C3 COLLABORATING FOR HEALTH

Local third-sector action to improve the chances of a healthy life for 14–24-year-olds in the UK

September 2017

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1. Summary

This report summarises a series of workshops held by C3 Collaborating for Health in 2017, which brought together UK third-sector community-based services that support young people aged 14 to 24. The work was commissioned by the Health Foundation to provide insight and intelligence to their Healthy Lives Directorate about the nature of locally led action to support young people. This will inform subsequent consideration of the action that the Health Foundation can take to improve the life chances of young people, which will focus on wider, more joined-up thinking, including on the social determinants of health. This report will also inform a major workstream within the Health Foundation – the Young People's Inquiry – on the future health prospects of this age group.

The report sets out the health issues confronting young people, the barriers that stand in the way of the third sector and how voluntary organisations tackle these challenges, drawing out insights from those who work closely with this age group. It builds on C3's 2016 review ***Healthy Lives: Children and Young People*** to bring real-world experience to bear on statistics, and a human perspective to the challenges that young people face.

2. 14–24: setting the scene for the rest of our lives

In 2016, there were around 8,726,000 young people aged 14–24 in the UK – a little over 13 per cent of the total population.[1] This period from age 14 to 24 is a crucial time in our lives, as we make the transition from adolescence to adulthood. Life changes – exams, leaving school and leaving home, going to college or university, entering the workforce, having a first child – are 'complex, non-linear and taking longer to complete',[2] and place significant stress on all young people (and this stress is greatly increased among vulnerable groups). Anxiety and depression are increasing, and there has been a deterioration in general mental health among young people.[3]

Habits formed during this period – notably smoking, drinking, alcohol and physical inactivity – are likely to impact long-term health and the development of non-communicable diseases in later life.

The prevention of ill health continues to be side-lined, despite calls to the contrary.[4] And, even within this scenario, our young people are particularly poorly served. There is no overarching wellbeing strategy for children and young people, and their needs are rarely mentioned in Sustainability and Transformation Partnerships (joint planning between the NHS and local councils across England).[5] The pressure of years of austerity on the social determinants of health, on welfare benefits and on the provision of services, have affected young people particularly hard.

Social determinants of health include poverty, money and resources, access to good work, a health-promoting local environment (including housing, and family and friends), education and skills, community, the food environment and transport.[6] These – not access to medical services – are the main drivers of the health and wellbeing of young people.

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[1] Statistics drawn from Office for National Statistics: https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2016/6698fee3.xls

[2] Scottish Government, *The Life Chances of Young People in Scotland: An Evidence Review for the First Minister's Independent Advisory on Poverty and Inequality* (2017): http://www.gov.scot/Resource/0052/00522057.pdf

[3] ONS, *Young People's Wellbeing 2017*: https://www.ons.gov.uk/releases/youngpeopleswellbeing2017

[4] For example, the NHS England *Five Year Forward View*.

[5] Alex Bayliss, 'What policies are needed to improve children's health?' (King's Fund blog, 30 May 2017): https://www.kingsfund.org.uk/publications/articles/big-election-questions-children-health

[6] See, for example, PHE, *Health Profile for England*, chapter 6, 'Social determinants of health' (2017): https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health

'[There is] public and political indifference to the importance of children and young people in society, with national political focus for children being short term, ephemeral, inconsistent and, in the case of some policies, proved untrustworthy' (Professor Sir Al Aynsely-Green)[7]

The workshops reiterated that the period from age 14 to 24 is one of change and transition. All young people face stress – from exams, leaving home, going into further education or the workplace etc., but for vulnerable groups (such as those who have been in care), these are particularly acute – described by one participant as a *'cliff edge'*. They may keenly feel the loss of support at school, and be severed from their friends. According to one workshop participant, the age of 16 – school-leaving age – is one of the key moments when a young person is *most susceptible to becoming involved in gangs* in some areas. And problems that adolescents face do not go away just because they have reached a particular age or are transferred into adult systems. One of the participants commented that *'the hardest thing is letting them go'* when they are too old to continue taking part in initiatives.

'Health is a really important determinant of how well people are doing in other aspects of their lives' (Southwark)

3. Why is the third sector so important?

Publicly funded opportunities for young people to be active, to socialise and have fun in a safe and nurturing environment, such as in schools or colleges, are all under threat as public-sector budgets are tightened. It is the charities and voluntary organisations that work with this age group that are increasingly being expected to plug the gap.

The third sector is a vital resource for the statutory sector – referring cases when individuals are in most need of statutory provision, but also taking referrals into their programmes from GPs, schools and others. The third sector is an integral but independent part of this system.[8]

But focusing only on the links with the statutory sector is to over-formalise the influence of the third sector on health. It was clear from the organisations that attended the workshops that it is their independence that gives them flexibility, approachability, and builds trust with the young people themselves. Many are based in the heart of the communities that they serve, and are in everyday contact with the young people with whom they interact, in an environment that is safe (both physically and socially). Through collaboration and signposting to each others' services, the third sector can work with and guide young people in a more holistic way – and many participants welcomed the opportunity to meet with other local organisations with whom they share concerns, as there are not always the channels to make connections locally.

Finally, although only 11 of the 53 participating organisations include health as a stated aim or vision, all recognised and understand the role that they take in the wellbeing of young people. The third sector is an essential stakeholder – along with the public sector and private sectors – in tackling the social determinants of health that underlie so many of the challenges facing young people.

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[7] 'Building communities with resilient children at their hearts' (Nuffield Trust blog, June 2017): https://www.nuffieldtrust.org.uk/news-item/building-communities-with-resilient-children-at-their-hearts

[8] However, as section 5.4.2 h) notes, there can be misunderstandings between the third sector and the medical profession: '*There isn't enough understanding in the health service, and there isn't enough understanding of what people mean when they talk about taking their services out into the community*.'

4. Workshop process and participation

4.1 Workshop locations

Eight workshops were held to gather insights from around the country, primarily in areas of socioeconomic deprivation, where the challenges facing young people are greatest.The workshops were held in locations across the four countries of the United Kingdom:[9]

- Halifax (16 February)
- Glasgow (28 April)
- Derry (3 May)
- Kent (12 May)
- Cornwall (15 June)
- Southwark (28 June)
- Leicester (30 June)
- Swansea (21 July)

Each location was chosen in part because of C3's pre-existing contacts in each area, but primarily because these locations are known to perform poorly against a range of national averages related to the matrix and therefore are more representative of those who are in the greatest need. (See statistics in the accompanying Excel spreadsheet.) Ethnicity of the local populations varied considerably (table 1), with Southwark (54.1 per cent white; 26.9 per cent black/African Caribbean/black British) and Leicester (50.5 per cent white; 28.3 per cent Indian) the most ethnically diverse. The other six workshop areas have a higher percentage of the population who are white than the UK average (87.2 per cent), with Derry the least diverse (98.3 per cent).

4.2 Identifying workshop participants

A series of key areas affecting 14–24-year-olds were identified: physical health, sexual health, mental health, substance misuse, youth advocacy, young people in care/leaving care, carers, education, employment/training (including NEETs – a young person who is no longer in the education system and who is not working or being trained for work), and youth provision.

A matrix (see Appendix 1) was developed to ensure that all these areas were covered; all were discussed in at least one workshop, and many issues recurred frequently.

Using a purposive sampling methodology, desk research was undertaken to identify the most appropriate participants from each geographical area. C3's network across the UK was used to sense-check the list of organisations and individuals. The success of the workshops depended on ensuring diversity and breadth of services provided, covering the full age range, disability, gender, ethnicity and LGBTQ issues.

In total, 60 people from 53 organisations attended the workshops between February and July 2017 (in addition to C3 and the Health Foundation). It was very clear from the workshops that the staff are hardworking, over-stretched, under-resourced – and care deeply about the work that they do and the young people that they support.

[9] Six of the eight workshops were focused on large urban centres. However, in more rural locations many of the participant organisations have a remit that covers a wider geographical area – hence, the workshops that were held in Faversham and in Truro are more accurately described as Kent and Cornwall respectively.

4.3 Organisations represented

The 53 organisations represented at the workshops are:

Action for Children	Extern Organisation	RAPID
Addaction	First Light	Reaching People
Antonine Youth Group	Hand On Heart Arts	Safer London
Autistic Spectrum Disorder Employment Support	Healthy Minds*	SAY Women
British Red Cross*	Ideas Test	Sheppey Matters*
Calderdale Community Coaching Trust *	KentCAN	St George's Community Trust
Carefree - Fostering Independence Cornwall	Kenward Trust	Step Up to Serve
Cathedral Youth Club	Leicester AIDS Support Services	Swansea Council for Voluntary Service
Chiraagh	Leicester LGBT Centre	Swansea Women's Aid
Choices	Men's Action Network	Switch Youth Café
Daybreak	Mytime Active*	The ALLIANCE Scotland*
Deal Festival	Newport Mind*	The Learning Partnership for Cornwall
Derry Well Women Derry*	North West Counselling	United Against Violence and Abuse
Disability Calderdale	Oasis Church Waterloo	Verbal Arts Centre
Dove House One Stop Shop	OSCA Foundation	White Gold Cornwall
Dreadnought	Pentreath*	WILD Young Parents Project*
Drugaid Cymru	Pink Ladies	Wise Up Arts
	Porchlight*	
	Plantation Productions	

Of these, 11 (indicated by *) have health or wellbeing as a stated aim or vision of the organisation. All, however, understand the impact of their work on young people's wellbeing and welcomed the opportunity to discuss it.

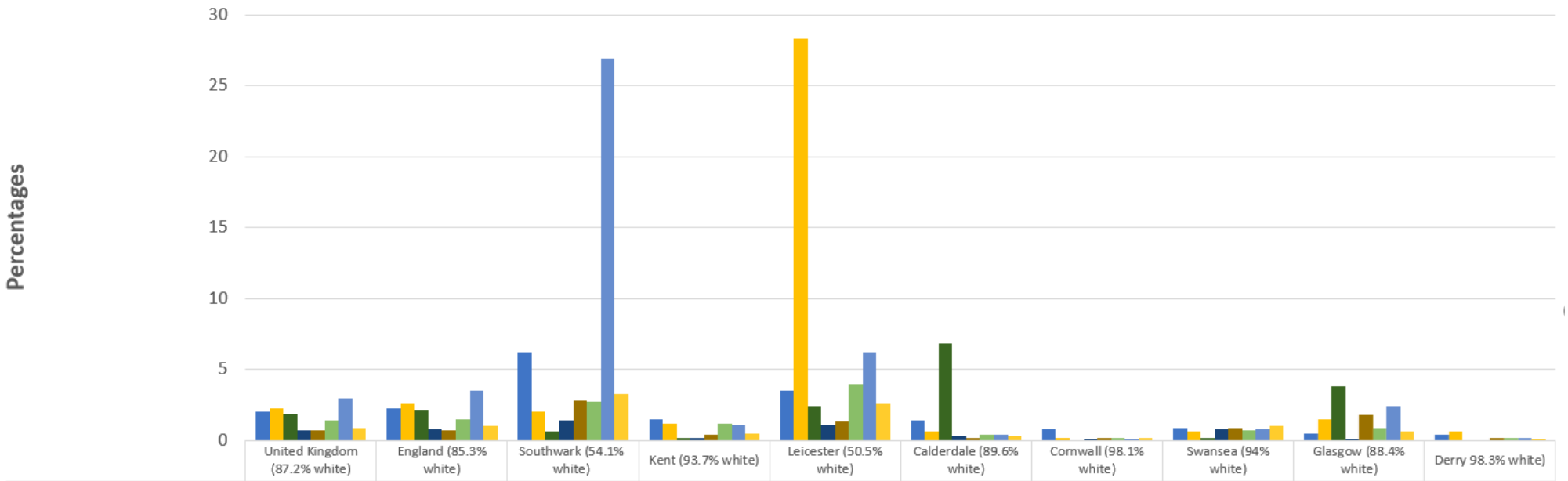
This report has been developed from the workshop discussions, with up-to-date context and statistics from the workshops. A series of telephone interviews were also held with people who had been unable to attend the workshops; insights from these interviews have been incorporated into this report (but are not included in the executive summaries).

Executive summaries of all eight workshops are included in this report in Appendix 2, along with a list of participants and some statistics on the health of young people in each location.[10]

[10] Each workshop was recorded in detail, from which the summaries and this report were drawn up. However, these notes are confidential (as participants are named) and are not included in this report.

Table 1: Ethnicity of the UK population and the eight workshop areas (2011)

Note that the proportion of the population that is white is indicated in the first row, not in the bar chart itself.



	United Kingdom (87.2% white)	England (85.3% white)	Southwark (54.1% white)	Kent (93.7% white)	Leicester (50.5% white)	Calderdale (89.6% white)	Cornwall (98.1% white)	Swansea (94% white)	Glasgow (88.4% white)	Derry 98.3% white)
Multiple Ethnicities	2	2.3	6.2	1.5	3.5	1.4	0.8	0.9	0.5	0.4
Indian	2.3	2.6	2	1.2	28.3	0.6	0.2	0.6	1.5	0.6
Pakistani	1.9	2.1	0.6	0.2	2.4	6.8	0	0.2	3.8	0
Bangladeshi	0.7	0.8	1.4	0.2	1.1	0.3	0.1	0.8	0.1	0
Chinese	0.7	0.7	2.8	0.4	1.3	0.2	0.2	0.9	1.8	0.2
Other Asian	1.4	1.5	2.7	1.2	4	0.4	0.2	0.7	0.9	0.2
Black/African Caribbean/ Black British	3	3.5	26.9	1.1	6.2	0.4	0.1	0.8	2.4	0.2
Other Ethnic Groups	0.9	1	3.3	0.5	2.6	0.3	0.2	1	0.6	0.1

Note: Halifax is a town within the Metropolitan Borough of Calderdale, for which information is available.

5. Workshop findings

Section 5 sets out the detailed findings of the workshop. Section 5.2 sets out the major health concerns facing 14–24-year-olds, drawing on data from wider studies to provide context for the comments made in the workshops. Subsequent sections focus on the comments made by participants: sections 5.3, 5.4 and 5.5 looks in detail at the drivers, challenges and solutions in young people's health (with minimal information drawn from other sources – all of which is referenced in footnotes). Comments from workshop participants are in *'italics'*, but individuals and their organisations are not generally identified in this report.[11] Some of the third-sector success stories recounted during the workshops are presented here throughout the text as small case studies.

5.1 Expectations

Some participants came with '*no particular expectations'*, but others were looking forward to the opportunity to learn from one another, to seek out ways to work together, to share success stories, and to make better use of scarce human and financial resources:

'I need to understand how organisations can work better together' (Halifax)

5.2 Health concerns of 14–24-year-olds

The morning discussion at each workshop focused on the work being done by each of the third-sector organisations, covering a wide range of issues specific to the concerns of each participant. However, in the afternoon session of the workshops the participants were asked two more general questions:

- What do you see as being the longer-term health concerns for young people?
- What are the challenges facing young people as you see them here, right now, and facing your organisation?

The top five responses were:

- technology and social media (cited 22 times across all workshops);
- mental health (cited 21 times);
- obesity (cited 17 times);
- body-image issues (cited 16 times); and
- lack of cooking and budgeting skills (cited 15 times).

Section 5.2 provides statistics and context for the core concerns (and others raised during the discussion), drawing on national evidence.

5.2.1 Mental health

Young people are a core target for the government's commitment to improving mental health.[12] A national ONS prevalence survey has not been carried out since 2004 but statistics indicate that the mental wellbeing of this group is declining, with young women's wellbeing significantly lower than that of young men,[13] and a YouGov survey of students suggests that more than a quarter have a mental-health problem.[14] The

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[11] This information is drawn from discussion at the workshops, sometimes supplemented with information from the organisations' websites. Full write-ups of each of the workshops have been provided to the Health Foundation separately and in strict confidence. Participants from each workshop also received a full transcript of their own workshop's write-up. It should be noted that the workshop write-ups reflect the concerns of the workshop participants and their local areas, so may not be reflective of young people as a whole.

[12] https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support

[13] The Warwick-Edinburgh Mental Wellbeing Scale; data from ONS, *Young People's Wellbeing 2017.*

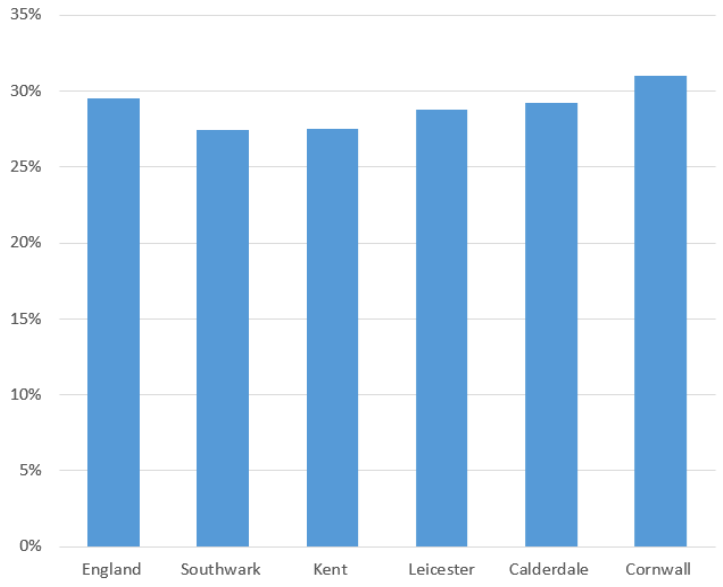
[14] YouGov (2016): https://yougov.co.uk/news/2016/08/09/quarter-britains-students-are-afflicted-mental-hea/

majority of mental-health issues begin to manifest themselves in teenage years, with 50 per cent of mental-health problems established by age 14 and 75 per cent by age 24[15] – so there is a need to understand and react to the triggers.

The drivers of mental-health issues among young people, which were discussed at the workshops, include unemployment, the stress of exams (during which there is a spike in mental health referrals) and poverty. Self-harm, which is on the increase (measured by A&E attendances),[16] has a knock-on effect on educational attainment and is linked with other risky behaviour such as drug use. For young transgender people, the situation is even more serious – nearly half have tried to take their own life.[17]

As table 2 shows, of the areas represented at the workshops it is only in Cornwall that young people (aged 15) report their general health as 'excellent' to a greater extent than the national average: in all other areas, young people see their health as less good than average.[18]

Table 2: 15-year-olds who report their general health as 'excellent'



5.2.2 Self-esteem

Low self-esteem is strongly related to depression, which is on the rise among young people. ChildLine figures suggest that half of all calls to its helpline are related to self-esteem and unhappiness, with a 19 per cent increase in 2015–16 alone, replacing family relationships as the top concern).[19] This needs to be caught and addressed before it escalates. The workshop participants talked about how self-esteem is bound up with cynicism and '*poverty of aspiration'* among the young people that they represent. These young people *'accept their lot'*, do not get involved in social action or politics, and resign themselves to the life that they can see – and no one at the workshops mentioned the (much-heralded in the media) engagement of young people with politics and Jeremy Corbyn. When all the statistics that young people

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[15] Mental Health Foundation: https://www.mentalhealth.org.uk/statistics/mental-health-statistics-children-and-young-people

[16] 'NHS figures show "shocking" rise in self-harm among young', *The Guardian*, 23 October 2016: https://www.theguardian.com/society/2016/oct/23/nhs-figures-show-shocking-rise-self-harm-young-people

[17] Stonewall: http://www.stonewall.org.uk/media/lgbt-facts-and-figures

[18] Public Health England, Young people: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000007/ati/102/are/E09000028/iid/92624/age/249/sex/4/nn/nn-3-E09000028

[19] Childline *Annual Review 2015–16*: https://www.nspcc.org.uk/services-and-resources/research-and-resources/2016/childline-annual-review-2015-16-turned-out-someone-did-care/

hear about their area are negative, they begin to define themselves by those statistics, and resign themselves to it. This lack of confidence means that many do not take opportunities even if they arise, thinking that this is not for them. This is reflected in recent statistics that suggest that there is 'deep social pessimism' among young people, with over half of 18–24-year-olds believing that your position in society is largely determined by who your parents are.[20]

Low self-esteem is also strongly bound up with social media use (below).

5.2.3 Social media and social isolation

A report on social media and children's mental health has estimated that 37.3 per cent of 15-year-olds are 'extreme' users of the internet (more than six hours outside school), significantly higher than the OECD average. 99 per cent of 16-24-year-olds use social networks at least weekly; on average for almost 2.5 hours a day (compared with 1.25 hours for adults). 12 per cent of children who do not use social media have mental-health symptoms; among those use it for three hours or more a day, this rises to 27 per cent.[21]

Participants at the workshops confirmed this impact on mental health. Bullying has made its way into homes through smartphones, and girls and young women are being set unrealistic standards for body image (and some boys are also *'bulking up'*). The '*pursuit of perfection'* is driving low self-esteem.

Overuse of social media can also drive social isolation, which itself has significant impacts on health (including lower education outcomes and higher likelihood of smoking and obesity).[22] This age group *'create an isolated world for themselves'*, which can escalate small mental-health issues into more serious ones.

Participants at the workshops reported that young people in rural areas are particularly likely to be socially isolated, due to the distances to travel and lack of public transport, restricting ability to see friends or take part in sporting activities.

5.2.4 Risky behaviour

Risky behaviour is often driven by wider social and environmental factors, including the ready availability of cheap fast food, lack of opportunity to be physically active, and particularly poverty, *'which increases the likelihood of having a poor diet and engaging in risky behaviours such as drug-taking and smoking, often as a means of escape'*. Some forms of unhealthy risky behaviour have fallen among young people (section 5.2.6 below), but there are still high-risk groups. There are biological factors that contribute to risky behaviour among adolescents, who are more susceptible to excitatory stimuli than children or older adults – and for many young people the risky behaviour is stimulated by boredom. Multiple risky behaviours are also more common in adolescents from deprived backgrounds.[23]

One participant noted that there are forms of risk-taking that can be positive – e.g. rock-climbing. These accommodate young people's desire for excitement – but there may not be any safe available opportunities.

a) Substance abuse and alcohol

Many of the participants work with young people who are involved in risky behaviour including abuse of a range of substances including legal highs, qat, prescription medications, solvents, cannabis and (mentioned by just one participant) heroin.

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[20] Social Mobility Commission, *Social Mobility Barometer* (June 2017): http://www.edf.org.uk/social-mobility-commission-social-mobility-barometer-2017/

[21] E. Frith, *Social Media and Children's Mental Health: A Review of the Evidence* (2017): https://epi.org.uk/report/social-media-and-childrens-mental-health-a-review-of-the-evidence/

[22] ONS, *Young People's Wellbeing: 2017*.

[23] R.R. Kipping et al., 'Multiple risk behaviour in adolescence and socio-economic status: findings from a UK birth cohort' (2015) *European Journal of Public Health* 25(1): 44–49: https://doi.org/10.1093/eurpub/cku078

Background information: Hospital admissions for substance misuse by 15–24-year-olds are 89 per 100,000 a year in England. Southwark (65) and Leicester (49) are much lower, and Calderdale (128) and Kent (96.9) are significantly higher. In Swansea, where age-specific data is not available, hospital admissions due to illicit drugs for all ages are 236 per 100,000 – higher than the Welsh average of 206.

Several noted that the younger age group are not able readily to buy alcohol (which can be *'cheaper than water'*), but that drugs are easily available online – and also that most users do not understand the risks: *'often they don't know what drugs they are taking'*. The Glasgow participants also noted that many young people have become addicted to drugs that have been prescribed by GPs, either to them or to a family member:

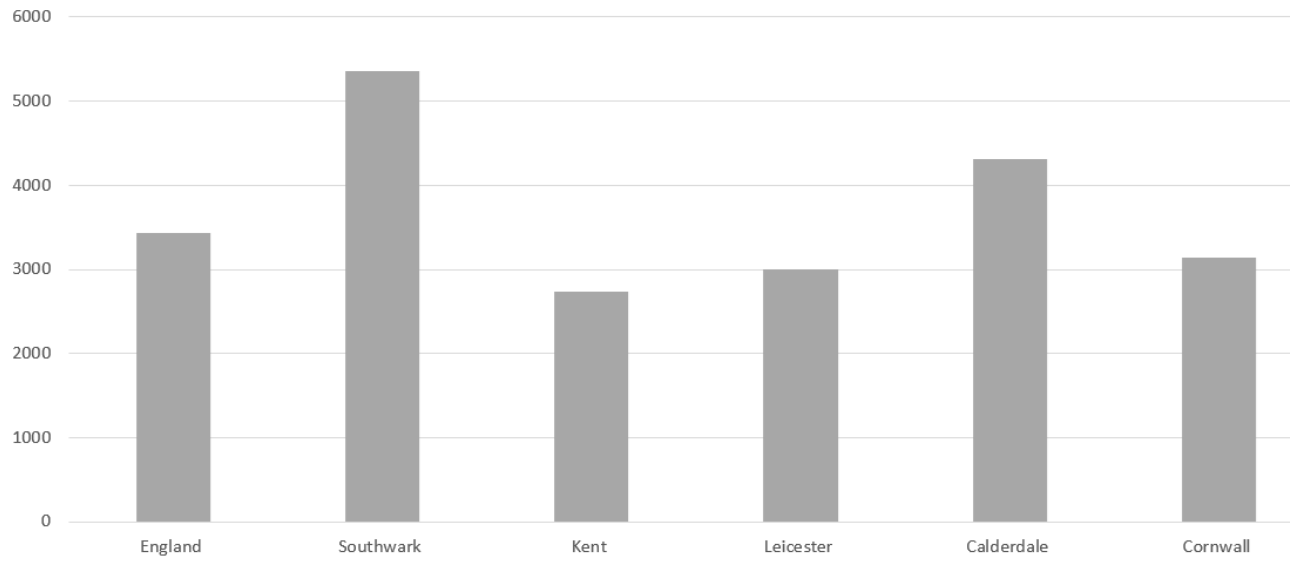
'*There is a tendency to give drugs to people just to keep them quiet'* (Glasgow)

b) Risky sexual behaviour

Substance abuse and risky sexual behaviour may also be the result of trauma (for example, among victims of childhood sexual exploitation or other forms of abuse). Sexually transmitted diseases (including chlamydia, syphilis and HIV) are higher in young people than in any other group,[24] but they are also the least likely group to access sexual-health services, because those services are not located where young people live, or because of concerns about privacy, or because of a lack of awareness of the risk.

Background information: Statistics are available on the number of new diagnoses of STIs among 15–24-year-olds in the five English sites – the highest is in Southwark (5,363) and Calderdale (4,305); the lowest, Kent (2,735), is 20 per cent below the England average of 3,432 (table 3).[25] (This statistic is not available at local-authority level in the other countries of the UK.)

Table 3: New sexually transmitted infections among 15–24-year-olds (2013), per 100,000



c) Food and physical activity

Only 52.4 per cent of all 15-year-olds in England eat the recommended five portions or more of fruit and vegetables daily (see table 4), and it was clear from the workshops that many young people (and their

[24] FPA factsheet on sexually transmitted infections: http://www.fpa.org.uk/factsheets/sexually-transmitted-infections

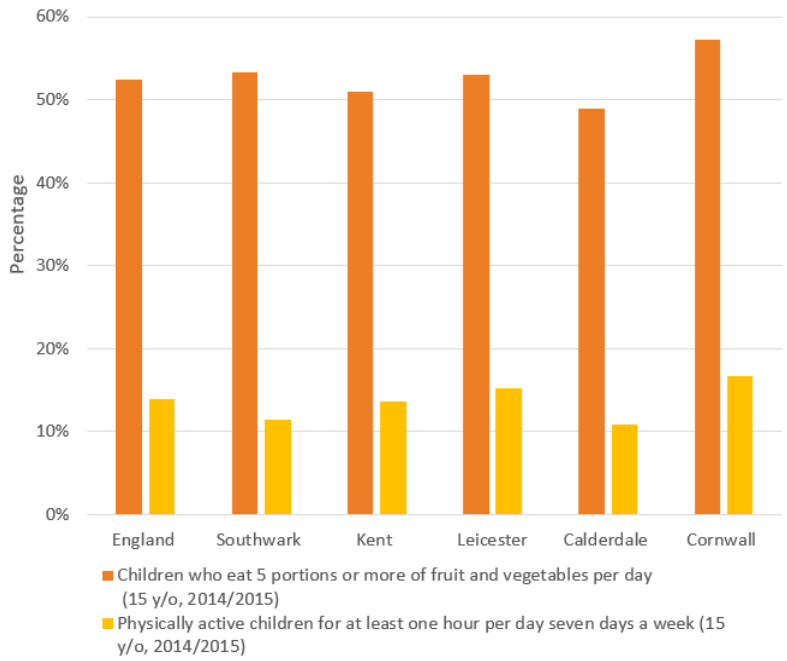
[25] Public Health England, 'Young people's profile – Local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

parents) do not know how to cook. Among families where one parent is under 20 in Cornwall, '*levels of poor nutrition are unimaginable'* – half of young families with whom one organisation works are using food banks, and the young mothers are often either underweight or obese.

There are not enough opportunities for play or for young people to meet – in some communities, such as Brixton, invisible barriers are in place between neighbourhoods, which young people will not cross to access parks or sports facilities. In some communities, church or family activities are prioritised over participation in sport. And the rise of social media and screen-based activities can keep young people indoors (particularly if they are being bullied).

> *Background information*: As table 4 shows, Calderdale has the lowest proportion of this age group meeting the recommendation (48.9 per cent) and Cornwall the highest (57.3 per cent). Even more concerningly, only 13.9 per cent of 15-year-olds meet the recommendation of an hour of physical activity on every day of the week – and again, Cornwall fares the best (16.7 per cent) and Calderdale the worst (10.9 per cent).[26] (These statistics are not available at local-authority level in the other countries of the UK.)

Table 4: 'Five a day' and physical activity among 15-year-olds



Participants at the workshops recognised that obesity is a serious long-term health issue – adult obesity in England has increased from 15 per cent in 1993 to 27 per cent in 2015, and one in three children in year 6 (the age group for which there are statistics) is overweight or obese. There is also a clear socioeconomic gradient in obesity: 26 per cent of year 6 children living in the most deprived areas were obese compared to 12% of those living in the least deprived areas.[27] However, few of the organisations at the workshops

[26] Sourced from Public Health England: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000007/ati/102/are/E09000028/iid/92624/age/249/sex/4/nn/nn-3-E09000028

[27] ONS, 'Statistics on obesity, physical activity and diet: England 2017' (2017; slide set): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/613532/obes-phys-acti-diet-eng-2017-rep.pdf

(other than a specifically weight-management organisation) are actively addressing it, although there were some success stories around encouraging healthy eating.

Success story: Mytime Active

The programme's success comes from its emphasis on behaviour change – such as building independence and skills – rather than on weight loss.

Having champions is key to engaging with young people in schools; if someone whom the kids respect is banging the drum for them, that can make all the difference. Engagement is better if sessions are incorporated within the school curriculum.

5.2.5 Coping mechanisms

Young people who have significant challenges in their lives may use unhealthy coping mechanisms to build their resilience, such as smoking. The ways in which third sector organisations deal with such behaviours will differ depending on the focus of their work and the nature of their service users. For example, one participant at the Leicester workshop explained that her priority for young transgender people is to create a space in which they feel accepted for who they are, and are allowed to express themselves in whatever way they wish (within the law, of course) – and if this includes smoking then so be it. In this case, allowing young people to continue to smoke so that they feel trusted and comfortable, and can build respect, will lead to more honest and open discussions and, ultimately, better outcomes.[28] On the other hand, some youth groups have banned smoking on their premises and will use this ban to create some often needed constraints for young people who may be lacking boundaries in other parts of their lives. One participant described their ban on smoking as being a way of showing their young people that they care about them.

5.2.6 Inequalities

There are some positive trends in the health of young people in the UK, with a decline in drinking, drug use, smoking, youth crime, suicide and teenage pregnancy.[29] However, the headline statistics mask significant inequalities:

- Smoking remains significantly more prevalent among people on lower incomes.[30]
- Young people are drinking less, although binge drinking, particularly among young women, is a concern[31] – and alcohol is particularly harmful to lower socioeconomic groups.[32]
- As noted by many participants in the workshops, *'it may be easier to buy drugs than alcohol'*, so some young people are substituting one harmful substance for another that is more harmful, unaware of the consequences:

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[28] The peer-reviewed evidence queries how much benefit smoking will actually be as a coping mechanism among this group, however: M. Rosario et al., 'Cigarette smoking as a coping strategy: negative implications for subsequent psychological distress among lesbian, gay, and bisexual youths' (2011) *J Pediatr Psychol* 36(7): 731–42: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146751/ (doi: 10.1093/jpepsy/jsp141)

[29] Cabinet Office, *Risk Behaviours and Negative Outcomes* (2014): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/452169/data_pack_risk_behaviours_and_negative_outcomes.pdf

[30] Action on Smoking and Health, *ASH Briefing on Health Inequalities and Smoking* (2016): http://ash.org.uk/information-and-resources/briefings/ash-briefing-health-inequalities-and-smoking/

[31] ONS, *Adult Drinking Habits in Great Britain: 2005 to 2016* (2016): https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2005to2016

[32] Alcohol Research UK, 'Understanding the alcohol harm paradox' (2015): http://alcoholresearchuk.org/alcohol-insights/understanding-the-alcohol-harm-paradox-2/

'The biggest drug dealer in the country – unknowingly – is the post man. Drugs are being delivered by the crown!' (Kent)

- While the number of young people in the UK not in education, employment or training (NEETs) has been steadily declining since 2012 (to 790,000 16–24-year-olds in June 2017, down 56,000 from the year before, a total of 11.1% of the age group[33]), the number who spent more than 12 months as a NEET between 2015 and 2016 increased 12 per cent – suggesting a rise in long-term unemployment among this age group.[34]
- At the Swansea workshop, it was noted by one participant that although teenage pregnancy had been falling until 2015, they have recently seen it rising again.

Young people '*live in the here and now'* and exhibit a '*massive lack of interest'* in healthy lifestyles. It is a real challenge to encourage this age group to engage with their own futures, when risky behaviour is so much more tempting than healthy behaviour. However, only 56 per cent of young people are mostly or completely satisfied with their health.[35]

5.3 Drivers of ill health

A consistent assertion throughout the workshops was that ill health among young people is driven by dysfunction in wider society: it is not the young people themselves who are to blame for poor lifestyle choices; instead, these choices are contingent on much deeper problems. There have been rapid, partly austerity-driven changes to determinants of ill health – such as family support, public health, housing, education, the job market and sports provision – as well as to public health and mental health provision, and the local environment in the areas in which the workshops were held is often in need of regeneration: *'There are no sectors unaffected by cuts*.' These issues cannot be solved by individuals in isolation, or even by the third sector, although the voluntary sector plays an important role; tackling the 'causes of the causes'[36] (social and environmental determinants) in a joined-up way also requires central government participation and support. This is the context within which the young people are living and the third sector organisations are operating.

'Funders need to understand that it is not about fixing young people; it is about fixing the broken system around them' (Southwark)

5.3.1 Poverty and inequality

Several examples were given at the workshops of the impact of poverty and inequality on ill health – in one deprived area of Halifax (with a predominantly Asian population), *life expectancy is 11 years below more affluent neighbourhoods*. There are impacts on education (which can lead to worklessness), and lack of financial skills exacerbates poverty and can have serious mental health implications. Eating fresh food (particularly your five-a-day) may be unachievable on a low income, when combined with a lack of knowledge of cookery and none of even the most basic kitchen utensils – in one programme, 42 out of 49 young families had never cooked a meal from scratch. If young people do not have access to a mobile phone or to a computer, it is much harder to access benefits and to identify local opportunities. And poverty correlates with other health issues: as already noted, clustering of risky behaviours is more common in adolescents from deprived backgrounds, and there are issues around adverse childhood events, including child sexual exploitation.

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[33] ONS Statistical Bulletin, August 2017: https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/youngpeoplenotineducationemploymentortrainingneet/august2017

[34] Impetus, *Youth Jobs Index 2017*: http://www.impetus-pef.org.uk/policy-initiatives/youth-jobs-index/

[35] ONS, *Young People's Wellbeing: 2017*, p. 4.

[36] A phrase coined by Geoffrey Rose and now used by Sir Michael Marmot, among others: e.g. Sir Michael Marmot, 'Social determinants of health inequalities' (2005) *The Lancet* 365(9464): 1099–104: https://linkinghub.elsevier.com/retrieve/pii/S0140-6736(05)71146-6

5.3.2 Education

One of the challenges highlighted by the workshops is that the education system does not prepare young people for the real world (such as vocational training, life skills and relationship skills including dealing with social media) – it is about how to pass exams, when what is needed is '*a curriculum for life'*. Health literacy is often low.

5.3.3 Homelessness and living conditions

Poor living conditions or homelessness can exacerbate young people's feelings of hopelessness, leading them to '*give up'*. Changes and cuts to benefits, particularly for this age group, have increased the need for help in navigating the system, but this is often not available. One participant noted that many young women are couch surfing when they are pregnant and the state has no obligation to provide housing until the foetus becomes '*viable'*.

5.3.4 Unemployment

For many young people in areas of high, long-term unemployment, there is a '*culture of non-work*', with '*intergenerational unemployment'*. This is exacerbated as job centres have been closing, making it harder to find opportunities. Unemployment (or poor working conditions or job insecurity) can have a serious impact on mental health.

Unemployment is a particular issue for young people with learning difficulties:

> '*The barriers to employment are really high for people with autism. They try so hard and will get lots of experience, but still can't get a foot in the door'* (Swansea)

Young people with autism are difficult to engage, but being in work can be very good for their mental health.

> *Background information*: In all but two of the workshop areas (Calderdale and Cornwall), unemployment was higher than the UK average (4.7 per cent), peaking in Southward (6.6 per cent) and in Leicester (5.6 per cent).[37] The proportion of young people aged 16–18 not in education, employment or training is low in Southwark (2.2 per cent) but much higher in Glasgow (8.1 per cent) and Leicester (6.3 per cent).[38]

5.3.5 Culture and ethnicity

Ethnicity can be a barrier to accessing health care – all programmes need to ensure that a '*white, Eurocentric model*' is not automatically and inappropriately applied to all communities. Ethnic minority communities or refugees may face significant language barriers and have complex needs often related to torture.

Some of the workshops noted specific cultural issues, for example:

- In Glasgow, asylum seekers are not given interpreters when visiting health professionals and instead rely on relatives to speak on their behalf, whose spoken English may also be quite bad. Interpreting complex mental-health needs around the trauma of torture, as well as physical health needs, requires great skill, but this is insufficiently recognised and the resources do not exist to make the necessary changes.

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[37] ONS (nomis) – official labour market statistics: https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx

[38] Department for Education, (2016): NEET data by local authority https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

- In Derry, there has been a breakdown in traditional church and structures. In the aftermath of the Troubles, social cohesion has *'collapsed'*, and there are now many fewer opportunities and activities for young people.
- In Glasgow, there is a particularly strong culture of *'don't be a grass'* – which is a barrier to young people, or others on their behalf, seeking help, for example, when they have been abused.

(See table 1, above, for ethnicity of the different workshop areas.)

5.3.6 Local environment

The food and physical activity environments can be very unconducive to healthy living. There is often a lack of space for young people (including those with young families) to meet and play safely, a preponderance of fast-food outlets, and little access to fresh food.

5.4 Challenges

5.4.1 Challenges of this age group

a) Communication with young people

Finding the right way, place and time ('*kids can be very nocturnal*!') to engage and talk to young people is essential – and is a challenge for the statutory and third sectors alike (one participant noted that CAMHS comes across as too formal and intimidating for some of the most vulnerable young people). If young people cannot talk with professionals in a way that they understand and to which they can relate, this can increase feelings of isolation. Messages need to be tailored to this age group – and within it, as a 14-year-old might be at a very different stage from a young adult. Conversely, some vulnerable young adults may be at the same developmental age as an average 14-year-old.

The mechanisms for communicating with young people have dramatically changed – and '*adults are still playing catch-up'* with social media, and are letting young people down with their lack of competence on up-to-date platforms. Some organisations encourage staff to use Facebook to contact the young people with whom they work; others see the use of social media as '*unprofessional'*. For young autistic people, online communication will not be effective. Other organisations use the phone to stay in touch or to provide advice – but this has the downside that the calls need writing up after the event.

It is also important to find ways to change behaviour that are not prescriptive – for example, one organisation presented the facts on smoking and allowing the young people to come to their own decisions. Young people want to make decisions for themselves.

Success story: Community Health and Learning Foundation (CHLF), Leicester

CHLF is getting young people engaged by involving them in their own choices, not just telling them what to do. CHLF's session on smoking, instead of just listing all the negative health impacts of smoking (which the young people know but don't care about – 'Yes, we know we can get cancer, but we enjoy it!'), encouraged them to look at cost – specifically, what it would have cost their parents to smoke over 15 years. It made the young people realise that their parents could have afforded a car or even owning their own house – so, rather than looking at 'health', this was investigating something that had an actual effect on their lives as they experience it. CHLF has held similar workshops investigating sugar levels in soft drinks.

Participants used a variety of means to inform young people of available services and initiatives – some have no funding for outreach:

- peer messaging via friends (word of mouth);
- social media (e.g. fundraising campaign during Refugee Week); and
- advertising in local hubs – e.g. youth centres.

'If you can't get the message out, there is no point doing anything!' (London)

One youth support service was the victim of its own success – it became well known for helping young people with very complex needs, but this reputation means that there are now whole groups who feel that the service is not for them, although it is available for all.

b) Gender

While some challenges – exams, leaving school etc. – are common to all, there are important gender-specific aspects of working with this age group.

- Girls and young women face '*unprecedented attacks'* from online abuse. There is a lack of services for young women – youth services are often aimed at boys, and then women's services are for older adults. Many of the organisations work with girls and women who have been victims of abuse (and the extent of child sexual exploitation was described by one participant as '*shocking'*) but there is often a lack of understanding about the effects of trauma – for example, describing behaviour as '*unladylike'*. Child sexual exploitation can lead to long-term risky behaviour, with young women being blamed for their behaviour and diagnosed with borderline personality disorder, rather than being treated as victims of violent crime in earlier life.
- Men and boys may disassociate from emotions early, and can be particularly susceptible to isolation, which can lead to addiction, depression and suicide. Services may be required that are specific to young men – such as for those displaying harmful sexual behaviour, or alternative weight-management solutions (as initiatives such as WeightWatchers do not appeal to men). Men are too often left out of decision-making for their children.

The way that young people define their gender and sexuality is changing. In one school in Cornwall, half of pupils do not identify as heterosexual – not necessarily because their sexual preferences would not fit into what is accepted as being heterosexual, but because they are not comfortable '*restricting their identity'* in this way.

Transgender people experience specific and complex challenges that are very much bound up in gender and gender discrimination. Levels of self-harm are high, and they face stigma and bullying.

c) Multiple challenges

A constant theme of the workshops was that many young people face multiple challenges and have very complex needs, which may go unacknowledged:

People never present with one problem [at a NEET support organisation]
– it's always multiple [issues]' (Halifax)

According to one participant and the data her organisation has been collecting, 75 per cent of the young parents they see (up to 20 years old, and 23 in some special cases) have suffered abuse, 42 per cent need help for substance abuse, and 30 per cent are unhoused, homeless or living in overcrowded accommodation. Young parents may also be unable to care adequately for their children – some young children have had to be given zimmer frames because they have never been taught to walk or have been found to have deformed feet because they have been kept in baby grows for too long.

One organisation in Cornwall ran a Duke of Edinburgh-style trek with a group of young people at the end of which, around the campfire, the young people started stripping off their socks. This might have been the first time that anyone had seen their feet for a very long time because foster parents can be wary about looking too closely at a young person's body – and seeing their feet was really distressing: many of the children had in-growing toe nails or septic toes, and no one knew this was happening. Once they had identified this as a problem, the organisation was able to work with the children's in-care nurses to address the issue. For people who have been neglected as children, it is really important to not neglect themselves and, in some cases, pass that neglect on to their own children.

The complexity of needs may not be immediately obvious. It is only by working closely with young people over time, in a place where they feel comfortable, that their needs can be fully assessed and appropriate support provided.

The web of challenges that young people face also makes it particularly important to facilitate smooth links between different services, and many participants argued that services need to be much more joined up if they are to be really effective.

> *'Sex, drugs and mental health have big overlaps, and a person will be pushed from pillar to post because of these three behaviours'* (Swansea)

d) Vulnerable groups

Many of the participants work with young people from vulnerable groups – young people in care, refugees, LGBTQ young people, victims of child sexual exploitation (CSE) or domestic abuse, and young people with disabilities – who face a raft of complex health challenges, particularly around mental health.

> *Background information*: The England average of the proportion of children aged 0–17 in need during 2015–16 was 6.67 per cent (up to 8.2 per cent in Southwark, and the lowest 4.45 per cent in Cornwall).[39]
>
> Swansea collects data on young people aged 18–20 in need of local authority care (0.73 per cent) compared to those aged 16–17 (3.63 per cent).[40]

Young refugees face numerous challenges. They are a diverse and diffuse group that does not form a cohesive community, and often arrive in the UK on their own. They face language barriers, and participants noted a lack of reliable translation services, making it even harder for them to access the help that they need. Long delays in processing may mean that they may be a child when they arrive in the UK, but are not put into the system until they have turned 18 and are already an adult. Refugees are also treated particularly poorly when it comes to accommodation – they are often placed in the worst housing available and in the most challenged cities.

LGBTQ people face stigma, lack of understanding and bullying. Young transgender people have particularly acute problems, with the lack of understanding extending into the statutory sector (80 per cent of nurses do not know how to talk to them about being transgender[41]) and even within the LGBTQ community itself.

Non-success story: transgender people in Leicester

One organisation talked about a young transgender person who moved to a new area and was keen to find a local support group for LGBTQ people. Having found a group, the youth worker who ran the sessions and who was supposed to support the young person, referred to them using the wrong pronoun, produced a leaflet on LGBTQ issues, and in so many words told them to go away. It turned out that in reality the LGBTQ group was an 'LGB' group. As a trans person they did not feel that they were welcome, and started to question their own appearance, undermining all the work they had done in terms of their transition.

Transgender people are more likely to struggle with issues around body image, and not being able to use changing facilities can be a very significant barrier to exercising (for example, if a young person is binding their chest). Many people think that being transgender is predatory – but it is young transgender people themselves who are in need of safeguarding.

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[39] Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

[40] StatsWales, 'Children in need by local authority and age group' (2017): https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-in-Need/childreninneed-by-localauthority-agegroup combined with population data (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland)

[41] '"Urgent" training need in care for transgender patients', *Nursing Times* (11 October 2016): https://www.nursingtimes.net/news/education/urgent-training-need-in-care-for-transgender-patients/7011385.article

Young people who have been victims of child sexual exploitation (CSE) are particularly vulnerable. CSE is a form of child abuse in which an under-18 is coerced, manipulated or deceived into sexual activity in exchange for something that the victim wants and/or for the financial advantage or status of the perpetrator[42] – and is particularly prevalent among young people in gangs. The sexual activity may appear consensual – because of which, young women may not receive appropriate support once they reach 18. One participant from Cornwall noted that in their area '*the extent of child sexual exploitation is shocking*', but it is often not recognised, and young victims may drop out of school.

> *Background information*: The proportion of children under 18 who are at risk of ongoing sexual abuse is highest in Calderdale (13.7 per cent – nearly 50 per cent higher than the England average of 7.25 per cent) and Leicester (10.3 per cent) and lowest in Southwark (3.2 per cent).[43] In Wales, the data is collected slightly differently (the proportion of children who are on the child protection register who are there because of sexual abuse), but the figure is high in Swansea (10 per cent).[44]

There may also be a fine line between those who are perpetrators and those who are victims. When young people have grown up in homes in which abuse has taken place, they may be more likely to become perpetrators of abuse themselves; they need to be shown that certain behaviours are not acceptable in healthy relationships.

Young people with disabilities face specific barriers to health. Financial support is being cut, and reassessment of disability benefits is '*a hideous process*' that can take 12 months. People '*lose heart*' and need support and encouragement to access the assistance to which they are entitled. Young people with learning disabilities, such as autism, also struggle to get into work, which can have major benefits for wellbeing.

Success story: Autistic Spectrum Disorder Employment Support

One organisation in Swansea described a case in which volunteering is working out really well for one young person. Having worked in a paid working environment, he had found it difficult to complete his tasks in an environment that he found very stressful. However, his new voluntary position in a charity shop makes him feel appreciated and the other staff are able to take the time to be supportive. It is a relaxed atmosphere, and he is serving customers and assembling furniture to be sold. He is appreciated and is 'glowing' – and has progressed from working one day each week to two or three full days.

There are other vulnerabilities, including experience of harmful cultural practices (such as witchcraft), where an understanding of the cultural context, including family structure, is key but is currently lacking.

5.4.2 Institutional challenges

a) Funding and cuts in services

The most frequently cited challenge – which affected almost all of the participating organisations – is a lack of funding and hence a lack of sustainability and predictability. Government funding has been cut over the

[42] PHE, *Child sexual exploitation: How public health can support prevention and intervention* (2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629315/PHE_child_exploitation_report.pdf

[43] UK Government, 'Characteristics of children in need: 2015–2016, Main tables – Table B3': https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016

[44] StatsWales, 'Children on child protection register by local authority, category of abuse and age group' (2017): https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-in-Need/childreninneed-by-agegroup-lookedafterstatus

years, particularly in prevention (public-health budgets in England were cut by £200 million in 2015),[45] which is seen as a soft option:

'It's easy money for the local authority to claw back when they're going through cuts. Lots of youth services are preventative, so are easy to get rid of' (Swansea)

This is happening even as the third sector is being told that it is more important than ever in delivering services to young people:

'Money is being pulled from the voluntary sector at the same time they are being told that their sector is really important' (Halifax)

Most funding is now provided on a short-term basis, leaving organisations in a permanent state of uncertainty as to whether they will be able to continue their work. Staff are constantly '*firefighting'* and unable to plan for the future. '*Short-term funding is not good for long-term health'* – particularly when it can take years to make a difference to a young person's life ('*3–4 years for a victim of sexual abuse'*). Funding cycles are often unclear so it may not be obvious when or how to apply for new or continued funding.

Core funding is very much needed but is in short supply. Instead, money is tied to specific programmes which leaves little flexibility either in engaging with young people or in delivering the initiatives. Often, programmes have been designed by a funder (e.g. in the statutory sector) that seems to have little understanding of the realities young people face – and the resulting programmes (which the third sector has to deliver in order to stay afloat) are inflexible, ill-thought-out and clunky. The statutory sector is threatened by cuts, too:

'It's very top-down – but soon even the "top" won't be there because of the funding cuts' (Glasgow)

Participants gave examples of programmes that have been cut ('*services are being obliterated'*) – including a programme for young people with mental-health issues who had been involved in the arts as well as new restrictions on the age groups being offered help with weight management. The fear of losing services is felt beyond the staff and the young people within the programmes – statutory services are *'starting to panic'* at the thought that the funding for one third-sector programme in Leicester could come to an end because there is nothing else that could take its place. Even the most successful initiatives – popular, effective and evaluated – are living on a timetable of just a few months of guaranteed income. Staff may now have to seek funding for their own programmes rather than relying on the organisation to find central funding. In some cases dedicated, highly skilled staff are asked to work on short contracts because organisations cannot guarantee them work in the longer term.

Success story: Pentreath taking the pressure off statutory services in Cornwall

Pentreath is a mental health charity for people aged 14 years and upwards, which understands that the more closely embedded with all facets of people's lives you are, the better engaged they will be.

Pentreath's ethos is that wellbeing is improved if young people are engaged in something in which they actively want to be engaged. At the point of referral, 80 per cent of Pentreath's clients have an active relationship with a clinician (receiving CBT, for example, or regularly presenting at the GP surgery). After their referral to Pentreath that is reduced to 30 per cent.

Where services have been cut, schools and other organisations are searching for programmes to take their place, sometimes '*desperately taking up quite spurious offers'* (such as a programme on alcohol misuse, delivered in a school by the landlord of the local pub).

[45] David Buck, 'Chickens coming home to roost: local government public health budgets for 2017/18' (King's Fund blog, July 2017): https://www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18

Funders are felt to lack an understanding and appreciation of the work that needs to be done to prepare the ground for initiatives. Building trust (within the community and with young people themselves) takes time but often there is a call for rapid results which does not give the space for this valuable preparation.

Rather than providing funding for existing, successful services, many funders call for innovation – leaving organisations scrambling to develop new ideas. This was felt by many to be a '*waste of time'* – particularly when one such bid was withdrawn by the funder, citing a rethink of their priorities. Even if a gap is identified, it rapidly '*becomes saturated by bids'*. Having fewer staff may mean that costs are lower and it is easier to keep operating – but there is then only very limited capacity to write even small proposals and larger applications for funds are out of the question.

Success story: Practical healthy lifestyle advice from the Swansea Council for Voluntary Services (SCVS)

Young local families who use food banks are helped to learn how to cook quick healthy meals; they are provided with saucepans if they do not have their own; and SCVS has worked with Tesco, which is providing ingredients for free such as olive oil, dried herbs and stock cubes, to make food parcels go further.

Sources of funding

'Never put all your eggs in one basket', one participant warned. Sources of funding noted during the workshops included:

- central and local government;
- the Big Lottery;
- BBC Children in Need;
- private funders (corporate or philanthropic);
- the European Social Fund;
- trusts and foundations;
- local schools and colleges;
- football clubs; and
- the police (although decreasingly so, as they are not funding charities in the same way)

Other, smaller ideas included encouraging wealthy local older people to donate their Winter Fuel Allowance, Tesco's 'Bag for Help' (local people vote with tokens for a local charity) or in-kind donations from supermarkets.

b) Evaluation

Participants in the workshops recognised the need for evaluation as a way to show impact and attract more funding – but it is difficult for all, and near impossible for some:

'Understanding the positive impact of good health and wellbeing is important – but being able to measure it is quite another' (Derry)

Evaluation can be a time-consuming process that is particularly onerous for small organisations with little capacity. Several participants referred to the requirement to '*tick-box'* against targets that are over-prescriptive or, in some cases, unrealistic. One organisation pointed out to their local authority how good it would be if young parents and their children were registered with dental services – and were given the unrealistic target of registering 100 per cent of young families! They achieved 70 per cent, which was a huge improvement on the starting level of 32 per cent.

There are numerous hoops through which organisations have to show they have jumped, with the reward of '*tiny pots of money*'. But participants felt that what they do is not about targets – they will go above and beyond – but tick-boxing leads to tension between the need to be flexible to young people's needs and the 'outcomes' that funders wish to see. There were calls for *'approach-based, rather than outcomes-based'* evaluation.

> *'In the third sector you will do anything to support people, regardless of your targets'* (Swansea)

While some organisations – such as those involved in young people's weight management – may take health measurements, most evaluation (for example, of sports initiatives) needs to be wholly non-intrusive.

In particular, cases of child sexual exploitation are unique to the individual, and progress is particularly difficult to measure – self-evaluation may not give an accurate picture and is hard to compare.

Many young people will drop in and out of services, making it harder to track their progress and the impact of the service (one organisation is seeking funding for a database that could help with this). The benefit of programmes may not be clear for many years – and many stories of success (see, for example, the Success Story about a boy and his coat) cannot be quantified.

Success story in Cornwall: The boy and his coat

A participant from Dreadnought in Cornwall spoke about a boy who was in care and had been suffering from neglect. On first meeting the boy, he asked the boy if he would like to take off his coat. No, he wouldn't… This scenario went on for a year each time they met. On a trip to the beach he once again asked the boy if he would like to take off his coat? No thanks. The following year on another trip to the same beach, he asked one more time if he would like to take off his coat? - and, at last, he took off his coat, showing a new level of trust and comfort with the request. Nurture is so important – but how do you measure that sort of progression and the impact of perseverance? The boy in the story is now 40+ years old and is a regular helper in the groups.

Some organisations have had evaluation done by external organisations – although one participant complained that the results of the evaluation had been delayed, leaving them unsure as to how to proceed.

Even where evaluation has shown organisations to be highly cost-efficient, the threat of funding cuts still loom (see Success Story on Changing Minds).

Success Story: Changing Minds in Wales

The Changing Minds initiative provides mental health support for 4–25-year-olds. It has been shown to have saved the NHS over £3 million in its third year alone – but still has no guarantee of funding when the current pot of money runs out in 18 months' time. CAMHS refers out to Changing Minds all the time. Where will this statutory service refer to if the programme is stopped?

c) Pressure on staff

The people working within the third sector are key to its success – they are why young people get engaged and continue to access the programmes that are provided. All the participants at the workshops keenly feel the value of what they do – but the lack of reliable funding means that it is an uncertain and stressful time to be in the sector, pay is low, and many said that they feel undervalued for the '*soft skills*' that they provide. It can be very emotionally stressful – causing '*sleepless nights*', and working conditions can be poor, with run-down facilities and no resources to improve them. In one case, a participant in Derry explained that their premises, which housed a number of third sector organisations, had been taken away from them by the local authority to house a temporary national sporting event. As a result, several of the smaller organisations folded because they were not able to find the funds for new premises. Unsurprisingly, some become cynical and disillusioned. This is not restricted to the third sector – it was noted that staff stress levels are very high in the statutory sector, too.

> *'People do it because they love it'* (Glasgow)

Sometimes staff are required to go part-time (which is a challenge to manage), and others leave entirely and may not be replaced – both of which add further to the pressure on colleagues (one Kent organisation had a staff of 250 a few years ago; this has now fallen to just five). When staff leave, the expertise goes with them and the skill set of the organisation narrows. Everyone is '*maxed out'*, and there is no time for staff to spend quality time with young people who would benefit from more one-on-one time. One participant expressed concern that his staff may be continuing to work on their own time with young people once they have moved on from services (most of which have an upper age limit).

Of the people who were unable to attend workshops at the last minute, many cited pressure of work. There is so little flexibility that they were unable to take advantage of the networking that the workshops provided.

d) Lack of choice and cuts to services

A theme of all the discussions was ensuring that young people have a genuine choice – but '*if we are the only place providing a service, we cannot say that young women truly have a choice*!' Statutory services are being cut – for example, sexual health drop-in centres and clinics – and some services have been consolidated and brought '*in-house'* into the local authority, where there is little expertise and little evaluation. CAMHS is so overstretched that young people who need preventative help have no chance of accessing them, and it is only when there is a crisis that they are entered into the system, whereas others with very serious mental-health issues may be seen as too serious a case: '*People are either too mad or not mad enough*', as one participant put it – indicative of the frustration felt and the seriousness of the issue. And this is not a choice.

'Once a young person accesses a service, the statutory services pull out.
It should be "as well as", not "instead of"' (Swansea)

e) Waiting times and lack of integrated services

The wait to access both third-sector and statutory services was mentioned many times. One participant organisation has capacity to work with four people and currently has 100 on its waiting list – despite having clearly demonstrated a substantial return on investment, it is struggling to get funding. In the statutory sector some young people are effectively forgotten once they are on a waiting list. For others, the delay leads to them becoming disengaged and leaving the system. Some young people have reported being driven to overt action (such as slitting their wrists) just to access the mental-health services that they desperately need.

Vulnerable young people too often get lost within the system as they move from childhood to young adulthood, and are not provided with access to the extra care that they need. Alternatively, when moving between parts of the system, they may have to answer the same questions multiple times, wasting their time and leading to disillusionment and frustration at the lack of connection – and removing themselves from the system completely.

When a successful initiative ends, there is often no signposting to follow-up programmes; for health to be sustained, young people need something to move on to.

Success story: Recovery College in Halifax

The Recovery College is not a simple option (like CAMHS) but a network of opportunities to help people's wellbeing. It is about bringing a huge network of great opportunities to one space and allowing the network to work more effectively, with easy lines of sight straight through to different options for 'recovery'. This might be about looking at what a diagnosis means for an individual person, but it might also be about providing broader information on how to keep yourself emotionally well, such as keeping physically active. The College offers all sorts of sports, as well as dance, climbing, and just being outdoors – bush craft, for example – and also creative activities such as writing, art and drama.

f) Bureaucracy

While a failure of joined-up thinking was a broad criticism, some young people face specific bureaucratic hurdles. For young refugees, a long waiting list may mean that they may be a child when they arrive in the UK, but are not seen until they have turned 18, or they might not be able to prove their age because they do not have any documentation. Some statutory services may be available only to young people who are in a stable home and if they are refused then their situation will worsen – so this is where third-sector organisations can be of particular benefit. Similarly, some services may operate a *'three strikes and you're out'* rule – but for some vulnerable young people, keeping the door open is essential and can pay dividends over time.

Some participants said that the statutory services should have more trust in the judgement of people working in the third sector, who have such expertise and knowledge. This lack of trust may lead staff to be very cautious, and not want to take any risks – which may not be in the best interest of the young people with whom they work.

g) Safeguarding, privacy and consent

While acknowledging that safeguarding is extremely important, some of the organisations struggle to complete the assessments, and there is no help available for implementation.

Privacy and consent are also challenges for the third sector – for example, when to share information with social services; you need to work with young people to persuade them that this is in their best interests:

> *'If you're going to disclose information to a social worker, you have to be sure you are talking to a good social worker – otherwise it might do more harm than good'* (Leicester)

What to share with parents, when trust has been placed in staff, is also a moral issue – and particularly difficult when there are issues around abuse, or with young LGBTQ people.

Among the younger age group (under 18), gaining parental consent for activities, as well as consent of the young person, can be an additional barrier.

However, while data protection is important, fear of sharing information can hamper joined-up working:

> *'We are professionals, so we should be trusted to share data when necessary'* (Kent)

Success story: Making community links through the ALLIANCE Scotland

Fifteen GP surgeries applied to be involved in a piece of research commissioned by the ALLIANCE Scotland, which used a questionnaire to ask patients a number of questions to ascertain a picture of the needs of the local population. Seven practices were picked to be intervention sites, with the remaining eight sites acting as comparison sites. Sharing data in this way helps to improve the service that is delivered across the wider community.

h) Barriers to partnership

There was strong agreement among the participants that working together, such as '*civic alliances'* between and across sectors, is efficient, necessary and valuable – and strengthens grant applications. Many of those attending hoped that the workshops would open avenues to new partnerships between the participants – particularly for organisations that have not, to date, focused effort specifically on health, but which are keen to do so.

However, there was discussion at all the workshops of the practical difficulties of partnership working. This can take the form of differences of opinion on the appropriate care pathway for young people ('*it's quite common to end up in very heated discussions with social workers*'), or of people being too keen to pursue their own agendas.

And the perceived problems go beyond a failure to think in a joined-up way. There was also frustration at what is seen as '*professional snobbery*', '*professional jealousy*' and '*protectionism*' of the statutory sector, including local authorities and the health service – much of it born of a lack of understanding of how health can be brought out of the health services and into the community. Many participants felt that their contribution and commitment to the health of young people is undervalued, and that there is a lack of courtesy and respect for local expertise.

> *'There isn't enough understanding in the health service, and there isn't enough understanding of what people mean when they talk about taking their services out into the community'* (Leicester)

i) Communication with other providers

Barriers to partnership often have roots in a failure to communicate adequately with other providers. There is insufficient sharing of learning between sectors. Words and acronyms can have subtly different meanings in different sectors, and it is '*hard to move out of one language into another*'. While participants place the young people at the heart of what they do, they find that clinicians think of the science rather than the person.

j) Older adults

Misunderstanding – and lack of appreciation – of young people by older adults is commonplace.

> *'Young people aren't respected by adults, but are expected to be like adults'* (Cornwall)

Young people are '*demonised*' and '*vilified*' in the media. They are the subject of dispersal orders even when they have not done anything wrong. Serious problems that the age group face are underestimated – such as dismissing self-harm as a form of attention-seeking. One participant's programme for young offenders was closed because neighbours objected to having them living locally, and staff who are not experienced or understanding of young people may leave programmes because of the '*attitude*' of young people.

> *'People would rather work with dogs, small children or the elderly than with young people'* (Kent)

Politicians also have no experience of the area of expertise that they represent – the third sector needs to get its messages across to them more effectively, because at the moment '*the government doesn't like young people!*'

k) Place

While the phrase 'place-based health' was not specifically used in the workshops, where young people live has a significant impact on their health. All young people need a place where they feel safe.

One participant commented that there are no hard-to-reach groups, only *'hard-for-me-to-look-for'* groups – the key to successful engagement is going to where young people are. One organisation worked with young people in their homes to identify the specific barriers to healthy living – such as not owning a saucepan. Traditionally, GPs visited homes and would have had a sense of the wider environment within which they live – but this is no longer the case.

In some cities, territory is proscribed by gangs – an invisible barrier from accessing services in the wrong postcode.

Young people in rural areas face their own challenges, for example around the distances that they may need to travel (there may be no public transport). Replicating provision found in cities is not sufficient. Participants from Cornwall highlighted that the county is large and long – the combination of its shape and its largely rural nature means that young people can find themselves particularly isolated.

5.5 Overcoming the barriers

During the course of the workshops, numerous examples were given of ways of working with young people that have proved successful, and that go some way to overcoming the many hurdles discussed in section 5.3. The best solutions will depend on the individual young person:

'There really isn't any such thing as "the young"' (Derry)

5.5.1 Working with young people

Participants all stressed the need to **place the young person at the heart of everything** that the organisation provides. They will not want to become involved until their confidence and trust has been built up, and from that point they can be supported to achieve much more – perhaps beginning with small achievements like being able to get a train alone. What is on offer for young people needs to be local and personalised, and be generous in taking circumstances into account: '*You can't tackle one bit of a person – you have to sort the whole person.'*

'Each young person is individual and has their own story that needs to be listened to' (Kent)

As far as possible, **respecting the wishes of young people** is a key way to build trust – *'never go against the wishes of the young person'*. This is particularly important for victims of abuse, who may have encountered language and attitudes that blame the victim and need to be challenged. One organisation collects physical and written evidence of sexual abuse from young people, but does not require them to report it to the police immediately – the physical evidence can be kept for two years, giving the space and support for the young person to make the right decision for them about when and if they might want to pursue a court case for example.

Young people are often undervalued, their views are discounted, and they feel disenfranchised and powerless. Providing a platform for them to **make their voice heard** and express their views will always be valuable – both to the young person and the service provider. Young people know what their needs are, and will come up with their own answers to meet those needs – so listening to them will not only make the individual feel more valued, but is also likely to lead to improvements in the programmes that are offered to them. There were several examples of young people being involved: in the design of youth centres, hiring staff and even designing their own substance abuse programme. They should be involved in the process of commissioning services, because otherwise there are so *many 'preconceptions about the way young people are, and what their hopes and aspirations might be'*. Co-producing programmes gives them a sense of purpose as well as ensuring that their needs are more effectively met.

'Young people should be able to influence decision-makers' (Derry)

Adolescence is often a time when young people push boundaries – and giving them agency over their decision-making is more likely to have a successful outcome. Trusting them to make the decision themselves means that they will be more motivated to make sustainable changes – *'ask what they want, rather than telling them how to change'*. This is about engaging with young people and asking what they want – **providing them with a choice** – rather than dictating. Where there is only a single option, that is not a real choice (although in many cases – for example in mental health services – even a single option may not be available): *'If we are the only place providing a service, we cannot say young women truly have a choice.'* This is particularly challenging in rural areas, where the concentration of services is much lower.

Providing flexibility, rather than being prescriptive, is valuable – one healthy living organisation leaves the final session of the course free for the participants themselves to choose what to discuss.

Adults are often viewed with mistrust by young people and are not the best communication channel. **Peers** can act as gatekeepers and consultants to third-sector organisations, and can spread the word about programmes. Young health champions have developed health messages to pass on to peers on social media. Some organisations employ adults with experience to which the young people can specifically relate – ex-offenders or previous users of the service, for example, perhaps in a mentor or buddy system. One organisation for young abused women has a former user of the service who now acts as a consultant. All involved in this way must, of course, be carefully chosen and well trained.

'Young people are more likely to do something if it's their peers telling them and not a doctor' (Leicester)

It takes **time to engage** with some young people, and many third-sector organisations are more generous than the statutory sector in allowing them to return sporadically, after poor behaviour, or even after initially pulling out of a programme. Sticking to a *'three strikes and you're out'* policy will end in complete

disengagement. One young man who had a history of drug use said that *'you were the only place that would always take me back'*.

Having **services that are available to all** – that all young people can access without having a clear, predefined problem – are very valuable.

Success story: Sheppey Matters

Sheppey Matters runs a range of projects supporting all the community. It runs a programme in the prison – on their allotments, as well as a community transport scheme, a radio station, a community shed, a food wagon that goes to schools and into communities and it works with a community gardener. Much of this hub activity is only made possible because they are located within the local Healthy Living Centre.

Being flexible, and using trial and error in what is offered, can pay dividends. One participant was working with refugees in an English-language class and became aware that their biggest need was relationship training. Another said that a class that is ostensibly providing massages for babies of young mothers has been providing mental-health support. A project to encourage reading has led to young people opening up about their lives. One charity for disabled people was asked by able-bodied youth if they could join in with sporting activities – using wheelchairs and enjoying spending time with the young disabled people.

Using **flexible, informal learning**, rather than more structured approaches, was recommended – particularly in areas such as sexual health, which this age group may not fully understand.

Although there were many concerns voiced about **social media** (section 5.2.3), it can be put to positive use and needs to be harnessed because it is the means by which young people communicate with each other. Staff can contact young people on Facebook before coming to sessions, or a closed Facebook group can be used to allow communication out of hours. Social media even has the potential to be an evaluation tool (photos of healthy behaviour).

There were many examples of the ways in which the third sector thinks **broadly and imaginatively** about its role:

- cultural flexibility in cookery classes that introduce young people to new foods and *'no one loses out and there is absolutely no sense of exclusion'*;
- providing condoms at a food bank;
- finding ways to avoid stigma – for example, avoiding the word 'weight' in a weight-loss programme (focusing instead on having fun and being active), not labelling an initiative as being about 'mental health support', or food being handed out from a third-sector organisation *where 'anyone can take it'* when visiting, rather than being seen attending the local food bank;
- 'nudge' techniques to encourage healthy eating – putting the fruit and yoghurt on display, with soft drinks available only on request; one organisation heard from a parent that she had had to change her shopping habits because her child wanted hummus rather than crisps; and
- involving young people in the arts, which is known to have health benefits, and countering the perception that music and the arts are elitist: '*being creative helps you to be resilient'*.

Finally, if programmes are not **enjoyable**, young people will not come back.

Success Story: Writing project for people with mental health issues

Newport Mind in Wales has a letter-writing scheme for people with mental health issues: One workshop participant described the case of a young woman with selective mutism. She found it hard to connect with people, and needed peer-to-peer support but that was hard because she wouldn't speak. Instead, someone from the group wrote to her, and they went back and forth writing to each other, including sending pictures. This method was picked up by others, and has meant that Mind has been able to access a whole

cohort of people suffering from mental health problems whose health was so bad that they couldn't leave home. Boys, in particular, are getting involved – and it allows them to keep their privacy.

5.5.2 Where to engage

Young people will not take part in initiatives unless they feel comfortable with the place where they are held – perhaps an old school site, or a café in the centre of town, with good transport links and where young people are likely to congregate naturally, or even in prisons. There is great value in creating a *'safe space*' where young people feel welcomed: '*I feel like I've come home when I go to the LGBT Centre.'*

Hubs for young people must be embedded within the local community. It is about *'meeting at the point of need*', rather than expecting them to come to you. One LGBTQ organisation is disappointed that it is currently not able to offer young people a social space as well as a crisis centre.

> *'The closer we embed with all facets of people's lives, the better engaged they will be'* (Cornwall)

Hubs can be both a place for young people to meet, but also coordinate ways in which they can be moved into the services they need more easily.

Success story: Switch Café in Maidstone

Using the café as the foundation of its work, the organisation informally engages young people in a variety of unique ways that fosters reflection, knowledge, education and opportunities for personal, social and emotional development.

Staff at Switch can make referrals out to other services if they see that someone is in need. They also provide a safe, non-judgemental space for young people to congregate. 20 per cent of the café's users are from the young LBGTQ community.

Measuring and mapping the assets within a community can help to situate programmes to best effect, as well as using the assets as efficiently as possible. One organisation suggested that a pilot study to look at differences in food provision within different local communities would be particularly interesting.

Co-location of programmes between third-sector organisations both maximises the use of space (and minimises cost) and can also be a way for young people to find out more about other initiatives that they might find valuable.

5.5.3 Funding

Almost all the participants were struggling to find sustainable funding streams – unallocated core funding (which allows for much greater flexibility in programme delivery) is in particularly short supply. But they had many ideas that could help the third sector to become more effective in seeking funding:

- more help for small organisations in bid-writing, which is time consuming and a very specific skill;
- constructive feedback from funders;
- more funding opportunities that are not tied to delivery of a specific (and often poorly designed) initiative;
- finding smart ways to fund health – for example, through sports initiatives;
- adapting to major funders' strategies as they change over time;
- linking with other initiatives – such as a fundraising campaign on social media, timed to correspond with Refugee Week; and
- working with other organisations to combine budgets and pool resources – widening the available offer and skill set, making successful applications more likely.

Success story: Children in Need helping with evaluation at the Young Transgender Centre of Excellence (YTCE) in Leicester

BBC Children in Need, which funds the YTCE, has been very helpful in measuring outcomes of the project. As part of the funding, a day's training is provided to talk through how and what outcomes and impact to measure. With Children in Need's help the YTCE chose to measure:

- young people being more able to express themselves;
- an increase in a positive sense of identity; and
- young people feeling safer.

In one case, the criteria set by the funder for a mental-health programme were quite strict, so the organisation put a young people's panel at the heart of the project. This panel identified parts of the programme that were of benefit and should be continued, but also suggested changes. The funder was then obliged to be flexible enough to accept the recommended changes, because they had come from the young people themselves**.**

5.5.4 Involving others

Part of working with the whole person involves looking at the organisations and individuals with which they interact. Among the younger age group, in particular, the meaningful involvement of **family** is important – and the parents may need support themselves.

Schools can be good partners in working with young people – providing teachers with tools and techniques to help vulnerable pupils who are in danger of self-harm or drug use, or to help them fully to appreciate and understand issues faced by young LGBTQ people or those at risk of sexual abuse and exploitation. To be able to communicate effectively, teachers must be comfortable and confident in discussing issues, and fully aware of the extent and potential severity of the challenges that the young people are facing.

Faith organisations can be a good conduit through which to reach minority ethnic groups – one participant will be doing awareness-raising and training with the local community through a temple.

GPs who appreciate the need to move health into local communities and out of the medical sphere can be an important conduit for both identifying young people who would benefit from particular third-sector services, and then directing them to the different options:

'GPs don't know who they can refer to. We need to have training that tells the right people about all the different areas and opportunities they need to be aware of' (Cornwall)

Some third-sector organisations are involved in **train-the-trainer** models – for example, a healthy-lifestyles project that encourages mental-health practitioners to shadow its staff, so that they can then deliver the messages themselves.

5.5.5 Joining forces

There was real enthusiasm for working together, joining forces and skills to ensure that young people can access all the programmes that they need and in order to minimise the tendency for different organisations to offer duplicate services. This is not always straightforward, and can cause tension (section 5.4.2 h) above) – so there was a call for '*collaboration training*'. Some organisations do network successfully – for example, regular meetings of all the local stakeholders working with refugees.

'The third sector is better at networking, and it's not appreciated!' (Cornwall)

Within large consortia, smaller partnerships can develop. Integrating services and raising awareness of all the initiatives on offer is necessary if young people in need are to move smoothly between programmes and into adult life.

6. Conclusion

While it is hard to draw specific conclusions from this work, it is possible to draw some softer conclusions from the insights gained from a range of third-sector organisations from across the UK who are experts in working with 14–24-year-olds.

The vital work that is being done with some of the most vulnerable people across the country requires very particular support that may not translate across groups of young people or to different geographical settings. As Professor Harry Rutter noted about childhood obesity, which is just as relevant in the context of the broader health of young people: 'the single most important intervention is to understand that there is no single most important intervention'.[46] For example:

- In Cornwall, the shape of the county impacts on young people's ability to access the services they need, adding its own dimension to the problems that young people encounter in the first place.
- In Glasgow, it was made very clear that there is no such entity as the asylum-seeking 'community'. Instead, these most vulnerable people will often find themselves living an isolated existence in a place that bears no relation to their own culture and which is hard for them to navigate both in terms of language and shared experience – an experience that may have included torture or trafficking.
- The need to stop young people from smoking might be a priority for those who are working with young people involved in the care system, as in Cornwall – but in Leicester the idea of telling young LGBTQ people who are struggling with their identity, are facing discrimination and whose experience will often be about hiding who they are or how they are able to express themselves, being told not to smoke could be considered as just one more thing over which they have no control, and can increase their sense of isolation.

The work has challenged even the basic idea that there are definable groups for whom services can be designed. People will always have multiple needs and human experience is so varied that any approach to support needs to be tailored to specific families or individual groups. Scaling up any successful model is likely to be a challenge – but it is a challenge that is worth taking on.

An important conclusion from this work, borne out in all eight of the workshops, is the need to heed and act upon repeated calls for more partnership working: joining-up thinking and integrating services, including better working between sectors, particularly between the third sector, the statutory sector and funders. Crucially, funding needs to be longer term, more flexible and there needs to be more of it!

The people with whom the workshops engaged are hugely passionate. They do not work in the third sector for money or praise, but out of a deep sense of compassion and empathy. And a significant conclusion to draw is that if the people who participated are in any way representative of the third sector, they have shown themselves to be a wonderful resource of talented people who are keen to find new ways of working to support young people.

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[46] H. Rutter, 'The single most important intervention to tackle obesity' (2012) *Int J Public Health* 57: 657–8 (doi: 10.1007/s00038-012-0385-6): https://link.springer.com/content/pdf/10.1007/s00038-012-0385-6.pdf

Appendix 1 – Matrix of participants

Identifying the right organisations to attend the workshops was key. C3 undertook desk research to identify a sample of voluntary and community organisations' services and activities across a number of third-sector areas: physical health; sexual health; mental health; substance misuse; the justice system, young people in, leaving or at risk of being in care; carers; education; employment/training; NEET (not in education, employment or training); and youth provision.

The desk research used a purposive sampling methodology, whereby the most appropriate participant organisations to be included in the workshops were determined in advance as much as possible. Participants were chosen to reflect the diversity and the breadth of the sample population – i.e. third-sector organisations with a remit encompassing 14–24-year-olds. While the aim of the workshops was not to produce a statistically representative sample or draw statistical inference, this approach offered some basis for suggesting indicative generalisations.

The diversity and breadth of the 53 participant organisations was captured using a grid system (see below) to ensure representation from each of the third-sector areas identified, against a set of matrices capturing disability, ethnicity, gender, LGBTQ and low-income groups. At each workshop participants were also asked to identify which parts of the matrix they felt their organisation worked across. This analysis is shown below:

	Physical health	Sexual health	Mental health	Substance misuse	Justice System	Social care	Carers	Education	Employment/ training	NEET (Not in Employment, Education or Training)	Youth Provision
Disability	17	13	23	12	10	14	12	20	17	17	22
Ethnicity	13	14	20	11	10	10	5	17	15	13	16
Gender	20	19	26	16	11	18	8	20	18	17	21
LGBTQ	14	15	22	12	11	11	7	19	13	13	17
Low income	18	19	27	14	10	15	9	21	17	18	22

Between the eight workshops, each cell of the grid (i.e. each issue) was covered. The cell of the grid that was represented least often was carers working with different ethnicities (five participants), and the most represented was those working in mental health with people on low incomes (27 participants).

Appendix 2.1 – Halifax

Statistics

Halifax is a town within the Metropolitan Borough of Calderdale, from which these statistics are drawn.

1. Children reporting general health as excellent (15 y/o, 2014/2015): 29.2% (England average 29.5%)

2. Children who eat 5 portions or more of fruit and vegetables per day (15 y/o, 2014/2015): 48.9% (England average 52.4%)

3. Physically active children for at least one hour per day seven days a week (15 y/o, 2014/2015): 10.9% (England average 13.9%)

4. Obese children in Year 6 (10–11 y/o, 2015/2016): 20.4% (England average 19.8%)

5. Percentage of children in need (of local authority to achieve reasonable health and development) during 2015-2016: 6.57% (England average 6.67%)

6. Hospital admissions due to substance misuse (15–24 y/o, 2012/13–2014/15, rate per 100,000): 128 (England average 88.8)

7. New sexually transmitted infections (16-24-year-olds, 2013, per 100,000): 4,305.9 (England average 3,432.7)

8. Percentage of children at risk of ongoing sexual abuse out of total children in need (under 18, March 2016): 13.68% (England average 7.25%)

9. Emergency hospital admissions for intentional self-harm 2015/16 per 100,000: 157 (England average 196.5)

10. Unemployed (16–64 years): 3.6% (GB average 4.5%)

11. NEET (16–18 years, 2015, percentage out of 16–18-year-olds known to local authority): 4.3%

12. Children age 17–18 who have formally entered the youth justice system (2013/14, per 100,000): 15.7 (England average 19.8)

Sources:

1–3. Public Health England, 'Young people – Calderdale': https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000003/ati/102/are/E08000033

4. Public Health England, 'Health profiles – Calderdale': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000003/ati/102/are/E08000016/iid/20301/age/1/sex/2

5. Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

6–7 and 12. Public Health England, 'Young people's profile – local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

8. UK Government, 'Characteristics of children in need: 2015–2016': https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016 (table B3)

9. Public Health England, Public Health Profiles (Calderdale – County and UA): https://fingertips.phe.org.uk/search/suicide#page/1/gid/1/pat/6/par/E12000003/ati/102/are/E08000033/iid/41001/age/285/sex/4

10. Nomis, ' Labour market profile – Calderdale': https://www.nomisweb.co.uk/reports/lmp/la/1946157125/report.aspx?town=Halifax

11. Department for Education, 'NEET data by local authority' (2016): https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

List of attendees

Organisation	URL
Disability Support Calderdale	http://www.disabilitysupportcalderdale.org/
OSCA Foundation	http://www.oscafoundation.org/
Chiraagh	Info on Calderdale Council website
St George's Community Trust	Info on Calderdale Council website
Calderdale Community Coaching Trust*	http://www.calderdalecct.org/
Healthy Minds*	http://www.healthymindscalderdale.co.uk/
Disability Support Calderdale	http://www.disabilitysupportcalderdale.org
Wise Up Arts	https://www.facebook.com/wiseuparts/

* Has health/wellbeing as a stated aim/vision of the organisation

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The Halifax workshop was held on 16 February 2017, and brought together eight people from eight organisations from across sport, disability, mental health, NEETs, the arts, community empowerment, and a youth centre.

Expectations of the participants varied from 'no particular expectations' and 'an open mind', to 'finding out what's going on with other organisations' and 'how my organisation could work together with others'.

'I need to understand how organisations can work better together,
and I hope today is helpful for that.'

Working with 14–24-year-olds in Halifax

Inequality and ethnicity in Halifax were quickly established as important for the locality, with an 11-year difference in life expectancy between a deprived area of Halifax (with a predominantly Asian demographic) and more affluent neighbourhoods. Ethnicity can be a barrier in accessing health care, and all programmes need to ensure that they provide experiences that represent all ethnic groups. It is important that a 'white, Euro-centric model' is not automatically applied to other communities.

Messaging around health for the 14–24 age group needs to be sensitively handled – it is essential that young people's voices are listened to and their needs understood, and that messages and programmes work to overcome stigma and offer real choice, rather than trying to force young people down a particular path. In a lovely example, a youth club provided free healthy food and charged for unhealthy options – over time they switched to the healthier options without being told to do so (and asked parents to switch, too).

Flexible, informal learning is used, rather than more structured approaches: 'the important thing is to try to understand the meaning for kids of the messages they are receiving'. This age group often has a lack of understanding about sexual health, for example.

The world in which young people live has changed dramatically over the past few years. 'Technology has been in their lives for all of their lives', and **social media** means that 'everyone knows everyone else's business'. Ironically, social media can affect relationship-building and communication skills, leading to social isolation.

Among young people from deprived areas, 'the world of work often doesn't picture in their head – they may come from **generational unemployment'**, so they need support in finding and taking advantage of opportunities.

'Unproductive behaviours develop because there's nothing else to do.'

Young people are often bored, especially in the face of closures of youth clubs etc. **Risky behaviour** is on the increase among children as young as 11 (alcohol, and drugs including qat, weed and legal highs) and sedentary activities (gaming etc.) reduces physical activity. Instant gratification tends to trump health issues.

The **built environment** needs long-term regeneration – it is tempting to buy chicken nuggets from fast-food outlets.

Providing young people with the space to make their own **choices** was stressed many times – rather than being prescriptive, enabling young people to understand and come to their own decisions about what is best for them.

And finally, 'people never present with one problem – there are always multiple issues'. Being flexible to young people's needs, and being able to signpost to a range of services, is key.

Financial challenges – organisational and personal

The challenges posed by **ongoing funding cuts** were raised throughout the workshop – cuts that have been 'devastating' for long-standing, embedded programmes: 'services are being obliterated'. As government funding is cut, there is cherry-picking of services that show restricted outcomes, and there is no linkage made between different organisations. It is also harder to build resilient organisations and intervene early when funding is limited – it is more about firefighting rather than systemic prevention.

'Organisations are absolutely stretched to the limit, and yet they are being asked to do more and more' – and this includes offering staff pensions and a living wage. This has a serious effect on **staffing**. Sometimes staff have to be laid off due to cuts; at other times, they move into the public sector where they can command higher salaries. Much of the work relies on the goodwill of employees, who sometimes may not be paid for their services.

'Money is being pulled from the voluntary sector at the same time they are being told that their sector is really important.'

Unrestricted, core funding is becoming ever more scarce, and applying for major funding is time consuming, so organisations may only have the capacity to apply for small grants. Particularly helpful are 'quiet philanthropists', who can help to access funds, and there is also a 'small but useful funding pot' of Tesco's Bag for Help – where customers put tokens in a box to vote for organisations.

The **personal financial support** available to families with disabilities is also being cut, with reassessment described as 'a hideous process' that can take 12 months. People 'lose heart' and need support and encouragement to access the assistance to which they are entitled: the two organisations that provide support at appeals stage have had 100% success rate in both mental-health and disability appeals.

Young people often have very limited personal finances, which limits their social mobility. There is a serious lack of opportunity in the job market, and work experience is often required – but if young people are not able to take up unpaid work, it is impossible to improve their prospects. Even where opportunities are available (for example, apprenticeships), young people may feel that it is not for them – a lack of self-esteem and confidence.

Other challenges

Evaluation can be a challenge, particularly when young people do not attend programmes regularly. Targets can be restrictive, and difficulties may arise when partner organisations have differing targets.

Staffing is an issue – and not just because of financial pressure. There can be serious issues with stress (at least one of the three people who were not able to attend the workshop was absent due to stress, having had to make colleagues redundant following local-government funding cuts). Pressure can also be increased if staff are not adequately trained or do not have the capacity to deal with some of the more anti-social behaviour that can be displayed by some young people, which spills over into the programmes and leads to resignations of staff.

Government processes – such as the Pupil Referral Units – can be too restrictive; you need to be flexible with young people.

Successes

It can be easier for an organisation in the third sector to make a **referral** (for example, to mental-health services) than it is for parents themselves to try to get a referral for children.

Where a third-sector organisation acts as a **coordinator/hub**, this provides young people with multiple gateways into services and programmes, 'making it really easy for people to bounce from service to service without any barriers'. This is particularly important as statutory services become increasingly limited (for example, CAHMS, which has restricted its intake and was, in any case, only open to young people from stable family backgrounds), and prevents money being wasted as people are sent to the wrong place when trying to access services. Coordination can also take the form of identifying better ways to use existing assets (such as buildings), directing organisations to use these assets.

Help with **form-filling** for benefits is not provided by the Citizens' Advice Bureau or social services – but the third sector can plug this gap, and can also assist with the intimidating appeals process (with, as noted above, very significant success).

Listening to young people, and **acting as their advocate**, helps to overcome emotional and other barriers to the job market – encouraging them to have the self-confidence to take advantage of opportunities that come their way. This advice can be given by peer role models or older staff.

Sports can be a good way to engage young people not only in physical activity but also in their health and other opportunities. Sports players can act as positive role models, and activities can be tailored for all abilities and ages (with the social aspects being just as important as the sport itself). Programmes for girls and young women 'help girls to aspire to more than getting pregnant' – building up self-esteem and increasing ambition.

Staff using **social media** – getting with young people on Facebook before coming to sessions, for example – is a good way to communicate with this age group.

'It's not all doom and gloom – there is a lot of positive stuff going on, too!'

Solutions

Among solutions discussed were:

- **financial and funding issues** – noting that the third sector needs to 'think outside the box' and not rely on the same funding pots (e.g. look at local football clubs, trusts, the European Social Fund and local colleges). Flexibility around funding and delivery are needed, and there needs to be more understanding along the length of the delivery chain – i.e. people with funds need to work with the people involved in delivery, rather than raising barriers to funding;
- an **awareness of referral pathways** and knowledge of all the services available; and
- **partnership working** and collaboration – including regular networking and discussions between local organisations, sharing of resources/policies/practices/staff, and running projects as consortia.

Appendix 2.2 – Glasgow

Statistics

1. Recommended amount (5 or more) of fruit and vegetable per day (16+, 2008–11): 19%

2. Recommended amount of physical activity (16+, 2008–11): 40%

3. Percentage of children aged 0-18 years old looked after by Glasgow local authority (2014): 2.86%

4. Scotland: hospital treated self-harm (2010–2012) per 100,000 population aged 15+ years: 283 (no statistic found for Glasgow)

5. Population (all ages) prescribed drugs for anxiety/depression/psychosis (2015/2016): 20.1%

6. Drug-related hospital stays (16+ y/o, 2016, per 100,000): 197.7 (Scotland average 133.6)

7. New sexually transmitted infections (all ages, 2009, rate per 100,000): 773.4 (Scotland average not known)

8. Percentage of children on child protection register who pose concerns of sexual abuse out of total children on child protection register (0–16+y/o, 2016): 9.17% (Scotland average 6.13%)

9. Unemployed (16–64 y/o, 2017): 5.0% (Scotland average 4.6%)

10. NEET (16–19 y/o, 2014, percentage out of 16–19-year-olds in Glasgow) 8.1% (Scotland average 6.4%)

11. No comparable statistics on the youth criminal justice system as a whole, but there were 183 violent crimes and offences per 100,000 in 2014/15 in Glasgow, and crime and offences in Glasgow are 51% higher than the Scottish average.

Sources:

1. Understanding Glasgow, 'Diet in Glasgow':
http://www.understandingglasgow.com/indicators/lifestyle/diet/glasgow

2. Understanding Glasgow, 'Physical Activity':
http://www.understandingglasgow.com/indicators/lifestyle/physical_activity

3. The Scottish Public Health Observatory, 'Health and wellbeing profile (Glasgow City)':
https://scotpho.nhsnss.scot.nhs.uk/scotpho/spineChartAction.do combined with population statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland)

4. NHS Health Scotland, 'Prevention of suicide and self-harm: Research briefing':
http://www.chooselife.net/uploads/documents/135-23356-Research%20briefing%20on%20prevention%20of%20suicide%20and%20self-harm.pdf

5. Scottish Public Health Observatory, 'Health and wellbeing profile':
https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

6. Information Services Division, 'Drugs and alcohol misuse': https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-09-27/2016-09-27-DrugHospitalStatistics-Report.pdf

7. ISD Scotland, 'All diagnoses by diagnostic group, gender and NHS Board of residence':
http://www.isdscotlandarchive.scot.nhs.uk/isd/4907.html#excel_tables_and_charts

8. Scottish Government, 'Children's Social Work Statistics Scotland – Table 2.2':
http://www.gov.scot/Publications/2017/03/6791/downloads

9. Nomis,'Labour Market Profile - Glasgow':
https://www.nomisweb.co.uk/reports/lmp/la/1946157420/report.aspx?town=glasgow

10. Scottish Government, 'Table 2 – LA NEET Leavers destinations and DWP benefits, 2003-2014':
http://www.gov.scot/Topics/Statistics/Browse/Labour-Market/LANEET/Table2

11. Understanding Glasgow,'Glasgow & Clyde Valley'
http://www.understandingglasgow.com/indicators/community_safety/violence/greater_glasgow_and_clyde

List of attendees

Organisation	URL
Plantation Productions	http://www.plantation.org.uk/
SAY Women	https://www.say-women.co.uk/
The ALLIANCE Scotland*	http://www.alliance-scotland.org.uk/
Antonine Youth group	http://www.antonine.org/
British Red Cross*	http://www.redcross.org.uk/en

* Has health/wellbeing as a stated aim/vision of the organisation

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The Glasgow workshop was held on 28 April 2017, and brought together five people from five organisations – a health and social care intermediary, an asylum-seeker group, a youth group for disabled people, an arts/media charity, and a service for young women who have suffered sexual abuse, and C3 Collaborating for Health (which has been working in a deprived area near Glasgow).

Working with 14–24-year-olds in Glasgow

'The Glasgow effect' is the level of poor health and low life expectancy in the city, compared with the rest of the UK – for which poverty alone does not appear to account (explanations could include high stress, social isolation and higher levels of poverty than suggested by the figures). Austerity has hit hard, with loss of useful provision such as reduced housing for those transitioning to adulthood, and sexual-health drop-in centres have been closed.

The areas of Glasgow in which the participants work are largely very deprived, with high levels of unemployment, alcohol and drug misuse. Many people have multi-morbidities or many different challenges in their lives – for example, the correlation between homelessness and sexual abuse among young women. Rates of suicide are high. Crime was not much discussed, but it has serious 'knock-on effects' – and in Govan it is particularly important not to 'be a grass', which can hamper (for example) child-protection efforts.

Tackling the **social determinants of health** was an important focus of the discussion, with links to social justice: the impact of low incomes and welfare cuts, increases in university fees (which reduces access to higher education), the availability of fast food (and expense of healthy food), and a lack of any opportunity to engage politically, so young people feel disenfranchised.

The area is increasingly multi-ethnic. One of the participants is working with **young asylum seekers**, many of whom are traumatised, isolated ('asylum seekers are not a "community"') and disbelieved about their age.

One strong theme of the workshop was the **medicalisation** of people with health problems, such as being diagnosed with borderline personality disorder, rather than recognising that they have suffered trauma and need different forms of help. Many people in Govan are on multiple prescription drugs, which can blur into addiction. And, more shockingly, 'there is a tendency to give drugs to people just to keep them quiet'.

While there are strong structures behind some services (e.g. child sexual abuse), this structure does not exist for other areas, such as asylum-seekers. **Accessing services** is often very challenging for young people – one participant noted that they may even have to resort to overt and harmful action (such as serious self-harm) just to access the mental-health help that they need.

There are **'destructive coping mechanisms'** such as drug abuse, with little understanding of the consequences, that lead to longer-term health problems, and there are also new risky behaviours –

technology (social media – the 'never-ending phone and screen addiction') and synthetic drugs – about which little is known.

Challenges

This workshop painted a grim picture of '**fighting for funding'** for projects. While statutory services are relatively well resourced, the third sector is not – and there is constant competition for funds, because of a lack of combined budgets or resource-pooling. Core funding has often been cut, leaving organisations to scale back what they offer. In other cases, money is available to 'suit the needs of the funders', with poorly designed and ineffective interventions that organisations feel obliged to accept because they come with funding attached. Funding is siloed, and professional jealousy and self-interest among some individuals has 'ruined the landscape of joined-up thinking'.

> *'Third-sector organisations are maxed out – we can't be responsive or develop to needs and wants, because of underfunding or lack of security for future funding.'*

There are frustrations with the **bureaucratic structure** within which the third sector is trying to work – and this is exacerbated by government instability, as any change in administration requires new relationships to be built and new policies to integrate. The statutory sector has a tendency to impose ideas on the voluntary sector without an adequate appreciation of what is needed – for example, deciding what training should be provided or requiring 'clunky and ill-thought-out' activities. There is a lack of a common language or understanding, and participants felt that they are not being listened to: 'you can't protect young people if your voice isn't being heard'.

> *'We are always fighting for a space to advocate for young people.'*

There is also a concern that there is **naivety** in the way that young people are supported – a failure to understand how to be relevant and age-appropriate: 'We are too punitive towards young people.'

The **pressure on staff** is clearly intense – all three people who sent last-minute apologies for not being able to attend were too busy to come ('unfortunately we are very understaffed this week'), despite being keen to do so. The emotional input required to deal with young people is intense – sleepless nights for the participants – and pay is low ('people do it because they love it'). Staff do not have the capacity to spend quality time with young people. These staffing issues are not restricted to the third sector – participants appreciated that people in the council are also struggling to do their jobs.

> *'It's very easy to become cynical because the imposed structures make it really difficult to make a difference.'*

Safeguarding and risk assessment was seen as important but onerous. In organisations that do not have child protection as core to their work, this can be a serious challenge: 'There isn't enough knowledge around how and when you can intervene in child protection.' It is hard to justify the time and energy it takes to do a child-protection assessment, as there is then not help available for implementation.

Often, people prefer to **go to the GP** to be told what to do, as they lack the agency to make decisions. But GP services are 'a lottery': although some GPs now think beyond their practice to consider wider health determinants (such as housing), others can be very unsympathetic to complex needs. There is also often a failure to provide interpreters – meaning that many will rely on a family member, who will also not have English as a first language, to explain their very complex health needs.

Fostering success

But it was not all doom and gloom – there were success stories. While child protection and the 'don't be a grass' culture can make it harder to tackle abuse, one participant noted that she worked successfully with a traveller community on this issue, because they fully appreciated the seriousness of the situation.

The **youth group for disabled people** has recently opened-up to non-disabled people, too – who have very much enjoyed getting involved in wheelchair balloon football or basketball, asking to borrow wheelchairs themselves to make the game fair. Fruit juice and yoghurt has been introduced, with sugary drinks hidden so that the young people have to specifically ask for it.

Two organisations have been involved in **asset mapping** locally, to better understand how to communicate with communities. The data becomes leverage that can influence decision-makers locally – 'a powerful story about a community and the problems it faces'. Asking local people what they want can yield unexpected answers – in one case, a chemist, which no one would have anticipated to be a priority.

Finally, despite the pressure on staff, there is 'a lot of passion and humanity'.

Solutions

Many of the solutions for the problems of this community that were suggested in the workshop were very **broad-brush**: universal income, safe and supported accommodation, youth engagement (and lowering the voting age to give young people a sense of responsibility), adequate public transport, and human rights assessments for the most vulnerable groups.

More specifically, there was a call for an early introduction to sex education, particularly talking to boys about acceptable sex, and early intervention on substance misuse and mental health. A move **away from the blanket medication** of the population was also called for, and it was suggested that healthy risky behaviour could be encouraged (such as rock climbing).

Finally, are there ways to get around the dependency on statutory funding by creating new structures for resourcing (such as crowdfunding). And it is essential to ensure **better resource allocation** based on longer-term strategies, with clear understanding of funding cycles so that the third sector can plan its work with statutory bodies:

'Integrating services is the only way to develop a community-wide response to the health crisis we are in.'

Appendix 2.3 – Derry

Statistics

1. Children who are obese in Year 8 (11–12-year-olds, 2012/2013–2014/2015): 8.5% (includes Strabane) – this is above the average for Northern Ireland of 7.3%

2. No statistics on children in care comparable with the rest of the UK, but 0.9% of children are in care in Western Health and Social Care Trust area (5 councils including Derry) in 2016 and 0.62% in foster care.

3. Unemployed (16-64 y/o, 2017): 5.1% (NI average 2.6%)

4. In Northern Ireland, 12.2% of 16-24-year-olds years are NEETs (statistics for Derry not available) (2017)

Sources:

1. Derry City and Strabane District Council, 'Mood and anxiety disorders, obesity and cancer': http://www.derrystrabane.com/getmedia/76237fc3-7102-41bf-85fb-071a668f5440/Mood-and-anxiety-disorders-Obesity-and-Cancer-220217.pdf

2. Child poverty levels 'a damning indictment'', Derry Journal, 18 April 2017: http://www.derryjournal.com/news/child-poverty-levels-a-damning-indictment-1-7919414 combined with population statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland)

3. Derry City & Strabane District Council,'Unemployment': http://www.derrystrabane.com/Subsites/Derry-and-Strabane-Statistics/Economy-and-Labour-Market

4. Northern Ireland Statistics and Research Agency, https://www.nisra.gov.uk/publications/quarterly-supplement-tables-january-march-2017

List of attendees

Organisation	URL
Pink Ladies	http://www.gasyardcentrederry.com/wordpress/?page_id=90
North West Counselling	http://www.mindingyourhead.info/service/north-west-counselling
Pink Ladies Members' Forum	http://www.gasyardcentrederry.com/wordpress/?page_id=90
Dove House One Stop Shop	https://www.facebook.com/people/Youthtransitionproject-Oss/100009996258521
Derry Well Women*	http://www.derrywellwoman.org/
Verbal Arts Centre	http://theverbal.co/
Men's Action Network	http://www.man-ni.org/
RAPID	http://www.rapidni.com/
Derry Well Women*	http://www.derrywellwoman.org/
Extern Organisation	http://www.extern.org/
Cathedral Youth Club	https://www.facebook.com/cathedralyouthclubfountain/

* Has health/wellbeing as a stated aim/vision of the organisation

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The Derry workshop was held on 3 May 2017, and brought together 11 people from nine organisations from across youth clubs, a rural organisation, counselling/support and the arts.

Participants were positive and open-minded, expressing the hope that they would listen to and learn from others, and that it would be a chance to share their own success stories.

Working with 14–24-year-olds in Derry

Note: It was perhaps a surprise that **the Troubles and the Catholic/Protestant divide** were barely mentioned during the workshop itself. This was welcomed by one of the participants, who noted that the day was 'fresh and different … [with] no sense of the political difficulties that trouble Northern Ireland', and she thought that this was 'interesting in itself'. However, in a follow-up discussion it was evident that the past still impacts on the lives of people in Derry (for example, victim survivors of the Troubles), with ongoing differences in opportunities and attitudes for the different communities.

This age group covers important **transitional phases** – particularly at 18, when young people may be severed from friends – which can be the catalyst for enormous problems, and may be dealt with in ways that young people do not recognise as being harmful. It is essential to try to understand the triggers for adopting unhealthy behaviour such as alcohol/substance misuse and risky sexual behaviour.

A counselling organisation noted that major **mental-health issues** include low self-esteem, body image, depression and the 'pursuit of perfection' – and there are high levels of suicide.

'Resilience in kids is a real problem… It doesn't matter who you are, everyone has had a bump in the road, and resilience is about being able to overcome those bumps.'

There has been a breakdown of the traditional **social cohesion** that was provided by the Church and family structures. Parents may not talk to their children about personal development, and may themselves be demonstrating poor behaviours. The number of children entering the care system are also 'the highest they have ever been'.

Poverty and worklessness leads to limited choices and economic disadvantage, and parents 'are passing on the culture of non-work'. Young people in Derry do not have high aspirations and are cynical about education, as they feel that there will be no employment for them, regardless of qualifications. In some local schools, only 30 children a year graduate with GCSEs. When negative statistics are used about communities, 'people start to define themselves by those statistics'. And the traditional 'three strikes and you're out' approach has to change: these are people with complex needs, often on the edge of care.

It was noted that the **community and the voluntary sectors** are very different and separate from one another. The 'voluntary' sector is (for example) the NSPCC; the 'community' organisations (such as youth centres) are not formal or organised, but do have a big impact locally.

The issue of **place** – engaging young people where they feel most comfortable – was raised several times: 'we need to bring support <u>to</u> people'. This is both about reaching people in their own communities (for example, physically siting an organisation on the route to the local college), but also about creating a 'safe space' for people to meet and interact. While there are concerns about health issues across the whole area, there has been particular social and economic decline of rural communities.

'Personalised thinking and local service is really important for individuals who are in need.'

Listening to and communicating with young people is essential – scolding young people is likely to be much less effective than talking to them about the consequences of decisions that they make, and working out how to use social media to positive effect. Talking to the potential recipients of programmes is also the best way to develop and improve initiatives.

Here, as elsewhere, young people form a hugely diverse group:

'There really isn't any such thing as "the young".'

Challenges

Although more and more people are in need of support, they do not come for help – making it **hard to reach those in need**. This demonstrates the importance of making it easy for people to find and access programmes, providing them where people live.

Organisations 'are often quite **protective of their own territory**', which means that what is offered to young people may be duplicated or fragmented. Even when people do want to work together across organisations, they do not know how to do it – it would be useful to be trained in how to collaborate. There is a 'lack of professional courtesy' between organisations and sectors. In addition, there is insufficient respect for local expertise, with regional organisations not appreciating the priorities for the local community. 'Times have changed' in Northern Ireland, and the services available have not yet caught up – and the statutory system tends to have to work to strict parameters. As was pointed out in the follow-up meeting, although the language of 'partnership' suggests moving away from the Troubles, power relationships continue: 'How do you make change when so many people rely on keeping the system of need intact?'

Financial sustainability is a concern – ending short-term funding can result in programmes closing. There is a need to identify economies of scale. Funding is often outcomes-based, rather than looking more broadly at the successes, and reporting/evaluation can be onerous – evaluation could be better done by another organisation with greater expertise – and funders should take more risks.

'We know we are having an impact and we need to be trusted in our expertise'

To get funding, communities have to describe why they are particularly disadvantaged – so it becomes a '**race to the bottom'**. However, Derry has been the recipient of EU funding towards the peace process and the lack of available funding streams was less of a topic of discussion than at many of the other workshops.

Organisations may be unwilling to engage with young people because of issues around **safeguarding** – they need assistance in feeling confident to work with this age group.

[A further point to note is that abortion is illegal in Northern Ireland – however, this was not raised in discussion during the workshop.]

Fostering success

Several of the organisations act as local **hubs** for young people. These may not be well known outside the vulnerable groups with which they work, despite having significant reach and impact within those groups – providing services and counselling in-house, but also with the knowledge and trust to direct people on to other programmes as appropriate. For example, a youth club works in partnership with a local college to provide education for the community, and also provides educational support for teenagers (and encourages family members to come to help), evening meals, counselling and cookery classes.

Using **reading** to engage young people has been shown to promote wellbeing through reducing isolation and anxiety, and encouraging conversation about the reading and about life more broadly. This is usually in groups of around 10, and is led by a trained facilitator. Providing access to the **arts** for people who never thought that this was something they could do is also valuable in expanding horizons and improving wellbeing.

Gender-specific organisations have also had success – men, for example, have often felt excluded from other services. However, these organisations recognise that men and women do not exist in a vacuum, and extend their work to couples (including working with men who have been in abusive relationships) and families, as appropriate.

In one case, a **scale model** of a local estate was made, with residents invited to see the model and identify and comment on barriers to their ability to live well and safely (including putting a coloured dot on their own house). There was real enthusiasm for the model and the initiative, and following the exercise several organisations committed to addressing the main issues that had been drawn out.

Solutions

Ways in which to **collaborate more meaningfully** were suggested – training in collaborative processes, and also developing an 'engagement platform' to discuss with young people how best to develop programmes, as well facilitate discussion with other organisations on how best to deliver services.

'Young people should be able to influence decision-makers.'

Appendix 2.4 – Kent

Statistics

1. Children reporting general health as excellent (15 y/o, 2014/2015): 27.5% (England average 29.5%)

2. Children who eat 5 portions or more of fruit and vegetables per day (15 y/o, 2014/2015): 51.0% (England average 52.4%)

3. Physically active children for at least one hour per day seven days a week (15 y/o, 2014/2015): 13.7% (England average 13.9%)

4. Obese children in Year 6 (10-11 y/o, 2015/2016): 18.7% (England average 19.8%)

5. Percentage of children in need (of local authority to achieve reasonable health and development) during 2015–2016: 5.6% (England average 6.67%)

6. Hospital admissions due to substance misuse (15–24 y/o, 2012/13–2014/15, rate per 100,000): 104.9

7. New sexually transmitted infections (16–24 y/o, 2013, per 100,000): 2,735 (England average 3,432.7))

8. Percentage of children at risk of ongoing sexual abuse out of total children in need (under 18, March 2016): 9.18% (England average 7.25%)

9. Emergency hospital admissions for intentional self-harm 2015/16 per 100,000: 204.8 (England average 196.5)

10. Unemployed (16–64 years): 4.8% (GB average 4.5%)

11. NEET (16–18 years, 2015, percentage out of 16–18-year-olds known to local authority): 5.0%

12. Children age 17–18 who have formally entered the youth justice system (2013/14, per 100,000): 15.3 (England average 19.8)

Sources:

1–3. Public Health England, 'Young people – Kent': https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000008/ati/102/are/E06000036/iid/92624/age/249/sex/4

4. Public Health England, 'Health profiles – Kent': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000008/ati/102/are/E06000036/iid/20301/age/1/sex/2

5. Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

6–7 and 12. Public Health England, 'Young people's profile – local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

8. UK Government, 'Characteristics of children in need: 2015–2016': https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016 (table B3)

9. Public Health England, Public Health Profiles (Kent – County and UAP): https://fingertips.phe.org.uk/search/suicide#page/1/gid/1/pat/6/par/E12000008/ati/102/are/E10000016/iid/41001/age/285/sex/4

10. Nomis, 'Labour market profile – Kent': https://www.nomisweb.co.uk/reports/lmp/la/1941962885/report.aspx

11. Department for Education, 'NEET data by local authority' (2016): https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

List of attendees

Organisation	URL
Sheppey Matters*	http://www.sheppeymatters.org.uk/
Porchlight*	http://www.porchlight.org.uk/
Hand on Heart Arts and Deal Festival	https://handonheartarts.com/
Addaction	https://www.addaction.org.uk/
Switch Youth Café	http://www.switchcafe.co.uk/
Ideas Test	http://ideastest.org.uk/
Addaction	https://www.addaction.org.uk/
KentCAN	http://www.kentcan.org/
Kenward Trust	https://www.kenwardtrust.org.uk/

* Has health/wellbeing as a stated aim/vision of the organisation

Interviews

[Kent Refugee Action Network: https://kran.org.uk/]

[Kent Enterprise Trust: http://kententerprisetrust.org/]

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The workshop in Faversham, Kent, was held on 12 May 2017, and brought together nine people from eight organisations from the arts/media, homelessness, addiction treatment and rehabilitation, ex-offenders, networking and a youth café.

Working with 14–24-year-olds in Kent

Kent is a large county with areas of severe deprivation. All the participants mentioned the problems with high levels of **obesity** arising from low physical activity and unhealthy food choices, and the underlying social determinants, such as poor housing and income. 'Poverty of aspiration' – resignation and a lack of hope and engagement – also holds young people back.

While there is often a lack of opportunities to socialise (which has a negative impact on health), many of the participants commented on the growing **gang culture**, which involve increasingly dangerous initiation ceremonies. Young people may be afraid of being threatened, which causes anxiety and can also lead to them carrying knives and becoming criminalised themselves. However, there is also a problem with the unfair 'vilification' of young people – for example, when they become the subject of a dispersal order because they are meeting a group of friends.

There has been a steady rise in **self-harm** among young people (measured by A&E attendances): 'the more we talk about it, the more people come out of the woodwork – so it's hard to know if more people are self-harming or whether we are just hearing about it more'. One initiative was set up following GPs' concerns that young people were self-harming but were not reaching the threshold to receive specialist mental-health services.

Drug use is also an issue, although this varies across the county (cannabis in Thanet; ecstasy in Gravesend). Cannabis use is leading to an increase in chronic obstructive pulmonary disorder, even as tobacco smoking levels are decreasing: 'it is easier to get drugs than it is to get cigarettes and alcohol'. Prescription drugs are being taken on the streets, sourced through the dark web – and some people are even using vet

prescriptions. At one time, Maidstone had several shops selling 'legal highs' – and because of the name, people wrongly assumed that they were safe.

'Knowledge is power for young people. Often they don't even know what drugs they are taking.'

Drug problems are often paired with other issues, including grooming and sexual exploitation, and youth offending. Many of the participants noted that they are likely to work with young people who are also being seen by others in the room.

The influence of **social media** is pervasive – it has an impact on sleeplessness and learning. One participant commented that while smoking is bad, it used to be a social activity; now, young people may get together to smoke while online, so even the social aspect is disappearing. Apps such as Tinder and Fuck Buddy are contributing to a rise in sexually transmitted infections. Social media is also linked to mental health through bullying and revenge porn on Instagram, Snapchat and Facebook. It can also contribute to obsession with body image, with young people becoming reliant on protein shakes and steroids.

Finally, young people have to cope with a '**lack of space and time**', of always having to learn: 'Sometimes they just need time to be.'

Challenges

Resourcing is a challenge common to all the participants, and there was frustration that funding is competitive rather than collaborative. Funding sources are being diversified, employees laid off, and organisations know that there is a gap between local need and availability. One organisation is now requiring staff to find their own funds for projects, and another has become community interest company that is reliant on membership for income. There is also greater dependence on volunteers – although it can be hard to find people willing to do this because of a bias against this age group:

'People would rather work with dogs, small children or the elderly than with young people.'

Access to funding is often dependent on demonstrating **impact**, which needs to go beyond measuring outcomes, which is problematic as it is hard to assess the effect of initiatives on long-term stability. For example, the café for young people had over 35,000 visits in the past year – but young people are not required to register, and discussions are informal, so it is 'really hard to get any data'. And, while the arts organisations know that 'being creative allows you to be resilient' (and the national agenda has shifted to recognise the benefits of the arts on health), there are gaps in knowledge about how to measure what they do and demonstrate the individual and community benefits.

'Kent isn't a diverse area' – which means that when there are challenges of language or culture (such as with asylum-seekers', organisations may not be equipped to cope.

Attendance is a significant challenge, and 'it's a struggle to accept when they're <u>not</u> ready': choosing the right time to engage is crucial, and young people need to be given as many opportunities to attend as they want. Services are not good at seeing when and how to refer young people between organisations. This makes it harder for young people to navigate the system – and if they have to repeat their stories multiple times as they are moved through the system, they are likely to lose trust in the assistance that is on offer.

It is also difficult to **communicate** with young people, and when young people are not able to express themselves, this masks potentially serious problems (such as self-harm). Trying to work in schools needs rethinking, as young people often have a very different identity outside school.

'Each young person is individual and has their own story that needs to be listened to.'

Joined-up thinking can be hampered by a **fear of sharing information** about young people. While data protection is important, 'we are professionals, so we should be trusted to share data when necessary'.

Finally, the highest-level challenge is that 'we have politicians in power – the health secretary, for example – who have no experience of the area of expertise they represent'. This needs to change!

Fostering success

Organisations have been successfully adapting to **changing needs**. For example, one organisation has evolved from finding housing for homeless people to helping them overcome addiction, and the café has just received funding from Kent Police to work on crime prevention.

The arts organisations struggle against a **perception** of art/music being 'elite' – but a local music festival has been set up, and now runs a programme throughout the year that includes offering the chance for young people to learn musical instruments. Survey-based evaluation has suggested that their programmes help with confidence and with attainment in school, and increase school attendance.

In another successful example of **evaluation**, the self-harm initiative has been evaluated by the University of Bath. The feedback has been good, and this will help to build the broader evidence base for this approach.

The café clearly provides a **safe space** for young people – around 20 per cent of those coming to the café are from the LGBTQ community, and the young people appreciate the non-judgemental approach. This sense of involvement is fostered by ongoing involvement by the young people themselves. The rooms in the café, for example, were designed and decorated by young people, and a panel takes part in interviews of anyone who wants to work there. The café also acts as a hub from which other programmes (that cannot be offered on site) can be advertised – getting the word out much more widely.

The broad **range of issues that 'health' encompasses** was highlighted by one organisation, including community transport, a community shed, food wagon and a community gardener.

Social media can be used positively – a group of young men wanted to continue to stay in touch to talk about self-harm, and an online forum and YouTube channel has been set up to help them do so.

Solutions

Among solutions discussed were:

- better communication about **what the third sector is doing locally** (for example through a networking hub, as provided by one of the participating organisations) to ensure that there is not replication of programmes and to link up funding and sharing of resources;
- the need to find staff who are **fully understanding of the issues** facing young people – for example, when addiction services are staffed by people with personal experience of addiction or crime (all fully risk-assessed) – then even the hard-to-reach are more likely to open up;
- giving young people a **voice** in developing initiatives can bolster their confidence and engage them much more fully: 'if you trust them, they trust you';
- making **education fit for purpos**e: 'a curriculum for life' that includes practical information on dealing with social media and an emphasis on vocational learning; and
- campaigning for a **positive media image** of young people.

Finally, it was suggested that the underlying causes of the problems affecting young people are so important and fundamental that they can only fully be tackled through the involvement of central government.

'You have to persuade people to see the value in young people. It's the underlying social problems that are the big thing, not the kids themselves.'

Appendix 2.5 – Cornwall

Statistics

1. Children reporting general health as excellent (15 y/o, 2014/2015): 31.0% (England average 29.5%)

2. Children who eat 5 portions or more of fruit and vegetables per day (15 y/o, 2014/2015): 57.3% (England average 52.4%)

3. Physically active children for at least one hour per day seven days a week (15 y/o, 2014/2015): 16.7% (England average 13.9%)

4. Obese children in Year 6 (10-11 y/o, 2015/2016): 17.3% (England average 19.8%)

5. Percentage of children in need (of local authority to achieve reasonable health and development) during 2015-2016: 4.45% (England average 6.67%)

6. Hospital admissions due to substance misuse (15-24 y/o, 2012/13- 2014/15, rate per 100,000): 96.9 (England average 88.8)

7. New sexually transmitted infections (all ages, 2013, per 100,000): 3,140.2 (England average 3,432.7)

8. Percentage of children at risk of ongoing sexual abuse out of total children in need (under 18, March 2016): 7.04% (England average 7.25%)

9. Emergency hospital admissions for intentional self-harm 2015/16 per 100,000: 235.2 combined with Isles of Scilly (England average 196.5)

10. Unemployed (16–64 years): 3.7% (GB average 4.7%)

11. NEET (16–18 years, 2015, percentage out of 16-18-year-olds known to local authority): 3.7%

12. Children age 17–18 who have formally entered the youth justice system (2013/14, per 100,000): 16.2 (England average 19.8)

Sources:

1–3: Public Health England, 'Young people – Cornwall': https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000009/ati/102/are/E06000022

4. Public Health England, 'Health profiles – Cornwall': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000009/ati/102/are/E06000022/iid/20301/age/1/sex/2

5. Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

6–7 and 12. Public Health England, 'Young people's profile – local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

8. UK Government, 'Characteristics of children in need: 2015–2016': https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016 (table B3)

9. Public Health England, Public Health Profiles (Cornwall – county and UA): https://fingertips.phe.org.uk/search/suicide#page/1/gid/1/pat/6/par/E12000009/ati/102/are/E06000052/iid/41001/age/285/sex/4

10. Nomis, 'Labour market profile – Cornwall': https://www.nomisweb.co.uk/reports/lmp/la/1946157349/report.aspx?town=Cornwall#tabempunemp

11. Department for Education, 'NEET data by local authority' (2016): https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

List of attendees

Organisation	URL
WILD Young Parents Project*	https://www.wildproject.org.uk/
Addaction	http://www.addaction.org.uk/
Carefree – Fostering Independence Cornwall	https://www.carefreecornwall.org.uk/
The Learning Partnership for Cornwall	http://www.cornwall-learning-partnership.org/
Dreadnought	http://thedreadnought.co.uk/
White Gold Cornwall	http://www.whitegoldcornwall.co.uk/
First Light	https://www.firstlight.org.uk/
Pentreath*	https://pentreath.co.uk/

* Has health/wellbeing as a stated aim/vision of the organisation

Interviews

[Battle Scars: www.battlescars.org]

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

This workshop was held in Truro, Cornwall, on 15 June 2017, and brought together eight people from eight organisations covering mental health, drug/alcohol misuse, working with young people in and leaving care, and working with young parents. They welcomed the chance to share experiences of working with young people and to feed into wider research, and one participant who had said he would leave half way through the day stayed to the end.

Working with 14–24-year-olds in Cornwall

Living in Cornwall is difficult for many young people – getting around is often dependent on being able to **drive**, but many cannot afford it, so this excludes them from opportunities such as to take part in sport (and many young people are 'physically weak').

Young people are concerned about the **future** – whether they will find a job or ever be able to afford their own home, added to real fears around climate change. Fewer young people are living independently than a decade ago.

The way in which **young people define themselves** is changing. In one local school, half of the pupils do not identify as heterosexual – not necessarily because they are not heterosexual, but because they do not feel comfortable 'restricting their identity' in this way. Young people are also more open about mental health, which is less stigmatised than in the past, but which seems to be on the increase (including anxiety and depression); there is a 'massive spike in referrals [to a mental-health charity] during exam times'.

Young people leaving care face particular challenges – they are often moved through several carers from within and beyond the family, and this uncertainty has effects on other aspects of their lives, including education: 'you have to be able to sustain relationships before you can learn'.

The health challenges facing **young parents** are also striking. There is food insecurity, with half of young families are using food banks, and many young mothers are either obese or are seriously underweight. Smoking rates among young mothers are high (up to around 50 per cent), and they are often physically inactive. They may be unable to care adequately for their children – some young children have to be given a zimmer frame because they have not been taught to walk. These families have higher morbidity and mortality rates than other young people.

There are many cases of sexual assault and rape, and in particular the **sexual exploitation of children** is a serious problem in Cornwall. Once girls reach 18, even though their experiences continue, it is often regarded as consensual, because it is no longer child sexual exploitation.

'The extent of child sexual exploitation is shocking.'

There are also threats to health from **drug misuse** (especially prescription medication, amphetamines, legal highs and cannabis) and binge drinking – and access to drugs may be easier than to alcohol for young people under 18, as drugs are readily available online. Young people with mental-health problems face a double hurdle – CAMHS will not see them if they are using substances. Cornwall also has a history of smuggling, and contraband, cheap cigarettes are a real problem.

'Substance misuse is a symptom related to physical activity, mental health, lifestyle and home life.'

Challenges

There are **resourcing challenges** across the board: one organisation noted that they receive three times the number of (substance abuse) referrals of five years ago, but with no increase in staff, and the referrals themselves are more complex. It is hard to access good quality, affordable training (for example around autism or child sexual exploitation). 'Everyone's funding is being squeezed', and where funds are tight, it is harder to be flexible in delivering programmes.

Timescales for funding are also an issue, with an acute problem at the end of the financial year, when it is often very unclear whether funding will be renewed. There was also a sense that those in the third sector are made to feel that they should provide services for free – but they do have a clear monetary value.

'We are always being told there is no new money.'

Schools and other organisations are **searching for programmes** to help young people, and 'desperately taking up quite spurious offers' – including a pub landlord who was delivering a programme on alcohol misuse in a local school.

Social media has introduced a new, negative impact on mental health: 'Adults are playing catch-up with social media, and children don't see the danger.' It is also a gateway to sexual abuse, as young people who have been neglected may find it particularly hard to discern who is genuinely concerned for their wellbeing and who is being predatory.

Unhealthy lifestyles are widespread, especially among vulnerable groups. The places where young parents live, for example, often do not have spaces for play or physical activity, and many young people have never been taught the life skills that they need for health, such as learning how to cook a cheap, nutritious meal.

'There is more understanding these days that people aren't choosing to put themselves at risk as a lifestyle choice; it is more to do with their negative experiences.'

The benefits of initiatives may only become fully obvious over a long time period, with benefits that are very **hard to measure** by traditional methods. For example, one boy who had been in care was asked if he would like to take off his coat at trips to the beach – and it was only once he felt comfortable (which took years) did he finally take off his coat. Young people may also take a long time to disclose trauma or behaviour that has put their lives at risk.

'You just don't know what your impact is until you hear back from people much later.'

There is a **failure to follow young people** who have been in care beyond the age of 21 – the system is not set up to help them to navigate life having followed the trauma of being in care, although as a group their health is worse than the national average.

Privacy issues are also a challenge. Organisations are unwilling to share information, even when to do so might be in the best interests of the child – and young people themselves need to be helped to understand that sharing information could help to improve their situation.

'Young people aren't respected by adults, but are expected to be like adults.'

Fostering success

Finding **charity funding** (rather than statutory funding) can allow for open, non-prescriptive programmes that provide significantly more flexibility in working, engaging with young people in whatever ways work for individuals.

Many young people will have been seen by multiple agencies and organisations, and **partnership working** can be successfully achieved between the statutory and third sectors. One participant noted that 'one of the great strengths of the third sector is that it isn't precious about working with other organisations or sectors'. Working together should be embraced by the statutory sector, as 'the third sector is better at networking'.

'It's people on the ground who join things up.'

Working **closely with young people** (often one-to-one to foster trust) to make their own decisions is key. 'We will never go against the wishes of the young person', even if their parents feel differently. This is particularly important for young people who have suffered sexual abuse – if a young person does not want to go to the police immediately, one of the organisations works with victims to collect evidence, which can be kept for up to two years, giving the individual the time to decide whether to pursue the case.

Working with young people **without a time limit**, and without refusing to work with them if they initially pull out of a programme, can be of benefit. One young man who had a history of drug use said that 'you were the only place that would always take me back'.

One organisation went **smoke-free** after consulting the young people who use it, which is seen as being 'part of a nurturing and parental environment' – there need to be some boundaries, and this stops non-smokers from being encouraged to take up the habit.

The organisation that works with young parents has demonstrated notable success both in **impact and in evaluating**: 75% of young dads improved their confidence in caring for their children, smoking rates among the mums fell from 54% to 43% in five years, and 83% of those with poor mental health show improvement through the programmes.

Solutions

Among solutions discussed were:

- finding a **variety of sources of funding**, including charity funding, the Big Lottery and the European Social Fund, and joint funding by schools: 'Never put all your eggs in one basket!' One project has asked local older people to contribute their winter fuel allowance to buy baby blankets and shoes, and to put a few pounds on the electric meter of poor families;
- **in-kind donations**, which can be a good resource – such as Waitrose donating organic vegetables to a programme for young parents; and
- **work with young people where they live** – going to meet them, rather than expecting them to come to an organisation, may be the way to engage. There are no 'hard to reach' groups if you go to where they live; rather, there are 'hard-for-me-to-reach' groups!

Appendix 2.6 – Southwark, London

Statistics

1. Children reporting general health as excellent (15 y/o, 2014/2015): 27.4% (England average 29.5%)

2. Children who eat 5 portions or more of fruit and vegetables per day (15 y/o, 2014/2015): 53.3% (England average 52.4%)

3. Physically active children for at least one hour per day seven days a week (15 y/o, 2014/2015): 11.4% (England average 13.9%)

4. Obese children in Year 6 (10-11 y/o, 2015/2016): 26.7% (England average 19.8%)

5. Percentage of children in need (of local authority to achieve reasonable health and development) during 2015–2016: 8.2%

6. Hospital admissions due to substance misuse (15-24 y/o, 2012/13- 2014/15, rate per 100,000): 64.6 (England average 88.8)

7. New sexually transmitted infections (16–24-year-olds, 2013, per 100,000): 5,363.4 (England average 3,432.7)

8. Percentage of children at risk of ongoing sexual abuse out of total children in need (under 18, March 2016): 3.20% (England average 7.25%)

9. Emergency hospital admissions for intentional self-harm 2015/16 per 100,000: 93.2 (England average 196.5)

10. Unemployed (16–64 years): 6.6% (GB average 4.5%)

11. NEET (16-18 years, 2015, percentage out of 16–18-year-olds known to local authority): 2.2%

12. Children age 17-18 who have formally entered the youth justice system (2013/14, per 100,000): 29.5 (England average 19.8)

Sources:

1–3. Public Health England, 'Young people – Southwark': https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people/data#page/0/gid/1938132988/pat/6/par/E12000007/ati/102/are/E09000028/nn/nn-3-E09000028

4. Public Health England, 'Health profiles – Southwark': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000007/ati/102/are/E09000028/iid/20301/age/1/sex/2/nn/nn-1-E09000028

5. Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

6–7 and 12. Public Health England, 'Young people's profile – local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

8. UK Government, 'Characteristics of children in need: 2015- 2016, Main tables' : https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016 (table B3).

9. Public Health England, Public Health Profiles (Southwark – County and UA): https://fingertips.phe.org.uk/search/suicide#page/1/gid/1/pat/6/par/E12000007/ati/102/are/E09000028/iid/41001/age/285/sex/4

10. Nomis, 'Labour market profile – Southwark': https://www.nomisweb.co.uk/reports/lmp/la/1946157256/report.aspx?town=southwark#tabempunemp

11. Department for Education, 'NEET data by local authority' (2016): https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

List of attendees

Organisation	URL
Daybreak	http://www.daybreakfgc.org.uk/
Oasis Church Waterloo	http://www.oasiswaterloo.org/
Step Up to Serve	http://www.iwill.org.uk/
Mytime Active*	http://www.mytimeactive.co.uk/
Step Up to Serve	http://www.iwill.org.uk/
Safer London	http://saferlondon.org.uk/

* Has health/wellbeing as a stated aim/vision of the organisation

Interviews

[Mencap: https://www.mencap.org.uk/]

[http://www.wgn.org.uk/]

[http://blackprincetrust.org.uk/]

[Music and Change (MAC UK): http://s673592965.websitehome.co.uk/]

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The London workshop was held on 28 June 2017 in Southwark, and brought together six people from five organisations – encouraging young people to take social action (volunteering), tackling obesity among children and young people, working to counter gang crime or child sexual abuse, an organisation delivering family group conferences, and a charity based around a geographic hub in south London. There were two organisations that were not able to attend at the last minute – perhaps because (unlike in other locations) they already felt well networked, so there was not the same incentive to participate.

Working with 14–24-year-olds in London

The workshop took place soon after the terrible Grenfell Tower fire in Kensington – an area of London where life expectancy in the north of the borough (where the tower block was situated) is 14 years lower than the more affluent south.

Gang culture was a concern of this workshop – and in particular the links with child sexual exploitation and domestic violence: 'it is really hard work stopping kids from entering gangs at age 16'. Sexually transmitted infections (including chlamydia, syphilis and HIV) are increasing – although teenage pregnancy is down, due to the available contraceptive choices.

Fewer young people smoke, but **substance misuse** is increasing, including the use of hard drugs and cases in which parents give pills to their children. Alcohol is particularly harmful to lower socioeconomic groups who are less likely to have support available.

Young people are often keen to be involved in **social action / volunteering** – but they may not know how best to go about this, and where to go to become involved. There is evidence that encouraging volunteering can significantly influence young people's decisions about their future, at the crucial transition point between school and the job market. It is also empowering for young people to take part.

Children on the Child Protection Register are often very unhealthy – and are sometimes referred on the basis of this ill health. **Mental health** issues still struggle with judgement and stigma (including from peers and the local community). **Obesity** among young people is 'particularly bad in Lambeth' (the adjoining borough to Southwark, where the workshop was held) – and concerns about body image are driven by

social media. Often families do not know what healthy food options might be, and young people are also increasingly unfit.

There is also **bias** against poorer families. As one participant noted, if poorer communities consumed the amount of alcohol drunk in some wealthy households, this would be seen to be a child protection issue:

'If you're rich and you use drugs or alcohol, you need child support.
But if you are poor, you need child protection.'

Challenges

While all agreed that **prevention** is the key to success across all areas (mental health, sexual exploitation etc.), too often it is prevention funding that is being 'slashed by government', leaving organisations firefighting, rather than intervening at an earlier stage – for example, taking referrals only once a case has reached the courts.

Funding is always in short supply and is often short term, leaving staff on short-term contracts with uncertainty as to their future (some are self-employed), despite having had to take on more work: 'you are always wondering if you're going to have a job'. One of the larger organisations present had only 50 per cent funding in place with just a month until the next cycle of funding is due to begin, and another has had to cut the age range with which it works. Former sources of funding – such as from the Police – are no longer available.

Evaluation has proven to be challenging in several ways. Each young person's situation is individual to him/her, which makes it very difficult to measure cases against each other, and when young people self-assess the impact of a service (on self-esteem etc.), this is also difficult to compare. Long-term data is lacking in family group conferences. Even where external research was required as part of a funding model, one organisation had no say in what was measured – and there can be a significant delay in acquiring the results of the research.

'You have to have so much evidence, which isn't always easy to collect,
and you have to jump through too many hoops to get tiny pots of money.'

It can be very hard for young people to **access** programmes (notably CAMHS, for which they 'have to prove they are worthy of the service') – and if a young person tries and fails to get help, they are less likely to try to seek help in the future. Retention can also be challenging (especially among the hardest to reach), and it is difficult to keep track of young people (and measure successes), as they dip in and out of programmes: 'it's hard to prove which intervention is the one to save the money'.

Among the younger age group, involving the **wider family** was mentioned many times – for example, where a child or young person is being sexually exploited, there is probably at least one carer or parent who also needs support. However, many in the 14–24 age group will be involved as parent/carer rather than as child.

Language can be a significant barrier in multi-ethnic London. The staff of one organisation speak 16 languages between them, and they always make the effort to match young people with the person who speaks the language.

Partnership working – 'thinking more carefully about how to create possibilities for better connections across different organisations' – still has a way to go. This was not, however, as frequently mentioned as it was during the course of many of the other workshops.

It is 'really hard to keep up' with **social media**, as new apps keep appearing (including one described as 'like Tinder for kids'). Staff often do not have the skill set to talk to young people about social media – bullying happens out of sight.

'[Image] is the most important thing to young people – but it's the least important to us.'

Fostering success

Success is more likely when young people can be reached in **places** that are familiar to them, and which are safe and confidential – a leisure centre or youth centre may be a more neutral and attractive venue than a

school. Staff knowledge of the local area (both in terms of place, and of other local services) is key to success.

Young people have been **successfully engaged** in a number of ways:

- The **social action organisation** is aiming to involve six out of ten young people by 2020 (for example, through charities involving young people as campaigners and volunteers), which has benefits for self-esteem and future opportunities.
- There are many benefits to involving young people in the **design of health-promoting programmes** – although this may be challenging when a programme is reactive to immediate circumstances, rather than proactively designed.
- Young people are also more likely to take information from their **peers** (on weight management, healthy eating etc.) than they are from an adult.

There were several examples of ways in which the different organisations **cooperate with the statutory sector** – the organisation that addresses gang crime is housed in the same office as social services, and the organisation working on sexual exploitation has strong links with sexual health services. However, the third sector retains the advantage of 'not being social workers', so families or young people may feel more comfortable.

One organisation has six years' worth of high-quality **data** – which has clearly demonstrated impact on the lives of young people (although even here, long-term funding has not been forthcoming). Measuring outcomes of (for example) a physical activity programme must not be at all intrusive, if young people are not to be put off attending (this is about having fun!) but indicators such as leadership skills or anger management can be assessed.

Being aware of the differences in needs between **young men and young women** is important – for example, targeted involvement of young dads ('often fathers are left out of the decision-making processes for their children'), or gender-appropriate campaigning (e.g. This Girl Can).

Social media can have positives – for example, one young man with anorexia, who used social media to talk about it with other men, and begin to change perceptions and attitudes.

Solutions

Among solutions discussed were:

- harnessing **social media as an evaluation tool** – for example, taking photos of healthy behaviour. There seem to be few (if any) organisations who are engaging in this way with young people. However, monitoring such an approach would be challenging;
- the need for **greater understanding and flexibility** from funders (including corporate funders) and simplifying the grant-application process;
- giving young people **more options** through broader partnership working; and
- **linking to local strategies** (for example, Guy's & St Thomas' Charity's five-year focus on child obesity and place-based health) as a way for organisations to better direct their efforts to find funding.

Appendix 2.7 – Leicester

Statistics

1. Children reporting general health as excellent (15 y/o, 2014/2015): 28.8% (England average 29.5%)

2. Children who eat 5 portions or more of fruit and vegetables per day (15 y/o, 2014/2015): 53.1% (England average 52.4%)

3. Physically active children for at least one hour per day seven days a week (15 y/o, 2014/2015): 15.2% (England average 13.9%)

4. Obese children in Year 6 (10–11 y/o, 2015/2016): 23.0% (England average 19.8%)

5. Percentage of children in need (of local authority to achieve reasonable health and development) during 2015–2016: 5.74% (England average 6.67%)

6. Hospital admissions due to substance misuse (15–24 y/o, 2012/13–2014/15, rate per 100,000): 49.2 (England average 88.8)

7. New sexually transmitted infections (16–24 y/o, 2013, per 100,000): 3,007.3 (England average 3,432.7)

8. Percentage of children at risk of ongoing sexual abuse out of total children in need (under 18, March 2016): 10.27% (England average 7.25%)

9. Emergency hospital admissions for intentional self-harm 2014/15 per 100,000: 133.3 (England average 196.5)

10. Unemployed (16–64 years): 5.6% (GB average 4.5%)

11. NEET (16–18 years, 2015, percentage out of 16–18-year-olds known to local authority): 6.3%

12. Children age 17–18 who have formally entered the youth justice system (2013/14, per 100,000): 33.5 (England average 19.8)

Sources:

1–3. Public Health England, 'Young people– Leicester': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000004/ati/102/are/E06000015/iid/20301/age/1/sex/2

4. Public Health England, 'Health profile – Leicester': https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/8000073/pat/6/par/E12000004/ati/102/are/E06000015/iid/20301/age/1/sex/2

5. Department for Education, 'Characteristics of children in need: 2015 to 2016' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564621/SFR52-2016_Main_Tables.xlsx (table B1).

6–7 and 12. Public Health England, 'Young people's profile – local authorities': http://atlas.chimat.org.uk/IAS/dataviews/report/fullpage?viewId=443&reportId=542&geoId=4&geoReportId=4502

8. UK Government, 'Characteristics of children in need: 2015–2016': https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016 (table B3)

9. Public Health England, Public Health Profiles (Leicester – County and UA): https://fingertips.phe.org.uk/search/suicide#page/1/gid/1/pat/6/par/E12000004/ati/102/are/E06000016/iid/41001/age/285/sex/4

10. Nomis, 'Labour market profile – Leicester': https://www.nomisweb.co.uk/reports/lmp/la/1946157130/report.aspx?town=leicester#tabeinact

11. Department for Education, 'NEET data by local authority' (2016): https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

List of attendees

Organisation	URL
United Against Violence and Abuse	http://www.uava.org.uk/
Reaching People	https://www.reachingpeople.co.uk/
Leicester AIDS Support Services	http://www.lass.org.uk/
United Against Violence and Abuse	http://www.uava.org.uk/
Leicester LGBT Centre	https://leicesterlgbtcentre.org/

Interviews

[Community Health and Learning Foundation, Leicestershire: http://www.chlfoundation.org.uk/]

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The Leicester workshop was held on 30 June 2017, and brought together five people from four organisations, one a consortium of voluntary organisations to improve young people's quality of life, and the other three focusing on specific challenges: young people who are transgender, young people who face violence and abuse, and young people at particular risk of chronic disease. Several people were unable to attend the meeting at the last minute, due to workload. The participants expressed real enthusiasm for the day – the chance to forge new links in health and with others working in complementary areas, to fill gaps in services and to learn how to approach new communities.

Working with 14–24-year-olds in Leicester

Because of the specific focus of the participating organisations on specific groups, the general challenges of working on health with young people were viewed through a lens of working with these vulnerable groups, who have **multiple challenges** – for example, victims of domestic abuse or sexual violence are often found where there is also poverty and substance abuse. This is complicated further because, when they move into the adult healthcare system, 'adolescents are often lost'.

'It's hard for young people…
They have so many different needs and there are so many different agencies.'

Self-identity and gender identification among young people is complex. Body image is a major concern – for all this age group, but particularly for young trans people.

Mental health issues are common. There is greater pressure to achieve at school than in the past, many young people face serious challenges with debt and money issues, and vulnerable groups are also subject to bullying and stigma. Negative behaviour becomes habitual for some young people: 'the prevalence of self-harm is now so high that it's almost becoming a normalised behaviour'. One participant noted that 45 per cent of transgender people have tried to take their own life. The rate of autism among transgender people – nearly 7 per cent – is higher than in the general population.

Family influences can have a negative impact on health and health behaviour: 'Parents are enablers of bad behaviours.' Intergenerational poverty is an issue, and as it is 'still easier and cheaper to buy bad food [rather than fruit and veg]', many young people grow up not knowing how to cook. Working with families – particularly around deeply engrained cultural norms, including witchcraft practices – is essential for the younger cohort within this age group, and for young parents. Young people who are caring for a traumatised parent may adopt perpetrator behaviours.

Young people spend more time indoors on their computers and phones, which means not only less **physical activity** but also spending less social time with 'people as a whole' (not just their peers). Young people who are bullied are less likely to venture out into public spaces. For young trans people, not being able to use

changing facilities is a very significant barrier to exercising (for example, if a young person is binding their chest). The widespread use of **energy drinks** (which lead to lack of sleep and failure to concentrate in school) was also mentioned.

Challenges

All the participants had concerns about **resourcing** within this sector, with one noting that her organisation is well recognised and relied on for its work locally, but has funding (from BBC Children in Need) only until October 2018 and 'people [e.g. the local hospital trust and local anti-bullying team] are starting to panic because the funding will run out and there is a risk that the project won't carry on'. Staff are also over-stretched – and there are too few of them to ensure the sustainability of working with individual young people for long enough to make a long-term difference. Organisations are also finding that staff are not being replaced as they leave, and it can be hard to manage services when many staff are part time.

'Not having staff is a weakness for bids, but it's a good model for staying in existence!'

The **bid process** itself was also criticised – one organisation developed and submitted a bid to the public health commissioner in Leicester, only to have the initiative shelved because the commissioner wanted to review what was required. This was a 'complete waste of time'.

Evaluation is important to demonstrate impact to funders – but it can be onerous and require very prescribed outcomes that do not always reflect the needs of young people: 'there is a battle to tick boxes and have enough flexibility'.

There was agreement that health must **go beyond a medical model and into the community**, but this is complicated by 'professional jealousy or a gate-keeping issue'. There is often a failure among medical professionals to look at patients as whole people, and protectionism around job roles.

'There isn't enough understanding in the health service, and there isn't enough understanding of what people mean when they talk about taking their services out into the community.'

The care services may also be unable to cope, which mean that when the third sector organisations raise concerns about young people, the problem is thrown straight back, leading to 'very heated discussions with social workers.'

The barriers to receiving **mental health support** for young people are significant. There is a long waiting period for CAMHS, and young people are only put on the waiting list when they have serious mental health issues, even if they would benefit much earlier. Young trans people face particular challenges – but 80 per cent of nurses do not know how to talk to patients about their gender, and it is not compulsory for schools to address it.

For organisations that work with young people **up to a certain age**, it is very difficult to have to detach from them as they move on.

'The hardest thing is having to let them go when they reach their 19th birthday.'

There is **stigma and ignorance**, with young trans people feeling unwelcome even within some LGBTQ groups or support systems. Many people (wrongly, of course) think that being trans is predatory – but it is the young trans people themselves who are in need of safeguarding.

Lifestyle choices that are unhealthy – such as smoking, drinking, and self-harm (which includes having sex with strangers) – can be a form of **coping mechanism** for some young people, which complicates the messaging and action that needs to be taken. Trying to prevent young people from smoking, for example, could make young people defensive and less likely to engage with or to trust the organisations that provide support.

'You can't deal with everything all at the same time.
You have to decide what is the greatest priority for someone.'

One of the organisations works with people across Leicestershire who have **debt and money problems**, but the programme is only available to people who are unwaged. However, although any young people are on very low incomes, it is available only to those who are unwaged (i.e. NEETs) – whereas in fact, 'everyone in

the room today will be working with people who could benefit from the service'. Almost half of those involved in the project have mental health issues.

Fostering success

Working together through a consortium not only maximises the opportunity of receiving funding (by bringing together different expertise), it also facilitates **partnerships** developing between specific organisations within the consortium. There are also opportunities to develop funding through social enterprise.

There is help for initiatives funded by BBC Children in Need in how to **evaluate**: a day's training to talk about outcomes and impact. Each organisation gets to choose three outcomes, and are given help in how to measure them.

Finding **common ground with health professionals** is key, so that approaches can be complementary rather than antagonistic: 'breaking down the barrier between people-as-patients and people-as-people'.

The initiative that helps the unwaged with their **financial skills** (around personal money management) also increases digital skills, helping to facilitate not only confidence with money but more generally assisting in accessing online services, using computers, and staying in touch with family and friends:

'You might say that [improving financial skills] isn't about health – but it is!'

Honesty and openness are a prerequisite in helping young people. This includes careful thought about privacy issues:

'If you are going to disclose information you have to be sure you are talking to a good social worker. If you're not, it might do the kid more harm than good.'

Young people communicate **online**, so there is certainly an argument for using this as a conduit, where appropriate – one organisation uses a closed Facebook page to allow young people to communicate outside hours. However, there were concerns about how this could be monitored in practice, and one participant noted that 'there is a strong argument that the work should be conducted face-to-face' (particularly with those with autism).

Reaching minority ethnic groups can be particularly challenging, and **faith groups** can be an important conduit. One organisation has recently spoken to a leader at a temple – and is returning to talk further, and will be doing awareness raising and training with the local community.

Solutions

Among solutions discussed were:

- branching out into **physical health** – some of the organisations could be a good conduit for these messages (although they would need training in how to deliver this);
- **training and advocacy around trans issues** in schools: 'It's important that people feel confident and comfortable when they are talking about trans people';
- **sharing expertise** –bringing in experts from other organisations to give talks on specific issues during staff meetings; and
- **small changes** – such as swimming pool sessions specifically for transgender people – that help to break down barriers to healthy lifestyles.

During the meeting, a request was made to one participant by another to give a talk on transgender issues – actively sharing expertise beyond the workshop.

Appendix 2.8 – Swansea

Statistics

1. People eating the recommended daily quantity of fruit and vegetables (all ages, 2012: 32%)

2. Recommended physical activity levels (adults, 2011–2012): 26%

3. Percentage of young people in need (of local authority to achieve reasonable health and development): 10–15-year-olds 3.42%; 16–17-year-olds 3.63%; 18–20-year-olds 0.73%.

4. Wales: admissions to inpatient care following self-harm 2010 per 100,000: 145.42 (no statistic found for Swansea)

5. Hospital admissions due to illicit drugs (2015/16, rate per 100,000): 236.1 (Wales average 205.7)

6. New sexually transmitted infections: (all ages, 2012, per 100,000): 928

7. Percentage of children on child protection register due to sexual abuse out of total children on child protection register (0–17 y/o, 2016): 10% (Wales average 7.47%)

8. Unemployed (16–64 y/o, 2017): 5.3% (GB average 4.5%)

9. NEET (Year 11 leavers, 2016, percentage out of Year 11 leavers): 2.1% (Wales average 6.5%)

10. Rates of young people (10–17) receiving their first reprimand, warning or conviction (2009–10, per 100,000): 890.

Sources:

1–2. City and county of Swansea, 'Full version - improvement objective G': http://www.swansea.gov.uk/article/2895/Full-version---improvement-objective-G

3. StatsWales, *Children in need by local authority and age group* (2017) https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-in-Need/childreninneed-by-localauthority-agegroup combined with population data (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland)

4. Office for National Statistics, '2011 Census: Population and household estimates for Wales , March 2011' https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011censuspopulationandhouseholdestimatesforwales/2012-07-16#main-points

5. Wales NHS, *Piecing the Puzzle: The Annual Profile for Substance Misuse*: http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf

6. Public Health Wales, 'HIV and STI trends in Wales – Table A4': http://www.wales.nhs.uk/sites3/documents/485/HIV%20and%20STI%20trends%20in%20Wales%20Report%20Dec%202013.pdf

7. StatsWales, 'Children on child protection register by local authority, category of abuse and age group': https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-in-Need/childreninneed-by-agegroup-lookedafterstatus

8. Nomis,'Annual population survey - Swansea': https://www.nomisweb.co.uk/query/asv2htm.aspx

9. Welsh Government, 'Young people not in education, employment or training (NEET) (2017): http://gov.wales/statistics-and-research/young-people-not-education-employment-training/?lang=en

10. Ministry of Justice, 'Young people aged 10–17 receiving their first reprimand, warning or conviction' (2012): https://www.gov.uk/government/statistics/young-people-aged-10-17-receiving-their-first-reprimand-warning-or-conviction

List of attendees

Organisation	URL
Swansea Women's Aid	http://swanseawomensaid.com/
Newport Mind*	http://www.newportmind.org/
Swansea Council for Voluntary Service	https://www.scvs.org.uk/
Action for Children	https://www.actionforchildren.org.uk/
Choices / Drugaid Cymru	http://www.choices.cymru/
Swansea Council for Voluntary Service	https://www.scvs.org.uk/
Autistic Spectrum Disorcer Employment Support	http://www.asdes.org.uk/
Action for Children	https://www.actionforchildren.org.uk/

* Has health/wellbeing as a stated aim/vision of the organisation

Interviews

[Powys Association for Voluntary Organisations (PAVO): http://www.pavo.org.uk/]

Executive summary

NOTE: This workshop was recorded in detail, from which this summary was drawn up. However, the full notes are strictly confidential (as participants are named) and are therefore not included here.

The Swansea (Wales) workshop was held on 28 June 2017, and brought together eight people (one a volunteer) from six organisations, covering mental health, healthy lifestyles, working with young people with autism, substance abuse, domestic violence and sexual abuse, and young pregnant women and new families. Two organisations were unable to attend at the last minute, due to illness or workload.

Working with 14–24-year-olds in Swansea

The point at which a young person leaves school is particularly challenging – both because it is a **transition** into adult life and responsibility, but also because it is the point at which young people lose the school-based support mechanisms and support for children (such as CAMHS) on which they had relied. Among the most vulnerable, there can be a 'revolving door' between social care and the police.

> *'Young people are pushed from pillar to post between services because they have complex needs.'*

Initially a programme for 7–12-year-olds in socioeconomically deprived areas, the healthy living project has found that there are **nutrition needs** across a wider age range – and in more affluent areas. Many families and young people do not know what eating 'five a day' means, and no idea how to reach it – many households do not own a saucepan. In one programme, 42 out of 49 families (all with parents aged under 25) had never cooked a meal from scratch. Physical access to food also varies considerably across Swansea – and may be too expensive even where it is available. There are problems of vitamin deficiency in this age group, and there are also certain medications that stimulate appetite. Young people may also feel under too much pressure to be able to process or action information on healthy living – 10,000 steps, five-a-day, quitting smoking etc.

Many young people from more deprived areas are meeting the **physical activity** guideline, because the fares are too high on public transport, and they cannot afford a car. Among those with autism, however, physical activity is low because they are often unwilling to leave the house.

Teenage pregnancy had been falling until 2015 – but it has recently risen again. There has also been an increase in blood-borne infections and sexually transmitted diseases. 'Chem sex' combines **risky behaviours** – namely, drugs such as GHB combined with often unsafe sex. Drug use (alcohol, cannabis or Valium dependency) often has its origins in mental health or sexual health: 'a person will be pushed from pillar to post because of these three behaviours'.

Future health – including stroke, heart disease and diabetes – is a concern: 'getting young people to buy into their own futures' is a challenge, and the anxiety that many experience can harm health in later life.

New **social norms** are redefining what people think of as healthy behaviour – such as pornography use – and advertising also changes attitudes. Young people 'create an isolated world for themselves', which can escalate small mental health problems into more serious issues.

Challenges

Sustaining services is a constant battle. Some programmes are taking a double hit as local authority money is no longer forthcoming, and several Big Lottery grants are coming to an end at the same time. The mental health programme for young people has a year and a half of funding left, and although 'when you talk to CAMHS they can't believe the service won't be there in 18 months', CAMHS has so far refused to enter into a dialogue about the future of the programme. It is estimated to have saved the NHS over £3 million in its third year alone. Organisations may not know whether they will receive more funding until the last minute – and need to prove that they require it, which is onerous. This lack of certainty has a knock-on effect on staff, who are already struggling with high case loads, and turnover is high – so organisations lose vital experience. Waiting lists are often very long (which causes many young people to disengage before receiving help) – one organisation can support four people in each county, but there are 100 people on each waiting list.

To get new funding, there may be a requirement to do something new – even if what is already in place is already working. **Bid-writing** is 'such a waste of time' – rewriting the same proposal but framing it in different language. Also, if a gap in funding is identified, it will become saturated with bids as organisations chase the money.

The third sector finds itself either being put under ever-increasing pressure to fill the gap as local authorities cut their support for young people –

'Once a young person accesses a service, the statutory services pull out.
It should be "as well as", not "instead of"' –

or statutory services are brought in-house, meaning that third-sector involvement is no longer required:

'Services have been taken in-house and they haven't been evaluated and they don't really know what they are doing.'

Healthy eating is not easy for many young people. Even where they have the means to cook, knowledge of how to cook, and access to a store selling fresh food (and families may feel that they cannot visit a supermarket because it is on the wrong side of a busy road), eating five a day may not be financially viable. 'Holiday hunger' among young people still at school is known to be a problem – but it is not yet a sufficiently high priority for the local authority for other partners (such as the supermarkets) to begin to tackle it.

Among programmes that have been cut are the C-card (free condoms for 13–24-year-olds), a 'radical bus' that travelled around giving advice about sexual health, and a 'diversionary course' that offered artistic opportunities (such as woodwork or music) to people with drug problems.

Sometimes **evaluation** is too numbers-focused and is only about ticking boxes – which says little about the success of a programme. 'In the third sector you will do anything to support people, regardless of your targets.'

There are particular difficulties faced by young people with **autism** when accessing the job market – one young man had successfully completed a placement, but when he applied online for a job with the same employer, he was unable to cope with a timed section of the application – so even though he had demonstrated his abilities, he did not get the post.

'They will try so hard, and get lots of experience, but still can't get a foot in the door'.

One organisation is suffering because it is now well known – it provides many services for young people, many of whom have very complex problems, and has built a reputation within the local community.

However, because of this reputation there are now groups who will not access it because they feel that it is not for them!

Fostering success

Finding ways to **communicate with young people** is essential (and challenging: 'kids don't have much trust in adults – they would rather talk to one another'). Support from peers who have been through the same experiences, such as ex-offenders, is particularly helpful, as long as they are appropriately trained. One organisation is working with young people with mental-health problems severe enough to prevent them leaving home, encouraging them to write to each other and send pictures. Boys have found this approach particularly helpful. This was welcomed by one of the other participants as 'a brilliant example of how the third sector can adapt really easily'.

Engaging young people with autism can be difficult, so social activity (activities that stimulate their interest) and communication is essential in helping them get into work. Understanding their different motivations can also be helpful: one young man struggled in a paid working environment because he was being told what to do, but he has felt appreciated in a voluntary charity shop, where staff take time to be supportive, and the atmosphere is relaxed.

Participant organisations have a **variety of funders**, including the Big Lottery – one organisation gathered more than 60 letters of support calling for the project to be set up, from other third-sector organisations, schools and public-sector bodies.

One successful **partnership** is between the healthy-eating programme and a local Tesco, which is supplying a number of important products such as mixed herbs, so that people who use food banks can make the most of their parcels.

Involving people in **'co-production'** of programmes is valuable – the healthy lifestyles programme always leaves one session free to be dedicated to the group's own priority: 'ask what they want, rather than telling them how to change'. This approach also tends to have more sustained outcomes – but statutory services often do not involve young people.

There may be innovative ways to get young people into a **pathway to the help they need** – one organisation provides baby massage, but sees its main role as being the mental health mothers, who can be directed into other services if needed.

This age group can be very challenging – but change can happen. One group of six 17–18-year-olds who lived together in lodgings provided by one of the participant organisations had begun by winding each other up and messing around. However, after three months they had completely changed, cooking for the whole group every day, going to the gym together, and supporting one another: 'You wouldn't have got the impression that they would do this [at the start] – but they did!'

Solutions

Among solutions discussed were:

- **consistency of funding** – when a service works, young people (and staff) need to know that it will continue;
- build on an earlier **food-mapping** exercise by running a pilot to look at the differences in local food provision so that this can be tackled and Swansea can live up to its position in the World Health Organization's Healthy City Network;
- there needs to be more **tuition about healthy eating** in schools – and getting information out to the wider family is really important; and
- using **dialectic behavioural therapy**, which is about making positive changes while also accepting who you are, and is particularly effective with young people with dysfunctional behaviours.

Appendix 3 – Statistics

As part of the research for this report, statistics across a number of areas that are relevant to the health of young people have been researched:

- Physical health
- Mental health
- Sexual health
- Ethnicity
- Education and employment
- Youth justice
- Substance misuse
- Social care

Wherever possible, the same data sets have been gathered. However, in many cases data is collected differently in the four countries of the United Kingdom, meaning that it is not possible to compare between all eight workshop sites (e.g. at local authority level, in England obesity is measured at year 6; in Northern Ireland in year 8; and not at all in Scotland and Wales). This complicates the graphs and analysis of the data (a full analysis is beyond the scope of this report).

Key points – particularly notable outliers in the data – have been noted in the report, along with bar charts where data is clear and comparable. Key statistics have also been pulled out for each area as part of the executive summaries in Appendix 2.

In addition, all the information compiled on the health of young people has been compiled within an Excel document, which will be made available to the Health Foundation as part of this project.