Bolton's HealthMatters

JSNA: Teenage pregnancy

Introduction

Teenage pregnancy is a significant Public Health issue that impacts upon inequalities, social exclusion, as well as the life chances and health and wellbeing of teenage parents and their children.

Teenage parents and their children can face a range of poorer health and socioeconomic outcomes in comparison to those faced by older mothers and their children. For instance, children born to teenage mothers have higher rates of infant mortality and low birth weight. Teenage mothers are more likely to suffer from post-natal depressions and experience poor mental health for up to three years after giving birth. Teenage parents and their children also face increased risk of living in poverty as educational and career opportunities can be severely limited. Also important, children born to teenage mothers are more likely to become teenage parents themselves and so perpetuate the disadvantage that young parenthood brings from generation to the next.

There is a strong economic argument for investing in measures to reduce teenage pregnancy as it places significant burdens on the NHS and wider public services. The cost of teenage pregnancy to the NHS alone is estimated to be £63m a year. Teenage mothers will also be more likely than older mothers to require expensive support from a range of local services, for instance to help them access supported housing and/or re-engage in education, employment and training.

Implications for commissioning

The challenge is to provide young people with the means to avoid early pregnancy as well as tackle the underlying circumstances that motivate young people to want to, or lead them passively to, become pregnant at a young age. Reducing teenage pregnancy therefore contributes to a wider strategy to reduce inequalities and social exclusion. For example, work to address the underlying causes of teenage pregnancy contributes towards the ambitions to reduce child poverty, infant mortality, and the transfer of disadvantage between generations.

Evidence from areas that have made the largest reductions in teenage pregnancy suggests a range of factors that must be in place for success:

1. Engagement of delivery partners: active engagement of all the key mainstream delivery partners who have a role in reducing teenage pregnancy: health, education, social services, youth support services, and the voluntary sector;

2. Selection of a senior champion: a strong senior champion who is responsible for the local strategy and can the lead in its implementation;
3. Effective sexual health advice service: the availability of a well-publicised contraceptive and sexual health advice service which is centered on young people. The service needs to have a strong remit to undertake health promotion work, as well as delivering reactive services;
4. Prioritisation of sex and relationships education (SRE): high priority to be given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationship education in all schools;
5. Focus on targeted interventions: a strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;
6. Training in sexual and relationship education for partner organisations: training for professionals in partner organisations who work with the most vulnerable young people such as youth workers, social workers, and Connexions personal advisers;
7. Well-resources youth service: providing things to do and places to go for young people with a clear focus on addressing key social issues affecting young people such as sexual health and substance misuse.

The *Final Report* of the Teenage Pregnancy Independent Advisory Group identifies the following as the immediate challenges going forward:

1. Public spending cuts: the challenge of maintaining the downward trend in teenage pregnancy during major reorganisation of the NHS, the removal of targets, and at a time of reduced public spending: "existing provision must be reviewed and cuts made strategically and thoughtfully";
2. Lack of national leadership: a major risk is that without explicit leadership and prioritisation of teenage pregnancy from central government, local areas will reduce the leadership and coordination of teenage pregnancy;
3. Cost effective contraception: evidence that there persists a lack of 'young people friendly' CASH (contraceptive and sexual health) services and too much variation across the country in provision and quality;
4. Sexual and relationship education: this must be improved if children and young people are to resist peer, partner, and media pressures and to understand issues such as sexual consent and responsibility. This is especially important given the consensus of support amongst teachers, health professionals, school governors, parents, and young people themselves;

5. Support for young parents: teenage parents are amongst the most excluded people in our society and improved support and inclusion is vital for a range of outcomes.

Who's at risk and why?

Teenage pregnancy is strongly associated with deprivation and social disadvantage with significantly higher rates seen in the areas of Bolton with such characteristics. Social exclusion is key as both a cause and consequence of teenage pregnancy; in addition the following outlines the broad areas relevant to further increased risk.

Risky behaviours

1. Girls having sex under the age of 16 are three times more likely to become pregnant than those who first have sex over 16;
2. Research suggests that regular smoking, drinking, and experimenting with drugs increases the risk of teenagers having sex under the age of 16 for both boys and girls;
3. Teenage boys and girls who have been in trouble with the police are twice as likely to become a teenage parent compared to those with nor previous contact with the police;
4. Several studies have suggested a link between mental health problems and teenage pregnancy.

Education

1. Teenage pregnancy is far higher amongst those with poor educational attainment, even after adjusting for the effects of deprivation. Surveys show that disengagement from education often occurs prior to pregnancy with less than half of teenage mothers attending school regularly at the point of conception. Dislike of school has also been demonstrated to have a strong independent effect on the risk of teenage pregnancy;
2. Poor attendance at school is associated with higher pregnancy rates. Amongst the most deprived 20% of local authorities in the country, those areas with more than 8% of half days missed had on average an under 18 conception rate 30% higher than areas where less than 8% of half days were missed;
3. Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex.

Family/background

1. Research from the 1970 British Birth Cohort dataset shows that being the daughter of a teenage mother is the strongest predictor of teenage mother;

2. Children who are/have been in care. Prevalence of teenage motherhood among looked after girls under 18 is around three times higher than that for all girls under 18;
3. White British, Black, and Mixed White and Black are overrepresented ethnicities amongst teenage mothers. All Asian ethnic groups are under-represented;
4. Children with poor family relationships;
5. Research shows that a mother with low aspirations for her daughter at age 10 is an important predictor of teenage motherhood;
6. Where young people experience multiple risk factors then likelihood of teenage parenthood increases significantly. For instance, young women with the following five risk factors have a 31% probability of becoming a mother under 20 compared to a 1% probability for someone with none of these risk factors (daughter of teenage mother, fathers social class IV and V, conduct disorder, social housing at age 10, poor reading ability at age 10). A similar increase in probability is seen in young men with the same five risk factors;
7. Children who have experienced sexual abuse.

The level of need in the population

In Bolton there are approximately 250 conceptions to teenage girls per year and currently the conception rate is higher than the national average, but lower than the rate in the North West region.

Local, regional, and national rates do show a slow decline over time but the reduction locally is very minor and not statistically significant. There has been a 13.7% reduction in Bolton between 1998-2000 and 2008-2010.

The proportion of Bolton mothers who are under the age of 18 (2.2%) is almost exactly average for Bolton's statistical peer group.

The under 18 conception rate in Bolton is 39.8 (per 1,000 women in age group), the maternity rate for the same age group is lower (23.6 per 1,000 women under 18), and the abortion rate for the same age group is 15.7 (per 1,000 women). The percentage of all teenage conceptions that lead to an abortion in Bolton is 39.9%.

There currently persist very strong geographical inequalities in the teenage conception rate across Bolton with the more deprived and predominantly White British areas having the highest rates. In particular, the local areas of Breightmet, Farnworth, Tonge with the Haulgh, and the South East parts of the Great Lever Ward (Townleys, Burnden, Moses Gate).

The Children's Centre Reach Areas with the highest proportion of delivery episodes where the mother is aged less than 18 are The Orchards and Tonge, followed by Leverhulme and Lord Street and Grosvenor.

The rate of legal abortions in teenagers in Bolton is similar to the regional average and 1bout 8-10% below the national average and follows similar trends. Bolton tends to have a lower percentage of repeat abortions in teenagers than seen elsewhere in the country.

Risky behaviours

Bolton has a higher rate of hospital admissions due to alcohol specific admissions in people aged under 18 than England but is lower than is average for the North West region. Similarly, 17.0% of Bolton children say they have been drunk once or more in the last four weeks which is again higher than England (15.0%) but just lower than our region (17.3%).

Bolton has a much lower proportion of pupils than average saying they have smoked cannabis or skunk more than once in the past four weeks – 2.0% compared to 4.0% nationally and 4.2% regionally.

Bolton also has a lower rate of young people (aged 10-17) receiving their first reprimand, warning, or conviction (940 per 100,000 population aged 10-17) than nationally (1,160) and regionally (1,180).

Education

Bolton has a similar rate of participation in education and work based learning for 16-17 year olds (90%) to that seen nationally (89%) and regionally (89%). The proportion of 19 year olds who hold a Level 2 qualification is lower in Bolton (74.1%) than England (75.9%) and the North West (75.1%). However, for Level 3 achievement by 19 years Bolton is higher than the North West (48.0% compared to 46.6%), but still lower than England (49.4%).

In Bolton, 8.0% of 16 to 18 year olds are NEETs (not in education, employment, or training), which is a greater proportion of the population than seen nationally and regionally. However, Bolton performs better than the national average for ensuring teenage mothers are in education, employment, or training as evidenced by Care2Learn[1].

Family/background

In 2011 the rate of children living in care in Bolton was 83 per 10,000 population aged under 18. This rate is higher than seen both nationally and regionally. Historically, Bolton has a

[1] Department for Education (2013) *Raising aspirations and educational outcomes for looked after children: a data tool for local authorities,* DfE. http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a00192332/raisingthe-aspirations-and-educational-outcomes-of-looked-after-children-a-data-tool-for-localauthorities

higher percentage of lone parent families (17.7%) than the national average but is lower than the North West.

Bolton is ranked in the bottom 20% of the country in the Indices of Multiple Deprivation 2010 and almost a third of our lower super output areas (LSOAs) are in the 15% most deprived in England.

Key JSNA Indicator Sheets

CHILD HEALTH: Teenage Pregnancy

Current services in relation to need

There are a number of sexual health services for young people in Bolton offering different levels of service. These include both universal and targeted services. Providers of sexual health services include the NHS, independent sector, local authority, and the voluntary sector. Sexual health service provision also includes programmes and schemes which are provided in partnership across a number of providers, for instance the chlamydia screening programme and the C Card scheme.

Bolton also has a dedicated young people's health centre, The Parallel, which includes a team working at the location as well as out in the community and is closely linked to the school health service. The Parallel is a universal service, with open access, providing six days provision a week including one on Saturday. There is one session a week provided by the Adult Sexual Health Service for Sexually Transmitted Infections (STIs). The services are specifically for young people aged 11 to 19 years and the uptake of the service is predominantly White British girls under 19. The numbers of young men using the service are low, although there has been a small but noticeable rise in young people from BME communities using the service since it opened. Satellite holistic health services are delivered from seven schools by the adolescent health nurses in addition to school nurse drop-in sessions at all high schools.

Opening in 2009 Brook have been running young people's clinics at two further education colleges, covering several sites across Bolton. There are also a number of specialist nurses who work with vulnerable and at risk young people and include nurses attached to the Youth Offending Team, Looked After Children, 360° Young People's Substance Misuse Service, Asylum Team, Children with Special Needs (Advanced Practitioner), Exit, for those at risk of sexual exploitation, and working with young parents.

There is also a targeted service for young women under 19 who have previously had a baby with the aim of reducing second conceptions. The service provides a link between maternity services, health visitors, and other support services for the teenage mother. Other community contraceptive services are provided by the Integrated Adult Sexual Health and

Reproductive Sexual Health Service through seven community clinics which are open to men and women in Bolton of any age. There are also seven local GP practices with a special interest in sexual health and several others who provide long acting reversible contraception (LARC).

Cost-effectiveness

Reducing teenage pregnancy rates cuts abortion and maternity expenses as well as the long-term costs associated with supporting vulnerable teenage parents, including work to improve outcomes for them and their children, payments of income support, housing, and child benefit.

The *Teenage Pregnancy Independent Advisory Group Final Report*[2] makes it clear that local areas must realise the cost benefits of reducing teenage pregnancy. Contraception use is the primary determinant of declining teenage pregnancy rates, but nationally NHS spending on contraception is relatively low, with some areas spending as little as 18p per woman per year on contraception, yet every teenage birth costs the NHS approximately £1,500 and every abortion £650. For every £1 invested in contraception services the NHS saves £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services. Also, if local areas stop investing in teenage pregnancy prevention they will face much more considerable costs within the same financial year. In addition, LARC has a lower failure rate than all other contraception methods and is the most cost effective method available. NICE guidance on LARC states that a CCG with a population of around 400,000 (i.e. with 100,000 women aged 15-49) could reduce unintended pregnancies and save up to £790,000 per year by implementing NICE guidance and improving access to LARC. Finally, dual savings can be made when condoms are promoted to both prevent pregnancy and reduce the risk of STIs.

Projected service use and outcomes

The under 18 conceptions rate in Bolton is forecast to reduce to 43.4 per 1,000 females aged 15-17 by 2020. Despite this, there has been local evidence that the profile of teenage conceptions in Bolton may be changing towards a pattern of increased conceptions in under 16s. If this continues, a more targeted approach to identifying those at increased risk of teenage parenthood coupled with earlier intervention will be required. Necessarily this will mean service provision and service use will need to change. The younger women becoming pregnant are often those from the most complex families facing many difficulties. This has been evidenced by the Family Nurse Partnership (FNP) service which started in November 2011. The nurses work with 100 families intensively over a two year period and have found

[2] Teenage Pregnancy Independent Advisory Group (2010) *Teenage pregnancy: Past successes – future challenges*, TPIAG.

that a high percentage (20% Level 2 child in need and 16% Level 3 child in need) of these have high level needs, and in addition 5% are care leavers.

Evidence of what works

There is no one intervention that can reduce teenage pregnancies, rather a range of interventions and prevention strategies are consistently required in order to ensure sustainable reductions in conceptions. The international evidence base for the national teenage pregnancy strategy[3] shows that the measures for which there is strongest evidence of impact on teenage pregnancy rates are comprehensive information, advice, and support for parents, schools, and other professionals combined with accessing young people friendly sexual and reproductive health (SRH) services. Strong sex and relationships education and improved access to contraception are they key to success. In areas of England with the best success rates the other key issues have been having local champions and strong strategic support from leaders in the local authority and NHS, investment in training of the wider children's workforce to ensure they are capable of delivering the right advice support and guidance, and the collection, sharing, and effective use of local data to inform targeted work and provide a more timely assessment of progress.

Bolton's Health Matters has created a collection of evidence and intelligence to ensure best practice in decision within this area. To view this collection, please click here: http://bit.ly/11saCuL

Community views and priorities

A snap shot survey was taken of young people aged under 19 and the findings highlight a number of gaps and unmet needs regarding sexual health service provision:

1. The majority of young people surveyed knew where to go locally for sexual health services but 10% did not and suggests more should be done to raise awareness and consistently promote uptake;
2. Information preference for the group was found to be high visibility advertising – posters, billboards etc. A smaller but significant proportion preferred lower visibility methods such as texting, website etc. Therefore, a range of communication approaches should be used to ensure effective targeting;
3. A multiplicity of provision is required as some young people preferred local neighbourhood services whilst others preferred a town centre location;
4. Respondents were inconclusive about school based services and school nurse drop in clinics. However, emerging evidence does suggest that school based sexual health provision is effective in terms of cost and prevention;

[3] Department for Children, Schools, and Families (2010) *Teenage Pregnancy Strategy: Beyond 2010*, Department for Children, Schools, and Families Publications.

5. Respondents wanted services within walking distance or within one bus ride. Therefore, there is a need to ensure all relevant service provision is as physically accessible as possible;
6. Young people say they want to the ability to access services within a few days and prefer a drop-in style of service with a wait up to a maximum of 30 minutes. This information confirms young people require flexible, responsive services and are reluctant to attend appointment only clinics.

Equality impact assessments

The full equality impact assessment for the local delivery plan for teenage pregnancy is available on Bolton's Health Matters. Below are the main issues raised by the impact assessment – the full document provides detail as to how these inequalities are to be met.

Ethnicity

- There are few teenage parents from ethnicities other than 'White British' in Bolton;
- Access to some services by some ethnic groups is low.

Religion

- Difficulties supporting faith schools to deliver good quality and full range of SRE;
- Unable to distribute condoms from youth clubs with high numbers of young people from Muslim faith.

Disability

- Some issues providing SRE to those with learning difficulties, few resources or staff trained to do this;
- Support for those wanting to get back into education with disability.

Gender

- Young fathers not accessing services as readily as young mothers;
- Boys not accessing sexual health and contraceptive services as often as girls.

Age

- All service users are in a defined age group;
- Teenage parents in particular are often socially excluded by other agencies and perceived negatively by press and members of the public.

Sexuality

- Very few teenage parents are not heterosexual;
- Some young people who are receiving SRE could be having issues about their sexuality.

Caring

- Client groups are often amongst the most vulnerable young people, often with little support.

Unmet needs and service gaps

There is a continued need to provide high quality sex and relationship education across the borough and many teachers are ill-equipped to deliver sessions on contraception and STIs. Local needs assessments have highlighted addressing this by having young people's health promotion trainers; this is an unmet need at present. The current spending review is impacting on the SRE support available to schools and so this needs further assessment and planning to try and ensure that some support can remain as it is evidenced that SRE is one of the main ways that areas can reduce teenage pregnancy. From March 2013 there will be no local authority post to provide this service to schools, parents, and governors, including training, policy, and strategy development and provision of resources. This could have a long-term cost to Bolton if more teenagers become pregnant and either have abortions or have babies and need extra support.

Over the last twelve months there has been a considerable change in the number of sites available for young people to access contraception with clinics developed in a number of localities with 11 based in schools and colleges alongside the central hub service in the town centre. Based on high teenage pregnancy rates and wider risk factors such as deprivation and low educational attainment the following areas of Bolton were particularly targeted: Breightmet, Farnworth, Tonge with the Haulgh, Burnden, Moses Gate, and Townleys. Increases have been observed in similar areas of Bolton such as Daubhill and Halliwell Road that differ by having high BME populations. We know that BME girls are underrepresented in teenage pregnancy statistics and wider analysis of maternities indicates that increases in these Wards are due to White British girls living in poor material circumstances.

Recommendations for further needs assessment work

Assessment and regular monitoring/analysis of the Public Health Outcomes Framework indicators linked to teenage pregnancy are necessary. These are: 1.1 Children in poverty; 1.3 Pupil absence; 1.4 First time entrants to the youth justice system; 1.5 16-18 year olds not in education, employment, or training; 2.4 Under 18 conceptions; 2.8 Emotional wellbeing of looked after children; 2.9 Smoking prevalence – 15 year olds; 3.2 Chlamydia diagnoses (15-24 year olds).

Further assessment of the needs of teenage parents and their children is required following local evidence of very high need from the FNP. This service only reaches 50% of new teenage parents and their babies (in a two year period). Therefore there is a gap in service

provision for the remaining 50%. Over a three year period there will be 300 new teenage mothers with only 100 of these able to access the FNP service (FNP are licensed to work with 100 teenage parents over a two year period). Universal and specialist nurse services will provide some support but with the current spending review and savings to be made in both health and local authority services these roles are already at risk with some planned to end by March 2013.

Key contacts

- Jayne Littler – Strategic Commissioning and Development Manager, Public Health