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. Yet young people’s health is critically important. This age group has a right to effective health provision, but also the appropriate management of adolescent health will pay long-term dividends for individuals and for society.

Last year we issued the first version of this position statement on the key issues in adolescent health in the UK today. This paper provides an update, incorporating the latest available statistics and taking account of the fast moving policy and practice context. The last year has seen an unprecedented level of debate about the structuring of health services in England, with the other UK countries keeping a watching brief on developments. Our line is that the particular needs of adolescents in the health field have to be kept at the forefront of debates about trends and provision. Too often, policy thinking deals with children and adolescents as one age group. The Kennedy Review (2010) on ‘Getting it right for children and young people’ described teenagers as “… ‘a forgotten group’, caught between child and adult, and therefore between bureaucratic barriers and professional spheres of influence” (p38). 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.

The reasons for encouraging a specific focus on adolescent health have not changed in the last year, of course. In summary, we believe that these include the following:

“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, England, 2007).

“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).
Increased risk: Adolescence is a period of life when many people will engage in behaviours which carry risks for their health, either because of lack of information, peer and societal pressure, or personal vulnerability. In addition some may be aware of the risks, but lack the skills and strategies to avoid them.

Long-term benefits for the individual: Intervening at this age point helps improve adult health outcomes, and is in line with young people’s rights under the UN Convention on the Rights of the Child to the “highest attainable standard of health”.

Long term benefits for everyone: Improving services to adolescents will lead to long-term cost benefits for the NHS and other services. For example, of every £8 spent on acute hospital care in the UK, £1 goes on diabetes, which also absorbs 7% of the UK drug bill. Tackling adolescent overweight will reap positive rewards in later years.

Information needs: We need better information on services and health management tailored specifically for young people. Surveys show that many young people are ignorant about the services in their locality, 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.

Service development needs: We need more support for development of youth-friendly services. Research 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. Young people report lower satisfaction with primary care than older adults. Many doctors are unaware that young people attend their GPs two or three times a year.

Key trends in adolescent health

There are two general views of adolescent health. On one hand, adolescence can be regarded as a time of general good health and physical fitness. This is not a life period dominated by the big threats of older age; heart problems, cancer and lung disease for example. In addition, medical advances have helped in the management of chronic conditions such as asthma and childhood diabetes. However, the second view is that there is, in fact, much to be worried about; if asked about health in this age group many professionals would mention widespread use of alcohol, rising levels of obesity and worrying rates of sexually transmitted infections. As researchers have pointed out, there have been significant improvements in overall health outcomes in the last few decades among all age groups apart from adolescence. 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.

Overall, taking both perspectives into account, a careful look at the trends for young people’s health shows that the picture is much more nuanced than we might assume, with areas which show little change, others where there have indeed been significant improvements, and yet others where things have got worse.
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, and that trend has continued since our last update in 2011. Previously, we noted that conception rates for under-16s and under-18s had fallen in England and Wales since the introduction of the national Teenage Pregnancy Strategy in 1998. The most recent statistics in 2010 showed the trend continuing. The under-18 conception rate had fallen again, to 35.5 per 1,000 girls aged 15-17, down from 47.1 in 1998, and the lowest rate for decades.10

Another area of significant improvement relates to suicide rates among 15 to 24 year-old young men. Rates here have fallen over the last 10 years from 16.5 per 100,000 in 2000, to 10.5 per 100,000 in the latest statistics from 200911. The equivalent statistics for young women were 4.4 in 2000, down to 3 in 2009. This means the actual number of recorded suicides and undetermined deaths in the UK fell by nearly one quarter from 2000 to 2009 (from 742 to 568), with young men accounting for nearly 80% of these deaths. There has, however, been little change in rates of self-harm, although this is an area where getting good statistics is notoriously difficult. We should also note considerable regional variation in these figures; in 2009, suicide rates among young adult males were very much higher in Northern Ireland (25.5 per 100,000) and Scotland (20.9) than in Wales (12.2) and England (8.7).

Turning to substance use, here again many of the trends continue to go in the right direction, as can be seen from evidence gained from studies carried out by the NHS Information Centre, the Health Behaviour in School Aged Children studies, the Department of Health funded SDDU studies, and the European ESPAD (see summaries in, for example, Key Data on Adolescence 201112). Overall, the extent of substance misuse has reduced substantially among 13 and 15 year olds in England and Scotland since 2002. In England, the proportion of 15 year old boys who reported having tried illegal drugs reduced from 39% to 27% between 2002 and 2010. Among the same group in Scotland, the proportion reduced from 35% to 21%. There have always been gender differences in drug use; at age 13, for example, the proportions of young people taking drugs are quite similar among girls and boys, but by the age of 15, higher proportions of boys report having taken illegal drugs. There are also gender differences in the country comparisons: at age 15, the extent of drug use among young females is 50% higher in England than in the rest of Great Britain. Of illegal drugs, cannabis is the most commonly used, with recent statistics suggesting that 21% of 15 year olds in England and 17% in Scotland having tried it in the last year; again, these figures represent an
improvement over recent years. There is good news about cigarette smoking as well. Among 16-19 year olds in Britain over a 25 year period, the proportion who smokes has fallen from a third to a fifth, but we remain concerned about smoking by young women, who smoke more than young men. Use of alcohol is more widespread and the trends are more complicated; we return to these below.

In terms of mental health, there is conflicting evidence, and it is hard to pin down recent trends. Taking the long term view, evidence from the big British birth cohort studies shows increasing rates of mental health symptoms (particularly anxiety, depression and conduct disorder) among 16 year olds between the mid 1970s and the late 1990s. Levels of mental health problems among this age group appear higher now than they did 30 years ago. However, the trends since 2000 are less clear. 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%. There have been no new data on this since our last update, but the data on reductions in suicide rates are encouraging as they will be related to other mental health trends.

This relatively positive picture has to be balanced against some trends which give rise to significant concerns. As far as alcohol use is concerned, the picture is mixed. The proportion of young people who drink alcohol has reduced substantially in the last decade across Great Britain – from approaching 50% of 15 year olds in England in 2002 to around 30% today. The levels are slightly higher in Wales and Scotland. However, among those who do drink, the average amount of alcohol they consume in a week has increased since the mid 1990s, and in England, the average amount consumed in the last week by 11-13 year olds who drink has trebled since 1994, from 4.1 to 12.1 units today. Among 15 year olds, average consumption levels doubled over the same period, from 6.4 to 12.9 units (note, however, that measurement of units has changed, which may have contributed).

Rising rates of sexually transmitted infections have also been of major concern, with Chlamydia and herpes and genital warts showing particularly marked changes among young people. New diagnoses of Chlamydia are the most significant, having increased by 25% over the past 10 years. However, numbers may have peaked in 2008 and appear to have fallen back substantially over the past two years from a high of 28,612 in 2008 to 21,655 in 2010, a reduction of 24% in just two years. Screening patterns may have contributed, and these trends need to be verified as reflecting underlying disease status, not policy and practice shifts. Interestingly, while same pattern is evident in new cases of genital warts (rise to 2008 then falling since), a different pattern is seen with new cases of herpes, where numbers are continuing to rise.

In addition to these trends, two other aspects of adolescent health give cause for anxiety. The first of these has to do with obesity, as around one third of young people aged 11-15 are overweight, and around 1 in 6 are obese (18% in England, 14% in Scotland). However, the proportions falling into these categories have fluctuated over the last 15 years. Indeed, although the levels in England appear to have reduced slightly since 2003/4, they are not significantly different today than proportions recorded in the late 1990s. The relation between exercise and weight is not clear-cut, and there will be many factors apart from physical activity that influence weight. That said, the recommended physical activity level for children in their mid-teens is at least 60 minutes of moderate-to-vigorous activity every day. Revised questions in the 2008 Health Survey for England led to much lower (and, it is believed, more accurate) levels of self-
reported physical activity being recorded than previously. These latest data suggest that the proportion of young people aged 11-15 who meet the minimum requirement may be less than one quarter.

The final concern giving anxiety is the increase in long-term conditions such as epilepsy, asthma and diabetes. The number of hospital admissions for adolescents with long-term conditions has increased substantially since 2002/3. In 2009/10, nearly 22,600 110-19 year olds with diabetes, asthma or epilepsy were admitted to hospital, and increase of 26% since 2002/3. The highest increases (31%) were recorded for adolescents with diabetes.

Longer term policy themes

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. 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 – 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).

In addition, a series of Acts of Parliament in 1998 devolved political power from the Westminster centre to Scotland, Wales and Northern Ireland, with regional variation in how this was operationalised. The implications of devolution on provision of health services for young people are not clear; it is likely that there are some differences emerging as the various regional forms of the NHS diverge, but as far as we know, no one has undertaken a health impact assessment of these alternative frameworks with a particular focus on adolescence. Some of the key differences between the systems include the fact that primary and secondary care are integrated in Scotland, unlike England, and that England has introduced a form of internal market competition, unlike the other three models. Scotland, Wales and Northern Ireland are generally held to have a better integration of social care and health care, and historically have had higher levels of funding per person for NHS care than in England. Rates of adolescent health needs often vary quite substantially between the regions, as we have indicated above in some of the key health trends.

All versions of the NHS have shared a number of longer term policy themes with particular relevance for young people, including:

- **Health inequalities.** Poverty is probably the major contributor to poor health; if society wishes to improve health outcomes, particularly for children and young people, then addressing inequality, disadvantage and family poverty has to be at the heart of any such objective. Young people growing up in circumstances of deprivation are more likely to engage in health risk behaviours, and are more exposed to risk factors such as poor nutrition, low levels of exercise, and limited access to good quality services. 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. These factors were emphasised in the Marmot review “Fair society; healthy lives; a strategic review of health inequalities in England” (2010), and
built upon 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). In Scotland, another example is provided by *Equally Well*, the 2008 report of the Ministerial Task Force on Health Inequalities. A broader international context is set by the World Health Organisation, with, for example, the 2007 *Commission on Social Determinants of Health* which concluded that the vast majority of health inequalities were avoidable, and their upcoming WHO strategy ‘Health 2020’, for which health inequality reduction is a key goal. The difficulty is putting mechanisms in place to actually reduce inequality in this age group, particularly when austerity cuts may hit the vulnerable groups harder.

- **The transition from paediatric to adult services.** In England and Wales the Department of Health has made a substantial effort to raise the profile of this issue \(^{18}\), with a view to 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. ‘Teenage transition’ is also one of four priority areas listed in *Improving Health in Scotland: The Challenge* (2003)\(^{19}\). That this is a critical issue in adolescent health care was emphasised in a recent systematic review on ways of improving services, which concluded that the most commonly used strategies in successful programmes were patient education and specific transition clinics.\(^ {20}\)

- **Young people’s participation** in the design and delivery of services. This has roots both in the encouragement of a patient-led NHS\(^ {21, 22}\) and also in the children’s rights movement. 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\(^ {23}\). 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).

- **Focus on outcomes.** Over the last decade, health policy throughout the UK has increasingly focused on measurable outcomes as a way of driving improvement, including, for example, Scotland’s National Performance Framework introduced in 2007, and the publication of the first NHS Outcomes Framework in England in 2010. While there is much to be welcomed in this kind of focus, the main difficulty is always that only a certain number of outcomes can be specified, and these are rarely adolescent-specific. In England and Wales, consultation (through the Children and Young People’s Health Outcome Forum) is ongoing to develop a specific Children and Young People’s Health Outcomes Strategy, to be published later in 2012.
All these themes will be as important, if not more important, in the coming years. This is partly because of the fast moving policy and practice context for provision of health services, but is also because of the possible negative impact of the economic climate on young people’s physical and mental health as they make the transition to adulthood. Of particular concern are the increase in youth unemployment, the widespread reduction in services for disadvantaged young people, and the possibility of an increase in health inequalities.

Recent policy developments

The last year has seen unprecedented levels of debate about how to commission and structure health services in England, with repercussions for the other three branches of the NHS within the UK. The Health and Social Care Bill had just passed its final hurdle in the House of Lords at the time of writing (April 2012). Clinical commissioning groups will take over commissioning from Primary Care Trusts, and a new regulator, Monitor, will protect patients’ interests, with patient voices being represented in another new national body, HealthWatch. Health and Wellbeing Boards should provide critical integration between the NHS and local authority services. One of the most controversial elements of the proposals relates to likely increase in private sector providers integrated into the NHS. In combination with these changes, a new body, Public Health England, will set national public health policy, with responsibility for measuring need and delivering being delegated to Local Authorities.

It is not yet clear what these developments will mean for the development of policy for young people in England, nor what lessons we might draw for other systems. Although they are not the primary focus of much of this debate, there is no doubt that young people are on the agenda at the moment. Recent relevant policy statements about adolescent health have included “Achieving equity and excellence for children” (2010), the Coalition Government’s response to the Kennedy review on children and young people’s health. The framework provided by the Department of Education’s ‘Positive for Youth’ policy statement also included two health related outcomes: the percentage of 11-15 year olds misusing drugs and alcohol, and the percentage of conceptions per 1000 15-17 year olds. However, there have been some concerns expressed by paediatricians, who have suggested that equality in outcomes and child safeguarding might both be more difficult to maintain in a more fragmented and locally-based health system containing more elements of competition. But none of the existing commentary is specific to adolescence; in the view of AYPH, this is a useful moment to interject a plea for this age group to receive attention as the next stage of the reforms unfold. They are of course included in the development of the Children and Young People’s Health Outcomes Strategy, mentioned above, and it is critical that this document makes a distinction between outcomes for younger age groups and outcomes for adolescents.

A final policy initiative that is worth mentioning is the Children and Young People’s Improving Access to Psychological Therapies project (IAPT). The IAPT project is rolling out NICE approved psychological therapies, and it is a useful moment to interject a plea for this age group to receive attention as the next stage of the reforms unfold.

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interventions for treating depression and anxiety, and in February 2012, the Coalition government announced £22 million new funding over the next three years.

The challenge is to do more than make a general acknowledgement that young people are important; bearing in mind recent key trends in adolescent health, we need to move forward with clear and practical ways of improving their profile in service provision. In the next section we look at what some of these innovations might look like.

**Improving service delivery in adolescent health**

There is much to be done, but we’ve picked five priority areas:

(i) Development of primary care

Huge numbers of young people go to their GP every year and primary care is often the main point of contact with health services – as it is for all of us. However, fears that there may be breaches of confidence, that the time allotted will not be long enough, and that they will not be understood, have emerged as enduring themes in research on teenagers’ attitudes towards primary care. 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?

"Young people should have easy access to health services they trust, for example accredited “You’re Welcome” young-people-friendly services". Healthy Lives, Healthy People, 2010.

The Well Centre, Streatham, is a drop-in youth health centre for young people aged 13-19 years, open three days a week. The project is jointly run by GPs and a local youth work charity. [http://www.thewellcentre.org/](http://www.thewellcentre.org/)

Existing practices can be improved by adoption of, for example, the English ‘You’re Welcome’ criteria, or the Scottish ‘Walk the Talk’ scheme, which suggest tried and tested ways of making the surgery more youth-friendly. Alternatively, development of special youth clinics have been piloted, both within the secondary setting (such as the 4US project), and in the community (such as the English Teenage Health Demonstration sites).

Particularly positive are the development of partnerships between GPs and local youth work teams, such as the Well Centre in Streatham. We also welcome the inclusion of ‘adolescent health’ in the 2012 BMJ masterclass series for GP’s professional development.
(ii) Focusing on health in schools

Turning now to the role of the school, this too is currently the subject of changing Government policy. In England and Wales, 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 2008 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.27 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. In England, this is likely to be exacerbated by the move to more independent academy status among secondary schools.

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.

(iii) Provision of hospital and secondary care services

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.28 Yet only around 2 out of 10 adolescent in-patients are cared for in adolescent wards. 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.

(iv) Training needs of professionals

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 takes input from a range of contributors, 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, p13).

There are some positive developments. The e-Learning for Healthcare initiative, a partnership between the Department of Health (England and Wales), the NHS and medical professional organisations, gives NHS health professionals access to bite-sized learning modules on adolescent health, including training on youth communication skills, consent and confidentiality. We also 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 concerned specifically with adolescent health.

(v) Improving data sources on adolescent health

A further issue that Kennedy drew 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 was recently undertaken 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, 2011” . The ChiMat website is an invaluable source of information and AYPH is working with ChiMat to populate the ‘knowledge hub’ on young people that forms part of the site. Another potentially useful source of adolescent data is the new Maternity and Children’s Data Set which is being developed for all NHS services as a driver to achieving better outcomes, which includes data on Child and Adolescent Mental Health Services, and on Children and Young People’s Health Services. In another initiative, NHS Health Scotland has just produced a paper on youth health epidemiology for use by local NHS Boards, signposting to useful sources of data .

As well as information for professionals, improving the dissemination of health information to young people is critical. Digital information is key here, not just in development of websites (eg, www.teenagehealthfreak.org; www.youngscot.org) but, perhaps more significantly, in harnessing the power of social networking to encourage the engagement of young people in health-related activities, and to increase participation.
Conclusion

As we have indicated throughout this report, the health of young people matters for us all. It is not all bad news by any stretch of the imagination, and the positive achievements of the last decade or so need to be recognised. However, we cannot take our eye off the ball at a critical time of transition in the health services. As Sir Liam Donaldson (2007) said, keeping adolescents healthy is a valuable investment, and apart from anywhere else there are strong economic arguments 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.

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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 available 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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Adolescent health in the UK today: where next?


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24 Similarly, in Scotland, the Scottish Government (2009) produced *Valuing Young People: principles and connections to support young people achieve their potential,* which aims to integrate policy areas including health.


