Adolescent health in the UK today: where next?

Dr John Coleman OBE, Senior Research Fellow, University of Oxford, AYPH Chair

Introduction - Why does adolescent health matter?

The health needs of young people are all too often given a low priority by both policy makers and by clinicians. However young people’s health is important not just because this age group has a right to effective health provision, but also because the appropriate management of adolescent health will pay long-term dividends for individuals and for society. The particular needs of adolescents in the health field are frequently missed because much policy thinking deals with children and adolescents as one age group. Furthermore adults, even professional adults, often know little about the stage of adolescence, and are therefore unaware that young people do have separate and individual needs where health matters are concerned (Coleman, 2010).

“One of the main cultural obstacles for young people is the lack of recognition of them as distinctly different from children as well as adults ......” (Kennedy Review 2010).

Whilst in the Kennedy Review “Getting it right for children and young people” (2010) the main focus is on the age group from 0-19 as a whole, the author does highlight some of the problems faced by adolescents in their contacts with the health service. At one point in the Review they are described as: “a ‘forgotten group’, caught between child and adult, and therefore between bureaucratic barriers and professional spheres of influence” (2010, page 38). Kennedy also says: “One of the main cultural obstacles for young people is the lack of recognition of them as distinctly different from children as well as adults ......” (2010, page 38).

“The effects of poor health during the teenage years can last a lifetime. Keeping adolescents healthy is a valuable investment in the nation’s future” (Chief Medical Officer’s report, 2007).

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In addition to the long-term benefits, both social and economic, which would flow from improvements in adolescent health services, understanding adolescent health is important for two further reasons. Firstly it is clear that many young people are not getting either the services or the information that they need to manage their health effectively. Polls taken by the UK Youth Parliament indicate that over 90% of young people want better sex and relationships education. Surveys show that many young people are ignorant about the services in their locality (Balding, 2009), whilst studies of adolescents’ use of GP services show that, whilst young people want to use primary care, they are sometimes unaware of their rights to confidentiality, and wish to see a doctor who is more understanding of teenage issues. Research also shows that adolescent patients get shorter consultation times than adults in the GP surgery, and that many young people struggle to get appointments at times that are convenient for them (Macfarlane and MacPherson, 2007). In a review of young people-friendly health services from a global perspective (Tylee et al. 2007) it was noted that, although some important initiatives can be identified, there is a dearth of appropriate supporting evidence since so few services are evaluated.

Secondly it is essential to acknowledge that during the adolescent stage some young people will engage in behaviours which carry long-term risks for their health. This is not the case for all young people, and there is no doubt that the majority seek good advice and make sensible decisions when it comes to health matters. Nonetheless during this stage of life there are some who take risks with their health, either because of lack of information or because of personal vulnerability. In addition some may be aware of the risks, but lack the skills and strategies to avoid them. It goes without saying that there is an enormous amount that adults can do to mitigate any harm that may result from these behaviours. In particular good quality health education, as well as ease of access to appropriate services, will be fundamental to good quality health care for young people (Coleman et al., 2007). We will return to these issues below.

**Key trends in adolescent health**

There is a general view that, where adolescent health is concerned, there is much to be worried about. If asked about health in this age group many professionals would mention increased use of alcohol, rising levels of obesity and worrying rates of sexually transmitted infections. As Viner and Barker (2005) have pointed out, there have been significant improvements in overall health outcomes in the last few decades among all age groups apart from the adolescent age group. For example, mortality rates amongst young people aged 15-19 and 20-24 have risen above rates for those in the 1-4 age group, a reversal of historical mortality trends. However the picture is not entirely negative, and indeed a careful look at the trends for young people’s health shows that the picture is much more nuanced, with areas which show little change, others where things have got worse, and yet others where there have indeed been significant improvements (Coleman and Brooks, 2009).

Looking first at the improvements, it is encouraging to recognise that the rate of teenage conceptions has shown a significant reduction over the last ten years. Conception rates for under-16s and under-18s have
fallen in England and Wales since the introduction of the national Teenage Pregnancy Strategy in 1998. As one example of this trend the 2009 under-18 conception rate was 38.2 per 1,000 girls aged 15-17, a decrease of 5.7% since 2008, and the lowest rate for almost 30 years (Office for National Statistics, 2011). Another area of significant improvement relates to suicide rates among 15 to 24 year-old young men. Rates here have fallen from 17 per 100,000 to 10 per 100,000 over the last 15 years. There has, however, been little change in rates for young women, nor has there been much change in rates of self-harm. In terms of mental health generally, there is conflicting evidence, and no clear trends have emerged. Where studies of psychiatric morbidity are concerned, little change has been discerned between the years 1999 and 2004, with rates for 11-15 year-olds staying at around 10% (Melzer et al., 2000; Green et al., 2005). Other studies, however, have pointed to increased rates of emotional problems and conduct disorders if comparisons are made between rates in the 1970s and 1990s (Collishaw et al., 2004).

Turning now to cigarette smoking and the use of cannabis, here again the trends are definitely going in the right direction, as can be seen from evidence gained from studies carried out by the NHS Information Centre (Coleman and Brooks, 2009). Among 16-19 year-olds in Britain over a 25 year period the proportion who smoke has come down from 33% to 20%. A similar trend can be seen in the 11-15 year age group. As far as cannabis use is concerned, again there has been some reduction in the last decade, with decreases in levels of use among 13-15 year-olds of roughly 20% (Coleman and Brooks, 2009).

This relatively positive picture has to be balanced against some trends which give rise to significant concerns. As far as alcohol use is concerned, here the evidence shows both that those young people who drink are drinking more, especially in the younger age groups, and that more young people are drinking than was the case in previous decades. As an example, mean units of alcohol consumed weekly by 11-15 year-olds in England and Wales doubled in the period 1990 – 2007 (NHS Information Centre, 2009). Rising rates of sexually transmitted infections have also been of major concern, with chlamydia and herpes showing particularly marked changes among young people. Rates of chlamydia increased by more than 100% in the period 2000 to 2007, reaching the figure of 22,000 new cases among 16-19 year-old young women in England and Wales in 2007. A note of caution should be sounded here, however, since this rise may partly be attributed to higher levels of awareness and to improved screening techniques.
In addition to these trends, two other aspects of adolescent health give cause for anxiety. The first of these has to do with obesity and the increasing numbers of young people who are overweight in the UK. Most recent figures show that obesity rates among 11-15 year-olds increased by 25% from 1995 to 2004, but it is encouraging to see that there has been a small decrease in these rates since then (NHS Information Centre, 2009). The relation between exercise and weight is not clear-cut, and there will be many factors apart from physical activity that influence weight. That having been said it is also encouraging to note that there was some limited increase in exercise levels among teenagers in Britain between 2003 and 2007, as defined by the numbers who do more than 2 hours of high quality physical exercise in a week (Craig and Mindell, 2008). The second concern to do with young people’s health that should be recorded has to do with the increase in long-term conditions such as epilepsy, asthma and diabetes. Figures quoted in the Chief Medical Officer’s report (Donaldson, 2007) note an increase of more than 20% in hospital admissions due to epilepsy and asthma in the years 2003 – 2007 among 10 – 19 year-olds in England.

Main policy themes of the last decade

It is undoubtedly the case that adolescent health has achieved a higher profile in the UK in the last ten years than in previous decades. This is partly as a result of the direction of government policy, but also partly to do with the efforts of key individuals who have worked hard to raise awareness of the health needs of adolescents through publications and contributions to policy debates. The Labour Government in the years 1997-2010 was responsible for a large number of policy initiatives, and it would be impossible to document them all. Three particular examples which have had a significant impact may be mentioned here – the National Service Framework for Children, Young People and Maternity Services (2003), the Public Health White Paper “Choosing Health” (2004), and the Healthy Child Programme 5 to 19 years old (2009).

Following these policy developments, and as has been mentioned above, the Kennedy review (2010) highlighted some key themes relating to children and young people’s health, and this has been followed by the Coalition Government’s response “Achieving equity and excellence for children” (2010). The Government has also published the White Paper on public health entitled: “Healthy Lives, Healthy People” (2010). We will refer to some of the proposals in these documents below.

There have been a number of service developments, among which it is important to mention the development of the “You’re Welcome” criteria for young people’s health provision (Macfarlane and MacPherson, 2007). It is encouraging to see that these criteria were given Government support in “Healthy Lives, Healthy People” (2010), where it is stated that: “Young people should have easy access to health services they trust, for example accredited “You’re Welcome” young-people-friendly services” (para 3.17). Another good example is the Teenage Health Demonstration Sites project, in which the Department of Health in London funded new community health initiatives in four areas of the country between 2008 and 2010. It is also of

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note that the voluntary sector has been encouraged to play a key role in promoting the health of young people, and the formation of the Association for Young People’s Health (www.youngpeopleshealth.org.uk) is one reflection of this trend.

In addition to the fact that adolescent health has received more attention, there have been particular topics that have been a focus for public and political concern. One of these is health inequalities. The Marmot review “Fair society; healthy lives; a strategic review of health inequalities in England” (2010) has served to highlight the fact that disparities in health outcomes in the early years have long-term implications for adult health. The review also emphasised the fact that inequalities in social and economic circumstances have a profound impact on health. Thus poverty is probably the major contributor to poor health, and Marmot underlines the fact that if society wishes to improve health outcomes, particularly for children and young people, then addressing disadvantage and family poverty has to be at the heart of any such objective. The Independent Review of Poverty and Life Chances chaired by Frank Field (2011), as well as The Review of Early Intervention chaired by Graham Allen (2011), have both recognised the conclusions of the Marmot review, and have built upon these in their deliberations.

Where adolescent health is concerned specifically, the Marmot review makes clear that society cannot afford to ignore the life experiences of young people who grow up in circumstances of deprivation. It is precisely these young people who are most likely to engage in health risk behaviours, and for whom risk factors such as poor nutrition, low levels of exercise, and limited access to good quality services are most prevalent. Adolescents making transitions from family life to relative autonomy, and from being passive recipients of healthcare to being responsible for their own health may be particularly vulnerable to the effects of deprivation. This is an issue which has become even more pressing in 2011 than it was when the Marmot review was published in 2010 in view of the increase in youth unemployment and the widespread reduction in services for disadvantaged young people.

Another theme which has been of concern to many is that of transition from paediatric to adult services. The Department of Health, assisted by individual professional “champions” across the country, has made a substantial effort to raise the profile of this issue. It has put in place events and activities that bring together the different medical specialities, and encouraged everyone concerned to consider ways and means of improving service delivery for those young people reaching the age of 16 or 18 and facing the transition from one type of service to another (McDonagh, 2007; Viner, 2008).

Lastly the growing importance of participation by young people in the design and delivery of services has been a notable shift in policy and practice. Government departments across the spectrum have begun to pay attention to the need to involve young people in one way or another in their work, and whilst some of this has undoubtedly been tokenistic, there have been some very encouraging developments. Numerous individuals and organisations have promoted effective programmes which encourage participation. The “Hear by Right” project developed by the National Youth Agency is one good example of this work (www.nya.org.uk), and the learning gleaned from the Teenage Health Demonstration Sites project,
disseminated by the Association for Young People’s Health, outlines strategies which allow agencies to create effective means of allowing young people to participate in service delivery. In the Department of Health’s response to the Kennedy Review “Achieving equity and excellence for children” (2010) there is a welcome emphasis on participation, and it is noted that: “Children and young people must also be offered opportunities to speak of their experiences and to say what in their view has and has not made a difference” (para. 2.4).

Issues for service delivery relating to adolescent health

The picture painted above indicates clearly that a variety of trends are at work where young people’s health is concerned, and these trends need to be taken into account where service delivery is being planned and delivered. Not all adolescent health is a litany of bad news, and the positive achievements of the last decade or so need to be recognised, and the lessons learnt need to be incorporated into future developments. However there are clearly some worrying trends in some of the indicators, and these urgently need to be addressed. At the time of writing (early 2011) significant changes are being planned in service delivery and in public health in England and Wales, and the outcome of these are as yet unknown. With that caveat in mind, some general conclusions will be outlined in this final section regarding service delivery based on what has been learnt over the past few years.

The role of primary care is a good starting point. As Kennedy (2010) notes, “General practice must be the single point of access .... at which the child or young person ..... is assessed and routed to the most appropriate professional.....”(page 9). However, as has been pointed out above, general practice does not always provide a service that matches the needs of adolescents, and what little research we do have highlights a number of areas that could be improved. To take one example, a study by Balding (2007) showed 25% of young women aged 15 to have felt uneasy or uncomfortable following a consultation with a GP. It should be noted, however, that there are some examples of excellent practice. In Herefordshire, for instance, the 4US project provides a health clinic once a week in secondary schools and in FE colleges, staffed by a GP and school nurse. Evaluation shows that approximately 30% of young people who attended the 4US service would not have attended a conventional primary care clinic.

It is clear that young people want to be able to go to the GP understanding the rules around confidentiality, and confident that they will be able to see a doctor who understands teenage issues. Apart from these issues there are also a variety of barriers to access, including living in a rural area with limited public transport, and being in a disadvantaged group such as growing up in care or being in custody. With Government policy moving in the direction of giving GPs greater responsibility for commissioning and planning service delivery, what can be done about improving matters for young people?

We wish to see:

- specific training for primary care personnel on the health needs of young people,
- greater priority given to the “You’re Welcome” criteria in surgeries and other health settings,
- greater support for the development of teenage health clinics in educational settings and in the community.
Turning now to the **role of the school**, this too is currently the subject of changing Government policy. Initiatives such as Every Child Matters, the Healthy Schools programme, and the promotion of pupil well-being are being modified or being made voluntary, and it is impossible to know how schools will respond to this changing environment. In a survey by the Sex Education Forum in 2009 it was reported that 30% of secondary schools had some sexual health service in place, although sometimes only at a minimal level such as having a school nurse available for consultation once a week. How schools choose to address the health needs of their pupils is at present a matter for the governors, thus leaving decisions open to the individual beliefs and values of the adults concerned.

Schools, and we should include sixth form and Further Education colleges here, do have an important part to play, since they have a central role in health promotion, as well as facilitating access to health services, and providing information about the services available in the community. In addition there are growing numbers in school with long-term conditions such as asthma and diabetes, and the school has an essential role to play in ensuring that the conditions of individual pupils are recognised, and that appropriate support, and medication where necessary, is provided. Schools are especially important in areas of health inequality, since they often represent a key resource in an otherwise impoverished landscape.

We support the need for:

- A much wider debate about the role of the school in health matters,
- A closer partnership between health and education professionals with regard to adolescent health promotion and the provision of health support.

As far as the **provision of hospital and other secondary care services** for young people is concerned there have been some promising trends in the last 10 years. Traditionally young people have been disenfranchised by both paediatric care (focussed on < 5 years) and adult care (focussed on the elderly). Young people repeatedly tell us in surveys that they wish for dedicated hospital services for their age group, and there is evidence that wards just for adolescents improve quality of care (Viner, 2007). While dedicating whole wards to young people will only be possible in larger hospitals, there is increasing interest in dedicating sections of children’s wards for teenagers.

We urge the need for:

- A commitment to ensure that all hospital services in the UK are youth-friendly,
- Work which will give priority to initiatives which are currently underway developing a secondary care version of the “You’re Welcome” criteria.

As will be apparent from the discussion on trends in adolescent health, there are some major public health issues where this topic is concerned. Improved health promotion is essential on topics such as diet and nutrition, physical exercise, sensible drinking and safe sex. This is not to say that efforts in areas such as
suicide prevention, reducing unwanted teenage conceptions, and discouraging smoking should be allowed to diminish in any way. Over the last decade it has been shown that concerted efforts by professionals from a variety of disciplines can make a significant difference to rates of risk behaviours in young people.

If health provision for young people is to improve in the future, serious attention needs to be paid to the **training needs of professionals** across the spectrum, from those working in the community to those in the hospital sector. This can only happen if health bodies at all levels play their part, including universities, royal colleges, voluntary agencies and government itself. Kennedy (2010) emphasises the need for better training many times in his report, with a special mention of the importance of mental health. As he says: “In particular there are significant shortages of professionals trained to care for young people with mental health problems. ... The current level of training is poor and getting worse. There is a pressing need to train GPs and others who work with them”. (2010, page 13).

We support the work of:

- The Royal College of General Practitioners, the Royal College of Nursing, and the Royal College of Paediatrics and Child Health in establishing special interest groups within their colleges concerned specifically with adolescent health.

We strongly recommend:

- Enhanced training on adolescent health for professionals across the spectrum, with collaboration between universities, royal colleges, the voluntary sector and government itself.

A further issue that Kennedy draws attention to is that of **available data** on the health of children and young people. As he states: “Data in many areas of health and healthcare for children and young people is poor or non-existent” (2010, page 11). As is noted in this report it is not just information on trends in health outcomes that is needed, but good robust data on health service performance is also essential if improvements are to be achieved. To take one example, It is a scandal that so little information is available on young people’s use of primary care, with virtually no studies having been carried out in this critical area since the year 2000. One attempt to collect and disseminate at least some data on adolescent health is being carried out by the Association for Young People’s Health in collaboration with the national Child and Maternal Health Observatory (www.chimat.org.uk), with the publication of **“Key data on adolescence”** (Coleman and Brooks, 2009). A further volume of this publication will be available in 2011, but far more attention should be paid to the issue of making good quality data available to all who work in this field.
We support the need for:

- Improved data collection on all aspects of adolescent health
- ChiMat acting on behalf of the Public Health Observatories to provide an annual report on adolescent health
- A greater distinction in the collection of data between outcomes for younger children and those in the adolescent age range

There is no doubt that one of the major concerns relating to improving services for young people has to do with questions of access. It is perhaps here more than with any other issue that the needs of young people must be considered to be paramount, and the necessity of listening to the voice of adolescent patients is critical. All too often services are designed without due attention being paid to the needs and experiences of the young people themselves, but the importance of this has gradually been recognised during the last decade. Indeed in the section on “Shared Decision Making” in the Department of Health’s “Achieving equity and excellence for children” (2010) it is stated: “Specific, tailored, age-appropriate methods are needed to communicate with children and young people so that they can understand their illness and the choices facing them” (para 2.19).

In addition the lessons learnt from the Teenage Health Demonstration Sites project, disseminated by the Association for Young People’s Health (www.youngpeopleshealth.org.uk) show clearly that, for example, finding out what young people want, ensuring that young people know about your service, considering how young people can actually get to your service, and telling young people clearly what your service offers, can all make a significant difference to uptake and value of the service. Taking questions of access seriously will go a long way to improving services for this age group. We support the concept, outlined in “Achieving equity and excellence for children” (2010), of local HealthWatch groups, and we are pleased to see that collecting views and feedback from young people, among other groups, is specifically mentioned (para 2.5).

Lastly some mention should be made of digital technologies, and in particular the role that appropriate websites can play for young people in enhancing access to good quality information. The website Teenage Health Freak is a good example of one such enterprise (www.teenagehealthfreak.org). It also has to be recognised that social networking can encourage the engagement of young people in health-related activities, and this is becoming a key medium for facilitating increased participation. The importance of digital technology is emphasised in all the recent Government reports and reviews on health, and it is clear that there are many new opportunities afforded by the internet in relation to young people’s health, especially for vulnerable and disenfranchised groups.
We suggest that:

- NHS organisations should open a dialogue with the UK Youth Parliament, and other key youth organisations, to take account of young people’s concerns and ideas concerning health matters, with a particular focus on issues to do with access;
- A high level national group should be convened to review the current health provision for young people with chronic disease who move to adult care;
- A young people’s panel should be established to advise on ways in which digital technologies might be used to provide health information, improve access to services, and encourage engagement and participation.

As we have indicated throughout this report, the health of young people matters for us all. As Sir Liam Donaldson (2007) said, keeping adolescents healthy is a valuable investment, and apart from anything else there are strong economic grounds for making sure that young people are provided with a health service which is appropriate for their age group. Whatever can be done to mitigate health risk, to improve training and awareness of the health needs of young people, and to facilitate access to health services will pay long-term dividends for society. Some progress has been made in improving awareness and service delivery, but there is a long way to go before we can feel confident that we are providing an adequate health service for the adolescent population. We urge those who read this to work together to bring about a better health service for young people.

Accessing the data
This paper refers to a range of data and trends for young people's health and well-being, such as teenage conceptions, smoking, alcohol use, drug use, and others. ChiMat has made this information easily accessible on the ChiMat website providing quick links to each of the indicators mentioned. You can view related data and trends for your area and make comparisons with others.

To access the data go to www.chimat.org.uk/youngpeople/AHUK#data
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References


