3 months and happy home life. Females

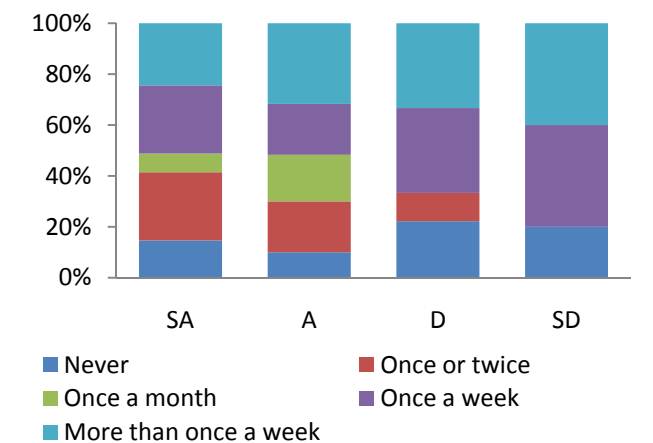


Figure 210 and 211 suggest that the majority of males and females have a happy home life with 87% agreeing or strongly agreeing. There were more male respondents who drink more than once a week (36.4%) and strongly agreed compared to those that had never drunk (9.1%). This pattern was the same for those that agreed and for those that disagreed. For females, of those that strongly agreed around 25% drank once or twice, drinking once a week and drinking more than once a week showed no clear relationship. However, as the graph shows, the proportion of regular drinkers (once a week or more) compared to non-drinkers increases as the response becomes negative.

Figure 212. Frequency of drinking in previous 3 months and ‘hard time saying no to sex’. Males

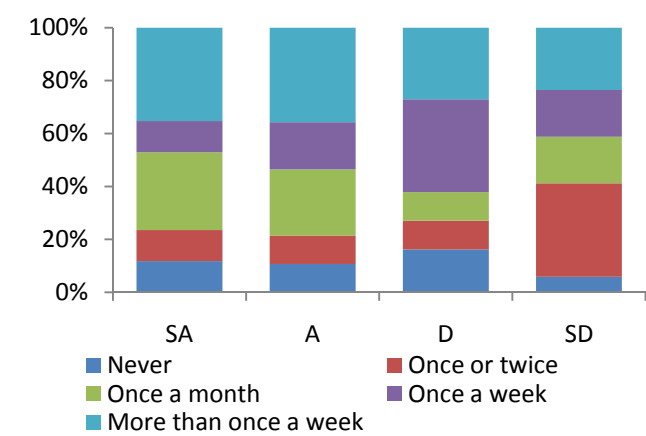
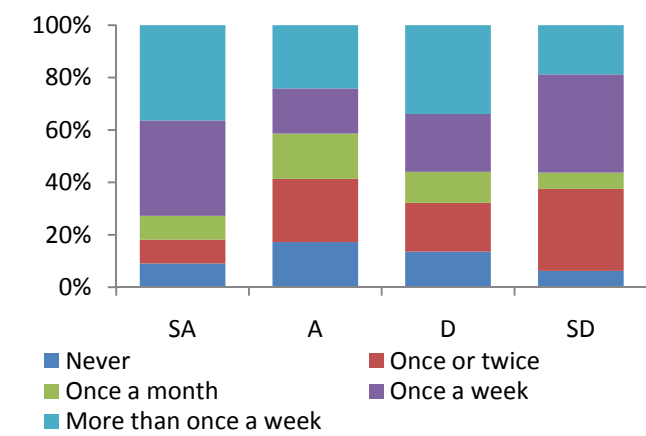


Figure 213. Frequency of drinking in previous 3 months and ‘hard time saying no to sex’. Females



Overall over 50% of males and over 60% of females disagreed or strongly disagreed with the statement ‘I have a hard time saying no to sex (figure 212 and 213). Slightly more males who had never drunk (50%) disagreed compared with those who had drunk more than once a week (33.3%) and vice versa for those who agreed or strongly agreed. However, with females a higher percentage of ‘never’ drinkers (33.3%) agreed compared to only 20% of ‘more than once a week’ drinkers. In addition a high proportion of these female heavy drinkers either disagreed or strongly disagreed than did those who had never drunk.

Figure 214. Frequency of drinking in previous 3 months and ‘a lot to be proud of’. Males

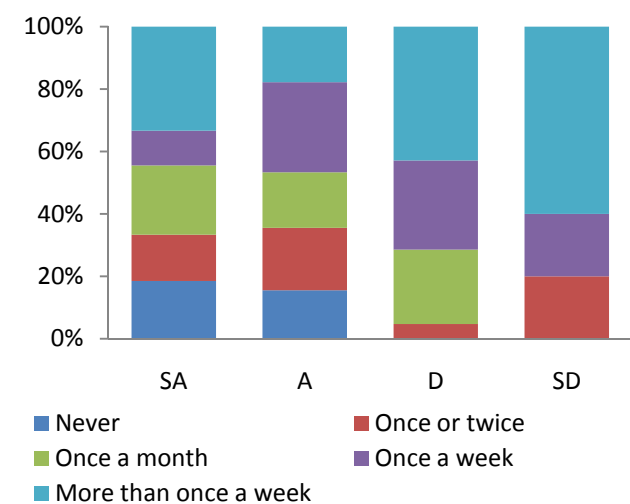
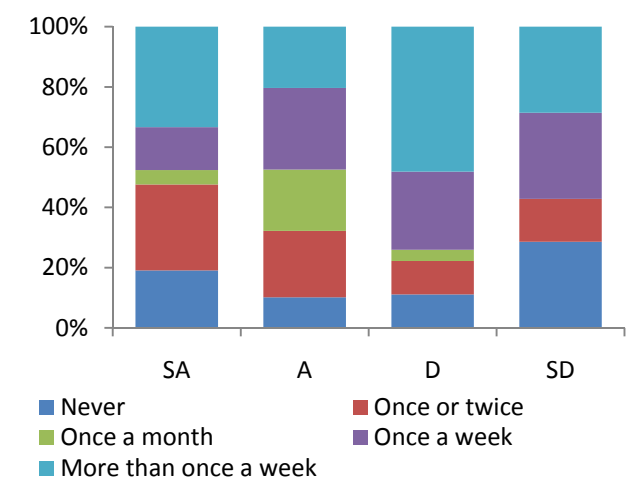


Figure 215. Frequency of drinking in previous 3 months and ‘a lot to be proud of’. Females



The majority of this sample agree or strongly agree that they have a lot to be proud of with around 70% of both males and females indicating this (figure 214 and 215). In relation to drinking the graph to the left shows that a large proportion of males who disagreed (42.9%) or strongly disagreed (60%) with this statement had been drinking more than once a week over the previous 3 months. This is also the case for females who disagreed with nearly 50% drinking more than once a week. However, for both genders who agreed or strongly agreed a higher proportion had been drinking more than once a week than ‘never’ or ‘once or twice’.

Figure 216. Frequency of drinking in previous 3 months in those who had rumours or mean lies spread about them. Males

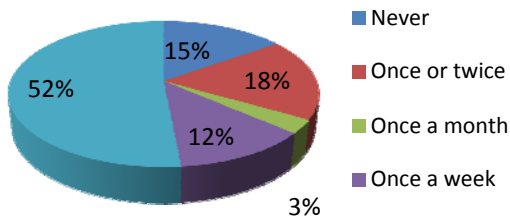
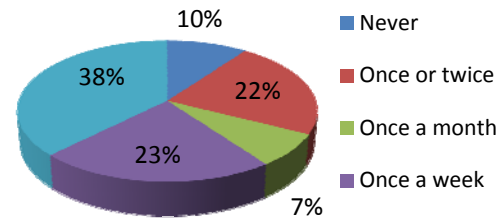


Figure 217. Frequency of drinking in previous 3 months in those who had rumours or mean lies spread about them. Females



Over 60% of both males and females responded 'no' when asked if they experienced rumours or mean lies spread about them in the previous 3 months. This related to drinking frequency with 52% of males and 38% of females responding 'yes' also indicating they had been drinking more than once a week over the previous 3 months (Figures 216 and 217). The results do not give cause and effect but indicate a significant relationship between experience of bullying and drinking behaviour ($p < 0.01$).

Figure 218 Frequency of drinking in previous 3 months in those who had sexual jokes or comments made about them. Males

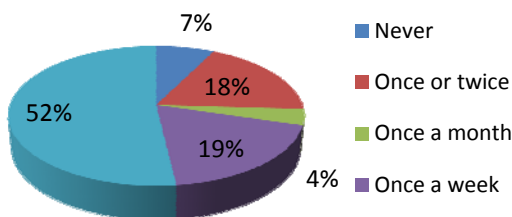
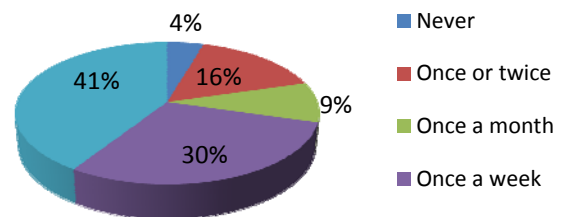


Figure 219. Frequency of drinking in previous 3 months in those who had sexual jokes or comments made about them. Females



A similar significant ($p < 0.05$) relationship was found regarding sexual jokes or comments made in the previous 3 months. Only 7% of male 'never' drinkers and 4% of female 'never' drinkers responded 'yes' (figures 218 and 219) suggesting drinking may be a coping behaviour for the individuals who had experienced bullying.

Box 43 Conclusions from the college pilot study

- Contraception use is high in this sample with only 11% of those who had had sex using nothing at the most recent time and only 3% indicating they did not know.
- There was also no clear relationship between lack of contraception and alcohol use found suggesting that alcohol use does not always precipitate risky sexual behaviour amongst young people.
- Experiencing alcohol related problems was directly related to the frequency of drinking, the amount drunk and the number of times drunk. Nearly 10% of both males and females who drank more than once a week admitted to getting into a fight or being injured, and nearly 5% admitted to getting in trouble with the police.
- The wellbeing indicators showed that the majority of the young people in this sample had good levels of self-confidence and that they have happy home lives.
- The majority of the sample had not experienced bullying in the previous 3 months, however for those who had were by majority heavy drinkers, drinking more than once a week. This suggests that young people may use alcohol as a coping strategy. More knowledge of support services could help those being bullied to find better ways of coping.

5 Glossary of Terms

AIDS – Acquired immunodeficiency virus

BME – Black and minority ethnic

CAMHS – Child and adolescent mental health services

DH – Department of Health

GONW – Government Office North West

GP – General Practitioner/Practice

GUM – Genito-urinary medicine

HIV – Human immunodeficiency virus

LARC – Long acting reversible contraception

LGBT – Lesbian, gay, bisexual, transsexual

LGBU - Lesbian, gay, bisexual, unsure

NEET – Not in education employment or training

NICE – National Institute for Clinical Excellence

PCT – Primary care trust

PHSE – Personal, health and social education

SH – Sexual health

SRE – Sex and relationships education

STI – Sexually transmitted infections

WiSHing - Wirral Sexual Health, Health and Wellbeing Needs Assessment of Young People


YP – Young people

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