The UK has 11.7 million young people aged 10-24 making up 19% of the population. Good health for young people is central to their wellbeing, forming the bedrock for good health in later life. There are encouraging developments, such as the reductions in the proportions drinking and smoking, but there are also worrying trends and large health inequalities. It is critical that we invest in this life stage.

The Association for Young People’s Health (AYPH) works closely with policymakers, young people, practitioners and researchers to promote awareness about young people’s health needs. In this update we set out the latest policy and practice debates, recent data on trends, and recommendations for ‘where next’.

**Key Messages**

- We continue to need a strong voice for young people’s health to ensure that adequate resources go to this critical life stage.

- Many trends in health behaviours and health outcomes for young people are going in a positive direction, but there are also some more worrying indicators.

- We are particularly concerned about the implications of new substance use behaviours; relatively high rates of sexually transmitted infections; the lack of a reduction in obesity; helping young people manage long term conditions and warning signs that mental health problems may be increasing.

- Although it is important to raise the profile of particular health conditions, we argue that we need more effort now on cross-cutting themes in young people’s health.

- These themes include the overlap between physical and mental health; promoting young people’s health in existing outcomes frameworks; understanding the role of adverse childhood experiences; promoting youth friendly health services; ensuring the most vulnerable young people have equal access to health services; and maximising the importance of the education setting for health promotion.

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The last couple of years have been a fast moving time in policy terms for young people’s health. Since our last update in 2014, a number of initiatives and key policy and guidance documents have been published. The following is not a comprehensive list, but highlights some important milestones and challenges in the current context:

At the time of our last update we flagged up recommendations made by the Chief Medical Officer for England in her important 2012 report on the health of children and young people. There has been some progress in relation to each of these, including:

- Development of a **youth social marketing programme** to address risky health behaviours – The ‘Rise Above’ website was set up for this purpose, a site led by young people to help other young people find out more about health. However it is not a ‘social marketing’ scheme as such, although a number of other initiatives are operating in this space including, for example, ‘Time to Change’ (a social marketing strategy to reduce stigma about mental health).

- Refreshment of the **You’re Welcome quality criteria** for youth-friendly services – this project is underway in a partnership between Public Health England (PHE), NHS England, and the Department of Health. The refresh is being undertaken by the British Youth Council, Association for Young People’s Health, and Youth Focus North West. When complete, this will update the content of the standards and the accreditation process, eliminate existing barriers, and set the basis for further roll out across a wider range of health settings. The aim is to improve access to services for young people. Unmet healthcare need during adolescence is a **predictor of poor health** in adulthood.

- Promotion of **resilience** in young people – interest in promoting resilience remains very high among commissioners and front-line practitioners, and PHE funded an on-line, interactive ‘Resilience resource’ as a result of this recommendation, published 2015.

- Publication of an **adolescent health and wellbeing framework** – PHE commissioned this framework from the Association for Young People’s Health, to help public health to set priorities for action to promote outcomes for young people. The framework was published and disseminated by PHE in 2015.

The CMO has also flagged up issues relevant to young people in two subsequent reports; in her 2013 report on mental health where she stressed the need for a greater focus on young people, and her 2014 report on women’s health, including a call for a focus on obesity and reproductive health, issues that are critical to young women.
Since 2014 there has been a flurry of activity on young people’s mental health, despite a lack of new epidemiological survey data, although we understand a new government funded survey is due to take place shortly. ‘Future in Mind’ (2015) contained the recommendations from the taskforce on children and young people’s mental health and wellbeing, and it set in motion a ‘transformation’ of local child and adolescent mental health services in England. Combined with new pledges of funding, this should improve waiting times for services and access to a wider range of interventions although the effects need monitoring over coming years. ‘Future in Mind’ followed a hard hitting inquiry report from the House of Common’s Health Committee on ‘Children and adolescents’ mental health and CAMHS’ at the end of 2014, also delivering a number of key recommendations. Reports from front line practice and patient experiences suggest something approaching a crisis in current provision, with a large treatment gap (up to 75% of those meeting a diagnosis not receiving timely treatment and 28% of referrals turned away), overuse of accident and emergency for mental health crises, and a lack of funding for prevention and early intervention. Referrals to specialist CAMHS have more than doubled in recent years, although without good epidemiological data it is not clear what is driving this increase.

There has also been activity in relation to obesity. In November 2015 the House of Commons Health Committee published the results of an enquiry into childhood obesity demanding bold and urgent action. In March 2016 a new sugar tax was announced in the UK Budget, aimed at high-sugar, particularly fizzy, drinks. This reflected the fact that while a single can of coca-cola contains 35g of sugar (7 teaspoons), the maximum recommended intake per day for those aged 11+ is 30g. In August 2016 the government’s Childhood Obesity Plan for Action was launched. However this has been criticised for not going far enough; the main levers are reduction of sugar consumption and increase in physical activity, but no measures to restrict advertising to children or price promotions, both of which had been firmly recommended by the Health Committee.

The UK government deficit reduction programme (the “austerity programme”) is a series of reductions in public spending initiated in 2010 and extended until 2018, although possibly halted now in the lead up to exit from the EU following the UK referendum in June 2016. It has been argued that cuts to date have disproportionately hit services to young people, the voluntary sector and youth work and indeed a number of local authority departments have disbanded their youth service in recent years. This has health implications, as these services can include, for example, mental health support and community contraception advice. Ensuring the survival of a robust voluntary sector is a critical part of protecting the health of adolescents and young adults.
Young People’s Health - an update on recent policy and practice

4 Following the political changes in the summer of 2016, there has been a reshuffling of responsibilities for various aspects of young people’s health in the main government departments in England and Wales. For example, responsibility for youth policy (including elements of promoting resilience) moved from the Cabinet Office, where it had been since 2013, to the Department for Culture, Media and Sport. Responsibility for different aspects of young people’s health are split across a number of departments including health, education, culture, law and order and others, not to mention the arm’s length agencies such as Public Health England, but in general the size of civil service teams focusing on the issue has shrunk in recent years. The concern is that it is difficult to promote a coherent policy for young people’s health when so many departments and agencies are involved, and when staff teams may be reducing in size. Fragmentation of responsibility for young people’s health is also happening at the service delivery level, being divided between local authorities, Clinical Commissioning Groups and NHS England as well as other partners.

5 The current emphasis on securing the best start in life in, for example, the Public Health England priorities, and the transfer of responsibility for public health of 0-5 years to local authorities has inevitably led to an increased focus of resources on the early years. This is clearly crucial, but can create a competing agenda in relation to investing in the health of teenagers. It is important that both are given equal weight. However, there has been a welcome new emphasis on prevention and early intervention in the lives of children and young people driven in part by the NHS five year forward view published in 2014. Although this is often thought to mean young children, it is also critical with adolescents – particularly as the NHS forward view explicitly aims to reduce risky health behaviour leading to obesity, smoking and unsafe alcohol consumption, all of which can settle in during adolescence.

6 In other policy domains, there is a positive new emphasis on the needs of the wider age band of young people/young adults (10-24), reflecting social change in young people’s lived experience, where transitions to adulthood may be slower in some domains than others and practical dependence on family of origin may be extended compared to previous generations. There is growing awareness of the supports needed while making the shift to taking responsibility for personal healthcare, particularly for those with long term conditions. Although there remain important challenges in navigating the transition from child (to 18) services and adult (from 18) services in healthcare, more and more agencies appreciate that 18 is not a magic marker for adult status. Many young people of 19, 20 or older still require more support than adults who are past their mid-20s while others may be ready to transition at age 16 or 17. For example, in 2014 in England significant legal reform obliged local authorities to support every young person who wanted to stay in foster care until their 21st birthday, extending this up from age 18. The National Institute for Clinical Excellence published new guidance on transitions in healthcare in 2016.

7 There continues to be a challenge posed by the ‘siloh approach to health issues, dealing separately with policies and resources for smoking, mental health or diabetes, rather than promotion of a holistic approach to young people’s health in the round. For example, the mental and physical health elements of obesity are rarely brought together. Yet young people continuously tell us that they see their health holistically and indeed do not make much distinction between issues of physical and mental health, seeing the two as closely related. Policy and practice lags some way behind.
The role of schools and colleges in promoting the health and wellbeing of young people has also been the focus of policy debate and practice initiatives in recent years. Evidence on the importance of schools to young people's health outcomes accumulates, and many areas continue to promote a healthy schools' approach. But there are challenges about how to implement and support positive initiatives at a time of fragmentation of the education system, academisation of secondary schools, and huge variation in education models. Challenges and opportunities are also posed by the recent extension of participation in education in England to age 18. Despite widespread professional, public and political support (including strong cross party support from five select committees), there has been limited progress on making Personal Social Health and Economic (PSHE) education a statutory requirement at secondary school. Yet there is growing evidence that young people want to learn these topics at school, and that learning them at school is beneficial to their wellbeing. Ofsted does not inspect PSHE provision but does look at personal development, behaviour and welfare outcomes. Other relevant issues that have received recent attention include how best to support and deploy the relatively small workforce of school nurses, and how to promote health literacy in the educational setting.

The last couple of years have seen an increased interest in, and pilots of, devolution of responsibility for health and social care from central control to local statutory organisations in regional areas. Devolution has started to go ahead in a number of locations including Greater Manchester. The potential benefits of devolution of health care include possibilities for better integration of services and a more joined up, locally relevant response to young people’s health needs. But more local control could mean that in some areas the focus on young people’s particular health needs get lost. It remains to be seen whether the benefits are positive or negative.

The Lancet Youth Commission, with a significant report in 2016, has provided a useful global perspective on the shifting determinants of health and health needs of the world’s adolescents and young adults. Consisting of 30 members from 14 countries, the commission points up the intractable burden of non-communicable disease for this age group and identifies an array of shared issues in engaging with young people and providing suitable services. The World Health Organisation has also published a global strategy for women’s, children’s and adolescents’ health (2016-30).

Finally, we want to stress the challenges of ensuring the funding stream for health improvement is informed by expertise specifically in promoting young people’s health. Following their establishment by the Health and Social Care Act in 2012, clinical commissioning groups (CCGs - clinically-led statutory NHS bodies) have set out what local health services will and will not fund. They may or may not have representatives who are familiar with the particular needs of the young people in their area, and members may not be aware, for example, of the particular role that voluntary sector services (such as sexual health charities) play in helping young people achieve good outcomes. CCGs are overwhelmed with information and requests for funding, and ensuring they have accurate up to date information about what works for young people is critical. In addition, groups of CCGs have been organised into 44 “footprints” across the country, working to shared sustainability and transformation plans (STPs). This might make it even more challenging in some respect to ensure young people’s health is on the agenda, but on the other hand there is an opportunity in larger groupings of CCGs to ensure that one person at least has young people expertise. More and more resources are available to help – for example, the Young People’s Health Partnership, a consortium of voluntary sector providers working to improve young people’s health, has produced a series of training and commissioning guides.
Adolescence is a critical time for laying the foundation for health and wellbeing in adulthood. Overall, statistics for the UK and/or England and Wales show that many of the trends in health behaviours and health outcomes for young people are going in a positive direction, but there are also some more worrying indicators.

**Substance use**

Traditional substance use is declining, but are new behaviours creeping in?  

<table>
<thead>
<tr>
<th>Year</th>
<th>11-15 year olds smoking at least once a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>10%</td>
</tr>
<tr>
<td>2014</td>
<td>3%</td>
</tr>
</tbody>
</table>

In 2014, 18% 11-15 year olds said they had smoked at least once, the lowest level recorded since 1982.

<table>
<thead>
<tr>
<th>Year</th>
<th>15 year olds reported taking drugs in the last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>38%</td>
</tr>
<tr>
<td>2014</td>
<td>18%</td>
</tr>
</tbody>
</table>

In 2014 6% of 11-15 year olds had been offered legal highs, 2.5% had taken them.

<table>
<thead>
<tr>
<th>Year</th>
<th>15 year olds drinking in the previous week</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>49%</td>
</tr>
<tr>
<td>2014</td>
<td>18%</td>
</tr>
</tbody>
</table>

Sexual Health and Pregnancy

Positive downward trends continue in under-18 pregnancy rates but the picture for STIs for young adults is unclear.

- The rate of under-18 conceptions in England (per 1000 women aged 15-17) has declined by 51% since the 1990s. This is the lowest level since 1969 when records began, although remains higher than many western European countries and shows much regional variation.

- Under 18 conception rates are correlated with rankings for English Indices of Multiple Deprivation at local authority level, and with unemployment rates and the percentage of children in poverty.

- The average age of first heterosexual intercourse has not changed over the last decade, remaining at age 16.

- In 2015, over 1.5 million chlamydia tests were carried out, and over 129,000 diagnoses made in England among 15-24 year olds. This is a reduction in testing and diagnoses.

- Young people aged 16-24 continue to experience the highest rates of chlamydia, genital herpes and genital warts.
Young People’s Health - the latest trends

**Obesity**

*Obesity rates do not seem to be increasing but neither are they declining*.\(^\text{vii}\)

- In 2014-15, **19.1%** children in Year 6 (aged 10-11) were obese and **14.2%** were overweight.

Obesity in 11 year olds increased from 1995-2004, and since then has levelled off.

**Long-term conditions**

*Rates of non-communicable diseases in this age group are an ongoing concern.*

- **25%** of young women take prescribed medicine weekly.
- **25%** of 11-15 year olds report that they have a long term illness or disability, including asthma, diabetes, epilepsy and arthritis.

**Mental Health**

*We still lack good, up-to-date prevalence data, but there are some warning signs that trends may not be positive.*

- **41,921** young people aged 10-24 were admitted to hospital for self-harm through either cutting, poisoning and other methods.\(^\text{ix}\)
- **75%** of mental health problems start before age 24.\(^\text{xiii}\)
- **0.7%** of NHS funding is spent on young people’s mental health.\(^\text{xi}\)
- **11% of the NHS budget being spent on mental health services overall.**\(^\text{xii}\)
- **Referrals to specialist child and adolescent mental health services (CAMHS) increased by 64% between 2012 - 2015.**\(^\text{xiv}\)

**Obesity rates do not seem to be increasing but neither are they declining*.\(^\text{vii}\)

\(^\text{vii}\) Obesity rates do not seem to be increasing but neither are they declining.

\(^\text{viii}\) Higher rates of obesity at age 10-11 are found in areas of higher deprivation.

\(^\text{ix}\) In 2014-15, 19.1% children in Year 6 (aged 10-11) were obese and 14.2% were overweight.

\(^\text{x}\) Obesity in 11 year olds increased from 1995-2004, and since then has levelled off.

\(^\text{xi}\) Percent of NHS funding spent on young people’s mental health.

\(^\text{xii}\) 11% of NHS budget being spent on mental health services overall.

\(^\text{xiii}\) 75% of mental health problems start before age 24.

\(^\text{xiv}\) Referrals to specialist child and adolescent mental health services (CAMHS) increased by 64% between 2012 - 2015.
In previous editions of these updates we have focused on the importance of developments in particular conditions (such as obesity). However, for this edition we have taken the different approach of highlighting some cross cutting-themes. It seems to us that this is where the main efforts should go at the moment, to emphasise young people's health 'in the round', rather than in relation to isolated topics.

In particular, we would like to draw attention to the following:

- The importance of developing our understanding of the overlap of physical and mental health for young people. This is being driven in part by discourse about *parity of esteem*, which is a principle stating that mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012, and should be used to reframe how we think about understanding and treating young people's health issues.

- The need to do more work on how to highlight and promote young people's health in the existing outcomes frameworks and health service incentive programmes. These include, for example, the NHS Outcomes Framework (NHSOF), the Public Health England Outcomes Framework (PHOF), the Quality and Outcomes Framework (QOF) for primary care, and the Care Quality Commission inspection standards. Indicators specifically relating to young people's health get short shrift in most of these, although they are not entirely absent. For example, under-18 conceptions, prevalence of obesity at age 11, smoking at age 15, and Chlamydia detection age 15-24 are all currently covered in the PHOF but there are no young people specific indicators in the NHSOF (although they are included in children with long-term conditions, and hospital admissions under 18-19). We need to ensure that young people's health remains at the heart of NHS, DH and PHE strategies. It is also important to promote the health elements in non-health frameworks such as the Ofsted Common Inspection Framework which touches on individual wellbeing.

- There is great interest at the moment (for example among frontline practitioners) in the importance of *adverse childhood experiences* in determining health outcomes. This represents a reframing of previous discussions about the long-term impact of early childhood, and emphasises the importance of understanding the effects of childhood sexual exploitation, abuse and violence in particular on young people's health outcomes. There is an opportunity here to marshal the research evidence on ACEs in relation to young people and feed into discussions amongst practitioners about their importance. The emphasis on ACEs helps develop arguments for the need to direct more resources at particularly vulnerable groups of young people.

- It seems likely that there will need to be more attention to the links between migration, radicalisation and health issues among young people in the coming years, both in terms of the wellbeing of adolescent refugees to the UK and also building resilience in potentially marginalised communities. Emerging evidence of links between depression and radicalisation emphasise the importance of health in this picture.

- We need a renewed emphasis on the importance of making sure the most vulnerable young people have equal access to health services. AYPH has recently produced an infographic, supported by NHS England, to highlight some of the marginalised groups whose voices may not be heard. These include young carers, young people in the youth justice system,
Young People’s Health - where next?

young people who are looked after by the local authority (LAC), homeless or in unstable housing, young people with learning disabilities, or those living in areas of multiple deprivation. Young care leavers may also be at particular risk, as may young people not in education, employment or training, or those who are transgender. A particular concern is those who have several vulnerabilities coexisting. It is critical to alert health services to the particular needs of these groups, and identify the strategies for making sure they are included in provision.

- Many of these vulnerability factors can be classified as **social determinants of health** – such as living in areas of multiple deprivation. It is important to draw attention to the variation in health outcomes by region and how this specifically affects young people. Public Health England data show that young people’s outcomes vary enormously by area. These variations have been very usefully highlighted recently in the RCPCH ‘State of Child Health Report 2017’.

- As part of the solution to the varied needs of young people, we need to continue to design and promote **youth-friendly health services**. Although this is a longstanding issue, it is worth re-emphasising now, as the health system partners (NHS/PHE/DH) are supporting a refresh of the existing ‘You’re Welcome’ quality criteria for young people’s health, as requested by the Chief Medical Officer in her 2012 report on the health of children and young people.

- As we noted at the outset, the importance of the **secondary education and university settings** as a context for health promotion is an issue of current debate. Expectations for what the school and college setting can achieve for young people’s health outcomes is on the rise, but this cannot be achieved without more resources. The school nursing workforce, for example, numbers fewer than 2,000, in the context of more than 3,000 secondary schools containing several million young people, in addition to all the primary schools. School nurses are also dealing with the workload of the new childhood flu vaccination programme. Again it is important to emphasise the provision of statutory personal, social, health and economic education. But beyond this, debates in this area need to focus on how to resource any other improvements; what can and cannot be done by non-nursing school staff and what can and cannot be done in these educational settings? Ways of creating better links between education and local primary and secondary care services are also needed.

Finally, as always we continue to emphasise the importance of **good, robust data** that shed light on the experiences and outcomes for the age group 10-24, as distinct from those under 10 or over 24. Accessibility to local data and benchmarking tools have greatly improved in recent years, particularly led by the work of the Public Health England Child and Maternal Health Intelligence Network (Chimat). In this context, the youth health sector is gearing up for the results of the new national mental health survey anticipated in 2018, which will provoke a new wave of discussion and analysis about time trends around emotional wellbeing. But continuing to ensure data on this age group are collected and disseminated is important in relation to all health topics, not just mental health.
References


ii ONS conception data, most recent statistics 2014


vii Health Survey for England


xi Key Data on Adolescents 2015, from Hospital Episode Statistics

x Key Data on Adolescents 2015, from Hospital Episode Statistics


xiv NHS CAMHS benchmarking Nov 2015
Acknowledgements

We are grateful to a number of colleagues for ongoing discussions about the agenda in young people’s health, including the members of AYPH’s Advisory Council, and the Young People’s Health Partnership, which AYPH leads [http://www.youngpeopleshealth.org.uk/yphp](http://www.youngpeopleshealth.org.uk/yphp)

Additional Resources

Resources including: ChiMat data pages [www.chimat.org.uk](http://www.chimat.org.uk)
Key Data on Adolescence [http://www.youngpeopleshealth.org.uk/key-data-on-adolescence](http://www.youngpeopleshealth.org.uk/key-data-on-adolescence)

For more information about AYPH’s work, including membership, please contact: info@youngpeopleshealth.org.uk
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