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Young people, health and youth policy

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Abstract

In this article we review public attitudes to the health of young people. We note that too often concerns about the health of adolescents are linked with a notion of risky behaviour. We review trends in health indices, and show that there have been improvements in many aspects of adolescent health, such as teenage pregnancy, smoking and drinking. We discuss risk in the context of health, and identify factors which might contribute to risky behaviour relating to health. We outline a range of interventions that may contribute to prevention strategies. We list some 'hot' topics in the sphere of health research concerning young people, including research on the adolescent brain and on sleep. Other 'hot' topics requiring attention include nutrition and mental health. Finally we discuss measures that would lead to the improvement of young people's health, and we link these considerations to more general youth policy.

Key words: Time trends, risk, intervention, prevention, health improvement.

IT IS ONLY relatively recently that young people's health has become a topic to which researchers and policy makers are paying serious attention. As West (2009:331) put it: 'Twenty years ago the health of young people barely featured on the social and health agendas of national and international institutions'. Today this situation has changed, and yet there remain serious misconceptions about adolescent health. In the first place, in spite of the fact that adolescents are the healthiest group in society it is still the case that they usually attend primary care several times a year – in fact an average of 4.5 visits for young women aged 15 to 19 (Hagell et al, 2013). In addition, studies of health inequality show that the adolescent population is very much affected by the social divisions in society. Young people living in poverty and deprivation have poor health and have particular needs in terms of service delivery (Marmot, 2010).

Another strand of discussion has to do with the fact that, broadly speaking, health indicators in Western countries have shown progress in all other age groups but less progress in the adolescent population. Viner and Barker (2005) pointed out that adolescence is the one age group where there was no discernible improvement in health between 1984 and 2004. Interestingly this may have changed in the last ten years, as we will show below. The same point, however, is made by Eckersley (2009). In reviewing health trends in Western countries, he argued that social change in these countries has led to a deterioration in the health of young people. In his view,

'Notwithstanding the complexities and uncertainties, the totality of the evidence suggests that fundamental social, cultural, economic and environmental changes are impacting adversely on young people's health and well-being' (p.359).

There is also a discourse about risk-taking. Commentators who write in this vein often take a gloomy view of adolescent health. They point to substance misuse, binge drinking, suicidal behaviours, road traffic accidents, sexually transmitted infections and other so-called 'risky behaviour' to illustrate that the current generation of youth has no regard for healthy living. They argue that these behaviours are a drain on the health service, and call for better health education. A good example of this view can be found in the British Medical Association report on adolescent health (Nathanson, 2003).

In this article we will take a closer look at the trends in adolescent health, drawing on the most up to date statistical information. We will review the literature on risk-taking, and argue that while it is easy to stereotype this generation, the evidence does not support the view that risk-taking in the health context is an inevitable feature of adolescent development. We will consider some current 'hot topics' in relation to adolescent health, such as sleep, nutrition and mental health. We will look at prevention and early intervention and at health education and promotion, and finally we will outline some strategies that might be developed to enhance the health of young people.

Recent trends in adolescent health

In spite of the fact that there is a negative tone in some of the writing we have quoted above, a surprising number of trends identified in recent data sets show an improvement rather than a deterioration in overall health (see Hagell et al, 2013). To take some examples: firstly, in the UK there has been a continuing fall in teenage conceptions since 1998. Data reporting conception rates in 2012 indicate that there has been a 41% reduction in these rates over a 14 year period (Office for National Statistics, 2014a). Secondly, there are also continuing reductions in smoking rates among young people, as well as a fall in the prevalence of drinking alcohol. Thirdly, in 2012 the rates of drinking were the lowest since 2000, with a fall of nearly 50% over this period in the 11-15 age group (HSCIC, 2014). Lastly there have also been falls in the use of illegal drugs, with 16% of adolescents reporting using illegal substances, a rate which is the lowest since 2001 (HSCIC, 2014).

Of course not all health behaviours have shown the same downward trend. In some areas where there have previously been increases, the trends appear to show a levelling off after rises in previous years. Two good examples here are obesity and chlamydia. Both these areas of health, one to do with eating behaviour and the other to do with sexually transmitted infections, have been areas of concern in recent years. Recent data, however, illustrate that the apparently remorseless upward trends have possibly been halted, at least for the present (Hagell et al, 2013).

One of the areas of greatest uncertainty as far as trends are concerned is mental health. This is partly because it is difficult to collect data on some aspects of mental ill-health, such as self-harm, and partly because the UK government has not been investing in appropriate research in order for trends to be monitored. The last large scale study of mental ill-health among adolescents in the UK was carried out in 2004 (Green et al, 2005). The one area in which we can be relatively confident about the data is that to do with suicide. The most recent data show that there was a downward trend among young men aged 15 to 24 from the mid-1990s to the mid-2000s. This trend has now levelled off, and there has been little change in the rate of suicide in this age group since 2005 (Office for National Statistics, 2014b).

Many of the trends outlined above are positive, yet there is no room for complacency. The actual rates of some health problems are still at a level above that of other high-income countries. One example may be drawn from the mortality statistics, which show that whilst mortality among adolescents in the UK has fallen in recent years, the reduction has not been as marked as in other similar Western countries (Viner et al, 2014). It is also noteworthy that there are substantial differences in health among different adolescent populations in the UK. There is large variation in rates of suicide, teenage conception, sexually transmitted infections and other health indicators, depending on the geographical locality of the individual adolescent. Analysis of data from the Health Survey for England has shown strong links between income inequality and general health among young people (Vallejo-Torres et al, 2014).

Risk and health

The concept of risk is a difficult one, and it is important to distinguish between risk factors and risky behaviour (see Coleman and Hagell, 2007). Thus risky behaviour, as we have already indicated, might include unsafe sex, serious substance misuse, binge drinking and so on. Risk factors, however, have a different meaning. We have already referred to health inequalities. This term indicates that those growing up in certain environments, such as poverty and deprivation, may experience a higher level of poor health than those growing up in affluent circumstances. In this sense the environment may be a risk factor for health. Here we will first of all consider the concept of risky behaviour before discussing risk factors in adolescent health.

In any discourse on health in adolescence, it is almost inevitable that the notion of risky behaviour will be considered. Many believe that adolescents will expose themselves to risk, whether they are engaging in the use of substances, becoming sexually active for the first time, binge drinking or eating unhealthy foods. It is this belief that lies at the heart of so many of the gloomy predictions about the health of young people today. Some sociologists go even further, talking about 'the demonization of youth'. In his article about young people, drugs and alcohol, Blackman (2009:270) states:

> *It would appear that the demonization of youth in relation to intoxication … shows youth conforming to one social type, that of the 'deviant other'. In the twenty-first century the media and popular magazines have used this 'othering' to concentrate on youth difference and to highlight youthful indulgence.*

The alternative view is that taking risks may be seen as part of a learning process. Without experiencing health behaviours that involve risk, adolescents cannot develop notions of what is safe and healthy for them. If all behaviours that have potential risks for health were to be avoided, then adolescents would not be able to learn how to manage challenges and overcome obstacles. In a thoughtful article about risk, Michaud (2006) pointed out that there is a close association between a general negative stereotype of young people, and the belief that they are likely to engage in high risk behaviours. He argued that the negative stereotype damages relationships between the generations, and that it is something we need to question at every opportunity. In fact risk behaviour in adolescence is not universal. Whilst most adolescents will experiment in one way or another with some health behaviours that could lead to risk, many do so in a responsible manner.

Behaviours such as the use of illegal substances, or early sexual experimentation can be seen as a threat to health, but they can also be seen as part of a phase of exploration. This fits with the conclusions reached by researchers such as Engels and van den Eijnden (2007), who studied alcohol use among adolescents. They pointed out that drinking has what they called a facilitating function for young people. In their view drinking helps adolescents deal with social situations and develop important social skills. Of course there are young people who take risks with their health, but they are in the minority, and of these many are likely to come from backgrounds of disadvantage or deprivation. It is for this reason that, Michaud (2006) argued, we urgently need to address the need for good quality health education among all sectors of society.

In recent years much of the discussion about risk-taking and risky behaviour has been influenced by research on the adolescent brain. This discussion has also focussed on the limitations of young people, and is very much of a piece with other deficit models of youth. Here the argument goes that during early adolescence two sites in the brain undergo especially significant development. One site is the prefrontal cortex, the location of thinking, reasoning and problem-solving. The second site is the amygdala, linked to sensation, arousal and reward-seeking. In recent years most neuro-scientists have argued for a notion of 'developmental mismatch'. By this is meant that one site, the amygdala, develops faster than the other, the prefrontal cortex.

This notion is directly relevant to risk-taking, since if the area in the brain linked to reward and sensation-seeking develops faster than the area related to thinking and reasoning, then it is possible that this could be an explanation for risk-taking in adolescence (Smith et al, 2013). However it is clear that not all young people are risk-takers, and other factors apart from the brain, such as the family environment, will have an impact on behaviour. Nonetheless recent studies of the

adolescent brain have been taken as support for the view that risk-taking is an inherent feature of adolescent development.

Turning now to a consideration of *risk factors*, it will be evident that there are a large number of possible factors which will impinge on an individual's health. One way of classifying risk factors is to distinguish between those that are independent and those that are non-independent (Coleman and Hagell, 2007). Events outside the control of the individual are considered to be independent, and may include poverty, family environment, accidents, natural disasters and so on. Non-independent events are those related to an individual's own behaviour, which may include relationship problems, taking risks with health, and so on. Another approach to understanding risk factors is to categorise them into individual, family and community factors. Some of the following are examples of these categories:

- *Individual factors*: temperament, intelligence, motivation;
- *Family factors*: genetic predisposition, parental health behaviours, conflict and stress within the home, trauma such as death or divorce, sibling behaviour;
- *Community factors*: economic circumstances, quality of housing, quality of schooling, the behaviour of the peer group, neighbourhood resources, availability of sports facilities.

Clearly this is not an exhaustive list, but it does provide some indication of the sorts of risk factors affecting health that may originate from different sources.

'Hot' topics in adolescent health

In recent years a number of topics have come to the fore as being of special notice due either to new research becoming available, or because of increased public concern. We will select three of these for consideration here. These topics include sleep, nutrition and mental health. Let us first look at *sleep* in adolescence. The hormone melatonin has an effect on our sleep patterns. When the level of melatonin rises in the body we become drowsy, and this helps us to go to sleep at night. As many people now know, research on adolescent sleep patterns has shown that among this age group melatonin levels rise more slowly at night, whilst the circadian rhythm is also altering, thus making it more difficult for young people to get to sleep.

This finding has important implications for health. We know that young people need at least 8 hours sleep at night, but if they are going to sleep later, and waking in time to get to school, they may be suffering a sleep deficit. Studies show that sleep deficits affect both learning and behaviour. This conclusion has led schools to reconsider their start times in the morning, and it has recently been announced that the Welcome Trust and the Education Endowment Trust are to fund 100 schools in the UK to delay start times and monitor future exam results for pupils who will be going to school later over the next five years (Education Endowment Trust website). In terms of health specifically, evidence is starting to appear showing that fatigue due to sleep deficit may also

lead to a higher level of accidents among this age group, as well as more common illnesses, stress and mental health problems (Orzech et al, 2014). It is important to note that much can be done in the home to help young people establish regular sleep patterns. Having a half hour to wind down before going to bed, turning off electronic devices, listening to soothing music and other strategies can all assist adolescents to take control of their sleep. The evidence is clear that the amount of sleep that young people are able to have, especially during the early years of adolescence, will make a difference to many aspects of health and behaviour.

The next topic to consider is that of *nutrition*. From the mid-1990s onwards there was a major public health concern about obesity in children and adolescents. However as the upward trend in obesity and overweight has begun to level out, attention has turned to dietary habits, healthy eating, the consumption of fruit and vegetables, and so on. The 'five a day' campaign has highlighted the fact that young people are not getting anywhere near the recommended level of consumption of fruit and vegetables. On average 11 to 18-year-old young women are eating only 2.8 portions of fruit and vegetables, whilst young men only eat 3 portions a day (Bates et al, 2012). Young people have also been shown to have low levels of daily intake of the necessary minerals, such as iron. In addition a significant number of British secondary school children report daily consumption of foods high in fat, salt and sugar. These foods are of course low in nutritional value (Zahra et al, 2013).

It should be noted, however, that nutrition in children and young people has many determinants. Food choice is to a large extent a social and cultural phenomenon. Diet will be influenced by family values, by family finances, as well as by the behaviour of the food industry. In recent years it has been recognised that schools can play a part in influencing diet, but there is a limit to the scope of this influence. Even more significant for adolescents is the fact that food choice has to do with identity. Young people use food to define difference, and this has echoes of the discourse about youth being the 'other' in our society. Adolescents choose foods that define them as different from adults, and in this way pizza, pot noodles, and fast foods become symbols of adolescent identity (Cote, 2009).

Despite many years of focus on *mental health* in young people, it remains one of the most pressing issues for this age group. Whilst most young people report high life satisfaction (Office for National Statistics, 2014c), mental health problems are not uncommon in this age group. According to the most recent large scale study (Green et al, 2005), around 13% of boys and 10% of girls in the 11-15 age group have emotional, behavioural or hyperactivity disorders. Half of all lifetime cases of psychiatric disorders start by the age of 14, and three quarters by the age of 24 (Kessler et al, 2005). From the young person's point of view, the concept of health is very much tied up with questions of stress levels, anxiety and depression. From the service perspective, much attention is being paid to the introduction of new therapeutic methods, and in particular the introduction of the NHS England's programme under the title 'Increasing Access to Psychological Therapies' or IAPT. Many believe

this is a positive step, whilst others, especially practitioners, have serious concerns as to the suitability of what is essentially a cognitive behaviour therapy model to all adolescent mental health problems.

In addition to all this there is a worrying reduction in funding going into the Child and Adolescent Mental Health Services (CAMHS). CAMHS has been particularly hard hit by the cuts in services over the last five years, and waiting times for a CAMHS appointment are currently longer than they have been for decades. However it is quite hard to keep track of what is happening in CAMHS at a national level. CAMHS services are not subject to mainstream comparisons and performance analysis across the NHS. There is much variability in what is on offer from one area to the next, and the thresholds for receiving treatment also vary. And CAMHS is only a small part of the story. At most the specialist services see around 1.5% of the age group or less (NHS Benchmarking Network, 2013). As we have suggested, a much higher proportion are likely to have symptoms that would benefit from intervention. This means that we need to broaden our attention to other delivery mechanisms for mental health interventions for this age group including making the best use of the services of the voluntary sector, primary care and counsellors in the education setting.

It is perhaps worth noting that, in considering the possible stresses and challenges facing young people today, many commentators see the digital world and the pressures of social media as being an important contributor to increased mental health problems. Issues such as cyber-bullying, as well as the constant demands involved in messaging and sharing images and content on-line may possibly lead to higher levels of stress or other disorders. Yet as researchers such as Livingstone and Sefton-Green (2014) indicate, there are numerous advantages and opportunities provided by the internet. It is important to retain a balanced view of the impact of new technologies on young people, and there is as yet no clear evidence that links rates of emotional disorder with the challenges of the digital world. In addition to the digital world, other suggested explanations for changing rates of mental health problems have included increasing experience of examination stress and the insecurities that have come with the collapse of the youth labour market (Hagell, 2012). However, at the time of writing we lack good trend data on young people's mental health problems over the last 10 years so it is not quite clear what we are trying to explain.

Prevention and intervention

One way to bring together thinking about risk factors and health is to consider how to approach the problem of prevention and intervention. For a variety of reasons the adolescent stage is a critical time for intervention. A major process of maturation is occurring at this time, and a wide range of behaviours are in the process of becoming embedded which will have significant implications for health. Before we commence this section it is important to note that prevention and intervention do not necessarily mean the same. Some universal interventions might be given to a whole population, with the intention of preventing future health problems. On the other hand some interventions may be put in place as a form of treatment where prevention is no longer possible.

Although the phrase 'early intervention' tends to be used to refer to programmes aimed at young children, in fact it is important to recognise that interventions in adolescence are especially important at this stage, particularly where health is concerned. What are the reasons for this? This is primarily because many of the potential threats to physical health emerge during this stage. Thus smoking and drinking are likely to occur for the first time, as are early sexual experiences. Patterns of exercise and diet become established during the adolescent phase, and it seems likely that the individual's set of attitudes and beliefs about health develop as part of wider identity formation. In addition to the threats to physical health, we know that many mental illnesses emerge during adolescence. Young people move through a sensitive period, with rapid brain development and newly manifesting genetic factors which influence health and illness. Rates of depression rise markedly as young people enter adolescence (Maughan et al, 2013), and other mental illnesses such as psychosis, obsessive compulsive disorder and suicidal behaviour begin to appear at this stage of life.

Due to the special characteristics of adolescence there are particular levers for health interventions that can be utilised at this time, increasing the potential for effectiveness. These levers include behavioural flexibility because health habits and attitudes are not yet fully formed, the possible role of the family, both parents and siblings, as mentors and agents of change, and lastly the key role of the peer group as a source of norms and influence. Furthermore there is the potential role of the educational context, whether school or college, as a context for health education. It is to this that we now turn.

It will only be possible in this article to highlight a few examples of interventions relevant to young people's health. The first illustration of such an approach is a school-based programme aimed at smoking reduction. Smokers who start before the age of 16 are twice as likely to go on to be adult smokers as those starting after 16, and as a result these early smokers represent an important target for health promotion. One prevention programme which has been successful is the ASSIST programme (A Stop Smoking in Schools Trial) (Campbell et al, 2008). This is a peer-led intervention aimed at preventing smoking uptake in secondary schools. Influential students are trained to act as peer supporters during informal interactions outside the classroom. Results have shown a 22% reduction of the likelihood of being a regular smoker in an intervention school compared with a control school. If this were to be implemented on a wider scale across many schools it could lead to a significant reduction in adolescent smoking. It is especially interesting as it illustrates what we said earlier about the levers available at this life stage. It deliberately sought to exploit the school context as well as informal channels of information exchange and peer influence outside the classroom.

An illustration of a different approach to intervention is the use of Motivational Interviewing to address alcohol or substance misuse, or violent behaviour. Motivational Interviewing usually consists of relatively brief sessions that do not attempt to pass on information or teach skills.

Rather the sessions explore and reinforce the young person's intrinsic motivation towards more healthy behaviour. Motivational Interviewing has a strong focus on autonomous decision-making, thus facilitating the adolescent's need for increasing independence. The sessions emphasise the importance of young people being able to make decisions for themselves, thus it is a good fit for the maturing adolescent as it is non-judgemental, empathic and collaborative.

It is a short intervention, usually consisting of one to three sessions, and can be delivered in different modalities, either in individual sessions, in a group or on the telephone. There are now in excess of 80 randomised control trials indicating effectiveness, particularly for substance misuse. It has been tested in a variety of different localities including primary care, education and youth work settings. It works well in situations where young people attend for a different reason, as for example in hospital Accident and Emergency departments (Barnett et al, 2012).

As a third example we will consider school-based resilience programmes. One of the most well-known of these is the Penn Resilience Programme (PRP). This is a programme that was developed in the USA by Seligman (1996), but was imported into the UK in the mid-2000s. It consists of sessions usually spread over two school terms and it is delivered by trained facilitators. The PRP is based on a combination of cognitive behaviour therapy and social problem-solving skills. It includes sessions on assertiveness, negotiation, decision-making and relaxation. Lessons use role play, short stories and discussions to develop skills. It has been used widely in UK secondary schools, and the programme has been subjected to a large number of randomised control trials, indicating that it is successful in reducing symptoms of depression and anxiety. In 2009 three UK local authorities signed up to its use, and the evaluation showed that, in schools where the PRP had been fully implemented, there was significant short-term improvement in depression symptom scores, school attendance rates and English attainment (Challen et al., 2011).

These three examples are indicative of the types of early intervention that are possible with this age group. They have all been subject to the most rigorous level of evaluation, namely the use of randomised control trials. Of course there are numerous interventions that may have some impact on health that do not reach this level of evaluation. The examples that we have chosen show that it is possible to make a difference to health behaviours at the adolescent stage, and interventions such as these should be part of any health improvement programme for this age group. We will now turn to some other possible strategies to influence health behaviours and enhance the health of this age group.

Improving the health of young people

In the previous section we have looked at prevention and intervention, and it is now time to turn to other facets of health improvement. One key element here is the way in which health is perceived by the different generations. High on the agenda of most adults when thinking about young people's

health will be smoking, drinking and drugs. However these are not the most pressing health issues for young people. For this age group issues such as appearance, nutrition, sports injuries, sexual and social relationships, and emotional well-being are likely to be of more concern. This fact has to be taken into account when planning health education programmes.

A strong theme which emerges from research into young people's attitudes is their desire to be able to act autonomously and have control over their own personal decision-making. Adolescents usually wish to make their own minds up about health behaviour after obtaining reliable information. The needs of young people in relation to their health can thus be summarised as follows:

- A chance to discuss implications freely without foregone conclusions.
- Information based on the context of their lives.
- Tailored resources for different genders and different ages.
- Up-to-date, relevant and non-judgemental information.

The fact that young people have their own views about health, and that in most cases they wish to be able to have control over decisions relating to their health has to be taken seriously when adults are planning health education or organising services. Far too often it is the case that adults decide what is best, forgetting that young people are service users whose needs may not necessarily be the same as those of adults.

These points link closely with considerations about the type of services that are best suited to the needs of young people. For ten years or so the Department of Health in London has promoted a set of criteria, known as the 'You're Welcome' quality standards. These standards were at first applied to primary care, but have now been extended to hospital care as well. The standards of 'You're Welcome' include:

Accessibility. A service should be available outside school hours, should be accessible by public transport, and it should be possible for a young person to make an appointment without the involvement of an adult.

Confidentiality. It is essential that professionals understand the importance of confidentiality for young people, and that services make their confidentiality policy clear to their adolescent patients. Young people, including those under the age of 16, have the right to a confidential service.

The environment. Waiting rooms and other public spaces should be welcoming to young people, and should provide useful and age-appropriate information.

Staff training. All medical staff should have basic training in communication with young people, and ideally should have some introduction to adolescent development.

Involvement of young people. Health professionals should get feedback from young people about services and about their suitability for this age group. If at all possible the views of young people should be taken into account in any practice developments.

While these criteria will facilitate more youth-friendly services, it is essential to understand young people's health against the background of the wider social influences on their behaviour. Most importantly young people need to be provided with the information and support which will enable them to face challenges and choices in relation to their health. Of course information alone is not sufficient, since knowing about the consequences of a particular behaviour will not necessarily lead to appropriate actions. Adolescents may well have good information about nutrition without engaging in healthy eating, just as they may know about safe sex but not be able to make use of that knowledge when it becomes directly relevant to behaviour. Most commentators take the view that social context is almost certainly the most important influence on health behaviours in adolescence. It is important therefore to understand the meanings young people themselves attach to their behaviours, as well as to acknowledge that young people, very much like adults, may well act in a contradictory fashion when it comes to health behaviour.

Conclusion – health and youth policy

To conclude this article we will consider how the topics covered are relevant to youth policy. In the first place there is the question of negative stereotyping, or the 'demonization' of youth. As we have seen this has a profound influence on how adolescent health is understood by the adult world. It also has a critical influence on how services are organised and delivered. It is essential that commentators, policy makers and practitioners seek to address the negative stereotype whenever possible, and ensure in their work that the stereotype is challenged so that a positive, strengths-based approach can be taken at all times.

Our second point has to do with the voice of the young person. In this article we have highlighted examples of interventions and services where the adolescent point of view is taken into account. This may be where young people are asked about service delivery, or where they are given an opportunity to state what they want from treatment rather than have an adult view thrust upon them. All the evidence shows that the more young people can be given a voice in health matters, the more they will engage with health and the more likely they are to pursue a healthy lifestyle. As an example of this approach the National Youth Agency developed a programme called 'Hear By Right' (Badham and Wade, 2005). This programme challenged adult-led organisations in the health field to ask themselves to what extent they were listening to young people in their work.

The point about youth voice has clear links to notions of participation and empowerment. The more young people believe that their voice is being heard, the more empowered they will feel. However, as Mackinnon (2007) points out, young people can participate without feeling empowered, and

indeed they can allowed to speak without anyone taking any notice of what they say. For this reason it is as much the quality and intention of the involvement of young people that makes the difference, rather than the formal arrangement established by the adults involved. There are many types of participation, ranging from the tokenistic to the fully engaged and involved, as has been well rehearsed in discussions about Hart's Ladder of Participation. It goes without saying that the greater the degree of genuine participation, the better it will be for the health of young people.

Finally it is worth underlining the importance of differentiating the needs of young people from the needs of children. All too often in the field of health, children and young people are seen as one group. Services are planned for and delivered to one group, and health data are very often collected in one age group, as for example 5-19, or 0-15. We cannot emphasise too strongly the necessity of understanding and recognising that adolescents have a range of different needs when it comes to health service provision. As we have pointed out, this stage is a time of gradually increasing autonomy, when it is essential that young people start to take responsibility for their own health. Adult professionals must be trained to recognise that adolescence is a stage, and that it has particular characteristics that should inform health services, health interventions and health promotion. To achieve this would represent a significant step towards better health provision for all young people.

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References

Barnett, E., Sussman, S., Smith, C and Spruit-Metz, D. (2012) 'Motivational interviewing for adolescent substance use: a review of the literature', *Addictive Behaviours*, 37, pp.1325-1334.

Bates, B., Lennox, A., Prentice, A., Bates, C. and Swan, G. (2012) *National Diet and Nutrition Survey*, London: Department of Health.

Badham, B. and Wade, H. (2005) *Hear by Right: Standards for the Active Involvement of Children and Young People*, The NYA/Local Government Association.

Blackman, S. (2009) 'Young People, Drugs and Alcohol Consumption', in Furlong, A. (ed.) *Handbook of Youth and Young Adulthood*, London: Routledge.

Campbell, R., Starkey, F., Holliday, J., Audrey, S., Bloor, M. and Moore, L. (2008) 'An Informal School-Based Peer-Led Intervention for Smoking Prevention in Adolescence (ASSIST)', *The*

Lancet, 371, pp.1595-1602.

Challen, A., Noden, P., West, A. and Machin, S. (2011) *UK Resilience Programme Evaluation: Final Report*, London: Department for Education.

Coleman, J. and Hagell, A. (eds.) (2007) *Adolescence: Risk and Resilience*, Chichester: John Wiley.

Cote, J. (2009) 'Youth Identity Studies: History, Controversies and Future Directions', in Furlong, A (ed.) *Handbook of Youth and Young Adulthood*, London: Routledge.

Eckersley, R. (2009) Progress, Culture and Young People's Well-being, in Furlong, A (ed.) *Handbook of Youth and Young Adulthood*, London: Routledge.

Education Endowment Foundation website http://educationendowmentfoundation.org.uk/projects/teen-sleep downloaded 28 December 2014

Engels, R. and van den Eijnden, R. (2007) 'Substance Use in Adolescence', in Coleman, J., Kloep, M. and Hendry, L. (eds.) *Adolescence and health*, Chichester: John Wiley.

Green, H., McGinnity, A., Melzer, H., Ford, T. and Goodman, R. (2005) *Mental Health of Children and Young People in Great Britain 2004*, London: Office for National Statistics.

Hagell, A. (2012) *Changing Adolescence: Social Trends and Mental Health*, Bristol: Policy Press.

Hagell, A., Brooks, F. and Coleman, J. (2013) *Key Data on Adolescence 2013*, London: Association for Young People's Health.

Health and Social Care Information Centre (2014) *Smoking, Drinking and Drug Use Among Young People in England in 2013*, Leeds: HSCIC.

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K. and Walters, E. (2005) 'Lifetime Prevalence and Age-of-onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication', *Archives of General Psychiatry*, 62, pp.593-602.

Livingstone, S. and Sefton-Green, J. (2014) *The Class*, New York University Press. (In Press.)

Mackinnon, D. (2007) 'Health Promotion and Health Education', in Coleman, J., Kloep, M. and Hendry, L. (eds.) *Adolescence and health*, Chichester: John Wiley.

Maughan, B., Collishaw, S. and Stringaris, A. (2013) 'Depression in Children and Adolescents', *Journal of the Canadian Academy of Child and Adolescent Psychiatry,* 22(1), pp.35-40.

Marmot, M. (2010) *Fair Society, Healthy Lives*, London: Department of Health.

Michaud, P-A. (2006) 'Adolescents and Risk: Why not Change our Paradigm?' *Journal of Adolescent Health*, 38, pp.481-483.

Nathanson, V. (ed.) (2003) *Adolescent Health*, London: British Medical Association.

NHS Benchmarking Network (2013) *Raising Standards Through Sharing Excellence, Royal College of Psychiatrists*, downloadable from http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1%281%29.pdf

Office for National Statistics (2014a) 'Conception Statistics, England and Wales 2012', *Statistical Bulletin*, London: ONS. http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/2012/2012-conceptions-statistical-bulletin.html

Office for National Statistics (2014b) 'Suicide Rates in the United Kingdom, 2012 Registrations',

Statistical Bulletin, London: ONS. http://www.ons.gov.uk/ons/dcp171778_351100.pdf

Office for National Statistics (2014c) *Measuring National Well-being: Exploring the Well-being of Children in the UK, 2014*, London: ONS. http://www.ons.gov.uk/ons/dcp171776_379712.pdf

Orzech, K., Acebo, C., Seifer, R., Barker, D. and Carskadon, M. (2014) 'Sleep Patterns are Associated with Common Illness in Adolescence', *Journal of Sleep Research*, 23, pp.133-142.

Seligman, M. (1996) *The Optimistic Child*, New York: Houghton Mifflin.

Smith, A., Chein, J. and Steinberg, L. (2013) 'Impact of Socio-Emotional Context, Brain Development and Pubertal Maturation on Adolescent Risk-Taking', *Hormones and Behaviour*, 64, pp.323-332.

Vallejo-Torres, L., Hale, D., Morris, S. and Viner, R. (2014) 'Income-Related Inequality in Health and Health-Related Behaviour', *Journal of Epidemiology and Community Health*, 68, pp.615-621.

Viner, R. and Barker, M. (2005) Young People's Health: The Need for Action, *British Medical Journal*, 330, pp.901-903.

Viner, R. M., Hargreaves, D. S. Coffey, C., Patton, G. C. and Wolfe, J. (2014) 'Deaths in young people aged 0-24 years in the UK compared with thye EU 15+ countries, 1970-2008: analysis of the WHO Mortality Database', *Lancet* 384 (9946) pp.880-892.

West, P. (2009) Health in Youth: Changing Times and Changing Influences, in Furlong, A (ed.) *Handbook of Youth and Young Adulthood*, London: Routledge.

Zahra, J., Ford, T. and Jodrell, D. (2013) *'Cross-Sectional Survey of Daily Food Consumption, Irregular Eating, Mental and Physical Health, and Parenting Style of British Secondary School Children'*, Child Care, Health and Development, 40(4), pp.481-91.

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