Chapter 2: The transitions of adolescence

Adolescence is the term used to describe the period of transition from dependent child to the relatively independent adult. Unlike the term puberty – which is defined by biological changes – adolescence has no scientific definition nor defined age range. For the purpose of this report, adolescence will encompass young people aged between 11-24 years. The American Academy of Child and Adolescent Psychiatry (2011) describes adolescence across three age groupings: early (11-13 years), middle (14-18 years) and late (19-24 years). These groupings are distinguished by differing experiences, pressures and transitions faced. The complex interplay between these variables will differ depending on the individual’s exposure, vulnerability and resilience/ability to cope as well as their life circumstances.

Physical aspects of puberty and ongoing brain development continue until about 25 years and influence susceptibility to risk taking behaviours and peer influences. A number of notable life course transitions are routinely experienced e.g. primary to secondary education, education to employment, family home to independent home or becoming a parent. These have an impact on health outcomes (Hogg 2013; Jackson et al 2010).

Figure 2.1 illustrates the differential influence of settings at different ages and stages of adolescent development and presents a framework for locating interventions.
An estimated 212,598 young people reside within the GGC board area (National Records of Scotland (NRS) 2012). Over 75,000 young people are estimated to live in the most deprived areas defined by Scottish Index for Multiple Deprivation (SIMD 2012), as shown in Figure 2.2. Young people born in the area, on the whole, have a significantly lower life expectancy than the rest of Scotland but where you are born within NHSGGC also has an impact.
Individual characteristics such as ethnicity, cultural background and faith, individual physical and biological make up as well as gender norms and values that can determine health outcomes. If population modelling (based on data from a range of sources applied to 2011 census data) of protected characteristics in NHSGGC is applied to young people, the estimated number of young people in the following groups would be:

- 15,620 from black and minority ethnic groups
- 2,126 asylum seekers
- 12,756 lesbian, gay, bisexual, and transgender.

In addition to protected characteristics:

- 2,126 with communication impairment
- 29,764 with literacy/numeracy issues
Whilst damaging lifestyle behaviours among young people have decreased across Scotland over recent years, data from lifestyle surveys show this decrease is less in the NHSGGC area (Black et al 2011; NHSGGC 2012; Currie et al 2012).

Adolescence is a period during which risk taking behaviours emerge (Gore et al 2011; Alwan et al 2010). These behaviours tend to cluster, further increasing the vulnerability of the young person involved.

Data from the Glasgow City Schools Health and Wellbeing Survey for S1-S4 pupils (NHSGGC 2012) demonstrates this clustering of behaviours: almost 200 pupils engage in regular smoking, drink alcohol once a week or more and have taken drugs. This clustering of behaviours carries on into older adolescence and adulthood with multiple risk taking behaviours most prevalent in the most deprived communities. This may suggest that – although many young people experiment with risk taking behaviours – children from more affluent areas are more likely to modify their behaviours as they mature.

Recent reports suggest vulnerable children are also at increased risk of social isolation and reliance on internet based social media, early sexualisation in the form of sexting and cyber bullying (Ringrose 2012) as well as increased use of legal highs (Scottish Drugs Forum 2013).

**Risk Factors**

The impact of child poverty is a major cause of ill health both in childhood and adolescence in later life (Gordon 2011). Children who grow up in poverty are more likely to suffer from poverty during their adult lives than non-poor peers. The direct association of child poverty with educational attainment is described by Gordon (Gordon 2011) as one where “the lack of command over resources over time that constitutes poverty results in social and material deprivations which are harmful to children’s health and education.”
Adolescence is a necessary developmental stage for independent living and for most this will be positive, punctuated by first experiences and enjoyment. For a minority of young people, however, adolescence can become reckless and damaging. Figure 2.3 illustrates the impact of drugs, poor mental health and physical violence as major causes of death in young people.

Figure 2.3: Inequalities in mortality in Scotland 1981-2001
(Source: Leyland (2007))

Protective factors
The US-based Search Institute has developed a comprehensive list of 40 developmental assets that cumulate within young people and mitigate the impact of negative social determinants of health and life circumstances (Search Institute 2006). The Search Institute suggests these assets are important to positive health outcomes and that there is a quantitative link between the number of assets and the levels of resilience. Critical to this concept is the recognition that protective factors can be developed and young people can acquire an increasing range of assets.

The range of life circumstances which increase vulnerability, coupled with poorer lifestyle choices, is a potent mix for poorer health outcomes and widening inequalities. Patterns of access to health services and programmes for health surveillance and protection are often significantly impaired for vulnerable children.
when compared with their more affluent counterparts (Scottish Government 2007). The emphasis on building assets within young people is therefore critical if we are to reduce the vulnerability associated with the widespread deprivation and challenging circumstances of our children and young people.

The SEARCH Developmental Assets have been matched with local health and wellbeing indicators (NHSGGC 2012; NHSGGC 2013; ISD 2010) in Figure 2.5 to provide insight into the level of development of different assets at a population level.
Across NHSGGC:
- 81% of 16-24 year olds said that if they have a problem, there is always someone to help them.
- School attendance rates range from 91.3% in Glasgow to 95.2% in East Renfrewshire.
- 70% of pupils agree that their school gives them advice & support to prevent them smoking.
- There are 26 MSYP representing LA’s

In Glasgow:
- 30% of young people live in a single parent household
- 80% of young people find it easy to talk to their Mum
- 64% of young people find it easy to talk to their Dad
- 40% find it easy to talk to a teacher
- 31% would find it easy to speak to a neighbour
- 69% of young people have a Young Scot card
- 29% of young people go to youth clubs
- 73% of young people used a sports facility
- 57% of young people had been to a library
- 45% had visited a museum
- 71% participate in sports clubs outside school
- 69% of young people report getting 8 hours of sleep on a school night
- 80% of pupils brush their teeth twice a day

What young people say

Across NHSGGC:
- 56-77% of pupils go on to further & higher education
- 11.7% of young people are in the NEET category
- 75% of 16-24 year olds feel safe walking alone in their community after dark
- 57% of 16-24 year olds feel in control of decisions affecting their lives.

In Glasgow:
- 70% of young people expect to go into further education
- 17% of pupils report that they have caring responsibilities across NHSGGC
- 66% of pupils on average have never tried smoking
- 61% have never drunk alcohol
- 91% of pupils report never having used drugs
- 90% of pupils had a high score on the pro-social scale of the strengths and difficulties questionnaire
- 85% of pupils had positive self-esteem
- 88% of pupils report that sexual health and relationships education at school had prepared them well for forming & dealing with relationships.
- 69% of pupils do not engage in anti-social behaviours

Figure 2.5: Local data mapped to developmental assets proposed by the Search Institute (2006). (Sources: NHSGGC (2012); NHSGGC (2013); Black et al (2011))
National policy Context
There is a strong body of opinion emerging (Lancet 2012 and WHO 2012) that the young person rather than the health issue should take centre stage and a better understanding of the unique challenges to their health and development is required for their immediate health and the longer term consequences on adulthood and older age.

Applying the theory of Getting it Right for Every Child (Scottish Government 2012), The Children and Young People (Scotland) Bill (2013) and United Nations Convention on the Rights of the Child (United Nations 1989) to the ecological/life course approach should not just address deficits through statutory service response but also proactive interventions to increase protective factors. The Resilience Matrix (Scottish Government 2012, p.22) is a key tool for practitioners, and developing an asset focused environment through which services, agencies and young people can build capacity as well as respond to individual needs is central to this discussion.

The engagement and involvement of young people is crucial to developing a realistic and relevant understanding of youth health issues. To describe the factors that affect the health of a young person it is best done by young people themselves and work undertaken within East Renfrewshire illustrated in Figure 2.6 provides insight into the complexity of this concept.
Young people are a disparate group. A protracted period of adolescence such as delays in leaving family home or lack of employment will impact on the individual's ability to develop assets appropriately. The concept of readiness for life is recognised as an important aspect of early intervention for older young people (Allen 2011). The significance of the development of connectedness through social relationships is important for successful transitioning to adulthood (Blum 2012).

Other critical influences include:

- Supportive parental relationships (Viner et al 2012)
- Parental engagement in activities with young people (Viner et al 2012)
- Improved secondary school environment and increased school connectedness (Bond 2004; Flay 2004)
- Bridging the school and employment gap with learning progression taking place in a range of positive destinations most situated to the learning needs of the young person (YouthLink Scotland 2013)
- The increasing importance of peers on health outcomes both in relation to peer norms and peer modelling of behaviours (Jackson et al 2010)
- Acquiring of social capital through engagement and participation in local communities (McPherson et al 2013; Morgan 2009).

A comprehensive multi agency approach to improving mental health and wellbeing in children and young people has already been developed within NHSGGC. The development of local networks of services focusing on resilience and early intervention across education and community settings has wider benefit than just supporting mental health. It affirms the need for this approach to be adopted in relation to the wider health needs of young people. The framework describes actions required to support protective factors and to promote both mental wellbeing and physical health outcomes. This framework will be a major strand of action on which to build.

Education is a key determinant for health. The schools setting has long been central to health development approaches for young people and the Health Promoting School was legislated as part of the Schools (Health Promotion and Nutrition) Scotland Act (Scotland 2007) recognising the importance of the wider school experience and social environment in supporting health development. This, in conjunction with the inclusion of Health and Wellbeing as a core component of Curriculum for Excellence (CfE) (Scottish Executive 2004), provides a robust foundation for schools to develop comprehensive curricular programmes and experiences that seek to increase knowledge and skills, and provide an inclusive and enabling environment in which young people can exercise healthier choices and maximise their potential.
NHSGGC has retained a strong focus on supporting school health promotion; local school health co-ordinator roles are funded within each CH(C)P. Whilst these roles are engaged in a number of the projects described here, this dedicated workforce could be capitalised upon to support school and community connectedness, strengthening opportunities to support ‘work readiness’ and employability skills of young people.

The Curriculum for Excellence (Scottish Executive 2004) approach to health and wellbeing is evident across all local authorities. Local and national school surveys identified opportunities for an increased focus within the curriculum on relevant public health issues. These issues should be underpinned by adopting a clustering approach to risk taking and health behaviours with a focus on increasing common protective factors and assets with young people. Work to support schools to address health development and strengthen life readiness skills with young people can be further developed.

The Valuing Young People framework (Scottish Government 2009) developed with young people recognises the role of youth work and community based services in engaging young people this is supported by a number of Scottish Government evidence reviews.

The local authorities covered by NHSGGC benefit from a strong youth third sector. Networking agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector support the third sector to work more with young people. There is scope to facilitate more joint working and build capacity for health development with third sector organisations. There is also potential to link third sector organisations with the activities and services provided by statutory agencies for young people. Scottish Government (2008) makes the case that “Local agencies should provide high quality, consistent information to young people in a whole range of settings, including easily accessible drop-in services, staffed by health professionals and youth workers.” The resources required and mechanisms for delivery, however, are not prescribed. Youth-friendly health services were highlighted as one of the nine delivery pillars that are important to the delivery of the Scottish Government National
Outcomes: “Our young people are successful learners, confident individuals, effective contributors and responsible citizens.”

The increasing autonomy associated with adolescence increases the importance of independent access to services including health (Scottish Government 2007). The need for age appropriate services and advocacy within healthcare based on the differing physical, social, emotional and cultural needs of children and young people across the age spectrum from birth to the late teens is recognised within Building a Health Service Fit for the Future (NHS Scotland 2005). The active engagement of young people and appropriate advocacy within both youth and mainstream health services is aligned with the United Nations Convention on the Rights of the Child.

Despite activities to review and refresh service models, the range of youth health services delivered and their links to wider primary care, specialist children’s services and wider statutory services vary. Good practice is evident but the absence of common expectations for youth health services creates differential access to services and does little to engage young people or other youth service providers. The provision of mainstream community and specialist services for children and young people is subject to local integration with partner agencies. Opportunities to develop a defined and more comprehensive approach to youth health services, including advocacy in health services routinely used by or targeting young people, is worthy of consideration. The added value of a discreet service should be articulated by both NHSGGC and young people in line with best practice identified in Walk the Talk (Scottish Executive et al 2000). The ability of youth health services to contribute to health development in the context of Getting it Right for Every Child (Scottish Government 2012) should be explored.
Local implementation and practice

Therefore a number of issues impact on the health of young people in Greater Glasgow and Clyde and actions can support the following health outcomes:

Supporting young people to adopt healthy behaviours

- Interventions that influence access to and affordability of products such as condoms, alcohol and tobacco are effective in addressing health behaviours such as reducing unintended pregnancy, harmful drinking and tobacco use in young people (Catalano 2012; Booth et al 2008) benefit all young people. Local examples include test purchasing and contraception programmes.

- Programmes in early adolescence should address multiple risk factors and promote a sense of control, self esteem and understanding of risk as well as developing communication, inter-personal relationships and ability to assert personal rights. The programmes should be contextualised in relation to the social norms experienced by young people and should account for clustered health behaviours rather than a single topic approach and build on peer led models. These programmes can build on topic specific programmes such as the Take a Drink project in secondary schools or ASSIST peer led tobacco intervention programme.

- Benefits of building the capacity of youth organisations to address youth health issues and promote health development skills in community settings is described by Catalano (2012). Examples include the development of Tobacco Control in Youth Sector: Tobacco Policy Support Guide (ASH et al 2003) and the H4U staff training in Youth Achievement Award in North East sector.

- The importance of developing modelled behaviours and building parenting skills and confidence at all stages of adolescence. Current parenting programmes such as Triple P are available across NHSGGC and should be promoted.

Supporting young people to develop and engage in a healthy culture

- There is a need to improve engagement of young people in planning and delivery of programmes and services to change behaviours and influence policy development. Previous examples of good practice include the The Big ShoutER, W-WEST (tobacco advocacy group), and Glasgow City school health summits.
• The school setting remains a credible and valuable environment for health improvement. We must recognise the increasing sophistication of young people as consumers of information, food and drinks and social activities. Work to enhance school connectedness can be strengthened by collaborative working which increases participation opportunities, culture of positive reinforcement and increase interpersonal communication between staff and pupils. This has been found to be an effective approach for early and middle adolescents drawing on evidence from Gatehouse project (Australia) and Seattle Social Development Project (USA).

**Supporting young people to develop social connectedness**

• Recommendations to improve work readiness for young people can be delivered through skills development from employability awards, sports or hobby participation, learning and volunteering opportunities as well as activity agreements and progressive accreditations. Bridging the gap from schools to such programmes is important in middle adolescence. Extending participation in schemes such as Duke of Edinburgh helps support positive school and community interface.

• The expansion and development of local networks (schools, further education facilities, young people services, youth work organisations) to facilitate cross referral and widen youth engagement across organisational interfaces is required to support a model of social prescribing. Agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector provide starting points.

• The opportunity for social prescribing for known vulnerable children is supported by Getting it Right for Every Child (Scottish Government 2012). There is potential to support young people to attend opportunities tailored to developing key protective factors or assets. Examples include Model of Integrated Diversionary Activities and Services (MIDAS), North West Glasgow along with employability programmes such as Modern Apprenticeship and Opportunities for All.
Reducing the impact of health inequalities in young people

- Interventions targeting specific groups of young people within schools and/or specific schools, based on local data and evidenced need can provide an effective and enhanced approach. Targeted programmes are most effective when delivered alongside universal programmes such as mainstream CfE. The Young Persons Support base at Smithycroft (pregnant young women), the Family Nurse Partnership and the Young Parents Support project at Rosemount Lifelong Learning are examples of approaches to develop life skills in specific groups.

- Groups of young people with life circumstances such as homelessness or having a caring responsibility will not necessarily be reached by programmes in traditional settings as they may not be attending school, or their links with family or community are fractured. We need to improve the identification and targeting of these young people to ensure access to support for health development.

- The Welfare Reform Act (2012) is likely to have an adverse impact on our most vulnerable young people due to changes in the benefit arrangements which will result in increased family fuel and food poverty, reassessment for passported benefits, and a widening of the circumstances in which jobseekers can receive sanctions which could result in destitution, debt or homelessness. Proposed changes within the housing sector will make it more difficult for young people to live independently, and be required to have budgeting skills as housing benefit will be paid directly to recipients as opposed to landlords. Young people who are transitioning from school into the workplace will also be affected by reduced opportunities for employment as a result of the current economic climate. Work is ongoing to support families and young people to access income maximisation, debt management, employability interventions and benefit from national entitlements available through the Young Scot Card.

We need to ensure these NHSGGC examples are scaled out sufficiently to achieve the required impact.
Priorities for Action

Priority 1: Develop clearer focus on youth health as a priority

We need to:
- Influence local Community Planning partners to address the needs of young people who are exposed to persistent poverty.
- Encourage local integrated children’s services planning partnerships to adopt a clearer focus on youth health and adolescent well-being.
- Ensure that a stronger focus on youth health, including the implementation of the Mental Health Framework for Children and Young People, is subject to routine monitoring across NHSGGC.

Priority 2: Strengthen evaluation, innovation and improvement activities

We need to:
- Review youth health services in NHSGGC to adopt common service characteristics; acknowledging local needs but with core components, branding, referral routes and connectivity with the wider youth sector.
- Ensure that health services routinely accessed by young people demonstrate best practice as identified in ‘Walk the Talk’.
- Learn from existing teen parenting support to extend reach and uptake.

Priority 3: Develop a robust youth health promotion programme

We need to:
- Develop a programme of joint work with health improvement, education and networking agencies such as Social Care Ideas Factory and local Councils for Voluntary Sector as well as individual third sector organisations to:
  - Pilot a model of multi-agency social prescribing which identifies and supports vulnerable young people to access a range of asset building interventions and opportunities.
- Develop greater health focus within existing youth networks and agencies to enable and respond to this inter-agency referral.
- Develop a robust youth health promotion programme that addresses multiple risk taking behaviours through life skills for use within education and youth settings.
- Target health promotion programmes within schools or groups of young people with greatest health need, ensuring programmes are contextualised by social norms and reflect recognised peer influencers. Support the delivery of universal programmes through the consolidation of mainstream ‘Curriculum for Excellence’ delivery.
- Strengthen health promoting environments and ethos within individual schools and further education establishments.
- Support schools to develop stronger links with local youth sector organisations to enhance the range of non-curricular opportunities to build assets and strengthen pre-employability skills including the development of local directories.
<table>
<thead>
<tr>
<th>Glossary of Terms</th>
<th>Description</th>
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<tr>
<td>CfE</td>
<td>Curriculum for Excellence</td>
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<tr>
<td>Community Health Partnership (CHP)</td>
<td>CHPs/CH(C)Ps are organisations that have been developed across Scotland to manage a wide range of community based health services. In some parts of NHS Greater Glasgow and Clyde health board these new partnerships will also be responsible for many local social care services and will therefore be called Community Health and Care Partnerships, CH(C)Ps</td>
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<tr>
<td>Health Inequalities</td>
<td>The gap between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds</td>
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<tr>
<td>ISD</td>
<td>Information Services Division, part of NHS National Services Scotland</td>
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<td>NRS</td>
<td>National Records of Scotland</td>
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<tr>
<td><strong>SAPE</strong></td>
<td>Scottish Area Population Estimates</td>
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<tr>
<td><strong>SIMD</strong></td>
<td>Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland in a fair way. It provides a wealth of information to help improve the understanding about the outcomes and circumstances of people living in the most deprived areas in Scotland</td>
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<td><strong>WHO</strong></td>
<td>World Health Organisation</td>
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## Acknowledgements

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Systematic Review. Glasgow Caledonian University and Glasgow Centre for Population Health.


http://www.search-institute.org/content/40-developmental-assets-adolescents-ages-12-18 [Accessed 11 December 2013]


