“Key Data on Young People 2017 draws out the health inequalities faced by those aged 10-24. If we do not tackle these disparities as soon as they occur, they will create even more inequality down the line. Increasing our understanding of the health experiences of our young people is vital so that we can plan to improve their health outcomes now and for the future.”

John Newton
Director of Health Improvement, Public Health England

“Adolescence is a period of rapid development and Key Data on Young People 2017 underlines the importance of prevention and early intervention for this age group as well as for very young children.”

Dame Sally Davies
Chief Medical Officer for England

“Young people are frequent users of health services and AYPH’s work in this area is critical in showing why investment in youth friendly health services and more effective transition to adult services is crucial.”

Dr Jacqueline Cornish
National Clinical Director, Children, Young People and Transition to Adulthood, NHS England
The Authors

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Association for Young People’s Health

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AYPH is the leading independent voice for young people’s health in the UK. We bridge the worlds of policy, practice and evidence to promote better understanding of young people’s health needs, and to advocate for youth friendly health services.
The Association for Young People’s Health (AYPH)

One of our central aims is to promote evidence-based practice by making research findings more accessible. By sharing learning and best practice we can promote and provide better services to meet young people’s particular health needs. The publication of our Key Data series forms a major part of this work.

We also undertake projects that facilitate more effective communication between practitioners, raise the profile and understanding of young people’s health needs, test out new ways of working, and ensure that young people’s involvement is central to service development.

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*Key Data on Young People* is part of the Health Foundation’s programme to improve the health of young people living in the UK. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Its aim is a healthier population supported by high quality healthcare. We are very grateful to them for the funding that made this publication possible.

Ann Hagell
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Summary

The transition from childhood to adulthood is an important, fascinating period of life. Young people in their teens and early 20s need particular support and special services, particularly those who may be marginalised. Pulling together age specific data about this age group can lead to a better understanding of their health needs, and can help us to provide more appropriate, youth-friendly health services.

In this comprehensive data review focusing specifically on the health of 10-24 year olds in the UK, we look at living circumstances, education and employment, information about health behaviours and lifestyle, sexual health, mental health, physical health and longterm conditions, and use of health care services. Our final chapter focuses on inequalities in health, highlighting groups of young people whose health may need extra resources and investment.

Introduction: There are 11.7 million young people aged 10-24 in the UK; one in five of the population. More than 20% is from an ethnic minority. Good health for young people is central to their wellbeing, and forms the bedrock for good health in later life. We need investment into the health of young people during this critical period.

Living circumstances, education and employment: The UK’s young people aged 10-24 experience a range of different living circumstances. Up to 18 the majority are living in families, with increasing numbers of those aged 15-24 now living at home. However, significant numbers of young people are registered homeless or are in the care of the local authority and some are asylum seekers. Overall 15% of secondary school pupils are claiming free school meals. The majority of young people are in some kind of education until they are 18 (71% in England), with 6.5% of the 16-18 age group not in education, employment or training. Beyond 18 the variety of their experiences increases, with two in five continuing into education and others moving into training and employment. The official unemployment rate for 18-24 year olds is decreasing, however there is a concern that young people in employment are disadvantaged more than other age groups by working practices such as zero hour contracts.

Health behaviours and lifestyle: Adolescence and early adulthood is a time when life-long health behaviours are set in place. Physical activity declines across adolescence, one in five school pupils aged 11-15 are obese and teenagers consume on average eight times the recommended daily sugar allowance. Rates of smoking, drinking and drug use in this age group have fallen over recent years. Among 15 year olds, 5% report smoking regularly, 15% of boys and 18% of girls report being drunk in the past 4 weeks, and 11% of boys and girls say they have tried cannabis. Use of smart phones has opened up a new world of swift, flexible communications and access to media, bringing both challenges and opportunities. 15% of 15 years olds reported experiencing cyberbullying in the past two months. One quarter of secondary school pupils say they do not get enough sleep.

Sexual health and identity: In the UK 3.3% of 16-24 year olds identify as gay, lesbian or bisexual although this is likely to be an underestimate. The average age of first heterosexual intercourse is 16. In 2015, rates of conceptions in the under-18 age group were at their lowest level since 1969, but the UK still has a relatively high rate of births among 15-19 year olds compared with other countries. The highest rates of sexually transmitted infections are among those aged 15-24
(particularly chlamydia), and continued testing is vital for this age. The average age when child sexual exploitation concerns are raised is 15-17. Primary care and community contraceptive services are important sources of information for young people aged 15-24, as is good quality sex and relationships education at school.

**Physical health, longterm conditions, disability and mortality**: Although the years 10-24 tend to be a time of good physical health, young people do experience a range physical health problems. Nearly a quarter of 11-15 year olds report that they have a longterm illness or disability and 1 in 10 of 10-24 year olds have a disability that affects their ability to do normal daily activities. Nearly half of 15 year olds have decay in their permanent teeth. Young people aged 16-20 are the group most likely to be diagnosed with asthma and age 11-14 is the peak age for diagnosis of Type 1 diabetes. Overall 2,477 young people aged 10-21 died in 2015. Many deaths are from preventable causes with injuries (including road traffic accidents) being the top cause followed by suicide.

**Wellbeing and mental health**: Three quarters of young people report their life satisfaction as high or very high, however the UK ranks 20th in life satisfaction scores internationally. There has been huge concern over the mental health of young people recently. Half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24. A quarter of women aged 16-24 show symptoms of anxiety or depression. Hospitalisation for self-harm and eating disorders are more common in young women compared to young men, and peak in girls aged 15. Suicide rates have generally fallen since the early 2000s for this age group but the age specific rate for suicide particularly in young men aged 20-24 remains high at 14.9 per 100,000.

**Health promotion and use of health services**: Young people are regular users of healthcare services. Half of year 10 pupils (aged 14-15) report that they have visited the GP in the last three months and a third of young people aged 15-19 will have attended accident and emergency in the past year. There is a particular shortage of CAMHS provision; despite at least 10% of the age group having mental health problems, only 24 in 1000 will be referred to CAMHS. There is a need to invest in age-appropriate health promotion and youth friendly health services in order to improve young people’s health outcomes.

**Inequalities in health outcomes**: Without equal access to resources and support, certain groups of young people are put at a disadvantage and have poorer health outcomes. A quarter of young people aged 11-19 live in households with the lowest incomes. Young people living in the most deprived areas are more likely to be killed or seriously injured on roads, more likely to be obese, and are more likely to have worse physical, mental and sexual health outcomes. Marginalised groups of young people may have poorer health outcomes than their peers, including looked after children, young carers, those from ethnic minorities, those with learning disabilities, young people who identify as LGBT and those who have experienced four or more adverse childhood experiences. Health inequalities can compound amongst these groups of young people making their health outcomes significantly worse, therefore early identification and prevention are key.
CHAPTER 1: Introduction

Definitions

Adolescence 10-19 years
Young people 10-24 years
Youth 15-24 years

One in five of the population is aged 10-24

11.7m young people in the UK aged between 10 and 24

Brain development can continue up to age 25

The effects of poor health care in adolescence can last a lifetime
Introduction

The transition from childhood to adulthood is an important, fascinating period of life. Young people between the ages of 10 and 24 need particular support and special services, particularly those who may be marginalised. They have different patterns of need from younger children or older adults. Yet the data on young people are often bundled up with other age groups. The data are also frequently compartmentalised into topics such as youth justice, obesity, or mental health, which may present information in different ways or relate to different age breakdowns. Drawing connections between the topics can therefore be challenging, yet we need to view young people holistically. This is the only way to get an overview of what they need to reach their full potential and the services that need to be commissioned. *Key Data on Young People* (KDYP) brings together all the robust and representative information we can find to get a full impression of young people in the United Kingdom (UK).

The ‘Key Data on Young People’ series

This is the 11th edition of the biennial publication previously entitled *Key Data on Adolescence*. The first was published in 1997 by the Trust for the Study of Adolescence. That first publication represented a ground breaking attempt to pull together essential descriptive information about the lives and wellbeing of young people in the UK, separated out from the data on younger children or adults. Twenty years have passed since the first edition and there is still an ongoing need for up to date, youth-specific data to inform the development of appropriate services for this age group. And young people’s lives are constantly changing so we try to distil data on the longer term trends as well as the current situation. Partly as a response to differences in how we think about the age group, with growing interest in young people into their early 20s, we have retitled the publication *Key Data on Young People (KDYP)*.

KDYP is a collaborative exercise and all the volumes have involved contributions from a number of organisations. *KDYP* is currently produced by the Association for Young People’s Health (AYPH). This edition was generously funded by the Health Foundation, as part of their inquiry into youth health. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Every new edition of *KDYP* is revised to reflect current interests and concerns about young people’s health. In this edition we have added a chapter on inequalities in health, highlighting groups of young people whose health may need extra resources and investment. This may be for reasons to do with deprivation, but also may arise from the impact of adverse childhood experiences or the overlap between physical and mental health. In this edition there are also new sections on sexual identity, bullying, and learning disability. Where possible we have focused on the relevant drivers in the Public Health Outcomes Framework and the NHS Outcomes Framework (PHE, 2016; Department of Health, 2016).

Why does *Key Data on Young People* go up to age 24?

The data presented in this publication relate primarily to young people in the second decade of their lives, aged between 10 and 20. However, with an increasingly elongated transition into adulthood and the challenge of transitions from children’s services into adult services, and from one stage of education to another, it has been important where possible to extend this range to age 24. It is important to cover the distinct needs of young adults as well as younger adolescents, a point becoming more widely acknowledged (for example, Chief Medical Officer for England, 2012). These age bandings map on to the United Nations General Assembly, Unicef, and World Health Organisation...
There is a growing awareness of the supports needed while making the shift to taking responsibility for personal health care, particularly for those with longterm conditions. Although there remain important challenges in the transition from child services to adult services in healthcare, more and more agencies appreciate that age 18 is not a magic marker for adult status. For example, in 2014 in England, significant legal reform obliged local authorities to support every young person who wanted to stay in foster care until their 21st birthday, extending this up from age 18.

**Developmental milestones age 10-24**

Young people experience huge physical, psychological and behavioural changes as they mature from children to adults. All of the data in the following pages should be viewed through the lens of human development. They all represent a snapshot for a group of people who are constantly changing. Some have support to help them make these transitions with ease – others are subject to social determinants of health that may hinder their progress. The data tell us important things about the experience of young people in the UK today and suggest ways in which we can improve outcomes.

The adolescent years (usually taken to be 10-19) are a particularly fast time of change, including:

- **Physical development.** The three or four years of pubertal development include a growth spurt, maturing of the reproductive organs, development of secondary sex characteristics and menarche in girls. There is wide individual variation in the timing of the start and completion of puberty. Generally, evidence suggests a peak age of puberty in the UK of around 12-13 years for girls, and 13-14 for boys (Patton and Viner, 2007).

- **Cognitive development.** Recent work has revealed that the brain undergoes a huge reorganisation and ‘fine tuning’ in the adolescent years. Changes in anatomy and functioning seem to result in a brain that is more efficient and more adapted to the surrounding environment. During their second decade, young people become better at weighing up risk, learning from experience, moral thinking, political thought and at controlling impulses (Coleman, 2011; Steinberg, 2005). There are important ongoing changes to the ‘social brain’, the part of the brain driving understanding and interacting with others (Blakemore, 2011).

- **Emotional development.** Key tasks of adolescence include firming up a sense of personal identity and self-esteem, developing autonomy and learning coping strategies for dealing with life events and challenges (American Psychological Association, 2002). Young people seek more independence and responsibility. Supporting the development of emotional health and wellbeing is a task for everyone who lives or works with young people.

- **Social development.** Peer groups become of paramount importance and peer influences are powerful, although families remain very significant (Brown and Bakken, 2010). Young people start to develop a sexual identity and to seek more relationships outside the family.

- **Behavioural development.** Brain changes mean that adolescents are more likely than other age groups to seek out novel experiences and take risks. This can present some challenges in terms of taking care of their health, but is an important part of learning. Many life-long health behaviours are set in train during adolescence.
However it does not all stop at age 19. Development on all these fronts continue long into the 20s. The transition to adulthood is more elongated and varied now than in the past (Arnett, 2004). There is evidence from MRI scans that brain development continues up to age 25 (Giedd, 2004). Many major social transitions occur in the early 20s. The average age of leaving home, for example, falls at around 24 years. Through their late teens and early 20s young people renegotiate their relationships with their parents and caregivers, build their peer network, and find ways to become financially self-supporting.

Population of young people in the UK

Young people form a significant proportion of the population. Chart 1.1 shows that of the UK population in 2016, 7.4 million were 10-19 year olds, and 11.7 million were 10-24 year olds. There were slightly more aged 20-24 and 15-19 than aged 10-14.

Chart 1.1: Usual resident population in the UK, by five-year age groups, 2016

As Chart 1.2 illustrates, young people aged 10-19 years old represent 12% of the total population of the UK, the same as the proportion aged 0-9. If we include those up to age 24, those aged 10-24 account for 19% of the population. We hear a lot about the increasing numbers of elderly people in the UK but the proportion of over-70s is also 12% – the same as 10-19s, and considerably smaller than the 19% for 10-24 year olds.

Chart 1.3 presents the recent historical trend in population of England and Wales, plotting the 2005 population figures against the current population pyramid from the 2015 population estimates. Adolescents may represent a falling proportion of the whole population because of extended longevity in older groups. But it is important to note there are still as many young people in absolute numbers as there were 10 years ago and there will be similar numbers in the next 10 years. In fact the numbers of 0-4 and 5-9 year olds have expanded in recent years, and will push through into adolescent services in the next ten years. This has clear implications for service delivery needs.
Chart 1.2: Proportion of population accounted for by different age groups in the UK, 2016


Chart 1.3 also shows the population distribution separately by gender. In the 10-19 age group there are 95 girls for every 100 boys. By the time the population is aged 70 and above, this has shifted to 122 women for every 100 men.

In the population as a whole there are more young people from ethnic minority groups than older people from these groups. Overall, the proportion of the population of England and Wales who classified themselves in a group other than white British is 19.5% (Office for National Statistics, 2012). These data have not been updated since the 2011 census.

Chart 1.4 shows the ethnic group of all those aged 10-19 in England and Wales, again from the 2011 census. Overall the proportion of this age group who classified themselves as not being white British was 21.5%. Younger people are more likely to come from ethnic minorities than older people.

Chart 1.4: Ethnic group of those aged 10-19 years in England and Wales, 2011

Source: Office for National Statistics, census data 2011  DOWNLOAD DATA
Reasons for investing in young people’s health

Health is important at all ages, but we need a strong voice for young people’s health to ensure that adequate resources go to adolescence and young adulthood. Good health for young people is central to their wellbeing, and forms the bedrock for good health in later life. The box presents a number of critical reasons for investing in young people’s health including:

- The first signs of many serious long-term conditions emerge at this age, including three quarters of lifetime psychiatric disorders
- Adolescence is a time when risk taking behaviours begin and life-long health behaviours are set in place
- Adolescent health is not improving enough compared to other age groups
- Ignoring chronic adolescent disease costs money for many years into the future
- Young people say they are not getting the health services or information they require, and their accounts are often less positive than those of other age groups
- The effects of poor healthcare in adolescence can last a lifetime so it is critical to get it right at this time
- Investing in adolescent wellbeing has benefits that extend well beyond health into many other aspects of life

Source: Association for Young People’s Health (2017)
Overview of data sources

There is a wealth of data about young people from decades of research around the world. The countries of the UK have undertaken repeated national surveys such as the census, the Health Survey for England, the Labour Force Survey, and the Annual Population Survey. But there are fewer large scale data sets that tell us about adolescent experiences across all of the UK’s constituent countries.

The main sources we rely on have had to meet some quality criteria. They need to draw on a significant sample size, result in generalised results to a known population, use reliable and valid survey instruments, and they need to adhere to the standards of ethical research methods. Where there are gaps in published data we have occasionally drawn on research undertaken with smaller sample sizes or in limited geographical areas. The text makes clear the sources in all cases and we say if we have reservations about generalising from data.

Unfortunately, despite efforts to fill the gaps, the data on many aspects of young people’s health are inadequate. Statistics are frequently recorded in ways that make it impossible to draw sensible conclusions by, for example, reporting data on those between the ages of 0-19 years, or from 16-59 years. Once again we wish to express our concern over this limitation and to emphasise that good commissioning depends on the availability of data relevant to the age group.

Supporting resources

An interactive version of this PDF is available for free download from AYPH’s website, where users will find hyperlinks to all key documents, and the facility to download Excel spreadsheets containing the original data on which the charts are based. A PowerPoint slide set of all the charts in the report is also available for download and use in your own presentations.

The AYPH website also has links to a number of resources to help in promoting young people’s health, including toolkits for frontline practitioners, briefing papers, support for engaging young people and promoting their participation in designing youth-friendly services, and much more (www.youngpeopleshealth.org.uk/resources).
References


CHAPTER 2:
Living circumstances, education and employment

70% of 10-19 year olds live with married or cohabiting parents

By age 25, 25% of young women and 35% of young men are still living at home

1,032,520 young people aged 11-19 in the UK live in families receiving means tested child-related income supplements

71.1% of 16-18 year olds were in full time education in England 2015/2016

41% of English 17-20 year olds were in higher education in England 2014/15

6.5% of 16-18 year olds were not in education, training or employment (NEET) in England 2015

52% of students at schools in England achieved 5+ GCSEs grades A*-C in 2016

33% of people on zero hours contracts are aged 16-24
Living circumstances, education and employment

The UK’s young people aged 10-24 experience a range of different living circumstances. Up to age 18 the majority are living in families and are engaged in some kind of education, but this does not apply to everyone of this age, and some are in different situations. Beyond 18 the variety of their experiences increases, with some continuing in education, and others moving into training and employment, with a significant proportion spending some time unemployed.

Family situation and living circumstances

There are approximately 27 million households in the UK, of which nearly five million (19%) contain at least one person aged 10-19 (Office for National Statistics, 2017). Indeed the majority of young people of this age are living in families. Chart 2.1 shows that in 2016 the majority (60%) of 10-19 year olds were living with their married parents. An additional 10% were living with cohabiting parents, and 23% were with lone parents. However, 7% live in other situations, including halls of residence (3%) or in their own newly constructed families (1.5% cohabiting or married and 0.5% are lone parents themselves). The remaining 2% labelled ‘none of these’ were living in local authority care, hospitals, prisons, or as lodgers, in house shares or with other family members such as siblings or cousins.

Chart 2.1: Living circumstances of young people in the UK aged 10-19, 2016

Source: Office for National Statistics, 2016 Labour Force Survey (LFS)  DOWNLOAD DATA
Increasing proportions of young people continue to live at home with their families into their early 20s. **Chart 2.2** shows that the numbers of young people aged 15-34 living at home has risen by approximately 800,000 since 1996 (39% of the age group), and by 600,000 for those age 20-34 (25% of the age group). Overall, young men are more likely still to be at home at any age. By age 25, 25% of young women and 35% of young men are still at home (Office for National Statistics, Labour Force Survey, 2016).

**Chart 2.2:** Proportion of young people aged 15-34 and 20-24 living at home with their parents, UK, 1996-2016

Although children and young adults are staying longer in the family home, these homes are more likely to be headed by lone parents than in the 1980s. However, as **Chart 2.3** shows, the proportion of young people living with lone parents is no higher now than it was in 2000. Overall, one in five young people is living with a lone parent. The majority of these are lone mothers.

**Chart 2.3:** Proportion of children living in couple or lone parent families, UK, 1981-2016


DOWNLOAD DATA
Some lone families will be the result of divorce. A significant number of young people experience their parents getting divorced although this has been lower over the last five years than it was previously. The trends are shown in Chart 2.4, demonstrating that approximately 11,000 fewer teenagers experienced divorce in 2014 compared to 2005. In 2014 a total of 38,313 young people aged 11-15 had parents who divorced that year. Alongside the trends for marriage and divorce, it is important to note that the numbers of cohabiting couples continues to rise, and there are no data on how many young people experience the separation of cohabiting parents.

![Chart 2.4: Children aged 11-15 whose parents divorced in England and Wales, 1990-2014](image)

Source: Office for National Statistics (2014 and previous releases), Divorces in England and Wales

Significant numbers of young people are also registered homeless. The UK government reported that there were 75,740 households in temporary accommodation in England at the end of December 2016, which is a 10% increase when compared to the same time in 2015. Of these 60,240 included dependent children and/or a pregnant woman. The majority of these households with dependent children were in self-contained premises. Of 5,990 households in bed and breakfast accommodation, 45% of these had dependent children or were pregnant (Department for Communities and Local Government, 2016). Figures for Scotland show that, on 30th September 2016, 3,174 households with children or pregnant women, were living in temporary accommodation, representing a total of 30% of all households in temporary accommodation (Scottish Government, 2017). Data are not available on the age of these children.

Chart 2.5 shows that the official statistics on the numbers of 16-24 year olds who were homeless has decreased since 2005. In total 12,930 households were accepted as homeless in 2016/17 where the main applicant was aged 16-24 (DCLG, 2017). However this is likely to be an underestimate, as there are significant numbers who stay temporarily with friends or sleep rough. There is evidence that more young people are approaching voluntary sector homelessness organisations for help with 68% of homelessness providers reporting an increase in young people seeking support (Homeless Link, 2015).
In some cases responsibility for young people is taken from families, and given instead to the local authority. Reasons for being looked after most commonly include neglect or other kinds of abuse, family dysfunction, acute family stress, parental illness or disability, and absent parenting. Chart 2.6 shows the numbers of looked after children in England, Scotland, Wales and Northern Ireland on 31 March 2016. The figures for looked after children are based on a snapshot over a census week and do not reflect the numbers in care during an entire year.

Chart 2.6: Total looked after children in England, Scotland, Wales and Northern Ireland on 31 March 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>70440</td>
</tr>
<tr>
<td>Scotland</td>
<td>15317</td>
</tr>
<tr>
<td>Wales</td>
<td>5660</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>2890</td>
</tr>
</tbody>
</table>


A significant proportion of looked after children (LAC) are teenagers and the proportion of older children in care has risen over the past four years. In England in 2016, 27,220 young people aged 10-15 and 16,460 young people aged 16 and over were in the looked after category at the time of the census. Overall 62% of looked after children are aged 10 or above in England (Department of Health, 2016).
There had been a steady rise in the numbers of looked after children in the 1990s, but as the figures in Chart 2.7 reflect, the numbers of 10-15 year olds have remained fairly constant through the 2000s, with increases in those aged 16 and over.

Chart 2.8 shows that the majority (75%) of looked after children are from white British backgrounds, but there are also many from other ethnic groups.

Source: Department of Health (2016) Children looked after in England (including adoption and care leavers) year ending 31 March 2016 and earlier releases
DOWNLOAD DATA
Asylum seekers are another group potentially made vulnerable by their living circumstances. **Chart 2.9** illustrates the rise in unaccompanied asylum seeking children up to age 18 in England between 2012 and 2016, showing nearly a 100% rise over this time. In 2016 unaccompanied asylum seeking minors represented 6% of the total looked after child population in England.

**Chart 2.9: Unaccompanied asylum seeking children (up to 18 years) in England, 2012–2016**

The majority of asylum seeking children are young men aged 16-17, as **Chart 2.10** demonstrates. In 2015 there were 1,813 young men and 209 young women of this age seeking asylum.

**Chart 2.10: Unaccompanied asylum seeking children under 18, applications received by age and gender, UK, 2015**

As well as those looked after children who are in local authority secure children’s homes, adolescents and young adults can also be resident in the criminal justice system. The number of children accommodated in secure children’s homes was 203 in England and Wales on 31 March 2017, which has decreased from 210 during the previous year (Department for Education, 2017a). Chart 2.11 illustrates that the numbers in youth custody (11-18 years) in England and Wales rose in the early 2000s but have recently been at the lowest levels since 2000, with 909 young people in custody in April 2017. Of these, 39 were aged 10 to 14 years of age. Again this is a snapshot of the situation during one month. As the average custodial sentence served by young people is much less than one year, many more young people will pass through custody over the course of a year. Many are very vulnerable; there were 12 deaths all due to self-harm among young people aged 18-24 in prisons and youth offender institutions in 2016 in England and Wales (Inquest, 2017). However, the general trend for falling custody numbers for this age group is to be welcomed.

Chart 2.11: Secure estate custody population (under 18) in England and Wales, April 2000-April 2017


Family income

Definitions of child poverty

- Combined Low Income and Material Deprivation: Children who live in households where the income is less than 70% of the current median income and where there is lack of basic goods and services to live in the UK

- Severe Low Income and Material Deprivation: Children living in households where the income is less than 50% of the current median income and who are also experiencing material deprivation

Department for Work and Pensions
The root causes of health inequality are bound up with economic factors such as low income. **Chart 2.12** shows that, according to the Department for Work and Pension’s measure of income inequality, 12% of those aged 0-19 years in the UK in 2015/16 were living in households classified as low income and materially deprived. This measure reflects a lack of resources to meet daily needs. Within this group, 4% were living in an even more constrained situation of severe low income and material deprivation, where household income had dropped below 50% of median income. The proportion in low income households has not changed substantially in recent years.

**Chart 2.12**: Children and young people (0-19) falling below thresholds of low income and material deprivation in the UK, 2010/11 to 2015/16.

![Graph showing percentage of children and young people falling below thresholds of low income and material deprivation from 2010-11 to 2015-16.]


**Chart 2.13**, shows the numbers of young people aged 11-19 in families receiving means tested child-related income supplements in England, Wales, Scotland and Northern Ireland. In total there were 1,032,520 young people of this age living in families whose income was being supplemented by the state.

**Chart 2.13**: Young people aged 11-19 in families in receipt of child tax credit (<60% median income), income support or job seeker’s allowance, England, Wales, Scotland and Northern Ireland.

<table>
<thead>
<tr>
<th>Country</th>
<th>11-15 years</th>
<th>16-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>554,345</td>
<td>312,700</td>
</tr>
<tr>
<td>Scotland</td>
<td>34,345</td>
<td>19,570</td>
</tr>
<tr>
<td>Wales</td>
<td>46,415</td>
<td>21,355</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>26,110</td>
<td>17,680</td>
</tr>
</tbody>
</table>

**TOTAL 1,032,520**

Another measure of income inequality is provided by receipt of free school meals. Overall, 15.2% of school children are eligible and claiming free school meals. Chart 2.14 compares the rates for different kinds of educational provision. The highest rates are found in pupil referral units, where the rate is 41.6%. The average for state funded secondary schools is 13.9%.

Chart 2.14: School pupils in England claiming free school meals 2015

Education and training

There are links between higher levels of educational achievement and better health outcomes. There are also elements in the education system that could contribute to poor emotional health, such as examination pressures, and schools are an important site for health education. There have been rapid changes in the UK’s education systems in recent years. In England, for example, this has included the growth of the academy programme, the introduction of ‘free schools’, the extension of the age for compulsory participation in education or training to 18 years, and a raft of changes to the educational qualifications themselves.

Almost all young people start on a programme of study at 14-16 (sometimes referred to as Key Stage 4) that is expected to lead to qualifications. For the majority of those in England, Wales and Northern Ireland, these will be from the General Certificate of Secondary Education (GCSE) series. In Scotland pupils sit ‘Standard grade’ or ‘Intermediate’ exams at the age of 15-16, as part of the Scottish Credit and Qualifications Framework (SCQF). This covers eight subjects including English and maths, a language and sciences.

In 2016, 52% of students at schools in England achieved 5+ GCSEs grades A*-C at GCSE including England and maths.
This is the last year that these results will be shown in this format. A new secondary school accountability system with different overall summary measures ('headline' measures) was implemented in England and Wales in 2016. In addition, from 2017 the GCSE grading system changed. The new GCSEs are graded 9–1, rather than A*–G, with Grade 9 the highest grade, set above the current A*. The new system is intended to help provide more differentiation, especially among higher achieving students. By 2019, all GCSE results will be using the new system.

A key new summary measure has been introduced called ‘Attainment 8’, which reports the average achievement of pupils in up to eight qualifications including English, maths, and further options from a specified list. In 2016 the Attainment 8 score for all schools in England was 48.2%. As in previous years, girls continue to do better for boys, with 52.1% of girls achieving an average Attainment 8 score, compared with 47.5% of boys (Department for Education, 2017b).

Chart 2.15 shows the proportion of young people achieving 5 GCSEs graded A*-C under the old system, separately by ethnic group. Achievement varies significantly by ethnic group. On average, the lowest levels of GCSE attainment are for young people from Black Caribbean and Pakistani groups. The highest levels are for those from Indian and Chinese groups.

Chart 2.15: Pupils in England achieving five or more GCSEs (including English and maths) at grades A*-C, by ethnic group, 2015/16

Source: Department for Education (2017b) Revised GCSE and equivalent results in England 2016

Note: 'Attainment 8' = pupil average attainment in up to 8 qualifications including English and maths
The examination achievement of children looked after by the local authority has long been a cause for concern, and once again the latest figures are not encouraging, although they are a slight improvement on 2014. Chart 2.16 shows that only 13.8% of children in Year 11 who had been continuously looked after by the local authority for 12 months or more achieved five good GCSEs, compared with 57.4% of their classmates.

Chart 2.16: GCSE (5+ A*-C including English and maths) achievements of looked after children in England, 2008-2016

Source: Department for Education (2017b) Revised GCSE and equivalent results including pupil characteristics in England 2015 to 2016, SFR 03-2017 DOWNLOAD DATA

Definition of a Disadvantaged Child
Pupils are defined as disadvantaged if they are known to have been eligible for free school meals in the past six years (from Year 6 to Year 11), if they are recorded as having been looked after for at least one day or if they are recorded as having been adopted from care.

GCSE achievements are also reported for disadvantaged children (see box for definition). In 2016, 27.7% of pupils at the end of Key Stage 4 (age 14-16) were classified as disadvantaged. Their attainment is lower than for all other pupils across the new ‘headline’ measures. Chart 2.17 compares achievement for five GCSEs including English and maths, and for the English Baccalaureate. The English Baccalaureate allows people to measure how many pupils obtain a C grade and above at Key Stage 4 level, in five core subjects that include maths, English, history or geography, the sciences and a language.

Being excluded from school clearly impacts on educational attainment and acts as a marker for a range of problems. Over the years, successive governments have made strenuous attempts to keep down the numbers permanently excluded. Chart 2.18 shows the trends since 2000/1, reflecting a slight rise to the middle of the 2000s and then a fall. However the latest available figures from 2014/15 show a slight rise again. It is too early to tell if this is a trend. The most common age for exclusion is age 14, and many more boys than girls are excluded across the whole of secondary school (Department for Education, 2016).
After formal examinations at age 16, there is now a legal requirement on young people in England and Wales to continue with some kind of education or training until they are 18. In Scotland the school leaving age remains at 16. A number of choices are open to 16 year olds in the UK at this age, depending on their examination achievements. The majority remain in full time education, usually pursuing academic qualifications, but others move into flexible pathways including various combinations of education, training and employment.

![Chart 2.17: Comparison of A*-C in 5 GCSEs including English and maths between disadvantaged children and all other pupils 2015/2016](source: Department for Education (2017) Revised GCSE and equivalent results including pupil characteristics in England 2015 to 2016, SFR 03-2017)

![Chart 2.18: Permanent exclusions from secondary schools in England, 2000/1 to 2014/15](source: Department for Education (2016) Permanent and fixed period exclusions by type of school state-funded primary, state-funded secondary and special schools SFR26,2016)
Chart 2.19 shows the time trends for participation in education and training at age 17 in England, from 1994 until 2015, demonstrating the social change that has impacted on this age group in particular. The proportion in full time education has risen in particular.

Overall, for 16-18 year olds in England, only 6.9% were in employment in 2016 (Department for Education, 2017c).
Scottish statistics show where their school leavers (16-18) are a year after leaving. By March 2017, 91.4% of Scottish school leavers from 2015/16 were in a positive follow-up destination, consisting of education, employment or training. Two thirds of young people were staying until the year they turned 18 (Scottish Government Education Statistics, 2017).

After age 18, nearly half of this age group now go on to higher education, particularly to study a degree at university.

Chart 2.20 shows that participation of domiciled students in the UK in higher education institutions (largely universities) has increased in 2015/2016 to 1.8 million when compared to 1.3 million two years ago in 2012/2013. However the participation number is lower when compared with 2011/2012.

Chart 2.20: UK domiciled students in UK Higher Education Institutions 1996/7 to 2015/16

Source: Department for Education (2017c) Higher education student enrolments and qualifications obtained at higher education providers in the United Kingdom 2015/16

DOWNLOAD DATA
Clearly not everyone goes on to further education or training. Evidence from Eurostat makes it possible to compare rates of early leavers from education and training across the European Union. **Chart 2.21** shows that the UK has the third highest percentage (11.2%) of early leavers aged 18-24 from education and training in the EU, who have at most lower secondary education.

![Chart 2.21: Early leavers from education and training in the EU: % population 18-24 years with, at most, lower secondary education and not in further education or training, 2016](http://ec.europa.eu/eurostat/statistics-explained/index.php/Early_leavers_from_education_and_training)

**Youth employment**

For those young people who are in employment, there is a concern that they are disadvantaged by working practices such as zero hour contracts. Young people on zero hour contracts receive a lower weekly pay compared to those who are not and work fewer hours on average. The prevalence of such contracts is higher among young people than any other age groups, with 33% of 16-25 year olds in employment with such contracts compared to 20% of those aged 25-34 (Department for Work and Pensions, 2017).

![Zero hours contracts](http://ec.europa.eu/eurostat/statistics-explained/index.php/Early_leavers_from_education_and_training)
Chart 2.22 portrays the percentage of 16-18 year olds who are not in education, employment or training (NEET) in the UK. The rate of NEET 16-18 year olds has slowly been decreasing since 2009 in the UK and stood at 6.5% in 2015.


![Chart 2.22: Percentage of 16-18 year olds not in education, training or employment (NEET) in England, 1995-2015](chart2_22.png)


Chart 2.23 also demonstrates that the unemployment rate amongst 18-24 year olds in the UK has been decreasing. Data from April-June 2016 show an unemployment rate of 9.6% down from 12.1% at the same time in 2015.


![Chart 2.23: Unemployment rate for young people aged 18-24 in the UK 1992-2016](chart2_23.png)

Source: Office for National Statistics, UK Labour Market 2016
Eurostat enables us to compare youth unemployment amongst 15-24 year olds across the EU. **Chart 2.24** shows that the UK has the fifth lowest unemployment rate amongst 15-24 year olds in Europe, with a rate of 14.2% in this age group.

**Chart 2.24**: Percentage of young people age 15-24 unemployed, OECD comparisons, 2015

Source: https://data.oecd.org/youthinac/youth-not-in-employment-education-or-training-neet.htm DOWNLOAD DATA
References


CHAPTER 3: Health behaviours and lifestyle

- A quarter of secondary school children report they do not get enough sleep.
- 15% of 15 year olds have experienced cyberbullying in the past 2 months.
- 15 year olds reporting illegal drug use in the previous year halved between 2001 and 2014.
- 5% of 15 year olds say they are regular smokers.
- 9% of pupils aged 11-15 say they have drunk alcohol in the last week, the lowest rate since the 1980s.
- 15% of 15 year olds have experienced cyberbullying in the past 2 months.
- 5% of 15 year olds say they are regular smokers.
- 95% of smokers start by age 25.
- 6% of 16-24 year olds say they are current e-cigarette users.

One in five 11-15 year olds are obese in England.

On average, teenagers consume 8 times the recommended daily sugar allowance.

A quarter of secondary school children report they do not get enough sleep.

By age 13-15, only 19% of boys and 7% of girls achieve one hour of exercise a day.

95% of smokers start by age 25.
6% of 16-24 year olds say they are current e-cigarette users.

One in five 11-15 year olds are obese in England.

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Health behaviours and lifestyle

Promoting healthy lifestyles is very important in adolescence and early adulthood. This is a time when life-long health behaviours are set in place. Health behaviours can directly affect health outcomes. In the long term these may include cancer, heart disease and Type 2 diabetes. Prevention and early intervention are not just relevant for young children; they are equally possible in adolescence (Hagell and Rigby, 2015). Understanding patterns of youth health behaviour informs health promotion and commissioning and can prevent long term difficulties from arising or escalating. In this chapter we focus on physical activity, nutrition and obesity, smoking, drinking and drug use, accidents, media and communication activities, and sleep. Sexual health is also critically important and this is the subject of the next chapter.

Physical activity

Young people’s physical activity levels are critical to their overall health (Department of Health, 2011a). Current UK guidelines for children and young people recommend at least one hour of moderate to vigorous physical activity every day (Department of Health, 2011b).

Data from the 2015 Health Survey for England in Chart 3.1 suggest that the proportion of young people aged 11-12 who achieved one hour of exercise a day was 20% for boys and 12% for girls. By the ages of 13-15, the rates were 19% for boys and 7% for girls. These levels were higher than for those age 8-10, who are included for comparison. For boys there was an increase; for girls there was a more complicated pattern with more exercise in 2015 by younger ages and less by older. It is difficult to interpret the trend from 2012 to 2015. The Health Behaviour in School-aged Children also shows physical activity declining across adolescence and the much lower levels of activity for young women (Brooks et al, 2015).


Chart 3.2 presents data on different kinds of physical activity (walking, informal sport and formal sport), again from the Health Survey for England for girls and boys in 2015. This shows that while rates of walking and informal activity are broadly comparable for boys and girls, girls have lower rates of formal physical activity, particularly among the older age group. However, rates of participation are much higher in this chart than in the previous one. It may be that many young people are participating in these activities to some extent, but not to the level of one hour per day as required by the guidelines. Levels of walking remain fairly constant from age 8-15, but rates of formal and informal sport decline with age, most noticeably in girls.

Chart 3.2: Participation in different physical activities by age and gender, England, 2015

The walking that young people undertake is usually generated by the journey to school or college. Drawing on data from the Department for Transport’s National Travel Survey, Chart 3.3 shows that 37% of trips to school in England by young people aged 11-16 are made on foot, with bus and car transport making up most of the remainder. Only a very small proportion travel to school by rail (2%) or on bicycles (2%). The survey also notes that the proportion walking was 45% back in 2002, suggesting a reduction of 16% in the last 15 years (Department for Transport, 2016).
Public transport and walking clearly have a big role to play in daily physical activity for this age group. As they get older, driving themselves plays only a small role, unlike in countries such as the USA. Young people can take a driving test at age 17 years. As Chart 3.4 shows, approximately a third of 17-20 year olds held a licence in 2015. The rates for young men and women are equal.
**Nutrition and obesity**

Adolescent nutrition is an area of increasing concern, partly but not only because of the relationship to obesity. As they get older and begin to move to more independence from their families, young people have more control over what they consume. Again, habits of a lifetime can be formed at this stage and poor nutrition has many implications for both current and future health status. Improving diet is a key indicator in the Public Health Outcomes Framework 2016-2019 (Department of Health, 2016).

Consumption of five portions a day of fruit and vegetables has become a marker for good diet. As we can see in Chart 3.5, average daily consumption of ‘five a day’ for males and females aged 11-18 years was reported to be 2.8 portions per day in the UK-wide National Diet and Nutrition Survey (averaged across surveys from 2012/13 and 2013/14). Adults ate an average of four portions.

**Chart 3.5: Average daily consumption of ‘five a day’ fruit and vegetable portions by age and gender, UK, 2012/13 and 2013/14 combined**

The most recent National Diet and Nutrition Survey also reported that only one in 12 young people aged 11-18 ate five portions of fruit and vegetables every day.

The National Diet and Nutrition Survey used dietary diaries and other methods to estimate the proportion of young people aged 11-18 years with low levels of daily intake of various minerals. As a baseline, the survey uses the Lower Reference Nutrient Intake, which is a level of intake likely to be sufficient to meet the health needs of 2.5% of the population, so it is a conservative measure of adequate intake.
**Chart 3.6** shows that worryingly high proportions of young men and young women do not appear to be consuming enough minerals. This is particularly the case for young women, of whom nearly half are estimated to be deficient in iron, selenium (an essential trace mineral) and magnesium intake. These estimates are indicative only, as the data are difficult to collect. However, they do alert us to the need to consider adolescent nutrition as a whole and they raise a particular concern about the nutrition of young women.

A tax on sugar filled soft drinks has been announced in England and is scheduled to take effect in April 2018. In the meantime, the UK National Diet and Nutrition Survey ([Chart 3.7](#)) shows the extent to which 11-18 year olds in particular currently exceed the daily recommended limits for sugar consumption (30 grams). Although there has been a reduction in sugar consumption in recent years, the data indicate the need for further youth-friendly interventions to reduce sugar consumptions for this particular age group. In the 2015 Health Behaviour in School-aged Children survey, one in eight young people in England aged 11-15 (13%) reported daily consumption of sugary carbonated drinks, and 7% were consuming energy drinks at least five times a week (Brooks et al, 2015).

One of the consequences of poor nutrition is, of course, obesity. Reducing excess weight in 4-5 year olds, 10-11 year olds and adults are health improvement indicators in the English Public Health Outcomes Framework (Department of Health, 2016). Obesity is one of Public Health England’s priorities for 2016-17 (Public Health England, 2017). [Chart 3.8](#) provides an overview of trends in obesity prevalence in 11-15 year olds since 1995, drawing on data from the Health Survey for England. According to these data, obesity peaked in 2004 at 24.3% for boys, and 26.7% for girls. By 2015 the respective rates were 18.9% and 15%. This measurement of obesity is based on the UK national BMI percentiles classification. BMI measurements that fall into or above the 95th percentile of the 1990 reference population are classified as obese. This is the recommended method for calculating obesity in children, rather than using cut offs. Overall, obesity levels in England for this age group have levelled out in recent years, but the trends are not very clear.
Separate estimates for obesity in England at age 10-11 (Year 6 of school) are provided by the National Child Measurement Programme (NCMP). The latest data from the programme showed that one in five children age 10-11 years (19.8%) were obese (NHS Digital, 2016); similar rates to those found in the Health Survey for England. Chart 8.2 in Chapter 8 presents obesity by deprivation, using the NCMP measurements; this showed that obesity rates in the most deprived decile were 26% compared with 12% in the least deprived decile (NHS Digital, 2016). An overall levelling out of obesity trends for this age group as a whole should not mask the fact that obesity for deprived groups is much worse (see Chapter 8).
Estimates of obesity in children for Wales and Scotland are available from their own health surveys, including the Scottish Health Survey and the Public Health Wales Measurement Programme. The latest Scottish Health Survey 2015 reported that 15% of young people aged 12-15 were obese (Scottish Government, 2016). The Welsh child measurement programme only includes children aged 4-5 years and comparable data for older children are not available. However, the Welsh report from the Health Behaviour of School-aged Children survey in 2015 concluded that 18% of children aged 11-16 were obese (Ipsos MORI 2015). In Northern Ireland, government statistics on childhood obesity are only given for all children aged 2-15 collectively, again reducing comparability. Estimates across the countries of the UK for children at secondary school thus range from 15-20%, but direct comparisons are not possible because of the variation in the age group covered in the measurements. There are also differences in how the estimates are calculated in surveys which may also contribute to variation in estimates (for example, by self-report in the HBSC or direct measurement in others).

Obesity is the extreme end of the weight distribution; there is also a group of young people who are overweight but not obese, as Chart 3.9 demonstrates. Once again obesity is a BMI that falls at or above the 95th percentile of the distribution and overweight is a BMI falling at or above the 85th percentile. Using combined data from 2008-2015, and including both those who are overweight and those who are obese, 33% of boys and 32% of girls aged 11-12, 29% of girls and 35% of boys aged 13-15 met this criteria. This is a substantial proportion of the adolescent population and is a continuing cause for concern.

The English Hospital Episode Statistics (HES data) provide information on incidents of inpatient care under a consultant, where the primary or secondary diagnosis was obesity. Chart 3.10 shows a substantial increase in the recorded number of these kinds of admissions between 2004 and 2015. However, HES data only reflect the information that has been sent in, and the coverage of HES data has improved over time, so more hospitals will now be returning the information, and the quality of the information has improved. Thus the increased rate may reflect these factors, rather than an increase in prevalence.
CHAPTER 3: Health behaviours and lifestyle

Chart 3.10: Finished hospital admission episodes with a primary or secondary diagnosis of obesity, young people age 16-24, England, 2004/5 to 2014/15

Hospital admissions specifically for bariatric surgery provide another index of trends and severity of obesity in this age group. Chart 3.11 shows these admissions for young people aged 10-24 in England over the last 10 years. The absolute numbers are small – never more than 225 in any one year, but still the rise in these figures is very concerning. Again, this may in part reflect improvement in the HES data coverage. In addition, recent research suggests many more teenagers may be eligible for surgery than receive it (Viner et al, 2017).

Chart 3.11: Finished consultant episodes with a primary diagnosis of obesity and a main or secondary procedure of bariatric surgery by age in England, 2004/05 to 2014/15
Smoking, drinking and drug use

Smoking causes one in six of all deaths (NHS Digital, 2017). It is the primary cause of preventable illness and premature death. Concern about levels of smoking among young people arises from awareness about the longer term outcomes such as cancer, but also the shorter term negative effects such as respiratory illness and impact on physical fitness. The regular Smoking, Drinking and Drug Use Surveys in England (SDDU) have shown that approximately one in five young people try smoking at some point (HSCIC 2015a). Regular smoking is less common. There are several other surveys that also provide estimates of regular smoking in secondary school aged children, and they arrive at similar estimates. In the 2014 ‘What about YOUth’ (WAY) survey, 5% of 15 year olds said they were regular smokers. In the latest round of the Health Behaviour in School-aged Children in 2015 (HBSC) in England, 6% of boys and 8% of girls aged 11-15 reported being regular smokers (Brooks et al, 2015).

Data from adult surveys suggest that two out of three smokers will have started by age 18, and 95% by age 25 (HSCIC, 2015b).

Different smoking measures are presented in the Welsh and Scottish HBSC reports, so it is difficult to compare. In Wales, 4% of young people aged 11-15 smoked once in the last week, rising to 9% of 15 year olds (Ipsos MORI, 2015). In Scotland, 6% of 11-15 year olds reported that they currently smoked, rising to 14% of 15 year olds (Currie et al, 2015). However current smoking is potentially a different measure from weekly smoking.

Drawing on the 2014 SDDU data, Chart 3.12 portrays a positive picture of the longterm trends for smoking behaviour in England, a pattern mirrored elsewhere. The proportion who reported regular smoking in 2014 (3% overall for all pupils 11-15) were the lowest since the mid 1990s.

![Chart 3.12: Proportion of 11-15 year olds who were regular smokers, by gender, England, 1982-2014](source)
introduction of a smoking ban in public places came into force in England in July 2007 and may have had some impact on the figures, although there was no noticeable acceleration in the downward trend at the time.

These downward trends are also apparent in the older age groups from 16-24 years, demonstrated in Chart 3.13. The gender patterns in these older age groups are not consistent; sometimes more young women smoke, sometimes more young men, but the overall direction of travel is positive. However, there is no room for complacency. The fact that a quarter of those aged 16-24 are regular smokers is still a serious concern.


Finally, robust, nationally representative data on use of e-cigarettes are only just emerging. Regular surveys by Action on Smoking and Health (ASH) have shown that awareness of and experimentation with electronic cigarettes has increased in recent years. In 2016, 12% of 11-18 year olds said that they had tried e-cigarettes once, which in fact had not risen since 2015. Regular use (once a month or more) was rare. Only 1% of 11-18 years used electronic cigarettes on a weekly basis (ASH, 2016). Most use is among those who smoke or have previously smoked. In 2016, 10% of those in the ASH survey using an e-cigarette had done so before they had first tried smoking tobacco cigarettes.

Source: Health and Social Care Information Centre (2015) Health Survey for England
Download Data

12% of 11-18 year olds have tried e-cigarettes

Source: ASH survey 2016
Chart 3.14 presents a chart from ASH’s latest briefing on e-cigarette use among this age group, comparing the rates of e-cigarette use in the main health surveys for this age group. Rates vary by survey, but regular use is rare. However, as a new technology with unknown consequences, this is an area to keep under scrutiny.

<table>
<thead>
<tr>
<th>Source</th>
<th>Ever tried</th>
<th>Use less than once a week</th>
<th>Use more than once a week</th>
<th>Use (at least monthly) in never smokers</th>
<th>Regular smokers who had tried e-cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH Smokefree GB youth survey (11-18) (2016-March)</td>
<td>12.00%</td>
<td>0.70%</td>
<td>0.90%</td>
<td>0.30%</td>
<td>70%</td>
</tr>
<tr>
<td>Health Behaviour in School-Aged Children, Wales (11-16) (Nov 2013-Feb 2014)</td>
<td>12.30%</td>
<td>1.5% (use at least monthly)</td>
<td>0.30%</td>
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<tr>
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<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>SALSUS Scotland survey (15 and 13 year olds) 2015</td>
<td>23.57%</td>
<td>1.53%</td>
<td>2.33%</td>
<td>0.52%</td>
<td>90.19%</td>
</tr>
<tr>
<td>The Smoking, Drinking and Drug Use survey (11-15 year olds) 2014</td>
<td>22%</td>
<td>3%</td>
<td>1%</td>
<td>Not reported</td>
<td>89%</td>
</tr>
<tr>
<td>What about YOUth Survey (15 year olds) 2014</td>
<td>18%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>84%</td>
</tr>
</tbody>
</table>


The Office for National Statistics 2016 Opinions and Lifestyle Survey asked about e-cigarette use in Great Britain among 16-24 year olds. Chart 3.15 shows that significant proportions had tried them (34% of young men and 25% of young women), but again much smaller proportions were current users (9% and 3% respectively).

Adolescent alcohol consumption patterns have been a concern for many years and recent data are encouraging. The ‘Smoking, Drinking and Drug Use’ surveys of 11-15 year olds in England have regularly shown that the proportions of young people who drink alcohol have been falling. By 2015, 64% of those aged 11-15 said they have never drunk alcohol. Under one in ten (8%) reported that they have drunk alcohol in the last week, the lowest rate since the SDDU survey began in 1988 (HSCIC, 2015a).
Estimates for rates of drinking among secondary school pupils are also given in the HBSC. HBSC Wales reports 7% and HBSC England reports 5% of 11-16 year olds drink alcohol on a weekly basis. HBSC Scotland reports 14% of 15 year olds consume alcohol weekly compared to 10.5% in England.

As we would expect, Chart 3.16 shows that rates of drinking increase with age. The rise in reports of drinking at age 13/14 may make Year 9 a potentially important group to target with alcohol related health promotion interventions. Among 15 year olds, these data from 2014 showed that at that time 18% reported drinking in the previous week. The SDDU report shows that this rate was slightly higher for males (20%) than females (17%) (HSCIC, 2015a).
Pupils aged 11-15 who reported that they drank in the last week drank an average of 10 units in 2014, with a median of 5.5 units (HSCIC, 2015a). This is also at the lowest level for a number of years.

Being drunk is a key indicator of alcohol misuse. There are various sources of estimates for the proportion of secondary school children who have been drunk, all suggesting fairly similar rates. The English WAY survey took place out of school, which is a different methodology to the HBSC or the SDDU. This might potentially result in more disclosure of drunkenness. The rates for 15 year olds who reported that they had been drunk in the last four weeks in the WAY survey were 15% for boys and 18% for girls (NHS Digital, 2015).

Turning to older teenagers and young adults, higher proportions drink than in the younger group. Chart 3.17 shows that the rate of non-drinkers is around one in five at this age. A significant minority of young people (23% of young men and 14% of young women of this age) report drinking in the risk categories.

**Chart 3.17: Estimated weekly alcohol consumption by 16-24 year olds, England, 2015**

The trend has been for a decline in drinking in this older age group, mirroring the pattern for secondary school pupils. However the Health Survey for England 2015 survey showed that the pattern for heavier drinkers (more than 14 units per week) between 2011 and 2016 is less clear, as is shown in Chart 3.18, suggesting that it is important to keep an eye on this trend.

**Chart 3.18: Alcohol consumption (more than 14 units per week) trends in 16-24 year olds by gender, England, 2011-2015**

![Chart 3.18](source)

Although drinking in young people is a serious concern because of the longterm health consequences and development of lifetime health habits, they are rarely hospitalised for alcohol related reasons when compared with other age groups. **Chart 3.19** presents Hospital Episode Statistics (HES) for alcohol related admissions, illustrating the pattern across the full population age range. By using data relating to the primary and secondary reason for admission, this ensures the data capture of all admissions that are alcohol related including, for example, accidents.

**Chart 3.19: Alcohol-related NHS hospital admissions by age, England, 2015/16, including primary and secondary cause of admission**

![Chart 3.19](source)
Against this backdrop, the rates of hospitalisation of young people for alcohol related conditions have generally been going down over the last decade, but Chart 3.20 shows while this is the case for 10-17 year olds, and for males aged 18-24, the trend is not going down for young women 18-24.

Chart 3.20: Hospital admissions for alcohol-related conditions per 100,000 population, 10-17 and 18-24 year olds, England, 2006/7 to 2015/16

There is a considerable amount of data relating to substance and illegal drug use among young people. However, not all findings are consistent as this is a challenging area to research and self-report studies have obvious potential limitations. Estimates of ‘ever’ use vary for the secondary school age group. The 2014 WAY survey, for example, reported that 11% of young people aged 15 in England had tried cannabis (NHS Digital, 2015). Estimates were 20% for 15 year olds in the HBSC England survey (Brooks et al, 2015), 15.8% for 15 year olds in the English SDDU survey (HSCIC, 2015a), and 18% for 15 year olds in HBSC Scotland (Currie et al, 2015). Cannabis is consistently reported as the most common drug used by this age group; in the WAY study, for example, 2% of boys and 3% of girls aged 15 had tried any other drug.

Chart 3.21 reports on the proportion of illegal drug use reported by the school population aged 11 and 15 in England over the 12 years from 2001 to 2014, as reported in the Smoking, Drinking and Drug Use surveys. Overall, the proportion of the school aged population who had reported using illegal substances in the last year has seen a downward trend since 2001. The fall for both male and female 15 year olds is notable, from 41% to 20% for males, and from 36% to 17% for females in the SDDU surveys. The chart illustrates the same relationship with age as seen for alcohol and smoking, with an increase from the younger to older teens. Overall, in 2014, 4% of 11 year olds reported that they had taken a drug in the previous year, rising to a fifth of 15 year olds.
One in five of 16-24 year olds report using an illicit drug in the last year


Among the older age group of 16-24 year olds, the Home Office 2016 misuse of drugs survey reported that one in five had used an illicit drug in the last year. Chart 3.22 shows the proportions using Class A and stimulant drugs in the last year from 2001/2 to 2015/16, again showing a decline.


**Chart 3.22: Proportion of 16-24 year olds reporting use of Class A and stimulant drugs in the last year, 2001/2 to 2015/16**
Multiple risk behaviour is of particular concern. Chart 3.23 presents data from the 2014 WAY study on the number of risk behaviours reported by boys and girls aged 15. Risks including currently smoking, drinking alcohol regularly (once a month or more), using cannabis in the last month, using other drugs in the last month, consuming fewer than five portions of fruit and vegetables on the previous day, and exercising for less than 60 minutes for seven days in the last week. As we have already seen, most young people will meet the criteria for two risks on this list, as very few eat five portions of fruit and vegetables or meet the exercise criteria. It is arguable whether these can be classified as risks in the same way as smoking. The concern then is for young people who hit three or four of these risks, and the rates for these are 11% and 3% respectively.

Finally, a note about legal highs, also known as new psychoactive substances. These are drugs that are designed to copy the effect of illegal drugs but are chemically different enough to avoid the law or are not regulated for other reasons. The term covers a range of substances including stimulants and sedatives, long and short acting, and digested in a variety of ways. The main risk to young people comes not necessarily from addiction but from toxicity. These substances constitute a moving target, in that drugs that fell into the legal high category become illegal as the law catches up; such as Mephedrone, Gamma-hydroxybutyrate and Benzylpiperazine which are all now classified as illegal.

Reliable representative data on prevalence of use are limited, but in 2014 for the first time the Smoking Drinking and Drug Use survey asked English secondary school children about use of legal highs. Overall, 2.5% of 11-15 year olds reported ever taking legal highs (also known as new psychoactive substances), and this dropped to less than 1% in the previous month (HSCIC, 2015a). Home Office drug misuse statistics published in 2016 suggested that new psychoactive substance use was uncommon amongst young people aged 16-24, with a reported use of 2.6% in the last year amongst this age group, although this is still three times higher than in older adults. Young men aged 16-24 (3.5%) were more likely to take new psychoactive substances than young women (1.6%) (Home
It is important that we continue to watch developments in drugs that are outside the usual substances covered in many existing regular surveys.

Bullying

There is increasing evidence that bullying is an adverse childhood experience and can have detrimental effects not only on young people’s self-esteem, emotional and mental health but also on their physical health. Studies have shown that children who are chronically bullied are more likely to self-harm, suffer from anxiety or depression, and more likely to be overweight as young adults (Arseneault et al, 2017, Baldwin et al, 2016).

Findings from the 2014 WAY survey report that over half (55%) of 15 year olds had experienced bullying in the past couple of months, with girls reporting higher rates (63%) than boys (48%). The HBSC surveys also collected data on bullying of 15 year olds in the same year and reported lower rates of 28% in girls and 30% in boys in England, 9% for all 15 year olds in Scotland and 28% for boys and 36% for girls in Year 11 in Wales. These differences in self-reported bullying between different surveys may be attributed to variations in the methods used. For example, the WAY survey asked specifically about different types of bullying, which may have resulted in higher levels of reporting.

Chart 3.24 demonstrates that emotional and psychological forms of bullying such as being called names or being excluded were more commonly reported by both genders than physical bullying. Being hit, kicked or shoved was more common in boys than in girls.


Media and communication activities

Perhaps the biggest shifts in young people’s behaviour over recent decades relate to the use of information and communication technologies. Traditional broadcast television viewing has been in decline among young people for some time, and the latest broadcasting statistics suggest that they watch less scheduled television than other age groups. The British Audience Research Board (BARB, 2016) reported that the average minutes of television viewing per day for both 4-15 year olds and 16-24 years olds declined from 2004 to 2015, from 144 to 111 for the younger age group, and from 156 to 124 for the older group.

However, by 2016 in the UK, 89% of households in Great Britain had internet access (ONS, 2016). In addition, the use of smart phones has opened a new world of swift, flexible communications and access to media. Much teenage viewing behaviour now centres around streamed and downloaded programmes from providers such as YouTube and Netflix. It is much less easy to obtain data about these behaviours. Young people are early adopters in all kinds of technological developments, with 90% of 16-24 year olds in the UK owning a smartphone, compared to 18% of those aged 65+ (Ofcom, 2016). New technologies bring both challenges and opportunities. The risks are widely discussed; the opportunities less so. However, there is growing recognition that new media and communications devices offer platforms for health interventions that may be particularly suitable for young people (Layard and Hagell, 2015).

Much screen time for young people is now occupied accessing the internet. The Office for National Statistics 2016 internet access survey shows the most common internet activities for 16-24 year olds compared with those aged 25-34. Younger people are more likely to be engaged in social networking and finding information (ONS, 2016).

An ONS survey on internet access (Chart 3.25) showed that 91% of young people aged 16-24 use the internet for social networking. There is emerging evidence about both the potential positive and negative impacts of social media on young people’s health. Enabling young people to be more connected with family and friends, share common interests and creativity, be more involved in the community by being made aware of volunteering activities and political activism, have access to health information and support networks, are all positive impacts of social media (Royal Society of Public Health 2017). However, further research is required to understand the possible negative impact of social media use on young people’s mental health.
Cyberbullying

Cyberbullying has many definitions but the term is commonly used to describe bullying that occurs online through social networking sites, instant messaging and through use of mobile phones and tablets. Cyberbullying can be in the form of creating and sharing embarrassing photos, being excluded from a social online group, receiving and being pressurised to respond to unwanted sexual messages and being pressurised to look a certain way.

Findings from the English WAY survey reported that 10% of boys and 19% of girls aged 15 have experienced cyber-bullying in the last couple of months in 2014. Chart 3.26 below demonstrates that out of the 15 year olds who reported cyberbullying, the percentage of boys and girls who experience sharing of inappropriate photos online was similar. In a study done by the NSPCC on the experience of 11-16 year olds on social networking sites in 2010 trolling (37%), being excluded from social group (22%) and violent behaviour (18%) were the top three upsetting experiences reported by those who were being cyberbullied (Lilley et al, 2014). A large study based on the findings from the English WAY survey found that victimisation from cyberbullying was related to poorer mental wellbeing. This study also found that cyberbullying, on its own, is relatively rare with face-to-face bullying remaining more common amongst teenagers (Przybyliski and Bowes, 2017).
CHAPTER 3: Health behaviours and lifestyle

AYPH | Key Data on Young People 2017

Chart 3.26: Type of cyberbullying experienced by 15 year olds, by gender, England, 2014

“Someone sent mean instant messages, wall postings, emails and text messages, or created a website that made fun of me”

“Someone took unflattering or inappropriate pictures of me without permission and posted them online”


Sleep

Young people’s sleep is an important topic that has been receiving more interest in recent years, as it becomes obvious that poor sleep (insufficient sleep and poor quality sleep) may be both the cause and the result of health problems. For example, sleep deficiency has been identified as a contributing factor in road traffic accidents (AYPH, 2012). There are also links with the previous topic, as overuse or particularly late evening use of smart phones, tablets and computers have been linked to sleep disturbances in this age group (Lemola et al, 2015).

However, there are very few representative survey data on young people’s sleep. The Exeter Schools Survey Unit undertakes a series of surveys, including a question on whether young people get adequate sleep to cope at school. Chart 3.27 shows that approximately half of those at secondary school report that they get enough sleep to concentrate and stay alert, and that this appears to decline between Year 8 and Year 10.


Source: Balding and Regis (2016) Young People into 2016 (unpublished) Reproduced with permission [DOWNLOAD DATA]

Similar rates of adequate sleep were reported in the most recent Health Behaviour in School-aged Children study. Overall 22% of 11-15 year olds reported that they did not get enough sleep. Again, reported rate of adequate sleep decreased as age increases (Brooks et al, 2015).
Accidents

Data from the Global Burden of Disease Study showed that road traffic accidents were the leading cause of adolescent death around the world in 2013 (WHO, 2017). Overall, in developed countries, the top four causes of death in adolescents were road traffic accidents, self-harm, interpersonal violence and drowning. In the UK, the top four were road injuries, self-harm, neoplasms (cancer) and congenital abnormalities. Preventing accidents is thus a key focus for improving health outcomes for this age group.

Looking more closely at road traffic accidents for young people, Chart 3.28 presents the numbers of young people killed or seriously injured by gender, road user type and age in Great Britain, in 2015. The age brackets used for presenting the data in the source vary by type of accident, so that those age 16 are included for some but not all of the categories. However, it is clear that riding larger motorcycles (over 50cc) is particularly risky.

Leading causes of adolescent death in the UK

1. Road injuries
2. Self-harm
3. Neoplasms (cancer)
4. Congenital abnormalities


Chart 3.28: Killed or seriously injured casualties by gender, road user type and age group, Great Britain, 2015

Drawing on both road traffic statistics and mid-year population estimates, Public Health England has calculated that the rate of fatal and serious injuries for 10-14 year olds was significantly greater for children from the 20% most deprived areas (37 per 100,000) compared with those from the most affluent areas (10 per 100,000). We return to this and other health inequalities in Chapter 8.
References


Department of Health (2011a) *Start Active, Stay Active: A report on physical activity for health from the four home countries’ Chief Medical Officers*. London: Department of Health

Department of Health (2011b) *Physical activity guidelines for children and young people (5-18 years)*. London: Department of Health


CHAPTER 4: Sexual health and identity

3.3% of young people aged 16-24 identify as gay, lesbian or bisexual

In 2015, the number of under 18 pregnancies was the lowest since 1969, at 20,351 (England). The number of live births to teenagers in Northern Ireland has fallen from 2,107 in 1984 to 839 in 2014.

In 2015 the under 18 pregnancy rate was 20.8 per 1,000 young women (England).

In England, Wales and Scotland the under 18 conception rate has continued to fall since the 1990s.

Average age for child sexual exploitation concerns to be identified is 12-15

Two thirds of new chlamydia diagnoses are made in those aged under 25

6.9% of young people aged 16-24 say they have been pressurised into sex.

688 young people aged 15-24 in the UK were diagnosed with HIV in 2015.
Developing a sense of sexual identity is a key task of the transition to adulthood. Staying safe, healthy and happy through the process is important. As a result, the sexual health and behaviour of young people is a huge topic in adolescent public health, with important ramifications for wellbeing, education and service provision. There is a lot that we know, but this is also a topic where there are many challenges in collecting regular, robust information.

Sexual identity

Overall in 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual. Chart 4.1 shows that among the 16-24 population this rose to 3.3%, the largest rate in any age group. This is likely to be an underestimate, as some respondents chose to respond “other” or “don’t know”, or did not give an answer (4.5%).

Sexual identity and gender identity are distinct, and data on gender identity in the UK are currently limited. There are no data, for example, on the proportion of young people who would identify themselves as transgender. A need for more data has been identified, but there are many challenges and difficulties in collecting the information (Office for National Statistics, 2017).
Sexual activity

The third National Survey of Sexual Attitudes and Lifestyle (Natsal-3) reported in 2013, providing a raft of information about sexual behaviour of adults aged 16-74 (i.e., over the age of consent) in Great Britain. These data will not be updated for some time now. The youngest age group in the published data were 16-24 year olds. Overall, three quarters of these respondents had had heterosexual vaginal sex in the last year (Geary et al, 2016). Chart 4.2 summarises the main findings about the sexual experiences of this age group as reported in 2012. The results confirm the fairly consistent finding that the average age of first heterosexual intercourse is 16 years, and that nearly a third of both men and women reported that they had first had heterosexual intercourse before they turned 16. This still means that the majority do not have sex until after 16. This is an interesting finding especially as parents and young people often overestimate levels of teen sexual activity.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at first heterosexual intercourse</td>
<td>16 years</td>
<td>16 years</td>
</tr>
<tr>
<td>Heterosexual intercourse before 16 yrs</td>
<td>30.9%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Average number of sexual partners</td>
<td>6.5</td>
<td>5.2</td>
</tr>
<tr>
<td>At least one new partner in last year</td>
<td>46.0%</td>
<td>38.3%</td>
</tr>
<tr>
<td>Genital contact without intercourse past year</td>
<td>71.3%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Occasions of sex in the last four weeks</td>
<td>5.1</td>
<td>5.8</td>
</tr>
<tr>
<td>Anal sex in the past year</td>
<td>18.5%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>


The patterns of sexual activity in Chart 4.2 are notably similar for men and women, although the men aged 16-24 reported an average of 6.5 sexual partners compared to the women, who reported 5.2, and men were more likely to report a new sexual partner in the last year. A significant proportion of both genders reported new partners in the last year and this is important when we consider how best to ensure they have the sexual health advice that they need.
For information about young people under 16, one of the main sources of data is the Health Behaviour in School-Aged Children (HBSC), which collected data for England, Scotland and Wales in 2014. Chart 4.3 presents the data on the proportions of 15 year olds in the English survey who reported experience of sexual intercourse in the HBSC report, and compares this to the rates reported in the previous sweeps in 2002, 2006 and 2010. We can see that a quarter of boys and a fifth of girls reported having had sexual intercourse by this age, and that this proportion has been falling over the last decade.

It is interesting to compare the HBSC trends and those reported in Natsal-3. HBSC trends indicate a declining trend in 15 year old sex from 2002 onwards. However, Natsal-3 found that the proportion reporting first heterosexual intercourse before age 16 years increased in successive birth cohorts (Mercer et al, 2013). It is not clear how we account for the trends seen in HSBC, nor the different picture suggested in Natsal-3, although it is worth noting the survey methods are not identical.

**Use of contraception**

Use of contraception is important both for preventing conception and also for protecting against sexually transmitted infections (STIs). The English Sexual Health Framework (Department of Health, 2013) specifically aimed to increase knowledge and awareness of all methods of contraception for all ages. The majority of young people use contraception during heterosexual sexual intercourse. Again, answering the question of how many poses methodological challenges. The Natsal-3 survey reported that of the 75% of young people aged 16-24 who were sexually active, 86% reported that they had obtained contraceptives in the last year (Geary et al, 2016). This cannot tell us if they used them on any given occasion, of course. Data on contraceptive use by those aged 15 is available from the Health Behaviour in School-aged Children study. Of those who had had sexual intercourse, the majority (85%) reported using some kind of contraception. Use of condoms at last intercourse was the most common method in this younger age group, used by 61% of the boys and 57% of the girls. The contraceptive pill was the second most common method, followed by the morning after pill or another method (Brooks et al, 2015).

Young people aged 16-24 who have had vaginal sex in the last year report that they are most likely to obtain contraceptives from general practice (young women), and retail outlets (young men), but
both genders use a range of sources. Data on the source of contraceptive supplies from the NatSal-3 survey (Geary et al, 2016) are shown in Chart 4.4. The chart also illustrates that community clinics are important to both genders. Overall, young people are the age group most likely to have visited community contraceptive clinics (HSCIC, 2014).

Chart 4.4: Source of contraceptive supplies, 16-24 year olds by gender, Great Britain, 2013


Chart 4.5 shows the proportion of young people who report that they have been in contact with reproductive health services in the last year. This rises from 3% of those under 16, to over a quarter of those aged 20-24.

Chart 4.5: Proportion of young people in contact with reproductive health services, by age, England 2015/2016

It can be seen from the data illustrated in Chart 4.6 that the most common type of contraceptive for all young women attending clinics remains oral contraceptives, followed by the male condom. Use of the male condom is highest in the youngest age groups and is overtaken by the oral pill in those aged 15 and above. However, long acting reversible contraceptives, such as IU devices, injectable contraceptives and implants, account for just under a third of contraceptive methods for young women aged 16-24 years; a significant proportion that has increased over the last five years.

<table>
<thead>
<tr>
<th>Method of Contraception</th>
<th>All ages</th>
<th>Under 16</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives</td>
<td>45</td>
<td>46</td>
<td>52</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Male condom</td>
<td>14</td>
<td>21</td>
<td>16</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Implant (LARCs)</td>
<td>15</td>
<td>23</td>
<td>19</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Injectable contraceptive</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Interuterine devices/system</td>
<td>14</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: LARCs – Long Acting Reversible Contraceptives
Source: HSCIC (2016) Sexual and Reproductive Health Activity Dataset DOWNLOAD DATA

According to official statistics, use of emergency contraception is not common in young women. Chart 4.7 shows that rates are under 3% for all ages up to 24, but the highest levels are in those between 16 and 19 years. Even here the rate is only 23 per 1000 young women of this age. However, it should be noted that this is likely to be an underestimate. Some young people, for example, will ask others to purchase these for them. It is clear that inequalities exist, with girls aged 13-15 provided emergency contraception at a rate three times higher if they are in the most deprived decile when compared to the least deprived decile (Chart 8.8).

Research has shown that young people receiving good quality sex and relationships education at school are more likely to use condoms and other forms of contraception when they first have sex (Kirby and Lepore, 2007). Natsal-3 asked about sources of information about sex while growing up, and the data suggest that those who reported that their main source of information had been in lessons at school were less likely to have an unplanned pregnancy (Wellings et al, 2013).

School was also the preferred source of information about sex when growing up: Chart 4.8 shows that both young men and young women aged 16-24 reported that they would particularly have liked more information from schools, their parents and health professionals. There are interesting gender differences; young women would prefer information from their mothers, young men from their fathers.
Chart 4.7: Young women provided emergency contraceptives by sexual and reproductive health services by age, rate per 1000 population, England, 2015/16


Chart 4.8: Preferred source of information about sex when growing up, young people age 16-24, Great Britain, 2012

Conception and birth

In England, the Teenage Pregnancy Strategy ran from 1999-2010. Over this time under 18 conception rates fell from 44.8 per 1,000 in 1999 to 34.2 in 2010, a reduction of 24% over the course of the strategy. In England the continuing priority of reducing teenage pregnancy is signalled by the inclusion of the under-18 conception rate as an indicator in the Public Health Outcomes Framework (Public Health England, 2016). Further reduction in the under 18 conception rate is also one of eight objectives in the Department of Health’s Framework for Sexual Health Improvement in England (Department of Heath, 2013). Although teenage pregnancy rates continue to fall, finding ways of supporting local efforts to maintain the downward trajectory is critical.

In 2015 the reported number of conceptions in the under-18 age group in England and Wales was the lowest since 1969 (ONS, 2017), at a figure of 20,351. The rate of under 18 conceptions for 2015 was also the lowest since records began in 1969 at 20.8 pregnancies per 1,000 women, compared to 47.1 in 1969. The rate has thus more than halved. However, there is considerable variation across the regions in England. In 2015 the North East had the highest under 18 conception rate (28) and the South West the lowest (17). Charts 4.9 and 4.10 illustrate how this rate (per 1,000 females aged 15-17) has fallen since the late 1990s, both in England and Wales and in Scotland. In addition, in England and Wales, the proportion of under 18 conceptions that result in an abortion has remained fairly stable since the mid-2000s and in 2015 stood at 50.8% (ONS, 2017).


Source: ONS, Conception Statistics, England and Wales, 2015 Conceptions outside marriage/civil partnership data  DOWNLOAD DATA
Conception rates among the under 16s are low but of considerable concern. **Charts 4.11 and 4.12** present the trends for England and Wales and for Scotland, again demonstrating a reduction over time. The proportion resulting in a termination of pregnancy is higher for the under 16s than for the older age group, at 60% in England (ONS, 2017).

As far as Northern Ireland is concerned, conception rates are not available, but we can look at the number of live births to teenagers (up to 19 years). These figures are shown in Chart 4.13 from which it can be seen that there has been a decline here too, with a reduction from 2,017 births in 1984 to 839 in 2014.

Chart 4.13: Births to teenage mothers in Northern Ireland, 1984-2014

Looking at international rates, comparable conception data are not available for other European countries, but again comparisons can be made for birth rates per 1,000 women aged 15-19. Chart 4.14 plots the births per 1,000 young women aged 15-19 in the UK in 2015 and the average for a selection of other countries. The data are collected at the age the mother gives birth, not adjusted for age of conception, so these data are not directly comparable to the under 18 conception data published annually by ONS. The UK birth rate among women aged 15-19 was higher than some economically similar countries such as Germany and France.
Chart 4.14: Births per 1,000 girls aged 15-19, Unicef international comparisons, 2015

Innocenti Report Card 14  DOWNLOAD DATA
Sexually transmitted infections

As well as pregnancy, sexual behaviour carries the possibility of sexually transmitted infections (STIs). Public Health England data on the number of STI diagnoses in England make it clear that the highest rates of infection in heterosexuals are among those aged 15-24. Indeed it is estimated that those under 25 accounted for 62% of all new chlamydia cases in 2016 (Public Health England, 2017), as well as significant proportions of other STIs as well.

Chart 4.15 demonstrates that the 20-24 age group is most at risk of STIs for both genders. Among women, the second age group at risk is 15-19 but in males it is the 25-29s (PHE, 2017). Under the age of 24, rates are higher in young women than young men. Helping all young people to protect themselves is a major public health issue, but the higher rates in young women indicate that particular attention needs to be paid to health promotion strategies targeted directly at them.

Chart 4.15: Rates of new STI diagnoses by age group and gender, England, 2016

**Chart 4.16** presents the rates of selected STI diagnoses, per 100,000 population, for young people in England in 2016 by gender and age. Chlamydia is clearly the most frequent STI diagnosis, followed by genital warts, herpes and gonorrhoea.

Improvements in screening and diagnosis have meant that more STI cases are identified now than previously, so untangling the underlying trends is complicated. England’s National Chlamydia Screening Programme, launched in 2003, has diagnosed well over half a million infections in 15-24 year olds. Modelling by the former Health Protection Agency (now Public Health England) suggested that it ‘probably decreased the prevalence of chlamydia among sexually active under-25 year olds’ (HPA, 2012).

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<table>
<thead>
<tr>
<th>YOUNG MEN</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia</td>
</tr>
<tr>
<td>Under 15</td>
<td>6.8</td>
</tr>
<tr>
<td>15-19</td>
<td>782.5</td>
</tr>
<tr>
<td>20-24</td>
<td>1717.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUNG WOMEN</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia</td>
</tr>
<tr>
<td>Under 15</td>
<td>81.6</td>
</tr>
<tr>
<td>15-19</td>
<td>2356.1</td>
</tr>
<tr>
<td>20-24</td>
<td>2603.9</td>
</tr>
</tbody>
</table>

Source: Public Health England Sexually Transmitted Infections and Chlamydia Screening in England, 2016  [DOWNLOAD DATA]
Chart 4.17 shows the data for chlamydia diagnoses by age group and gender from 2012 to 2015. The rates of new diagnosis of chlamydia for males aged 15-19 and 20-24 since 2012 have remained fairly similar. There has been an increase in chlamydia diagnosis amongst females aged 15-19 and 20-24 across these years. It is worth noting that PHE chlamydia screening policy is to achieve a diagnostic rate of 2,300 per 100,000 15-24 year olds in order to find the infection, treat and bring down prevalence.

Chart 4.17: Rates of chlamydia diagnoses per 100,000 population by age and gender, England, 2012-2016

Public Health England notes that there is considerable geographical variation in chlamydia testing coverage. The percentage of young people tested ranged from 16% in the West Midlands to 27% in London (PHE, 2017a).

The introduction of the HPV (human papilloma virus) vaccination in adolescent girls through the National HPV Vaccination programme has potentially had an impact on recent trends in a new diagnosis of genital warts, which have shown a reduction for both males and females aged 15-24 as seen in Chart 4.18. In 2016 the rate of first episode genital warts diagnoses among young women aged 15-17 attending services was 72% lower than it had been in 2009. There was also a 62% decline in young men of a similar age, who may be benefitting from improved outcomes for the young women (PHE, 2017a).
Sexually transmitted infections in young people in other countries of the UK show a similar pattern. In Scotland in 2015, 68% of all chlamydia diagnoses were made in people under 25 (57% of male and 75% of female diagnoses in this age group respectively). The majority of these diagnoses were in those aged 20-24. The diagnosis rates per 100,000 people aged 15-24 were 2,023 for women and 1,009 for men (ScotPHO 2016).

Finally, in 2015 there were 688 new HIV diagnoses among those aged 15-24 years in the UK. In addition, 315 children under 15 were receiving care for diagnosed HIV infection, together with 2,427 young people aged 15-24 (Public Health England, 2016). This is important as one of the Public Health Outcomes Framework sexual health indicators is late diagnosis of HIV.
Sexual abuse

It is not possible to establish the number of sexual offences against children in the UK, as the age of the victim of the sex offence is often not given. Only a very small minority of sexual offences against children will get as far as a prosecution, and most sexual abuse is not reported. Interviewing children about sexual abuse is a very skilled area of research and requires particular ethical scrutiny. This is an area where estimating prevalence is extremely difficult.

However, some studies have suggested that a significant proportion of young people aged 10-24 will have experienced sexual abuse. Radford et al (2011) undertook a major piece of NSPCC research, interviewing 1,761 young adults aged 18-24 years, 2,275 children aged 11-17 years and 2,160 parents of children aged under 11. The authors estimated that 1 in 20 young people will have experienced contact sexual abuse in the UK. Rates are higher (up to 1 in 6) for all kinds of sexual abuse.

The Natsal-3 survey provided important data on rates of non-volitional sex in the 2014 survey. Respondents answered questions about whether anyone had made them have sex against their will. In the 16-24 year old group (of whom there were 1,700), 16.4% reported that someone had attempted to have non-volitional sex with them, and 6.9% reported that they had experienced non-volitional sex. In a quarter of the cases, the young people had told the police (Macdowall et al, 2013). The median age for the whole sample (aged 16-74) to report non-volitional sex was 18 in women and 16 in men. The majority of the perpetrators were reported to be family, friends or current intimate partners. The Natsal-3 researchers concluded that this kind of sexual experience is mainly one that happens at a young age, and is strongly associated with poor health (physical and mental), risk behaviour such as binge drinking, and abortion and pregnancy before age 18. Natsal-3 also showed that young women who cited school as the main source of sex and relationship education were less likely to report having non-volitional sex, although this did not apply to young men.

Finally, official estimates of the numbers of young people who are trafficked or are victims of sexual exploitation are very low, because so few cases become subject to official proceedings. However, high profile cases in recent years have shed light on the number of cases that can be involved. The English Children’s Commissioner at the time estimated that at least 16,500 children in England were at risk of child sexual exploitation between April 2010 and March 2011, and 2,409 children were victims of CSE in gangs and groups between August 2010 and October 2011 (Berelowitz et al, 2012). In the Rotherham case, 1,400 children are thought to have been sexually exploited over a 16 year period (Jay, 2014). Between November 2014 and October 2015, around 9,000 children at risk of child sexual exploitation were identified by police forces across England and Wales (NSPCC, 2017). The average age when concerns are first identified has been suggested to be 12-15 years (Beckett et al, 2017), and the majority of victims are girls (NSPCC, 2017).
References


CHAPTER 5: Physical health, longterm conditions, disability and mortality

**31,500** children and young people under the age of 19 have **diabetes** in the UK

- 23% of 11-15 year olds report that they have a **longterm illness** or **disability**

- 10% of young people 10-24 have a **disability** that affects their ability to do normal daily activities

- 46% of 15 year olds have decay in their permanent teeth

- Those aged 16-20 are the group most likely to be diagnosed with **asthma**

- 2,400 young people age 15-24 are diagnosed with **cancer** every year in the UK

- External causes of mortality (injuries and intentional self-harm) are the **most common cause of death** in those aged 10-24

- **2,477** young people aged 10-24 died in 2015
CHAPTER 5: Physical health, longterm conditions, disability and mortality

Physical health, longterm conditions, disability and mortality

Although the years 10-24 tend to be a time of good physical health, many young people will experience a range of short term physical health problems. A significant minority will have longterm chronic conditions or some kind of disability.

Headaches, abdominal pain, muscular skeletal disorders, allergies, skin disorders and acne, coughs and respiratory infections are some of the common physical health problems for which young people seek medical advice. Young people are more frequent users of primary care services than is often thought (see Chapter 7).

However there are no up to date robust prevalence data on the regular short term health problems of this age group. The topic has not been covered in the Health Survey for England since 2002, and there have been no large scale studies of why young people in particular present at general practice since Churchill et al (2000).

Research on individual topics such as headaches (Abu-Arafeh et al, 2010) and skin conditions (Scholfield et al, 2009; Scholfield et al, 2011) suggest these may be very common in this age group. For example, it has been estimated that over half of children and adolescents have suffered headaches (Abu-Arafeh et al, 2010). Prevalence of acne, which usually starts in puberty, has been estimated at between 50% of 14-16 year olds (Smithard et al, 2001) to 80% of all those aged 12-24 (Lynn et al, 2016). The Global Burden of Disease Study 2010 suggested that lifetime prevalence of eczema in children and young people is between 15-30% in industrialised countries, a rate that has increased three fold in the last 30 years (Pawankar et al, 2013). More UK data on young people’s routine health concerns (other than longterm conditions such as diabetes) are urgently required for planning services and training GPs and other primary care professionals.

The 2013 Health Survey for England (HSE) did cover the use of prescribed medicines and revealed that in the 16-24 age group, 14% of young men and 25% of young women had taken at least one prescribed medicine in the last week. These were largely medicines for respiratory conditions, or antidepressants, antibacterials, analgesics or non-steroidal anti-inflammatory drugs (HSCIC, 2013).

Longer term conditions – where more data are available – include asthma, diabetes, epilepsy, arthritis, cancer and physical and mental health conditions. Overall, results for England from the Health Behaviour in School-aged Children study (HBSC) in 2014 found that 23% of young people aged 11-15 reported that they had a longterm medical illness or disability. Asthma accounted for over half the cases. Of those with a disability, 59% said they were taking medication (Brooks et al, 2015).
Dental health

A national Children’s Dental Health Survey has been undertaken every ten years since 1973, with the latest taking place in 2013 (HSCIC, 2015). It provides estimates on the dental health of 12 and 15 year olds in England, Wales and Northern Ireland, using data collected during examinations undertaken in schools on a random sample of the population of this age.

Trend data between 2003 and 2013 showed an overall reduction in the extent and severity of tooth decay for this age group. However, a third of 12 year olds (34%) and nearly half of 15 year olds (46%) had decay in their permanent teeth. More than a quarter of 15 year olds reported being embarrassed to smile or laugh due to the condition of their teeth. Young people who were eligible for free school meals were twice as likely to have severe or extensive tooth decay (see Chapter 8 for more on health inequalities).

Asthma, diabetes, epilepsy and arthritis

Asthma is a chronic inflammatory disorder of the airways affecting many young people. It is a complex and episodic disorder. Drawing together data from a number of different national datasets, the British Lung Foundation’s ‘Respiratory Health of the UK’ project estimated that 8 million people – over 12% of the population – have been diagnosed with asthma at some point (Mukherjee et al, 2016; Snell et al, 2016). Since 2008, young people aged 16-20 have been the group most likely to be diagnosed. Overall, Asthma UK (2017) has estimated that 1 in 11 children and young people have asthma. Taken together, these statistics suggest that something in the region of a million young people between the ages of 10 and 24 are likely to have asthma.

There has been much debate about whether rates of asthma have increased in recent years, but time trend data from the Respiratory Health of the UK project, from 2004 to 2012 suggested that lifetime prevalence of asthma had declined in children and increased in adults over that period. The trend for children is clearly to be welcomed. It is worth noting that a smoking ban in public places was introduced in Scotland in 2006 and in England and Wales in 2007. In addition, as we saw in Chapter 3, smoking by young people had fallen over recent decades before the ban, which may have played a role.

However, research has shown that there are a number of barriers to successful management of asthma in this age group which need addressing in order to improve young people’s outcomes still further, including concerns related to side effects (weight gain for example), social stigma and feelings of embarrassment and exclusion (Simoni et al, 2017). In addition, although the overall trend in lifetime prevalence for young people is looking positive at the moment, absolute levels of asthma are still very high, and hospital admissions for 10-18 year olds rose in England from 2006/07 to 2014/15 as shown in Chart 5.1.
Diabetes also represents a key concern for this age group. Diabetes is a serious life-long health condition, where the amount of glucose in the blood is too high because the body cannot use it properly. It may cause longterm complications and needs to be well managed. Reducing recorded diabetes is an outcome indicator in the Public Health Outcomes Framework (Public Health England, 2016). Drawing on surveys from England, Wales and Scotland, the charity Diabetes UK has estimated that there are approximately 31,500 children and young people under the age of 19 who have diabetes. Of these, the great majority have Type 1 diabetes (95%), with approximately 533 (2%) known to have Type 2. The remainder have other rare forms (Diabetes UK, 2016). On this basis, Diabetes UK estimates that local authorities can expect between 100-150 young people under 18 to be living with diabetes in their area.

Similar estimates of prevalence are provided in an annual national paediatric audit undertaken by the Royal College of Paediatrics and Child Health. The audit aims to monitor the incidence and prevalence of all types of diabetes among children and young people receiving care from a paediatric diabetic unit in England and Wales. The 2015/16 audit included all 173 paediatric diabetic units in England and Wales and collected data on 28,439 children and young people up to the age of 24 years under the care of a paediatric consultant (all young people with diabetes should be under the care of a consultant but some may not be). The audit recorded 2,834 new diagnoses of diabetes in 2015 in young people aged 0-15. The overall incidence of Type 1 diabetes in England and Wales was estimated to be 25.9 per 100,000 population, representing an increase since the previous audit in 2014/15 (RCPCH, 2017).

The peak age for diagnosis of Type 1 diabetes is between 10 and 14 years of age. Type 2 diabetes is nine times more common in children of South Asian origin than white children, and six times more likely in African Caribbean children. Slightly more diagnoses are made in boys (52%) than girls (48%) (Diabetes UK, 2016). Type 1 diabetes is not related to obesity, but a rise in obesity among young people may result in more Type 2 diagnoses in the longterm.
Management of diabetes in young people can present challenges. All those over 12 years should have certain checks that are required to screen for various complications arising from the disease. In the 2015/16 audit, only two thirds of young people aged 12 and above had the required foot check (65.8%), a retinopathy screen (66.2%) or urinary albumin recorded. It was noted that children with Type 1 diabetes had worse diabetic control if they lived in a deprived area, were of a non-white ethnicity, or were female (RCPCH, 2017). Indicators of complications were found in significant proportions.

Older young people with Type 1 diabetes were at increased risk of eye disease, with 20.5% of 17 year olds screened having an abnormal result. Macrovascular complications and high cholesterol levels were also recorded in significant proportions. These findings suggest that age-appropriate education and interventions are required to target better diabetes control in young people.

Looking at the rate of hospital admissions for diabetes per 100,000 population for 10-18 year olds from 2006/7 to 2014/15, Chart 5.2 suggests that the trend has been for admissions to remain reasonably level across this period.

**Chart 5.2: Hospital admissions of 10-18 year olds for diabetes, England 2006/7 to 2014/15**

Epilepsy is another important longterm condition affecting teenagers. Epilepsy is a neurological condition resulting in a tendency to have recurrent seizures and the term represents a group of over 40 types of the condition. One in 50 people will have epilepsy at some time in their lives, with around 500,000 (1 in 100) with the condition at any given time (Epilepsy Society, 2017). The National Institute for Clinical Excellence (NICE) has estimated that there were approximately 34,000 young people under 18 with a diagnosis of epilepsy and taking antiepileptic drugs in England (NICE, 2013). For 12-17 year olds, the incidence of new diagnoses was 0.3% for the age group as a whole, approximately similar to other age groups.
Chart 5.3 shows that the rate of hospital admissions for epilepsy per 100,000 of the population aged 10-19 in England has remained fairly level since 2006/7.

There is evidence that epilepsy levels are higher in urban areas, areas of social deprivation and areas without specialist services (Thomas et al, 2012), suggesting that social determinants of health play a part in its development. See Chapter 8 for more on health inequalities.

Arthritis, an inflammatory joint disease, is rare in young people. It covers several related conditions occurring before the age of 16, including juvenile rheumatoid arthritis and juvenile idiopathic arthritis (definitions of which overlap). Despite being rare, it is estimated that juvenile idiopathic arthritis affects 15,000 children in the UK with more than 2,500 developing the condition every year (Arthritis Research UK, 2014). There are no UK prevalence data and this is an obvious gap.

Cancer

Cancer is also relatively rare in young people, but is one of the leading causes of death for those in their teens and early 20s. Drawing on data from the cancer registries, Cancer Research UK estimates that around 2,400 young people aged 15-24 years are diagnosed with cancer every year in the UK and approximately 280 of this age group die from cancer each year (Cancer Research UK, 2017).

On average, 2,400 young people aged 15-24 are diagnosed with cancer every year

Source: Cancer Research UK (2017)
Cancer Statistics for the UK

Chart 5.4 shows the incidence of cancer diagnoses in young people aged 15-24 is similar in the four countries of the UK. The rate for females appears higher in Wales but the absolute numbers are very small. Rates do not differ significantly among the other countries for either gender (Cancer Research UK, 2017).
CHAPTER 5: Physical health, longterm conditions, disability and mortality

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Chart 5.5 shows the most common cancers for this age group are lymphomas, including cancer of the lymph system, Hodgkin Disease and non-Hodgkin Lymphoma, followed by carcinomas (malignant tumours on the surface or lining of a body organ). Cancers show different distributions by gender; there are more lymphomas, germ cell tumours (in cells producing sperm and eggs) and leukaemias (cancer of the white blood cells) among young men and more carcinomas and malignant melanoma among young women (Cancer Research UK, 2017). The rates balance out, however, and overall it is estimated that the male:female ratio for cancer in this age group is equal.

The cancer registry data compiled by Cancer Research UK suggests an increase of one fifth in cancer diagnoses among 15-24 year olds in the UK since the 1990s. Mortality, however, has fallen, almost halving since the 1970s (Cancer Research UK, 2017). Overall, over 84% of those diagnosed survive five years or longer.

Chart 5.5: Average number of teenage and young people’s cancers by diagnostic group, age 15-24, UK, 2012-2014

Source: Cancer Research UK (2017) Teenagers’ and young adults’ cancer incidence statistics
Disability

The UK Equality Act 2010 defines disability as a physical or mental impairment that has substantial and longterm (usually one year) negative effects on a person’s ability to do normal daily activities. This is, therefore, a functional definition rather than one based on the type of problem faced. Disability might include some of the conditions covered above such as arthritis and cancer, or other conditions including HIV, chromosomal and gene problems (for example, Downs Syndrome, cystic fibrosis, haemophilia and spina bifida), or loss of physiological and psychological functions such as mobility, sight, hearing and learning capacity. Disability can result in social, economic or environmental barriers restricting full and equal participation in society.

Chart 5.6 shows the rates of disability by this definition, by five year age bands up to age 24, drawing on data from the most recent national Family Resources Survey. Between the ages of 10 and 24, 10% of young people meet the definition, with very similar rates for young men and women. For children, the most common types of impairment reported were social/behavioural, learning, and stamina/breathing/fatigue (Department for Work and Pensions, 2017). The rate of disability for the population as a whole is 20%, which is mainly accounted for by the rise in the rate above age 50.

Chart 5.6: Average disability prevalence by age and gender, UK, 2013/14 to 2015/16

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All disabled people</th>
<th>% Male disabled</th>
<th>% Female disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people</td>
<td>20</td>
<td>19</td>
<td>22</td>
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<tr>
<td>0-4</td>
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<td>5-9</td>
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<td>20-24</td>
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</tbody>
</table>

Data are presented as an average over three years as there are small sample sizes for some age groups.


Estimates vary in different surveys depending on the definition of disability used and the age bandings employed in the study. The 2015 English HBSC survey (of 11-15 year olds) arrived at a slightly higher estimate (1 in 8), although this was a broader construct including longterm illness and disability (Brooks et al, 2015).

A learning disability is defined by the Department of Health as “a significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood” (Department of Health, 2001). There is an overlap between learning disability and autism spectrum disorder, but not all young people with autism will have learning disabilities or vice versa. Incidence of learning disabilities is more common in boys than girls, and it has been estimated that there are
286,000 children and young people aged 0-17 in the UK with a learning disability (Mental Health Foundation, 2017).

The definition of special educational needs is broader than that for learning disability, and in 2016 the Department for Education estimated that 1,228,785 school pupils (primary and secondary) had special educational needs (SEN) in England. Nearly a million children (11.6% of the total pupil population) received SEN support at school. Fewer (236,805) had a formal statement of special educational needs or – as it is now known – an Education, Health and Care (EHC) plan. Autistic spectrum disorder is the most common primary type of need for pupils with a statement or EHC plan, accounting for more than a quarter of those with a statement or plan (Department for Education, 2017). The number of children and young people with statements and EHC plans has increased each year since 2010. Chart 5.7 presents the trends for 11-15 year olds and 16-19 year olds. Of all those 11-19 year olds with a statement or EHC plan, those aged 11-15 account for the largest proportion (Department for Education, 2017).

Professor Sir Ian Kennedy (2010) reported that disabled young people faced major barriers in the NHS in accessing quality health services. He noted they are given lower priority, face a lack of co-ordination between services and have to navigate the sheer complexity of the services they need. This remains a concern.

Leading causes of disability in young people in the UK:
1. Social/behavioural
2. Learning difficulties
3. Stamina/breathing/fatigue
4. Mobility

Source: DWP (2017) Family Resources Survey

Chart 5.7: Number of children and young people with statements or EHC plans by age group, England, 2010-2017

Source: Department for Education (2017) Statements of Special Educational Need (SEN) and Education, Health and Care plans EHC plans: England, 2017
**Mortality**

Over the last 50 years, age specific mortality rates have fallen for all age groups from 0-24 years (Office for National Statistics, 2017). While adolescence is a generally healthy life stage those aged 10-24 do die, often from preventable causes. **Chart 5.8** shows the age specific mortality rate for young people aged 10-14, 15-19 and 20-24. The older group has higher rates of mortality than the younger age groups. Males have higher rates than females. However, mortality rates for all young people never exceed 0.5 per 1000 population.

![Chart 5.8: Age specific mortality per 1000 population age 10-24, England and Wales, 2015](source)

**Chart 5.9** presents the main causes of death for young people in these three age brackets (10-14, 15-19 and 20-24). The most common causes of death for all young people 10-24 are those described as external (accidents, and self-harm) and cancer. As young people get older, the number of deaths from external causes increases. Altogether, 54% of the deaths to 10-24 year olds in 2015 were due to external causes, a significant proportion of which could be considered preventable through good quality health care and wider public health interventions.
Breaking down these external causes of mortality for young people aged 15-24, Chart 5.10 makes it clear that accidents are the most common category (which will include both accidental injury and traffic accidents), followed by self-harm. Other external causes include accidental poisoning, exposure to noxious substances, assault, drowning and falls. The pattern is similar for males and females although males are much more likely to die. Young men aged 15-24 are three times more likely to die of accidents and almost four times more likely to die of intentional self-harm than young women. It is also important to note that 31 young men died of accidental drowning in England and Wales in 2015, compared with five young women in the same age group. ONS has reported that suicide and self-inflicted injuries was the only cause to see an increase since 2014 in children and young people (NHS Digital, 2017). Legislation and effective implementation may help to reduce deaths caused by accidents in young people (Wolfe et al, 2014; Patton et al, 2016). Consideration of how to reduce preventable deaths caused by self-harm is also important in the face of emerging evidence of possible rises in mental health problems in the 16-24 age group (McManus et al, 2016; see Chapter 6).

Chart 5.11 shows the adolescent mortality rate per 100,000 population in rich countries in 2015, as collated by the World Health Organisation in their Global Health Observatory Data. For comparison we have selected results for just the rich countries presented in Unicef’s report on child wellbeing (Unicef, 2017). The overall UK childhood mortality rate is higher than in some other high income countries, but lower than others. However, concern has been expressed that the UK has relatively high rates of death among certain subgroups including, for example, young people with chronic conditions (Wolfe et al, 2014).
Chart 5.11: Adolescent mortality rate per 100,000 population, rich countries, 2015

Source: WHO Global Health Observatory Data Repository  DOWNLOAD DATA
References


CHAPTER 6: Wellbeing and mental health

On average, three quarters of young people rate their life satisfaction as ‘high’ or ‘very high’

Three quarters of mental health problems start before the early 20s

A quarter of young women age 16-24 show symptoms of depression or anxiety

Among 16-24 year olds, common mental disorders are three times more frequent in young women than men

1 in 7 16-24 year olds screen positive for ADHD

Between 1/4 and 1/3 young women report self-harming between the ages 15-24

Since 2007 both self-reported and hospital recorded self harm show rises

Suicide rates are higher for young men than women

Approximately 1 in 100 young people aged 10-24 have autism spectrum disorder

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CHAPTER 6: Wellbeing and mental health

There is much debate about whether today’s generation of young people is more anxious, depressed and stressed than previous generations (Collishaw et al, 2004; Hagell, 2012), but there is no doubt that mental health disorders in young people are surprisingly common. Those most frequent in the teenage years include anxiety and depression, eating disorders, conduct disorder (serious antisocial behaviour), attention deficit and hyperactivity disorder (ADHD) and self-harm. This age also witnesses the early emergence of rarer psychotic disorders such as schizophrenia (Green et al, 2005). In fact, half of all lifetime cases of psychiatric disorders start by age 14 and three quarters start by age 24 (Kessler et al, 2005). Other estimates suggest that most of these problems in fact start before the age of 18 (Kim-Cohen et al, 2003).

Mental health problems have important implications for every aspect of young people’s lives including their ability to engage with education, make and keep friends, engage in constructive family relationships and find their own way in the world. Detection, treatment and support for young people with mental health problems are all important parts of the services provided to this age group. Mental health problems are also a major contributor to the global burden of disease (Whiteford et al, 2013) and untreated problems are likely to be very expensive for health services as young people grow into adulthood. We will return to mental health services in Chapter 7, but it is worth noting that the issue of young people’s mental health is currently subject to considerable policy and public debate.

Young people’s reports of their own wellbeing

Before exploring symptoms of mental ill health, it is worth noting that young people usually rate their own overall wellbeing as fairly high. Wellbeing is not the opposite of poor mental health (you can have a mental health problem and high wellbeing) but it is a part of general mental state. Low wellbeing may be a contributing factor to the development of later mental health problems. In recent years the Office for National Statistics has done a considerable amount of work on the measurement of wellbeing, with the result that several large surveys use the same measures with different age groups (ONS, 2014). This usually consists of self-reported ratings for questions including “How satisfied are you with your life nowadays”; “To what extent do you feel the things you do in your life are worthwhile”, and “How happy did you feel yesterday”. The Health Survey for England 2015 uses these ONS wellbeing measures with children aged 13-15. Chart 6.1 shows the average proportion of young people of this age who gave high or very high ratings to these questions. Generally the ratings are positive, with life satisfaction ranging from 75% to 88% depending on age and gender.
A similar question on life satisfaction was also included in the ‘What About YOUth’ (WAY) survey of 15 year olds, where 75% of boys and 55% of girls gave high or very high ratings (HSCIC, 2015). The questions are also asked of 16-24 year olds in the ONS annual population survey, although results in the main publications are not broken down by gender. Chart 6.2 shows their responses to the same three questions on life satisfaction, worthwhile life and happiness yesterday. As with the younger age group, the majority reflect high levels of wellbeing according to these questions. Between 82 and 89% rate their life satisfaction as high or very high.

https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing
Young people who report being bullied in the last couple of months tend to give lower ratings to their wellbeing. In the What About YOUth survey 2014, 19% of those bullied reported low life satisfaction, compared to 7% of those who had not been bullied (HSCIC, 2015).

The most recent Prince’s Trust Youth Index drew attention to gender differences in aspects of life satisfaction. Young women aged 16-25 were more likely than young men to feel they have no control over their lives or future, and more likely to struggle with feelings of self doubt (Prince’s Trust, 2017).

There is always interest in international comparisons of life satisfaction in young people. The 2013 Unicef Innocenti Report Card (Unicef, 2016) ranked the life satisfaction of secondary school-aged children in rich countries, drawing on data from the Health Behaviour in School-aged children surveys. Chart 6.3 shows that of the 35 countries listed, the UK ranks at number 20.

Finally, young people aged 16-24 seem to give slightly less positive satisfaction ratings in relation to their health, compared with their general life satisfaction responses. In the British Understanding Society survey, 56.2% were mostly or completely satisfied with their health. More than one in five (21.4%) said they were dissatisfied (ONS, 2017).
### Chart 6.3: International comparisons in life satisfaction

<table>
<thead>
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<td>Turkey</td>
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*Source: Unicef (2016)*


[DOWNLOAD DATA](#)
Prevalence of mental health problems among young people

The data on the prevalence of diagnosed mental health conditions in the UK’s population of young people aged 10-15 is not measured regularly and this shortage of good, up to date, data is a real issue in understanding the picture. Two large scale and robust surveys by the Office for National Statistics (ONS) in 1999 (Meltzer et al, 2000) and 2004 (Green et al, 2005) are the source of most information on the younger end of the age range, but these data are now very out of date. A new survey is underway but results are not available at the time of writing. There are some routine data on 16-24 year olds in, for example, the Adult Psychiatric Morbidity Survey, but overall we lack a complete picture of mental health problems for the 10-24 age group as a whole. It is critical to repeat these kinds of representative population surveys, particularly as there has been concern expressed recently by academics and practitioners about the possible impact on this age group of the economic crisis of 2008, ongoing cuts to services, changes to the examination system, and concerns about the impact of exiting from the European Union (Faculty of Public Health, 2010; Young Minds, 2015; Young Women’s Trust, 2016).

In the meantime, drawing on the older data from the last Office for National Statistics survey of child and adolescent mental health in 2004, we can see (Chart 6.4) that the most common mental health problems in young people aged 11-16 at that time were conduct disorders in boys and emotional problems in girls, although both were common in the opposite gender too. Overall, around 13% of boys and 10% of girls were rated as having some kind of disorder.

In the adult psychiatric morbidity survey which included 16-24 year olds, the overall rate of common mental health problems for adults over 16 was one in six. In the 16-24 age group, total symptoms of common mental disorders in this age group were about three times more common in women of that age (26.0%) than men (9.1%). Chart 6.5 shows the rates of various different common mental disorders in this age group.
Turning to time trends, analyses of successive British birth cohorts suggested that there was a significant increase in some mental health problems up to the year 2000 (Collishaw et al, 2004). However in the beginning of the 21st century this trend seemed to have slowed down or stopped. Comparison of the two large scale ONS surveys in 1999 and 2004 mentioned above showed little change over this five year period (Collishaw et al, 2004). Since then the trends have been unclear and there is a shortage of data.

One study compared overall rates of mental health difficulties in early adolescence (11-13 years) in two cross-sectional studies from secondary schools in England from 2009 to 2014, using the Strengths and Difficulties Questionnaire (SDQ). The samples were not nationally representative as the second study had a larger than usual ethnic minority sample, and the first study was weighted to match. However, the results were interesting finding no large differences between the cohorts but a change in pattern. The results suggested an increasing burden of emotional problems for girls, and an indication of a decrease in overall difficulties for boys (Fink et al, 2015).

Although not based on any representative sample, it is interesting to note that ChildLine (the UK’s free, 24-hour helpline for children and young people) has reported rising levels of counselling sessions, with over 300,000 sessions in 2015/16, an increase of 5% on the previous year (Childline/NSPCC, 2016). Finally, analysis of data returns to the Higher Education Funding Council for England has shown that the proportion of university students who formally identify themselves as having mental health problems doubled between 2008/9 and 2013/14 (Institute for Employment Studies, 2015).

**Emotional disorders, low mood and anxiety**

ONS does not routinely collect data on clinically diagnosed cases of depression or anxiety, although it does collect them on symptoms of depression, self-report anxiety and other indicators. Some psychiatric data for common mental disorders in those over age 16 are available from the 2014 Adult Psychiatric Morbidity Survey in England (McManus et al, 2016). As noted above, we have no data on clinically diagnosable depression and anxiety in the younger age group beyond those available from 2004. Some other population surveys include measures that indicate symptoms of depression or anxiety for this younger age group even if they do not provide a diagnosis.
Pulling together information from these sources, it seems that a significant proportion of young people 10-24 will have symptoms of depression or anxiety at some point through these years, and that young women are more likely to suffer (or to report) than young men. However, estimates of the levels of emotional problems vary by the age of the sample, and by the types of measurements used.

Data from the 2004 population survey of children concluded that 6% of girls and 4% of boys aged 11-15 had clinically significant levels of anxiety or depression. A cross-sectional survey of young people aged 11-13 in 2014 also concluded that emotional problems (a high score on the Strengths and Difficulties Questionnaire, not a clinical diagnosis) were more common in the girls; 20% compared to 7% in the boys (Fink et al, 2015). In the Adult Psychiatric Morbidity survey undertaken in 2014/15, 24.6% of young women aged 16-24 and 14.7% of young men showed signs of depression or anxiety. The authors concluded that young women were a high-risk group in the population (McManus et al, 2016).

However, comparing these data cannot tell us anything about time trends as the surveys were very different and applied to different age groups. For this we have to look to surveys that repeat the same methods at several different time points. Fink et al (2015) compared the 2014 results to the same survey undertaken in 2009, and concluded that there was an increasing burden of emotional problems for girls. Some time trend data for the older age group were presented in the Adult Psychiatric Morbidity survey, as again the same measure was used across several years. Chart 6.6 shows the proportions of young people aged 16-24 showing signs of depression or anxiety by gender from 2009/10 to 2014/15. The trends are not very clear although there was a slight rise for young women from 21.7% in 2009/10 to 24.6% by 2014/15. The rates for young men did not change substantially across the period.

Chart 6.6: Proportion of young people aged 16-24 showing signs of depression or anxiety by gender, 2009/10 to 2014/15

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Note: Score of four or more on the General Health Questionnaire (GHQ)

Source: ONS Understanding Society: the UK household longitudinal study
Measures of self-reported symptoms of anxiety and depression also suggest higher rates in young women. Although it is not possible to extrapolate from day to day feelings of depression and anxiety to a full blown diagnosis (the former is normal, the latter an illness), the former may shed some light on the mental health of a cohort. Chart 6.7 shows the proportion of young people aged 13-15 reporting that they felt anxious yesterday. At each age the rates are higher for girls, and there is a trend for rates to increase with age.

The same question was asked of 16-24 year olds in the ONS Annual Population Survey 2016, and 17% reported that their anxiety yesterday was high. This is a little lower than the overall average for the young people aged 13-15 which was 24%.

**Self-harm**

Self-harm (usually deliberate cutting and scratching) is a key part of the picture of mental health for young people as the majority of people who self-harm are aged between 11 and 25 years (Mental Health Foundation, 2006; Association for Young People’s Health, 2013).

Self-harm is not a psychiatric disorder in its own right, but it is indicative of major mental distress (McManus et al, 2016). However, self-harm is a very private behaviour and a very sensitive topic, which means that there is a shortage of reliable information about young people who do not make use of accident and emergency or other services.

There have been several attempts to estimate prevalence of self-harm among young people in recent years. In the English Health Behaviour in School-aged Children study (Brooks et al, 2015), 22% of the 15 year olds in the study reported that they had self harmed. These rates were three times as high for girls (32% of girls compared with 11% of boys). The majority of those self-harming said they were doing so once a month or more. One in four...
(25.7%) of the young women aged 16-24 in the Adult Psychiatric Morbidity Survey reported that they had self-harmed, compared to one in ten (9.7%) of the young men. In this age group self-harm was predominantly self-cutting. Time trends in self-harm were estimated from face-to-face interviews in the Adult Psychiatric Morbidity Survey. Overall, less self-harm was reported face-to-face than in the self-completion part of the study. However, rates did increase across time. Chart 6.8 shows the increase in reporting for men and women from 2000 to 2014. The increase may reflect an increase in self-harm, or may be a function of reduced stigma, or increased categorisation of the behaviour as self-harm.

A minority of people who are self-harming will end up in hospital, but these cases provide important information about this behaviour. Reducing hospital admissions caused by self-harm in under 18s is a key public health outcome indicator (NICE, 2012). Chart 6.9 shows the age distribution for young people age 10-24 admitted to hospital after an episode of self-poisoning in England, 2015/16. The majority of these episodes will be drug overdoses but some will include methods such as swallowing bleach. Although the peak age for admissions is 15, with a total of 3,853 admissions, there are steady rates of admissions into the early 20s. In total there were 36,624 admissions of 10-24 year olds for self-poisoning in 2015/16. These numbers do not necessarily reflect the numbers of individuals admitted, as some young people will be admitted several times over the course of a year. In addition, some incidents will be accidents. Nonetheless, this figure represents a huge number of young people in extreme distress, particularly if we consider this to be the tip of a much larger iceberg including those who do not go to hospital. Self-poisoning is one of the most common acute medical presentations in the UK (Camidge, Wood and Bateman, 2003).
CHAPTER 6: Wellbeing and mental health

Time trends in hospital admissions for self-harm follow similar trends to the self-report data in the community. Chart 6.10 shows the rate of hospital admissions for all kinds of self-harm per 100,000 population aged 10-24. This allows us to compare year on year controlling for changes to the numbers of 10-24 year olds in the population, so it is a more accurate way of reporting trends than absolute numbers of admissions. Results are broken down by five year age groupings (10-14, 15-19 and 20-24), which illustrates that the rise is in the younger two groups rather than those in their early 20s.

Finally, rates of self-harm are particularly high amongst groups of vulnerable young people, such as those in the youth justice system. Youth justice statistics for 2015/16 report 1,400 incidents of self-harm among 11-17 year olds (and some 18 year olds) in the prison estate, with a rate of 8.9 incidents per 100 young people. This is an increase of 5% on the previous year. This is despite the number of young people in custody falling (Youth Justice Board/Ministry of Justice, 2017).
Suicide

Suicide is rare among young people but it remains a key public health target. Reducing numbers who commit suicide is a Public Health England outcome indicator and reducing suicide by 20% has been a recent target of the Scottish Government. Chart 6.11 shows the age specific suicide rates in the UK for young men and women aged 15-19 and 20-24. Rates are higher in the older age group, and higher among young men than young women; a quite different pattern to that seen above with self-harm. In addition, the chart shows a peak in suicide in the mid 1990s, but a decline in rates from then until around 2005. After this, rates seem to have been fairly stable, although it is not clear if the rise in the last year is the beginning of an upward trend or just fluctuation. In 2015 the rates for young women were 3.1 per 100,000 for 15-19 year olds and 3.9 for 20-24 year olds, and for young men were 8.3 for 15-19 and 14.9 for 20-24.

More information on suicidal behaviour among the older age group is found in the Adult Psychiatric Morbidity Survey. Overall, 1 in 15 people reported that they had made a suicide attempt at some point (6.7% of the population), with more women (8%) than men (5.4%) having done so. Rates for young men aged 16-24 were roughly similar to those for men as a whole. However, rates for young women were notably high, at just under 13%.

Adolescent (15-19) suicide rates vary widely between high-income countries. The 2017 Innocenti Report Card from Unicef presented suicide rates for this age group per 100,000 population based on data from 2012/13. These are presented in Chart 6.12, showing that the UK’s rate in 2012 was half the average of the 37 high income countries studied.
Chart 6.12: Suicide rates of adolescents aged 15-19 per 100,000 population in high income countries 2012/13

Eating disorders

In western countries the prevalence for eating disorders in adolescents and young adults has been estimated to be approximately 3% for females and 0.1% for males. A larger proportion will have ‘subthreshold’ symptoms (Nagl et al, 2016). A study of the incidence of eating disorders in the UK 2000-2009 using a primary care register reported an age-standardised annual incidence rate of 164.5 per 100,000 for girls aged 15-19 years, more than double the rate for other ages (Micali et al, 2015). About 90% of eating disorder cases are female (NICE, 2017). By mid-life, around 15% of women will have met the criteria for eating disorders (Micali et al, 2017). There can be extensive physical and psychiatric consequences of a longterm eating disorder. Anorexia nervosa in particular has the highest mortality rate of any psychiatric disorder (Arcelus et al, 2011). The average age for the start of eating disorders is in the mid-teens and understanding these complex and distressing disorders is important when thinking about this age group. However, like self-harm, eating disorders may be underestimated in the general population. Significant proportions will not seek help and good representative community surveys are rare.

On the basis of routine Hospital Episode Statistics, the Health and Social Care Information Centre has reported that young people aged 10 to 19 years account for more than half of hospital admissions for eating disorders (HSCIC, 2014). Looking at the age range 10-24 Chart 6.13 shows, as usual, the largest number of admissions in 2015/16 was for 15 year old girls. Although bulimia is more common, anorexia accounts for a larger proportion of the hospital admissions.

Comparing the hospital episode statistics between 2011/12 and 2015/16 for admissions for eating disorders shows that there has been a rise in admissions for young women but the trends are less clear for young men, for whom the numbers of admissions are much smaller (Chart 6.14).
Conduct disorder and behaviour problems

Almost everyone gets involved in something that would be classified as antisocial at some point. Some risk taking in adolescence is normal. Taking risks and challenging authority can be part of adolescent identity development. In addition, what is defined as antisocial is to some extent culturally and generationally specific. At any time, there are all sorts of different ways to be antisocial, some more concerning than others.

However, serious violent behaviour in this age group is relatively rare and can be associated with longterm negative outcomes. ‘Conduct disorder’ is the official, psychiatric term for serious antisocial behaviour (for example, American Psychiatric Association, 2013), including the extremes of aggressive behaviour (fighting, being cruel to others or animals), destructive behaviour (arson or vandalism), deceitful behaviour (lying, stealing) and violation of rules (running away, truanting). As we have seen above in Chart 6.4 prevalence estimates for conduct disorder from the 2004 ONS survey suggested a rate of around 6.5% for young people aged 11-15%, with a higher rate in boys than girls.

Another measure of levels of behaviour problems is the rate of first time entrants to the youth justice system. This is not a completely objective rating of behaviour problems as it is affected by processing by the police and courts, which are themselves affected by policy changes. The number of young people aged 10-17 receiving their first substantive outcomes (reprimand, final warning or court disposal) in 2015/16 was 18,300. This was down 75% from 2003/4. Overall there were 90,769 proven offences by young people under 18 leading to a caution or conviction in 2013/4, down 8% on the previous year and down 83% since 2006 (Youth Justice Board/Ministry of Justice, 2017). A number of reasons have been suggested for the fall including reductions in crime levels as a whole and changes in the way children are dealt with, including the development of more informal and constructive approaches within the youth justice system (Allen, 2011).
Attention deficit and hyperactivity disorder

ADHD is a neurobiological disorder. Key symptoms of ADHD are inattention, impulsiveness and hyperactivity. It has been estimated that it affects around two to four percent of teenagers in the UK, with rates consistently higher in boys than girls (AYPH, 2012). It can affect educational attainment, peer relationships, self-esteem and can contribute to youth offending. In the Green et al (2005) epidemiological survey of 11-15 year olds, 2.4% of males and 0.4% of females of this age met the criteria.

The picture seems rather different for the older age group. For those aged 16-24, the Adult Psychiatric Morbidity Survey estimated that 14.6% of this age group screened positive for ADHD in 2014 (which will produce a larger group than those actually meeting the criteria for diagnosis). In this age group rates were broadly similar for young women and young men (McManus et al, 2016).

Autism spectrum disorders

The majority of young people become increasingly focused on their peer groups and social interaction during adolescence so this can be a very difficult time for young people who find it hard to manage their relationships with others. Those with autistic spectrum disorders (such as Asperger’s) may find this a particularly challenging life stage. The newest Diagnostic and Statistical Manual was published in 2013, drawing together the various diagnoses of autism, autistic spectrum disorder and Asperger’s under one umbrella diagnosis of ‘autism spectrum disorder’. This has three levels of severity and there is also a related diagnosis of social communication disorder (American Psychiatric Association, 2013).

The defining characteristics of autistic spectrum disorders are impairments of social interaction, communication and imagination and often a reliance on repetitive, habitual activities and behaviours. However, as a spectrum, a very wide range of functioning is included under the overall heading and people may vary considerably in their experiences.

Again, the only national survey data we have to draw on relating to prevalence derive from the 2004 ONS survey by Green and colleagues. This suggested a prevalence rate of approximately 1% for autistic spectrum disorders (Green et al, 2005). Similarly, in a prevalence study involving a total population cohort of 56,000 children aged 9-10 in south London, Baird et al (2006) estimated a total prevalence rate of all autistic spectrum disorders as 116 per 10,000. Extrapolating from available figures, the National Autistic Society has estimated that there could be approximately 133,500 young people under 18 years in the UK with an autistic spectrum disorder (National Autistic Society, 2012).

It is important to note that there is a strong gender differential in autistic spectrum disorders, with around five times as many boys as girls, and on average half of the children diagnosed with autistic spectrum disorders have learning disabilities (Fombonne et al, 2011).

The Adult Psychiatric Morbidity Survey provided estimates for adults meeting the criteria for autism spectrum disorder, but because of low prevalence rates the data were presented for 16-34 year olds, rather than 16-24 year olds. Rates were 1.7% for men and 0.2% for women (McManus et al, 2016).
References


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Leeds: Health and Social Care Information Centre

Institute for Employment Studies (2015) *Understanding provision for students with mental health problems and intensive support needs.*
London: IES http://www.hefce.ac.uk/media/HEFCE,2014/Content/Pubs/Independentresearch/2015/Understanding,provision,for,students,with,mental,health,problems/HEFCE2015_mh.pdf


London: MHF http://www.mentalhealth.org.uk/content/assets/PDF/publications/truth_about_self_harm.pdf


Prince’s Trust (2017) *The Prince’s Trust Macquarie Youth Index 2017.* London: Prince’s Trust


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.

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

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<thead>
<tr>
<th>Source</th>
<th>Males</th>
<th>Females</th>
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<tr>
<td>Lessons at school</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Father</td>
<td>40</td>
<td>20</td>
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<td>Health professionals</td>
<td>40</td>
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<td>Media</td>
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<td>Mother</td>
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<td>Friends</td>
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<td>5</td>
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<tr>
<td>First sexual partner</td>
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<td>5</td>
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<tr>
<td>Internet (exc pornography)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Pornography</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Other</td>
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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).
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.

Source: Balding and Regis (2016), Young People into 2016, unpublished report  DOWNLOAD DATA
Reproduced with permission

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

![Chart showing data]

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.
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.

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.

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

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.

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 long term 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**

![Chart 7.9](image-url)

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**

![Chart 7.10](image-url)

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).

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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CHAPTER 8: Inequalities in health outcomes

26% of young people aged 11-19 live in households with the lowest incomes

44% of LGBT+ young people aged 16-24 say they have had suicidal thoughts

Young people living in socially deprived areas were more likely than other young people to be admitted to hospital with asthma

10-14 year old pedestrians living in deprived areas are 3.7x more likely to be killed or seriously injured on the roads

15 year olds in most deprived areas are 2x as likely to report that they smoked regularly than those in the least deprived areas

2x higher under 18 conception rate in the most deprived areas compared to least deprived

Obesity rates for 10/11 year olds are 2x in the most deprived area compared with the least deprived

Young adults with four+ adverse life experiences are more frequent users of health services than their peers
Inequalities in health outcomes

Social inequalities can lead to health inequalities (Marmot et al, 2012). In fact it has been argued that health is more a function of lifestyles linked to living and working conditions than a function of healthcare (HM Government, 2010). Health inequalities happen across the whole life course, but there has been less attention looking specifically at the evidence on the social determinants of health for adolescents and young people as distinct from other age groups. Yet without equal access to resources and support, some young people are put at a disadvantage (Viner et al, 2012). This may set in motion inequalities that continue to play out across the rest of the life course.

Inequalities related to deprivation

Low income is the most salient social disadvantage. Government population surveys consistently show that young people are disproportionately represented in families with lower levels of income. As reported in Chapter 2, over a million young people in the UK age 11-19 live in households where the family income is being supplemented by the state. In 2015, around 1 in 4 young people in the UK (25%) lived in households with less than 60% of the UK’s median income. This proportion has increased since 2008 when around 1 in 5 (19%) of 16-24 year olds lived in households with less than 60% of median income (ONS, 2017). Over a quarter of those aged 11-19 are living in the bottom quintile of income distribution (DWP, 2016). One in seven secondary school aged children are eligible and claiming free school meals.

The quality of the local environment is also an important social determinant of health. The latest English index of multiple deprivation (IMD) indicated that over five million people lived in the most deprived areas of England. In these areas, 44% of the children were income deprived. Overall, the authors estimated that almost two in five children up to age 16 were living in families that were income deprived (Department for Communities and Local Government, 2015).

Death and accidents: There are very few data looking specifically at variations in different kinds of adolescent mortality in the UK in relation to deprivation. It is a difficult task due to the very low number of deaths in this age group. In addition, as Viner et al (2012) pointed out, most adolescent mortality is caused by social and environmental causes (such as self-harm, road traffic accidents and drowning) rather than by directly income related causes, although income may play a part in this list. Public Health England analyses have shown that among 10-14 year old pedestrians, those living in the 20% most deprived areas were 3.7 times more likely to be killed or seriously injured on the roads than those from the least deprived areas. Those aged 15-19 from the most deprived areas were twice as likely to be killed or seriously injured (PHE, 2015). Chart 8.1 shows the variation in mortality up to age 17, in areas with different characteristics. Child and adolescent mortality is higher in deprived areas with higher proportions of young people and greater ethnic diversity.
Obesity: There is good evidence that rates of obesity in young people are higher for those living in deprived areas. This has been consistently demonstrated in the English National Child Measurement Programme for secondary pupils in Year 6 (age 11/12), as Chart 8.2 shows, as rates are double in the most deprived area compared with the least deprived.

**Chart 8.1:** Child mortality (0-17) in different types of areas, England, 2013-2015


* CCG = Clinical Commissioning Group

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**Chart 8.2:** Prevalence of obesity in Year 6 (age 10-11), by deprivation according to school area, England, 2015/16

The relationship between weight and deprivation is stronger for obesity (95th percentile of weight distribution) than it is for being overweight (85th percentile of weight distribution), as is shown in Chart 8.3.

**Chart 8.3: Relationship of area deprivation to prevalence of overweight and obesity in Year 6 (age 10-11), England, 2015/16**

<table>
<thead>
<tr>
<th>Decile</th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (1st)</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Least deprived (5th)</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>


**Smoking and drinking:** Regular smoking by 15 year olds is related to whether young people live in an area of multiple deprivation as Chart 8.4 illustrates. Those in the most deprived areas were more than twice as likely to report that they smoked regularly than those in the least deprived areas.

**Chart 8.4: Regular smoking in 15 year olds by Index of Multiple Deprivation quintiles, England, 2014**

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived (1st)</td>
<td>7%</td>
</tr>
<tr>
<td>2nd</td>
<td>6%</td>
</tr>
<tr>
<td>3rd</td>
<td>5%</td>
</tr>
<tr>
<td>4th</td>
<td>4%</td>
</tr>
<tr>
<td>Least deprived (5th)</td>
<td>2%</td>
</tr>
</tbody>
</table>

Children and young people are also more likely to be exposed to the cigarette smoke of others in deprived areas. Chart 8.5 presents measurements from saliva, showing elevated cotinine levels for non-smoking children aged 4-15 in lower income families. Cotinine is an alkaloid found in tobacco and also the predominant metabolite of nicotine.

Chart 8.5: Smoke exposure for children aged 4-15, by household income (measured by salivary cotinine levels), England, 2015

![Chart 8.5: Smoke exposure for children aged 4-15, by household income (measured by salivary cotinine levels), England, 2015]

The relationship of deprivation to teenage drinking is less clear, as Chart 8.6 shows. There is no discernable relationship between the proportion of 15 year olds who have been drunk in the last four weeks by whether they live in an area of deprivation or not.

Chart 8.6: Percentage of 15 year olds who have been drunk in the last four weeks by Index of Multiple Deprivation (those who have had an alcoholic drink), England, 2014

![Chart 8.6: Percentage of 15 year olds who have been drunk in the last four weeks by Index of Multiple Deprivation (those who have had an alcoholic drink), England, 2014]
**Conceptions, pregnancy and sexual health:** Young women in situations of income deprivation in England are more likely to experience sexually transmitted infections (Chart 8.7), use emergency contraceptives (Chart 8.8), and to become pregnant under 18 (Chart 8.9).

**Chart 8.7:** Chlamydia detection rates for those aged 15-24 (per 100,000) by Index of Multiple Deprivation, England, 2016

**Source:** PHE’s NCSP data tables; Chlamydia detection and screening in England 2016  [DOWNLOAD DATA]

**Chart 8.8:** Girls aged 13-15 provided with emergency contraceptives by Index of Multiple Deprivation, England, 2015/16

**Source:** NHS Digital 2016 Statistics on Sexual and Reproductive Health 2016  [DOWNLOAD DATA]
Chart 8.9: Under 16 conception rate by area deprivation deciles, England, 2015

Source: Public Health England  DOWNLOAD DATA

Chart 8.10 shows that the relationship with deprivation is similar for under 18 conceptions in Scotland. This remains the case for both pregnancies that end in termination and those that end in delivery of a baby, both of which are more frequent in more deprived areas.

Chart 8.10: Under 18 conceptions, by area deprivation deciles, Scotland 2014

**Longterm conditions:** Overall the relationship of asthma to deprivation is not clear. Information for adults tend to be based on treated asthma (either at the GP or hospital), and so does not reflect the full picture of asthma prevalence in the community, and the results concerning social inequalities tend to be equivocal. Up to date data on the relationship of asthma in the community and deprivation for young people are not available. However, Chart 8.11 presents hospital episode statistics on admission to hospital for asthma among those aged 10-18 in England, 2014/15, demonstrating a clear relationship. Young people living in socially deprived areas were more likely than other young people to be admitted to hospital with asthma. Whether this is because there was a higher prevalence of asthma in the first place, or more passive smoking, or poorer treatment in those areas is not clear.

**Chart 8.11:** Hospital admissions for asthma for those aged 10-18 by Index of Multiple Deprivation, England, 2014/15

**Mental health:** The Millennium Cohort Study is a longitudinal study, which is following a sample of children born in the United Kingdom between September 2000 and January 2002. The age 11 sweep of the study was carried out in 2012 and included 13,287 parent interviews and cognitive assessments of cohort members. **Chart 8.13** demonstrates that children in the bottom quintile for income were 4.5 times more likely to experience severe mental health problems when compared to those children in the highest income quintile.

**Chart 8.12** shows that the relationship is not as clear for admissions for epilepsy for those under 19, although there is a trend for those in the least deprived areas to be admitted less than those in the more deprived areas.

**Chart 8.12:** Hospital admissions for epilepsy under 19 years by Index of Multiple Deprivation, England, 2014/15

11 year olds from the lowest income families are **4.5 times** more likely to experience severe mental health problems when compared to those from the highest income families.

Source: Gutman et al (2015)
Millennium Cohort Study 2012
The Millennium Cohort Study also collected data on the proportion of 11 year olds with severe mental health problems analysed according to their parent’s highest academic qualification. Chart 8.14 shows an inverse relationship between parental education and prevalence of child mental health problems. Young people whose parents had no academic qualifications or their highest qualification was grade D-G at GCSE were four times more likely to have severe mental health problems than those children whose parents had a higher degree.

The 2015 Adult Psychiatric Morbidity Survey looked at social determinants of mental health problems but did not separate these out for those aged 16-24. Generally it was reported that most mental health disorders were common in people living alone, those in poor physical health and those unemployed. The pattern for socioeconomic inequalities in treatment provision was less clear, although it was noted that adults living in the lowest income households were more likely to have sought help for mental health problems but not have received treatment (McManus et al, 2016).

Life satisfaction as measured in the What About YOUth study in 2014 shows a consistent but less strong relationship with living in a deprived area, as shown in Chart 8.15. Ratings of high or very high satisfaction by 15 year olds were 71% for those in the less deprived areas, and 61% for those in the more deprived areas.

Chart 8.15: High life satisfaction rates in 15 year olds by Index of Multiple Deprivation, England, 2014

Targeting particularly vulnerable groups

**Looked after children:** Children who are under the care of the local authority face a number of inequalities that may have consequences for their health. In England all looked after children should complete a Strengths and Difficulties Questionnaire (SDQ) once a year, to keep track of rates of emotional difficulties. A higher score on the SDQ indicates more emotional difficulties. A score of 0-13 is considered the norm, a score of 14-16 indicates cause for concern, and a score of 17 and over is likely to indicate mental problems. Chart 8.16 shows that, on average, throughout their teens, looked after children score above the norm on the SDQ, indicating high rates of mental health problems in the looked after population. At least a third meet the criteria for concern (a score of 14 or more). This compared with 8% of the general population aged 11-15.


Chart 8.17 shows that among all children who have been classified as having special educational needs, those who are looked after children tend to have more social, emotional and mental health problems than their peers. Their peers are more usually experiencing problems associated with autism and speech and language.

Chart 8.17: Different kinds of special educational needs in looked after children compared with their peers at secondary school, England, 2016

**Young carers:** Young people with caring responsibilities for others are often hidden, falling under the radar with respect to additional support. Young carers are at increased risk of missing out on education and social opportunities, and may be carrying a significant emotional burden. The Office for National Statistics concluded from the 2011 census that there were 177,918 children and young people under 18 helping to look after someone in their family who was ill, disabled or misusing drugs or alcohol (ONS, 2013). The Carers’ Trust has estimated that this may represent as many as 1 in 12 secondary school aged pupils (Carers’ Trust, 2017). Many miss school due to caring duties, and as many as two thirds (68%) have reported being bullied at school (NHS England, 2014).

One study has estimated that young carers are 1.5 times more likely to have a special educational need or disability (Hounsell, 2013). Another found that over a third of young carers (38%) reported having a mental health problem (Sempik et al, 2013). Young unpaid carers in English regions and Wales who were providing care for 50 or more hours a week have been found to be between 4.4 (in Wales) and 5.9 times (in the South East of England) more likely than those providing no care to report their general health as ‘not good’ (ONS, 2013).

**Chart 8.18** compares a range of health behaviours as reported by young carers and all Year 10 children (11/12 year olds) in one local authority. This demonstrates the elevated risk of reporting certain health behaviours in the young carers’ group. Clearly this is not representative of young carers in the country as a whole, but in the absence of more data, it is an indicator that this is a group at risk of significant health inequalities as they go through their teens and into early adulthood.

**Source:** Balding and Regis (2016) Young people into 2016. Unpublished report  [DOWNLOAD DATA]
**Ethnicity:** Higher proportions of children from certain Black and minority ethnic groups live in low-income families when compared to children from white backgrounds. In 2015/16 within the UK, for children where the head of the family identified as white, 16% were in relative poverty compared to 42% for Pakistani families, and 44% for Bangladeshi (PHE, 2017). This demonstrates how inequalities can be compounded, and it is difficult to assess whether health inequalities are due to deprivation, ethnicity or a combination of factors. Statistics on obesity illustrate this point. We have already seen that being overweight and obese is related to deprivation. However, ethnicity also plays a role in excess weight at age 10-11. Children from Black and minority ethnic backgrounds were more likely to be overweight than their peers from other groups. For children in the Black African group, 45% were overweight or obese, compared with less than a third in the Mixed White and Asian group (29%). This correlates with Black and Asian children having a higher incidence of Type 2 diabetes and worse glycaemic control in Type 1 and Type 2 diabetes (RCPCH, National Paediatric Diabetes Audit Report, 2017).

Inequalities based on ethnicity are also seen amongst prevalence of mental health in young people. The Green et al (2005) ONS mental health prevalence survey showed that the prevalence of disorders among 11-16 year olds varied by ethnicity. **Chart 8.19** shows that rates of mental health problems were higher in some ethnic minority groups (Black) and lower in others (Indian, Pakistani and Bangladeshi).

![Chart 8.19: Prevalence of mental disorders among 11-16 year olds in Great Britain, by ethnicity, 2004](DATA)

Inequalities may be further compounded by other factors. For example, young carers are 1.5 times more likely to be from ethnic minority backgrounds and more likely to speak English as a second language (Hounsell, 2013) than their peers. Black and ethnic minority young people who identify as lesbian, gay, bisexual or transgender (LBGT) are another minority within a minority. They report worse mental health and sexual health outcomes when compared to white LGBT young people (PHE, 2016).
**Young people with learning disabilities:** Having learning disabilities may also contribute to health inequalities for young people. For example, **Chart 8.20** shows that young people with learning disabilities are more likely to have a higher body mass index (BMI) than their peers.

**Chart 8.20:** Prevalence of BMI over 30 in young people age 10-24 with learning disabilities, England, 2015/16

![Chart 8.20: Prevalence of BMI over 30 in young people age 10-24 with learning disabilities, England, 2015/16](image)


**Lesbian, gay, bisexual, transexual and other groups (LBGT):** Over recent years there has been a growing body of evidence that LGBT young people face significant social and health inequalities. This can start at school; many children begin to identify as LGBT in school and there is evidence that nearly half of LGBT pupils are bullied because of their sexual or gender identity, and many report missing school because of this (Stonewall, 2017). The numbers of transgender young people in schools is very low, and obtaining reliable statistics on their experiences is difficult, but a 2013 Ofsted report concluded that one in four had experienced physical abuse by other pupils (Ofsted, 2013).

LGBT young people may also face mental health inequalities. The Metro Charity’s Youth Chances survey in 2016 included over 6,000 young people who self-classified as LGBT. **Chart 8.21** shows the rates of self-reported symptoms of anxiety and depression in this group compared with their peers, demonstrating elevated levels of seeking help for anxiety, self-harming, or having suicidal thoughts.
Rates of mental health problems may be particularly high in transsexual young people. The charity Stonewall has reported very high rates of self-harm (84%) and suicide attempts (45%) amongst transexual students (Stonewall, 2017). Rates were still high, but not as high, for lesbian, gay and bisexual young people who were not transsexual; three in five (61%) reported self-harming and one in five (22%) reported that they had attempted to take their own life.

LGBT young people are also more likely to undertake behaviours such as smoking and recreational drug use. In a longitudinal study of young adults in England carried out by Hagger-Johnson et al (2013) lesbian, gay and bisexual young adults were twice as likely to have a history of cigarette smoking as those reporting a heterosexual identity at age 18/19. Lesbian, gay and bisexual young people aged 16-24 are also more likely to report recreational drug use when compared to the general population of the same age (Buffin et al, 2011).

LGBT young people may also experience inequalities related to sexual health and screening. In a recent report only 20% of LGBT+ pupils reported that they had learned about safe sex in relation to same sex relationships at school (Stonewall, 2017). A systematic review carried out by the Royal College of Obstetricians and Gynaecologists found that the rates of teenage pregnancy and terminations were slightly higher in lesbian and bisexual adolescents when compared to the general population (Hodson et al, 2017). However more data are needed in this area, including in relation to sexually transmitted infections and cervical cancer screening in LBGT groups.
Adverse childhood experiences

Adverse childhood experiences (ACEs) are stressful events that occur in childhood and that may contribute to later health outcomes (Bellis et al, 2014). They include being a victim of abuse and/or living with adults with serious problems of their own. In their review of the impact of ACEs on health, Hughes et al (2017) found the ACEs that had been most studied included childhood physical abuse, household substance abuse, childhood sexual abuse, household mental illness, exposure to domestic violence, or emotional, psychological or verbal abuse.

The longterm effects of adverse childhood experiences such as these have been studied for some time, and there is growing evidence to show impacts on both physical and mental health as an adult. Individuals with at least four ACEs in childhood have been shown to be at particular risk of later sexual risk taking, mental ill health, problematic alcohol use, and suicide (Hughes et al, 2017). In a study undertaken with 7414 adults in England and Wales, Bellis et al (2017) reported that for those now aged 18-29, people with four or more ACEs in childhood were three times more likely to have seen the GP recently, and more than twice as likely to have been to the accident and emergency department or had an overnight stay in hospital.

Young adults (18-29) with four+ adverse life experiences (ACEs) in childhood are 3x more likely to have seen the GP in the last 12 months than those with no ACEs

Source: Bellis et al (2017)
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Concluding comments

The Association for Young People’s Health is committed to improving accessibility of data on young people’s health as a way of improving outcomes for young people. We hope that Key Data on Young People 2017 provides useful ammunition to help practitioners, policy makers, researchers and others make the case for investing in the 10-24 age group.

The data drawn together here make it clear that young people have a significant range of health issues that are particular to their age group, and that they make good use of health services. There are many positive time trends – rates of drinking, smoking and teenage pregnancy have all continued to fall. However, the teens and early 20s remain a ‘risky period’ in health terms, for a range of issues that will have lifetime implications, including:

- diet, activity and obesity
- sexually transmitted infections
- the peak age for diagnosis of a number of chronic conditions such as asthma and Type 1 diabetes
- the peak age for hospitalisation for challenging conditions such as eating disorders and self-harm
- the most common age for concerns around child sexual exploitation
- and different health behaviours – such as smoking – that still set in before the age of 25.

Contrary to popular understanding, young people are frequent users of health services. They draw more than other age groups on community based services such as sexual health clinics, they often visit the GP, either alone or with their families, and approximately a third of the age group attend accident and emergency departments in any given year.

Despite young people being frequent users of health services, many such services are not youth friendly. Young people consistently rate their experiences as less satisfying than other age groups, and often find that the service offer is not designed around their needs. Training in adolescent health is limited, and there are large ‘treatment gaps’ where those with problems do not receive help. This is particularly the case with mental health services for the age group.

Finally we would like to draw attention to the role of inequality in impairing the lives of young people. Health inequalities occur across the lifespan, but they begin to emerge in childhood. Arguably the period between 10-24 is critical in confirming and extending inequalities that then last a lifetime. This is the time when young people start to move outside family influences and control, and establish their own places in the world as independent adults. It is a critical period in the intergenerational transmission of inequality and offers a unique opportunity to interrupt the trajectories before they are set in stone.

Despite young people’s health needs being different they are often grouped together with those of younger children or older adults. We think that in health terms 10-24 year olds are an invisible generation. It is vital that we continue to collect data and commission services specifically to meet the health needs of this age group. This is to improve their health now and also to give them the best chance of healthy adulthood in the future.
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“Key Data on Young People 2017 draws out the health inequalities faced by those aged 10-24. If we do not tackle these disparities as soon as they occur, they will create even more inequality down the line. Increasing our understanding of the health experiences of our young people is vital so that we can plan to improve their health outcomes now and for the future.”

John Newton
Director of Health Improvement,
Public Health England

“Adolescence is a period of rapid development and Key Data on Young People 2017 underlines the importance of prevention and early intervention for this age group as well as for very young children.”

Dame Sally Davies
Chief Medical Officer for England

“Young people are frequent users of health services and AYPH’s work in this area is critical in showing why investment in youth friendly health services and more effective transition to adult services is crucial”

Dr Jacqueline Cornish
National Clinical Director, Children, Young People and Transition to Adulthood, NHS England