

The National Youth Agency

Research Programme Series

Being Healthy: The implications for youth work of Every Child Matters

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Book 1: **Introduction**

Book 2: **Being Healthy**

Book 3: **Staying Safe**

Book 4: **Enjoying and Achieving**

Book 5: **Making a Positive Contribution**

Book 6: **Economic Wellbeing**

Being Healthy

Key Points

- Being Healthy underpins all the other ECM outcomes: healthy young people are more likely to enjoy, achieve and contribute and, hence, to achieve economic wellbeing.
- It's important to distinguish between practical health issues and moral panics about 'inappropriate' behaviours – remembering that 'age appropriate' behaviours are culturally and historically determined.
- Government policy is aimed both at raising health standards overall and reducing the significant inequalities that exist; universal and targeted provision go hand in hand, as do policies aimed at education, prevention and support.
- The main Be Healthy aims in the ECM Outcomes Framework are that children should be: physically healthy; mentally and emotionally healthy; sexually healthy; living healthy lifestyles (alcohol, smoking and healthy eating); choosing not to take illegal drugs. Trends in each of these areas are largely, though not universally, negative: the teenage pregnancy rate is decreasing (though still higher than comparable EU countries) and while some STIs rates are increasing some are falling; alcohol and smoking rates are not decreasing but Class A drug use has stabilised.
- While the government recognises structural forces at work – for example with significant investment in poorer neighbourhoods and its emphasis on joined up working – there is also a tendency to emphasise personal responsibility in young people's risky health behaviours. There may be some tensions for youth workers in promoting the 'right' choices as opposed to making personal, well-informed choices.
- Basing so much of the universal, educative aspect of provision in schools may mean that the people most in need of such education are the least likely to receive it; poor health and risky lifestyles are generally linked with disengagement from school.
- The government has invested heavily in Personal, Social and Health Education (PSHE)

in schools as part of the National Healthy Schools Programme, but there are question marks as to whether it is fully effective. Many young people know the risks of STIs, and drug misuse, for example, but it does not necessarily influence their behaviour.

- Youth work offers a wealth of experience in promoting informed decision making and opening up services to the needs and interests of young people and thereby can provide a complementary forum and methodology for effective PSHE, especially where disengaged young people are concerned.

1. Introduction

'Being healthy' can be seen to underpin the other four ECM outcomes, given the often quoted hierarchy of human needs developed by Abraham Maslow (1954). This suggests that unless the more basic human needs for physical and emotional wellbeing are met, then humans do not strive towards the 'higher' needs of academic achievement and self actualisation.

Health may be more controversial than the other four strands of ECM, since it includes behaviours that have been at the centre of 'moral panics' for centuries – early pregnancy and the use of legal and illegal drugs. An early transition from childhood to adulthood may be welcomed in the other areas of the ECM Framework – for example, there are often newspaper articles around the time of GCSE and A-level results about the young prodigies who are getting A-levels at the age of 16 (*Enjoying and achieving*); similarly, young entrepreneurs who drop out of education to set up successful businesses (*Achieving economic wellbeing*). However, when young people make early transitions into normal adult recreational behaviour such as having sex, drinking alcohol and smoking, it is seen as a cause for concern. There are definite health risks from engaging in legal and illegal drug use, and from early pregnancy and parenthood – and harm reduction will always be an important element of any health strategy. However, it is important to distinguish between concerns about health and more moralistic concerns about 'age-appropriate' behaviours. What counts as age-appropriate differs across cultures

and historical periods, and strategies may need to take these cultural differences into account. (Higginbottom, et al, 2005)

This initial foray into the field of health suggests that senior youth work policy makers and practitioners need to be:

- ▶ aware of government initiatives, while also being able to subject them to critical review – deciding when it is appropriate to comply, and how best to act in the interests of the young people that they serve in any locality;
- ▶ aware of the facts, while also being aware of the limitations of official data and the potential for misinterpreting different perceptions of ‘risky’ health behaviours; and
- ▶ clear about the value of youth work and its potential contribution to the health strand of ECM in general and to each of its five main aims.

This Briefing Paper, therefore: outlines the **policy context for Being Healthy**, discusses some different **perspectives on young people’s risk-taking**, and then examines four key areas of health identified in government papers: **Being physically healthy; Being mentally and emotionally healthy; Being sexually healthy and Making healthy lifestyle (drug use) choices**¹. Under each of these four headings, it outlines the current state of young people’s health; government concerns and initiatives; and the contribution that youth work can and does make.

2. The policy context for Being Healthy

Developing and maintaining healthy lifestyles is of critical importance to all of us; good health can enrich and prolong our lives. For the government there are additional concerns and considerations including:

- ▶ the costs – to individuals, to the NHS and other public services, and to the economy, through work absence – when people fail to take care of their health;
- ▶ the significant health inequalities that still exist between different social groupings and between regions despite increased national prosperity, wider opportunity and improving health over the last 20 years ... ‘*people in poorer areas become healthier more slowly than those in privileged neighbourhoods*’ (DoH, 2005a, Ministerial foreword); and
- ▶ the cycle of health inequalities – *A major challenge is to break the cycle by which poor health is passed down from one generation to the next* (DoH, 2005a, Ministerial foreword).

The government has identified a range of approaches to addressing health concerns including:

- ▶ strategies that focus on education and prevention as well as treatment;
- ▶ addressing inequalities through targeted provision whilst also aiming to raise the nation’s health through improved and more accessible universal services;
- ▶ a recognition that health inequalities are tied up with other provision, such as housing, employment and the physical environment, necessitating joined-up working and holistic approaches; and
- ▶ a recognition that services need to be organised around the needs and interests of the people that they serve and to encourage active involvement of those user groups in design, delivery and evaluation of provision.

The main health concerns are very similar for adults and young people – for example *Delivering Choosing Health* (HM Government 2005b) has as its priorities: tackling obesity; improving mental health and wellbeing; improving sexual health; reducing the numbers of people who smoke; and encouraging sensible drinking, while in the Every Child Matters Outcomes Framework, the key aims are for children to be:

1 These categories are based on ECM, but adapted in line with the National Healthy Schools and You’re Welcome standards. For example:

- ▶ ECM includes healthy eating under Living healthy lifestyles – along with alcohol consumption and smoking – whereas it appears to fit more closely with concerns about obesity and physical exercise under ‘Physically healthy’. The You’re Welcome standards place healthy eating and weight management together in their consideration of the key health issues for adolescents.
- ▶ ECM has legal and illegal drug use in different categories. This appears to be something of a false distinction and the National Healthy Schools Standards groups them together.

- ▶ physically healthy (with targets for obesity);
- ▶ mentally and emotionally healthy;
- ▶ sexually healthy;
- ▶ living healthy lifestyles (with targets for smoking and alcohol consumption); and
- ▶ choosing not to take illegal drugs.

And, as with adult health, tackling inequality is a priority:

... inequalities still impact on children and young people. Some find it difficult to access the services they need, simply because of where they live or because of their circumstances. Child poverty, though greatly reduced, still means that children and young people from disadvantaged backgrounds risk not realising their full potential as they grow and develop into adolescence and adult life.'

Dr John Reid in the Foreword to the National Service Framework

In *Youth Matters* (H M Government, 2005), the government laid out six key principles underpinning its approach to reform of services for young people and these principles are reflected in a range of strategies including:

- ▶ **strategies focused on young people** – aiming to ensure that children and young people are well informed about their health and about the support services that are available to them. These include universal and targeted programmes – for example, the National Healthy Schools Programme is aimed at all primary and secondary school pupils; but there are also strategies directed towards specific groups of young people for specific purposes, such as the Teenage Pregnancy Strategy.
- ▶ **strategies focused on providers** – intended to make health services more accessible to teenagers for both prevention and treatment, by:
 - actively involving young people in the design and delivery of services so that *they are provided in a way and a place that encourages usage* (DH2006a);
 - demonstrating that services are becoming more young-people friendly *'Teenagers are one group who do not always use traditional NHS services. We have sought to make such services more young people friendly by publishing the 'You're Welcome'*

quality criteria'. (DH 2006a) The *You're Welcome* criteria require health services to take young people's needs into account and The NYA's *Hear By Right* participation standards are being used in development of the young people's involvement strand;

- taking services out to where young people are *'... seeking to make health an integral part of the everyday services that young people use'* (DH 2006a) and expecting *'provision to be made in non-formal educational settings, such as youth centres'* [emphasis added] (DH 2006a);
- ensuring a holistic approach through partnership working *Making progress in providing health services in educational and youth-centred settings* [emphasis added] *will require close partnership working between the NHS and local authorities* (HM Government. 2006a); and
- basing services on need – for example the Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (H M Government, 2006b), talks of designing *'a unified system in each local area which will create a clear picture of what children and young people need, will make the best use of resources, and will join up services so they provide better outcomes than they can on their own.'*

3. Perspectives on young people's risk-taking

Young people take risks with their health for a variety of reasons – some personal; some structural. From the **personal** angle, the FAQ section of the Drugscope website, for example, suggests that ... *probably the main reason why young people take drugs is that they like them*. Similarly having sex, drinking alcohol, smoking and eating to excess can all be pleasurable activities. Personal level reasons also include youthful curiosity and experimentation and acts of rebellion against adult restrictions. Young people may also use alcohol or drugs as a form of escape from difficult circumstances.

From the **structural** perspective, choices are shaped by social circumstances.

An illustration of the two perspectives is provided in a study on ‘planned’ pregnancies among young people from poor and disadvantaged backgrounds. Cater and Coleman (2006) found that:

- ▶ Parenthood was seen by young people as a *reasonably rational choice and, unlike most alternative ways of changing their life, one that is within their own control*. It offered an opportunity to gain independence; a new identity; a sense of purpose and satisfaction.
- ▶ Structural factors – such as limited job opportunities in the area; bad experiences at school; and a local acceptance of teenage parenthood – all contributed to the view of parenthood as a positive step. Choices are not just personal choices but are socially conditioned.

Lisa Catan (2004) has argued that much government policy acknowledges structural factors at work in the area of ‘difficult’ youth transitions – in its provision of substantial and continuing investment in services in poor neighbourhoods. However, *policies on post-16 education and training policy have emphasised the importance of individual self-betterment and control over, or responsibility for, one’s own destiny*. While social inequalities in access to education and training appear to have increased, rather than decreased, suggests Catan, the government continues to emphasise individual responsibility for decision-making.

Risk-taking based on personal choice raises the issue of **‘age-appropriate’ behaviours** and whether young people have the right to make their own decisions about the risks they are prepared to take. Different government papers illustrate different attitudes to risk-taking – for example:

- ▶ In Youth Matters: Next Steps, risk is seen as a learning opportunity ... *Typically, it is when we are teenagers that we are most alive to exploring new ideas. New experiences, travel, taking risks and having the opportunity to be responsible for their own decisions all widen young people’s horizons.* (HM GOVERNMENT, 2006a).
- ▶ In guidance to Local Authorities on the Teenage Pregnancy Strategy, the government is less positive about risk taking and talks of:
 - young people being supported in developing not just skills and confidence to make well-informed decisions, but an appropriate values framework to make and carry through positive choices; and

- *giving young people at risk of early pregnancy the choice and motivation to aspire to further education and rewarding careers, leaving the decision to have children until later when they are better equipped to deal with the demands of parenthood.* (DfES, 2006a).

This appears to indicate that young people should be making the ‘right’ choices, as opposed to well-informed personal choices; and that there are ‘appropriate’ values frameworks for making those choices. (It also begs the question of whether rewarding careers are available for all.)

There may be some tensions for youth workers around who defines ‘appropriate’ choices and values; and whether prompting the ‘right’ choices is in line with basic youth work tenets about promoting independent adult thought, while:

- ▶ providing young people with the knowledge, skills, and support for decision-making;
- ▶ helping young people to deal with the consequences of their actions and to learn from their experiences; and
- ▶ keeping open the doors to education, training and employment so that young people don’t become permanently excluded from society.

Having looked at some of the general issues involved in promoting the Be Healthy element of Every Child Matters, this paper now considers four key areas of health – in each case looking at: the current state of young people’s health; government concerns and initiatives; and the contribution that youth work can make.

4. Being physically healthy

The current state of young people’s physical health

Within the ECM Outcomes Framework, the main target for physical health is reducing obesity. This is often linked, in government reports, with healthy eating and physical activity. On the obesity side:

Among boys and girls aged 2 to 15, the proportion who were obese increased between 1995 and 2004, from 11 per cent in 1995 to 19 per cent in 2004 among boys, and from 12 per cent in 1995 to 18 per cent in 2004 among girls.

19 per cent of boys and 22 per cent of girls aged 2 to 15 will be obese by 2010 if no action is taken (Information Centre for Health and Social Care, 2006)

As for healthy eating and physical exercise:

- ▶ Less than three in ten students in years 7, 9 and 11 eat fruit or vegetables daily (Morgan et al, 2006), compared with the five portions a day target in the ECM Outcomes Framework.
- ▶ Over half of students in years 7, 9 and 11 failed to meet an internationally recognised indicator for physical exercise of at least an hour a day, on at least five days a week (Morgan et al, 2006).
- ▶ In 2003, just over half (52 per cent) of young men aged 16 to 24 achieved the recommended level of physical activity, compared to a third (32 per cent) of young women. (Source: *Social Trends*, No. 36, 2006)

Government concerns and initiatives

The government expresses concerns about health per se:

'Childhood obesity is a serious health problem that can follow people much later into life. It is a causal factor in a number of chronic diseases and conditions including high blood pressure, heart disease and type 2 diabetes.' (Audit Commission et al 2006)

... and also about the costs to the economy

'It is estimated that obesity already costs the NHS directly around £1 billion a year and the UK economy a further £2.3 billion in indirect costs ... if the present trend continues, by 2010 the annual cost to the economy would be £3.6 billion a year' (Audit Commission et al 2006).

The childhood obesity target – to halt the increase in obesity by 2010 – is jointly owned by three government departments: the Department of Health (DoH); the Department for Education and Skills (DfES); and the Department for Culture, Media and Sport (DCMS) and there are four main programmes in place:

- ▶ **The DfES/DCMS School Sport Strategy**
– aimed at broadening and deepening sports participation: increasing the numbers of 5 to 16-year-olds engaged in sporting opportunities and increasing the percentage who spend a minimum of two hours a week on high quality PE and sport – both within and outside the school curriculum.

Contributory initiatives include:

- School Sports Partnerships – which aim to enhance sporting opportunities by bringing together specialist sports colleges and schools in the same area.
- Club Link – aimed at strengthening links between schools and local sports clubs.
- Improvements in school playgrounds.

- ▶ **The DCMS programme for children's play**

The Public Health White Papers *Choosing Health* (DH, 2004); *Delivering Choosing Health* (2005) and *Choosing Activity* (2005) all identify the contribution that play can make to improving children's fitness, health and wellbeing. On the physical activity side, play ... 'came second only to PE in calorific intensity and the study concluded that 'walking and playing provide children with more physical activity than most other activities' (DCMS, 2006). In addition, play helps children to learn more about themselves and each other – contributing to social and emotional wellbeing. (Tessa Jowell, cited in DCMS, 2006).

- ▶ **The DfES programme for improving school meals**

tuck shops and vending machines – reducing the fat, salt and sugar content and increasing the consumption of fruit and vegetables.

- ▶ **The DH/DfES National Healthy Schools Programme**

in which two of the four main standards are the healthy eating standard and the physical activity standard – both of which are based on agency and structure: encouraging healthy decision making while having supportive policies and procedures in place:

- Pupils are to be encouraged to make well informed healthy food choices – and to understand how physical activity can improve their lives.
- Healthy food and drink is to be made available across the school day (for example, in breakfast clubs, break times, and lunchtimes) – and students should be given a minimum of two hours structured physical activity a week, plus opportunities for extra-curricular activity.

These four programmes should also mesh with broader programmes to achieve cleaner, safer and greener public spaces, which increase the opportunities for children and young people to be active (Audit Commission et al, 2006), although this

doesn't address general public antagonism to young people 'hanging around' and being active in public spaces.

The contribution that youth work can make

Three of the four programmes outlined above are schools-based. Cale and Harris (2006), however, point out that given that the majority of young people's physical activity occurs outside school, there's now growing recognition of the importance of community-based programmes and the involvement of the community at all levels if interventions are to be successful.

Tim Brighouse, in a 1999 speech, calculated that, even if children attended school full time, the time spent in school would account for only nine minutes of every waking hour between birth and 16. Policies therefore need to reflect what happens to them in the other 51 minutes – minutes that are spent at home and in their community. This led The NYA, in 2004, to join with partner agencies such as the Children's Play Council, Groundwork and the Commission on Architecture and the Built Environment's Space project in issuing the '51 Minute Challenge' – to find safe places and public spaces in which children and young people could play.

Traditionally, youth work has included a variety of sporting activities, sometimes in partnership with sports professionals, which could contribute to this aim. Dance, theatre, games and outdoor education are also part of the youth work repertoire which get young people on the move.

The first example of youth work's contribution to Being Physically Healthy, below, illustrates the sports element; the second demonstrates the experience of youth workers in facilitating participatory methods, while the third builds on another traditional role – providing food as a means of 'bonding'.

Alive and Kicking

This project worked with two Sunday football leagues to raise awareness about healthy lifestyles. The project was organised in the form of a competition, with the prizes, league tables and prize presentation providing an impetus for clubs involved. Team members were able to have a health check-up, carried out by bank nurses on training nights. There were also ten task sheets, devised with the help of the local Health Promotion Team,

with some asking for individual work and others encouraging group discussion or activity. Two hundred young men took part. The community and youth worker visited clubs, watched games and helped club secretaries to organise the completion of tasks. The local Premiership Club's Community Officer also visited clubs and offered them free training which proved extremely popular. The tasks rated most useful were: healthy eating; a man's guide to avoiding cancer; and the health check up. A key success factor was thought to be the community education approach – reaching out to young men where they were most comfortable and using the strong unit of the football team to motivate them to participate. (CEDC/ Continyou)

Youth on Health (YOH!)

YOH! – a part of the Leeds Education Healthy Schools Initiative – is a city wide health forum, run by and for young people aged 8 to 18. The Project West Yorkshire Youth Association works in partnership with Leeds Education Service and Leeds Primary Care Trusts.

Members are recruited from primary and secondary schools across the city. They identify health issues in their schools and develop action plans for bringing about positive changes, identifying sources of support within their schools and communities. Specific examples include healthier school dinners and tuck shops.

West Yorkshire Youth Association's contribution includes facilitation of the 36 + sessions a year, administration of the programme and access to creative and participatory methods expertise and experience.

Ham and Petersham Youth Centre

Communal cooking is fundamental to the ethos of this youth centre. The centre has two good cookers and quite a large cooking area. Small groups of members make light meals for club members who want to pay a nominal charge. They plan menus, buy supplies, cook and wash up. At any one time there might be 25-30 young people on the roster for taking charge of an evening's cooking. 'For some young

people, it's the only cooked meal they get – we have a lot of disadvantage locally. And they all pick up cooking skills, learn about basic nutrition and learn how to work as a team in a relatively confined space. There's been a marked effect on the club community. Cooking is a tangible way of caring for each other.' There is also evidence that young people transfer their experience from the club into their home – contributing to the cooking and to promoting healthy eating in their family.

5. Being mentally and emotionally healthy

The current state of young people's mental health

The main targets within ECM are reductions in the death rates from suicides and undetermined injury along with improvements in access to Child and Adolescent Mental Health Services (CAMHS).

Some 24 per cent of 14 to 15-year-olds say they worry 'a lot or quite a lot' about school work problems, 13 per cent said the same about health problems, 21 per cent about the way they look, 24 per cent about career problems, 19 per cent about family problems, 13 per cent about problems with friends, 8 per cent about puberty and growing up, 6 per cent about bullying and 3 per cent about being gay, lesbian or bisexual. On the plus side, 46 per cent didn't worry greatly about any of these. (Young People in 2003: Schools Health Education Unit).

One in 15 young people aged 11 to 25 has self-harmed. (Mental Health Foundation/ Camelot Foundation, 2006)

'Around 19,000 young people aged 15 to 24 attempt suicide every year and about 700 of these die as a result.' (MIND website)

In 2004 the suicide rate for young men aged 15 to 24 was around 12 per 100,000 and for young women 4 per 100,000 (*Social Trends*, No. 36, 2006)

Government concerns and initiatives

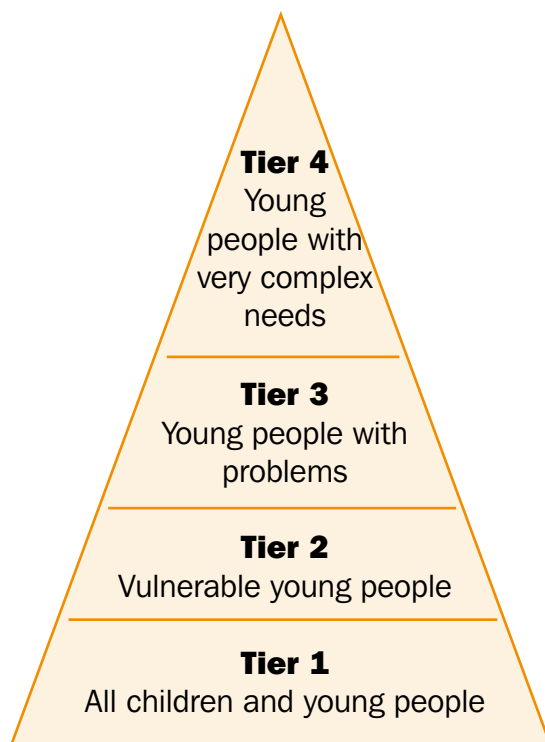
There is a whole spectrum of mental health. At the

one end are mentally healthy children and young people who are able to:

- ▶ play and have fun;
- ▶ grow and develop with confidence and enjoyment, making the most of their abilities and opportunities;
- ▶ initiate and sustain mutually satisfying friendships and relationships;
- ▶ recognise and respond appropriately to their own emotions and those of other people; and
- ▶ overcome difficulties and adversity; resolving and learning from problems.

At the other end are young people with severe and complex mental illnesses.

This has been recognised by the government in setting up Child and Adolescent Mental Health Services (CAMHS) in a four tier structure, which has also been adopted in a range of other health arenas such as drug misuse and crime prevention work.



In Tier 1 a whole range of non-specialist professionals working with children and young people – including youth workers, along with GPs, teachers, school nurses and social workers, for example – are expected to: promote mental health; help young people develop the skills to cope with adversity; offer general advice to young people with problems; and recognise when to refer to more specialist services in Tiers 2 and 3.

Tiers 2 to 4 employ increasingly specialised mental health professionals for children with increasingly severe mental health problems. At these levels, the main thrust within ECM is to improve access to mental health services: making them more user friendly; developing services in non-stigmatising settings; and ensuring that mental health professionals are supporting non-specialists at Tier 1.

The contribution that youth work can make

At Tier 1 level – youth workers use activities and conversations to enable young people to have fun; learn from experience; build mutually satisfying relationships; engage in well-informed problem-solving and decision-making; and, as a result, gain the confidence and self esteem that provide resilience in dealing with adversity.

The informal conversations at the heart of youth work support the development of emotional literacy – learning self-awareness; self-management; social awareness; and the cultivation of social relationships (Goleman 1994).

Moving towards Tier 2, youth workers also provide informal support and advice – someone to talk to when the going gets tough – but are able to recognise when the problem is something that needs more professional mental health support and who might provide it.

Young people involved in the evaluation of the impact of youth work (Merton et al, 2004) provide a number of examples of youth workers building emotional health and wellbeing:

Z (youth worker) has helped me get my confidence back, has helped me with my problems – all of them! ... she has helped me stand on my own two feet, not rely on others and not be so demanding ... they give you ideas, a way forward ... they back you up and egg you on ... they help you know you can do this. (Young person, After Care Service, North West).

They talk more on your own level as they are not there to teach you but support you. You tell them what you need rather than vice versa. I don't ever feel patronised like I did before. They do more to help than social workers. If it needs doing they do it. They don't talk over you and they definitely work at your pace (Young people, After Care Service, North West).

'I feel confident in telling them [youth workers] anything.'

'Helping me get my confidence back.'

'They know us, other people don't even talk to us. You can put your trust in them to help you and it's easier to talk to them than ordinary (sic) adults. You know they want to talk to you.' (Young person, PAYP, North West)

Quotes taken from Merton et al (2004) pp43–49

Some structured **educational group work** may also fall into the category of **Tier 2 provision** – for example, working on identity and self-concept; friendships; handling emotional issues – as do **support groups**, for example on bullying, racism, sexism and other forms of oppression. These often form a part of the youth work curriculum.

Both voluntary and statutory youth work sectors have a long history of initiating, developing and maintaining – directly or indirectly – Youth Information, Advice and Counselling Services (YIACS). There are 360 YIACS in England. Well over two thirds provide a one-stop-shop combination of counselling, advice, information, outreach and personal support services. The YIACS are supported, at a national level, by Youth Access (www.youthaccess.or.uk) which has received DfES funding for its A2C (Access to Counselling) programme, promoting stronger links between YIACS and CAMHS. Youth Access has developed quality standards and partnership working tools to facilitate the integration of YIACS into the planning and commissioning of mental health services. Some YIACS are formally recognised by CAMHS as providing Tier 2 and/or 3 services.

A recent, admittedly limited, piece of research (Oliver and Storey, 2006) in three areas – Bedfordshire, Camden and Manchester – indicated that health promotion initiatives targeted at young men were more likely to be successful if they used community based locations, such as youth centres and youth-oriented services rather than expecting young men to attend more formal service settings such as GP surgeries. This is partly due to them being seen as less threatening to young men's self esteem; and partly to perceptions of them as less risky (with staff being less likely to share information with the police, for example).

The BMA – in the person of the Head of Ethics and Science, Dr Vivienne Nathanson – has endorsed the idea that *skilled youth workers have the ability to reach out to many of the young people most vulnerable to mental health problems*. Speaking

at the launch of Youth Work Week 2006, which focused on mental health, she said that the BMA report on Child and Adolescent Mental Health (BMA 2006) showed that *a key barrier to young people using mental health services is that they are not tailored to meet their needs ... the skills of youth workers in engaging with young people and enabling them to get their voices heard and to influence service provision can make a big difference to improving the situation.*' (The NYA 2006, page 6)

The illustrative examples show a range of youth work interventions at different tiers, with differing levels of partnership with mental health services.

PRAM – Positive Approach to Anger and Misery

This project was run by Peterborough City Council Youth Service in partnership with Cambridgeshire CAMHS. The project adopted two different approaches:

- **creative workshops with excluded young males using masks to help develop emotion-related communication skills; and**
- **enabling young people to produce a short film exploring mental health.**

Ideas from these two development projects are to be used to develop a training package for youth workers in developing work with young people who have emotional difficulties. (From *Hold Your Head Up*, page 13)

Hear Our Voice Cornwall

The multi disciplinary team here works with 11 to 25-year-olds who are experiencing or at risk of experiencing mental health difficulties. It has developed a youth work approach to engaging young people often using art, music and more recently working with young people to produce literature in many different formats, including CD-Roms and DVDs. Information gained in this way is then fed back to the appropriate organisation giving young people an opportunity to influence services.

Y.E.S. Plymouth

Y.E.S. started in 1991, primarily as a counselling service for young people aged

13 to 25 in a street-based agency in the city of Plymouth. It is one of the largest Youth Information, Advice and Counselling Services in the country with 18 different projects. The Y.E.S. mission is to assist young people in living healthy, secure and satisfying lives, by enabling and supporting them to make informed choices. It uses a holistic approach, providing needs-based services that aim to improve the economic, social and emotional wellbeing of young people in the area.

Its services include:

- **Insight – an early intervention service for 16 to 19-year-olds experiencing their first episode of psychosis.**
- **Icebreak – a new multi-disciplinary team set up to work with young people who have received a PDS diagnosis.**
- **Counselling – ongoing person centred counselling sessions.**

6. Being sexually healthy

The current state of young people's sexual health

Within the ECM Outcomes Framework the two main outcomes are reductions in teenage pregnancy and STIs.

▶ Teenage pregnancy

Since the Teenage Pregnancy Strategy was launched, in 1999, the under-16 teenage pregnancy rate has fallen by 15.2 per cent, and the under-18 rate by 11.1 per cent and they are at their lowest levels since the 1980s.

However:

- the rates are still higher than in comparable EU countries;
- there is still some way to go in halving the teenage pregnancy rate by 2010 – the original target set in the original Teenage Pregnancy Strategy; and
- *Nearly every local authority has at least one 'hotspot' neighbourhood, where more than 6 per cent of girls aged 15 to 17 become pregnant every year (DfES, 2006a)*

▶ **Sexually Transmitted Infections**

A recent report by the Health Protection Agency (HPA 2006) identified young people as one of the key groups needing targeted prevention work for STIs because:

rates of HIV, chlamydia, syphilis, genital wart, and genital herpes diagnoses have continued to rise in this group; and

'In 2005, young men accounted for 57 per cent and 75 per cent of all chlamydia diagnoses and 39 per cent and 70 per cent of all gonorrhoea diagnoses, respectively ... one in ten young people are positive for chlamydia

Chlamydia is the fastest growing infection – an increase of 81 per cent between 2001 and 2005 in men aged 16 to 19; and 74 per cent among men aged 20 to 24. Among young women, the increase is 47 per cent among 16 to 19-year-olds and 39 per cent in 20 to 24-year-olds.

On a more positive note: rates of gonorrhoea diagnosis among young people fell by 17 per cent between 2004 and 2005; and uptake of voluntary, confidential testing is higher among young people than among people over 25.

Government concerns and initiatives

Teenage pregnancy rates are important for: (DfES, 2006a, p8):

- ▶ young teenage mothers themselves – because they are likely to finish their education early and damage their employment prospects, thus potentially excluding themselves from mainstream society;
- ▶ their children – because:
 - the infant mortality rate is higher among children born to teenage mothers; and
 - teenage mothers are more liable to physical health problems and to post-natal depression and other emotional health problems; to be smokers; to choose bottle, rather than breast, feeding; and to experience poverty and housing problems. Their children, therefore, are more likely to start life at a disadvantage and to become teenage parents themselves;
- ▶ for public services – since
 - *the cost of teenage pregnancy to the NHS is estimated to be £63 million a year; and*
 - *teenage mothers are more likely than older*

mothers to require targeted support from a range of local services, to help them access supported housing and/or to re-engage in education, employment and training, for example; and

- ▶ the economy – since *benefit payments to a teenage mother who does not enter employment in the three years following birth can total between £19,000 and £25,000 over three years.*

Similarly, with STIs, there are concerns both for the young person (with young women at risk of ectopic pregnancies or infertility if the infections go undetected for example); and for the public purse.

The government's Teenage Pregnancy Strategy, launched in 1999, represents the first coordinated attempt to tackle both the causes and consequences of teenage pregnancy. It has two main targets:

- ▶ halving the under-18 conception rate by 2010, and establishing a firm downward trend in the under-16 rate; and
- ▶ increasing the participation rates of teenage parents in education, training or employment, to reduce the risk of long-term social exclusion.

The Teenage Pregnancy Strategy has four broad themes:

- ▶ **Joined-up action** – with teenage pregnancy staff in each local authority, coordinating the delivery of local strategies, drawing on support from a wide range of local partner agencies.
- ▶ **A national media campaign** – targeted on independent radio and teenage magazines, backed up by a dedicated 'Sexwise' helpline and RUThinking website.
- ▶ **Prevention** – improving sex and relationships education, and facilitating access to contraception and sexual health advice services.
- ▶ **Support for teenage parents** – including tailored maternity services; advice and support from Connexions personal advisers and (in the 35 local authority areas with highest conception rates) Sure Start Plus advisers; financial support for childcare for those in education and training; and help to access supported accommodation.

The strategy has led to considerable research on what works in reducing under-18 conception rates. This, in turn, has led to guidance for local authorities on best practice – using the 'what works' research to change the services that they provide. Their main advice centres on the following identified key needs:

The identified problem	Government initiatives
<p>Poor knowledge and skills among young people on sex, relationships and sexual health risks (Provision of SRE is demonstrably better in higher performing areas)</p>	<p>There have been a number of school-based initiatives to provide high quality information about sex and relationships including:</p> <ul style="list-style-type: none"> ● SRE guidance for schools ● PSHE assessment guidance by QCA ● PSHE certification programme for teachers and community nurses ● National Healthy Schools programme ● New Ofsted framework more closely aligned with ECM outcomes <p>(With teenage pregnancy <i>strongly associated with the most deprived and socially excluded young people</i> (DfES, 2006b, emphasis added) the lack of emphasis on education programmes in the non-formal education sector is notable.)</p>
<p>Poor contraceptive use among young people</p>	<p>Here the emphasis has been on making contraception services more accessible and user-friendly with:</p> <ul style="list-style-type: none"> ● <i>Our Health Our Care Our Say</i> – commissioning young people friendly services ● The <i>You're welcome</i> quality criteria ● <i>Delivering Choosing Health – making healthier choices easier</i>
<p>Lack of support for parents/carers and professionals on how to engage with young people on relationships, sex and sexual health</p>	<p>The government has sponsored programmes for parents and carers – for example, the fpa's <i>Speakeasy</i> and Parentline Plus's <i>Time to Talk</i> – so that parents can support young people in making positive choices</p>

The contribution that youth work can make

The government has recognised the contribution of youth work specifically. Following reviews of statistically similar areas, with contrasting rates of progress, carried out in 2005, they have identified seven key factors in areas that were successful in reducing teenage conception rates. Out of these, three specifically mention the Youth Service:

- ▶ active involvement of all the key mainstream delivery partners who have a role in reducing teenage pregnancies (Health, Education, Social Services and **Youth Support Services** – and the **voluntary sector**);
- ▶ the availability and consistent take up of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, **Youth Workers**, and Social Workers) working with the most vulnerable young people; and
- ▶ **a well-resourced Youth Service**, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse. Youth workers in the successful areas had been equipped with the knowledge and skills to support young people on sex and relationship issues. (DfES 2006b)

Further evidence indicated that progress in reducing teenage pregnancy was greatest when the four key agencies involved in delivering the strategy – PCT, education, social services and **youth services** – worked in partnership.

A review of the evidence into young people, pregnancy and social exclusion identified a range of factors related to teenage pregnancy, centred around dissatisfaction at school, poor material circumstances and low aspirations. Many of these issues could be addressed within a youth work context. (Harden et al 2006).

A review of the impact of the Youth Service, undertaken in 2004 showed that most youth services:

'... are involved in some forms of sexual health education'. (Merton et al, 2004)

'... have existing partnerships with health services, and well over half of youth services are actively involved in developing teenage pregnancy strategies locally – in a few cases being the lead service. Two out of every five highlight this work as a policy priority for youth work locally. (Merton et al, 2004)

The study also showed that primary care trusts were

making good use of youth work skills and contacts, to promote sexual health education among young people.

A recent review of teenage pregnancy research findings (Harden et al, 2006) has argued the case for youth development approaches to teenage pregnancy – *Happiness, enjoyment of school and ambition can all help to delay parenthood.*

The first three examples of practice below illustrate such approaches – combining self esteem building and fun activities with SRE – while the YWCA campaign represents another strand of work: counteracting negative images of young mothers.

Gateshead Youth Service is cited as an example of effective youth service contributions in DfES guidance to local authorities (DfES 2006a) It is a key player in the Teenage Pregnancy Strategy through: delivery of SRE programmes in schools; youth workers ‘meeting and greeting’ young people at contraceptive and sexual health clinics; the inclusion of SRE in part-time youth worker training programmes; and as a major outlet for the C-Card scheme (for access to free condoms).

Three specific projects cited as good practice by the guidance were:

- **Urban Bush Craft** – a programme for young men, encouraging them to reflect on their roles and behaviour in the community and on traditional views of masculinity. Most of the young men said that it was the first time they had talked openly about relationships and sexual health and ... found activity based discussions useful in helping them to think beyond their own immediate experience
- **Up 2 U** – an outreach programme in a hot spot area of drug and alcohol misuse, which engaged them in activities aimed at helping them to understand their risk-taking and the possible consequences of both substance misuse and sexual activity. Young people – many of whom had been banned from youth clubs – started to use services in their communities and form supportive relationships
- **A Sexual Health residential** organised, by the Young Women’s Development Group, for young women identified as having low self esteem problems and very little knowledge of sexual health. Some had already experienced teenage pregnancy; some were from areas with high teenage conception rates and some from backgrounds where they received very little SRE (*and sensitive negotiations had to be held*

to allow them to take part). The youth workers involved had completed or were attending accredited sexual health training.

GFS Platform is a Young People’s Development Programme working with young women who are either pregnant or who have children and may be excluded from mainstream education and society. Many of the activities involve accreditation and health is a strong feature of the programme, with the young women being encouraged to think carefully about their relationships and risky sexual behaviour. Three of the young women in the Great Yarmouth project are training to go into schools once they are 16, to act as sexual health peer educators.

The Edge Project

The Edge Project is a statutory Youth Service Partnership Project hosted by Derby Youth Service. It provides support and informal education for young people who are involved in or at risk of sexual exploitation and abuse through prostitution. It has drop-in facilities for young people, providing a safe confidential space for young people to start putting their lives back together. The Project also delivers education sessions to young people in Derby City’s secondary schools, in order to break down stereotypes about prostitution and ensure that young people know how to access support.

YWCA – Respect Young Mums campaign www.ywca.org.uk/youngmums/

Popular stereotypes, from policy makers and the media – that teenage mums are ignorant, irresponsible and/or incapable of being good parents – have a profound effect on how young mums are treated, both by the public and the people who work in services designed to support them. This campaign set out to challenge the stereotypes and to show that:

- teenage pregnancy was a complex issue often linked to poverty, low educational achievement and low self-esteem;
- some young women make a positive choice to become pregnant and have a child; many find pregnancy and motherhood as rewarding an experience as older mothers do; and many create happy and successful families; and
- rather than pregnancy and motherhood

being the problem, it is often the ongoing social exclusion and poverty experienced by young mums – because of lack of access to education, childcare and support services – which make young motherhood ‘problematic’.

What young mums need, they argued, is not censure but support to overcome the barriers that they face.

7. Making healthy lifestyle (drug use) choices

The current state of teenage drug use

Within the ECM main aims for Being Healthy, there is a distinction between legal and illegal drug use whereas the National Healthy Schools standards groups them together (along with sexual health which, as just mentioned, is often linked) under the topic of PSHE (Personal, Social and Health Education). This Briefing adopts the latter strategy in discussing drug use / misuse.

The fourth key aim of the Be Healthy ECM Outcomes Framework – for children and young people to live healthy lifestyles – is linked to targets for reductions in the percentages of children and young people who consume alcohol and smoke.

For the fifth key aim of the ECM Outcomes Framework – that children and young people will choose not to take illegal drugs – the related targets and indicators are reductions in the harm caused by illegal drugs, and in the use of Class A drugs.

- ▶ With the exception of cigarette smoking by boys, the use of tobacco, alcohol and cannabis among 15-year-olds in the UK is amongst the highest in Europe.
- ▶ Among the 6.8 million 16 to 24-year-olds in the UK:
 - almost a third are daily smokers;
 - nearly 30 per cent drink more than twice the recommended daily alcohol limit at once a week;
 - one million have used an illegal drug in the past month; and
 - multiple drug use is common at all ages.

Young tobacco smokers are much more likely to use illegal drugs than non-smokers. Advisory Council on the Misuse of Drugs, 2006

Alcohol

Of all the drugs, alcohol has shown the most recent growth in use and causes the most problems among young people in the UK today. The most alarming recent development has been the growth in the number of young women who are drinking frequently and to excess. In the past decade the proportion of women drinking more than twice the recommended weekly limit has doubled. (Advisory Council on the Misuse of Drugs 2006)

- ▶ In 2004, **young people aged 11 to 15** in England who had drunk alcohol in the previous week consumed an average of ten units a week, double their consumption of around five units in 1990. (Source: *Social Trends*, No. 36, 2006)
- ▶ In 2005, **41 per cent of 14 to 15-year-olds** had consumed at least one alcoholic drink in the previous week. (Source: *Young People into 2006*, Schools Health Education Unit, 2006)
- ▶ In 2004-05, **young men aged 16 to 24 were the most likely to binge drink**, with one third (32 per cent) having done so in the previous week. Binge drinking is defined by the Department of Health as consuming twice the recommended daily limits (three to four units of alcohol a day for men and two to three units a day for women). (Source: *Social Trends*, No. 36, 2006)

Smoking

- ▶ A recent factsheet issued by ASH (2006) indicates that about one in six boys and one in four girls are regular smokers by the age of 15; that two-thirds of teenage smokers say they would find it hard to go without cigarettes for a week; and that half of smokers under 16 who try to buy cigarettes from shops succeed in doing so.
- ▶ ASH (2006) points out that young people who smoke are two to six time more susceptible to respiratory diseases and therefore take more time off school. Smoking therefore has a knock on effect for the ECM outcomes on enjoying and achieving; as well as increasing the cost burden to the NHS.

Illegal drugs

- ▶ In 2004-05 **a third (33 per cent) of young men and 21 per cent of young women aged 16 to 24** had used drugs. Cannabis was

the most commonly used drug, used by 30 per cent of young men and 18 per cent of young women. Ecstasy and cocaine were the most commonly used Class A drugs, each used by 7 per cent of young men and 3 per cent of young women. (Source: *Social Trends*, No. 36, 2006)

- ▶ Most young people do not use illegal drugs, and, of those who do, most do not use regularly or develop problems related to their drug use. (Drugscope and Alcohol Concern, 2006)
- ▶ Each year an estimated 20,000 young people become adult problem drug users. However, Class A drug use among young people has stabilised at around 8 per cent of 16 to 24-year-olds (*British Crime Survey 2005-06*) and 4 per cent of 11 to 15-year-olds (DH School Survey 2005)

Links between different forms of 'risky behaviour'

- ▶ More than a quarter of those who drank at least once a week had taken drugs in the last month compared with only 8 per cent of those who drank one to three times a month and 1 per cent of those who had not drunk alcohol in the previous year. Of those who drank at least once a week, 43 per cent reported smoking regularly compared with only 2 per cent of non-drinkers (Matthews et al 2006)
- ▶ One in seven young people has unsafe sex after drinking alcohol and one in ten had drunk so much that they were unable to remember if they had had sex or not. (Matthews et al 2006)
- ▶ Those who drank at least once a week reported committing more offences than those who drank less frequently. The relationship was even more marked for violent offences with 26 per cent of those who drank one to three times a month committing violent offences and 39 per cent of those who drank at least once a week. In comparison – for those who had not drunk at all in the previous year 11 per cent reported committing violent offences.
- ▶ Drug users may commit 'acquisitive' crimes such as burglary and robbery to feed their habit; they may commit violent offences whilst under the influence of drugs or be involved in violent 'gangland' rivalries (Drugscope website). For young women, a drug 'habit' may lead to prostitution as a way of raising the money required to buy drugs.

Government concerns and initiatives

As with other strands of health, legal and illegal drug taking among young people can cause problems for young people themselves and also represent a burden on the NHS – partly from the direct effects of drugs; partly (in the case of illegal drugs) because of the links with HIV infection; partly because of the increased likelihood of damage to self and others whilst under the influence of drugs (for example, in traffic accidents); and partly because of links with other aspects of health – for example, between alcohol consumption and risky sexual health behaviour.

Every Child Matters indicates that the aims of reducing drug use among youth people are to be achieved by ensuring that:

- ▶ a full range of substance misuse work – from education through prevention and treatment – are embedded in mainstream services; and
- ▶ all professionals working with children and young people are able to identify, assess and undertake appropriate action for addressing substance misuse issues. (2:37)

There is a similar four tier strategy for networking between different professionals – with Tier 1 representing universal services for all young people and Tier 2 involving professionals with some drug and alcohol experience and youth specialist knowledge in providing activities and education for those at risk of drug misuse. At Tier 3, specialist drug and alcohol services work with CAMHS provide specialist assessment and interventions for young people already involved in drug and alcohol use; and at Tier 4, psychiatrists and psychologists provide specialist treatment in collaboration with substance misuse services.

The government's **Drugs Strategy** involves joint working between the Home Office, the DfES and the DoH and has a four pronged approach:

- ▶ **information** – primarily through schools, with 'teachernet' guidance on how drugs education should be delivered. Since research indicates that drugs education has little, if any impact, on future drug use (Advisory Council on the Misuse of Drugs, 2006), the government has also commissioned the Blueprint research programme to identify what does work. (<http://www.drugs.gov.uk/young-people/blueprint>);
- ▶ **easy access to advice** and information on drugs and services – for young people and their families. Many areas have built successful approaches based round the national FRANK

helpline and website;

- ▶ **prevention** – by ensuring that all young people have direct access to core health, education, housing and family support services; and that there is prompt access to specialist young people’s services when required; and
- ▶ **social inclusion programmes** – such as the **Positive Future** programme offering a range of sports and other activities aimed at ensuring that children and young people stay engaged or re-engage with their families, education and the community. (DfES 2005)

The **Alcohol Harm Reduction Strategy** (2004) is aimed at improving public awareness of the harm that alcohol can cause; changing the increasingly common culture of ‘drinking to get drunk’; encouraging the drinks industry not to manufacture drinks aimed at under-age drinking and to ensure advertising doesn’t promote excessive drinking; and encouraging licensees not to sell to under-age drinkers or those who are already drunk. At a local level, Drug (and Alcohol) Action Teams (DA(A)Ts) coordinate community wide efforts to reduce the harm from drugs and alcohol.

The **Every Child Matters: Change for Children** programme on Young People and drugs (DfES, 2005) has set out how those responsible for delivering services for children and young people and the drug strategy should cooperate and plan responses for young people who are using drugs, at risk of using them or otherwise affected by drug misuse.

The **National Healthy Schools Standards** require schools to demonstrate that:

- ▶ pupils have received drugs education – including both knowledge and skills development – which is appropriate to their age, ability and level of maturity;
- ▶ pupils (in secondary schools) are less likely to be offered illegal drugs; and
- ▶ they have school smoking and drugs policies.

The contribution that youth work can make

A recent publication from Drugscope and Alcohol Concern (2006) argues that youth work organisations are in contact with young people who are more vulnerable than others to drug misuse and who may not be in school to receive the NHSS programmes. This contact, along with

their commitment to the personal development of young people, puts them in a good position to affect the factors that protect young people from problematic drug use. These protective factors include: strong bonds with the local community; a supportive relationship with at least one adult and clear boundaries for acceptable behaviour. Other protective factors include strong family bonds and family involvement in the lives of children, which may raise questions about the extent to which youth workers should also work with the parents of young people.

The study of the Impact of the Youth Service in 2004 found that well over half of youth services at the time were *key partners with the local Drugs and Alcohol Action Teams [DAAT], mainly as part of a multi-agency initiative to reduce substance misuse and educate young people about drugs* (Merton et al, 2004)

The Positive Futures final report found that, although sports activities could have social value, this could only be *fully realised within a social and personal and development approach*. The most effective projects *had management teams with appropriate front line experience of grass roots youth work ...* This experience, the report argues, provides a clearer understanding of the contrasting values of the authoritarian diversionary approach and developmental work – and ways of harnessing the strengths of each. http://www.drugs.gov.uk/publication-search/young-people/0607_YPSMPG11?view=Binary

The Basement Project is a voluntary sector project offering information, advice, counselling, complementary therapies and referral for socially excluded young people aged 12 to 30, on housing, benefits, employment, medical and legal matters and substance use. It is holistic, client-led and committed to anti-discriminatory practice. It operates from two London sites – one in Earls Court, one in North Kensington. Its services include drop-ins, needle exchanges and a well-woman clinic. It also delivers regular drugs and sexual health outreach sessions at local youth projects and hostels, and has collaborated with other agencies on drugs and sexual health awareness work.

Fitzrovia Youth Action (FYA) is a community based youth action project using sports and youth work to engage young people and support them in developing projects which benefit the community and improve relationships between

people from different ethnic and age groups throughout the London Borough of Camden. One strand of its work is a peer-led drugs education project in which young people increase knowledge and awareness of drugs among other young people.

Streetreach is a voluntary organisation in Doncaster that offers support and advice to prostitutes. A drop in centre provides support and counselling, sexual health advice and a drug misuse programme – many of the young women are involved in prostitution to fund their drug addiction. Streetreach also runs distance learning courses to help young women to get an education, while partnership working with Reed employment has provided links with employers who are able to understand the chaotic lifestyle of potential employees.

The **impact study** (Merton et al, 2004) has some quotes from young people that demonstrate the impact youth work can make:

'If I come here, I'm good and don't get into trouble. If I hang out, I smoke weed, go jacking phones, start a fight and pick on shopkeepers ... If I come here I stay calm.' (Young person, Summer University, London).

'I used to smoke loads of cannabis and now I don't. I offloaded lots of issues and started doing a diary. My general self is better and I'm healthier.' (Young Person, Sexual Health Education project, North)

8. Conclusion

The government has invested heavily in schools-based education programmes – including the National Healthy Schools Programme; support for schools-based PSHE provision and funding for a new PSHE Association (again schools-based). However, the young people who are most likely to engage in risky behaviour are the ones most likely to be disenchanted with or disengaged from school and there are additional arguments for a corresponding investment in youth and community-based provision. For example:

- ▶ *Intervention should aim for a holistic approach, for community-based interventions and integrated service delivery which should involve families and communities in addition to the*

young people themselves suggest Luther and Cicchetti (2000), in exploring the construct of resilience and its implications for social policy.

- ▶ A recent paper by the Sex Education Forum (2006) argues that delivery of SRE in non-formal settings enables workers to *reach young people in environments where they feel safe but where risk-taking and potentially health-compromising behaviour may also be taking place. It also argues that youth workers are often best placed to reach marginalised young people who may have slipped through mainstream SRE in schools and who are unlikely to access other services.* Similar arguments could be applied to other areas of health.

The effectiveness of purely educational programmes has also been contested – for example: *There was no evidence to suggest a general trend in safer behaviour with higher levels of knowledge. This suggests that raising awareness of STIs will not substantially reduce risk-taking behaviour* (Jones and Hayes, 2006).

Similarly Douglas Kirby (1995) a US sex and relationships expert, argues that sexual behaviour is strongly influenced by factors such as hormones, a desire for acceptance and peer and personal values. On this basis, *we should not accept brief periods of instruction, however well designed, to have a dramatic impact on adolescent sexual behaviour.* He suggests, therefore, that youth settings may be more effective than the school setting – partly because of small group work, partly because young people are voluntarily involved, and partly because youth work agencies can tailor their programmes to meet the needs of different young people.

Within the previous four sections, this Briefing paper has indicated a variety of ways in which youth work can contribute to different elements of Being Healthy – for example:

- ▶ On the proactive side, youth workers can:
 - provide young people with information, education and advice on health matters;
 - support and encourage young people in making healthy choices, while also ...;
 - ... promoting their right and ability to make their own, well informed, choices;
 - equip young people with the self-confidence and social skills to resist peer pressure, form positive relationships and handle conflict;
 - promote resilience, through having fun,

learning from experience, and engaging in activities that foster success and ambition;

- help young people to access, improve and evaluate health services, partly by working with young people and other service providers to site more accessible, youth friendly services in appropriate settings at times that suit young people; partly through advocacy work on behalf of young people; and partly through facilitating the active involvement of young people in the planning, delivery, monitoring and evaluation of these services;
 - link those who are disengaged from school with alternative education opportunities to bolster achievement, ambition and self confidence; and
 - enable young people to educate their contemporaries through peer education and mentoring approaches on health issues.
- ▶ On the reactive side youth workers can support young people who are experiencing mental or physical ill-health – including that arising from the use of legal and illegal drugs or risky sexual behaviour; campaign to reduce the stigma associated with health problems; and act as advocates for young people having difficulties in accessing services.

It will be important for all youth workers in Tier 1 and Tier 2 services to be fully up to date with knowledge and developments in each of the four main areas of health education and aware of the relevant partner agencies in their communities to whom they can refer young people at risk or with problems.

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The National Youth Agency

works in partnership with young people and with organisations and services to ensure better outcomes for young people. It is an independent, development organisation located between government and funding bodies on the one hand and service providers and their users on the other.

We strive to ensure that the work of services and organisations is:

- relevant to the lives of young people;
 - responsive to policy;
 - effective and of a high standard;
- efficient and provides good value; and
- successful in securing the best outcomes for young people.

Our five strategic aims are:

- Participation: promoting young people's influence, voice and place in society.
- Professional practice: improving youth work practice, programmes and other services for young people.
- Policy development: influencing and shaping the youth policy of central and local government and the policies of those who plan, commission and provide services for young people.
 - Partnership: creating, supporting and developing partnerships between organisations to improve services and outcomes for young people.
- Performance: striving for excellence in The Agency's internal workings.

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