

# Health and Wellbeing Needs of Young Adults age 18-25

Joint Strategic Needs Assessment (JSNA) Report

The Royal Borough of Kensington and Chelsea

The City of Westminster

## This report

This needs assessment on young adults supports the development of strategy and Local Authority (LA) and Clinical Commissioning Group (CCG) commissioning intentions to improve services for young adults.

It covers the health and wellbeing needs of young adults, focussing on 18-25 year olds but considering wider age groups where appropriate, in the London Borough of Hammersmith and Fulham, The Royal Borough of Kensington and Chelsea, and the City of Westminster. The report focuses in particular on:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

Data has been collected from a number of sources, including the 2011 census from the Office for National Statistics, and local data provided by stakeholders and providers. Workshops and interviews were conducted with key local stakeholders and providers.

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## Acknowledgements

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## Joint Strategic Needs Assessments (JSNAs)

The purpose of JSNAs is to improve the health and wellbeing of the local community, and reduce inequalities for all ages, by informing all relevant parties about the health and social care needs of the local population and how these may be addressed. They are assessments of the current and future health and social care needs of the local population, with the core aim of developing local evidence-based priorities for commissioning and strategies. The needs identified may be met by the local authorities, CCGs, NHS or others.

JSNAs are a continuous process of strategic assessment and planning, and are an integral part of CCG and local authority commissioning and planning cycles. Their agreed priorities are used to help determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. Past reports can be found at [www.jsna.info](http://www.jsna.info).

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## 1 Executive summary

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not fully understood or being met (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group is needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). It is therefore difficult to obtain a more specific understanding of the needs of young adults.

It is important to understand the health and care needs of this population better in order to improve their immediate and long-term outcomes (not just health), particularly those with long-term conditions. This will ensure that services are configured to meet the particular needs of young adults, and to support the transition from children’s to adults’ services. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

An interactive summary of the key data and findings can be found on the [Online JSNA](#).

### 1.1 Key themes

A number of cross-cutting themes with this age cohort became apparent across the different chapters:

<p><b>Age 18 cut-off and transitioning into adult services</b></p>	<p>Across service types, practitioners and evidence suggest that having a cut-off point at age 18 is arbitrary and unhelpful. The needs and ‘emotional ages’ of 18 years olds differ widely, and some young adults may receive more appropriate care in a young people service than an adult service. This is unlikely to be resolved via a change to a different cut-off, so services should move towards a model of being needs-led.</p> <p>Additionally, young people and professionals agree on the value of continuity and stability at age 18, especially given the changes happening in people’s lives at this age. The interruption of having to transition before the person is ready can have a negative outcome.</p>
<p><b>Use of health services including GPs</b></p>	<p>The model of care in a traditional GP practice is not well suited to this cohort. Young adults are less likely to go to their GPs for a variety of reasons: one being a fear of their confidentiality being breached if they have a family GP, another being that they tend to seek help in a crisis, and so will use urgent care or A&amp;E rather than waiting to see a GP.</p> <p>Additionally, young adults are more likely to disengage with services or be discharged for missing an appointment, particularly if they do not have a parent or carer to encourage them to seek help and attend.</p>
<p><b>Training and awareness</b></p>	<p>Professionals who do not work solely with young adults, such as GPs, may benefit from training and awareness to identify issues that particularly affect young adults, how to discuss these constructively, and work with parents, carers, family and friends where appropriate.</p>
<p><b>Transient populations</b></p>	<p>The young adult population has a higher migration rate in and out of the boroughs than the rest of the population. They are more likely to leave home during this time, such as for university. This can interrupt delivery of health or care services or treatment, and</p>

	<p>may require coordination between different boroughs and Clinical Commissioning Groups (CCGs).</p> <p>They are more likely to be registered with a GP in a borough they do not live in. This challenges the continuity and integration of care that local services can offer, and requires empowerment of this cohort to effectively manage their own health and seek advice when required.</p>
<b>Participation and user involvement</b>	<p>Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users. Alternative methods should be explored such as online platforms, youth forums and community networks.</p>
<b>Joined-up working and co-location of services</b>	<p>The importance of effective communication across professional boundaries, in particular children’s and adults’ services but also between health, local authority and the voluntary sector, is key to person-centred care. This was highlighted as an area for improvement locally in some of the key chapters examined in this report.</p> <p>Co-location has been consistently identified as a way to make services more user-friendly for young people, making them more likely to engage. The Well Centre in Lambeth co-locates GPs and youth workers, with close working with other services such as sexual health and substance misuse services. This also makes it easier for professionals to discuss the needs of the person.</p>
<b>Service design</b>	<p>Common service design requirements for young adults include flexibility, evening and weekend hours. Alternative models such as telephone, text and online appointments are also recommended.</p>
<b>Gender</b>	<p>Differences in gender can be seen in young adults. Young women are three times as likely to have a common mental disorder and ten times as likely to have an eating disorder as young men. Young men are more likely to have problematic substance misuse and less likely to be seen in services in their expected numbers.</p>

## 1.2 Summary of Key Recommendations

Chapter	Gap / challenge	Recommendation
Primary care	<p>The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups.</p> <p>Young adults would benefit from primary care services configured to their health needs, such as at The Well Centre in Lambeth.</p>	<p>Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults’ health.</p>
Eating disorders	<p>A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Evidence shows better outcomes when ED is treated promptly, but waiting times locally are long.</p>	<p>Review the eating disorder pathway as part of Like Minded <i>Serious and Long Term Mental Health Need</i> population group Business Cases. Consider ways</p>

	<p>National and local strategies require the development of out of hospital services. There is currently only a service in secondary care.</p> <p>The exemplar primary care eating disorder service in Bristol provides cost-effective help before the patient's condition deteriorates.</p>	<p>to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.</p>
Care leavers	<p>The greatest area of unmet health and wellbeing needs of care leavers is mental health needs which would not meet the threshold for Adult Mental Health Services.</p>	<p>Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.</p>
Substance misuse	<p>The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.</p>	<p>Allow flexibility substance misuse services to provide for young adults up to the age of 25, based on a professional assessment of their need.</p>
General	<p>Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.</p>	<p>Coproduce the redesign of services with young people.</p>

The full recommendations are at the end of every chapter, and summarised together in Chapter 10.

## 2 Introduction

### 2.1 National picture

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not being met or fully understood (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group are needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). This makes it difficult to obtain a more specific understanding of the needs of young adults.

Consensus is emerging through legislation and guidance that the needs of children and young people do not end at age 18, and a number of recent legislative changes and likely future legislative changes use the upper age limit of 25. The Children and Families Act 2014 has made this legislation for children with Special Educational Needs and Disabilities (SEND). The government report *Future in Mind* (Department of Health & NHS England, 2015) advised the age limit of children's mental health services should extend to age 25. The *Keep on Caring* strategy (HM Government, 2016) will extend the government duty to care leavers up to age 25 (see chapter 6). A recent NSPCC report (Bazalgette, Rahilly, & Trevelyan, 2015) described the withdrawal of CAMHS at 18 as a "cliff edge", and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25.

Young adulthood is a time of significant change in life. It is an important phase of development where individuals lay the foundations for their adult futures and set behaviour patterns. Both positive and negative experiences can have a long-lasting effect. It is a time of transitioning away from being a child towards independence; living away from family; moving from school to work or university. For those with health and social care needs it can involve moving from paediatric to adult health and care services, for which NICE have produced best practice guidance (NICE, 2016). Person-centred care is particularly important for this age group, given their range of needs and 'emotional ages'.

However, young adults report widespread difficulties in accessing care (Hagell, Coleman, & Brooks, 2015). Young adults are regular users of healthcare; although many are satisfied with their experiences, many are not, and the proportions saying they are not tend to be higher than in other age groups (Healthy London Partnership, 2015). Government guidance on young people friendly services – the 'You're Welcome' quality criteria (Department of Health, 2011) - is not widely known about or used consistently.

## 2.2 Young adults in Hammersmith and Fulham, Kensington and Chelsea and Westminster

Young adults (age 18-25) make up around a tenth of the resident population in the three Boroughs (12.2% in Hammersmith and Fulham, 9.6% in Kensington and Chelsea, and 10.7% in Westminster) and a slightly smaller proportion of GP registered patients in Hammersmith and Fulham Clinical Commissioning Group (9.3%) and West London CCG (8.1%). In Central London CCG this age group constitutes 16% of GP registered patients. Despite this, very little evidence has been gathered about their health and wellbeing needs.

Locally, there is an understanding that this age group is transient, culturally diverse, and includes a significant student population. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

## 2.3 Definitions and scope of the Young Adults JSNA

This JSNA will focus on 18-25 year olds, and in some areas people about to turn 18. However, data is not being systematically collected in this exact age bracket, and so in some instances this report will cover broader age ranges. Where this occurs, it will be made explicit in the text. In addition, the diagram below shows which age groups are covered by the data sources we have used.

Table 1: Age groups covered by data sources

	15	16	17	18	19	20	21	22	23	24	25
GLA 2014 Round (population estimates) 18-25				█	█	█	█	█	█	█	█
ONS (various population estimates) 18-25				█	█	█	█	█	█	█	█
HSCIC (CCG data) 18-25				█	█	█	█	█	█	█	█
Primary Care Mortality Database 18-25				█	█	█	█	█	█	█	█
NICE (LAC and Care Leavers data) 15-17 and 18+	█	█	█	█	█	█	█	█	█	█	█
Frameworki (regarding UASC) 16-18		█	█	█	█	█	█	█	█	█	█
Public Health England (Drug use trends) 18-24				█	█	█	█	█	█	█	█
ONS Opinions & Lifestyle Survey 2013 16-24		█	█	█	█	█	█	█	█	█	█
National Drug Treatment Database 15-24	█	█	█	█	█	█	█	█	█	█	█
LAPE (PHE) 16-24 and 18-25 (varies)		█	█	█	█	█	█	█	█	█	█
GUMCAD (sexual health) 15-24	█	█	█	█	█	█	█	█	█	█	█
LASERS (sexual health) 16-24		█	█	█	█	█	█	█	█	█	█
NOMIS (employment data) 18-24				█	█	█	█	█	█	█	█

In agreement with key stakeholders, this report will seek to explore some particular issues which affect this age group where we are currently lacking a strong evidence base for commissioning:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

This report will complement and build on other local projects, such as the needs assessment on [Children and Young People's Mental Health](#) undertaken by the Anna Freud Centre on behalf of the North West London Like Minded work programme.

The needs of young people with complex needs transitioning from Children's Services to Adult Social Care (such as children with a learning disability or autism spectrum disorder) are different to the needs described in this document. They are therefore out of scope and will be looked at in a further deep-dive JSNA on people age 0-25 with complex needs and disabilities. Additionally, the review of the wider determinants of health for this cohort – including crime and safety, housing, and employment – in chapter 9 will not go into as much detail as other chapters, as work in this area is covered in greater detail in other departments.

### 2.4 Relation to commissioning

This JSNA will highlight unmet need, which can inform CCG commissioning intentions, as well as the local authorities, providers of services and the community and voluntary sector.

The findings and recommendations in this report should be considered in relation to the opportunities arising in each borough.

#### *Cross-borough/CCG programmes*

- [North West London Sustainability and Transformation Plan](#)
- [North West London Like Minded](#) Strategy and Programme – mental health transformation (see Chapter 5 recommendations)
- Children and Adolescent Mental Health Services transformation (see Chapter 6 Recommendations)
- Development of policy and guidance for the issue of a personal budget for children and young people with an Education, Health and Care Plan with a focus on outcomes, which could be adapted into a consistent approach for care leavers (see Chapter 6 Recommendations).

#### *Hammersmith and Fulham*

- Old Oak redevelopment
- GP Practice Redesign at urgent care practices (see Chapter 4 Recommendations)
- Redesign of Urgent Care Centres (see Chapter 4 Recommendations)

#### *Kensington and Chelsea*

- West London CCG's new Living Well Service for mental wellbeing
- Adult IAPT accepting new patients from age 16
- Development of hubs model of delivery of health and care services including children's hubs, Whole Systems Integrated Care hubs and Care Leaver hubs currently in development (see Chapter 6).

#### *Westminster*

- Harrow Road redevelopment
- Church Street redevelopment
- Two specialist young adults GP practices at Imperial and King's College (see Chapter 4)
- Development of hubs model of delivery of health and care services (see Chapter 4)

## 2.5 Objectives

The key objectives of this document are:

- To capture the unique health and wellbeing needs and issues affecting young adults aged 18-25 years
- Identify the provision and gaps in provision of services for young people
- To identify how to improve early interventions in issues which could affect people's long term outcomes.

### 3 Population profile

This chapter will describe the young adult population in Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

The majority of the data available in the report is for 18-25 year olds; however, some data is not routinely collected for this age group. Whenever a different population age group is used, it is explicitly stated. The data used in the report is the latest available at the time of writing.

#### 3.1 Summary

The young adult population of the three boroughs and CCGs is more ethnically diverse and more transient than the adult population. The areas most densely populated by young adults tend to be close to universities. Central and West London CCG's registered population are more likely than most CCG's patients to be resident in a borough other than Westminster and Kensington and Chelsea, due to the student population registering at university practices but living elsewhere.

#### 3.2 Behaviours and characteristics

##### 3.2.1 Risk taking

Young adults are known to have higher risk-taking behaviours such as smoking, binge drinking, substance misuse and unprotected sexual intercourse.

##### 3.2.2 Use of technology

In 2015, 90% of 16-24 year olds owned a smartphone (Ofcom, 2015). Adolescents and young adults use technology to access information in their daily lives, but services have not yet successfully adapted to this.

##### *NHS Go app*

Through the NHS's Healthy London Partnership patient engagement activities, it has been recognised that young people often lack basic knowledge of how to access healthcare services. Engagement with young people highlighted easier access to services, particularly ways to get support out of hours and at weekends, as a priority. This gap in providing more readily accessible information needs to be filled in a way that is inclusive to young people by using forms of technology that they already utilise.

Young people co-designed an app to enable easily access information about health services, as well as healthy lifestyle advice, via a 'youth friendly portal'. The app can be downloaded through mainstream app stores.

##### 3.2.3 Students

There are a number of large universities in central London, and many students either reside in the three boroughs, or are registered to GPs in the three boroughs – in particular Central London CCG, which has two student GP practices at King's College and Imperial.

### 3.3 Demography

#### 3.3.1 Numbers or resident and registered young adults age 18-25

The population figures below are projected estimates for 2016 produced by the Greater London Authority. These projections take into account new housing developments.

Table 2: Estimated resident and GP registered population age 18-25

Local Authority / CCG	Estimated Residents		CCG registered		% of residents registered with CCG
	Resident	% of resident population	Registered	% of registered population	
LBHF / H&F CCG	22,294	12.5%	19,640	9.3%	88.1%
RBKC / WL CCG	15,582	9.6%	19,742	8.1%	126.7%
WCC / CL CCG	29,845	10.7%	34,338	16%	115.1%

Source: GLA R2014 SHLAA EGPP – capped, GP registered list size population (Jan 2016), HSCIC

The GP registered young adult population in two of the boroughs is higher than the resident population, as is the case for all ages. However, Hammersmith and Fulham has fewer young adults registered with a GP than young adults in its resident population.

Westminster and Kensington and Chelsea have an inflated registered population because patients who work or study in the two boroughs register with a GP practice near their university or work rather than in the CCG where they reside. This problem is relatively unique to inner London boroughs and CCGs, as most of England are registered and resident within the same borough and CCG boundary. In addition to this, many people die or emigrate to other areas or overseas and remain on the register, which is another cause of inflation in the GP practice population.

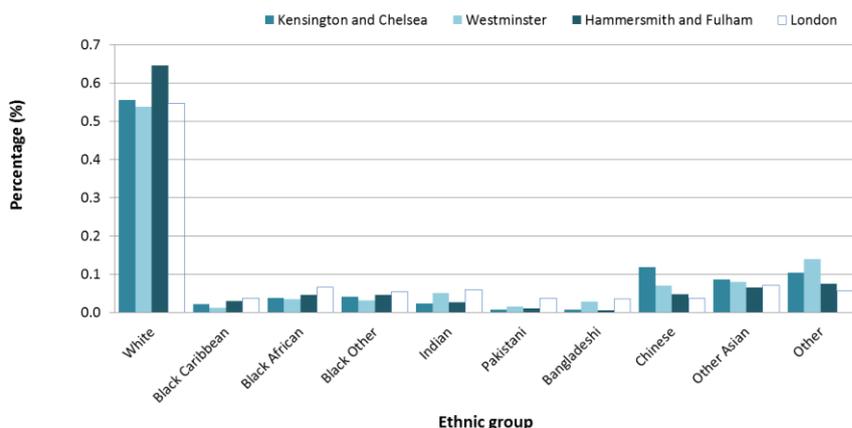
Although Westminster has higher numbers of young adults, Hammersmith & Fulham has the highest proportion (12.2%) of young adult residents of the three, while Kensington and Chelsea has the lowest proportion of young adults with 9.6%.

**Central London CCG has significantly higher proportion of young adults than the other two CCGs** (16% compared to 8.1% in West London CCG and 9.3% in Hammersmith and Fulham CCG). The two student GP practices inflate their numbers.

From Table 2, an estimated 26.7% of young adults in Kensington and Chelsea (4,160) and 15.1% in Westminster (4,493) are eligible to access local healthcare services as they are registered with a GP there, but not eligible for local authority-provided services as they are not resident in these boroughs. This may impact upon person-centred care and good integration of health and care services that are commissioned and provided by the local authority and the NHS.

### 3.3.2 Ethnicity

Figure 1: Estimated young adult population by ethnic group, 2016



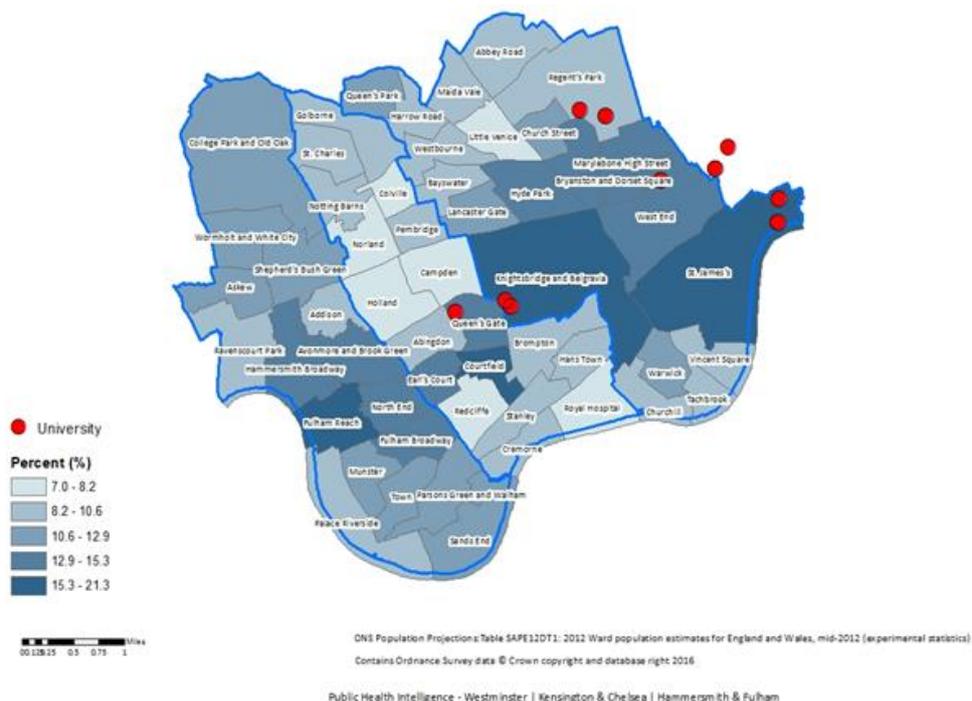
Source: GLA R2014 SHLAA EGPP – capped

The populations of each borough are predominately ‘white’, however there is a higher proportion of BME groups amongst 18-25s than the general population.

### 3.3.3 Location

The electoral wards with the highest proportion of young adults are Fulham Reach (18.3%) in Hammersmith & Fulham, Courtfield (18.7%) in Kensington & Chelsea, and Knightsbridge and Belgravia (21.3%) in Westminster. Many of the wards with the highest concentrations of young adult population are those in which a university is located.

Figure 2: Map showing percentage of young adult population by ward, 2015



Source: ONS, 2015

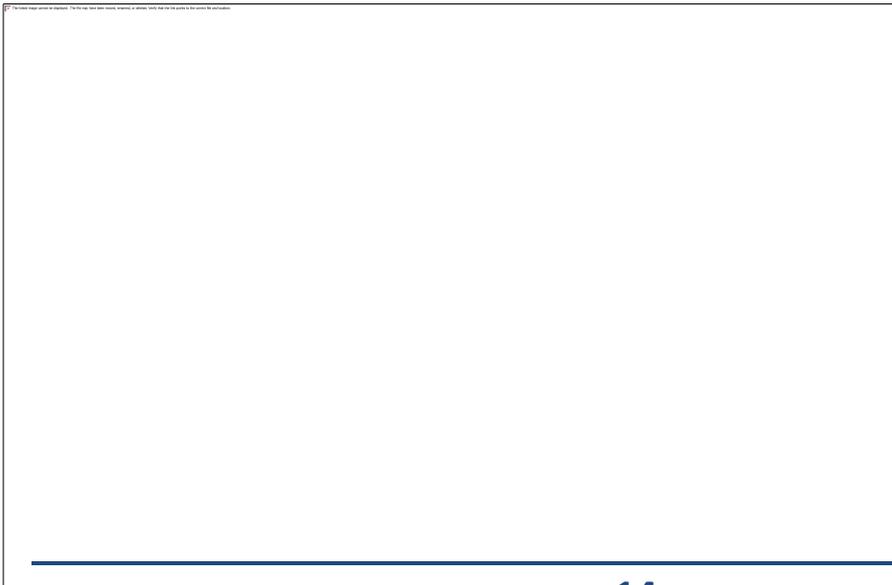
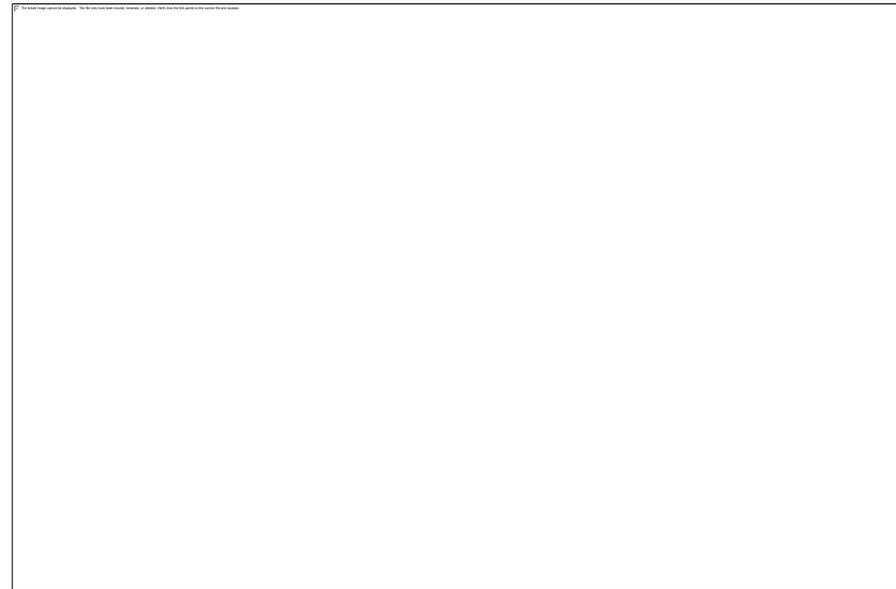
### 3.3.4 Migration

The young adult population of the three boroughs is significantly more mobile; they make up a far higher percentage of the estimated migration in and out of the borough than their percentage of the general population. Westminster has the highest net migration, and each borough has a higher rate of migration in that out.

This shows that this age group is more likely to leave home during this time, such as for university. This can interrupt a health or care service they may be receiving, or require coordination between different boroughs and CCGs. They are also more likely to be registered with a GP where they no longer live. This challenges the continuity of care that local services can offer, and requires empowerment of this cohort to manage their own health and seek advice when required.

Transitions for university students, such as for mental health services, have extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support at

Figure 3 Internal migration patterns

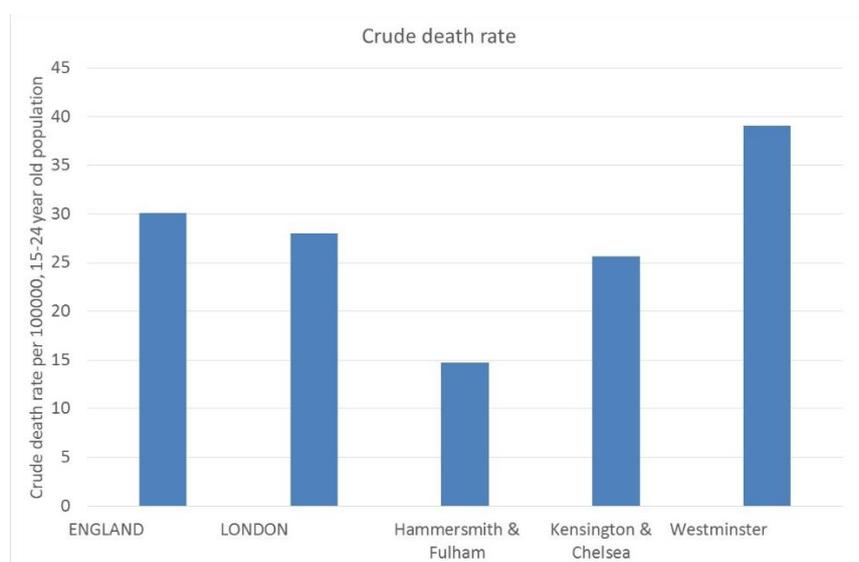


home and at university, from both primary and secondary care services. The production of best practice guidance for CCGs and GPs around student transitions, encouraging close liaison between the young person’s home-based and university-based primary care teams, and promoting adherence to NHS guidelines on funding care for transient populations (Department of Health & NHS England, 2015), would be valuable to ensure seamless care.

### 3.3.5 Deaths

Although numbers of deaths in 15-24 year olds are low, in comparison with London and England Westminster has a significantly higher rate. **The most frequent cause of death is accidents and a significantly higher number are young men**, as is consistent nationally.

Figure 4 Crude mortality rates for young people age 15-24, 2010-14



Source: Office for National Statistics mortality data by age

## 4 Primary and Secondary Care health services

### 4.1 Primary Care

Nationally, 16–24 year-olds are less satisfied than older adults using GPs (Hagell et al., 2015). They have greater difficulty in booking GP appointments and are twice as likely to attend A&E or a walk-in centre.<sup>1</sup>

The Association for Young People's Health (AYPH) carried out the *GP Champions for Youth Health* project<sup>2</sup> from 2012-2015, funded by the Department of Health. This identified the issues adolescents and young adults experience with GPs, and through collaboration between GPs and the voluntary sector, developed new services and referral pathways for young people. The project produced the *Toolkit for General Practice*<sup>3</sup>, a resource for all GP practices, and CCG guidance on *Commissioning Effective Primary Care Services for Young People*<sup>4</sup>. This includes taking sufficient time to understand underlying problems they may struggle to disclose, as well as practical elements such as drop-in appointments after college, and enabling online appointment booking.

The project explored GPs working jointly with the community and voluntary sector through the Youth Information, Advice and Counselling Services (YIACS) network to provide better health services for young people by: offering good health information through other services, supporting self-management of health needs, developing strong relationships, focussing on the holistic needs of young people, and more commonly working with people up to age 25 to support them through transition.

#### 4.1.1 Issues with primary care

GPs provide a key universal healthcare service to people across the life course, and are a key referral point for specialist services. However, primary care was consistently highlighted as an area for improvement for young adults' health locally, in workshops relating to other chapters in this report such as substance misuse, eating disorders and care leavers, and in consultation with young people.

**Confidentiality:** An issue which has been raised consistently by young adults and professionals is a lack of trust in the confidentiality between GPs and young adults, particularly with a family GP.

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<sup>1</sup> GP Champions for Youth Health Project. *Toolkit for General Practice (online)* [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit\\_ONLINE.pdf](http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf) (accessed 14.12.16)

<sup>2</sup> AYPH. *GP Champions (online)* <http://www.youngpeopleshealth.org.uk/our-work/young-peoples-participation/gp-champions> (accessed 14.12.16)

<sup>3</sup> GP Champions for Youth Health Project. *Toolkit for General Practice (online)* [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit\\_ONLINE.pdf](http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf) (accessed 14.12.16)

<sup>4</sup> GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners\\_ONLINE.pdf](http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf) (accessed 14.12.16)

**Help seeking behaviour:** In focus groups with local young people, they tend to seek help in a crisis, and so will use urgent care or A&E rather than waiting to see a GP.

**Experiences at the GP:** several young people reported negative experiences of GP practices from GPs and reception staff, particularly when they went without parents.

**Care leavers:** consultation with local care leavers raised the issue of continuity being important for care leavers, but them being unable to see the same GP and build a relationship. The group reported that they tend to use A&E, even for a check-up of a long term condition in one case. (See chapter 6 – Care Leavers).

#### **Good practice case study: The Well Centre, Lambeth, provided by Redthread**

[The Well Centre](#) in Lambeth is an example of the community and voluntary sector supporting good primary care for young people. It is a 'one-stop shop' providing GP services, youth work and nurse-led mental health services from one location attached to an existing youth centre. By providing healthcare in a youth-oriented environment, the Well Centre's founders – the [Redthread](#) youth work charity and the Herne Hill Group Practice – aim to address the common concerns of young people regarding primary care. This group frequently reports dissatisfaction with accessing healthcare, and often finds it difficult to speak to GPs over fears of breached confidentiality or being misunderstood. However, early intervention is vital: half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24.

Young people can either attend on a drop-in basis or by booking an appointment in advance, and as of December 2015 over 1400 had signed up. Well Centre staff also run workshops, lessons, and youth work outreach activities – including school assemblies, PHSE and regular counselling sessions in schools. Approximately 30% of the Well Centre's patients are aged 18 or over, and 43% visited from beyond the Lambeth CCG area, suggesting a wider demand for the service in terms of both age and geography.

A 2015 study (Hagell & Lamb, 2016) of the Well Centre suggested that it was accomplishing its goal of providing services to more vulnerable and socially excluded residents. Although outcome measures are still in development, 59% of young people have reported an improvement in their life satisfaction since first starting to attend. One-third of those studied in 2014 reported having no other doctor, while the proportion of those living in single-parent households was over double that of the general population. A disproportionately high number were not in education, employment or training. In terms of cost-effectiveness, a preliminary cost benefit analysis undertaken in May 2014 calculated that the Well Centre cost £450 per client; every case seen potentially saved the NHS £713 through avoided A&E visits and other long-term costs.

**4.1.2 Local primary care use: General Practitioners (GPs) Practices**

A few GP practices were identified as having a higher number of young adults on their patient list, particularly the practices attached to universities such as Imperial and Kings College Practices.

**Table 3: List of GP practices with highest numbers of young adults by CCG**

CCG	Practice name	18- 25: Male	18- 25: Female	18- 25 all persons
Hammersmith and Fulham CCG	<b>NORTH END MEDICAL CENTRE</b>	644	917	<b>1561</b>
	THE MEDICAL CENTRE, DR JEFFERIES & PARTN	565	716	<b>1281</b>
	THE BUSH DOCTORS	443	610	<b>1053</b>
West London CCG	<b>KINGS ROAD MEDICAL CENTRE</b>	<b>400</b>	<b>640</b>	<b>1040</b>
	KNIGHTSBRIDGE MEDICAL CENTRE	416	553	<b>969</b>
	FLUXMAN HARROW ROAD HEALTH CENTRE	375	441	<b>816</b>
Central London CCG	<b>IMPERIAL COLLEGE HEALTH CENTRE</b>	5269	3526	<b>8795</b>
	KINGS COLLEGE HEALTH CENTRE	2476	5314	<b>7790</b>
	MARVEN MEDICAL PRACTICE	474	590	1064
	VICTORIA MEDICAL CENTRE	451	611	1062

**4.1.3 Common mental disorders (CMD)**

CMD includes depression, anxiety and sleep disorders, and are usually treated in primary care. Prevalence of mental health issues has not been measured at a local level. However, the national Adult Psychiatric Morbidity Survey (APMS) last conducted 2014 measures prevalence. Using these validated surveys, the estimated prevalence of CMD among 18- 24 year olds in our local population suggests that **1 in 5 18-24s (21.07%) suffered from CMD in 2014, compared to 17.1% amongst adults age 16-64 generally, showing that CMD is more of an issue for young adults.**

The APMS 2014 results showed that CMD symptoms were about **three times more common in women age 16-24 (26.0%) than men (9.1%). The gap has grown since 1993, when 16-24 year old women were twice as likely (19.2%) as 16-24 year old men (8.4%) to have symptoms of CMD.**

**Figure 5 Common Mental Disorders prevalence in 18-24s, estimated using 2014 APMS and 2015 ONS population projections**

Local authority	Male	Female
Hammersmith and Fulham	<b>890</b>	<b>2,616</b>
Kensington and Chelsea	<b>701</b>	<b>1,883</b>
Westminster	<b>1,255</b>	<b>3,133</b>

**4.1.4 Improving Access to Psychological Therapies (IAPT)**

IAPT is the primary care service for CMD. Data was available for the use of the IAPT service in Kensington and Chelsea and Westminster IAPT service January-December 2015. This showed that young men constituted only 35% of referrals in Kensington and Chelsea, and 34% in Westminster, which matches the rates of CMD by gender found in the APMS.

However, of those who entered treatment, the completion rate was 67% for females and only 33% for males in Kensington and Chelsea (this data was not available for Westminster). Young adults age 18-25 were less likely than the general adult population to complete treatment.

**4.2 Recommendations**

Gap / challenge	Potential solution / recommendation
<p>The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups.</p> <p>Young adults would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth.</p> <p>Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers.</p>	<ol style="list-style-type: none"> <li>1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health.               <ol style="list-style-type: none"> <li>a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups.</li> </ol> </li> </ol>
<p>Small changes that all GP practices can facilitate would make a positive difference. The AYPH's primary care guidance has been endorsed by the Royal College of General Practitioners (RCGP) and contains actions all GPs could carry out to improve primary care services for young people.</p>	<ol style="list-style-type: none"> <li>2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's <i>Toolkit for General Practice</i><sup>5</sup>. CCGs should make use of the GP Champions for Youth Health Project's <i>Commissioning Effective Primary Care Services for Young People</i><sup>6</sup>.</li> </ol>

<sup>5</sup> GP Champions for Youth Health Project. *Toolkit for General Practice (online)* [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit\\_ONLINE.pdf](http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf) (accessed 14.12.16)

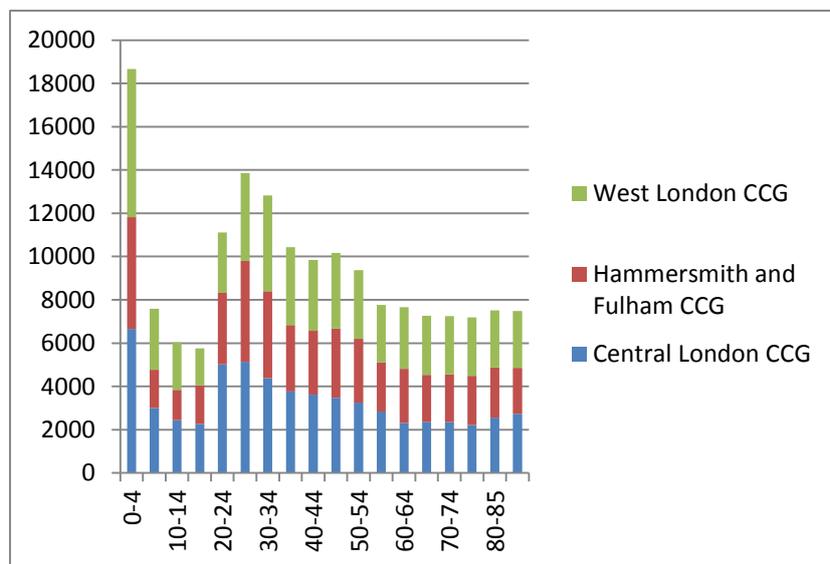
<sup>6</sup> GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners\\_ONLINE.pdf](http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf) (accessed 14.12.16)

### 4.3 A&E and Urgent care use

#### 4.3.1 Urgent care

There is a significant spike in Urgent Care Centre use at age 20-24 as shown in table 4 below. In consultation with young people, many said that they preferred to use A&E or urgent care than GPs.

Table 4 Non-elective Attendances of all Urgent Care Services in the Three Boroughs (2014/15)



When looking at the rates of use (per 1,000 people) of Urgent Care Centres (UCC), A&E and Walk-in Centres (WiC), urgent care is the preferred unplanned secondary care service for young adults. Table 5 shows that the rate of attendances at walk-in centres is significantly higher amongst young adults than all age groups, however urgent care centre use is even higher in young adults. A&E use is lower amongst young adults than the general population, as the older populations have more co-morbidities and so are frequent users of A&E services.

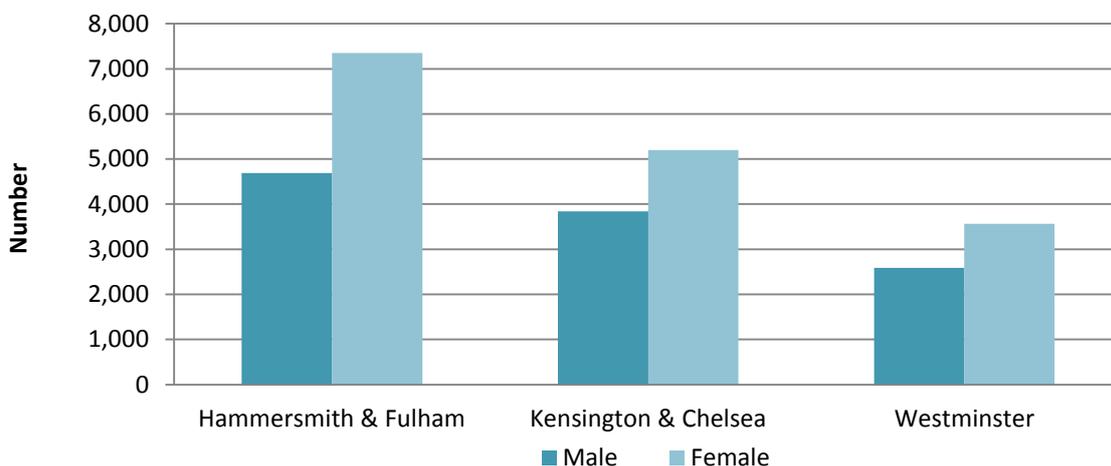
Table 5 Rate per 1,000 people of users among 18-25 year olds from the three boroughs compared with all age groups (2015/16)

	A&E		UCC		WiC	
	18-25	All other ages	18-25	All other ages	18-25	All other ages
<b>Rate of attendances per 1000 population</b>	<b>238.2</b>	287.1	<b>351.5</b>	243.5	<b>57.5</b>	31.1

4.3.2 Accident and Emergency (A&E) use

In 2015/16, there were 27,221 A&E attendances from the populations of the three boroughs aged 18-25, **11.5% of the total attendances**.

Figure 6: Numbers of A&E attendances in young adults age 18-25 by local authority and gender, 2015/16



The majority (80%) of A&E attendances in young adults were first attendances; 1% were follow-up attendances and 19% were not coded. **There was a higher number of females attending A&E in all three boroughs.**

The chart below shows A&E attendances in young adults by ethnicity, as a proportion of the resident young adult population. There is a high proportion of young adult population in the Other, Black Caribbean and Bangladeshi groups that have attended an A&E department in the last year, in particular in Kensington and Chelsea. However, the numbers may be skewed by individuals with high attendance rates in those ethnic groups.

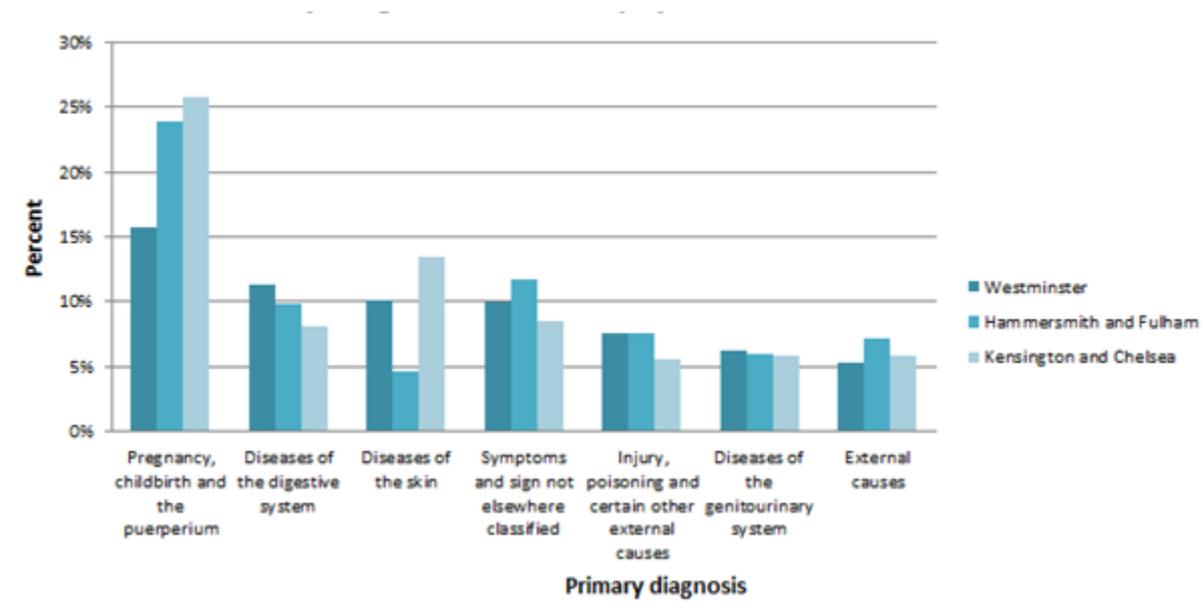
Figure 7: A&E attendances as a proportion of resident population by ethnic group, 2015/16



#### 4.4 Inpatient admissions

Figure 8 below shows the most common primary diagnoses in young adult inpatients in each local authority. The top five diagnoses make up 54.6% of young adult inpatient admissions in Westminster, 60.0% in Hammersmith and Fulham and 61.5% in Kensington and Chelsea. “Pregnancy, childbirth and the puerperium” is the number one reason for admission in the young adult population in all three boroughs. There are higher hospital admissions in BME groups, due to their lower average age of pregnancy.

Figure 8: Young adult hospital admissions by main primary diagnosis and local authority, 2015/16



The most common inpatient diagnoses highlight some key themes that will be investigated further in this report, such as diseases of the genitourinary system (see sexual health chapter 8), injury, poisoning and certain other external causes (see substance misuse chapter 7) and diseases of the digestive system (likely to be alcohol related – see substance misuse chapter 7).

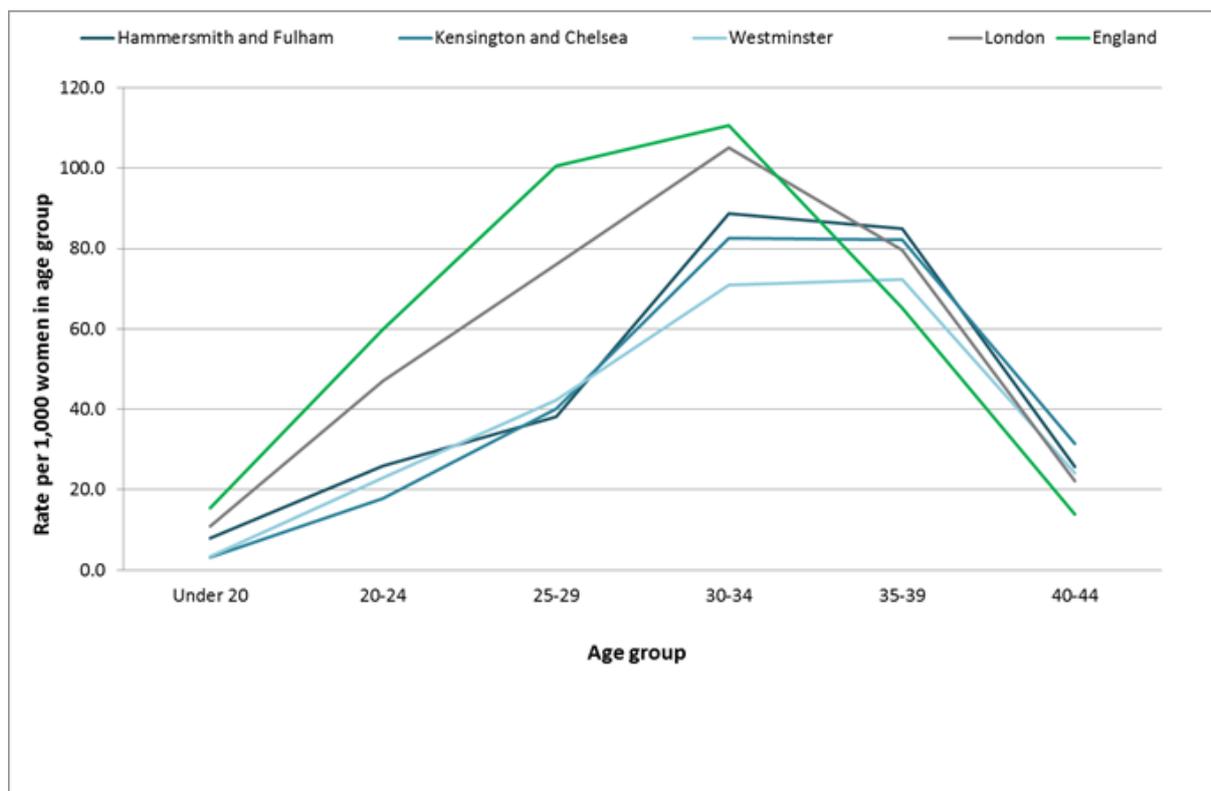
##### 4.4.1 Births

The rates of births to mothers age 18-25 are lower in all three boroughs compared to London and England averages. Hammersmith and Fulham has higher numbers, particularly in mothers under the age of 20.

In 2014, there were 160 mothers age 20-24 in Central London, 232 in Hammersmith and Fulham and 229 in West London.

Figure 9 below compares the distribution of birth rates by age of mother between local boroughs, London and England. **Compared to the London and England average, all local boroughs have a lower birth rate among mothers aged less than 30 years.**

Figure 9: Live birth rates per 1,000 females by age of mother, 2014



Source: ONS Live Births by Area of Usual Residence

## 5 Eating disorders

### 5.1 What is the issue?

Eating disorders are illnesses which disproportionately affect adolescents and young adults, and so constitute a key area of investigation in this report.

Eating disorders are mental health disorders that are characterised by an attitude towards food that causes people to change their eating habits and behaviour. Someone with an eating disorder may have a preoccupation with their weight and/or body shape which may lead to harmful eating habits, impacting negatively on their physical health and sometimes proving fatal.

The long-term negative effects of eating disorders can be seen across education, employment opportunities (lost employment is estimated to account for 69% of the total cost to society of eating disorders (McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008)), fertility, relationships and parenting. It puts a huge burden on family and carers (PricewaterhouseCoopers, 2015). Comorbidities commonly associated with eating disorders include depression and obsessive-compulsive disorder.

Table 4: Types of eating disorders

Eating disorder	Symptoms
Anorexia nervosa	Seeking to maintain a low body weight as a result of a preoccupation with weight: either a fear of fatness or a pursuit of thinness.
Bulimia nervosa	Recurrent episodes of binge eating and then trying to prevent weight gain through any one or a combination of behaviours, such as vomiting, fasting, or excessive exercise.
Binge eating disorder	Recurrent episodes of binge eating without compensatory behaviour (e.g. vomiting, fasting, or excessive exercise).
Atypical eating disorders	May closely resemble anorexia nervosa, bulimia nervosa, and/or binge eating, but do not meet the precise diagnostic criteria.

## 5.2 What do we know nationally?

### 5.2.1 Prevalence and incidence

Although eating disorders are not considered common, **over 1.6 million people in the UK are estimated to be affected**, and are most common in teenagers and young women. **For every male with anorexia or bulimia, there are 10 females** (Joint Commissioning Panel for Mental Health, 2013; NICE, 2014a).

Atypical eating disorders are the most common, followed by binge eating disorders and bulimia nervosa. **Anorexia is least common, but has the highest mortality amongst all psychiatric disorders.** Research has shown that incidence of eating disorders (in particular atypical eating disorders) has been increasing (Micali, Hagberg, Petersen, & Treasure, 2013).

### 5.2.2 Link to substance misuse

Eating disorders show high levels of comorbidity with substance abuse disorders, depression, and anxiety disorders (World Health Organization, 2004). Individuals with eating disorders were up to 5 times as likely as those without eating disorders to abuse alcohol or illicit drugs, and those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have had eating disorders. Up to 50% of individuals with eating disorders abused alcohol or illicit drugs, compared to 9% of the general population. Up to 35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population (National Center on Addiction and Substance Abuse at Columbia University, 2003).

### 5.2.3 Causes of eating disorders

The evidence base on what causes an eating disorder is weak as is the evidence for successful prevention, but positive body image and healthy eating messages are thought to help. However, professionals should understand common risk factors to help identify an eating disorder:

- Family history of eating disorders, depression or substance misuse
- Gender – women and girls are more likely to develop eating disorders
- Age – eating disorders tend to present in adolescence and young adulthood
- Adverse life events, particularly involving relationships with close family or friends
- Socio-cultural factors such as the pressure to be thin
- Premorbid characteristics – perfectionism, low self-esteem<sup>7</sup>

### 5.2.4 Effective treatment

Treatment of eating disorders requires co-ordinated and multidisciplinary care across primary, secondary and tertiary care. Psychological interventions seek to address the core attitudes and improve longer-term outcomes for patients.

#### *Existing good practice*

Vincent Square uses guided self-help with a book for patients with low level needs. This is an evidence-based approach which is cost effective as each book is approximately £12, compared to £100 per person cost for web based self-help with lower engagement.

<sup>7</sup> NICE Clinical Knowledge Summaries. *Eating disorders (online)*. <https://cks.nice.org.uk/eating-disorders> (accessed 19.12.16)

NICE set guidelines of evidence-based effective treatment in 2004 for all tiers<sup>8</sup>; an update is expected in 2017. In addition the Joint Commissioning Panel for Mental Health has produced guidelines for commissioning mental health services for people with eating disorders (2013).

**Evidence- based treatment for eating disorders such as Cognitive Behavioral Therapy (CBT) should be available in a primary care setting.** NICE guidance states that for people presenting in primary care, GPS should take responsibility for the initial assessment and coordination of care, and determine the need for emergency medical or psychiatric assessment.

**Early detection and treatment may improve outcomes and so a key theme for effective treatment across eating disorders and levels of severity is waiting times.** NICE advise that people with eating disorders should be assessed and receive treatment at the earliest opportunity. The more entrenched the illness, the less likely it is to be treatable. The FREED study demonstrated higher uptake of treatment when waiting times were greatly reduced and illness was in its first 3 years (Glennon, South London and Maudsley NHS Foundation Trust, & King's College London, 2015).

#### Good practice case study: Bristol

Bristol's Student Health Service initiated a discussion with Bristol Primary Care Trust (PCT) to set up an additional eating disorder service outside of secondary care, for people with less severe eating disorders who may not have been seen by the existing service, for example if they did not meet BMI criteria. The service had its pilot year in 2009 and has now been rolled out to the whole of Bristol due to its success. This service is a satellite of the main service and managed by the same provider, delivered in a timely way and crucially in partnership with GPs.

The GP can refer any suspected eating disorder patient to a specialist rapid assessment and triage service with the appropriate skills level (more specialist than a normal IAPT practitioner), which will either continue to see the patient in a primary care setting, or refer them onto the specialist secondary care service if appropriate. It is important that high need patients are not treated in this service without the expertise and wrap-around support of the secondary care service.

The service provides evidence that a primary care-based service can offer an appropriate and highly cost effective assessment process. Further, where interventions can be appropriately provided in primary care (i.e. for less complex cases) this too is more cost effective alternative than a referral to secondary or tertiary services. This allows the secondary care service to focus on offering a specialist, multi-disciplinary approach to those who need it most. It is estimated that the service is about 1/3 of the price per patient than the secondary care service. Additionally, it prevents cases from worsening to the point where secondary care is inevitable.

The service has received positive feedback from service users and local GPs, and effectively stitches together primary and secondary care for eating disorders.

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<sup>8</sup> NICE Pathways. *Eating Disorders (online)* <https://pathways.nice.org.uk/pathways/eating-disorders> (accessed 14.12.16)

There is a clear pattern of delay in seeking help for eating disorders, which in turn delays diagnosis and treatment, creating more severe and long term impacts. A recent survey of eating disorder patients indicates that the speed at which help is initially sought has a material impact upon likelihood of relapse (PricewaterhouseCoopers, 2015). Effective treatment needs to take into account other health impacts such as dental issues and substance misuse for people with bulimia nervosa (NICE, 2004).

### 5.3 What do we know locally?

#### 5.3.1 Local service provision

**Specialist:** The eating disorder service for the three boroughs, Vincent Square Clinic, is provided by Central North West London Mental Health Foundation Trust (CNWL). Vincent Square Clinic provides inpatient and specialist outpatient care for children and adults in one service.

**Other services:** there are other services that identify patients with an eating disorder, but are not eating disorder specialists and may be unable to treat such patients. These include:

- Primary care - NICE recommends that GPs should take the responsibility for the initial assessment and coordination of care, as well as determining the need for emergency medical or psychiatric assessment. There must be a clear agreement between primary and secondary or tertiary care about who takes responsibility for monitoring people with an eating disorder.
- Dietetics – who will refer back to the GP to get a referral for eating disorder services.
- Talking Therapies (IAPT) – when an eating disorder is detected, they will refer back to the GP if this is the key presenting issue.

#### 5.3.2 Gaps in local service provision

The only specialist eating disorder service for adults is in one secondary care clinic for all three boroughs. National and local strategies require the development of out of hospital services and early intervention to protect mental and physical health and wellbeing, so eating disorder patients should be able to receive treatment in the community closer to home – in particular patients who are not yet severely unwell or do not meet diagnostic criteria. Treatment in primary care is highly cost efficient and preferable for lower level patients. (see Bristol Case Study above).

Such a service would offer NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs, without the need for referral to Vincent Square clinic, and, as clinically indicated, up to 26 weeks of CBT and GP-based support for those with emerging but not life-threatening Eating Disorders, or onward referral to Vincent Square for those who require it.

#### 5.3.3 Numbers in eating disorder services

Table 7 below shows that the majority of patients are treated for anorexia nervosa and bulimia nervosa and 'unspecified' (which often resembles anorexia and bulimia but does not meet all of the diagnostic criteria such as BMI). Although anorexia nervosa is the least common eating disorder, it is the most common to receive treatment for locally and nationally due to the seriousness of the illness. The numbers receiving a service (Tables 7 and 8) is not a good measurement of local need, as demand is high and waiting times are long.

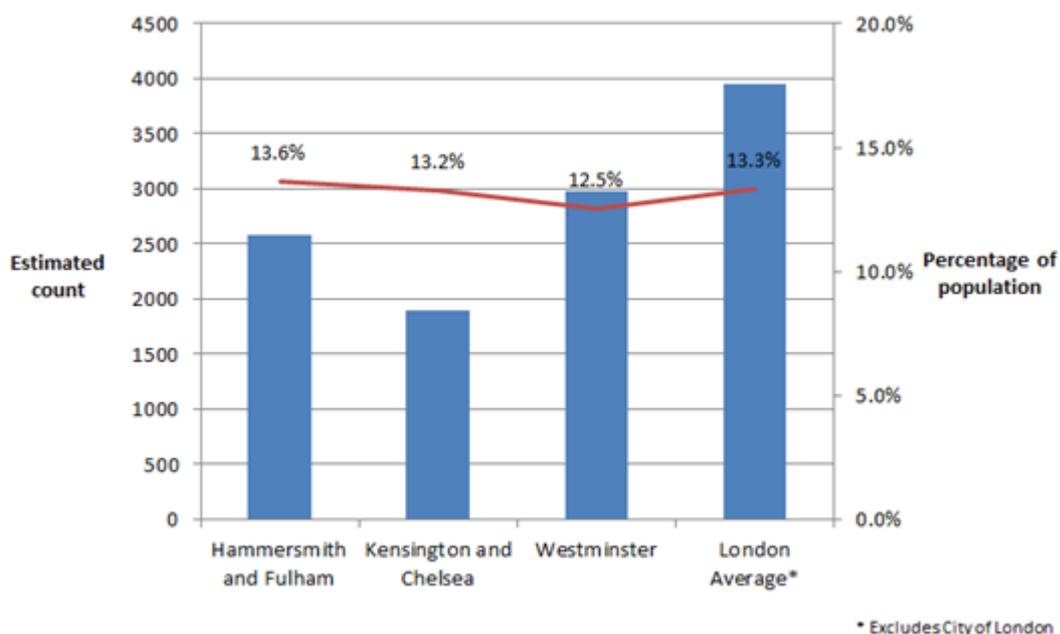
Table 5: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 from the three local CCGs by type of diagnosis

Anorexia nervosa	Bulimia nervosa	Eating disorder, unspecified
80	90	62

5.3.4 Estimated prevalence

Scoring two or more on the SCOFF scale is the clinical threshold that should prompt a more detailed investigation to be undertaken to diagnose eating disorder, although not everyone scoring two or more on this scale would be eligible for a service. If more GPs were trained to use the SCOFF scale more actively, there would be an even greater pressure on the current service for assessments, but would importantly enable eating disorders to be picked up proactively before the condition deteriorates. Figure 10 below shows the estimated numbers of local people age 16-24 who score two or more on the SCOFF scale.

Figure 10: Estimated prevalence of potential eating disorders among young people



Using the estimates in Figure 10, table 8 shows clearly that the current service is only able to see a small fraction of the estimated number of people with an eating disorder.

Table 6: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 by CCG

CCG	CNWL Patients	Estimated prevalence (borough)
Central London CCG / Westminster	126	2975
Hammersmith and Fulham CCG/ borough	87	2580
West London CCG / Kensington and Chelsea	79	1899

5.3.5 Referrals

The GP practices with the highest numbers of referrals to Vincent Square are the practices with the highest numbers of registered young adults in each CCG. However as a percentage of young adult population, **the highest patient referral rates came from Richford Gate (1.41%), Marylebone Health Centre (1.05%) and King’s Road Medical Centre (1.06%).**

5.3.6 Access to services

Using a model that estimates ED prevalence based on ethnicity (Solmi, Hotopf, Hatch, Treasure, & Micali, 2016), it appears that **locally ‘white’ patients have a significantly better access to services than ‘Black’ or ‘Asian’ as well as ‘Other’.**

Table 7: Ethnicity of Vincent Square patients from the three boroughs compared to estimated prevalence

Ethnicity	Number of patients	Estimated number of people with eating disorders	Estimated % accessing a service
White	207	2265	9.1%
Black	7	725	1%
Asian	18	1638	1.1%
Other	40	954	4.2%

5.3.7 Challenges identified by local practitioners

- **Waiting times for services:** Whilst the children’s eating disorder service sees new referrals very quickly, particularly since the launch of the new rapid access service, the adult service has a waiting time of up to a year and frequently over 8 months. Whilst the secondary care service is very good, less severe patients would benefit from an early intervention community service based in primary care. As mentioned above, the less entrenched the illness, the higher the chance of recovery and patients seen within a short time of referral are significantly more likely to enter treatment.
- **Transfers of care:** Transitioning from the children’s to adults’ service works well locally as the provider is the same, but it is more challenging when a young adult moves to a different borough, which is common at this age (see figure 3 above - migration).
- **Liaison between services:** Good relationships and links between services are hindered by capacity. There is a lack of a network of professionals who come into contact with

*Existing good practice*

LBHF have a Child Health Network WhatsApp group through which professionals communicate about problems and advise each other.

eating disorder patients. Other services may be unaware of appropriate referral pathways.

- **Training:** Training was identified as a red flag for improvement in several areas. Clear guidance is needed on identifying and monitoring eating disorders.
  - Professionals outside of ED services are inconsistently knowledgeable of how to work with people with eating disorders, particularly if it is not the primary issue they are presenting with, and do not know the correct pathways. Clear guidance is needed on how to manage ED patients in primary care, e.g. how to monitor blood and weight, particularly as BMI isn't always the best indicator. **Free resources for health care professionals can be found [here](#).**
  - Training for frontline staff in a motivational interviewing approach was identified by local experts as a positive opportunity to effectively upskill the workforce
- **Awareness:**
  - Many young people are not aware of the health risks of being underweight
  - Many people, including young adults, professionals and families, are not aware of the signs of eating disorders
  - There are opportunities to raise awareness amongst young people with eating disorders such as in bathrooms in colleges and university buildings.
- **Gender:** Young men are underrepresented in their estimated numbers in services. Local practitioners identified that boys and young men are not aware of having an eating disorder, but have similar characteristics related to an obsession with body image such as excessive exercising and not eating a healthy and balanced diet. However, they are less likely to engage with services. This perception is supported in recent research (Räisänen & Hunt, 2014; Strother, Lemberg, Stanford, & Turberville, 2012; Sweeting et al., 2015) which also highlights the potential impact that delayed help-seeking behaviour may have on treatment outcomes (Räisänen & Hunt, 2014).
- **System / Commissioning issues:** As NHS England commission the local specialist mental health service for eating disorders, the CCGs are less involved and do not receive monitoring information. Currently, there is only an eating disorder service in a secondary care setting.

### 5.3.8 Opportunities

The North West London CCG Collaborative mental health transformation programme Like Minded, of which *Serious and Long Term Mental Health Need* is a key population group has resources for transitional support until funding can be transferred from secondary care when demand is reduced.

## 5.4 Recommendations

Gap / challenge	Potential solution / recommendation
<p>A small fraction of the estimated numbers of young adults with eating disorders are being seen in services. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long.</p>	<p>1. Review the eating disorder pathway as part of Like Minded <i>Serious and Long Term Mental Health Need</i> population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and</p>

<p>National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing.</p> <p>There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.</p>	<p>assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.</p> <p>a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.</p>
<p>Current NICE guidelines are from 2004, and new guidelines are expected in 2017.</p>	<p>2. Review existing services against new NICE guidelines when available in 2017.</p>
<p>Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.</p>	<p>3. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals.</p> <p>4. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder.</p> <p>a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.</p>

## 6 Care Leavers

Care leavers are a group of young people who are disproportionately affected by some of the issues discussed in this JSNA. Although their physical health has not been found to be substantially different to the general population, their mental health needs are higher and some lifestyle choices affect their health needs (such as higher usage of substances). Additionally, former unaccompanied asylum seeking children (UASC) have particular physical and mental health needs.

Care leavers are a highly transient population, and some will experience the breakdown of placements, which can cause interruption to health services they are receiving. These issues may shape their help-seeking behaviours.

Whilst many care leavers go on to have good health and wellbeing as adults, a number are more vulnerable and require consideration as a specific cohort. New research underway by The Care Leavers Association suggests that there may be more long-term impacts on the physical and mental health, later in life, of people who have been in care.

### 6.1 Who are Care Leavers?

The term 'care leavers' refers to a person aged 25 or under, who has been looked after by a local authority for at least 13 weeks since the age of 14. At age 18, a looked after child is no longer in care, but the local authority still has a responsibility to them as a care leaver until age 21, or up to age 25 if they are in full time education. Looked after children can stay in stable foster placements up to the age of 21, but those in residential care must leave at age 18 and are likely to be more vulnerable.

The definition also includes current and former Unaccompanied Asylum Seeking Children (UASCs), who are care leavers who have more particular health needs. UASC are defined as people under the age of 18, who are applying for asylum in their own right, and are separated from both parents and are not being cared for by an adult who in law or by custom has responsibility to do so. The number of UASC has almost tripled in the last two years. The Home Office statistics show that 61.3% of UASC are aged between 16 and 17 when they arrive, and so would go almost straight into leaving care services.

Young adults that the local authority has a responsibility towards because they have been remanded in Local Authority care or in a Young Offender institute for 13 weeks or more also become care leavers. Both groups have specific needs.

Care leaver statutory requirements are set out in the Children Act 1989 (Department of Education, 2014) and in the Children Leaving Care Act 2000<sup>9</sup>.

New legislation is expected to come in 2017 following the *Keep on Caring* government strategy (HM Government, 2016) which will extend the duty on local authorities to provide a personal advisor and other services, such as training costs for apprenticeships, for all care leavers up to the age of 25

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<sup>9</sup> HM Government. *Children Leaving Care Act 2000 (online)*  
<http://www.legislation.gov.uk/ukpga/2000/35/contents> (accessed 14.12.16)

(instead of 21). This will mean that the local authority will have a duty to a far greater number of young people, and will be unlikely to have more resources.

## 6.2 What do we know nationally?

Care leavers face complex psychological challenges. While most young people make a gradual transition to independence, supported by their family, care leavers often experience multiple, overlapping and simultaneous changes in their living circumstances.

National evidence shows that care leavers consistently experience some of the worst health, social, educational and employment outcomes in our society (Driscoll, 2011; Dunlop, 2013; Philip Mendes, 2009; P. Mendes & Moslehuddin, 2006). For example, **care leavers are more likely to have poor mental health, have poor dental health, experience homelessness, not succeed academically, live in poverty, and be more commonly represented in the criminal justice system. Additionally, nearly half of female care leavers are mothers by the age of 24** (Fallon, Broadhurst, & Ross, 2015). This is often a consequence of living a fragmented life, moving from one placement to another, and severing important relationships with family and support networks. The disadvantages that care leavers experience before entering care can then be compounded by their experiences in care (P. Mendes & Moslehuddin, 2006).

## 6.3 What do we know locally?

The numbers of current care leavers and LAC about to become care leavers can be seen in table 10 below. Table 11 shows that **33-45% of young people in the three boroughs come into the care system at age 16 and over**, which is when preparation for adulthood and leaving care takes place. This is compared to 20% nationally and 30% across London coming into care age 16+.

Table 8: Current numbers of LAC and Care Leavers in services (2015/16)

	Looked After Children age 15-17	Care Leavers age 18+
LBHF	94	165
RBKC	52	134
WCC	64	178

Table 9: Age at which children and young people enter care, by borough

Age (years)	Hammersmith & Fulham		Kensington & Chelsea		Westminster	
	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016
0 to 15	66%	71%	57%	62%	62%	65%
16 and over	<b>33%</b>	<b>30%</b>	<b>43%</b>	<b>38%</b>	<b>39%</b>	<b>35%</b>

6.3.1 Current and former Unaccompanied Asylum Seeking Children (UASC)

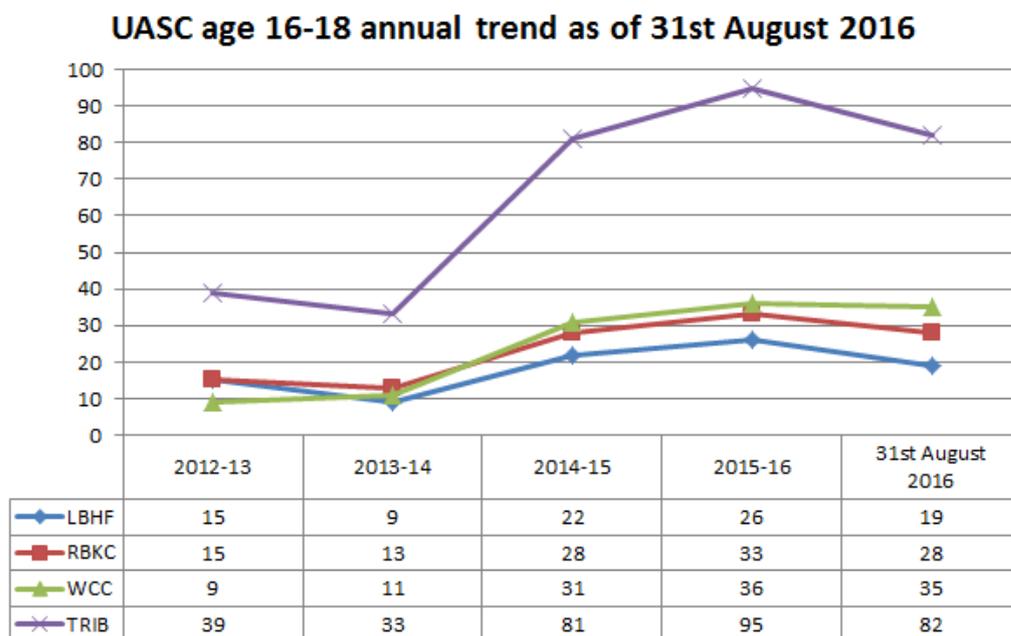
The number of care leavers who are either under the age of 18 and so still UASC, or ‘former UASC’ if over the age of 18 but with similar health needs, has also increased locally (see Figure 11 for UASC age 16-18).

Local Authorities are expected to take a number of UASC that equates to 0.07% of their child population. In the 16-18 age group, many of whom are in the process of becoming care leavers, Kensington and Chelsea and Westminster have higher numbers than their quota and so services will need to be particularly aware of their needs. However numbers are not expected to increase as sharply as they have over recent years as numbers above the 0.07% will be distributed to other local authorities.

Table 10: Number of former UASC care leavers by borough

Local Authority	Count as of 31 <sup>st</sup> March 2016	% of all care leavers
Hammersmith and Fulham	52	31.5
Kensington and Chelsea	53	39.7
Westminster	29	16.3

Figure 11: Numbers of UASC looked after children age 16-18 in the three boroughs, 2010-31st March 2016 (Source: Frameworki)



The UASC that the three local authorities have responsibility for are placed all over London, so are not concentrated in one particular area. NICE quality standards state that looked-after children and young people who move across local authority or health boundaries must continue to receive the

services they need.<sup>10</sup> However, an audit of UASC in England found that the receiving local authorities are rarely informed of these transfers and keep no record of unaccompanied children placed from other local authorities (Humphris & Sigona, 2016). Although the three local boroughs have a clear system for their UASCs placed out of borough, it could be inconsistent for care leavers from other boroughs placed within the three boroughs.

## 6.4 Care leaver health needs

An audit of the health records of care leavers in the three boroughs suggests that their physical health needs are not different from a normal child or young adult. However, they find it harder to engage with health services, so conditions deteriorate. Not having a parent-type figure telling them to go to a doctor can mean they are less likely to do so.

The health needs of care leavers are described below using: national evidence; evidence from a workshop for local professionals who work with care leavers; evidence from groups of care leavers consulted in the process of developing this JSNA; and evidence from the formal consultation held on health for each of the Corporate Parent Boards.

### 6.4.1 Mental Health needs

**Children in care have higher rates of mental health problems than the general population; nearly half have a mental health disorder (HM Government, 2011, 2013).** For many, this persists past the age of 18. The risks of not addressing mental health needs (including ‘low level’ mental health needs) are known to impact on physical health, education, employment, and relationships. **National and local evidence overwhelmingly supports the option to extend CAMHS for care leavers up to age 25 based on need:**

- The government report *Future in Mind* (Department of Health & NHS England, 2015) acknowledges that care leavers are more vulnerable to mental health problems and find it harder to access help, and that mental health services must get it right with this cohort. The report recommends promoting resilience, prevention, and early intervention for good mental health for all. The report adds that for many, adult services are either not available or not appropriate, and recommends flexibility around age boundaries and transition based on individual circumstances rather than age.
- In a 2015 report (Bazalgette et al., 2015) the NSPCC have described the withdrawal of CAMHS at 18 as a “cliff edge” and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25. Extending mental health support for care leavers until the age of 25 was also included in the Alliance for Children in Care and Care Leavers’ seven key recommendations to the House of Commons Education Committee report (House of Commons Education Committee, 2016).
- Locally, [the Anna Freud Centre needs assessment of CAMHS](#) recommends a ‘tapered transition’ to Adult Mental Health Services (AMHS) between the ages of 16-25, which would allow people already receiving CAMHS could continue even though they wouldn’t meet the

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<sup>10</sup> NICE (2013). *Looked-after children and young people (online)* <https://www.nice.org.uk/guidance/QS31> (accessed 28.10.16)

eligibility criteria for adults. It would also allow a young person to choose whether to be seen in Children or Adult services if they are aged 16 or over when they first become known to mental health services.

- **Local practitioners identified that the biggest area of unmet need is in mental health needs that do not meet AMHS threshold or diagnosis criteria.** It is recognised nationally and by local practitioners that adults' services are very different to those offered to children, as CAMHS has a far lower eligibility threshold than AMHS. The tapered transition from CAMHS up to age 25 would make a significant difference, however, **professionals have identified that many young care leavers are only just ready to start engaging with CAMHS at the age of 18 or over.** This 'tapered' model would not allow them to start engaging with the service at that age – they could only continue an existing relationship. Additionally, LAC CAMHS provides a more specialist service with more therapeutic interventions and specialism in trauma, which is particularly needed with such high numbers of former UASCs.

Furthermore, CAMHS must be able to work flexibly with this cohort as some lead more chaotic lives and are more likely to miss appointments and prefer visits outside of clinical settings.

The consultations with care leavers discussed emotional wellbeing and mental health. A number of issues were reported:

- It can be difficult for an individual to recognise when they (or someone else) has a mental health condition
- Some lack of awareness of mental health, of services available, and of coping strategies such as mindfulness
- Mixed experience of therapies. One consultation reported that talking therapies were popular for emotional issues as young people said that they needed someone who would listen and be reliable. In the other group, all of those who spoke of counselling reported negative experiences and that it made matters worse.
- Young people didn't want to be told it is 'only mental health' in response to their emotional problems.

#### 6.4.2 Alternatives to CAMHS / AMHS

In some cases, IAPT may be a suitable option and should be promoted to care leavers. A practitioner noted that IAPT is not popular with care leavers as it is not well understood as a service by professionals, who then do not advise care leavers to try it. However, IAPT is best suited to people with a structured definition of depression or anxiety, whereas **many care leavers' problems are emotional, behavioural and relational, but do not fit a diagnosis category.** Local clinicians reported that sometimes a diagnosis such as personality disorder is given to get the young person a service, but this may be unhelpful and carry a stigma.

#### *Local good practice*

Local professionals noted that having a clinical psychologist in the Leaving Care team has made a noticeable difference just working 2/3 days a week in RBKC.

For some care leavers, **their need could be met outside a clinical setting.** A study of mentoring for young people leaving care concluded that mentoring offers them a different style of supportive relationship but one which complements formal professional support. In the study, 93% had some 'positive outcomes' from their mentoring relationship (Clayden, Stein, & University of York, 2005).

#### 6.4.3 Emotional needs

Many care leavers are not mentally ill, but are emotionally vulnerable. There are a wide range of 'emotional ages' and the needs of care leavers will vary considerably.

The **quality of individual relationships** is very important to care leavers, and often requires great flexibility on behalf of the professional. Care leavers have a variety of people they may form a particularly close and trusting relationship with; this can be their social worker, personal advisor, a nurse, CAMHS worker, guardian or foster parent, or key worker from a provided service.

**Continuity is felt to be incredibly important** for people going through the transition of leaving care. For example, the Virtual Schools are felt to be effective, but the teachers want to continue to work with the young person after they turn 18.

**Care leavers have less support infrastructure with more pressure than other people their age.** Young care leavers often live alone at a far younger age than their peers, causing social isolation which is well evidenced to cause deterioration in health and wellbeing (Durcan, Bell, & UCL Institute of Health Equity, 2015).

**The issue of confidentiality around physical and emotional health was important to care leavers,** as this was not always possible when they were looked after children. The young people interviewed also had some flexibility in their views on confidentiality, stating that if it was "life or death" or "puts someone else at risk" then there may be exceptions to their confidentiality.

#### 6.4.4 Substance misuse and chaotic lives

A small number of care leavers lead 'chaotic lives', bringing them into contact with a range of services and professionals. Substance misuse is often a symptom or cause of a chaotic lifestyle; it is estimated that 11% of care leavers have problematic alcohol use and 21% have problematic drug use. Care leavers are twice as likely to have used illegal drugs as the general population.

#### 6.4.5 Dental health

Looked After Children have regular dental checks, however care leavers are more likely to experience poor dental health than their peer groups. During consultation with a group of local care leavers, none had been to the dentist in the last 12 months because of the cost.

#### 6.4.6 Sexual health

The care leavers at the Corporate Parent Board consultation reported that the most talked about health topic was sexual health.

Professionals have identified that **'inappropriate' sexual relationships** which are not illegal present a challenge to professionals where they believe a young person is vulnerable, but has mental capacity. This links to the findings when discussing sexual health with young people around peer pressure (see chapter 8 – sexual health, where this topic is discussed in more detail), but may be more extreme in care leavers who have not seen a model of a positive relationship.

#### 6.4.7 Pregnancies

A quarter of young women leaving care are pregnant or already mothers. **Almost half of female care-leavers become mothers between the ages of 18 and 24,** compared to 29% of women aged 24

or under in the general population.<sup>11</sup> Young people with a background in care are more likely to continue a pregnancy, planned or unplanned. This group is also more likely to experience poor outcomes including having a low birth weight baby, single parenthood, and symptoms of depression, and are more likely to smoke during pregnancy (Fallon et al., 2015).

Research also suggests that teenage motherhood (defined as conception under the age of 20) has a detrimental effect on later life outcomes. Teenage mothers, by age 30, experience lower rates of employment, lower wages, lower levels of educational attainment and higher benefits needs. This effect is more pronounced for young women who conceived between the ages of 18 and 20 (Walker, Goodman, & Kaplan, 2004).

### **6.4.8 UASC-specific physical health needs**

UASC have very different physical and mental health problems to the indigenous population. Examination of the LAC nurse's records and relevant social work notes reveals a range of physical and emotional effects as a result of the journey, and sometimes of conditions and experiences in the young people's home countries beforehand.

Typically, the medical history of a UASC is unknown, including vaccinations. Common physical complaints, which seem to be the result of deprivation on the journey, are abdominal conditions and various musculo-skeletal issues. There also seems to be a high incidence of dental need, but it is not entirely clear whether these are the result of pre-existing conditions or as a result of the journey to the UK. Common low-level health problems are ringworm and scabies when UASC first arrive.

### **6.4.9 UASC-specific mental health needs**

NICE states that UASCs have an increased likelihood of mental health problems, suicide attempts and mental illness, due to post-traumatic stress disorder and ongoing stress arising from language barriers, immigration systems and being separated from loved ones and community (Simmonds, Merredew, & British Association for Adoption and Fostering, 2010).

Separation, bereavement and uncertainty about the fate of loved ones often has a negative emotional impact. Additionally, emotional distress can sometimes be observed due to a lack of understanding of the situation after arrival due to language barriers.

Anxiety over the immigration process and the implications of getting a negative decision, such as the threat of an involuntary return to their home countries, are also influential factors on UASC's wellbeing. It has also been suggested by some practitioners that anxiety caused by the effort of maintaining a (potentially false) story to be conveyed to the Home Office may have a negative effect on wellbeing.

Several young people were supported to cope with the effects of these issues through LAC CAMHS specializing in trauma up to the age of 18, but are not necessarily eligible for adult mental health services.

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<sup>11</sup> According to Community Care research article, citing earlier research briefing by SCIE. Available at <http://www.communitycare.co.uk/2008/01/23/teenage-pregnancies-among-children-in-care-research/> (accessed 19.12.2016)

**6.4.10 Care leavers in custody**

The recent Ofsted inspection of the three boroughs’ Children’s Services noted that greater focus needs to be given to young care leavers in custody. Nationally, care leavers are over-represented in the criminal justice system. Research by the Ministry of Justice (Williams, Papadopoulou, & Booth, 2012) found that **24% of the adult prison population had been in care at some point as a child**, and reported that this was comparable with the 1991 National Prison Survey showing that 26% of adult prisoner were in care as a child (only 2% of the general population spend time in prison). As discussed under ‘mental health’ above, there is also an over-representation of mental health needs in this cohort, and so early identification and better outreach should be done proactively with care leavers in custody.

**6.5 Local service provision and use**

Consultation with practitioners during the JSNA process has highlighted **tension between wanting to teach care leavers to be independent adults, and offering additional support**. Care leavers are the most vulnerable group of young adults; if services cannot be flexible to them, they will continue to fall between the cracks.

**6.5.1 Services up to age 18**

Up to age 18, the following services are used by Looked After Children and younger care leavers:

Service	Description
LAC CAMHS	Many care leavers would have accessed CAMHS up to age 18.
LAC Nurses	This service is only available to looked after children and care leavers up to the age of 18. The LAC nurses give annual health checks to young people and oversee regular dental checks. In practice, LAC nurses often give ongoing support and advice and communicate with their patients’ personal advisors
Healthcare summaries	At the request of young people, care leavers are offered a health summary when they leave care.
Focus on Practice clinicians/ family therapist	Work with young people to provide an effective therapy service.

**6.5.2 Care Leaver services**

The following services are for care leavers over the age of 18:

Service	Description
Leaving care teams / Independence Support Team	Leaving care teams facilitate the transition for a young person from being ‘looked after’ to being a ‘care leaver’.
Care Leavers Child Psychologist (RBKC only)	One psychologist placed within the Leaving Care team
Personal Advisors / keyworkers / foster carers	Provide health and wellbeing support such as healthy eating classes

The Children's Services and Leaving Care services have been recently rated as 'Outstanding' and 'Good' by Ofsted.<sup>12</sup> Local professionals have noted that the quality of social work has improved, particularly since the Focus on Practice training.

**A challenge that has been identified locally is that care leaver services are provided during the week during working hours, however care leavers often need support 'out of hours' too.**

### 6.5.3 Access to universal services

The key issue highlighted throughout the development of the JSNA was the transition from children's services to adults (over 18s) and the different inherent philosophies – under-18 services focus on the family unit, while adult services focus on the individual self-managing. Young adults' personal motivation and confidence to seek help and support may be in its infancy, and therefore they may not take up services that are geared towards self-determination and self-help. As a result, there can be issues with care leavers (and young adults generally) engaging with services. This is particularly prevalent when attempting to access mental health assessments.

A number of barriers to accessing services were reported by the small group of care leavers in Westminster, including:

- cost of certain services, particularly dentistry/oral health
- not always able to make an appointment with GP
- not always able to see the same GP or other health professional – continuity was important for care leavers
- transition from children's services to adult services was highlighted as an important issue (for example from CAMHS to adult mental health services).

#### *Local good practice*

Outreach work by LAC nurses has a positive impact, especially where the nurse is able to discharge to a GP with an understanding of young adults, and is able to discuss the transition with the care leaver at an early stage so they know how to independently access adult general health services.

When asked about developing health services for young people, awareness about drugs and smoking was suggested (for more information on substance misuse, see chapter 7).

At the consultation for the Corporate Parent Boards the majority of young people rated health as important. However barriers to prioritizing health included:

- the cost of gyms
- being busy with other things such as work or college
- living on a very tight budget.

### 6.5.4 Help-seeking behaviour

Most of the care leavers in Westminster reported waiting until a problem is severe before seeking help, and would often go directly to A&E rather than their GP. This was partly due to previous negative experiences with GPs.

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<sup>12</sup> Inspection reports can be viewed on the Ofsted website <https://www.gov.uk/government/organisations/ofsted> (viewed 28 October 2016)

When seeking advice on health issues, care leavers mentioned non-health professionals such as social workers, personal advisors, key workers and carers. **The importance of a strong and trusting relationship with a professional or guardian/foster parent to help care leavers through different challenges in life was a recurring theme.**

A recommendation from one of the consultations was use of a health app for young people with tailored information. NHS Go provides this platform, and promoting it and ensuring local services have up to date information on NHS Choices (the information source for NHS Go) would be more cost effective than creating a new app.

### 6.5.5 Communication and Co-location of services

Communication between children’s services and adults’ services was highlighted as an area for improvement. Although good practice exists, it is not always consistent between all relevant services.

Co-location was consistently discussed as an effective way to improve communication and encourage young adults to access a range of appropriate services. Young adults are more likely to miss appointments and less likely to visit GPs to obtain referrals, which has been improved in other areas through co-location. (See case study in chapter 6, primary care).

#### *Co-location local good practice*

Care leaver group drop-in sessions in Westminster which take place one evening a week have been used by staff to have ‘health days’: care leavers visit stations relating to different health issues such as oral health and sexual health. The group sessions have other positive impacts; participants are encouraged to discuss their feelings and build a peer support network.

## 6.6 Recommendations

Gap / challenge	Potential solution / recommendation
<p>Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. During consultation with care leavers, there was a lack of awareness of mental health and coping strategies.</p> <p>However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.</p>	<ol style="list-style-type: none"> <li>1. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers.                             <ol style="list-style-type: none"> <li>a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.</li> </ol> </li> </ol>
<p>The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services.</p>	<ol style="list-style-type: none"> <li>2. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the</li> </ol>

<p>The Anna Freud Centre needs assessment for CAMHS recommended a tapered transition from age 16-25.</p> <p>LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.</p>	<p>service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.</p> <p>a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.</p>
<p>A significant proportion of local care leavers are former UASCs, and have specific health and care needs.</p>	<p>3. Professionals including Leaving Care teams to be fully trained on NICE guidance for unaccompanied asylum seeking and trafficked care leavers</p>
<p>Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&amp;E and urgent care.</p> <p>The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.</p>	<p>4. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP, and encourage seeking help in the appropriate setting.</p> <p>a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs.</p>
<p>A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.</p>	<p>5. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.</p>

## 7 Substance misuse

### 7.1 What is the issue?

Substance and alcohol misuse is a key issue for adolescents and young adults. The level of any drug use in the last year was highest among 16 to 19 year olds (18.8%) and 20 to 24 year olds (19.8%). In contrast, the level of drug use was much lower in older age groups (2.4% of 55 to 59 year olds). **5.1% of young adults aged 16-24 were classed as frequent drug users. Drug related deaths reached record levels in 2015;** 3,674 drug poisoning deaths involving both legal and illegal drugs were registered in England and Wales in 2015, the highest since comparable records began in 1993 (Lader & Home Office, 2015).

Cannabis, ecstasy and powder cocaine are most commonly used by 16-24 year olds, with **16.3% using in the last year**, compared with 6.7% for the general population (Lader & Home Office, 2015).

Drug and alcohol interventions can help young adults get or stay in education, employment and training; prevent homelessness; and improve family relationships key to recovery, bringing a total lifetime benefit of up to £159m. **Every £1 spent on young adults’ drug and alcohol interventions brings a benefit of £5-£8** (Public Health England, 2014).

Figure 12: National age-specific trends in drug use

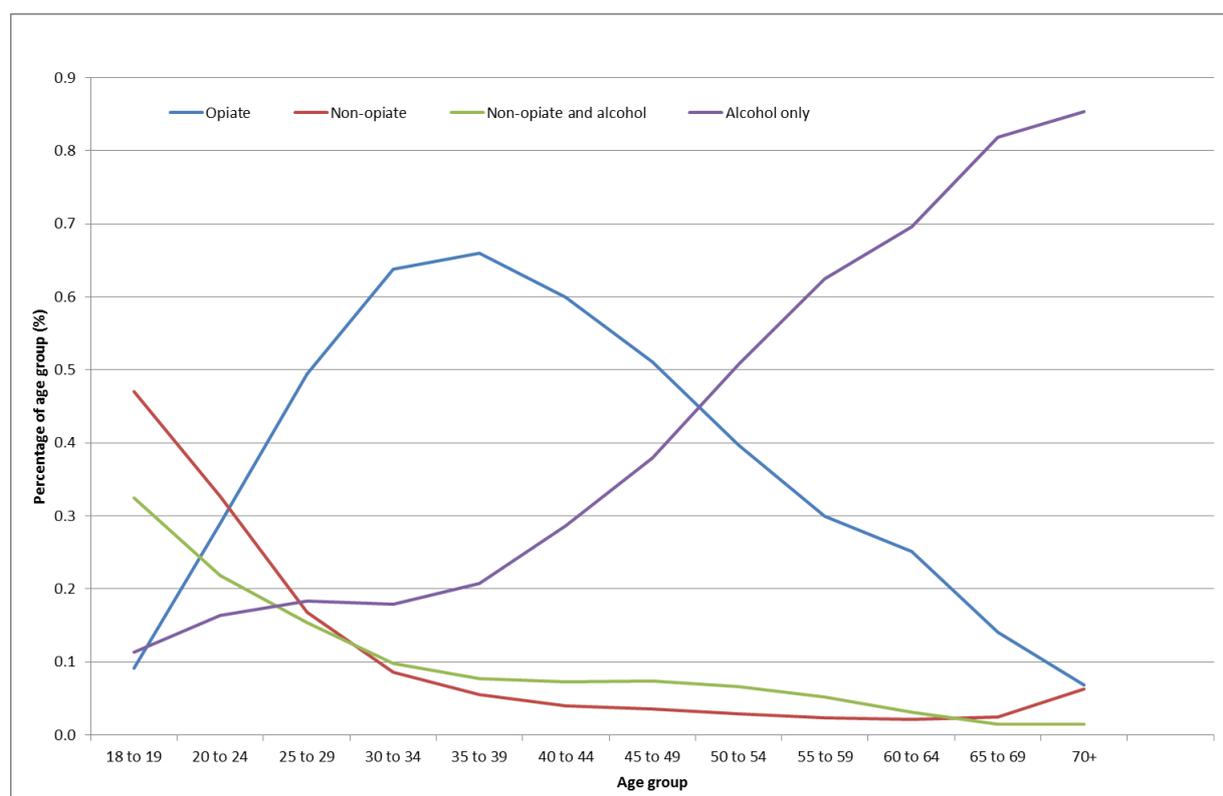


Figure 12 above shows that the key drug that adults present for treatment is opiates, however this is only the case after the age of 24. **For 18-24 year olds, non-opiates and combined non-opiates and alcohol are the primary drugs. This information is based on treatment population, so although it**

may not necessarily be indicative of need in the wider population, it does highlight the disparity around the substances which bring people into services.

#### *Links to other chapters*

As discussed in chapter 5 on Eating Disorders, those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have eating disorders - up to **35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population** (National Center on Addiction and Substance Abuse at Columbia University, 2003).

As discussed in chapter 8 on sexual health, there is a strong link between alcohol abuse and poor sexual health outcomes, including unplanned teenage pregnancy and sexually transmitted infections (P. Cook et al., 2010).

## 7.2 National strategy and guidance

### 7.2.1 Drug Strategy 2010

The Government's 2010 Strategy (Home Office, 2010) stated that specialist interventions should prevent young people's drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults.

### 7.2.2 NICE Guidance: Substance misuse interventions for vulnerable under 25s

Chapter 6 highlighted that care leavers have higher rates of substance misuse, which is true of other vulnerable groups. NICE has produced evidence-based public health guidance (NICE, 2007) which focuses on reducing substance misuse among vulnerable under-25s with a number of recommendations. This includes pathways for both alcohol use disorders<sup>13</sup> and drug misuse<sup>14</sup>.

The guidance recommend that local authorities should **develop a local strategy** that will help them to reduce substance misuse in vulnerable young people in their area. Services and professionals should **identify young people who are at risk of using drugs**, and refer them to services that can support them. These services should include **family based support** and **parental skills training**. Psychosocial interventions ('talking therapies') such as CBT and motivational interviewing, which explore the underlying causes of the substance misuse and seek to change the young person's attitude and behaviour towards drugs and alcohol, are considered to be most effective.

## 7.3 What do we know nationally?

### 7.3.1 Alcohol

Nationally, in the short term **1/4 of all deaths among 16-24 year old men** are attributable to alcohol. Alcohol use in adolescents and young adults causes long term health problems including **risks to**

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<sup>13</sup> NICE Pathways. *Alcohol use disorders (online)* <http://pathways.nice.org.uk/pathways/alcohol-use-disorders> (accessed 16.12.16)

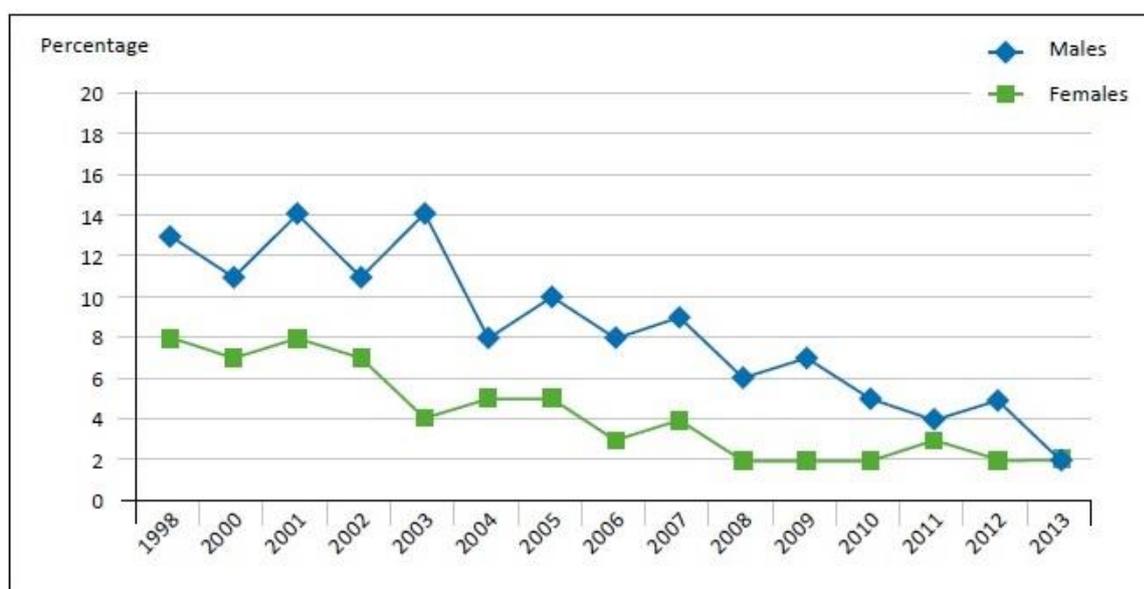
<sup>14</sup> NICE Pathways. *Drug misuse (online)* <https://pathways.nice.org.uk/pathways/drug-misuse> (accessed 16.12.16)

**brain development and long term memory, mental health disorders and social problems, and increased risks of teenage pregnancy and contracting sexually transmitted infections (STIs).**

The highest levels of alcohol dependence in women is amongst those aged 16 to 24 (9.8%), however they are under-represented within services. In men the highest levels of dependence were in those aged between 25 and 34 (16.8%) (National Centre for Social Research & University of Leicester, 2009).

There has been a fall over time in regular drinking (5 or more days per week) in 16-24s. However, young drinkers were more likely than any other age group to consume more than the weekly recommended limit in one day. **Among 16 to 24 year old drinkers, 17% consumed more than 14 units compared with 2% of those aged 65 and over** (Office for National Statistics, 2016).

Figure 13: Young people aged 16-24 years drinking on 5 days per week or more, Great Britain, 1998-2013



Source: Office for National Statistics, Opinions and Lifestyle Survey, Adult Drinking Habits in Great Britain, 2013

### 7.3.2 Cannabis and synthetic cannabinoids

Cannabis is particularly harmful in under-18s in terms of physical impact on health, as well as social impacts from misuse. A study in New Zealand found that adolescents who used cannabis regularly were at **risk of cognitive impairment including reduced intelligence, memory loss, and reduced attention span** (Meier et al., 2012).

Most young adults in England smoke ‘skunk’, a higher grade and more chemically based version of cannabis produced in the UK, which has a severe impact on frequent users including mood swings and loss of motivation. Although cannabis is not considered addictive, frequent users feel dependent.

Synthetic cannabinoids such as ‘Spice’ and ‘Black Mamba’ are significantly more potent than cannabis, have a drastic impact on behaviour and are highly addictive. They have been legal until

recently, and different versions may emerge which are not yet illegal. Synthetic cannabinoids are more likely to lead to emergency medical treatment than any other drug.<sup>15</sup>

### 7.3.3 *New psychoactive substances (NPS)*

Estimating the prevalence of NPS usage is often a challenge, especially through general population surveys. One insight is provided by the 2014 Flash Eurobarometer, a survey of just over 13,000 young adults aged 15–24 in the EU Member States, which asked about the use of NPS. It found that 8% of respondents had used an NPS at least once, with 3% using them in the last year (European Monitoring Centre for Drugs and Drug Addiction, 2015).

The majority of deaths from NPS (a total of 114 in England and Wales in 2015) reference mephedrone (a stimulant) and GHB (a sedative). According to the Global Drug Survey, in the UK patients are 3 times more likely to end up seeking emergency medical treatment with NPS than traditional drugs.

### 7.3.4 *Inequalities*

- Vulnerabilities increase likelihood of young people using drugs and alcohol. Care leavers and victims of domestic abuse, sexual assault and/or sexual exploitation are disproportionately likely to be seen in services, as are people with lower socio-economic status.
- Issues may differ by gender. There is a far higher rate of substance misuse amongst young men compared to young women.
- Gay or bisexual adults were more likely to have taken any illicit drug in the last year than heterosexual adults. In particular, gay or bisexual men were the group most likely to have taken any illicit drug in the last year (33%), with higher levels of illicit drug use than gay or bisexual women (23%) and heterosexual men (11%) (Health and Social Care Information Centre, 2014).

### 7.3.5 *Risk factors*

Risk factors include neglect, truancy, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse (Donaldson, 2009). Mental health is a key factor in problematic substance misuse as both cause and effect.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances (Public Health England, 2016).

### 7.3.6 *Protective factors*

Physical and mental wellbeing, and good social relationships and support are all key protective factors of problematic substance misuse. Important predictors of wellbeing include positive family relationships, a sense of belonging at school and in local communities, good relationships with adults outside the home, and positive activities and hobbies.

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<sup>15</sup> Global Drugs Survey. *Global Drugs Survey 2016 (online)* <https://www.globaldrugsurvey.com/past-findings/the-global-drug-survey-2016-findings/> (accessed 16.12.16)

### 7.3.7 *Barriers to accessing substance misuse services*

The authors of a review of the characteristics, needs and perceptions of 18-25 year old drug users in Liverpool identified the following potential barriers to accessing services:

- **Age restrictions or cut-offs for services:** users stated that services needed to listen to them more. Passing them on when they reached a certain age was a barrier to staying in treatment.
- Differences in the **definition of a ‘young person’** among young people and service providers alike could lead to confusion as to which service they should attend and how **transition** should be managed.
- Adolescents and young adults are more likely to seek advice **from family or friends** than from professionals.
- Poor attitudes of some service providers act as a barrier, as young adults find it important to have someone that they can rely on and trust.
- Services focusing on single needs (e.g. drug use) – services should address a **range of needs**.
- Lack of ‘joined-up’ services and multiple points of entry – it would be preferable to have a single source organisation instead of having to move from one service to another. (Wareing, Sumnall, & McVeigh, 2007)

## 7.4 What do we know locally?

Each borough provides a substance misuse service for young people under the age of 18 and a range of adults’ services for over 18s.

### 7.4.1 *Specialist services: Young People Services*

Each borough provides a service for children and adolescents.

- **Insight Blenheim – RBKC, up to age 24**
- **Hungerford Turning Point – WCC, up to age 18**
- **Children’s Services – LBHF, up to age 18**

In H&F, Public Health contributes the funding of Hammersmith and Fulham Children’s Services for young people’s sexual health and drug/alcohol misuse provision for residents. In RBKC and WCC, Blenheim and Turning Point are commissioned to provide specialist interventions and training to professionals to aid identification. Services are provided through satellites and both agencies work closely with other young peoples’ services.

The services provide both preventative interventions and treatment for young people. They run hot cafés, weekly workshops and a variety of health and wellbeing activities. They go into schools and colleges to undertake training sessions for parents, foster carers and teachers.

The Hammersmith and Fulham service works across statutory and voluntary services including Youth Offending Teams, Family Support and Child Protection, CAS, Early Help services in the north and south of the borough, and Family Assist. They also provide support to looked after children, attend parenting groups to provide substance misuse education, and deliver training to professionals within the borough around substance misuse.

7.4.2 Specialist services: Adult Services

The three boroughs have jointly commissioned adult drug and alcohol services for people over the age of 18. The treatment system was reconfigured in April 2016, with the new model focusing on transforming services to ensure they are responsive to local need, embed a culture innovative service user involvement, and embody an ethos of ambition for individual success.

**Drug & Alcohol Wellbeing Service (DAWS):** Turning Point and Blenheim jointly run the DAWS service in Hammersmith and Fulham, Kensington and Chelsea and Westminster, providing support for those using drugs and/or alcohol.

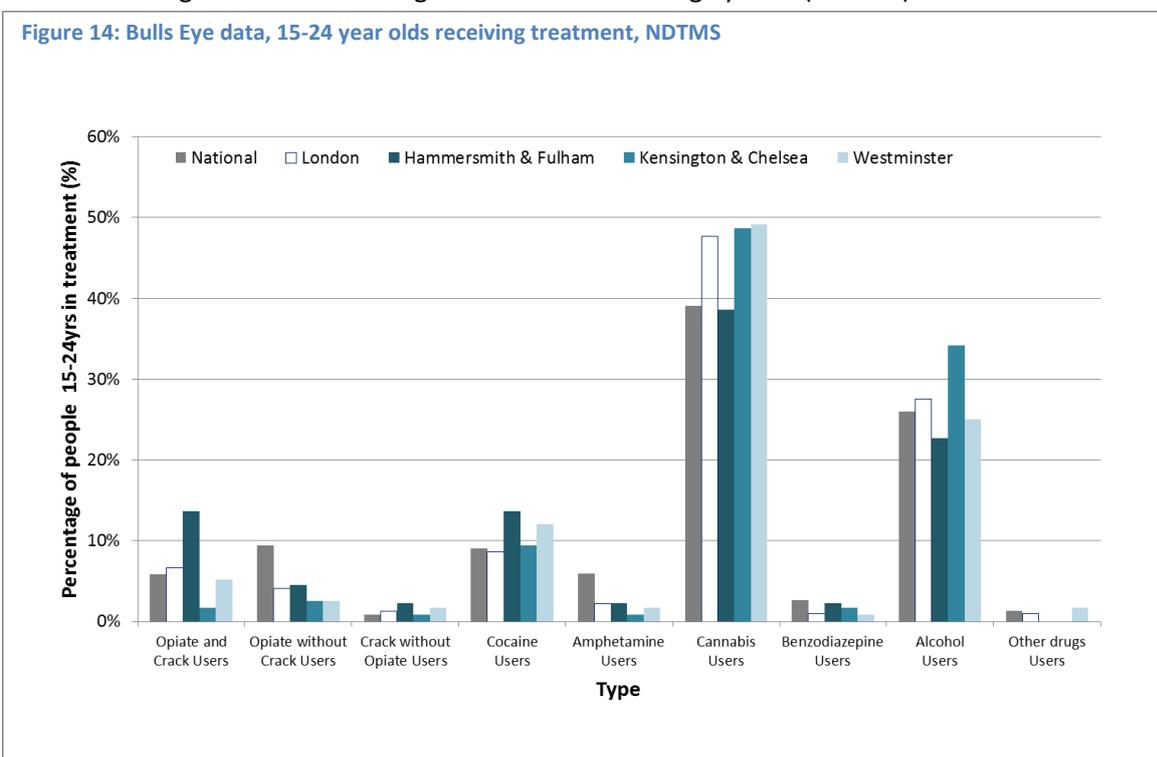
**Change Grow Live (CGL):** There is a separate alcohol-specific service which also operates in [Hammersmith and Fulham](#), [Kensington and Chelsea](#) and [Westminster](#).

**Club Drug Clinic:** Provided by CNWL, this service covers the three boroughs and focuses on ‘club drugs’ such as MDMA, cocaine and ketamine as well as NPS use. It also offers a bespoke service for those from LGBT communities, especially men who have sex with men.

**Primary Care Support Service:** The Blenheim service works in partnership with GPs and primary care staff across Hammersmith & Fulham, Kensington and Chelsea, and Westminster. It offers a free, friendly and confidential service which is open to people aged 18 or above who have alcohol or drug problems.

7.4.3 Specialist Service use

The majority of 15-24 year olds receiving a service in the three boroughs do so for cannabis, followed by alcohol, as is the case nationally. The numbers receiving a service for crack and opiates are small. Figure 14 shows Bulls Eye data on what young people are being treated for, obtained from services through the National Drug Treatment Monitoring System (NDTMS).



7.4.4 Club Drug Clinic use by young adults

The Club Drug Clinic (CDC) is an innovative service for adults in the three boroughs who have developed problems with club drugs and new psychoactive substances (NPS). Established in 2010, the clinic has seen over 700 clients, of which a relatively small percentage has been aged 18-24. Research tells us that NPS use seems to be concentrated among young adults between the ages of 16 to 24 years, which is more than 3 times higher than adults in general. It is also particularly so among young men. It can be assumed that most young people who use NPS will do so without any significant acute harm or long-term effects. However, some will suffer from adverse effects, which can be severe. It is in no doubt that more research is needed on the specific needs of young adults.

The CDC is actively involved in research and hosts Project NEPTUNE, the comprehensive clinical guidance on NPS. It is therefore well placed to identify new and emerging drug trends. The main drugs used by the 18-24 year old cohort of clients to date are MDMA, ketamine, LSD and mephedrone.

The experience of the CDC service also suggests that some young people may have problems associated with hallucinogenic drugs. 15% of clients presented with symptoms of hallucinogen persisting perception disorder (HPPD). This is a condition characterized by a continual presence of sensory disturbances, often visual, that can be experienced for up to two years after using hallucinogenic substances.

7.4.5 Prevalence of opiate, cocaine and crack use

Service use does not necessarily reflect needs. Although we don't often see residents aged 18-25 years olds accessing services for support with opiates, cocaine and crack, there is a local need. In 2011/12 when prevalence estimates were last updated, prevalence of **opiate and crack cocaine use in 15-24 year olds was estimated (per 1,000 population) as H&F – 69, RBKC – 54, WCC – 130.**<sup>16</sup>

It is known that many people do not seek help from a service until reaching a crisis point, but start using substances a long time before – see figures in section 7.1 above showing that drug use is highly prevalent in this age group. Adult treatment data collects information on the age that the first problematic substance was used. Table 10 shows that **the majority of people receiving a service for opiates, cocaine and crack started using in their early twenties.**

Table 11 Age that first problematic substance was used, 2012-13 NDTMS

		H&F	RBKC	WCC
Opiates	% who began use aged 25 or under	64%	70%	76%
	Mean age	24 years	24 years	22 years
Powder Cocaine	% who began use aged 25 or under	85%	81%	87%
	Mean age	22 years	21 years	20 years
Crack Cocaine	% who began use aged 25 or under	76%	52%	65%
	Mean age	20 years	27 years	24 years

<sup>16</sup> NTA. *Facts and figures: prevalence data (online)* <http://www.nta.nhs.uk/facts-prevalence.aspx> (accessed 19.12.16)

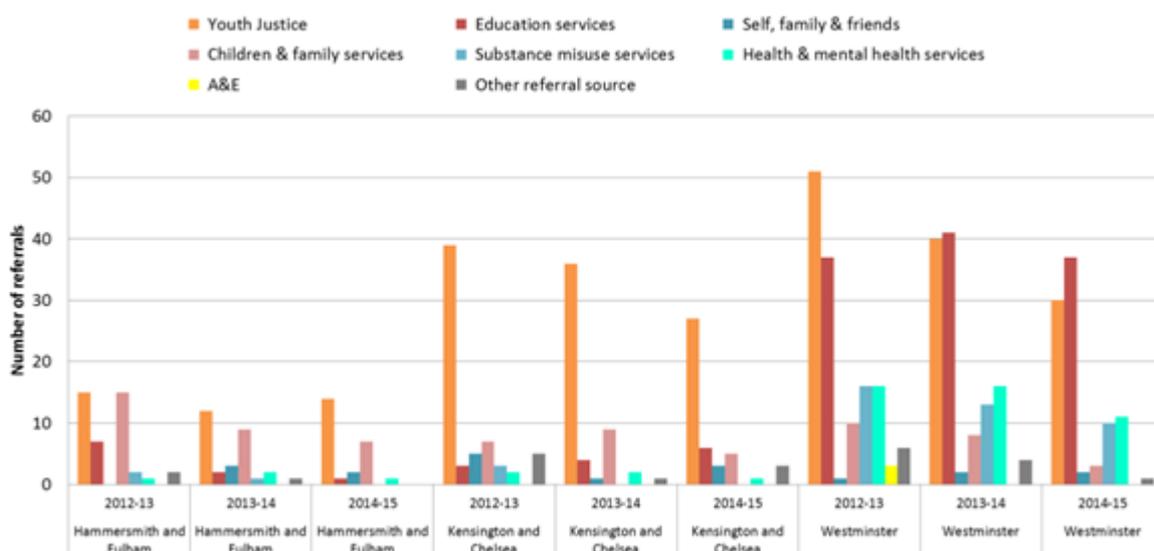
While cannabis and alcohol tend to be the substances that young people present to services with, there is a wider need. The service offer for residents aged 15-24 therefore needs to be flexible and able to respond to a range of needs. Proactive preventative outreach work and harm reduction, such as needle exchanges, therefore need to be available for people not yet in touch with services.

**7.4.6 Referral sources to specialist services**

Substance misuse services work closely with a number of other services. Figure 15 below shows that common referral sources are from Youth Justice and Education services, as well as Children and Family Services. Referrals also come from GPs, Leaving Care teams, homeless hostels, schools, mental health services, as well as referrals from family, friends and self-referrals.

Differences in the numbers accessing services or referral pathways are often indicative of changes to process or service design. The reduction in referrals in RBKC and WCC, and the historically low level of referrals in H&F, reflects the increased emphasis on training other professionals to identify misuse and provide tailored harm reduction and brief interventions. Referral sources are heavily impacted by resources and location. For example, Westminster’s benefit from the secondment of a CAMHS worker means referrals from mental health services look comparatively high. Changes to young people’s housing provision can grow or shrink a referral route.

Figure 15: Numbers of young people up to age 18 referred for treatment 2012/13 to 2014/15



**7.4.7 Primary care**

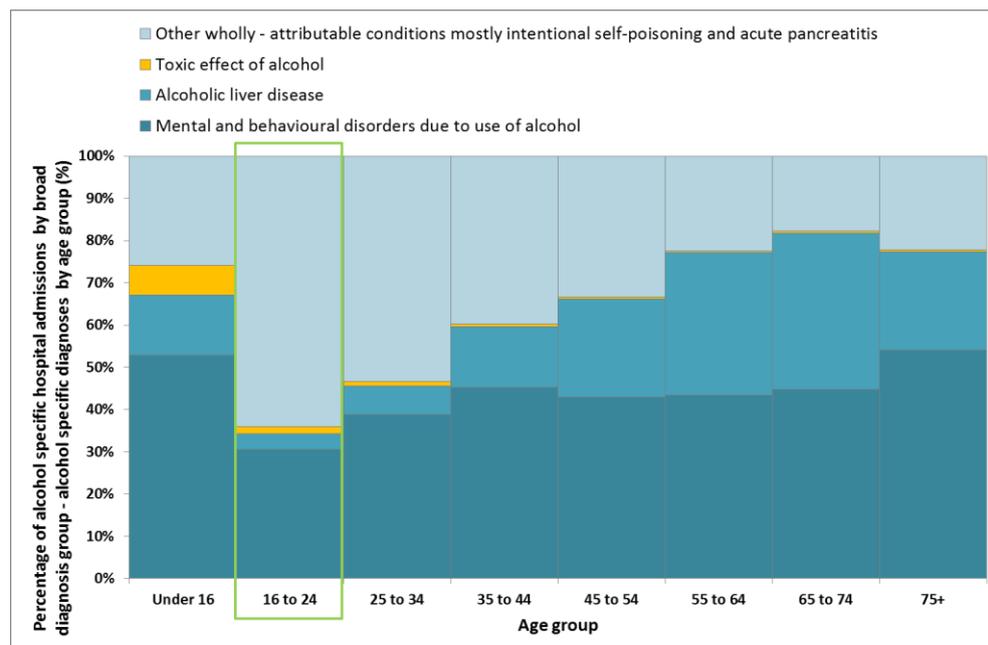
Currently, there is a relatively low number of referrals into services through GPs. As substance misuse is relatively common in young adults, although not necessarily identified as problematic, it is important that GPs are comfortable proactively discussing substance and alcohol misuse with young people. Many young adults are not aware that they have an issue until they reach a crisis. GPs must be aware of new trends in substance misuse, such as the emergence of new psychoactive substances.

However, GPs should be aware that young adults may be concerned about visiting their GP because of confidentiality/privacy fears at practices that relatives also visit. (See chapter 4 – Primary Care).

7.4.8 Alcohol misuse treatment in secondary care

Anecdotally, it is known that many young adults are misusing alcohol but do not proactively engage with services; however, a number of people will attend hospital services due to alcohol-specific causes or alcohol-related conditions. Figure 15 below shows how this affects 16-24 year olds differently from other age groups nationally. This shows that alcoholic liver disease is low in young adults, and so successful early intervention at this age will prevent alcoholic liver disease later in life.

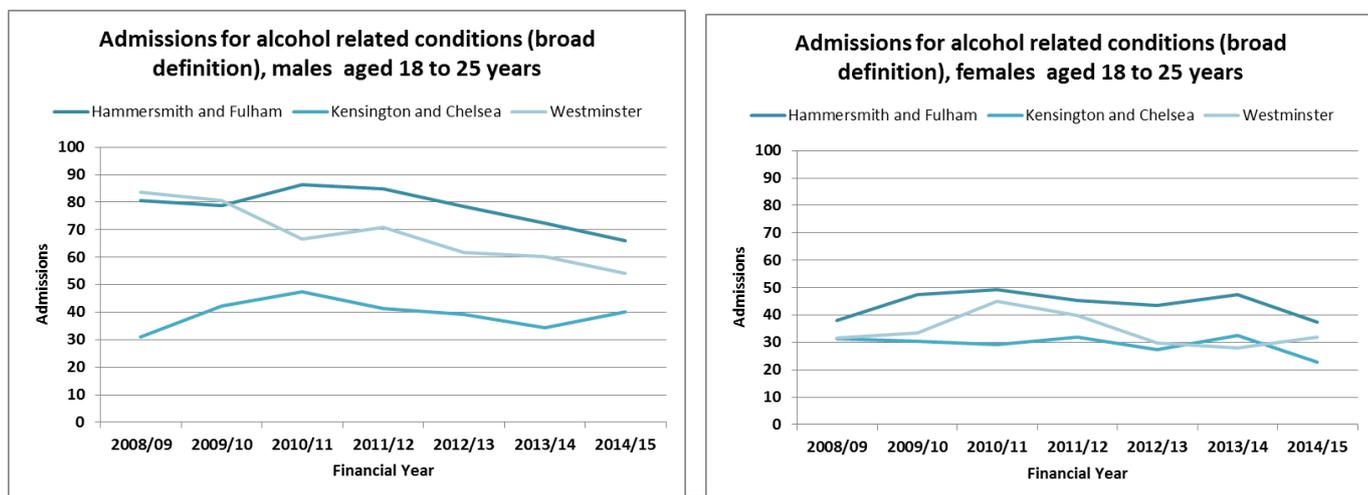
Figure 16 Distribution of alcohol specific diagnoses by broad type: National



SOURCE: LAPE

Figure 17 shows the number of alcohol related hospital admissions by borough for males and females respectively. The data relates to the ‘broad’ definition of alcohol related hospital admissions. For both sexes, numbers are higher in Hammersmith and Fulham and lowest in Kensington and Chelsea. Levels of admissions are generally higher for males but have fallen more rapidly than for females over the 7-year period. Rise in male admissions in Kensington and Chelsea and females in Westminster are noted in the most recent period.

Figure 17: Alcohol related admissions: males and females, aged 18-25 (Source: LAPE, 2015)



**Alternatives to secondary care: Soho Alcohol Recovery Centre (SARC) Pilot**

The SARC pilot project ran in 2010 around Christmas time to relieve pressure on A&E and the London Ambulance Service (LAS). It comprised of a single site in the centre of Soho staffed by LAS. **58% of the patients were in the 18-25 age group**, with an equal gender split. Based in the West End, the service was created to address the medical needs of intoxicated patients which can be effectively dealt with outside a hospital environment and without an ambulance. The project used Alternative Response Vehicles known as the ‘Booze Bus’, instead of ambulances, which can take up to 5 people at a time.

The Centre successfully treated 88% of those who required sobering up, with no further medical intervention required. At particularly busy periods such as New Year’s Eve, **treating patients in the Centre was more than half the estimated cost of treating them in A&E**. On less busy nights, the costs were similar to A&E but analysis shows wider benefits beyond savings to A&E such as identifying high risk drinkers. The **evaluation highlighted the need to develop initiatives to reduce the likelihood of re-presentations amongst under- 25s**.

**7.5 Challenges and barriers identified by local commissioners and practitioners**

Practitioners from substance misuse services, social work teams, the community and voluntary sector, and other related services discussed the services in a workshop in July 2016. A number of challenges were identified for young adults specifically.

**7.5.1 Challenges with specialist services**

**Appropriate settings for treatment:** As discussed above, the majority of young adults in services are receiving treatment for cannabis or alcohol, which is the focus of the young people’s services (as opposed to the adult service which focusses on crack and opiates). Services should be needs led, and allow flexibility for whether a young person would be best treated in an adult service or a young person’s service. Flexibility should also be offered in the setting for care; if a young person is uncomfortable in a certain building because of other service users, services should be available in the community. Practitioners also identified that the ‘emotional age’ and needs of young adults differ widely, and many young adults prefer the more creative style of the young people’s services.

**Local good practice**

The new adult substance misuse services have a single triage form to ensure that a service user doesn’t have to complete multiple assessments if they enter the service at the wrong point.

**Challenge of reciprocal arrangements with other borough and integrated services:** substance misuse services are provided by the council for residents only, however health professionals including GPs have a large registered population who do not live within the boroughs, particularly in central London with registered students (see chapter 3 – Population Profile). Effective recovery from substance misuse may require the cooperation of professionals across organisations, and the disconnect between health and council-provided services could hinder recovery if not well coordinated. As Kensington and Chelsea and Westminster have more young adults registered with GPs in the borough than actually living in the borough, they must receive treatment for substance misuse in their borough of residence. Services not being integrated also presents as a barrier and

may mean some young adults fall between the cracks, and so it is important that professionals foster strong reciprocal relationships, in particular GPs with substance misuse services in other boroughs.

**‘Postcode Wars’:** For a few very vulnerable young adults, it may be unsafe to travel to particular areas due to gang tensions. If a young person is moved outside of the borough (e.g. ‘Tom’ from the case study below) further complications arise with their treatment.

**Identifying with diagnosis:** Some people, particularly those who are still considered highly functioning, find it difficult to identify and accept that they have an unhealthy relationship with substances. They are therefore more challenging to work with and engage. Substance problems may remain unapparent in university students due to a culture of widespread alcohol misuse and the unstructured nature of university life. They are more likely to enter treatment services after a hospital visit.

**Cross agency working:** The case study below highlights how many different professionals may be involved with a young person with substance misuse. However, there are safeguarding issues regarding whether sensitive patient information can be shared between services.

#### **1.1.1 Case study**

‘Tom’ was referred to the LBHF substance misuse worker from the Early Help team as his cannabis use was impacting on his engagement with education or employment; he had begun using and dealing cannabis, where he became indebted to the people he was dealing for. He disengaged with the service when he was confronted directly about his dealing.

Tom was arrested and the substance misuse worker worked with the Youth Offending Team (YOT), and successfully reengaged with Tom’s parents, who soon informed the worker that Tom was a risk to the family home and could not remain there. Tom stayed briefly with other family members, but the relationships soon broke down, and he was placed in a young person’s hostel. He continued to use cannabis, and hostel staff suspected he had restarted dealing. At this point, Tom was being supported by the substance misuse worker, his allocated YOT social worker, a specialised worker in violent offences and young people (as Tom had been arrested and had also admitted to dealing), his hostel worker, and an allocated social worker from Children’s Services.

Tom was stabbed following direct orders from people he had known and associated with, who believed that he still owed a debt.

He was then moved out of borough due to concerns about his life, however there were disputes across borough around providing the funding for Tom to reside in his new safe hostel. He was granted LAC status and was able to remain in his chosen hostel where he is engaging well with services but socially isolated, which escalated his cannabis use.

Tom has now turned 18 and the substance misuse worker is obliged to close the case. Drug services in Tom’s new area are limited, and focussed on people using crack and heroin.

**Funding for Preventative Work:** Service specifications and contracts must incentivise or support prevention and early intervention so services do not only cater to people with high support needs.

### 7.5.2 *Challenges with key related services*

- **Training:** Professionals working with or close to young adults (e.g. health professionals including GPs, social workers, family, carers) need to be well educated in substance misuse in order to identify it and react appropriately.
- **Housing:** The key area of the environment where change is needed for a young person to change their lifestyle, but equally is very difficult to change.
- **A&E:** Young adults are more inclined to visit A&E or urgent care in a crisis or with substance-related issues than engage proactively with substance misuse services, so good referral routes from secondary care into specialist services need to be in place such as through alcohol liaison nurses.
- **Dealing:** Responsibility for addressing drug dealing lies with youth offending or substance misuse teams. Funded tailored interventions for those who are dealing would be more effective. There are more complex issues around dealing such as the ‘grooming’ of young men, who are then very vulnerable once they start dealing but are criminalised rather than supported to escape that lifestyle.
- **Prevention work in schools:** From January 2017, school nurses will be required to deliver substance misuse teaching as part of the school health offer. This may have a positive impact on preventing harmful substance misuse in young adults if tackled effectively whilst the young person is still in school.
- **Prison:** Some staff report working with individuals who go into prison and come out heavy drinkers or substance users, particularly of Spice (synthetic cannabinoids). There is a feeling that more support is required to work with this group perhaps before they go into prison.

#### 1.1.2 *Local good practice*

**Outreach work** works well with young people such as treatment services within the local community. For example, the MetroSexual Centre and St Georges encourage clinicians to ensure that thorough questions about the bigger aspects of person’s health are asked about rather than just the presenting issue.

### 7.5.3 *Youth Council feedback*

Members of the Westminster Youth Council confirmed many of the points made above, including that cannabis use had become normalised, with many young people believing it was not really illegal and daily expenditure on cannabis of over £20 was common, funded through dealing. The young people consulted as part of this project were not aware of substance misuse services but supported the principle of young adults being treated in appropriate settings.

It was noted that advice in the case of substance-related sickness or overdose is not easily or quickly accessible to find good quality information and advice. First-aid training specific to these types of incidents was recommended.

7.5.4 Recommendations

Gap / challenge	Potential solution / recommendation
<p>The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.</p>	<p>1. Review adult and young people’s service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people’s substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.</p>
<p>Vulnerable groups are more susceptible to harmful substance misuse.</p>	<p>2. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under-25s as recommended by NICE (2007).</p>
<p>Although numbers in services are relatively small, substance misuse is widespread amongst young adults.</p> <p>There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.</p>	<p>3. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities.</p> <p>a. Work with young people’s services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.</p>

## 8 Sexual Health

National statistics show that young people aged 15-24 experience the highest rates of new sexually transmitted infections (STIs) than other age groups. As with substance misuse, this is characteristic of more risk taking behaviour in young adults. The consequences of poor sexual health can be serious as many sexual infections have long-term health impacts, such as infertility and cervical cancer. Furthermore, there are inequalities in sexual health – there is a clear link between social deprivation and poor sexual health. Women, gay men, young people and people from Black and Minority Ethnic (BME) groups are disproportionately affected by poor sexual health.

### 8.1 Link to substance misuse

Sexual health issues are linked to alcohol and substance misuse. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use and multiple sexual partners. Sexual assault is strongly correlated with alcohol use by both victim and perpetrator (Royal College of Physicians, 2011).

Although a causal link cannot be proven, 16-24-year-olds are among the highest consumers of alcohol in the UK as well as having the highest rate of sexually transmitted infections. Young people are also more likely to become re-infected with STIs. In a review of 11 studies on the subject, 8 were found to show a significant relationship between alcohol consumption and at least 1 STI. This did not appear to vary according to gender or pattern of alcohol consumption (R. L. Cook & Clark, 2005).

Alcohol is also often given in interviews as a factor contributing to teenage pregnancy. 85% of the increase in alcohol-related hospital admissions that occurred between 2005/2006 and 2006/2007 in 15–17-year-olds was in the local authorities with the highest teenage pregnancy rates (RCP 2011). In young adults, alcohol is a key causal factor in unplanned pregnancies.

### 8.2 Best practice guidelines

In 2011 the government published *You're Welcome - Quality criteria for young people friendly health services* (Department of Health, 2011). These standards are largely in line with the NICE guidance on contraceptive services for the under-25s (NICE, 2014b). The Department of Health *Framework for Sexual Health Improvement for England* (Department of Health, 2013) sets out ambitions for improving sexual health outcomes for 16-24 year olds.

These criteria include assurances of confidentiality for young people (as far as safeguarding allows) and the routinely offered opportunity for patients to be seen without a parent or carer present. It is advised that staff receive training on young people's health needs, and in supporting young people to make their own, informed choices about their health and care. Vulnerable groups (including care leavers and UASC) may also need specialist services made available to them according to their particular needs.

STI testing and treatment (or 'seamless' referral to a more relevant service) and opportunistic chlamydia screening should be offered to young people. Free contraception, condoms, pregnancy testing and emergency hormonal contraception should be made available, including to young people who are not ordinarily patients of that service. Referrals for abortions and antenatal care should be offered when appropriate; in the case of unplanned pregnancy it should be possible for young

women to immediately be seen by an impartial practitioner (e.g. with no ethical opposition to abortion).

The Framework promotes resilience by enabling young people to make informed decisions and prioritise prevention through information as well as access to appropriate sexual and reproductive health services.

Other criteria refer to staff training in speaking to young people about sexual health issues, contraceptive options, and STI and pregnancy prevention. This should be sensitive to the person's age, gender, sexual orientation and ethnicity.

### 8.3 What do we know locally?

The percentage of new STI diagnoses made in GUM clinics of patients aged 15-24 were 31% for Hammersmith and Fulham, 27% for Kensington and Chelsea and 25% for Westminster compared to an average of 46% in England.

Reinfection rates among our resident in this age group, within a 5 year period, varies from **20% to 18.4% for women and 17.5% and 16.5% for men.**<sup>17</sup>

The *Framework for Sexual Health Improvement in England* (Department of Health, 2013) outlines several ambitions specific to the improvement of sexual health outcomes for 16-24-year-olds. These include rapid access to appropriate sexual and reproductive health services and the prioritisation of prevention. Reduction of unwanted pregnancies (in women of all fertile ages) is also cited, and is linked to the ambition to ensure young people are aware of the risks of unprotected sex.

Measures such as chlamydia detection rates, rates of repeat abortions in under-25s, and conceptions in 15-17-year-olds are indicative of how well these ambitions are being achieved. Data presented below is taken from Public Health England's *Sexual and Reproductive Health Profiles*<sup>18</sup>.

#### 8.3.1 STI Diagnosis rate

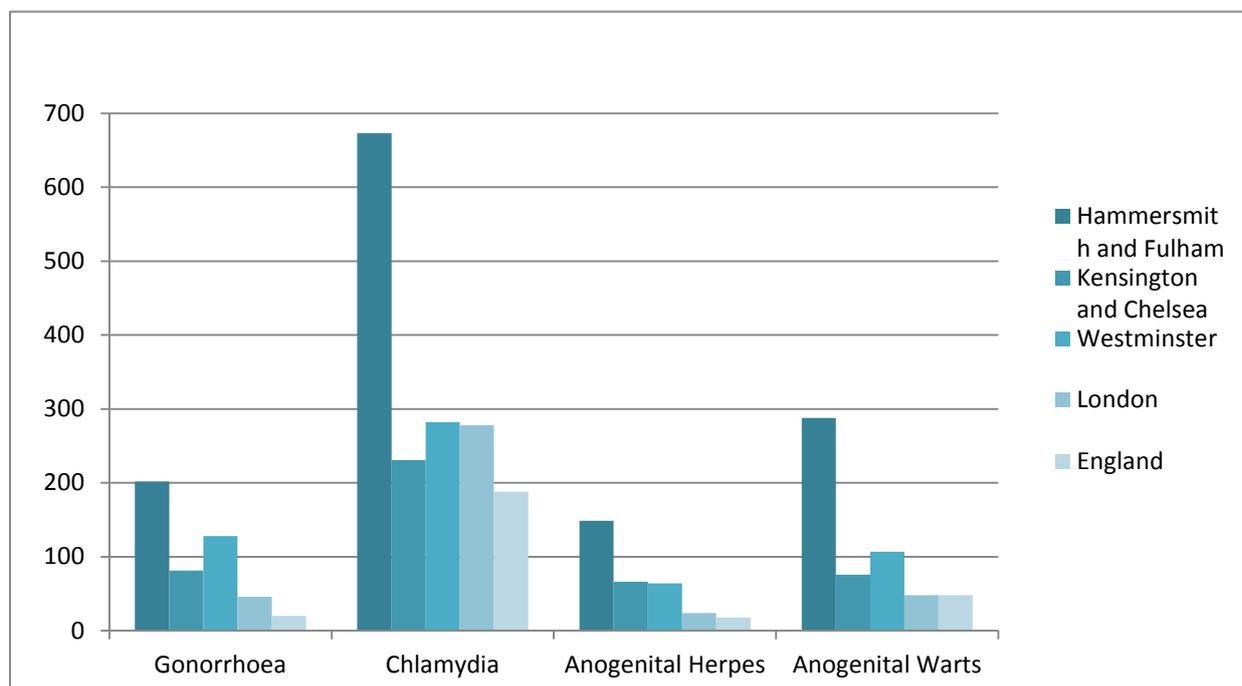
As shown in figure 18, sexual health outcomes for the three boroughs vary according to the metric of measurement but broadly perform well against London averages, with the exception of Westminster's chlamydia detection rate.

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<sup>17</sup> Public Health England (2015). Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014.

<sup>18</sup> Public Health England. *Sexual and Reproductive Health Profiles*  
<http://fingertips.phe.org.uk/profile/sexualhealth/> (accessed 16.12.16)

Figure 18: Rates of STI diagnosis per 10,000 16-24-year-olds (2014/15) (GUMCad)

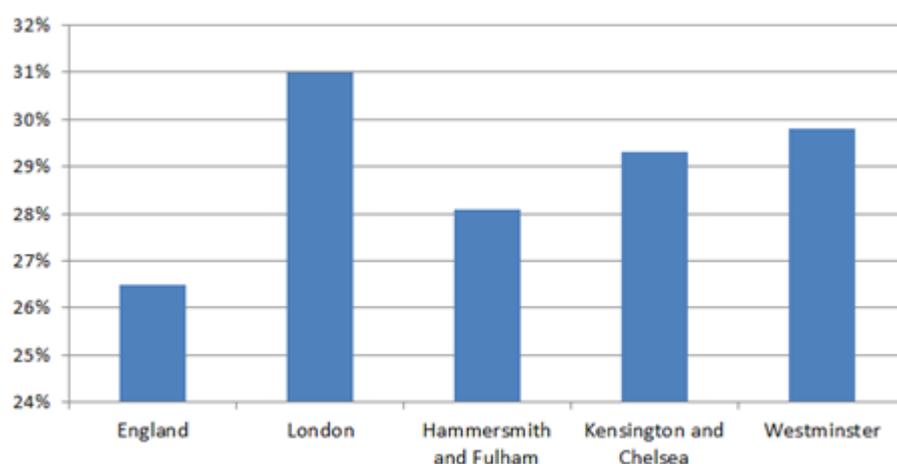


As chlamydia is most often asymptomatic, a high detection rate reflects success at screening coverage which will aid identification of infections that, if left untreated, may lead to serious reproductive health consequences. **The detection rate is not a measure of prevalence.** PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it; other areas should work towards it. Figure 18 shows that Hammersmith and Fulham are performing well at detection rather than having significantly higher prevalence. Westminster’s detection rate requires improvement.

**8.3.2 Unplanned pregnancies**

There is a public health need to ensure that rates of abortion and repeat abortion in women of all ages, but particularly young women, are managed. Although the three boroughs are doing better than the average for London, figure 19 shows that they are behind nationally.

Figure 19: Percentage of repeat abortions\* in under-25s (2015 data, PHE)



\*The percentage of women having an abortion who have had at least one abortion in any previous year

### 8.3.3 Contraception

Long Acting Reversible Contraceptives (LARCs) offer young women an effective choice and in so doing, reduce rates of unplanned pregnancy. LARCs are also known to be highly cost effective. However, the rates of LARC prescription in Hammersmith and Fulham are below average, and are the lowest in London and England for Kensington and Chelsea and Westminster. Improving the rate of LARC prescription will contribute to ensuring that rate of under-18s conceptions and repeat abortions is maintained and further reduced.

Table 12 rate per 1,000 of Long Acting Reversible Contraception 2014 (PHE Sexual and Reproductive Health Profiles)

Borough/Area	LARCs rate /1,000
Hammersmith & Fulham	29.9
Kensington and Chelsea	18
Westminster	20
London	35.3
England	50.2

Table 13 Under 25s choosing LARC as their main source of contraceptive in Sexual & Reproductive Health Services (%) (PHE Sexual and Reproductive Health Profiles)

Borough/Area	%
Hammersmith & Fulham	14.4%
Kensington and Chelsea	13.0%
Westminster	13.4%
London	17.1%
England	20.1%

## 8.4 Youth Council feedback

### 8.4.1 Services

Discussion with the Westminster Youth Council revealed a sense of there being a lack of reliable access to good sexual health information, advice and support. It was felt that by the time sexual health among teenagers and young people ceased to be a taboo, sexual activity had already become normalised. Difficulty in accessing contraceptives was raised and the Come Correct scheme<sup>19</sup>, offering free condoms to young people aged 13-24, was mentioned; however, the three boroughs are not participating at present. Freedoms provides our local condom distribution service. This service is available, although not targeted at young people.

### 8.4.2 Psychosocial issues

Confidence, peer pressure and technology were discussed at length. It was mentioned that girls often concede to pressure to have unprotected sex or be filmed or photographed in sexual situations, which can then be used for blackmail or circulated on social media. One participant recommended that instilling confidence, and in particular empowering girls to say ‘no’, should be prioritised over ‘online safety’ education. Teaching a better understanding of the consequences of sharing material online was also suggested.

This consultation informed that there is a common issue of distribution of sexual images of under 18s around schools in the borough (usually female, and without the consent of the person pictured), which raises legal and safeguarding concerns.

## 8.5 Recommendations

Gap / challenge	Potential solution / recommendation
Sexual health is a key health issue for the vast majority of young adults.	1. Ensure all commissioned sexual health services adhere to the <a href="#">You're Welcome standards</a> .
There is a strong link between substance misuse and risky sexual behaviour.	2. Consider integration of substance misuse and sexual health services for young people.
There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of unplanned pregnancy than the general young adult population.	3. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.
Young people consulted reported that adults and professionals over medicalise what to them is a social issue.	4. Develop sexual health services to proactively address the psychosocial aspects of sexual health.
The <i>Framework for Sexual Health</i>	5. Collaborate with other London boroughs to

<sup>19</sup> Come Correct <http://www.comecorrect.org.uk/> (accessed 16.12.16)

<i>Improvement in England</i> recommends the prioritisation of prevention and that all young people are informed to make responsible decisions, and are aware of the risks of unsafe sex.	prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions.
	6. Improve local prescription of Long Acting Reversible Contraception (LARCs).

## 9 Wider determinants of health

Housing, employment and crime and safety are key health and wellbeing issues for young adults. Each of the three boroughs is tackling these issues through local authority departments in slightly different ways.

### 9.1 Crime and safety

There is a well evidenced link between crime and safety, and health and wellbeing (P. S. M. Marmot, 2010). This applies to young adults both as being a victim of crime, as well as perpetrators, and particularly the issue of gang life and the risk of violence for this age group. Drug and alcohol misuse (chapter 7) has a significant impact on violent crime.

#### *Gang crime*

Gang crime is an important issue in the three boroughs. As well as the severe impact and consequences for the victims of gang crime, there is evidence that those involved in gang crime have poor health outcomes. 2015 research from John Moores University on males aged 18 to 34 years found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men. Using standardised screening tools, 86% of gang members were identified as having antisocial personality disorder, 67% alcohol dependence, 59% anxiety disorder, 58% drug dependence, 34% suicide attempt, 25% psychosis and 20% depression (Centre for Public Health, 2015).

A 2013 report undertaken by the Public Health (Madden, 2013) team highlighted that young people in gangs had higher rates than the general population or offender population of antisocial personality disorder; anxiety disorders; psychosis; and suicide attempts. In addition, young people involved in gangs have higher rates of drug and alcohol misuse.

This is a cohort who do not engage conventionally with universal mainstream services, especially where any stigma on mental health exists. Consideration needs to be given on how to help this cohort access support.

#### *Student crime*

Crimes involving the student population are hard to identify. The *Complete University Guide*<sup>20</sup> has produced heat maps based on crime statistics described as the most relevant to students – robbery, burglary, and violence and sexual crimes - for the previous 12 months, based on student term-time addresses. However, the figures are for all victims, not specifically students.

Most support services linked to the juvenile justice system only cater for young people up to the age of 18. In contrast, there are relatively few programmes specifically targeted at the rehabilitation of young adults aged 18-20 who are in transition from Young Offenders' Institutions to adult prisons, where conditions and treatment can be remarkably different (Garvey et al., 2009).

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<sup>20</sup> Complete University Guide. *Crime in student cities and towns* (online)  
<http://www.thecompleteuniversityguide.co.uk/crime-in-university-towns-and-cities/> (accessed 16.12.16)

## 9.2 Housing

The evidence relating good quality, appropriate housing and health is well evidenced (Building Research Establishment, 2008; Leng, 2011; M. Marmot et al., 2010). Any young adult age 18-25 is likely to be living independently for the first time and so the associated challenges of managing finance, bills and regular payments may be difficult due to lack of experience. Whilst there is a lot of good advice on these matters, signposting to it is important for any health and wellbeing service that regularly comes into contact with young adults.

The boroughs cover one of the most densely populated areas in the country and demand for accommodation is very high, as reflected in house and rent prices. There is limited housing which is affordable on low incomes, benefits or student loans, and demand for social and affordable housing outstrips supply, leading to long waiting times. In addition, a large proportion of properties in the private rented sector are in poor condition.<sup>21</sup>

By 2020, it is estimated that there will be a significant decrease in young adults owning their own properties and having their own social rented tenancies. Private renting is estimated to increase, as are young adults living with parents in all accommodation types (Clapham, Mackie, Orford, Buckley, & Thomas, 2012). Housing benefit payments are restricted to the rate of a single room for people under 35, which many young adults find undesirable.

Some groups of young adults are particularly vulnerable to housing problems and homelessness, including NEETs, care leavers, former unaccompanied asylum seekers, ex-offenders, young parents and people with disabilities. Leaving care is a time that young adults are more vulnerable to homelessness. Whilst some care leavers go into specialist supported accommodation, many move into social housing, and increasingly commonly in the three boroughs into shared houses due to high costs. Chaotic housing pathways and homelessness are predicted to increase (National Youth Agency).

Research led by the National Housing Federation shows that those aged 16 to 24 and living in social housing often face specific difficulties in managing their finances (National Youth Agency).

Homeless young people may experience vulnerabilities that are less common amongst the general population of young people. For example, to try and support themselves, homeless young people may be tempted towards the opportunistic sale of drugs or sex. This clearly adds to the vulnerabilities experienced by young people who are homeless including of sexual exploitation. It is known that some sub-populations of young people such those who are LGBT are at particular risk of homelessness or hostile housing environments. Additional factors such as sexuality and gender may further exacerbate the vulnerability of those young people to exploitation.

Young adults are also vulnerable to fuel poverty. Although this is commonly associated with older people, it is also common amongst students. Though the health impacts are less severe in young adults, it impacts negatively on health and wellbeing.

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<sup>21</sup> Housing and Care JSNA [www.jsna.info/housingandcare](http://www.jsna.info/housingandcare) (accessed 16.12.16)

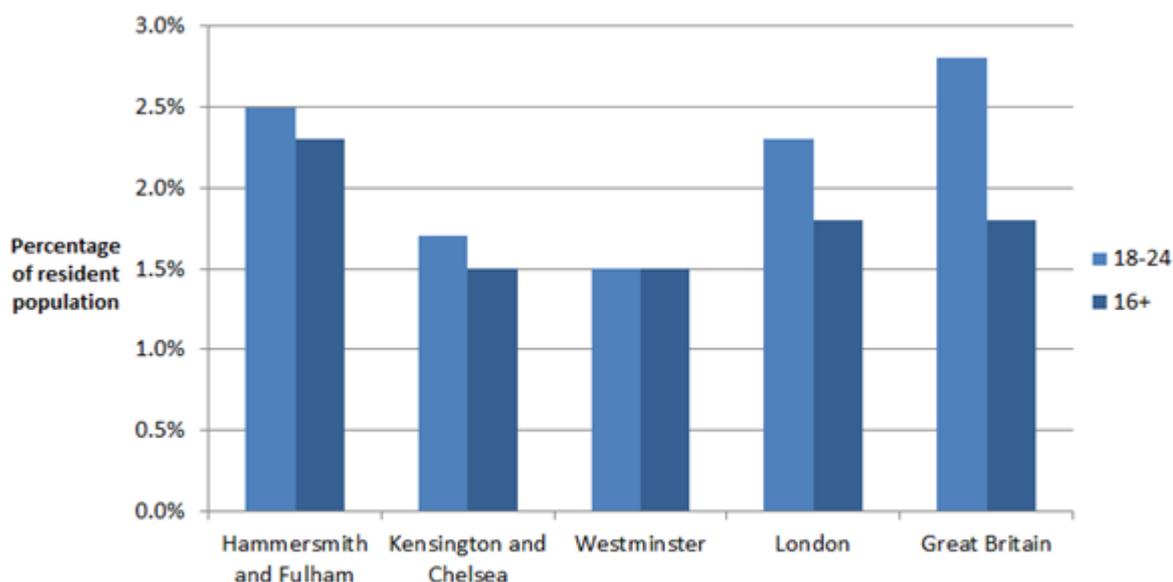
### 9.3 Employment

The relationship between employment and good health outcomes is well understood, and this link is particularly pronounced among young adults. According to a 2014 evidence review (Allen & UCL Institute of Health Equity, 2014), unemployment is linked to premature death, deteriorating mental health and increased suicide risk. Young men not in employment, education or training (NEET) were three times more likely to be depressed than those who were not. Unemployment is also linked to increased unhealthy behaviours (such as substance misuse) and to having a criminal record, although the causal relationship is hard to establish. Those who have been supervised by a Youth Offending Team and/or have disclosed substance abuse are over twice as likely to be NEET for six months or more.

Young adult unemployment is a risk factor for long-term unemployment. Those who are NEET at the age of 18-19 are 28% more likely than others to be unemployed five years later, and 20% more likely to be unemployed ten years on.

The effects are extremely persistent, with evidence showing that unemployment under the age of 23 can still lower health status and life satisfaction over twenty years later. It is also the case that young people with a history of unemployment tend to then move into low-paid jobs, which are themselves associated with poorer health outcomes.

Figure 20: Claimant count by age across the three boroughs, September 2016



Source: [Nomis local authority profiles](#)

As shown, with the exception of Westminster, the claimant count is higher (as a proportion of population) among 18-24-year-olds. However, this contrast is less marked than that between the target group and general population in both the London and Great Britain averages.

## 10 Summary of Recommendations and Conclusion

### 10.1 Recommendations

The recommendations emerging from throughout this report are summarised here by chapter.

Topic	Gap or challenge	Potential solution/recommendation	Supporting Evidence in JSNA	Implementation lead
Primary Care	<p>The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults.</p> <p>YA would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth.</p> <p>Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers.</p> <p>Small changes that all GP practices can facilitate would make a positive difference.</p>	<p>1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health.</p> <p>a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups.</p>	<p>Section 4.1 – YA less satisfied with GPs, number of issues e.g. Confidentiality</p> <p>Section 4.3 indicates high usage of urgent care and A&amp;E among this age group</p>	<p>Hammersmith and Fulham CCG - Toby Hyde</p> <p>West London CCG – Rachel Krausz – Strategic Delivery Lead</p>
	<p>2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's <i>Toolkit for General Practice</i>. CCGs should make use of the GP Champions for Youth Health Project's <i>Commissioning Effective Primary Care Services for Young People</i></p>	<p>Section 4.1 – the GP Champions for Youth Health Project</p>	<p>Central London CCG - Chris Neill</p>	

<b>Eating disorders</b>	<p>A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long.</p> <p>National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing.</p> <p>There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.</p>	<p>3. Review the eating disorder pathway as part of Like Minded <i>Serious and Long Term Mental Health Need</i> population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.</p> <p>a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.</p>	<p>Section 5.3 – in particular 5.3.2 indicating estimated prevalence and 5.3.3 for numbers being treated in Vincent Square clinic</p> <p>Section 5.2.4 for importance of early treatment (national evidence and guidance)</p> <p>Section 5.2.4 Effective Treatment – Bristol case story</p>	<p>West London CCG and Central London CCG – Glen Monks, AD for Mental Health</p> <p>LBHF CCG – Julie Scrivens, Head of Planned Care and Mental Health</p>
	<p>The current NICE guidelines are from 2004, over a decade old, and are currently being updated with publication expected in 2017.</p>	<p>4. Review existing services against new NICE guidelines when available in 2017.</p>	<p>Section 5.2.4 (national guidance)</p>	

<p><b>Eating disorders</b></p>	<p>Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.</p>	<p>5. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals.</p> <p>6. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder.</p> <p>a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.</p>	<p>Section 5.3.6 and 5.3.7. Qualitative evidence Identified through consultation with local stakeholders</p>	
<p><b>Care Leavers</b></p>	<p>Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. In consultation with care leavers, there was a lack of awareness and coping strategies.</p> <p>However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.</p>	<p>7. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers.</p> <p>a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.</p>	<p>Section 6.3.1. National evidence and supported by local qualitative evidence through consultation.</p> <p>Mentoring supported by evidence in section 6.4.2</p>	<p>3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers</p>

<b>Care Leavers</b>	<p>The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services. Nationally, ‘Future in Mind’ and locally, The Anna Freud Centre needs assessment for CAMHS recommend a tapered transition from age 16-25.</p> <p>LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.</p>	<p>8. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.</p> <p>a. The offer to care leavers should include flexibility if appointments are missed or service users don’t want to be seen in a clinical setting.</p>	<p>Section 6.3.1 and 6.3.2. As above - national evidence and supported by local qualitative evidence through consultation</p>	<p>Steve Buckerfield – Head of Children’s Joint Commissioning</p> <p>Angela Caulder - CAMHS commissioner</p>
	<p>A significant proportion of local care leavers are former UASCs, and have specific health and care needs.</p>	<p>9. Professionals including Leaving Care teams to be fully trained on national guidance for unaccompanied asylum seeking and trafficked care leavers</p>	<p>Section 6.4. Combination of national evidence and local evidence from practitioners (LAC nurse records and social work notes)</p>	<p>3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers</p>

<b>Care Leavers</b>	<p>Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&amp;E and urgent care.</p> <p>The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.</p>	<p>10. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP and encourage seeking help in the appropriate setting.</p> <p>a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs</p>	<p>Section 6.3, 6.5.3 and 6.5.4. Evidence largely drawn from consultation with professionals and care leavers but also supported by national evidence</p>	<p>3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers</p> <p>Steve Buckerfield – Head of Children’s Joint Commissioning</p>
	<p>A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.</p>	<p>11. Pilot a transitions panel similar to the disabled children’s panel for cases of care leavers with multiple or complicated needs.</p>	<p>Section 6.2 – national evidence of care leavers chaotic lives</p> <p>Section 6.4 wide range of care leaver mental and physical health needs</p>	<p>3B Leaving Care teams</p>

<b>Substance misuse</b>	<p>The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.</p>	<p>12. Review adult and young people’s service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people’s substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.</p>	<p>Section 7.1 drawn from national data and reflected in 7.4.3 from local service data</p>	<p>Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health</p>
	<p>Vulnerable groups are more susceptible to harmful substance misuse.</p>	<p>13. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under 25s as recommended by NICE (2007).</p>	<p>Section 7.3.3 drawn from national data from HSCIC on inequalities</p>	
	<p>Although numbers in services are relatively small, substance misuse is widespread amongst young adults.</p> <p>There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.</p>	<p>14. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities.</p> <p>a. Work with young people’s services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.</p>	<p>Section 7.1 widespread substance misuse amongst young adults.</p> <p>Section 7.4 numbers in local services</p> <p>Section 7.5.2 flags training as an issue – drawn from local stakeholders</p> <p>Section 7.4.5 Local data showing referrals from key partners locally</p>	

<b>Sexual Health</b>	Sexual health is a key health issue for the vast majority of young adults.	15. Ensure all commissioned sexual health services adhere to the You're Welcome standards.	Section 8. National evidence show that 15-24s experience highest rate of STIs.	Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health
	There is a strong link between substance misuse and risky sexual behavior.	16. Consider integration of substance misuse and sexual health services for young people.	Section 8.1 National evidence of link between substance misuse and risky sexual behavior.	
	There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of pregnancy than the general young adult population.	17. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.	Sexual health and pregnancies for care leavers drawn from national and local research and highlighted in section 6.3.5 and 6.3.6.  Sexual health and inequalities described in Section 8.	
	Young people consulted reported that adults and professionals over-medicalise what to them is a social issue.	18. Develop sexual health services to proactively address the psychosocial aspects of sexual health.	8.4 Youth council feedback	
	The <i>Framework for Sexual Health Improvement in England</i> recommends the prioritisation of prevention and that all young people	19. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions.	Section 8.2, 8.3 give more information on the Framework	

	are informed to make responsible decisions, and are aware of the risks of unsafe sex.	20. Improve local prescription of Long Acting Reversible Contraception (LARCs).	Section 8.3.3 low rates of local LARC prescription.	
General	There is existing good practice guidance for services working with young adults on transitions and service design.	21. Health and care services should self-assess against the NICE guidance on transition from children’s to adults’ services for young people using health or social care services, and services that young people access should adopt the Government’s ‘You’re Welcome’ quality criteria to be more suited to young adults.		ALL Service Leads
	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	22. Coproduce the redesign of services with young people.		ALL Service Leads

### 10.2 Conclusion

In conclusion, many of the recommendations include flexibility in the age restriction on services to incorporate young adults into young people services, early intervention, adaptation of current service models to better meet the needs of young adults, and upskilling health and care professionals with knowledge and skills to recognise and address young adults’ needs. The chapters all had strong crossovers with each other, and so co-location, collaboration and joint working is key.

These approaches are not always easy to implement, especially where they have not been done before. For example, young people’s services that accept adults may need to consider adequate child protection and safeguarding. However, it is clear that better person-centred care and health outcomes can be achieved when services focus on the needs of the individual, not strict age criteria.

## 11 Resources for professionals

### 11.1 Resources for professionals

#### 11.1.1 *Eating disorders*

- Free resource for health care professionals, patients and carers on support for Eating Disorders <http://www.network-ed.org.uk/>
- Joint Commissioning Panel for Mental Health. (2013). [Guidance for commissioners of eating disorders services](#). 2013: Joint Commissioning Panel for Mental Health.

#### 11.1.2 *Substance misuse*

- Public Health England. (2016). [Young people – substance misuse JSNA support pack 2017-18: commissioning prompts](#). Good practice prompts for planning comprehensive interventions. London: Public Health England.

#### 11.1.3 *Primary care*

- The GP Champions for Youth Health Project's [Toolkit for General Practice](#)
- GP Champions for Youth Health Project's [Commissioning Effective Primary Care Services for Young People](#)
- NHS guidelines on funding care for transient populations

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## Appendices

### 13.1 Appendix 1: Engagement

#### *13.1.1 Professionals workshop: Care Leavers*

A workshop was held with professionals from the three boroughs who work with care leavers.

#### *13.1.2 Professionals workshop: Substance Misuse*

A workshop was held with professionals from the three boroughs who work with substance misusers.

#### *13.1.3 Professionals workshop: Eating Disorders*

A workshop was held with professionals from the three boroughs who work with people with eating disorders.

#### *13.1.4 Westminster Youth Council*

A workshop was held at Westminster Youth Council with 17 year olds.

#### *13.1.5 Hammersmith and Fulham Youth Council*

A workshop was held at Hammersmith and Fulham Youth Council with 14-17 year olds.

#### *13.1.6 Westminster Care Leavers group*

A workshop was held with a group of care leavers in Westminster at a peer support group.

#### *13.1.7 Central London CCG Transformation Redesign Group (TRG)*

The TRG was consulted and feedback was incorporated into the final draft.

#### *13.1.8 Hammersmith and Fulham CCG Governing Body Development Session*

The Governing Body was consulted and feedback was incorporated into the final draft.

#### *13.1.9 West London CCG Transformation Board*

The Transformation Board was consulted and feedback was incorporated into the final draft.