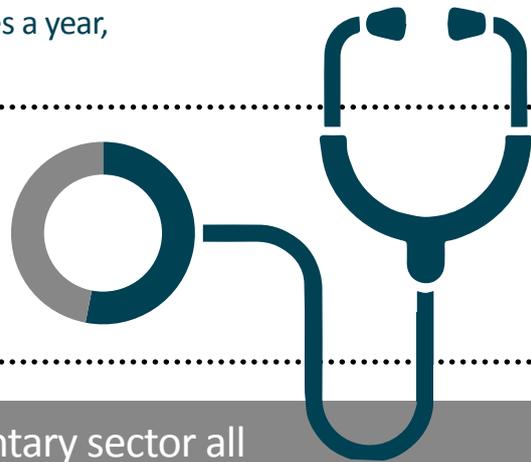


CHAPTER 7: Health promotion and use of health services



On average, young women visit their GP four times a year, young men twice a year

Half of year 10 pupils (aged 14-15) report that they have visited the GP in the last three months (48% boys, 54% girls)



Schools, parents, peers and the voluntary sector all play a major part in health promotion for young people

For every 1000 people under 18, although approximately **100** will have mental health problems...



only **24** will be referred to formal child and adolescent mental health services...



and only **18** will be taken on



A&E attendances for 15-19 year olds have been steady in recent years



Health promotion and use of health services

Good outcomes for young people rely on an interaction between their needs and how well services can meet them. In this chapter we look at young people’s views on and use of health services, from community based health promotion through to NHS inpatient care.

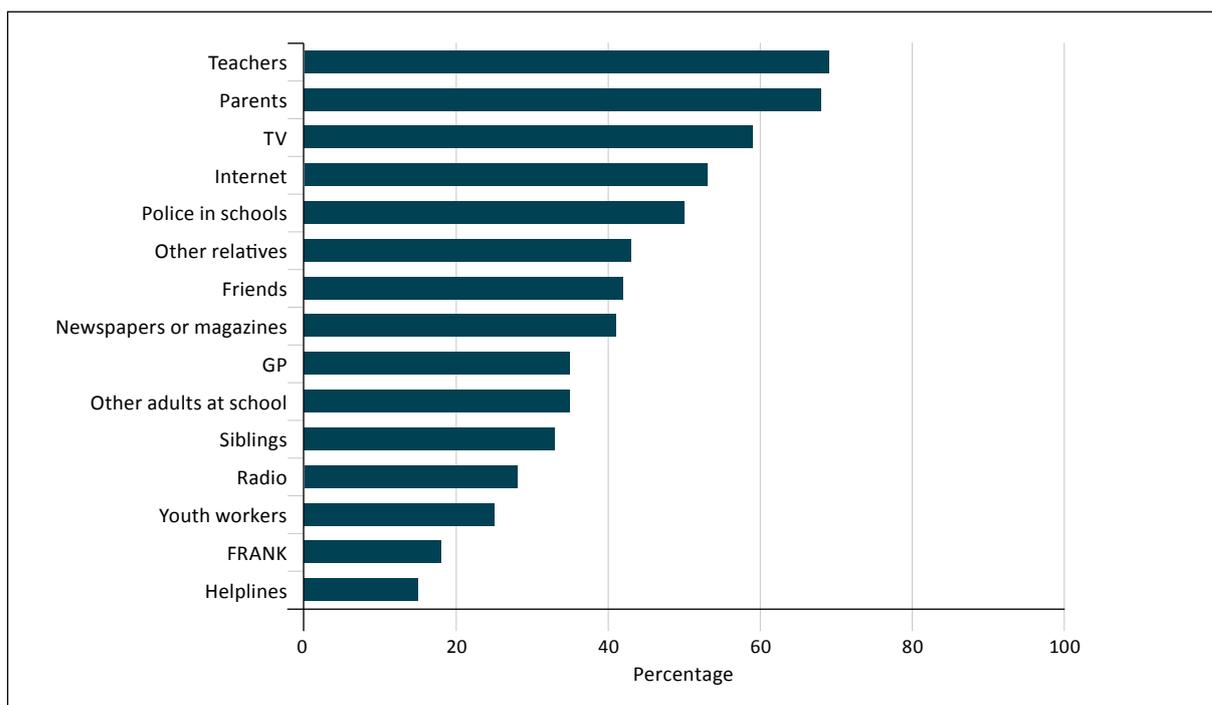
Health promotion

One of the key challenges for young people is the transition to independence that takes place across the second decade of life. Learning how to recognise health issues and manage the process of getting help is very important at this time. Supporting young people through this process means empowering them to take control of their health and giving them the information they need to seek appropriate services.

Health promotion for this age group often focuses on sexual health, physical activity, smoking, drinking and drug use, and diet and nutrition. Interventions to promote health can address individual behaviour and can also involve wider social and environmental factors. Wider population interventions might include media information campaigns or policy such as advertising bans, tax incentives and pricing structures (for example, in relation to alcohol sales) and clearer food labelling. There are very few representative data on how these might impact on young people. However, health promotion can also work through information in school, vaccination programmes, access to helplines and individual level support and advice and we have more information about these.

When asked about sources of helpful information, for example about drug use, young people report that they use a wide range of sources. Questions asked in the 2013 HSCIC Smoking, Drinking and Drug Use Survey (SDDU) showed teachers and parents came top of the list. **Chart 7.1** ranks the sources that young people mentioned in the survey.

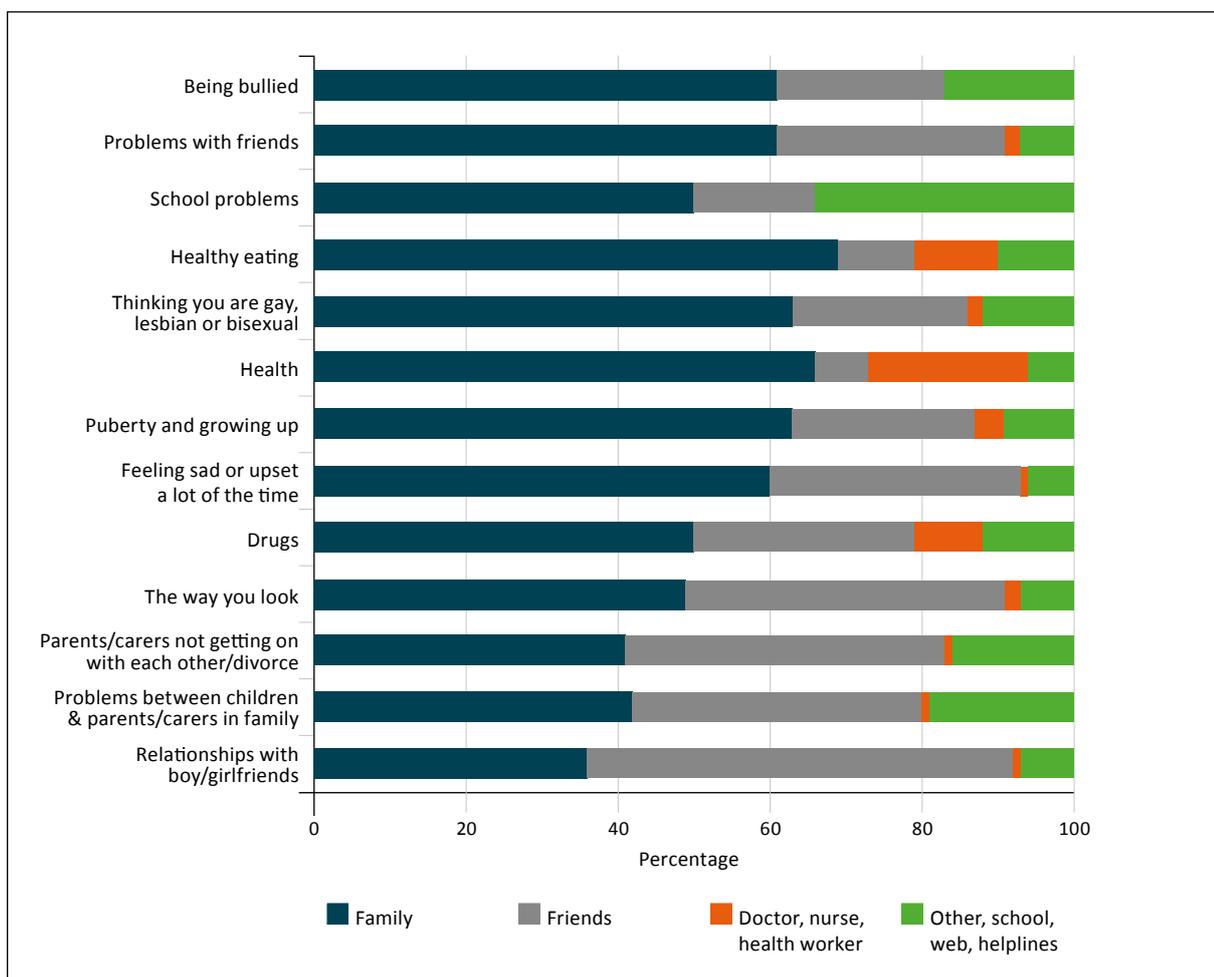
Chart 7.1: Sources of helpful information about drug use, school pupils in England, 2013



Source: HSCIC (2014), Smoking, Drinking and Drug Use Among Young People in England [DOWNLOAD DATA](#)

Chart 7.2 draws on data from the Exeter Schools Health Education Unit to show peers feature strongly as sources of information and support among 12-15 year olds. However, many young people often report turning first to their family for information, help and advice, with the exception of sex and relationships and marital conflict. These findings illustrate the value of providing support to parents in communicating with their teenage children. Importantly, primary care services also feature as a source of advice and help for a wide range of issues, highlighting the value of helping GPs and others to prioritise young people's health.

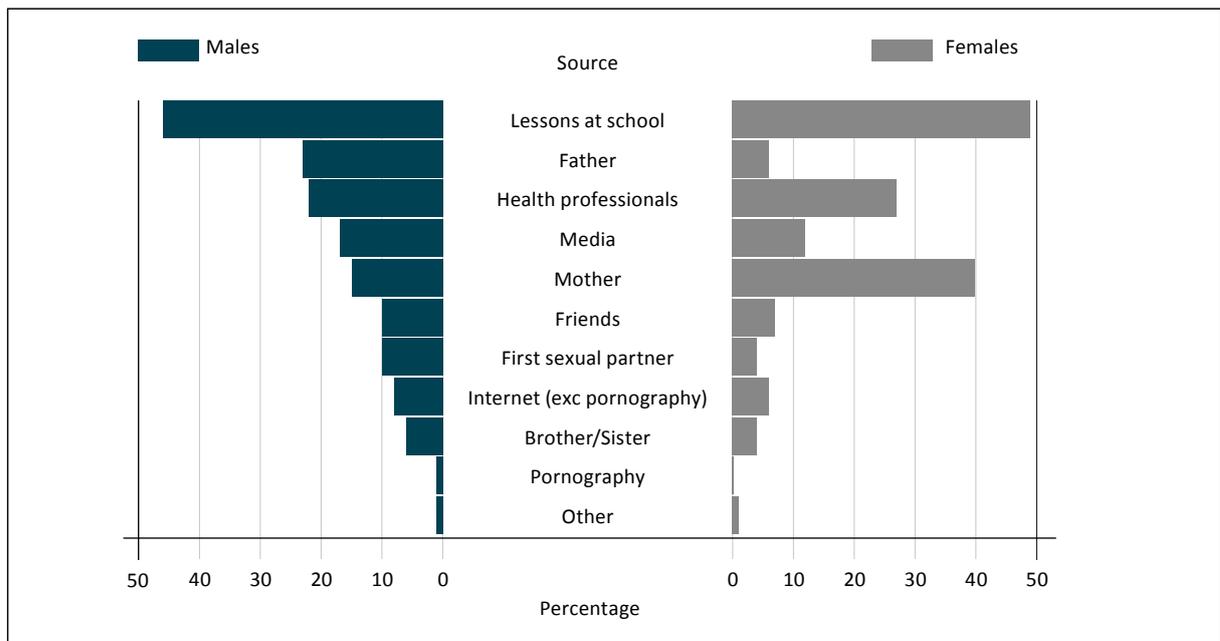
Chart 7.2: Where 12-15 year olds first go for help or information about emotional and physical health issues, 2014



Source: Balding and Regis (2014), Young People into 2014 [DOWNLOAD DATA](#)

Chart 7.3 presents findings from the most recent National Survey on Sexual Attitudes and Lifestyle (Natsal-3), showing schools, parents and health professionals are the preferred sources for information about sex and relationships, for 16-24 year olds.

Chart 7.3: Preferred source of information about sex when growing up, young people aged 16-24, Great Britain, 2012



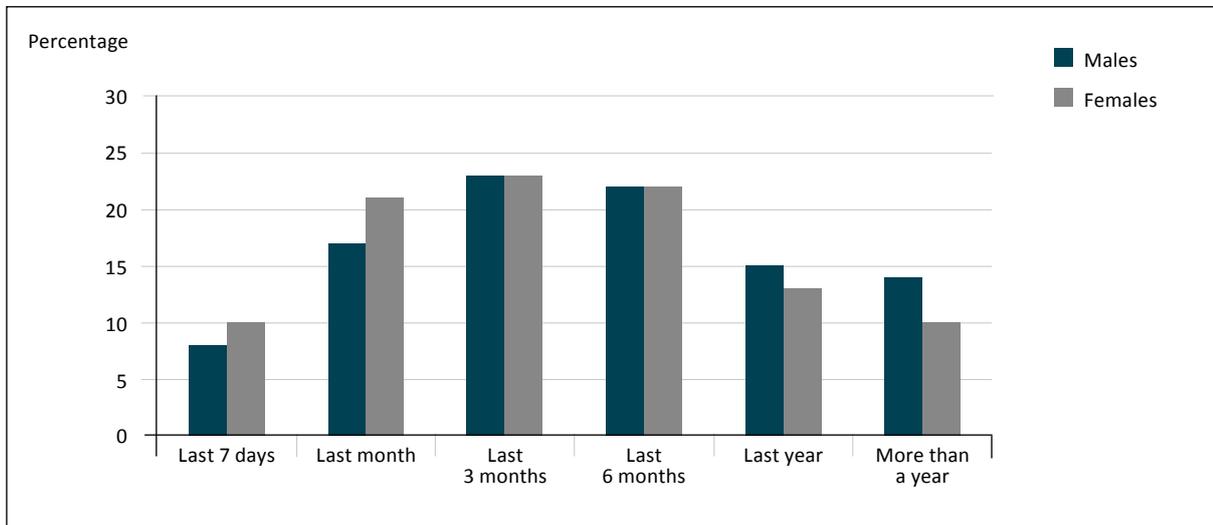
Source: Sex Education Forum (2015) Sex and relationship education: the evidence.
 Data source National Survey on Sexual Attitudes and Lifestyle 2014 (NatSal-3) [DOWNLOAD DATA](#)

As these three surveys all show, schools clearly play a major role in health promotion through the provision of personal, social, health and economic education (PSHE). PSHE is considered a necessary part of the school curriculum in the UK, although in England and Wales it is not mandatory. However the 2017 Child and Social Work Act did make sex and relationships education statutory in all secondary schools (DfE, 2017). The wider aim of PSHE is "...to equip pupils with a sound understanding of risk and with the knowledge and skills necessary to make safe and informed decisions" (Department for Education, 2013). Schools may also be involved in developing wider, whole school approaches, such as Healthy Schools in England (Arthur et al, 2011). Overall, in the SDDU study, more than one third of school pupils thought their school had not given them enough information on smoking (40%), alcohol (44%) or drugs (46%) (HSCIC, 2015).

General Practice (GP) consultations

Young people access their GPs regularly for a wide range of health issues. Generally it is estimated that young people visit the GP several times a year. In their teens this averages out at approximately twice a year for young men and more than four times for young women (HSCIC, 2009). Both the Exeter Schools Health Unit 'Young People into 2016' study, and the HBSC study, provide more up to date estimates of the time since last visit to the doctor. **Chart 7.4** shows the data from the 'Young people into 2016' study where in total half of Year 10 pupils (aged 14-15) reported that they visited within the previous three months (48% boys, 54% girls).

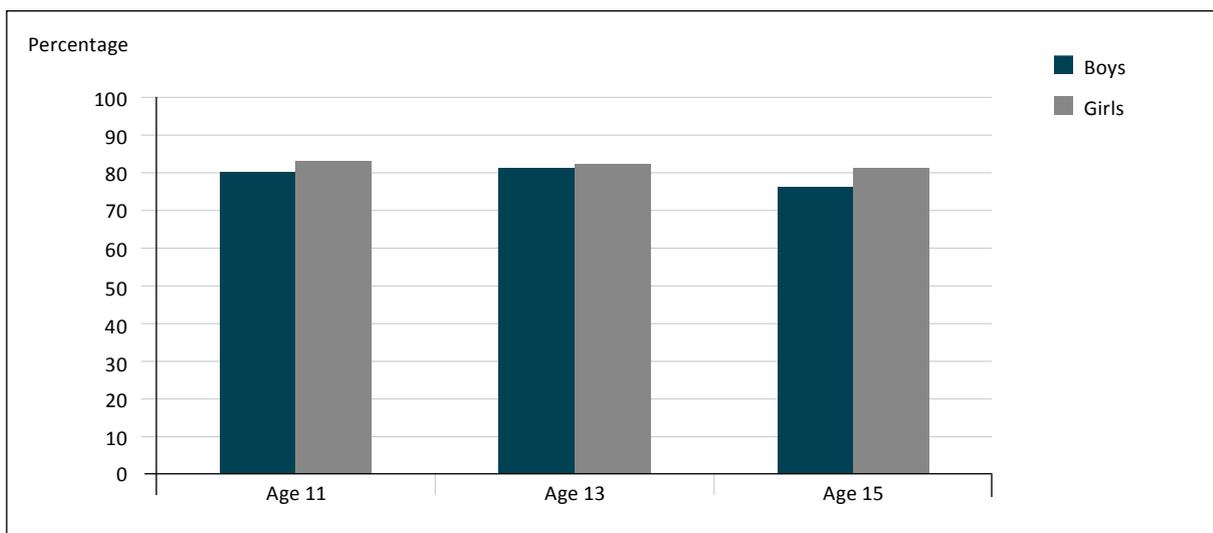
Chart 7.4: Last visit to the doctor by Year 10 pupils (aged 14-15), 2016



Source: Balding and Regis (2016), Young People into 2016, unpublished report [DOWNLOAD DATA](#)
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Slightly different rates of consultation were reported by the 11-15 age group in the last HBSC survey in 2015, where overall 78% of boys and 82% of girls said they had visited the GP in the last year (Brooks et al, 2015). **Chart 7.5** shows that there was little variation in the rates by gender or age across these years. Although estimates of attendance vary depending on age group and survey, it is evident young people are frequent users of primary health care, particularly young women.

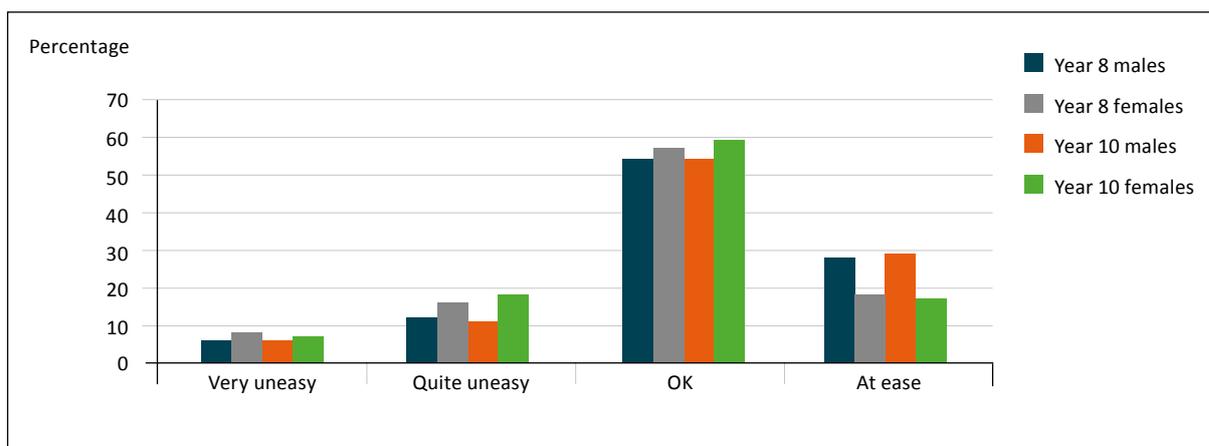
Chart 7.5: Proportion of young people 11, 13 and 15 visiting the GP in the last year, England, 2014



Source: Brooks et al (2015) Health Behaviour in School-aged Children England National Report [DOWNLOAD DATA](#)

The ‘Young People into 2016’ survey (Balding and Regis, 2016) reported on teenagers’ experience of talking to their GP, with **Chart 7.6** showing one quarter of girls (24% of Year 8 and 25% of Year 10) reported feeling ‘quite uneasy’ or ‘very uneasy’ with their doctor on their last visit, while boys reported more ease. In comparison, in the latest HBSC survey 89% of young people reported that their GP treated them with respect, and 52% reported that they were able to talk about personal things with their doctor (Brooks et al, 2015). Overall the findings highlight the importance of supporting GPs to provide youth friendly services.

Chart 7.6: Extent to which young people at secondary school felt at ease with their GP at their last visit, by age and gender, 2016



Source: Balding and Regis (2016), Young People into 2016, unpublished report [DOWNLOAD DATA](#)
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Experiences of young people aged 18-24 are assessed in NHS patient surveys, and **Chart 7.7** shows that while the majority are satisfied with their experience, a significant proportion are not. The majority felt able to get to see or speak to someone, but only around one third went to the appointment they were offered, rated the experience as ‘very good’, or the convenience ‘very good’. Over half said that they definitely had confidence and trust in their GP. These rates were lower than for older age groups. Young people’s preferred method of booking an appointment was by telephone, with only 8% saying that they booked online. Just over one quarter were ‘very satisfied’ with surgery opening hours.

Chart 7.7: Experiences in general practice of young people aged 18-24, England, 2017

Able to get appointment to see or speak to someone	80%
Convenience of the appointment, very good	40%
Helpfulness of receptionist, very good	32%
Overall experience of making an appointment, very good	26%
Satisfaction with opening hours, very satisfied	29%
Preferred method of booking appointment at GP surgery	
by phone	87%
on-line	8%
in person	23%
Went to the appointment I was offered	34%
Went to Accident and Emergency instead	5%
Had a telephone consultation	5%
Saw a pharmacist instead	4%
Overall experience of the surgery, very good	31%
Confidence and trust in GP, yes definitely	56%

Source: GP Patient Survey 2017 Ipsos MORI for NHS England [DOWNLOAD DATA](#)

We have previously noted the dearth of up to date information about young people's usage of primary health care services and further research is still needed. Fifteen years ago, Churchill et al (2000) undertook a survey identifying the range of conditions that prompted young people to seek a primary health care consultation. The most common were respiratory, dermatological and musculoskeletal conditions and problems associated with ears, nose and throat. New data on this topic are now needed urgently. Data on young people's experiences with the wider range of professionals involved in primary health care – such as practice nurses – are also lacking.

Child and adolescent mental health services (CAMHS)

Child and adolescent mental health services (CAMHS) are provided through a network of providers offering universal, targeted and specialist services. These are organised in four 'tiers'. Tier 1 consists of universal services provided through early year services and primary care. Tiers 2 and 3 provide targeted services through youth offending teams, school and youth counselling, and specialist community based psychiatric and psychological services. Tier 4 consists of inpatient and very specialised outpatient services.

Of 1000 young people under 18, **24** will have a referral to **child and adolescent mental health services** (Tiers 2 and 3)

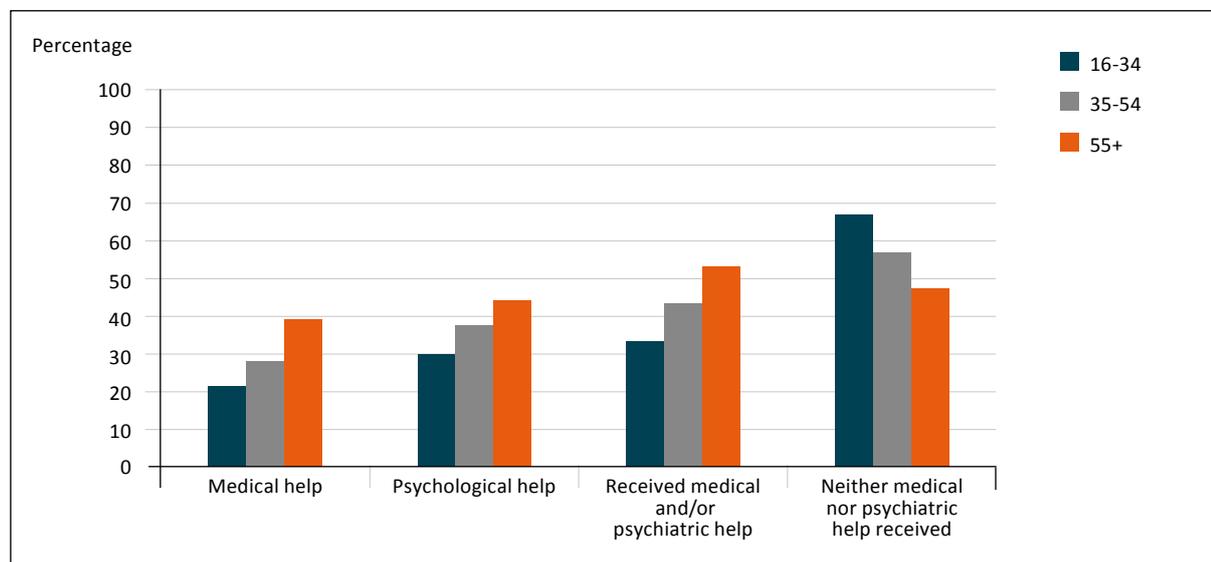
Source: NHS England (2016)

Useful information about the structure and provision for CAMHS in England are provided in NHS England's CAMHS benchmarking reports. The 2016 report estimated that if England were a village of 1000 children and young people, of these 24 would be referred to community mental health services (NHS England, 2016). As the estimate of the level of problems is approximately one in 10 of the population of this age (Chapter 6), this suggests a very small proportion are referred. This figure relates to referrals to Tiers 2 and 3. In a survey of 3,750 young people aged 12-16 in UK secondary schools, only 5% of those at high risk of depression or self-harm had seen specialist CAMHS in the previous six months. Amongst those with probable depression, 79% had seen their GP (Sayal et al, 2014).

After referral there is a further treatment gap, as on average only 18 of those 24 children and young people will be accepted for treatment (NHS England, 2016). Analysis of CAMHS service eligibility criteria has showed that this is often because there are high thresholds for access to services, and something has to go drastically wrong before services will intervene (Frith, 2016a). Once a referral is accepted, there may then be a significant wait for services, with wide variation for different providers (Frith, 2016a). In addition to limitations in capacity to respond at Tiers 2 and 3, specialised inpatient beds (Tier 4) are also very limited with approximately 1,600 across the whole of England. It is important to note that information on CAMHS from these sources does not record provision from the voluntary and independent sectors, who often provide services to fill the treatment gap. These deal with a significant proportion of young people who do not meet the threshold for CAMHS.

Analysis of the Adult Psychiatric Morbidity Survey has provided estimates of the proportions of people aged 16-34 who report receiving treatment after a suicide attempt. As **Chart 7.8** shows, rates for receiving treatment are lower for this age group than for older adults, with 67% of those aged 16-34 receiving no intervention at all, compared with 47% of those over 55 years. This may be as much about help seeking behaviour as about availability of treatment options, but all available statistics point to a shortfall of services particularly for the younger age groups.

Chart 7.8: Proportion of those who have attempted suicide who report receiving medical or psychological help, by age, England, 2014



Source: McManus et al (2016) Adult Psychiatric Morbidity Survey [DOWNLOAD DATA](#)

This continues to be an area of considerable policy debate, with recent reports from the House of Commons Health Committee (House of Commons Health Committee, 2014), the Child and Adolescent Mental Health Task Force (DH/NHS England, 2015), NHS National Services Scotland (Information Services Division Scotland, 2015), the Royal College of Psychiatrists (2015), and the Independent Mental Health Commission (Frith, 2016a and b), amongst others.

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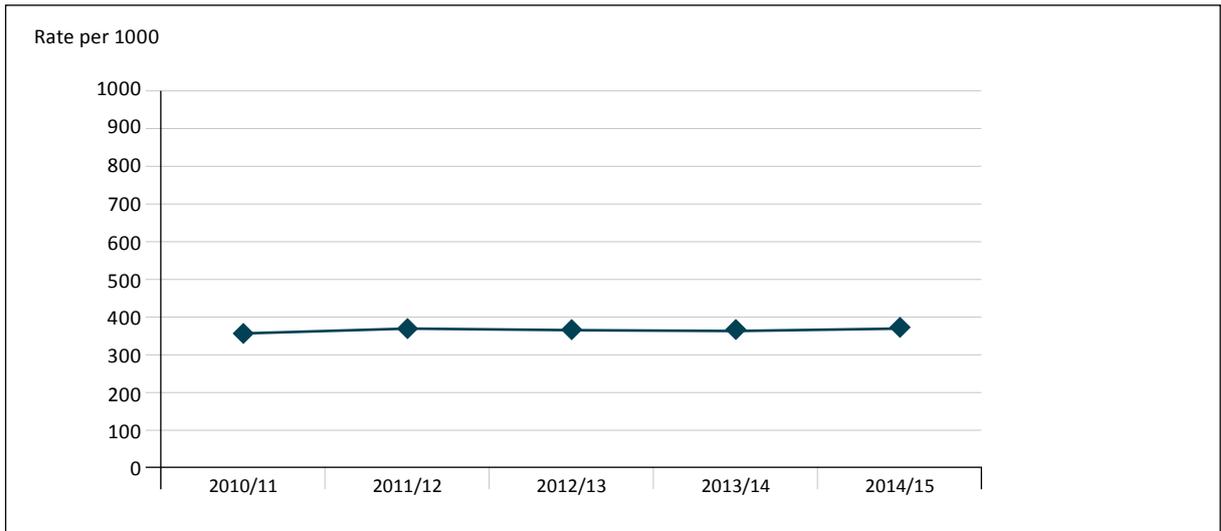
Hospital admissions

Young people have lower overall morbidity than older age groups and this fact can result in their health needs being overlooked within health design and commissioning. Nationally there are very few hospital facilities specifically for teenagers. Yet many young people are at risk of hospital admission, particularly those with a longterm or chronic condition. Age appropriate services can make an important difference for young people.

Many hospital admissions take place through accident and emergency (A & E) departments. The Care Quality Commission (CQC) estimates place this at 47% of admissions for those aged 12-15 (CQC, 2015). A study of 10,455 attendances by 8,303 young people aged 13-17 has shown that reasons for attending A & E include injuries (72%), abdominal pain (16%), self-harm (11%), fits, faints and funny turns (10%), breathing difficulties (7%) and intoxication (6%) (Shanmugavadivel et al, 2014). It is also worth noting that around one quarter of teenagers and young adults with cancer are diagnosed at A & E, having presented as emergencies (National Cancer Intelligence Network, 2013).

The NHS England Hospital Episode Statistics in **Chart 7.9** show that rates of attendances at A & E departments for those aged 15-19 have not risen significantly in recent years. Reported rises in emergency attendances for those under 19 have tended to feature much younger children. Particular rises have been seen in recent years for those aged under 0-4, rather than teenagers (Keeble and Kossarova, 2017).

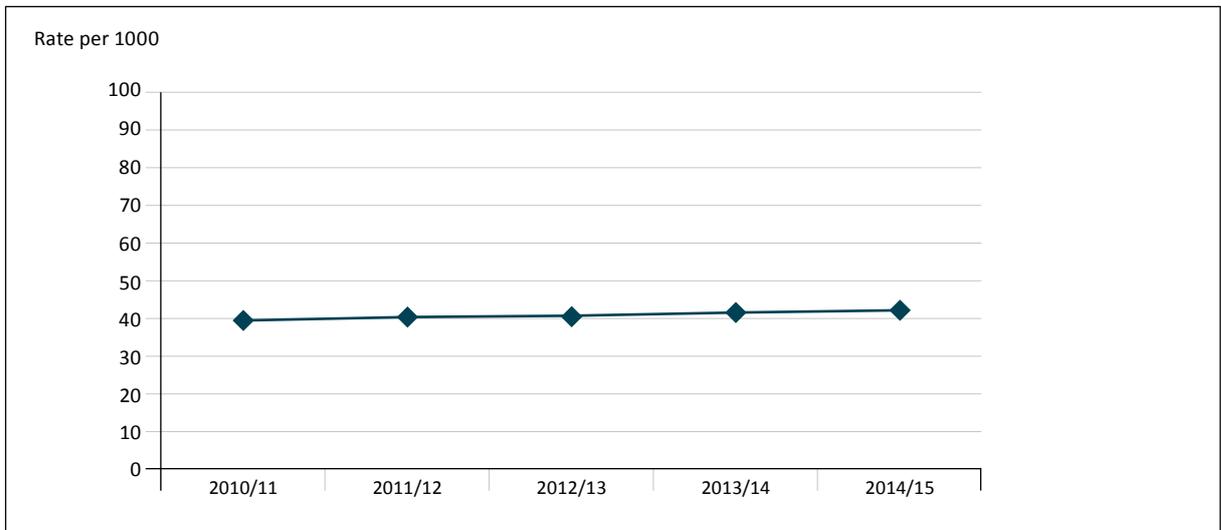
Chart 7.9: Accident and emergency hospital attendances 15-19 years, England, 2010/11 to 2014/15



Source: NHS Digital Hospital Episode Statistics (HES) 2016 [DOWNLOAD DATA](#)

Other than A&E attendance, young people are also admitted to hospital as non-emergencies. **Chart 7.10** shows that rates of elective admission for this age group has risen slightly in recent years.

Chart 7.10: Elective admission to hospital for 15-19 year olds, England, 2016



Source: NHS Digital Hospital Episode Statistics (HES) 2016 [DOWNLOAD DATA](#)

In 2014 the Care Quality Commission surveyed 19,000 under-16s about their experience of being in hospital. **Chart 7.11** shows that among those aged 12-15, 10% were treated on teenage/adolescent wards. This figure has not changed in the 10 years since the 2004 NHS National Young Patient Survey. The 2004 NHS survey also included 16-17 year olds, 62% saying they wanted to be treated on teenage/adolescent wards (Viner, 2007).

Chart 7.11: Young people's views on hospital inpatient experiences, aged 12-15, England, 2014

For most of your stay in hospital, what type of ward were you on?	
Children's ward	88%
Adult ward	2%
Teen/adolescent ward	10%
If you had any worries, did someone at the hospital talk with you about them?	
Yes	77%
Sort of	17%
No	6%
Were you involved in decisions about your care?	
Yes	57%
A little bit	30%
No	13%

Source: Care Quality Commission (2014) Children and young people's inpatient and day case survey 2014 [DOWNLOAD DATA](#)

Finally, Hospital Episode Statistics have suggested children and young people from more deprived areas account for a greater proportion of inpatient care than those from more affluent areas (Hargreaves et al, 2012). For more on health inequalities, see **Chapter 8**.

Transition from children's to adult services

Increasing numbers of children with longterm conditions are surviving into adulthood because of improved healthcare. Adolescence is a time of moving to independent use of healthcare. Successful management of ongoing conditions can reduce the need for emergency care and improve outcomes. Continuity of care is vital in longterm conditions such as diabetes, kidney disease and epilepsy as well as mental health (Royal College of Nursing, 2004; Singh et al, 2009; Allen et al, 2010; Brodie et al, 2011; Joint Commissioning Panel for Mental Health, 2012; Hepburn et al, 2015). Good transition programmes have been shown to result in statistically significant improvements in outcomes (Crowley et al, 2011).

However, there are very few data on young people's journeys through the transition from child services to adult services. The CQC report on children's transition to adult health services reported that only 50% of young people and parents said they had received support from a lead professional in the process leading up to transition (CQC, 2014). In one of the few studies to follow a systematically identified cohort of young people Singh et al (2010) reported one third were not referred on to

adult services and one fifth of those referred on were never seen. Fewer than four per cent were reported to have experienced optimal transition. The study was relatively small and only explored mental health services, but suggests the need for more data on this topic. Recent guidelines from the National Institute for Health and Care Excellence (NICE, 2016) aim to improve the planning and delivery of care for this age group as they move from child to adult services. Evidence is growing that elements of successful transition programmes are patient education and specific transition clinics (Crowley et al, 2011).

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