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Addressing the health needs of adolescents in Europe

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Baroness Doreen MASSEY, United Kingdom, Socialists, Democrats and Greens Group

Summary

It is in adolescence that we make important choices and lay down foundations for our adult life. Yet, too many young people across Europe struggle with serious health-related issues, such as anxiety and depression, eating disorders, early pregnancy, sexually transmitted diseases, self-harm, addictive or violent behaviours and suicidal thoughts. Young people feel that they do not get the help they want when they need it. Too often, they are demonised or medicalised.

We need to try harder to understand why our societies are failing many of our young people and develop solutions that work. Research needs to be supported. Local communities and adolescents themselves need to be involved. Media and education should raise awareness of challenges and good practices and promote public support for health systems that meet the needs of every young person.

Investing in adolescents' health is beneficial for the well-being of societies and future generations. Furthermore, it has a substantial economic impact. Governments should give higher priority to providing health services for adolescents that are free, inclusive, timely, welcoming, confidential and non-punitive. The social determinants of health, for example poverty, deprivation, prejudice and stigma, should also be addressed.

1. Reference to committee: Doc. 14182, Reference 4262 of 23 January 2017.

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A. Draft resolution[2]

1. The Parliamentary Assembly recalls that health is a human right and health services appropriate for every age group are an essential element of cohesive and democratic societies. It reaffirms its commitment to the United Nations Sustainable Development Agenda 2030, including Goal 3: Ensure healthy lives and promote well-being for all at all ages.

2. The Assembly recognises that the health of adolescents, namely children aged from 10 to 18, is an important area of development, embracing issues of inequalities, gender, economic status, race, ethnicity, religion, sexuality and physical and mental ability. It is during adolescence that behaviours are shaped and the foundations for healthy lifestyles are laid.

3. The Assembly notes that addressing violence is an essential dimension of health, and reaffirms its commitment to the Council of Europe Convention on Protection of Children against Sexual Exploitation and Sexual Abuse (CETS No. 201, "Lanzarote Convention"), the Council of Europe Convention on Action against Trafficking in Human Beings (CETS No. 197) and the Convention on Cybercrime (ETS No. 185), and the Council of Europe Campaign "Start to Talk" on the protection of children against sexual abuse in sport.

4. The Assembly acknowledges that the participation of adolescents in decisions about relevant health policies is important for meeting their needs and developing efficient health systems. The Guidelines of the Committee of Ministers of the Council of Europe on Child-friendly Health Care and other tools developed in the framework of the Council of Europe Strategy on "Building a Europe for and with Children" and of youth and education programmes provide useful guidance on how this could be done.

5. In the light of the above, the Parliamentary Assembly recommends that the Council of Europe member States:

5.1. with respect to health services:

5.1.1. promote the need for a focus on adolescent health through funding for services and advocacy;

5.1.2. ensure that services for young people are accessible, free, inclusive, timely, welcoming, confidential and non-punitive;

5.1.3. ensure that there are sufficient high-quality staff trained to advise and support adolescents who need help;

5.1.4. recognise that adolescents may have general as well as specific health concerns and provide services (such as health hubs) where adolescents can receive advice covering a variety of health issues;

5.1.5. recognise that some adolescents are particularly vulnerable to health disorders – for example those in the criminal justice system, migrants, refugees, those who are physically or mentally disabled, and those not in education or training;

5.2. with respect to research:

5.2.1. encourage further research into the needs of adolescents;

5.2.2. recognise the "life course" of health and address each phase with equal vigour in research, information and services;

5.3. with respect to government and local authorities:

5.3.1. ensure that co-ordination across government departments and in local structures is activated or reinforced in order to ensure holistic action on adolescent health;

5.3.2. support participation of adolescents and their communities in influencing decisions about health services and involve them at national and local level through local and regional authorities, non-governmental organisations (NGO s) and Commissioners for Children;

5.4. with respect to other actors in the health field:

5.4.1. harness the media, including social media and advertising, to provide positive encouragement to the public, including adolescents, to develop healthy lifestyles;

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2. Draft resolution adopted unanimously by the committee on 4 December 2018.

5.4.2. encourage the private sector to collaborate with good practice in health initiatives and in research;

5.4.3. ensure that NGOs who are working with adolescents have sufficient financial and other support and that they are consulted when developing national and local policies on health;

5.4.4. ensure that parents and carers are involved, where appropriate, in developing interventions to help the adolescents in their charge;

5.4.5. involve adolescents themselves in the design of the services catering to their needs, where possible;

5.5. with respect to schools and colleges:

5.5.1. ensure that schools and colleges have access to counsellors, nurses and doctors who have specialist knowledge of adolescents;

5.5.2. ensure that the school and college curriculum includes mandatory personal, social and health education, including comprehensive sexuality education, which empowers adolescents to make informed choices;

5.5.3. ensure that schools and colleges have a pastoral system which protects, supports and enables young people to receive support;

5.6. in general:

5.6.1. address the social determinants of health, for example poverty, deprivation, prejudice and stigma, in order to address inequalities in health;

5.6.2. identify and share examples of good practice and proven effectiveness at local, national and international level.

B. Explanatory memorandum by Baroness Doreen Massey, rapporteur

1. Introduction

> *"Unprecedented global forces are shaping the health and well-being of the largest generation of 10- to 24-year olds in human history. Population mobility, global communications, economic development and the sustainability of ecosystems are setting the future course for this generation and, in turn, mankind. At the same time we have come to new understandings of adolescence as a critical phase in life for achieving human potential."*
>
> *The Lancet Commission on Adolescent Health and Wellbeing"*[3]

1. Adolescents can be challenging. They are sometimes demonised and medicalised in relation to "problems". Adolescents can also be enthusiastic, energetic and passionate about issues relevant to their own concerns such as education and health and to the future of the world such as poverty, climate change and migration. Adolescents are generally healthy, but there are sufficient numbers who have problems to merit an increased focus on research and interventions. Adolescence is a time in which positive changes can be made and difficulties addressed and resolved. We must take better account of the potential of adolescence for achieving human potential, for the benefit of the whole society.

2. The United Nations Committee on the Rights of the Child (UNCRC) notes that achieving the right to health is dependent on the realisation of many other rights, such as those inherent in social determinants – the conditions in which people are born and live.[4] The World Health Organization (WHO) produced as long ago as 1993 a report on the health of adolescents[5] and has continued to publish statements and guidance. The United Nations Children's Emergency Fund (UNICEF) has published a draft "Young People's Agenda" for consultation. It calls for a response to the Sustainable Development Goals (SDGs) by involving leaders from governments, private sector, civil society and youth organisations in delivering change in protecting and empowering adolescents through education, health, skills and training.[6]

3. This report takes up some of the global implications raised by the Lancet Commission[7] and by international organisations. Five key principles underpin its content: 1) adolescence is a key stage of life and merits attention and investment; 2) young people should participate in developing strategies which affect their health; 3) welfare and other services should be co-ordinated in a holistic way; 4) inequalities seriously undermine health and must be addressed in order to prevent poor outcomes; 5) international strategies for action need to be implemented at national, regional and local levels and success or failure evaluated. These principles will be reinforced in the sections related to mental health, sexual health and obesity. The report seeks to present a brief overview, a "snapshot" of factors influencing the health of adolescents and what may be done in order to improve their lives and involve them in doing so. It is based on selected research and the experiences of young people, researchers and practitioners, and draws conclusions on how the nations of Europe might develop and implement health strategies which serve all adolescents, irrespective of their backgrounds. A study visit to Sweden provided examples of challenges and good practice (for further information, see document AS/Soc/Inf (2019) 01 on the website of the Committee on Social Affairs, Health and Sustainable Development).

2. Adolescence is a key stage of life which merits attention and investment

2.1. Defining adolescence

4. For the purposes of this report, the WHO definition is adopted: an adolescent is a person between the ages of 10 and 19; young people are individuals between the ages of 10 and 24. A child is someone between the ages of 0 and 18.

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3. Patton G.C. et al. (2016). Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet*, 387, 2423-2478.
4. United Nations (2013). Conventions on the Rights of the Child. New York, USA.
5. WHO (1993). The Health of Young People: a challenge and a promise. Geneva, Switzerland.
6. UNICEF (2018). A Young People's Agenda. New York.
7. Patton G.C. et al (2016), op. cit.

5. Adolescence is a unique phase of life in that it is one of biological development, social experiences and identity building. In particular, the impact of hormonal changes and an increased emphasis on relationships and sexuality can make life complex for adolescents. Added to this, the digital age and social media, whilst offering opportunities for learning and interaction, also pose problems of the potential exploitation of young people, including sexual exploitation. Facebook and Google have been urged to take more responsibility for the pressures they place on young people.

2.2. The life course approach

6. Delivering health services for adolescents is more than focusing on individual aspects of health, such as smoking, drug use, diet, mental health and sexual health at a specific age. Young children become adolescents, who in turn become adults and grow old. Over this period, health needs will change and a life course approach to health is required. Such an approach aims to introduce or reinforce interventions throughout life. It includes a healthy start to life and addresses the needs of people, with their participation, at all stages. It addresses the causes of ill health and promotes timely investment and a good return for money spent. For example, education about relationships and sexuality is delivered from different sources, before the onset of sexual relations. In schools a "spiral" curriculum can be developed which introduces and repeats concepts such as friendship as the child matures. This can lead on to discussions about contraception, sexually transmitted infections and sexual relationships at later stages.

7. Recent research indicates that the influence of brain development, within physical and hormonal changes and social and environmental influences, contributes greatly to adolescent health outcomes. The Welcome Trust has an extensive programme of research on the teenage brain entitled "Neuroscience and Education".[8] In 2017, the UNICEF office of research (Innocenti) produced a compendium of articles under the title: "Adolescent Brain Development: a Second Window of Opportunity". They include: the developing brain in its cultural contexts; poverty and the adolescent brain; helping teenagers develop resilience; mindfulness mediation and its impact; and the perils and the promise of technology for the adolescent brain.[9]

2.3. Characteristics of adolescent health

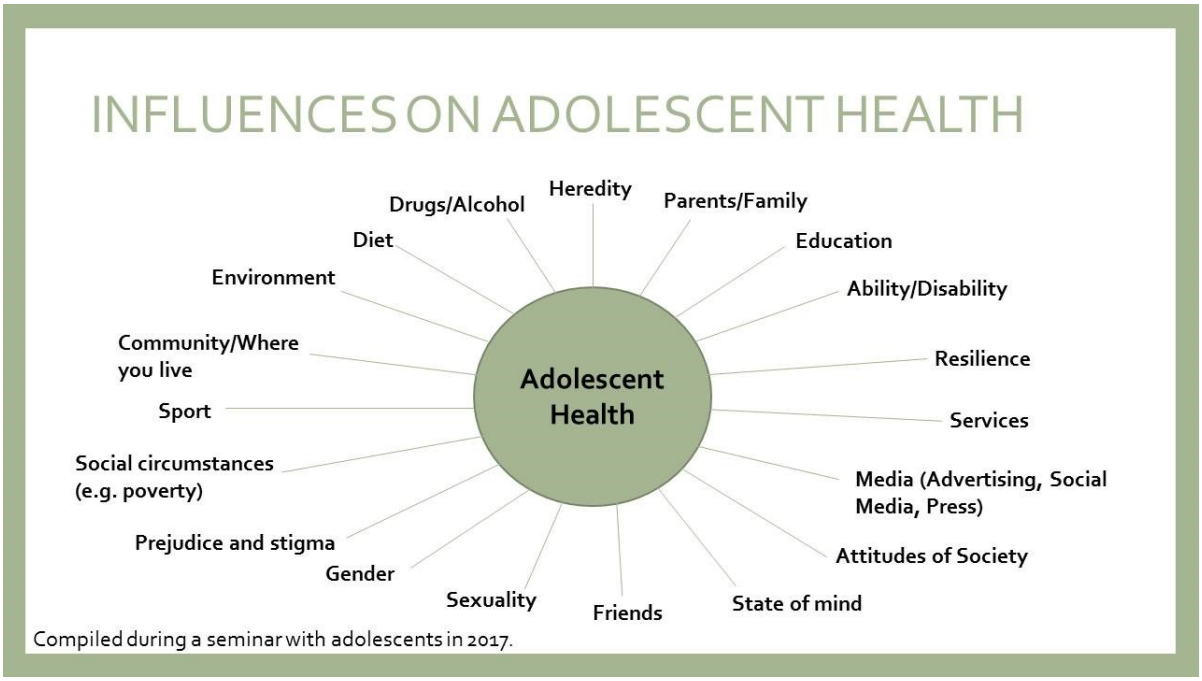
8. According to the United Nations World Population Prospects revision of 2015, the proportion of the adolescent population in countries of Europe is 14%.[10] The number of adolescents has grown as a result of prevention and intervention focused on childhood health problems such as malnutrition, infant mortality and infectious diseases. Whilst in some countries these concerns still exist, what we are now seeing is a rise in concerns about mental health, obesity and sexual health.

9. Adolescents are not a homogeneous group and the concept of health cannot be separated from the context in which it exists. Health has social determinants which influence health and well-being status (see Diagram 1 below). Health inequalities still exist and will profoundly affect the life chances of adolescents. WHO considers that gender and socioeconomic differences in young people's health and well-being are of fundamental importance[11]. Some young people have greater health risks than others, particularly those living in deprivation, those with disabilities, those from ethnic minorities, lesbian, gay, bisexual, transgender or intersex (LGBTI) young people and those in the youth justice system. Young people living in zones of armed conflict are vulnerable to exploitation and trauma.[12] Lack of stability due to displacement and migration, poor education, abuse and lack of support have powerful negative impacts and need to be addressed in urgent ways.[13]

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8. Welcome Trust. (2018): https://wellcome.ac.uk.
9. UNICEF (2017). The Adolescent Brain: A second window of opportunity. Office of Research – Innocenti. New York, 8.
10. United Nations (2015). World Population Prospects – Key findings & advance tables: The 2015 Revision. New York, USA.
11. WHO (2016). Growing up unequal: gender and socioeconomic differences in young people's health and well-being: Health Policy for Children and Adolescents, No. 7.
12. Resolution 2204 (2018) on protecting children affected by armed conflicts and the report of the Committee on Social Affairs, Health and Sustainable Development, Doc. 14461 (rapporteur: Ms Sevinj Fataliyeva, Azerbaijan, EC).
13. Resolution 2220 (2018) on integration, empowerment and protection of migrant children through compulsory education and the report of the Committee on Migration, Refugees and Displaced Persons, Doc. 14524 (rapporteur: Ms Petra De Sutter, Belgium, SOC).

Diagram 1: Influences on adolescent health[14]



10. Increased emphasis on education, especially for girls, provides greater opportunity, potential and encourages ambition. Laws such as those on forced marriage and female genital mutilation, whilst not always adhered to, exist to protect young people. Other laws may restrict their rights; sexual rights, for example, are, in some countries still limited and deny the education and services essential to the welfare of adolescents. Whilst most countries have ratified the United Nations Convention on the Rights of the Child, cultural practice and national laws may lead to young people's rights being infringed.

2.4. Health services for adolescents

11. Two opinions from young people reflect the importance of having readily accessible services specifically designed for young people. A 20-year-old woman said: "I believe promoting more youth friendly health services is the most significant point, as I feel there is great importance in making health care accessible for young people." Another stated: "Very often there is no help available until the problem has become totally unmanageable."[15] Many adolescents are not getting the help they want when they want it. The situation is further complicated by adolescents being on the cusp between childhood and adulthood. They are all too frequently pushed into services designed for adults and run by professionals without specific training to deal with the needs of a younger age group. There is an urgent need to improve levels of trained staff and to co-ordinate between the different services. As one young person from an advocacy group stated: "Young people do not want to be sent to a different service for every different problem they are dealing with. They want someone to help them through a variety of different issues, recognising that they are often connected."[16]

12. Education for health is also important, particularly when linked to other services. Health Promoting Schools[17] and Rights Respecting Schools[18] exist in small numbers across Europe. In these schools, young people learn about their rights and health options. In addition, they may be put into contact with professional services outside school. Health Education, however, is rarely given mandatory status in the curriculum. Where it exists, it is often purely biological and consists of one-off lessons. Some schools do have programmes which not only include information, but also encourage pupils to explore their attitudes and values and foster decision- making skills. That said, the numbers of school nurses and counsellors are often inadequate to cope

14. Drawn up at a seminar on "Children's Mental Health and Child-friendly Justice", organised by the United Kingdom Parliament in co-operation with the Parliamentary Assembly of the Council of Europe (London, 6-7 November 2017).
15. Association for Young People's Health (2017). Key Data on Young People 2017: Recommendations for Action. London, United Kingdom.
16. Ibid.
17. WHO (2018). What is a Health Promoting School?, Geneva, Switzerland.
18. UNICEF (2018). What is a Rights Respecting School?, UNICEF UK.

with young people's health problems.[19] In England, after many years of lobbying of government by politicians, professionals, parents, young people and non-governmental organisations (NGOs), Personal, Social and Health Education (PSHE) has been made mandatory and includes wider aspects such as relationships and interaction with environmental factors.[20] Higher education institutions need greater support to develop health and pastoral care systems.

2.5. Why invest in adolescent health?

13. The 2016 Lancet Commission considers that adolescent health has been grossly neglected.[21] The 2014 WHO report on adolescent health states that adolescence is a critical time for human development and should be given particular attention.[22] A 2018 World Bank report estimates that over 90% of research publications focus on children under five.[23] Unarguably, the early years of human life are important. Children deserve attention, and good access to services,[24] but so do adolescents. Attention paid solely to the under-fives may result in national deficits of data, research, funding, policy and action for adolescents. Focus on the early years has undoubtedly helped with achieving the Millennium Development Goals (MDGs), but development which occurs just before adulthood is equally important due to its complex nature and amenability to intervention.

14. Adolescence is a dynamic and formative stage in the passage to adulthood which can greatly contribute to satisfaction and achievement, but can also give rise to negative experiences and difficulties.[25] UNICEF stresses the need to invest in adolescence, not only because it is "right in principle" but also because it safeguards the initial investment in health and provides an early start for societal goals such as alleviating poverty, achieving equity and eliminating discrimination.[26] Investment in health also helps to equip adolescents with the necessary tools and coping skills for present and future challenges.[27] The Lancet Commission states that investment in adolescent well-being brings a triple dividend of benefits now, in future adult life, and for the next generation of children. Tackling preventable and treatable adolescent health problems will bring huge social and economic benefits. This is key to addressing health issues in all countries by 2030.[28] See the Appendix for further information.

3. Mental health

15. Research shows that most mental health problems begin before the age of 25 and are most common between the ages of 11 and 18.[29] Mental health disorders can affect general health. For example, depression may result in overeating and physical inactivity, with adverse consequences. Not all problems persist into adulthood, especially if the episodes are brief and appropriate interventions are applied, which are community based with integration of services across health, education and social sectors.[30] Public health expenditure is relatively cost effective compared with health care expenditure. Public Health England has estimated that the median return on investment is 14.3 to 1.1.

16. WHO defines mental health as "a state of well-being in which every individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community".[31] Mental health problems may be more or less common, may be acute or long lasting and may vary in severity. They manifest themselves in different ways at different ages – for example, in children they may manifest themselves as behavioural problems.[32]

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19. *The Times* (2018). Almost 200 pupils a day referred for mental care. 14 May 2018. Page 4.
20. Hayman J. (2017). How the campaign for compulsory relationships and sex education was won. Hayman Consulting.
21. Patton G.C. et al. (2016), op. cit.
22. WHO (2014). Health for the world's adolescents: www.who.int/maternal_child_adolescent/documents/second-decade/en/.
23. The World Bank (2018). Child and Adolescent Health and Development: Optimizing Educational Outcomes: High-Return Investments in School Health for Increased Participation and Learning: https://openknowledge.worldbank.org/bitstream/handle/10986/28876/33813.pdf?sequence=8.
24. Resolution 2139 (2016) on ensuring access to health care for all children in Europe and the report of the Committee on Social Affairs, Health and Sustainable Development, Doc. 14194 (rapporteur: Ms Stella Kyriakides, Cyprus, EPP/CD).
25. Gates M. (2016). Advancing the adolescent health agenda. *The Lancet*, 387, 2358-2359.
26. UNICEF (2011). The state of the world's children – adolescence: an age of opportunity. New York.
27. Resnick M.D., Catalano R.F., Sawyer S.M., Viner R. and Patton G.C. (2012). Seizing the opportunities of adolescent health. *The Lancet*, 379, 1564-1567.
28. Patton G.C. at al. (2016), op. cit.
29. Department of Health and Social Care. Department for Education (2018). Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps.
30. Faulconbridge D. and Law D. (2018). Think Piece – a manual for a News Movement in Clinical Psychology.

3.1. Influences on mental health

17. In Diagram 1 above, influences on adolescent health are suggested, recognising that such determinants may have their origins in childhood and may persist into adulthood (the Life Course). Determinants of mental health may include: truancy rates at school and lack of education, attainment in the early years, first contacts with the justice system, being in care, domestic abuse, suicide of family or friends and stigma (including racial, religious and sexual orientation prejudice). In addition, students in schools and higher education report stress and depression due to tests and examinations. The influence of the media can be positive (for example, in the promotion of access to services and advice), but also can be detrimental, for example in cyberbullying, the portrayal of violence, as well as pornography and grooming. In the United Kingdom, out of 1 000 young people aged between 11 and 25, 47% had experienced bullying.[33]

18. Over one third of 15 year olds in the United Kingdom are "extreme internet users" – that is, they spend more than six hours of a weekend day on the internet and 94% use the internet before and after school.[34] This year WHO has added "gaming disorder" to its International Classification of Diseases.[35] Spending too much time online can create social isolation. It can also create sleep deprivation and poor quality sleep, which can cause problems with concentration and with behaviour and self-image – 38% of young people report that social media had a negative impact on how they feel about themselves; 48% of girls stated that social media had a negative impact on their self-esteem.[36]

3.2. Addressing issues related to mental health

19. A Council of Europe/United Kingdom Parliament seminar held in 2017 highlighted the links between mental health and justice. The seminar brought together young people, parliamentarians, NGOs, academics, lawyers and police officers. The recommendations included the following: improving public awareness; reducing stigma through campaigns; increasing funding for professional and non-professional help for young people; improving access to school nurses and psychologists; developing interdisciplinary services; ensuring that teachers are trained to recognise signs of mental strain; and ensuring that young people are listened to and their concerns taken into account, including when developing laws and policies. At the Council of Europe level, the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) should be encouraged to take more interest in centres for mental health for children. Concerns were expressed in relation to the number of young people with mental health problems who enter the justice system, the effect of the justice system on health and the disproportionate number of young black men in the justice system. Positive examples included: Austria (a high level of training for the judiciary), France (a family court system based on multi-agency co-operation), Iceland (a Children's House model – a "one-stop shop" support system), and Nordic States (increasing use of child-friendly interview techniques, including video links and written statements). A young participant stated: "Young people are experts by experience and their stories should be heard."[37] Another seminar for young people held recently in London has expressed the need for the youth justice system to be rehabilitative rather than punitive, with a particular emphasis on mental well-being.[38] The Spanish interdisciplinary network for the promotion of mental health and emotional well-being in the young (PROEM) gives a comprehensive argument for the prioritisation of mental health and effective interventions).[39]

20. In the United Kingdom, the number of children referred for mental health treatment by schools has soared by more than a third in the last three years.[40] However, Child and Adolescent Mental Health Services (CAHMS) have to turn away 23% of children and adolescents. Evidence of the increase in mental health problems, sometimes referred to as "a crisis", has resulted in a number of initiatives. There is a national strategy "No Health without Mental Health".[41] A green (consultation) paper "Transforming children and young

31. WHO (2014). Mental health: a state of well-being. Geneva, Switzerland.
32. United Kingdom Government (2017). No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.
33. Young Minds (2018): https://youngminds.org.uk.
34. Frith E. (2016). Children and Young People's Mental Health: Time to Deliver. Education Policy Institute.
35. WHO (2018). www.who.int/features/qa/gaming-disorder/en/.
36. British Educational Research Association (2018). Social Media's impact on children and young people's mental health: www.bera.ac.uk/blog.
37. Council of Europe (2017). Children's Mental Health and Child-Friendly Justice – Seminar Report. Committee on Social Affairs, Health and Sustainable Development.
38. Zumu B. et al. (2016). Just Health. Commissioned by NHS England and assisted by Peer Power and Clear View Research.
39. PROEM (2018). Recommendations for promoting Mental Health and Emotional Well-Being in Young People.
40. National Society for the Protection of Children (2018). School referrals for mental health treatment rise by over a third.

people's mental health" was issued in 2017.[42] The government has committed an additional £1.4 billion to transform children and young people's mental health services. See the Appendix for information on cost-effectiveness.

4. Sexual health

21. Encouraging adolescents to enjoy respectful and satisfying relationships and to protect themselves not only from unplanned pregnancy, but also from sexually transmitted infections, requires a combination of accurate information and advice, services which are welcoming and friendly, and the participation of young people in identifying their needs and giving advice on what they find most useful.

22. According to WHO, in 2018, "[s]exual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence".[43] The terms "sexuality" and "sexuality education" are adopted in this report rather than the frequently misconstrued "sex" and "sex education" which have biological connotations and, to some, implies "having sex". Educators working with young people have often found this perception problematic.

4.1. Data on adolescent sexual activity

23. Data may be questionable, due to lack of accurate records and incorrect statements by adolescents, but in Europe, there is reasonably comprehensive data on the sexual activity of adolescents. For example, there are four teenage births to women per 1 000 between the ages of 15 and 19 in the Netherlands, 14 in the United Kingdom, 38 in Georgia and 37 in Albania. Sexually transmitted infections are rising amongst adolescents in European countries and the increase is higher than in any other group. Condom use is more frequent than the pill, but the lack of condom use amongst adolescents leaves them vulnerable to STIs, the rates of which are climbing; the highest numbers of infections are found among adolescents from lower and middle income groups.[44] Whilst advances have been made globally in the prevention of new HIV infection, progress has been slow. Globally, HIV/AIDS was the ninth leading cause of death amongst young people between the ages of 10 and 19 in 2015.[45] Only 36% of young men and 30% of young women aged 15 to 24 had a good knowledge of how to prevent HIV according to available data for 2011-2016 in 37 countries.[46] Adolescents in Europe are lacking accurate information, and the skills to negotiate safer sex. They frequently describe their knowledge about sexuality as "Too little, too late".

4.2. Addressing issues related to adolescent sexual health

24. The reasons for early sexual activity and lack of protection are varied: socio-economic status, lack of family openness in discussing sexuality and the use of alcohol or other substances which lower the locus of control.[47] It is clear that improvements in awareness and practice can change sexual habits. The UK Teenage Pregnancy Strategy combines efforts from communities, young people, schools and services with focus on reducing the high rates of teenage pregnancies.[48] Between 1992 and 2014, conception rates fell by 51% with considerable reductions in geographical areas of high conceptions.[49]

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41. UK Government (2017). No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.
42. Department of Health and Social Care. Department for Education (2018). Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps.
43. WHO (2018): www.who.int/topics/sexual_health/en/.
44. The International Planned Parenthood Federation. Federal Centre for Health Education (2018). Regional Overview of the Status of Sexuality Education in 25 Countries of the WHO European Region.
45. UNAIDS (2015). Leaders from round the world are all in to end the AIDS epidemic among adolescents. Geneva, Switzerland.
46. UNAIDS (2017). The scales have tipped – UNAIDS announces 19.5 million people on life-saving treatment and AIDS-related deaths halved since 2015. Geneva, Switzerland.
47. Advocates for Youth (2018). Youth and the State of Science: Health, New Technologies, Ethics and Human Rights: www.advocatesforyouth.org/publications/publications-a-z/454-youth-and-the-state-of-science-health-new-technologies-ethics-and-human-rights.
48. Public Health England (2018). Teenage Pregnancy Prevention Framework. Local Government Association.
49. Office for National Statistics (2014). Conceptions in England and Wales: 2014.

25. Young people should have the right to advice at the start of their sexual and reproductive lives. However, parents may be reluctant to engage in such discussions, adolescents may not wish to discuss sexuality with their parents, and information from friends or the media might be misleading. Specialist health or education services are therefore important in providing advice and information.

26. A consensus statement from Public Health England supports a positive, life course approach involving choices and control as opposed to the absence of disease or poor outcomes; services that are inclusive of the population's needs and responsive to diverse characteristics; an agreed ethical framework, which takes account of stigma and shame at all stages of life at an institutional and individual level; and campaigns that challenge stereotypes and taboo.

27. Young people have made it clear what kind of services they find most helpful: non-judgmental, confidential, free, and staffed by sympathetic and knowledgeable staff. One example of such services is provided by Brook Advisory Centres for young people in nine regions of the United Kingdom, established over 50 years ago, amidst great controversy, by the pioneer Helen Brook. These Centres provide comprehensive services in sexual health for young people up to the age of 24.

4.3. Comprehensive sexuality education

28. Comprehensive sexuality education follows the concept of the life course approach to adolescent health. It advocates structured programmes, which begin with simple information and discussion about friendship and body parts and move on to more complex aspects of relationships and sexual behaviour as the child matures into adolescence and beyond.

29. An overview of sexuality education in the 25 countries of the WHO European Region concluded that "remarkable progress" in developing sexuality education has been made since the year 2000.[50] Other evidence supports this, but quality and comprehensiveness may not be universal in the region. Many service providers and educators have struggled to establish even minimal rights for young people to be provided with information.

30. UNESCO puts forward the following framework for consideration: comprehensive sexuality education should cover the full range of topics (even if they are challenging in some social and cultural contexts); it should be based on a human rights approach, which includes gender equality, and should encourage young people to recognise their own rights, respect the rights of others and advocate for those whose rights are violated. It may have reference to the overall well-being of young people whilst impacting the prevention of HIV, STIs, unintended pregnancy and gender-based violence. It should provide opportunities to nurture positive values and attitudes toward sex and relationships and develop life skills to support healthy choices.[51] Comprehensive sexuality education may be included in health education which encompasses not only the formal school curriculum, but also school ethos and policies, liaison with parents and communities, and linking with youth organisations. See the Appendix for information on cost-effectiveness.

5. Obesity

31. Obesity in children and young people is a relatively new phenomenon, but the problem is global and has spread at a disturbing rate. It has been called one of the most serious public health challenges of the 21st century[52] and is increasingly affecting low and middle income countries, particularly in urban settings.

32. The body mass index (BMI) is a person's weight in kilograms divided by their height in metres squared. Obesity is defined as a BMI of 30 and above. Overweight is a BMI of 25 to 29.9.[53] BMI is measured differently in adults and children and is evaluated using age and gender specific charts that take into account the different growth patterns. Weight and the amount of fat in the body differs for boys and girls and those levels change as they grow; it is expressed as percentiles. BMI levels in children and adolescents are expressed relative to other children of the same age and gender. In adolescence a percentile higher than 95 is considered obese and an 85 to 95 percentile as overweight.[54]

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50. The International Planned Parenthood Federation. Federal Centre for Health Education (2018). Regional Overview of the Status of Sexuality Education in 25 Countries of the WHO European Region.
51. UNESCO (2018). International technical guidance on sexuality education. Geneva, Switzerland.
52. WHO (2017). Tenfold increase in childhood and adolescent obesity in four decades: new study by Imperial College London and WHO. Geneva, Switzerland.
53. National Institutes of Health, USA (2010). NIH study identifies ideal body mass index: www.nih.gov/news-events/news-releases/nih-study-identifies-ideal-body-mass-index.

5.1. Data on obesity

33. Globally, in 2016, the number of overweight children under five was estimated at over 41 million. In the WHO Europe region, in 2008, one in three 11-year olds were overweight; over 50% of both men and women were overweight and 23% of women and 20% of men were obese. Currently 30% to 70% of men and women are overweight and 10% to 30% are obese.[55] Whilst the European region has achieved great success in improving adolescent health in recent years, obesity continues to rise in all but a few countries, with marked disparities. In 10 of the 16 countries and regions, patterns of social inequality were observed. However, none showed a significantly higher prevalence of obesity amongst the most affluent adolescents.[56]

5.2. Influences on obesity

34. Adolescents become overweight or obese for a number of reasons, most commonly due to genetic factors, lack of physical activity, unhealthy eating patterns or a combination of these factors. In some rare cases, obesity is caused by a medical condition such as a hormone problem. TV viewing is decreasing across Europe, but computer usage increased significantly between 2002 and 2014. Increases in computer use are more evident in girls. The current guidelines of less than two hours a day of computer or TV usage is not met by the majority of European adolescents.[57] Poor nutrition is the largest factor contributing to poor health, with one particular cause being the drinking of sugar-laden fizzy soft drinks, drinks from concentrates, milk drinks, sports and energy drinks and flavoured waters. Their promotion often targets children and adolescents. Obesity is more common in lower socioeconomic groups. Such inequalities are either unchanged or have become greater since 2012. An estimated 27% of all adolescent obesity in Europe in 2014 was attributed to socio-economic differences.

5.3. Consequences of obesity

35. Most health problems related to obesity do not become apparent until adulthood. Childhood obesity is strongly associated with risk factors for cardiovascular disease, type 2 diabetes, orthopaedic problems and musculoskeletal problems such as osteoporosis.[58] If this trend continues then there will be 88 million people living with diabetes in 2045 in comparison with 58 million today and the total health-care costs of diabetes will rise to 175 billion euros in 2045, not taking into account other indirect costs.[59] Obesity could be linked to 12 types of cancer and will overtake smoking as a leading cause of death within a couple of decades in countries such as the United Kingdom.[60] Obese children are at greater risk of school absence, psychological problems and social isolation deriving in part from lower self-esteem.[61]

5.4. Addressing obesity in adolescence

36. Targeted efforts are needed to break the cycle of obesity. Services should be aimed at adolescents, to help them make positive changes in health behaviour. Policies should promote awareness of, and access to, healthy diets and physical activity,[62] through co-ordinated actions of different government departments, communities, the media and the private sector.[63] Parental influence is significant, and needs to be supported. An overall healthy lifestyle in mothers has an impact on the risk of obesity in children.[64]

37. Policy actions such as a tax on sugar sweetened drinks, school food policies, marketing restrictions, food labelling and targets for the food industry are needed to reduce levels of obesity. Taxes on sugar, tobacco and alcohol have been suggested as a means of achieving the Sustainable Development Goals (SDGs) and as part of a broader public health approach in addressing the commercial determinants of health.[65] In the United Kingdom a regulatory approach was introduced in April 2018: companies

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54. Centre for Disease Control and Prevention, USA (2016). Defining Childhood Obesity: www.cdc.gov/obesity/childhood/defining.html.
55. WHO (2018). Data and Statistics – Obesity. Regional Office for Europe.
56. WHO (2017). Adolescent obesity and related behaviours: trends and inequalities in the WHO European Region, 2002-2014. In collaboration with the Health Behaviour in School-aged Children.
57. Ibid.
58. WHO (2018). Why does childhood overweight and obesity matter?: consequences of an unhealthy lifestyle during childhood. Geneva, Switzerland.
59. International Diabetes Federation (2017). IDF Diabetes Atlas. 8th edition.
60. Boseley S. (2018). Obesity now linked to 12 different cancers. *The Guardian.* 23 May 2018.
61. WHO (2018). Why does childhood overweight and obesity matter?, op. cit.
62. Gatineau M. and Dent M. (2011). Obesity and mental health. National Obesity Observatory: Oxford, United Kingdom.
63. WHO (2017). Ending Childhood Obesity: Implementation Plan. Geneva, Switzerland.
64. Smyth C. (2018). Health-conscious mothers cut children's obesity risk. *The Times.* 5 July 2018.

manufacturing soft drinks with added sugar have to pay a levy and there is a higher rate for drinks with higher levels of sugar. This levy appears to be having a positive effect as companies are substantially reducing the sugar content in drinks. The voluntary reduction of sugar in foods was disappointing, with only a 2% reduction in sugar in the first year. Companies tend to work around public health concerns to preserve profit margins. Other areas where legislation could have a positive effect are in agricultural policy, food marketing and pricing, non-broadcast advertising and sponsorship.

38. The United Kingdom Parliamentary Health Committee recommended restrictions on advertising and food promotion and giving greater powers to local authorities to control fast food outlets and billboard advertising.[66] In 2016, the United Kingdom set out a plan to combat childhood obesity and built on this plan in 2018. A summary of actions includes sugar-intake reduction, calorie reduction, consulting on advertising by introducing before the end of 2018 a 9 p.m. watershed on television advertising of high fat and sugar foods. Local trailblazer programmes will be introduced with local partners to show what works in different localities. See the Appendix for information on cost-effectiveness.

6. Conclusions

39. Mental health problems among adolescents are of growing concern across Europe, challenges to the well-being of adolescents in relation to sexuality are numerous and obesity rates are growing at a disturbing rate. Meanwhile, it is in adolescence that behaviours can be changed and foundations for healthy and fulfilling lives can be laid. Addressing the health needs of adolescents is imperative, not only for the present generation, but for the future well-being of populations.

40. Addressing health issues of adolescents has substantial economic benefits for their societies, including a significant economic impact on the health system and the wider economy, with implications for the Europe 2020 Strategy for Growth.

41. Although the amount of research into the consequences of adolescent behaviours and attitudes is increasing, it is still behind the amount of research into other age groups. This must be remedied at national and international levels. It is not clear how many nations in Europe have a national policy focusing on the needs and potential of adolescents and the social and economic benefits of directing attention to this age group.

42. As with other health-related interventions, it is difficult to isolate the impact of a particular intervention on any health issue from the determinants of health. It is clear, however, that tackling these determinants will be key to overcoming poor health. For example socio-economic status, in particular poverty, inequality and deprivation, play a dominant role. Economies, which are based on profit and have few incentives to pay attention to public health concerns, have a major impact. Media promoting physical perfection at any cost can be a major influence. Exclusive focus on individual responsibility is therefore not sufficient, and systemic approaches need to be developed. States need to formulate approaches to adolescent health which are human rights based, non-patronising, inclusive, and collaborative and which counteract stigma or discrimination.

43. Statements and declarations from international bodies are useful and supportive. Improving adolescent health in the Council of Europe member States is an important contribution to the United Nations Sustainable Development Goals.

44. At country level, local initiatives based on needs assessment and involving local communities are essential in order to deliver and evaluate the impact of any initiative, and to share best practice. Health interventions have proved to be most successful and efficient when they meet the needs of adolescents. Adolescents are the best experts on their health problems and concerns, and their views must be taken into account when developing relevant policies and practices.

65. Marten R. (2018). Sugar, tobacco, and alcohol taxes to achieve the SDGs. *The Lancet*, 391, 2400-2401.
66. Pallan M. (2018). Childhood obesity: time for more comprehensive regulation of the food industry. University of Birmingham.

Appendix – Why invest in health interventions for adolescents?

1. Why invest in adolescents' mental health?

While one in four EU citizens can expect to experience a mental health problem during their lifetime, poor mental health has a significant economic impact on the health system and the wider economy, with implications for the Europe 2020 Strategy for Growth. Globally, mental health problems are the leading cause of years lost due to the inability to function adequately. The overall prevalence of depression in adolescents is around 6% and that for children younger than 13 is 3%. Major depressive disorder puts adolescents at a greater risk of suicide as they are seven times more likely to commit suicide than those without such a disorder. Suicide accounts for 9% of deaths in the 15 to 19 age group. It is the third ranking cause of death in this group, after accidents and assault. Depressive disorders, anxiety, behavioural problems and self-harm are among the greatest contributors to young people's burden of disease.[67]

Gender factors are significant. After puberty, girls' risk of depressive disorders increases substantially. Girls are more likely than boys to be diagnosed with clinical depression. A review of gendered influences estimated that 67 000 adolescents die each year from self-harm.[68] One in five girls in the United Kingdom self-harm because of worries about their appearance or what other children have said about their sexual behaviour.[69]

According to research from the Department for Education for England and Wales, children with higher levels of emotional, behavioural, social and school well-being generally have higher levels of academic achievement and are more engaged in school, both concurrently and in later years[70]. Children with better emotional well-being make more progress in primary schools and are more engaged in secondary school. This alone suggests a good return for efforts undertaken in academic settings.

In Public Health England's "Health Economics: Evidence resource",[71] interventions for child mental health are listed and analysed and have quantified costs and benefits. For example, as regards prevention of conduct disorder, every pound spent would yield £7.83, early intervention in psychosis would yield £10.27 and suicide prevention would yield £43.99. This includes costs linked to health-care, police and other emergency services, loss of productivity due to premature death, as well as grief and shock experienced by relatives.

An article published by the European Union in 2011 estimated the relative cost and benefits of actions across the life course focused on mental health promotion, mental disorders prevention and early intervention in relation to parenting initiatives and social/emotional support for children. Programmes were estimated to have a return on investment of up to 8 euros for every one euro in a United Kingdom context. Most of the benefits of better mental health and well-being were seen outside the health sector, for example in criminal justice and education.[72]

2. Why invest in sexual health for adolescents?

Young people receiving relevant services are more likely to delay the start of sexual activity, to have a decreased number of partners, to reduce risk taking, to use condoms and other forms of contraception, to have a first sexual experience which is consensual and to be aware of, or report, sexual abuse. In addition, young women are less likely to become pregnant before the age of 18 and to experience an unplanned pregnancy in later life.[73] There is evidence to show cost effectiveness of positive interventions regarding safeguarding, school readiness, being in education, employment or training and mental health.[74]

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67. Das J.K. et al. (2016). Interventions for Adolescent Mental Health: An Overview of Systematic Reviews. *Journal of Adolescent Health, 59*, S49-S60.
68. Singh S., Zaka N. and Zeck W. (2018). Gendered influences on adolescent mental health in low-income and middle-income countries: recommendations from an expert convening. *The Lancet*, 2, 85-86.
69. The Children's Society (2018). The Good Childhood Report 2018: www.childrenssociety.org.uk/good-childhood-report.
70. Gutman L.M. and Vorhaus J. (2012). The Impact of Pupil Behaviour and Wellbeing on Educational Outcomes. Department for Education. Childhood Wellbeing Research Centre.
71. Public Health England (2017). Health Economics: Evidence Resource. Public Health England.
72. McDaid D. (2011). Making the long-term economic case for investing in mental health to contribute to sustainability: From a health, public sector and societal perspective. Under the impact contract to support European Pact for Mental Health and Well-being.
73. UNESCO (2018). International technical guidance on sexuality education. Geneva, Switzerland; and Public Health England (2018). Contraceptive Services: estimating the return on investment. United Kingdom Government.
74. Public Health England (2017). Health Economics: Evidence Resource.

A Public Health England report on the return on investment in contraception calculated the direct costs of health care including delivery and postnatal costs, ongoing childcare costs and other indirect costs to local authorities – education, welfare etc. of each pregnancy not averted through contraceptive use. Public funding of contraception is highly effective. There is a return on investment across the public sector of £4.64 per £1 spent over five years and £9 per £1 invested over 10 years. These returns are shared across the whole public sector with health-care savings featuring more strongly in the short term whereas non health-care savings are a more important factor in the long term.[75]

3. Why invest in interventions to address obesity?

Evidence indicates that health, self-confidence, educational and employment outcomes are likely to suffer if a young person or adult is obese. In the conclusions to the 2020 Health report,[76] two issues are emphasised: "Strong and mandated central policy, supporting bold, holistic local action is needed to impact what is arguably the greatest health challenge of the 21st century …" and "Learning from joined-up programming emphasises the importance of not only improving child nutrition, health education and physical activity, … but also water consumption, access to affordable nutritious food, parent education … and including improvements in the built environment."

Public Health England's "Health Economics: Evidence Resource, 51 Interventions for Obesity and Physical Activity" gives examples of costs and benefits. One example targeted at a million citizens of Birmingham in the English Midlands and highlighted by the Local Government Association, reported that half the scheme's users were overweight or obese and that, in total, for every £1 spend on the scheme, £23 was recouped in health benefits.

An American study showed that in public health interventions aimed at obesity, three interventions saved costs, two saving US$55 and US$38 respectively for every dollar spent.[77] The cost effectiveness of a four-year randomised controlled trial in a school-based obesity programme in 18 elementary schools saved US $317 per student balanced against the cost of the intervention.[78]

Other interventions such as taxation policies on sugar have been instituted in some countries, including Mexico and Hungary, but it is too soon to estimate their effect. A Japanese school lunch policy to support balanced diets shows evidence of improvements in diet but no data related to its impact on obesity.[79]

75. Public Health England (2018). Contraceptive Services: estimating the return on investment. United Kingdom Government.
76. James M., Parkhurst A. and Paxman J. (2018). Tackling Obesity: What the UK can learn from other countries. 2020 Health.
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