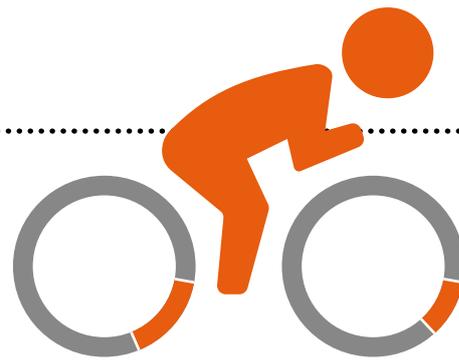


CHAPTER 4: Health behaviours



By age 14-16, **ONLY 16% OF BOYS AND 10% OF GIRLS** meet the daily recommendations for physical exercise

In 2017 a quarter of 11-15 year olds in England were obese (23% male, 24% female)



Nearly all 16-24 year olds in the UK own a smartphone



1 in 5

young adults aged 16-24 are current smokers

21% FEMALE

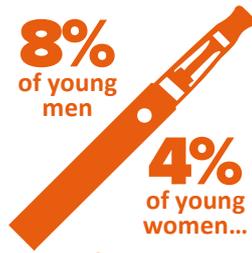
17% MALE



8% of young men

4% of young women...

aged 16-24 use e-cigarettes



Surveys consistently show physical activity declining across adolescence and lower levels of activity particularly for young women



14% of young people age 11-16 say they have spent their own money on gambling in the last week



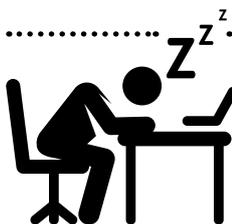
Among 16-24 year olds, **one in five** say they have used an illegal drug in the past year



In England in 2016 **66%** of young people aged 11-15 said they had never drunk alcohol



A QUARTER (23%) of 15 year olds who admitted drinking reported being drunk in the last four weeks



31%

of 14-15 year old females say they don't get enough sleep to stay alert and concentrate.

The proportion of 14 year olds sleeping for less than 8 hours a night doubled between 2005 and 2015



Health behaviours

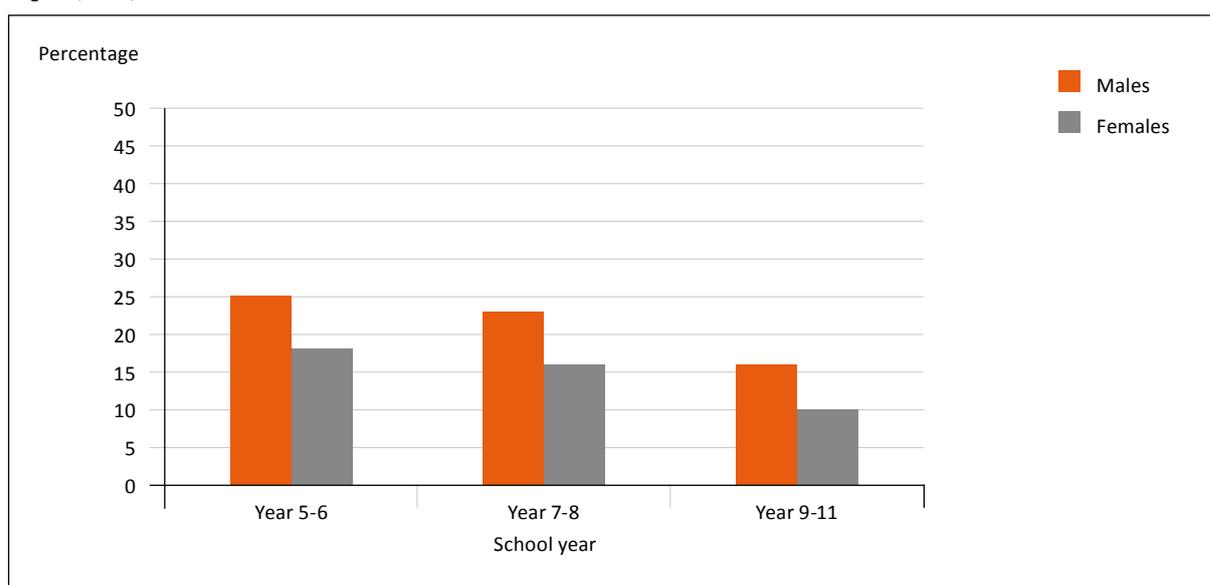
Promoting healthy behaviours is very important in adolescence and early adulthood. This is a time when life-long health behaviours are set in place. Health behaviours can directly affect health outcomes. In the longterm these may include cancer, heart disease and Type 2 diabetes. Prevention and early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

Physical activity

Young people's physical activity levels are critical to their overall health (Public Health England, 2018a). Current UK guidelines for children and young people recommend at least one hour of moderate to vigorous physical activity every day, including activity to strengthen muscles and bones on three days per week (Department of Health, 2011).

Data from the 2017/18 Active Lives Survey show activity rates for primary and secondary school aged children. In terms of the proportions meeting physical exercise guidelines of a full hour a day, **Chart 4.1** present the overall pattern for young people at school in England in 2017/18, illustrating a decline in exercise levels during secondary school. By Years 9-11, when they are age 14-16, relatively few young people are meeting the daily recommendations. By this age the rates were 16% for boys and 10% for girls. Generally surveys consistently show physical activity declining across adolescence and lower levels of activity particularly for young women.

Chart 4.1: Proportion of pupils meeting physical activity recommendations of 60+ minutes per day by school year and gender, England, 2017/18

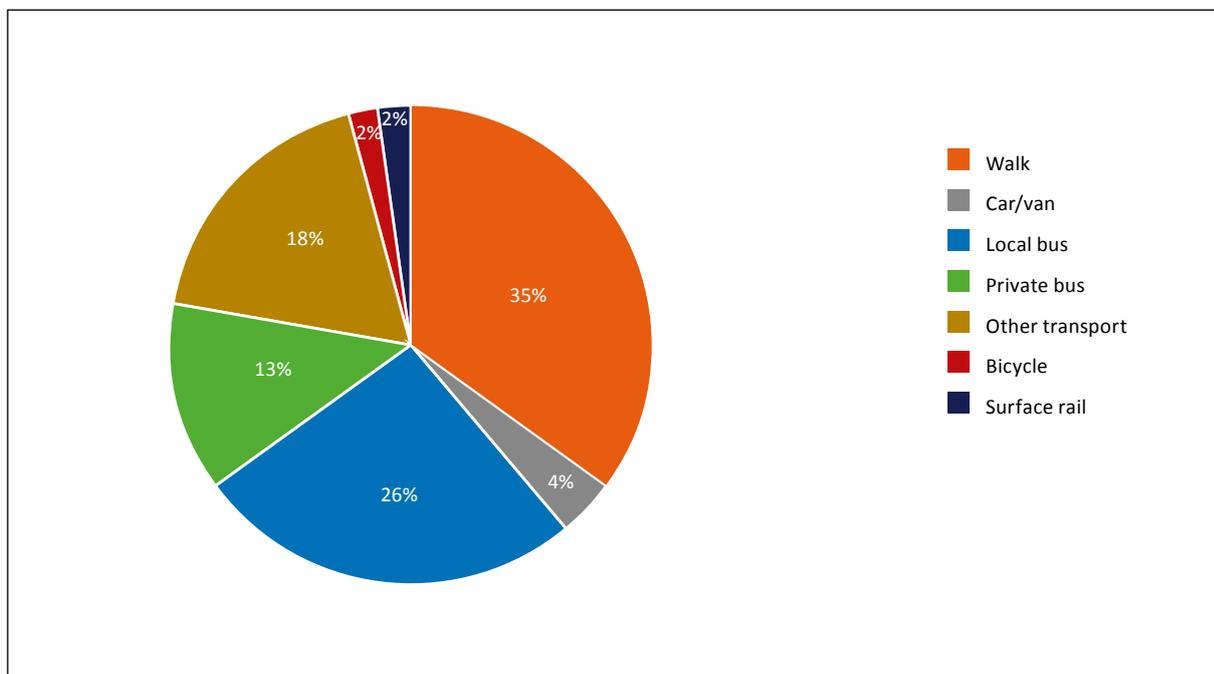


Source: Sport England Active Lives Survey 2017/18, England > [DOWNLOAD DATA](#)

The physical activity module of the Health Survey for England gives more details on what kinds of exercise young people are doing, but the module has not been repeated since 2015 and the data are now a little out of date. At that time they showed that while rates of walking and informal activity were broadly comparable for boys and girls, girls had lower rates of formal physical activity, particularly among the older age group (NHS Digital, 2016).

The walking that young people undertake is usually generated by the journey to school or college. Drawing on data from the Department of Transport's National Travel Survey, **Chart 4.2** shows that 35% of trips to school in England by young people aged 11-16 are made on foot, with bus and car transport making up most of the remainder. Only a very small proportion travel to school by rail (2%) or on bicycles (2%). The proportion of this age group walking to school is 10% lower than it was in 2002 (Department for Transport, 2018).

Chart 4.2: Trips to school by main mode for young people aged 11-16, England, 2017



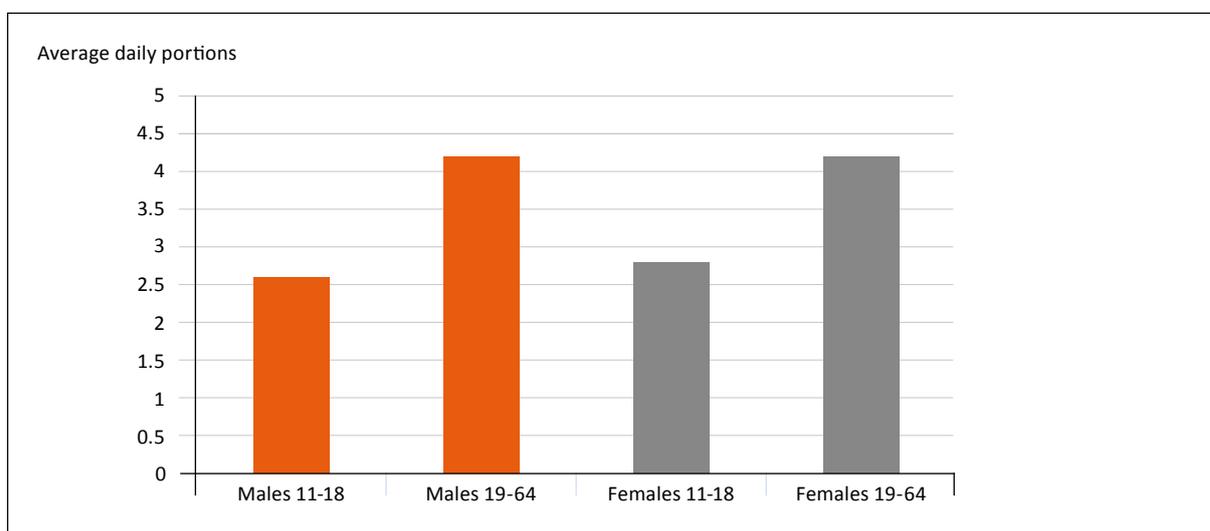
Source: Department for Transport (2018): National Travel Survey Statistics. Travel by age and gender England > [DOWNLOAD DATA](#)

Nutrition and obesity

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

Consumption of five portions a day of fruit and vegetables has become a marker for good diet. As we can see in **Chart 4.3**, average daily consumption of 'five a day' for males and females aged 11-18 years was reported to be 2.7 portions per day in the UK-wide National Diet and Nutrition Survey (averaged across surveys from 2014/15 and 2015/16). Adults ate an average of 4.2 portions per day.

Chart 4.3: Average daily consumption of 'five a day' fruit and vegetable portions by age and gender, UK, 2014/15 and 2015/16 combined



Source: Public Health England/Food Standards Agency (2016). National Diet and Nutrition Survey > [DOWNLOAD DATA](#)

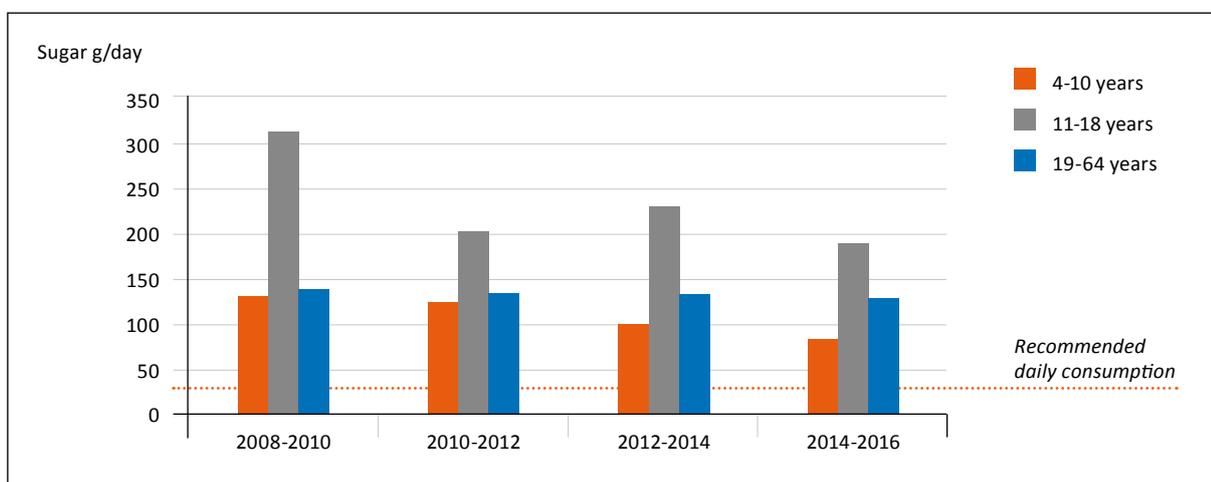
The most recent National Diet and Nutrition Survey also reported that only one in 12 young people aged 11-18 in the UK ate five portions of fruit and vegetables every day. The survey also uses dietary diaries and other methods to estimate the proportion of young people aged 11-18 years with low levels of daily intake of various minerals. High proportions of young men and young women do not appear to be consuming enough minerals. This is particularly the case for young women, of whom nearly half are estimated to be deficient in iron, selenium (an essential trace mineral) and magnesium (Public Health England, 2018b). These estimates are indicative only, as the data are difficult to collect and commonly reliant on self-reporting. However, they do alert us to the need to consider adolescent nutrition as a whole and they raise a particular concern about the nutrition of young women.



Source: National Diet and Nutrition Survey (2015/16 & 2016/17)

A industry levy on sugar sweetened soft drinks in England was introduced in April 2018. It is too early to tell whether not this is having an impact on sugar consumption. In the meantime, the most recent UK National Diet and Nutrition Survey (**Chart 4.4**) showed the extent to which 11-18 year olds in particular currently exceeded the daily recommended limits for sugar consumption (30 grams) in the years just before the ban. Although there had been a reduction in sugar consumption among young people under 19 in the years to 2016, the data indicate that considerable improvements still need to be made to get the level down to the recommended limit. Rates for 11-18 year olds remain considerably higher than for other age groups. In the 2015 Health Behaviour in School-Aged Children survey, one in eight young people in England aged 11-15 (13%) reported daily consumption of sugary carbonated drinks, and 7% were consuming energy drinks at least five times a week (Brooks et al, 2015).

Chart 4.4: Sugar consumption from soft drinks, grams per day by age group, UK, 2008-2016

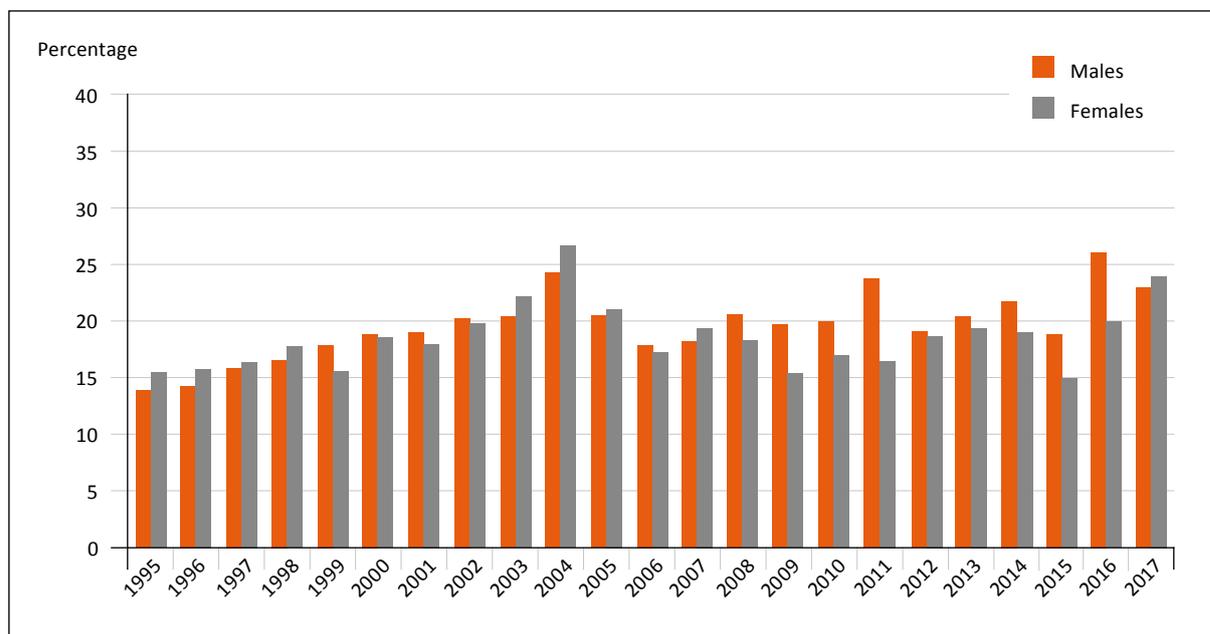


Source: Public Health England/Food Standards Agency (2018)
National Diet and Nutrition Survey: Results from Years 7 and 8 (combined) of the Rolling Programme (2008/09-2015/16)
> [DOWNLOAD DATA](#)

One of the consequences of poor nutrition is, of course, obesity. Reducing excess weight in 4-5 year olds, 10-11 year olds and adults are health improvement indicators in the English Public Health Outcomes Framework (Public Health England, 2016), and improving weight is one of the Scottish Government's six public health priority areas (Scottish Government, 2018a). **Chart 4.5** provides an overview of trends in obesity prevalence in 11-15 year olds since 1995, drawing on data from the Health Survey for England. This measurement of obesity is based on the UK national body mass index (BMI) percentiles classification. BMI measurements that fall into or above the 95th percentile of the 1990 reference population are classified as obese. This is the recommended method for calculating obesity in children, rather than using a BMI cut-off of 30, which is the usual method for its calculation in adults. However this makes direct comparison between child and adult rates difficult.

According to these data, obesity in England peaked for boys in 2016 at 26%, and for girls in 2004 at 26.7%. By 2017 the respective rates were 23% and 24%. Overall the underlying trend is not clear. Although there was a general rise in the decade to 2004, since then rates have gone up and down. In 2017 they were relatively high, looking back at the previous 20 years.

Chart 4.5: Obesity prevalence among 11-15 year olds by gender, England 1995-2017



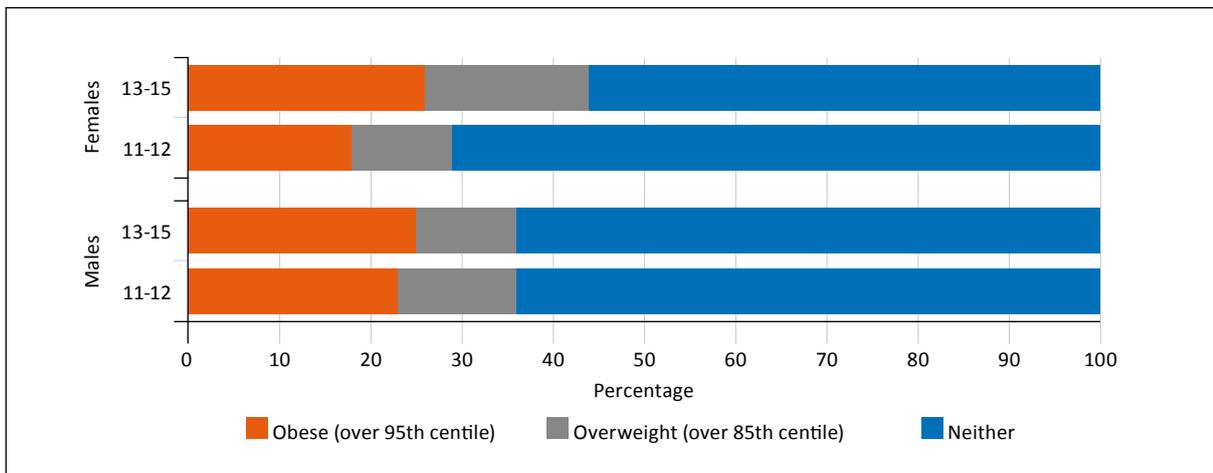
Source: Health and Social Care Information Centre (2017) Health Survey for England > [DOWNLOAD DATA](#)

Separate estimates for obesity in England at age 10-11 (Year 6 of school) are provided by the National Child Measurement Programme (NCMP). The latest data from the programme showed that one in five children age 10-11 years (20.1%) were obese (NHS Digital, 2018b); similar rates to those found in the Health Survey for England. Chart 9.2 in Chapter 9 presents obesity at age 10-11 by area deprivation, using the NCMP measurements; obesity prevalence was over twice as high in the most deprived areas (26.8%) than the least deprived areas (11.7%). This gap has gone up by 59% since 2006/07, from 8.5% to 13.5% (NHS Digital, 2018b).

Estimates of obesity in children for Wales and Scotland are available from Country specific health surveys, including the Scottish Health Survey and the Public Health Wales Measurement Programme. The latest Scottish Health Survey 2017 reported that 16% of young people aged 12-15 were obese (Scottish Government, 2018b). The Welsh child measurement programme only includes children aged 4-5 years and comparable data for older children are not available. However, the Welsh report from the Health Behaviour of School-Aged Children (HBSC) survey in 2015 concluded that 18% of children aged 11-16 were obese (Ipsos Mori, 2015). In Northern Ireland, government statistics on childhood obesity are only given for all children aged 2-15 collectively, again reducing comparability. Estimates across the countries of the UK for children at secondary school thus range from 15-24%, but direct comparisons are not possible because of the variation in the age group covered in the measurements. There are also differences in how the estimates are calculated in surveys which may also contribute to variation in estimates (for example, by self-report in the HBSC or direct measurement in others).

Obesity is the extreme end of the weight distribution. There is also a group of young people who are overweight but not obese, as **Chart 4.6** demonstrates, using English data. Once again obesity is a BMI that falls at or above the 95th percentile of the distribution and overweight is a BMI at or above the 85th percentile. Including both those who are overweight and those who are obese, 36% of boys and 29% of girls aged 11-12, and 36% of boys and 44% of girls aged 13-15 met these criteria. This is a substantial proportion of the adolescent population and is a continuing cause for concern due to the longterm health consequences of obesity.

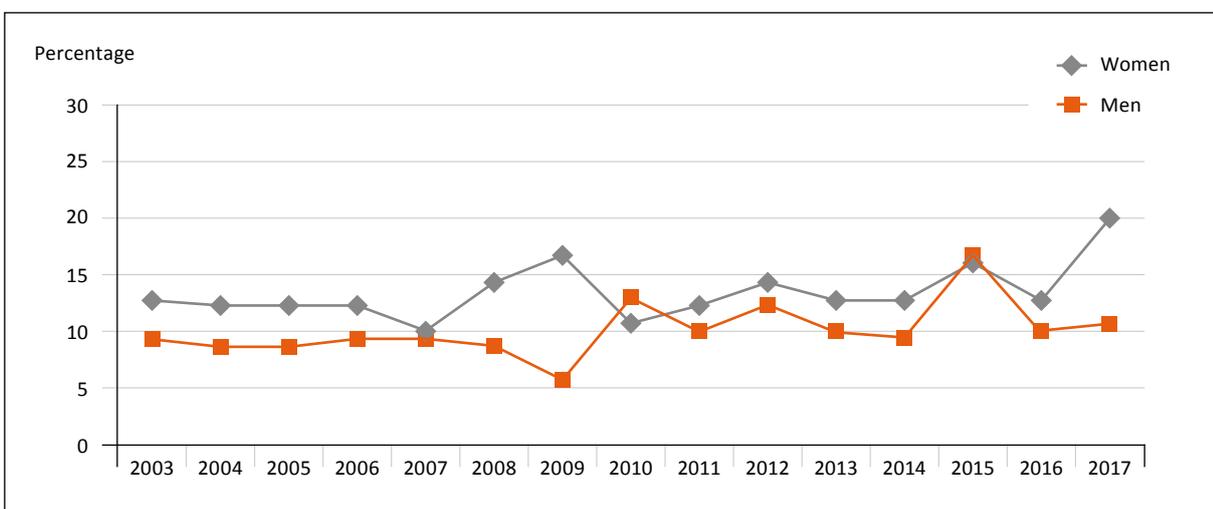
Chart 4.6: Body mass index (BMI) prevalence of overweight and obesity, 11-15 year olds by gender, England, 2017



Source: Health Survey for England 2017, Children's BMI, overweight and obesity > [DOWNLOAD DATA](#)

Obesity in 16-24 year olds is measured using BMI rates themselves, rather than their position on percentile charts. A BMI of more than 25 is considered a measure of overweight, and a BMI of 30 or more is considered a measure of obesity. **Chart 4.7** presents the proportions of 16-24 year olds who were obese, by gender, in England from 2003 to 2017. Again the trends are not entirely clear, and it is

Chart 4.7: Proportions of 16-24 year olds who were obese, by gender, England 2003-2017

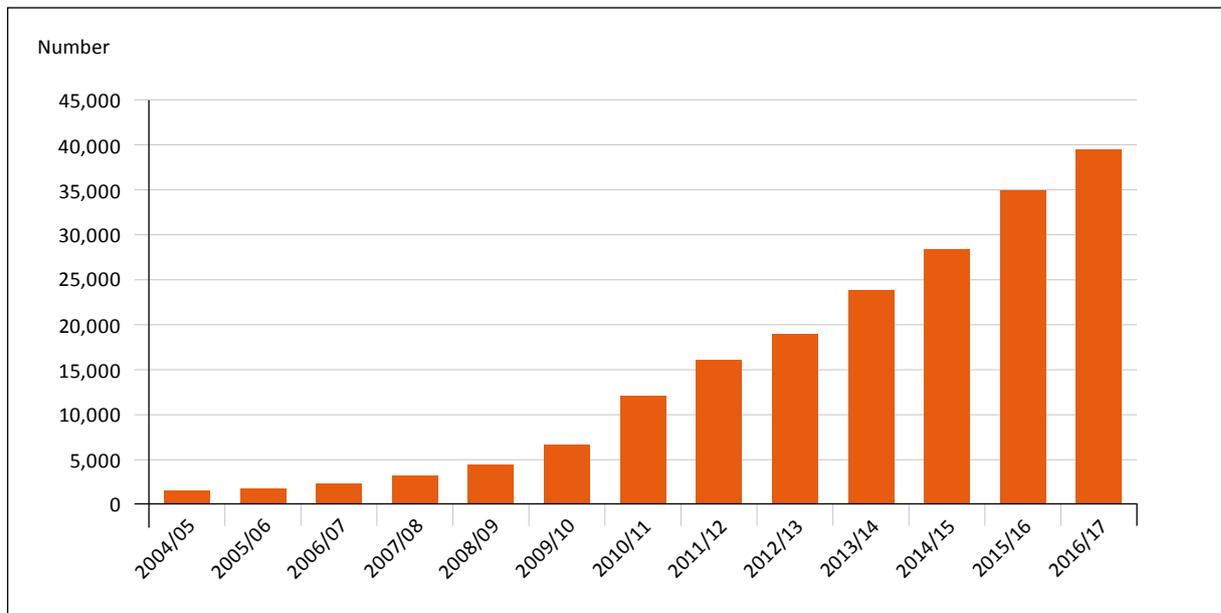


Source: Health Survey for England, 2017, Adult and child overweight and obesity weight tables > [DOWNLOAD DATA](#)

too soon to tell whether the rises from 2016-2017 are longterm. In 2017, 11% of young men and 20% of young women in this age group were obese. Rates reported in the Scottish Health Survey 2017 for this age group were very similar, at 11% for young men and 24% for women (Scottish Government, 2018b).

The English Hospital Episode Statistics (HES data) provide information on incidents of inpatient care under a consultant, where the primary or secondary diagnosis was obesity. **Chart 4.8** shows a substantial increase in the recorded number of these kinds of admissions between 2004 and 2017. However, HES data only reflect the information that has been submitted by services. The coverage of HES data has improved over time, so more hospitals will now be returning the information and the quality of the information has improved. Thus the increased rate may reflect these factors, rather than an increase in prevalence.

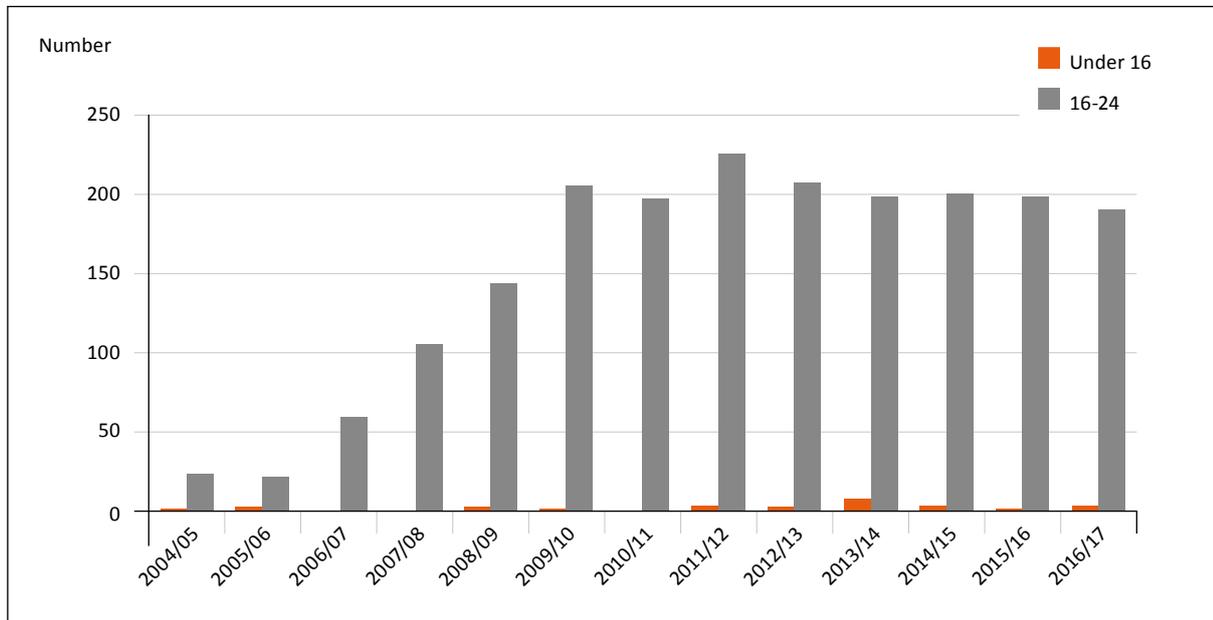
Chart 4.8: Finished hospital admission episodes with a primary or secondary diagnosis of obesity, young people age 16-24, England, 2004/5 to 2016/17



Source: Health and Social Care Information Centre (2018) Hospital Episode Statistics (HES) > [DOWNLOAD DATA](#)

Hospital admissions specifically for bariatric surgery provide another index of trends and severity of obesity in this age group. **Chart 4.9** shows these admissions for young people in England aged under 16 and 16-24 over the last 10 years. The absolute numbers are small – never more than 225 in any one year, and they have been steady for the last 10 years or even falling slightly. Given what we know about rates of obesity in the general population, this may indicate unmet need rather than a fall in demand, or use of different clinical treatments other than surgery.

Chart 4.9: Finished consultant episodes with a primary diagnosis of obesity and a main or secondary procedure of bariatric surgery, under 16 and 16-24, England, 2004/05 to 2016/17

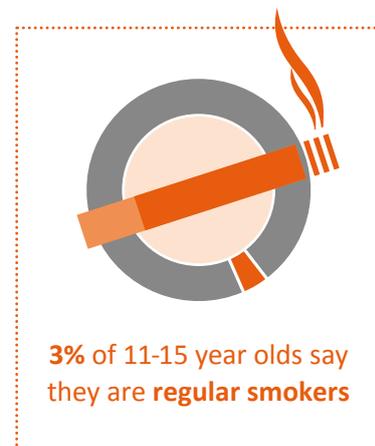


Source: Health and Care Social Information Centre (2018). Statistics on Obesity, Physical Activity and Diet > [DOWNLOAD DATA](#)

Smoking, drinking and drug use

Tobacco kills up to half of its users (World Health Organisation, 2019). Tobacco use contributed to around 20% of deaths in men and 12% of deaths in women aged over 35 in England in 2017 (NHS Digital, 2018a). It is the primary cause of preventable illness and premature death, and the biggest contributor to health inequalities (NHS Digital, 2018a). Concern about levels of smoking among young people arises from awareness about the longterm outcomes such as cancer, but also the shortterm negative effects such as respiratory illness and impact on physical fitness.

The 2016 Smoking, Drinking and Drug Use Survey in England (SDDU) showed that approximately one in five (19%) of young people age 11-15 try smoking at some point (NHS Digital, 2017). Regular smoking in this age group is less common (3%). Other surveys that also provide estimates of regular smoking in secondary school aged children arrive at similar estimates (NHS Digital, 2014; Brooks et al, 2015).

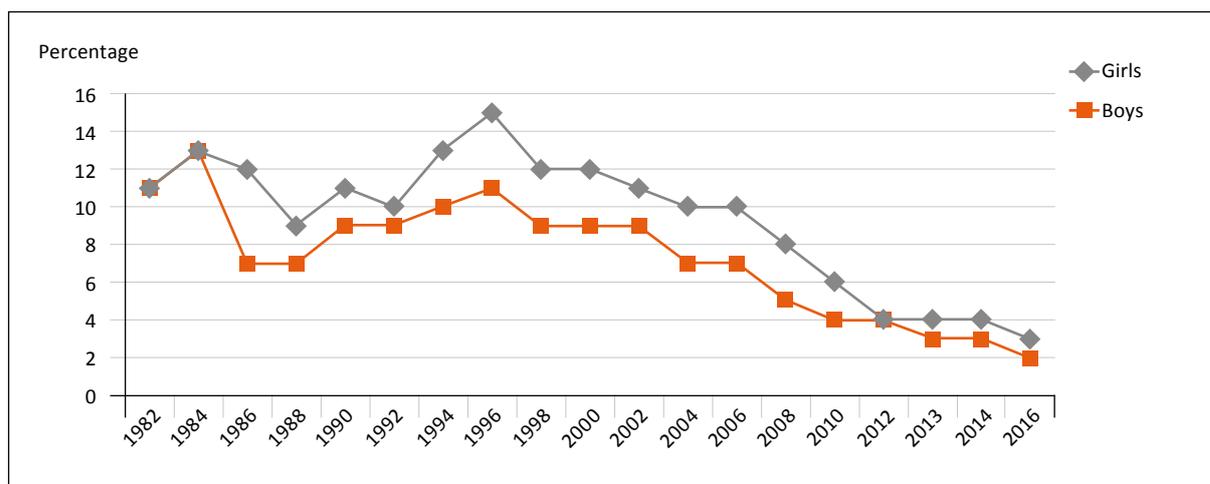


Source: SDDU 2016

Different smoking measures are presented in other surveys such as the Welsh and Scottish Health Behaviour in School Aged Children reports, so it is difficult to compare. In Wales, 4% of young people aged 11-15 smoked once in the last week in 2014, rising to 9% of 15 year olds (Ipsos Mori, 2015). In Scotland, 6% of 11-15 year olds reported that they currently smoked, rising to 14% of 15 year olds (Currie et al, 2015). However current smoking is potentially a different measure from weekly smoking.

Whichever measure is used, it is clear that youth smoking has been in longterm decline as in the overall population. Drawing on the 2016 SDDU data, **Chart 4.10** portrays a positive picture of the longterm trends for smoking behaviour in England, a pattern mirrored elsewhere in similar high income countries (Shah et al). The proportion who reported regular smoking in 2016 (under 3% overall for all pupils 11-15) was the lowest recorded. The introduction of a smoking ban in public places came into force in England in July 2007 and may have had some impact on the figures, but other facts may be changes to packaging, increased pricing and public health messaging. Tobacco displays at the point of sale have been prohibited in supermarkets and large shops in England since April 2012 and in small shops from April 2015.

Chart 4.10: Proportion of 11-15 year olds who were regular smokers, by gender, England, 1982-2014



Source: HSCIC (2017) Smoking, Drinking and Drug Use Among Young People in England in 2016 > [DOWNLOAD DATA](#)

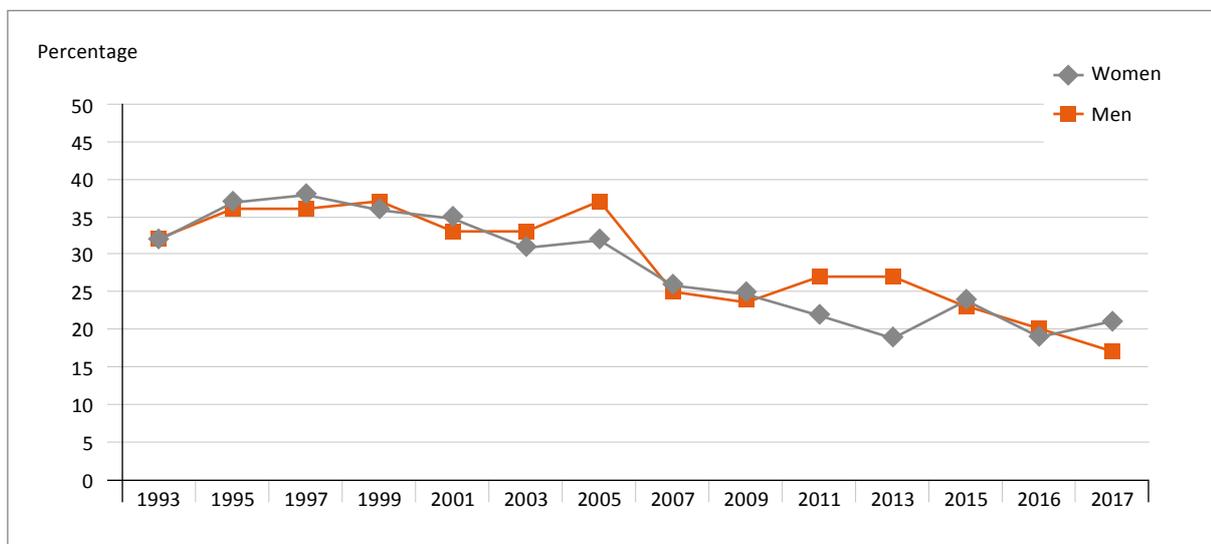
There is an increase in smoking prevalence as young people head into their late teens and early 20s. Data from adult surveys suggest that two out of three smokers will have started by age 18, and 95% by age 25 (Health and Social Care Information Centre, 2015). The Health Survey for England suggests that 1 in 5 young adults aged 16-24 are current smokers (17% of young men, 21% of young women), a considerable increase on the younger age group. The survey also reported that nearly half of these smokers would like to give up.

95%
of adult smokers
start by age 25

Source: HSCIC General Lifestyle Survey 2011

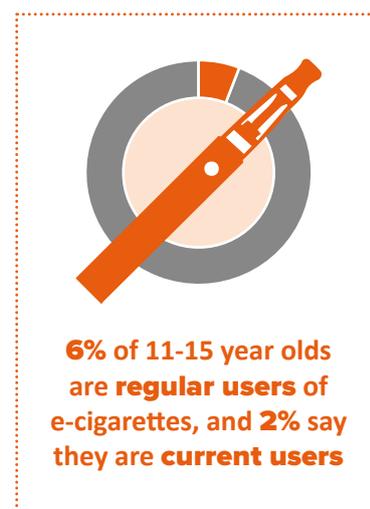
The overall downward trend seen in the younger age group is also apparent in the older age groups of 16-24 year olds, demonstrated in **Chart 4.11**. The gender patterns in these older age groups are not consistent; sometimes more young women smoke, sometimes more young men, but the overall direction of travel is positive. However, the fact that approximately a fifth of those aged 16-24 are current smokers is still a serious concern. It is too early to tell whether the slight recent rise in young female smokers is going to become a new trend.

Chart 4.11: Proportions of 16-24 year olds who smoke, by gender, England 1993 to 2017



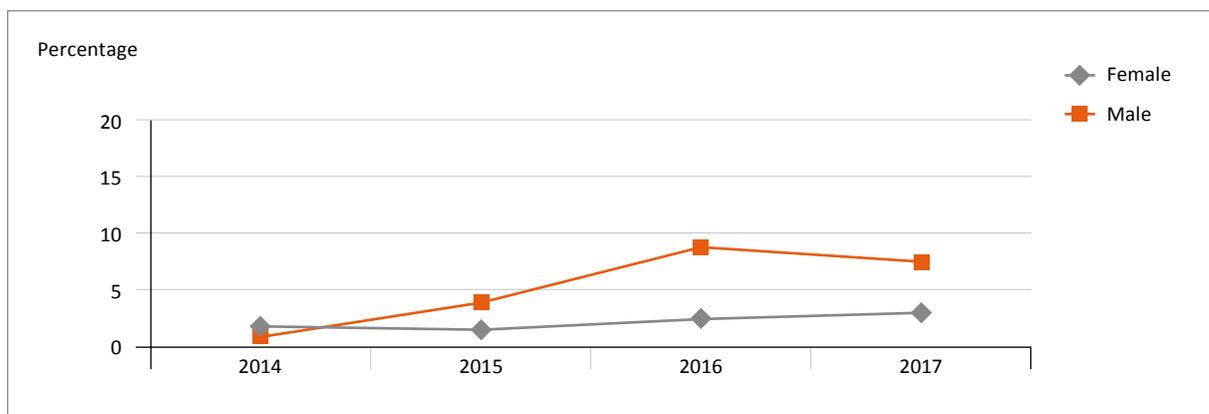
Source: Health and Social Care Information Centre (2018). Health Survey for England 2017 > [DOWNLOAD DATA](#)

Routine data on use of e-cigarettes are now being collected in several surveys. New legislation came into force in England and Wales in 2015, introducing a minimum age of sale of 18 for e-cigarettes and prohibiting the purchase of these products on behalf of someone under the age of 18. The SDDU survey of 2016 reported that 6% of 11-15 year olds were regular users of e-cigarettes, with 2% saying they were current users (NHS Digital, 2017). For the older age group, the latest Health Survey for England reported that the prevalence of e-cigarette use among young men was almost double that among young women (8% of men compared to 4% of women in the 16 to 24 age group). These rates are similar to those for current use from a separate 'Opinions and Lifestyle Survey' undertaken with the same age group in the same year (7.6% of young men and 3.1% of young women) (Office for National Statistics, 2018a). **Chart 4.12** presents data for 16-24 year olds in e-cigarette use from 2014 to 2017. It is too early to predict whether this represents a stabilising of the rate of current use, or a continuing increase.

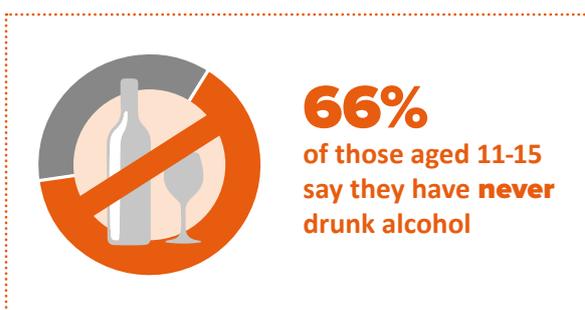


Source: HSCIC (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016

Chart 4.12: Proportions of 16-24 year olds who currently smoke e-cigarettes, by gender, Great Britain, 2014-2017



Source: Office for National Statistics (2018) Opinions and Lifestyle Survey. E-Cigarette Use In Great Britain, 2017 > [DOWNLOAD DATA](#)



Source: HSCIC (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016

Adolescent alcohol consumption patterns have been a concern for many years but recent trend data have been encouraging, generally showing a decline. The international Health Behaviour of School Aged Children study has shown, for example, that many of the European countries involved have seen a decline in alcohol use in parallel with an increase in the number of adolescents who abstain from alcohol use altogether (Inchley et al, 2018).

In 2016 the English Smoking, Drinking and Drug Use survey reported that 66% of secondary school pupils aged 11-15 said they have never drunk alcohol. The majority had tried it by the time they were 15 (68%), but only 24% of 15 year olds had drunk it in the previous week (NHS Digital, 2017).

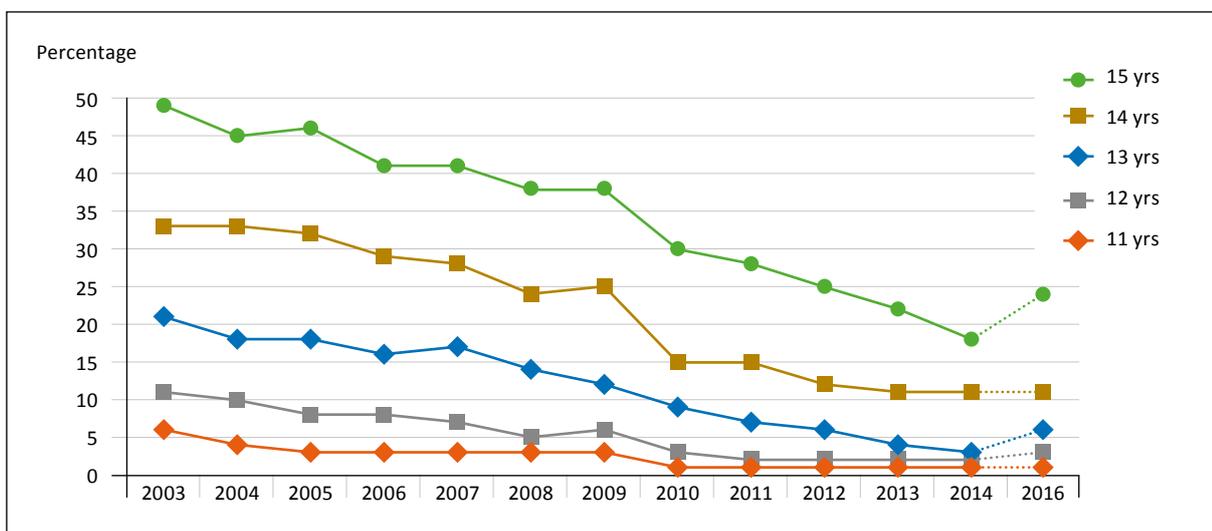
Estimates of alcohol consumption by 11-15 year olds from around the UK are also available from studies such as the HBSC study and the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), although the data relate to slightly different years and sometimes different questions are asked. Despite this, reports tend to be generally comparable, with low rates of regular drinking in single digits for 11 and 13 year olds, and higher rates for 15 year olds. In the SDDU study in England, rates went up from 6% for 11 year olds to 24% for 15 year olds. The 2014 HBSC Wales survey reported that 6% of 11 year olds had drunk alcohol at least once a week, compared to 14% of 15 year olds. HBSC Scotland also reported 14% of 15 year olds consumed alcohol. Also in Scotland the SALSUS study reported that 4% of 13 year olds and 17% of 15 year olds had drunk alcohol in the seven days prior to being surveyed.

Chart 4.13 shows that although rates of drinking among secondary school aged children as reported in the English SDDU are still historically very low, there appeared to be a slight rise in prevalence rates between 2014 and 2016. However, the question on alcohol consumption was changed in 2016, as it

appeared there may have been some underreporting previously due to a misunderstanding around what a ‘proper’ or ‘low alcohol’ drink was (both elements included in the original question). The authors suggest that “Whilst this means the survey now gives an improved picture of the proportion of young people who have drunk alcohol, comparisons with previous years are not possible.” (NHS Digital, 2017, p35).

Chart 4.13 also confirms that rates of drinking increase with age. The rise in reports of drinking at age 13/14 may make Year 9 a potentially important group to target with alcohol related health promotion interventions.

Chart 4.13: Prevalence of drinking alcohol in the last week, age 11-15, England, 2003-2016



Source: HSCIC (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016 > [DOWNLOAD DATA](#)

Being drunk is a key indicator of alcohol misuse. The SDDU survey suggested that nearly a quarter (23%) of 15 year olds who admitted drinking reported being drunk in the last four weeks. The SDDU also reports some interesting statistics on where young people get alcohol. In terms of framing interventions, it is useful to know that 61% of current drinkers aged 11-15 said they never buy alcohol themselves. The most common sources are being given it by parents or friends, or taking it from home. Pupils who lived with people who drank alcohol were more likely to drink alcohol themselves (NHS Digital, 2017).

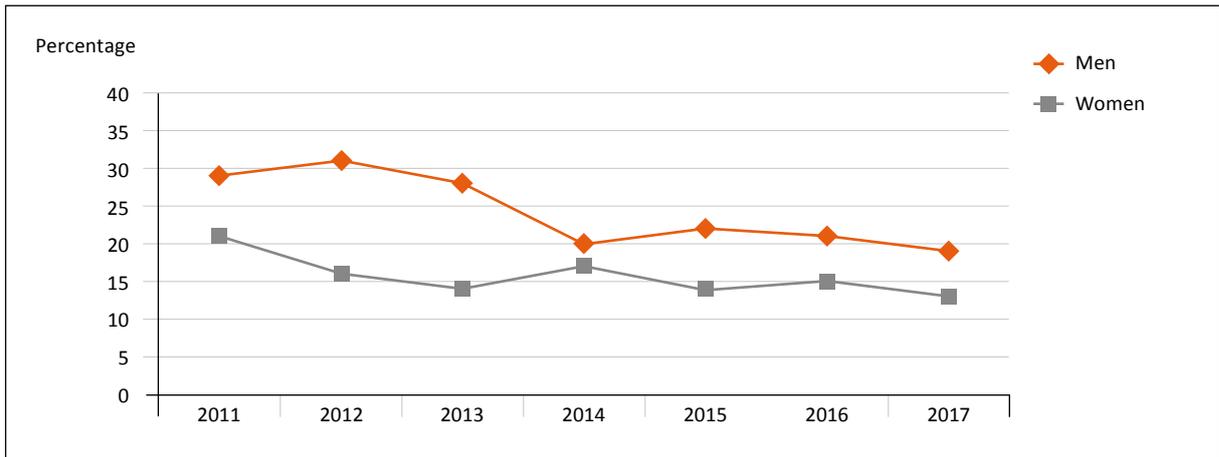
In England, **23%** of 15 year olds who drank reported having been drunk in the last four weeks in 2016

Source: HSCIC (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016

Turning to older teenagers and young adults, higher proportions drink compared with the younger group. The latest Health Survey for England reported that the proportion of young people aged 16-25 who had not drunk in the last year was around one in five (22%), although the questions are not directly comparable to those used in surveys with the younger age group. A significant minority of young people (20% of young men and 13% of young women age 16-25) reported drinking in the risk categories (NHS Digital, 2018a).

The trend has been for a decline in drinking in this older age group aged 16+, mirroring the pattern for secondary school pupils. The Health Survey for England 2016 survey showed that the pattern for heavier drinkers (more than 14 units per week) between 2011 and 2017 is less clear, as is shown in **Chart 4.14**.

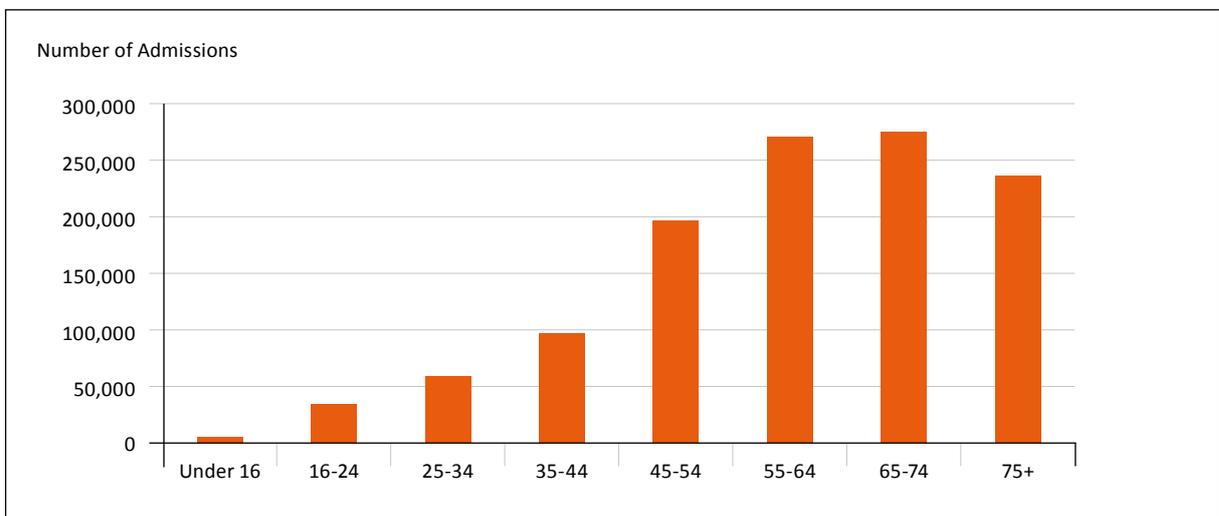
Chart 4.14: Alcohol consumption (more than 14 units per week) trends in 16-24 year olds by gender, England, 2011-2017



Source: NHS Digital (2018). Health Survey for England 2017 > [DOWNLOAD DATA](#)

Although drinking in young people is a serious concern because of the longterm health consequences and development of lifetime health habits, they are rarely hospitalised for alcohol related reasons when compared with other age groups. **Chart 4.15** presents Hospital Episode Statistics (HES) for alcohol related admissions, illustrating the admissions pattern across the full population age range. Young people under 25 represent a very small proportion of all these admissions. By using data relating to the primary and secondary reason for admission, this ensures the data capture all admissions that are alcohol related including, for example, accidents.

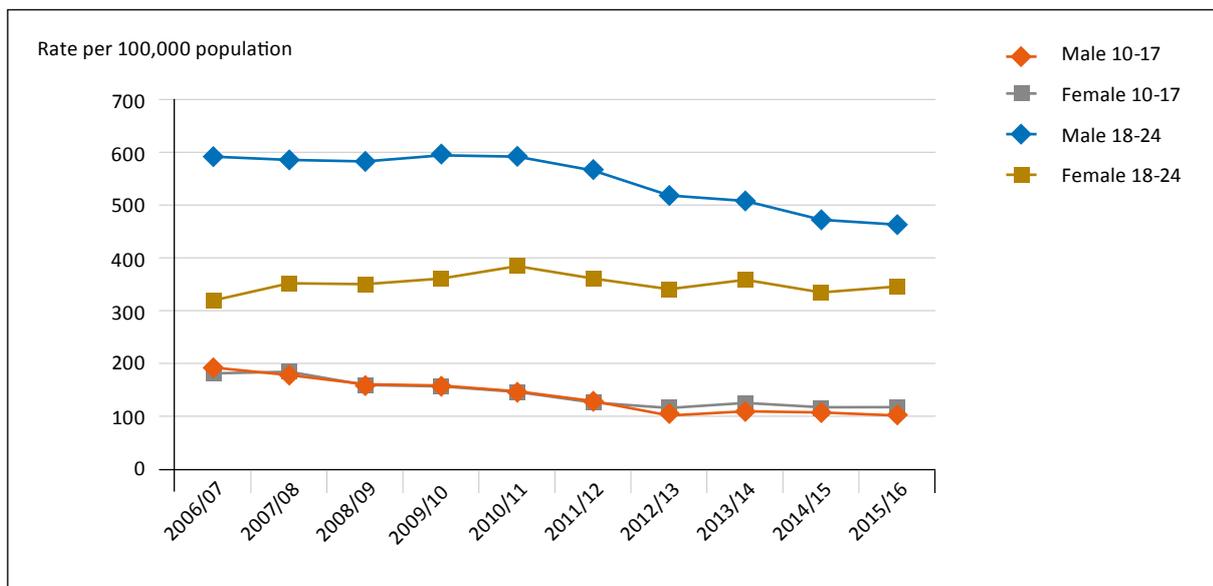
Chart 4.15: Alcohol-related NHS hospital admissions by age, England, 2017/18, including primary and secondary cause of admission



Source: NHS Digital (2018) Statistics on Alcohol England > [DOWNLOAD DATA](#)

Although rates of hospitalisation of young people for alcohol related conditions are low in absolute terms, the trends are not straightforward. **Chart 4.16** compares the longterm trends for 10-17 year olds and 18-24 year olds. While rates have gone down for males aged 18-24 and for 10-17 year olds of both genders, young women aged 18-24 have not shown a decline.

Chart 4.16: Hospital admissions for alcohol-related conditions per 100,000 population, 10-17 and 18-24 year olds, England, 2006/7 to 2015/16



Source: Hospital Episode Statistics > [DOWNLOAD DATA](#)

There is a considerable amount of data relating to substance and illegal drug use among young people. However, not all findings are consistent as this is a challenging area to research and self-report studies have obvious potential limitations. Changes in popularity and availability of drugs influences trends, and inevitably survey questions have to change to account for these, making it hard to establish underlying trends.

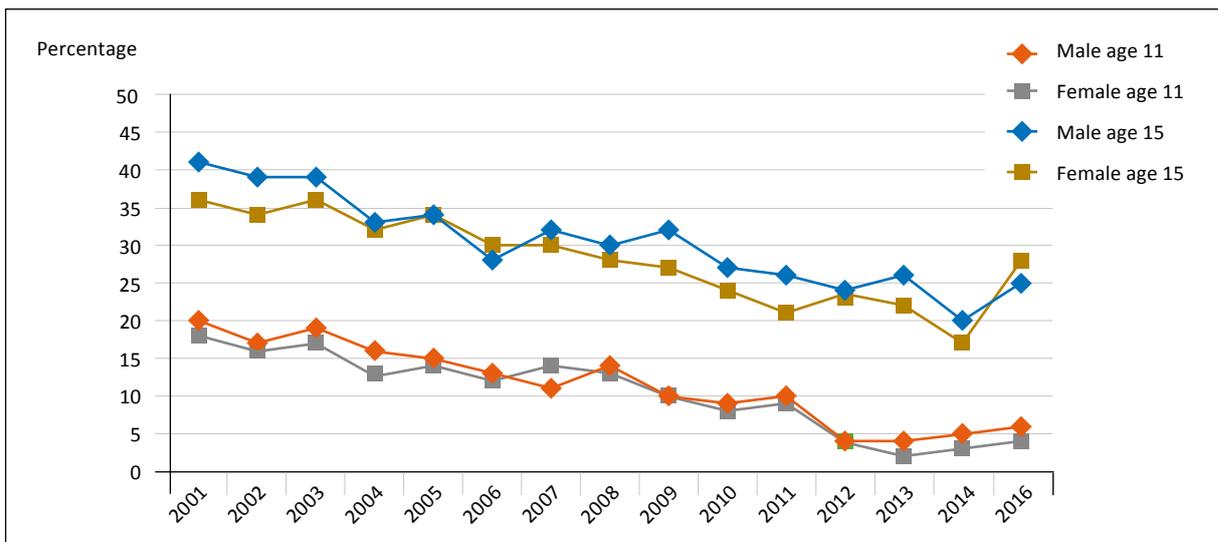
For example, estimates of 'ever' use vary for the secondary school age group. The 2014 WAY survey, for example, reported that 11% of young people aged 15 in England had tried cannabis (NHS Digital, 2015). At around the same date, estimates were 20% for 15 year olds in the HBSC England survey (Brooks et al, 2015), 15.8% for 15 year olds in the English SDDU survey of that year (HSCIC, 2015a), and 18% for 15 year olds in the HBSC Scotland survey (Currie et al, 2015). In the 2016 SDDU survey, a quarter (24%) of pupils aged 11-15 reported having ever tried drugs (rising to 37% of 15 year olds), with 18% saying they did so in the last year. But the question in the 2016 version of the survey included the addition of nitrous oxide and new psychoactive substances, which may have partly (although not entirely) resulted in the higher rates in comparison to other surveys. Cannabis is consistently reported as the most common drug used by this age group.

Chart 4.17 reports on the proportion of illegal drug use reported by the school population aged 11 and 15 in England over the years from 2001 to 2016, as reported in the Smoking, Drinking and Drug Use surveys. Overall, the proportion of the school aged population who had reported using illegal substances in the last year has seen a downward trend since 2001, but that trend has been bucked in the most recent sweeps. The SDDU authors note “As there is no substantial evidence from other data sources that is consistent with the increase seen in this survey then an estimate from the next survey in 2018 is needed before we can be confident that these survey results reflect a genuine trend in the wider population. In the meantime the results for drug taking from this survey should be treated with caution.” (NHS Digital, 2017, p65).

Cannabis is the drug that pupils are most likely to have taken in the last year, with **8% saying they had done so** in 2016; similar to 2014 but well below the 13% reported in 2001.

Source: HSCIC (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016

Chart 4.17: Proportion of pupils who had used illegal drugs in the last year, by age and gender, England, 2001-2016

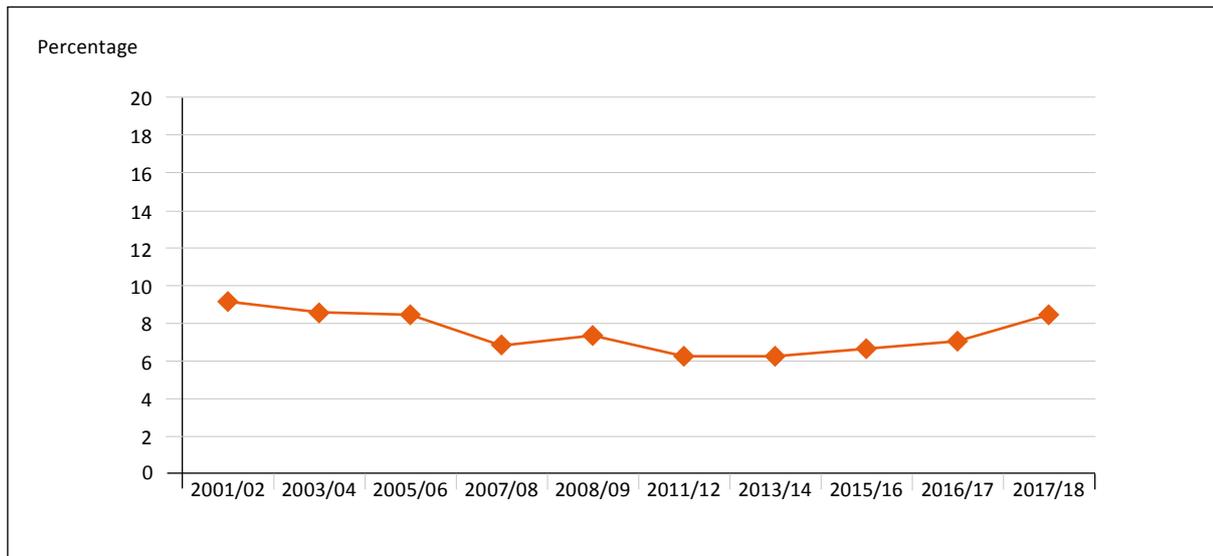


Source: NHS Digital (2017), Smoking, Drinking and Drug Use Among Young People in England in 2016 > [DOWNLOAD DATA](#)

Note: Drugs include amphetamines, anabolic steroids, cannabis, cocaine, crack, ecstasy, heroin, ketamine, LSD, magic mushrooms, methadone, poppers (eg, amyl nitrite), tranquillisers, volatile substances such as gas, glue, aerosols and other solvents, and other non-prescription drugs.

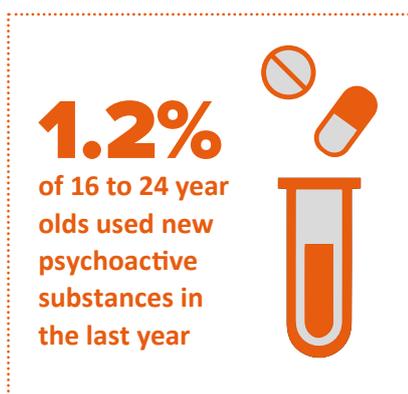
Among the older age group of 16-24 year olds, the Home Office 2018 misuse of drugs survey reported that one in five had used an illicit drug in the last year. **Chart 4.18** shows the proportions using Class A drugs in the last year from 2001/02 to 2017/18, which has also shown evidence of a recent rise.

Chart 4.18: Proportion of 16-24 year olds reporting use of Class A drugs in the last year, 2001/02 to 2017/18



Source: Home Office (2018) Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales > [DOWNLOAD DATA](#)

Note: Any Class A drug comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin and methadone plus methamphetamine since 2008/9. Any stimulant drug comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite plus methamphetamine and mephedrone.



Source: Home Office (2018) Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales

Finally, a note about new psychoactive substances (NPSs), previously known as legal highs. These are drugs that are designed to copy the effect of illegal drugs but are chemically different. The term covers a range of substances including stimulants and sedatives, long and short acting, digested in a variety of ways. The main risk to young people comes not necessarily from addiction but from toxicity. The Psychoactive Substances Act 2016 restricted the production and sale and supply of NPSs. The SDDU estimated that 4% of 11-15 year olds had tried nitrous oxide, and 2% NPSs in the last year.

Home Office drug misuse statistics published in 2018 suggested that new psychoactive substance use was uncommon amongst young people aged 16-24, with a reported use of 1.2% in the last year amongst this age groups.

Gambling

Gambling related harm is defined as “adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society. These harms are diverse, affecting resources, relationships and health, and may reflect an interplay between individual, family and community processes. The harmful effects from gambling may be short-lived but can persist, having longer term and enduring consequences that can exacerbate existing inequalities” (Wardle et al, 2018, p4). Increasingly, addressing gambling related harm is being considered a public health issue and the Gambling Act 2005 specifically singles out children as a vulnerable group who should be protected from being harmed or exploited by gambling. Young people in the UK are growing up with ready access to online environments and because a lot of gambling activity occurs online, they may be more easily targeted. Most gambling is legal from age 18. The National Lottery and football pools have a minimum age of 16 years, and low stakes gambling machines (such as fruit machines) can be played at any age. Informal private gambling (such as between friends) is unregulated.

Rates of problem gambling across 10-24 year vary by survey. Different surveys use different questions and scales. Data on gambling among 11-16 year olds are provided by regular Ipsos Mori surveys undertaken for the Gambling Commission (Gambling Commission, 2018c). Drawing on a representative sample of approximately 3,000 young people in England, Scotland and Wales, this survey has been administered since 2011. The most recent data show that 14% of young people in this age group spent their own money on gambling in the last week, a rate that has been reasonably stable for the last five years. This has included making private bets, buying scratch cards, playing fruit/slot machines and playing cards. Overall 3.9% of the age group were classified as problem or at risk gamblers. Over half of past-week gamblers engaged in an activity that was illegal for their age, including online gambling.



Source: Gambling Commission (2018) Young People and Gambling

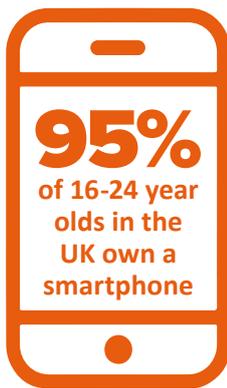
Secondary analysis of longitudinal data from the Avon Longitudinal Study of Parents and Children (ALSPAC) has shown that the prevalence of moderate harm/problem gambling more than tripled between the ages of 17-20 in this sample (to 4.6%), although the base rate at 17 was lower than that reported in the Gambling Commission study (Forrest and McHale, 2018).

Data on gambling in 16-24 year olds are provided by the Health Survey for England. In the 2016 survey, 44% of this age group had engaged in some kind of gambling activity over the last 12 months, the majority of which was National Lottery draws. A smaller proportion (14%) had engaged in online gambling. According to a standard problem gambling scale, 2.1% of the age group were classified as moderate risk and problem gamblers (Gambling Commission, 2018b).

Although rates of problem gambling are relatively low across the 10-24 age group, at around 1 in 20, participation in some form of gambling is quite common. Reducing gambling related harm among young people may require different approaches as their needs are different and primary prevention efforts need to be targeted at the 10-24 age group before they have gambled, with a focus on preventing the initiation of online gambling (Gambling Commission, 2018a).

Media and communication activities

Perhaps the biggest shifts in young people's behaviour over recent decades relate to the use of information and communication technologies. Traditional broadcast television viewing has been in decline among young people for some time, and the latest broadcasting statistics continue to confirm that they watch less scheduled television than other age groups (British Audience Research Board, 2018). Much teenage viewing behaviour now centres around streamed and downloaded programmes from providers such as YouTube and Netflix. It is difficult to obtain accurate data about these behaviours.



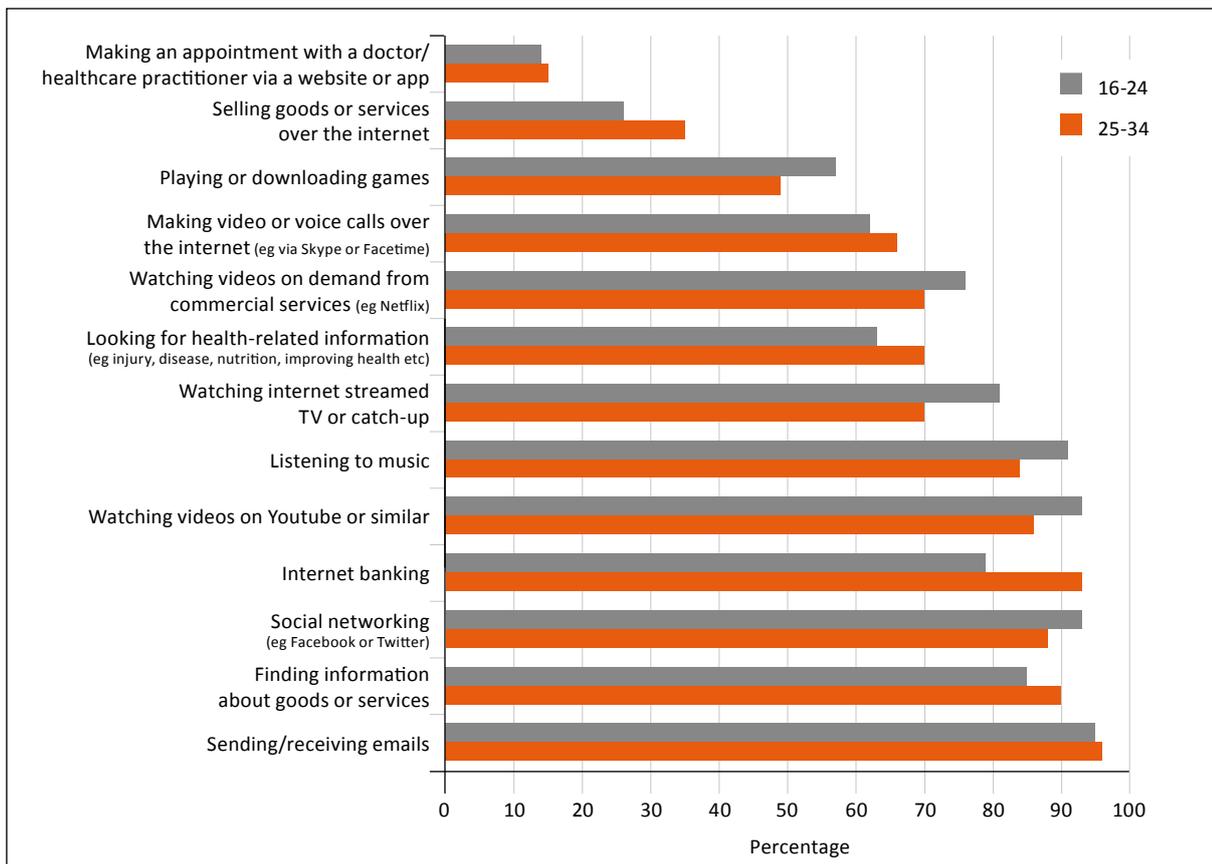
Source: Statista
Statistical portal

Nearly all 16-24 year olds in the UK (95%) own a smartphone (Statista, 2019). New technologies bring both challenges and opportunities. The risks are widely discussed; the opportunities less so. However, there is growing recognition that new media and communications devices offer platforms for health interventions that may be particularly suitable for young people (Reid Chassiakos et al, 2016; Royal Society of Public Health, 2017; House of Commons Science and Technology Committee, 2019).

Much screen time for young people is now occupied accessing the internet. The Office for National Statistics 2018 internet access survey shows the most common internet activities for 16-24 year olds compared with those aged 25-34 (Chart 4.19). Younger people are more likely to be engaged in social networking and finding information (Office for National Statistics, 2018b). The most common reasons for using the internet in the 16-24 age group were for emails, social

networking, watching videos and listening to music.

Chart 4.19: Internet activities for 16-24 and 25-34 year olds, Great Britain, 2018



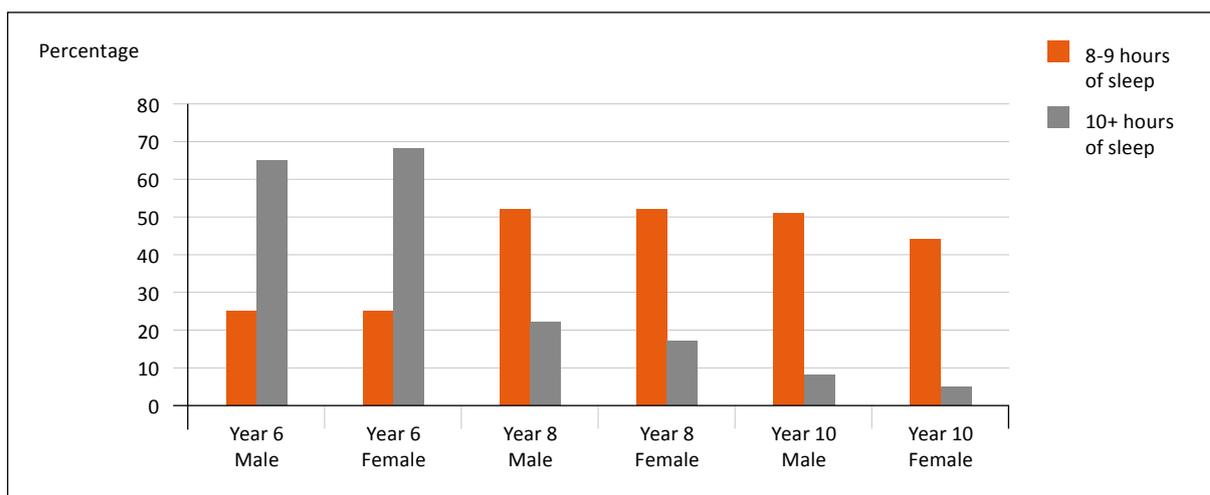
Source: Office for National Statistics (2018) Internet Access. Households and Individuals > [DOWNLOAD DATA](#)

Sleep

In adolescence one of the physiological changes that occurs is a natural shift in the timing of the body clock, usually by an hour or two. We see this in the timing of melatonin release, the 'sleep hormone', with adolescents' levels rising, and peaking, later than adults (Onaolapo and Onaolapo, 2017). This means that young people in their teenage years feel sleepy later in the evening and are less awake in the mornings compared to adults.

There is no 'set' amount of sleep required by a young person but it is thought that the average recommended number of hours of sleep required by young people aged 14-17 is between 8-10 hours a night (National Sleep Foundation, 2015). **Chart 4.20** shows the percentage of young people in years 6 (age 10-11), 8 (age 12-13) and 10 (age 14-15) who report getting 8-9 hours or 10+ hours, based on surveys by the Exeter Schools Health Unit. The total proportions who have 10 or more hours sleep drops quite considerably by year 10, particularly for girls.

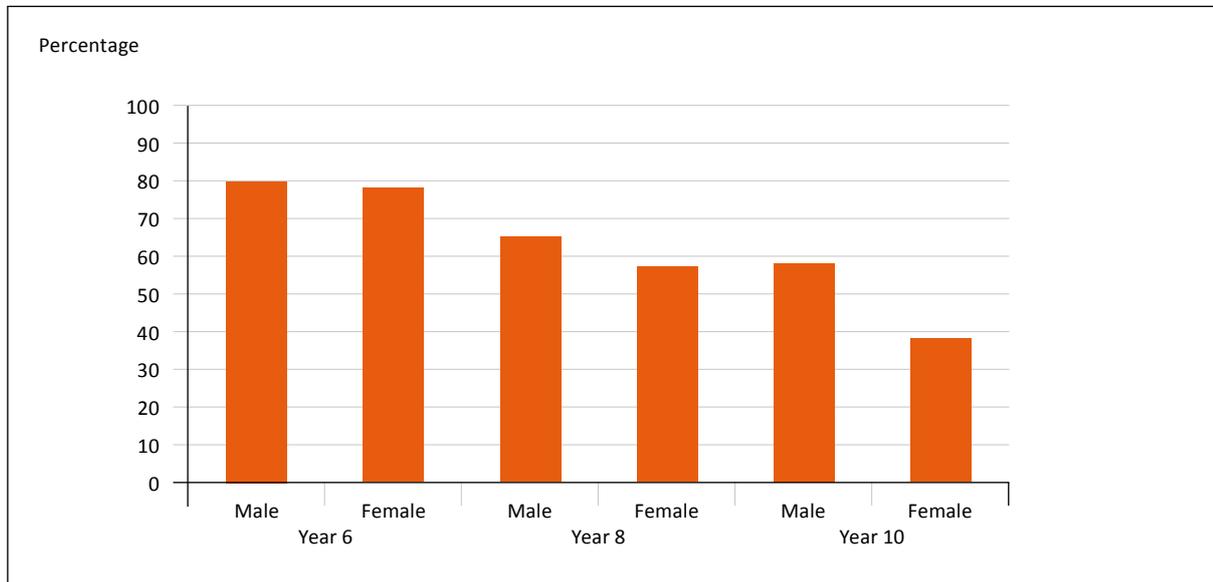
Chart 4.20: Percentage of students in Years 6, 8 and 10 (10-11 years to 14-15 years) sleeping for 8-9 hours or 10+ hours in the last night, 2018



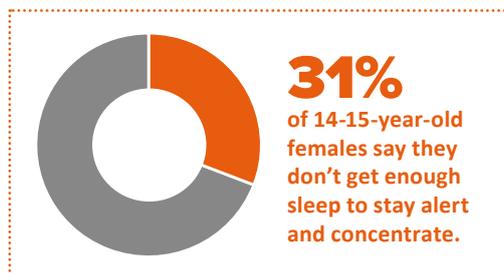
Source: Balding and Regis (2018) Young People into 2018 > [DOWNLOAD DATA](#)

There is increasing evidence that adequate sleep is one of the key contributors to adolescent wellbeing (Gireesh, Das and Viner, 2018). Insufficient sleep and poor quality sleep may be both the cause and the result of health problems. Sleep deprivation in adolescence has been linked to increased psychosocial problems, poor school performance, increased risk-taking behaviour, excess food intake, poor diet and obesity (Chaput and Dutil, 2016; Medic, Wille and Hemels, 2017). Overuse or particularly late evening use of smart phones, tablets and computers have been linked to sleep disturbances in this age group (Lemola et al, 2015). The Schools Health Education Unit also asked young people if they felt they were getting enough sleep for their health, and their responses shown in **Chart 4.21** reflect the reduction in sleep across the teen years shown in Chart 4.20 above.

Chart 4.21: Is the amount of sleep you normally get enough for your health?
Percentage of pupils who answered 'yes' by gender and school year, 2018



Source: Balding and Regis (2018) Young People into 2018, Exeter Schools Health Unit > [DOWNLOAD DATA](#)



Source: Balding and Regis (2018) Young People into 2018

Similarly the Health Behaviour in School Aged Children study asked 11-15 year olds whether they got enough sleep, and 22% reported that they did not. Reported rate of adequate sleep decreased as age increased (Brooks et al, 2015). Nearly a third of 14-15 year old girls who responded to the 2018 Schools Health Education Unit surveys said that they did not get enough sleep to stay alert and concentrate (Balding and Regis 2018).

Reports that exist suggest the prevalence of inadequate sleep may be increasing over time. Secondary analysis of two British population cohorts has shown an increase in the proportion of 14 year olds sleeping less than the recommended eight hours a night (Patalay and Gage, 2019).

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