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Situation of young people in the European Union

Accompanying the document

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Engaging, Connecting and Empowering young people: a new EU Youth Strategy

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4. Health and Well-being

EU youth indicators

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4.1. INTRODUCTION

The EU Youth Strategy supports the health and well-being of young people, 'with a focus on the promotion of mental and sexual health, sport, physical activity and healthy life styles, as well as the prevention and treatment of injury, eating disorders, addictions and substance abuse' ⁽¹⁾. The foundations for lifelong good health and well-being are laid in childhood and adolescence. While young people generally feel healthier than older age groups, with a large majority of them considering that they are in good or very good health ⁽²⁾, young people are more prone to 'risk behaviour' than older age groups. This is partly related to the normal changes young people undergo in their physiological and social development, and partly due to the difficulties they face in their transition to adulthood and independence. Vulnerable groups of young people such as those experiencing unemployment, poverty or social exclusion may be particularly prone to more serious problems in their physical and mental health.

This chapter provides a snapshot of the main trends in areas covered by the EU Dashboard of Youth Indicators ⁽³⁾. It is divided into two sub-sections: first, it looks at the main health risks (obesity, substance abuse and road traffic accidents resulting in injury); and second, it discusses two indicators related to young people's mental well-being (psychological distress and suicide).

4.2. HEALTH RISKS

Behaviours considered to put young people's health at risk such as smoking, alcohol consumption, drug use, unhealthy eating, physical inactivity and unsafe sexual practices often cluster together and reinforce each other ⁽⁴⁾. They are all influenced by social factors such as deprivation and social exclusion, poor access to education, as well as problematic family, school and living environments ⁽⁵⁾. Moreover, these behaviours do not only have a strong impact on young people's health and well-being at the time they occur, but they also have life-long effects ⁽⁶⁾.

Young people are most vulnerable to risk behaviours when their life is in transition ⁽⁷⁾. As they grow up, they move from childhood to adolescence, from education to work, and from living with their parents to living independently (Chapter 7). In this context, barriers to accessing higher levels of education, leaving school prematurely, long periods of unemployment or insecure housing situations all increase the probability of young people engaging in risk behaviours ⁽⁸⁾. Moreover, these transition periods are becoming longer and more complex, thereby increasing young people's vulnerability ⁽⁹⁾. This section therefore examines the most important health risks and looks at young people's susceptibility to 'risk behaviour'.

⁽¹⁾ Council Resolution of 27 November 2009 on a renewed framework for European cooperation in the youth field (2010-2018), 2009/C 311/01.

⁽²⁾ Source: Eurostat, Statistics on income and living conditions (SILC), 'Self-perceived health' [hlth_silc_01]. Data extracted on 22.06.2017.

⁽³⁾ European Commission, 2011.

⁽⁴⁾ Jackson et al., 2012.

⁽⁵⁾ Ibid.; Viner et al., 2012.

⁽⁶⁾ Sawyer et al., 2012.

⁽⁷⁾ Furlong et al., 2003; Jackson et al., 2012.

⁽⁸⁾ Furlong, 2002; Jackson et al., 2012.

⁽⁹⁾ Ibid.

4.2.1. Obesity

Obesity and being overweight are serious health risks. Childhood obesity has lasting consequences, often lifelong⁽¹⁰⁾. In addition to an early onset of chronic diseases and lower life expectation, obese children and young people will likely experience bullying and poor attainment at school, lower productivity and less rewarding careers⁽¹¹⁾. This also impacts negatively on national healthcare systems, government budgets and the productivity of the European economy⁽¹²⁾.

There are worrying trends surrounding weight issues in Europe and around the world, as more and more people – adolescents and young adults among them – suffer from health problems related to being obese or overweight⁽¹³⁾. Researchers even talk about an 'obesity epidemic'⁽¹⁴⁾, which is difficult to halt and results from a combination of factors such as sedentary lifestyles with low levels of physical activity, as well as unhealthy food and eating habits⁽¹⁵⁾. Young people from lower socio-economic backgrounds are especially vulnerable to becoming overweight or obese⁽¹⁶⁾.

European statistics presented here confirm that obesity is becoming more and more widespread, both among young people and in the total population. The increase between 2002 and 2008 in the proportion of obese young people was highlighted in the 2012 Youth Report⁽¹⁷⁾. Figure 4-A depicts the continuation of this trend through to 2014: the proportion of obese young people aged 18-24 increased in almost all countries with available data, with the biggest increases registered in Bulgaria, Germany and France. The proportion of obese young people decreased only in four countries: in Belgium, Czech Republic, Spain and Romania. In all four of these, the proportion of obese young people is below the EU-28 average (5.8 %).

This 5.8 % average obesity rate among young people aged 18-24 in the EU-28 is around one third of the obesity rate in the total population (15.4 %) (Figure 4-A-b). However, countries vary greatly in this respect. The smallest difference between the rate for young people and that for the total population is in Ireland. Although the reliability of the data is low in this case, they indicate that the proportion of obese young people is only marginally lower than that of the total population. With roughly 1 in 6 young people who could be considered obese, Ireland is also the country registering the highest proportion of young people with a Body Mass Index (BMI) of 30 or above (Figure 4-A). Besides Ireland, the proportion of obese young people is also above 10 % in Malta (12 %) and the United Kingdom (10.8 %). On the other hand, obesity among young people aged 18-24 is below 3 % in Croatia, Lithuania, Romania and Slovakia.

⁽¹⁰⁾ WHO Regional Office for Europe, 2017.

⁽¹¹⁾ See for example WHO Regional Office for Europe, 2014.

⁽¹²⁾ OECD, 2016.

⁽¹³⁾ Ibid.

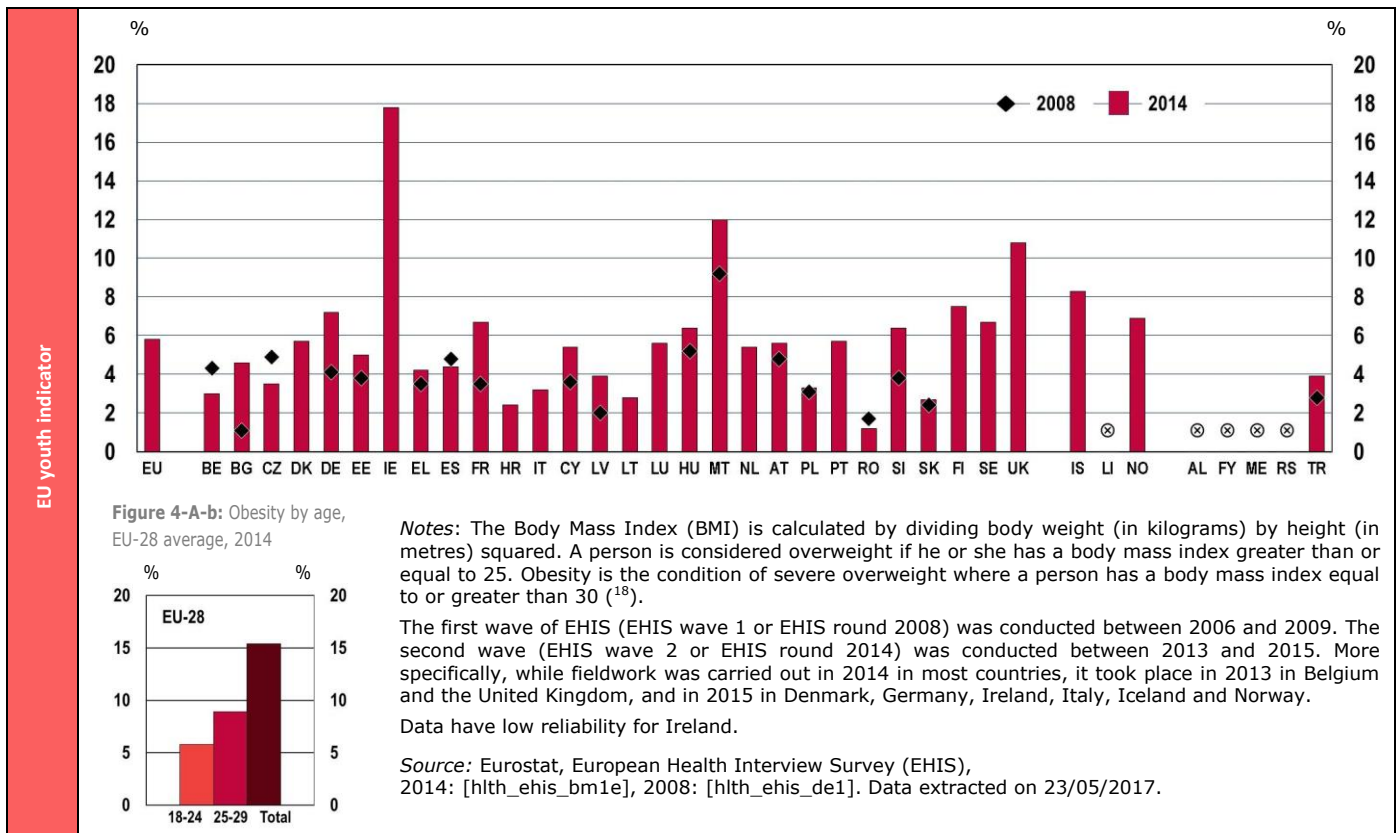
⁽¹⁴⁾ See for example Roberto et al., 2015.

⁽¹⁵⁾ WHO Regional Office for Europe, 2017.

⁽¹⁶⁾ Ibid.

⁽¹⁷⁾ European Commission, 2012a.

Figure 4-A: Proportion of young people aged 18-24 with a Body Mass Index of 30 or above (obesity level), by country, 2008 and 2014



Obesity among 25-29 year-olds is higher than for 18-24 year-olds. In 2014, on average in the EU-28, 8.9 % of 25-29 year-olds could be considered obese (Figure 4-A-b). Countries follow roughly the same pattern in this regard: there are more obese young people in the 25-29 age group than among 18-24 year-olds, but still fewer than within the total population. In 2014, obesity within the 25-29 age group was the highest in Malta (20.2 %), Ireland (16.5 %), Iceland (14.5 %) and the United Kingdom (14 %) ⁽¹⁹⁾.

As mentioned above, obesity is partly linked to unhealthy eating habits, such as excessive consumption of foods high in fat, salt and sugar as well as low consumption of fruit and vegetables ⁽²⁰⁾. Looking at the countries at the two extremes, this relationship is partly supported by data on the frequency of fruit consumption ⁽²¹⁾. Ireland, Malta and the United Kingdom are among the countries with a relatively high percentage (above the EU-28 average of 11.1 %) of young people aged 15-24 reporting that they never or only occasionally consume fruit (though other countries are also on this list, most notably France and Belgium). At the same time, in Croatia, Latvia, Lithuania and Slovakia, the proportion of young people never or only occasionally consuming fruit is among the lowest in Europe, below 5.5 %.

Obesity of young people is a growing concern across Europe, partly linked to unhealthy eating habits such as low levels of fruit and vegetable consumption.

⁽¹⁸⁾ Source: Eurostat Health Glossary (Eurostat, 2017d).

⁽¹⁹⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Body mass index (BMI)' [hlth_ehis_bm1e]. Data extracted on 23/05/2017.

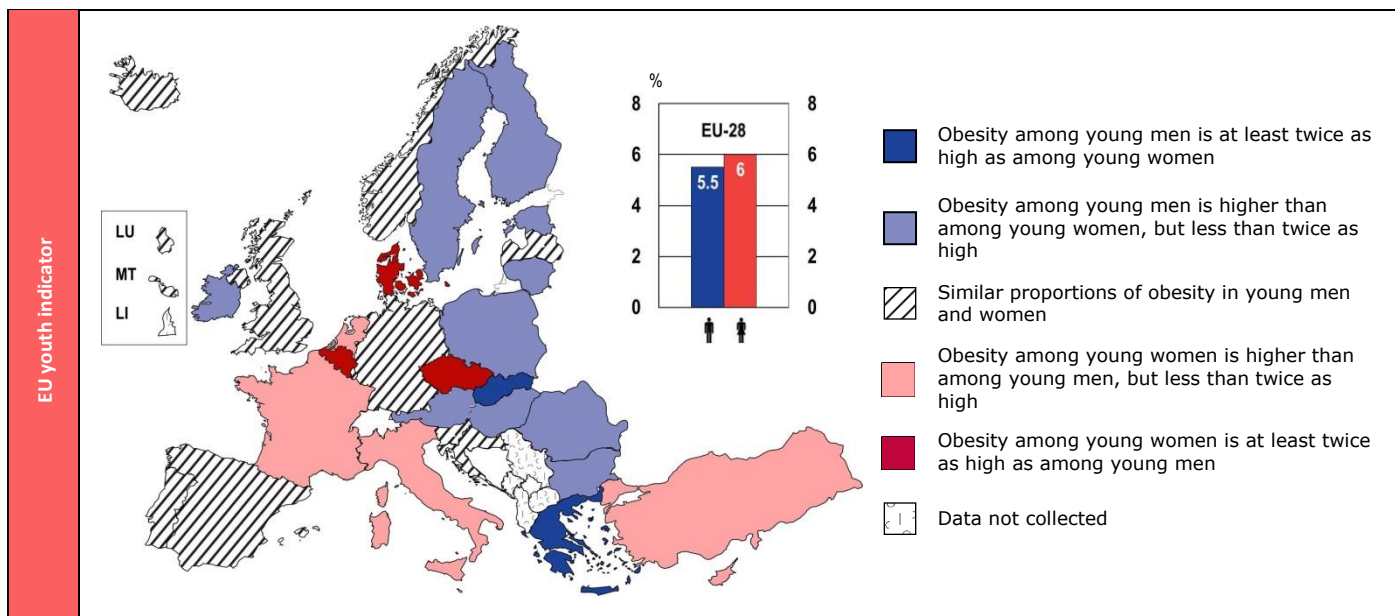
⁽²⁰⁾ WHO Regional Office for Europe, 2017.

⁽²¹⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Frequency of fruit and vegetables consumption' [hlth_ehis_fv1e]. Data extracted on 23/05/2017. According to this dataset, in Ireland, 19.7 % of young people aged 15-24 never or only occasionally eat fruit.

Nevertheless, it also has to be noted that not every country with a high percentage of young people who never, or only occasionally consume fruit have a high obesity ratio (see, for example, Belgium), so eating habits are only one factor among many contributing to obesity in young people. However, it is still of concern that as a general pattern, the proportion of young people aged 15-24 consuming fruit or vegetables at least once a day is around 10 percentage points lower than that of the total population in the EU-28⁽²²⁾. This pattern holds true in a large majority of European countries.

Though socio-economic background is a stronger predictor of obesity than gender, gender differences in the proportion of obese young people aged 18-24 are prominent in some European countries (Figure 4-B). On average in the EU-28, young women and men have similar obesity rates, with young women being slightly more affected than men. However, countries show diverse gender patterns when it comes to obesity: while more than twice as many young women as young men are obese in Belgium, Czech Republic and Denmark, the opposite is true in Greece and Slovakia.

Figure 4-B: Gender differences in the proportion of obese young people aged 18-24, 2014



Notes: The second wave of EHIS (EHIS wave 2 or EHIS round 2014) was conducted between 2013 and 2015. More specifically, while fieldwork was carried out in 2014 in most countries, it took place in 2013 in Belgium and the United Kingdom, and in 2015 in Denmark, Germany, Ireland, Italy, Iceland and Norway.

Data have low reliability for Ireland.

Obesity in young men and women was regarded as similar if the male/female ratio was between 0.85 and 1.15.

Source: Own calculation based on Eurostat, European Health Interview Survey (EHIS), [hlth_ehis_bm1e]. Data extracted on 23.05.2017.

Such diverse patterns of gender difference could be partly due to multiple lifestyle differences between women and men: while women are more likely to have a healthy diet (young women consume more fruit and vegetables than young men in almost every European country⁽²³⁾), they engage in less physical activity than their male peers⁽²⁴⁾. Differences between young men and women not engaging in any physical activity are especially striking in south-eastern European countries, where young people in general tend to be less active. In Greece,

⁽²²⁾ Ibid.

⁽²³⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Frequency of fruit and vegetables consumption' [hlth_ehis_fv1e]. Data extracted on 23/05/2017.

⁽²⁴⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Time spent on health-enhancing (non-work-related) aerobic physical activity' [hlth_ehis_pe2e]. Data extracted on 23/05/2017.

Spain, Romania and Turkey, the proportion of young women aged 15-24 spending no time on health-enhancing (non-work-related) aerobic physical activity is 20 percentage points or more higher than that of young men. At the other extreme, young people are engaged in physical activities to a greater extent in Nordic countries, and differences between men and women tend to be much smaller in this region. In Denmark, Estonia, Sweden and Iceland, the proportion of young women not engaging in any physical activity is even lower than that of young men ⁽²⁵⁾.

In addition to differences in diet and physical activity, studies have shown the importance of socio-cultural factors in influencing gender differences in obesity ratios. These include the cultural association between obesity and social status among men (for example in Greece), and the different cultural norms or standards of beauty that result in pressure on women to be thin ⁽²⁶⁾.

4.2.2. Substance abuse

Young people – especially in adolescence – are particularly vulnerable to substance use and its related disorders. Late adolescence and young adulthood is often described as the age of 'experimentation', when young people try new substances, often without becoming addicted to them or misusing them ⁽²⁷⁾. However, as mentioned above, the insecurity experienced in this transition period, together with factors such as unemployment, deprivation, an insecure family environment or peer pressure all increase the likelihood of risk behaviour. Therefore, for some young people, experimentation might turn into excessive use, bringing physical, mental and social risks ⁽²⁸⁾.

This sub-section looks into the three main forms of substance abuse: regular smoking, excessive drinking and cannabis consumption.

a) Smoking

Smoking is a well-known health risk and is the leading cause of preventable death ⁽²⁹⁾. As with most risk factors, tobacco use is also influenced by socio-economic factors, with young people from disadvantaged backgrounds being more vulnerable ⁽³⁰⁾.

The proportion of people smoking daily has been steadily decreasing, though not in all countries and not for every group.

The proportion of people smoking daily has been steadily decreasing since the beginning of the 2000s in almost all European countries with available data ⁽³¹⁾, pointing towards the effectiveness of anti-smoking campaigns and smoke-free spaces legislation ⁽³²⁾. This trend is confirmed by the last two rounds of the European Health Interview Survey (EHIS), which is the data source used to calculate the EU youth indicator ⁽³³⁾. As Figure 4-C depicts, the proportion of daily smokers in the 15-24 age group decreased between 2008 and 2014 in almost all countries with available data, the only exception being Slovakia. In the 25-29 age group, increases in regular

⁽²⁵⁾ Ibid.

⁽²⁶⁾ Kanter and Caballero, 2012.

⁽²⁷⁾ WHO Regional Office for Europe 2016, p. 157.

⁽²⁸⁾ Ibid.

⁽²⁹⁾ WHO Regional Office for Europe 2016, p. 147.

⁽³⁰⁾ Ibid.

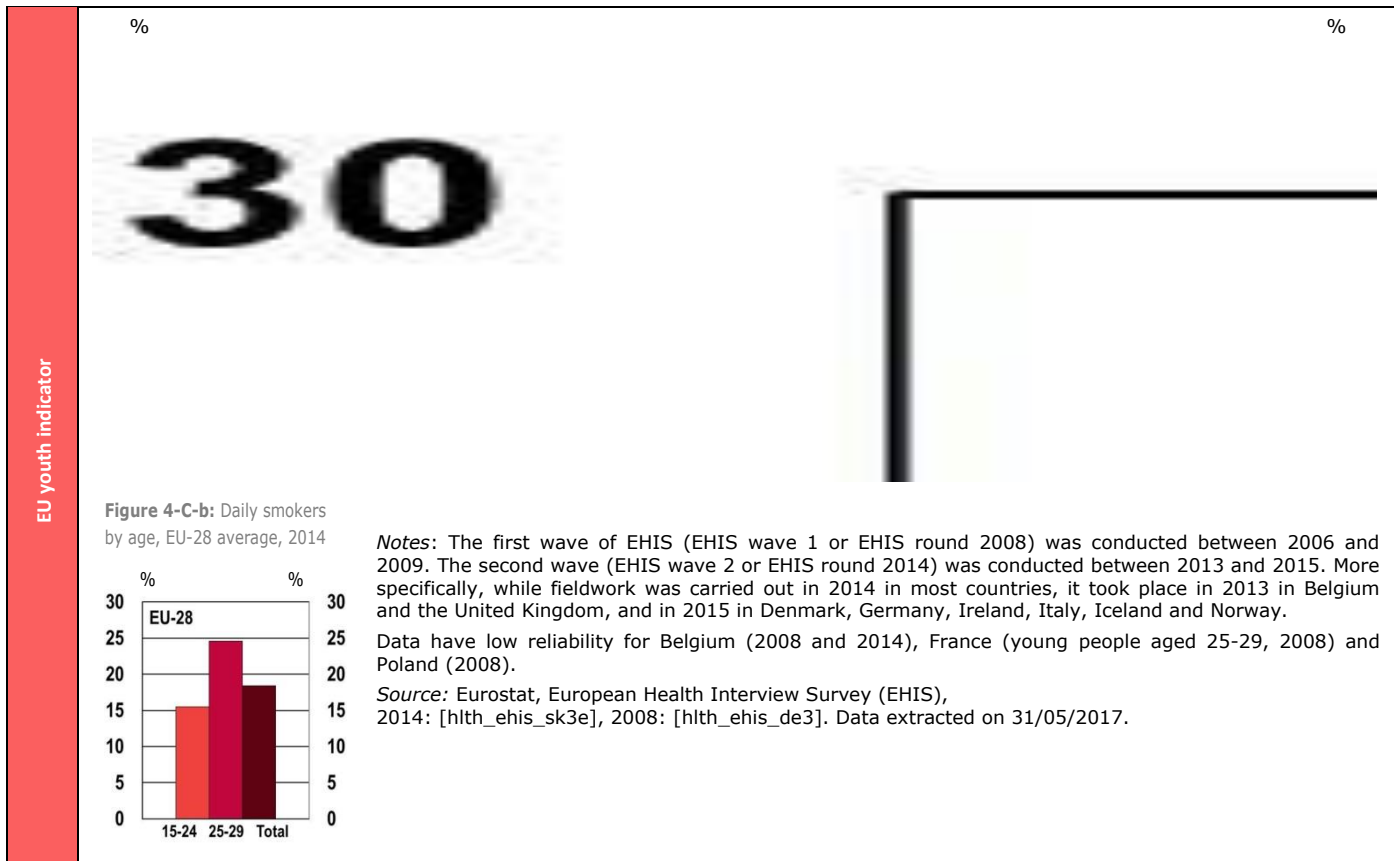
⁽³¹⁾ European Commission 2016b, p. 231.

⁽³²⁾ See e.g. WHO, 2014a.

⁽³³⁾ Eurobarometer surveys (see Special Eurobarometers 429 (2015) and 458 (2017) on the Attitudes of Europeans towards tobacco and electronic cigarettes) show a recent rise in young smokers in the 15-24 age group. However, these surveys do not make it possible to follow changes in the proportions of daily and occasional smokers separately over time.

smoking took place only in France, Hungary, Austria and Slovakia ⁽³⁴⁾. The proportion of daily smokers among young people was the lowest in Norway, both in absolute terms and in comparison to Norway's total population.

Figure 4-C: Proportion of daily smokers among young people aged 15-24, by country, 2008 and 2014



However, a relatively large percentage of young people still smoke daily in (at least some) European countries. In 2014, 15.5 % of young people aged 15-24 and 24.6 % of 25-29 year-olds smoked daily in the EU-28 on average (Figure 4-C-b). As Figure 4-C also depicts, the proportion of young people aged 15-24 smoking daily was relatively high in Hungary (27.2 %), Austria (26.8 %) and France (22.2 %). In these three countries, the proportion of 15-24 year-olds smoking daily was larger than the proportion of daily smokers in the total population ⁽³⁵⁾.

The overrepresentation of young people among daily smokers is on the other hand quite clear in the 25-29 age group: in almost all European countries, a larger proportion of young people aged 25-29 smoke daily in comparison with the proportion in the total population ⁽³⁶⁾.

⁽³⁴⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Daily smokers of cigarettes' [hlth_ehis_sk3e]. Data extracted on 31/05/2017.

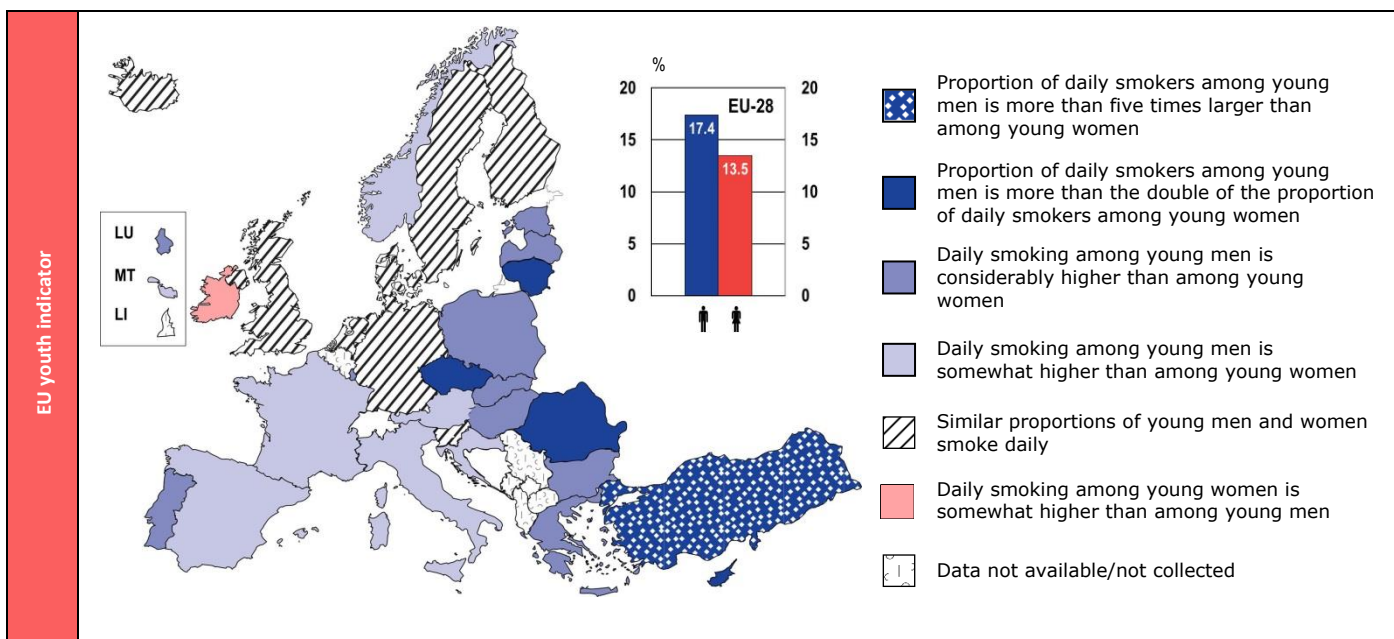
⁽³⁵⁾ Ibid.

⁽³⁶⁾ Ibid.

Young men are particularly prone to daily smoking – with more of them smoking on a daily basis than young women in almost all countries with available data (Figure 4-D). On average in the EU-28, while 17.4 % of young men aged 15-24 were smoking daily in 2014, only 13.5 % of young women of the same age were doing so. The differences are especially pronounced moving from west to east and north to south (Figure 4-D). The biggest gender differences are in Czech Republic, Cyprus, Lithuania, Romania and Turkey, where young men are more than twice as likely to smoke daily as young women (in Turkey, this ratio is 5 to 1).

Young men are much more likely to be habitual smokers than young women. However, differences between women and men are narrowing in some countries, with increasing proportions of female daily smokers.

Figure 4-D: Gender differences in the proportion of daily smokers among young people aged 15-24, 2014



Notes: The second wave of EHIS (EHIS wave 2 or EHIS round 2014) was conducted between 2013 and 2015. More specifically, while fieldwork was carried out in 2014 in most countries, it took place in 2013 in Belgium and the United Kingdom, and in 2015 in Denmark, Germany, Ireland, Italy, Iceland and Norway.

Daily smoking among young men is regarded as 'considerably higher' than among young women where the male/female ratio is between 1.5 and 2; it is regarded as 'somewhat higher' if the ratio is between 1.15 and 1.5; and regarded as 'similar' if the ratio is between 0.85 and 1.15.

Source: Own calculation based on Eurostat, European Health Interview Survey (EHIS), [hlth_ehis_sk3e]. Data extracted on 31/05/2017.

The only country with more young female daily smokers than male is Ireland. However, while the total proportion of regular smokers aged 15-24 only increased in Slovakia between 2008 and 2014, the proportion of young female daily smokers increased in more countries: in Belgium (1.8 p.p.), Estonia (0.3 p.p.), Latvia (2.4 p.p.), Slovenia (0.8 p.p.) and Slovakia (2.6 p.p.). In contrast, the proportion of young male daily smokers only increased in Czech Republic (0.7 p.p.) and Slovakia (1.7 p.p.)⁽³⁷⁾.

⁽³⁷⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Daily smokers of cigarettes' [hlth_ehis_sk3e] and [hlth_ehis_de3]. Data extracted on 31/05/2017.

b) Alcohol consumption

Alcohol is one of the most widely available and most commonly used psychoactive substances⁽³⁸⁾. However, drinking alcohol, especially frequent drinking and drunkenness is not without health risks. Apart from being connected to hundreds of medical conditions and diseases, it can have 'adverse psychological, social and physical health consequences, including academic failure, violence, accidents, injury, use of other substances and unprotected sexual intercourse'⁽³⁹⁾. Not only the volume of alcohol consumed but also consumption patterns play an important role in this respect; for example, heavy episodic drinking (or 'binge drinking') is particularly risky for young people. Therefore it is important to pay attention to the drinking habits of young people, especially in the youngest age groups.

Figure 4-E depicts the proportion of students turning 16 in the year of data collection who reported having been drunk at least once during the preceding 30 days. Data is from the European School Survey Project on Alcohol and Other Drugs (ESPAD).

Figure 4-E: Proportion of students turning 16 who reported having been drunk at least once during the past 30 days, by country, 2011 and 2015



Notes: The ESPAD target population is defined as students who turn 16 in the calendar year of the survey and are present in the classroom on the day of the survey. Students who were enrolled in regular, vocational, general or academic studies were included, excluding those who were enrolled in either special schools or special classes for students with learning disorders or severe physical disabilities.

Belgium: Data collection was limited to the Flemish Community of Belgium.

Germany (2011): Data collection was limited to five out of sixteen states (*Bundesländer*): Bavaria, Berlin, Brandenburg, Mecklenburg-Western Pomerania and Thuringia.

Spain: Data is from the Spanish national school survey. Nevertheless, since the instruments used in the Spanish survey overlap to a large degree with the ESPAD questionnaire, the methodology used allows for rough comparisons across countries.

United Kingdom (2011): Limited comparability of data due to the low school-participation rate.

Source: ESPAD Reports 2011 and 2015.

The figure shows a rather encouraging trend between 2011 and 2015: no country has registered a significant increase in the proportion of students reporting recent incidents of intoxication⁽⁴⁰⁾. In addition, there have been substantial decreases in the proportion of students reporting on their recent drunkenness in several countries, especially in Ireland, Spain and Slovakia. Nevertheless, incidents of intoxication are still relatively common in Denmark, with almost one third of students experiencing drunkenness in the 30 days preceding the data

⁽³⁸⁾ WHO Regional Office for Europe 2016, p 157.

⁽³⁹⁾ Ibid.

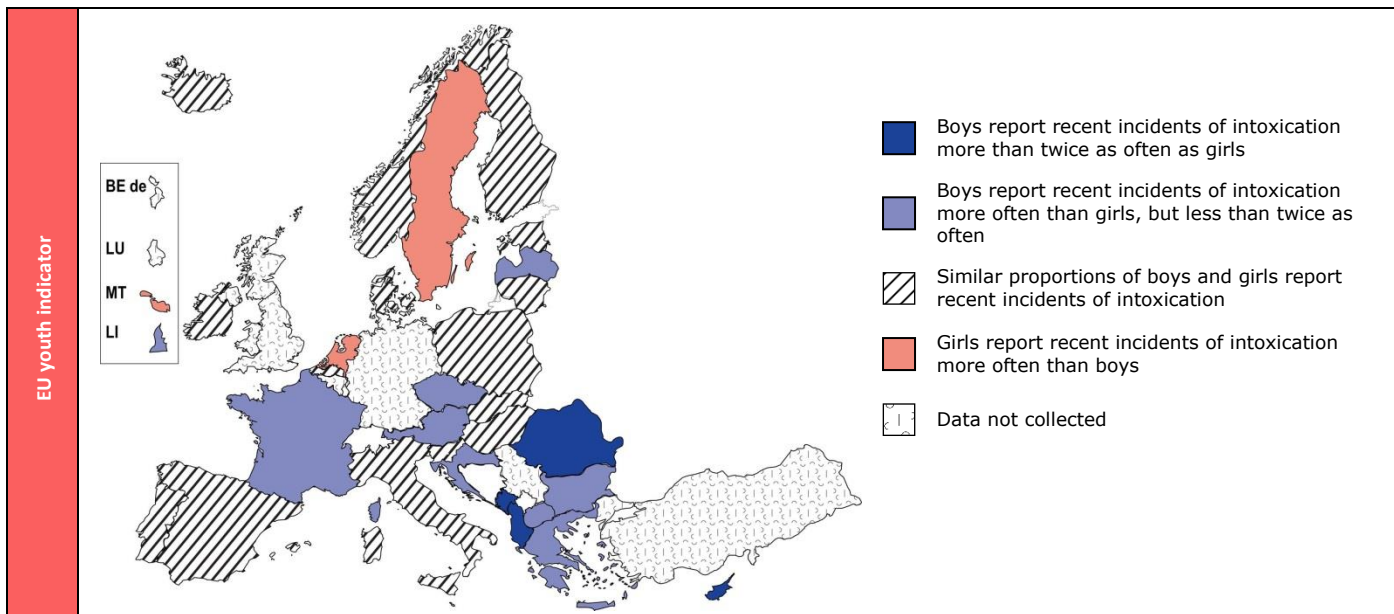
⁽⁴⁰⁾ According to the ESPAD report, only differences more than ± 3 percentage points should be considered as a 'real difference' (The ESPAD Group 2016, p. 27).

collection. Other countries with a relatively high proportion of students (around or over 20 %) reporting intoxication are Spain, Hungary and Austria.

Figure 4-F looks at gender differences in the reported incidence of drunkenness. As the figure depicts, in general, boys and girls report recent incidents of drunkenness in similar proportions in many of the European countries with available data. Nevertheless, there are more countries where incidents of intoxication are reported more often by boys than girls. Moreover, in Cyprus, Romania, Albania and Montenegro, boys are more than twice as likely to report drunkenness as girls (in Montenegro, this ratio is 3 to 1). As is evident from the map, the geographical patterns are similar to those for daily smoking habits (Figure 4-D), but are less pronounced.

Fewer 16 year-olds report recent incidents of intoxication than four years ago. Boys report more incidents of drunkenness than girls, though gender differences are relatively small in many countries.

Figure 4-F: Gender differences in the proportion of students turning 16 who reported having been drunk at least once during the past 30 days, 2015



Notes: The ESPAD target population is defined as students who turn 16 in the calendar year of the survey and are present in the classroom on the day of the survey. Students who were enrolled in regular, vocational, general or academic studies were included, excluding those who were enrolled in either special schools or special classes for students with learning disorders or severe physical disabilities.

Spain: Data is from the Spanish national school survey. Nevertheless, since the instruments used in the Spanish survey overlap to a large degree with the ESPAD questionnaire, the methodology used allows for rough country comparisons.

The proportions of boys and girls reporting recent incidents of intoxication were regarded as similar if the boy/girl ratio was between 0.85 and 1.15.

Source: Own calculation based on ESPAD Report 2015.

Besides recent incidents of intoxication, another important indicator on alcohol consumption which is highly relevant for young people is related to experiencing heavy episodic drinking. In the European Union, 15.4 % of 15-19 year-olds reported monthly experiences of heavy episodic drinking in 2014, but this proportion was over 40 % in Denmark and Norway, and over 30 % in Belgium and Austria⁽⁴¹⁾. Regarding gender differences, 15-19 year-old boys reported monthly episodes of heavy drinking more frequently than their female peers. Differences are greatest in Croatia, Cyprus, Hungary, Poland and Turkey. On the other hand, higher proportions of 15-19

⁽⁴¹⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Frequency of heavy episodic drinking' [hlth_ehis_al3e]. Data extracted on 25/10/2017.

year-old girls than boys experience heavy episodic drinking every month in Denmark, the United Kingdom and Iceland ⁽⁴²⁾.

c) Cannabis use

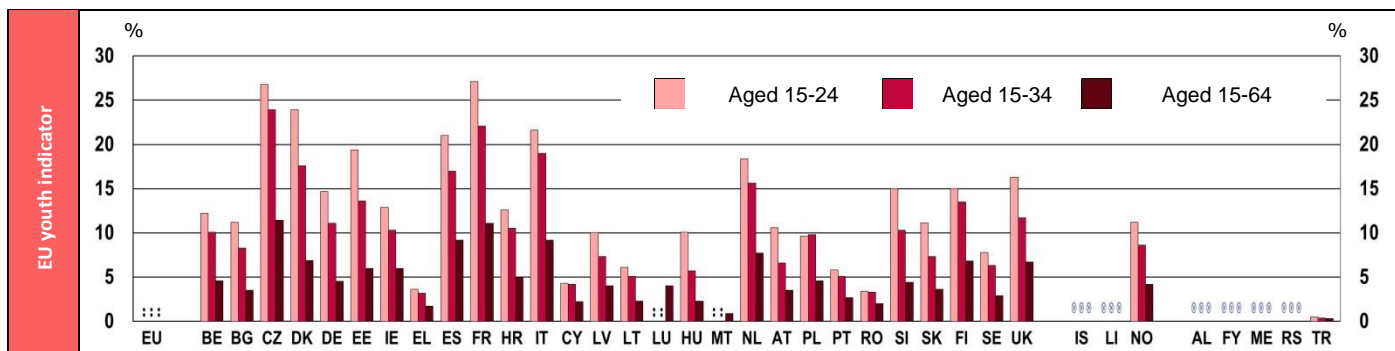
This section focuses on cannabis, the most popular drug used by young people. Though it can be harmless when consumed in moderation, cannabis use is a known risk factor for mental disorders ⁽⁴³⁾. As with other forms of substance abuse, cannabis use is also linked to experiences of insecurity in young adulthood: for example, increasing unemployment rates among young people in recent periods have been associated with increasing levels of cannabis consumption ⁽⁴⁴⁾.

Young people are more prone to using cannabis than older age groups: according to national surveys collected by the EMCDDA, in all countries with available data, the likelihood of using cannabis decreases with age.

Young people are more likely to use cannabis than older age groups. Young men are more prone to substance use than young women.

Thus, young people aged 15 to 24 are much more likely to use this substance than older age groups (Figure 4-G). In addition, cannabis use is associated with the other two most common forms of substance abuse: those who drink and smoke more are also more likely to use illicit drugs, mostly cannabis ⁽⁴⁵⁾.

Figure 4-G: Prevalence of cannabis use in the past 12 months, by country and by age, year of the last available national survey



Notes: LU: 1998; EL: 2004; HU: 2007; AT, EE: 2008; SK: 2010; IE, LV, TR: 2011; BG, DE, HR, CY, LT, PT, SI: 2012; BE, DK, ES, MT, RO: 2013; CZ, FR, IT, NL, PL, FI, SE, UK, NO: 2014.

United Kingdom: Data are for England and Wales only.

Source: EMCDDA.

As Figure 4-G depicts, the proportion of young people using cannabis in the past 12 months is the highest in France (27.1 %), Czech Republic (26.8 %) and Denmark (23.9 %). Data for these countries are all based on relatively recent national surveys. The greatest differences between cannabis use among young adults and that of the wider population (between 15 and 64 years of age) are in Hungary, where young adults are more than four times more likely to have used cannabis in the past year than the wider adult population. The differential is also high in Croatia and Romania at three-and-a-half times.

Given that data presented on Figure 4-G have different reference years for different countries, it is difficult to draw conclusions on recent trends in cannabis consumption. Nevertheless, ESPAD reports can provide some insight into the changes in cannabis consumption among 16 year-old students. According to ESPAD data, the

⁽⁴²⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Frequency of heavy episodic drinking' [hlth_ehis_al3e]. Data extracted on 25/10/2017.

⁽⁴³⁾ WHO Regional Office for Europe 2016, p. 169.

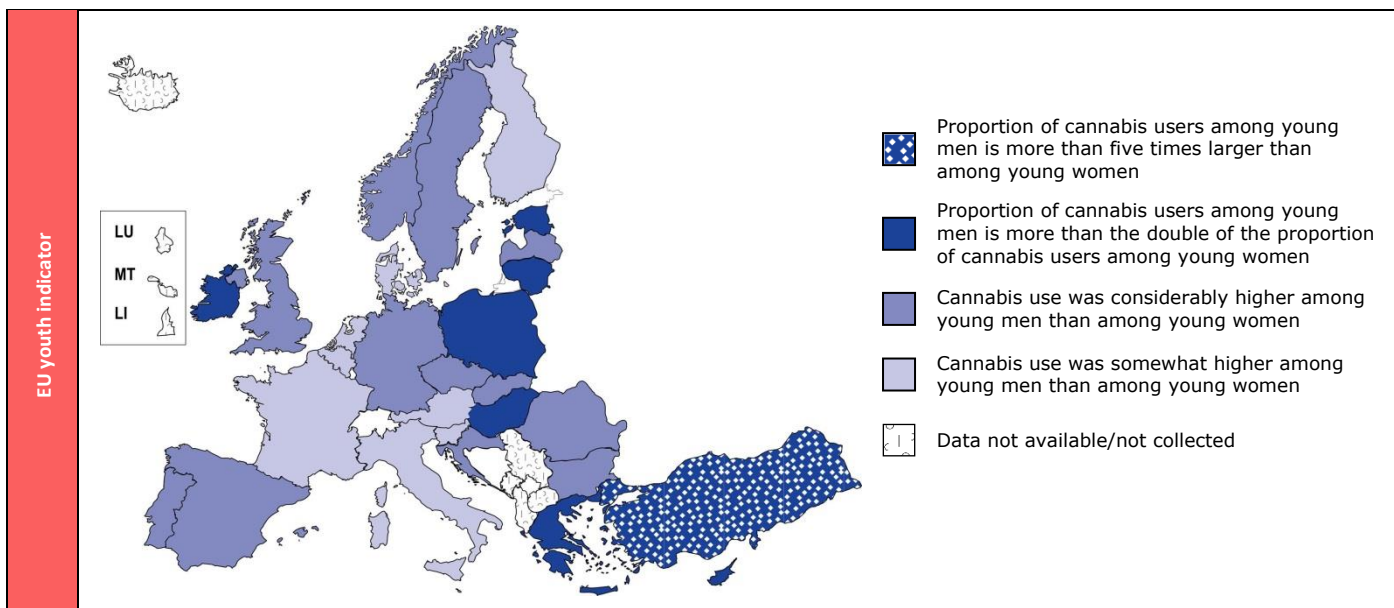
⁽⁴⁴⁾ Ayllón and Ferreira-Batista, 2017.

⁽⁴⁵⁾ See e.g. Mattick et al., 2017.

12-month prevalence of cannabis consumption increased significantly in Bulgaria, Croatia, Italy and Liechtenstein, while decreased in Belgium (Flemish Community), Denmark, France, Hungary, Latvia and Iceland⁽⁴⁶⁾.

As with regular smoking, men are more prone to cannabis use than women in all countries with available data (Figure 4-H). Nevertheless, geographical patterns are less clear-cut. Gender differences are the largest again in Turkey, though cannabis consumption is very low for both men and women. Young men are more than twice as likely to use cannabis as young women in Estonia, Ireland, Greece, Cyprus, Lithuania, Hungary and Poland. Differences are the smallest in Belgium.

Figure 4-H: Gender differences in the prevalence of cannabis use in the past 12 months among young people aged 15-24, year of the last available national survey



Notes: LU: 1998; EL: 2004; HU: 2007; AT, EE: 2008; SK: 2010; IE, LV, TR: 2011; BG, DE, HR, CY, LT, PT, SI: 2012; BE, DK, ES, MT, RO: 2013; CZ, FR, IT, NL, PL, FI, SE, UK, NO: 2014.

The prevalence of cannabis use in the past year among young men is regarded as 'considerably higher' than among young women if the male/female ratio was between 1.5 and 2; and it is regarded as 'somewhat higher' if the ratio was between 1.15 and 1.5.

Source: EMCDDA.

⁽⁴⁶⁾ Source: ESPAD reports 2011 and 2015 (Hibell et al., 2012 and The ESPAD Group, 2016).

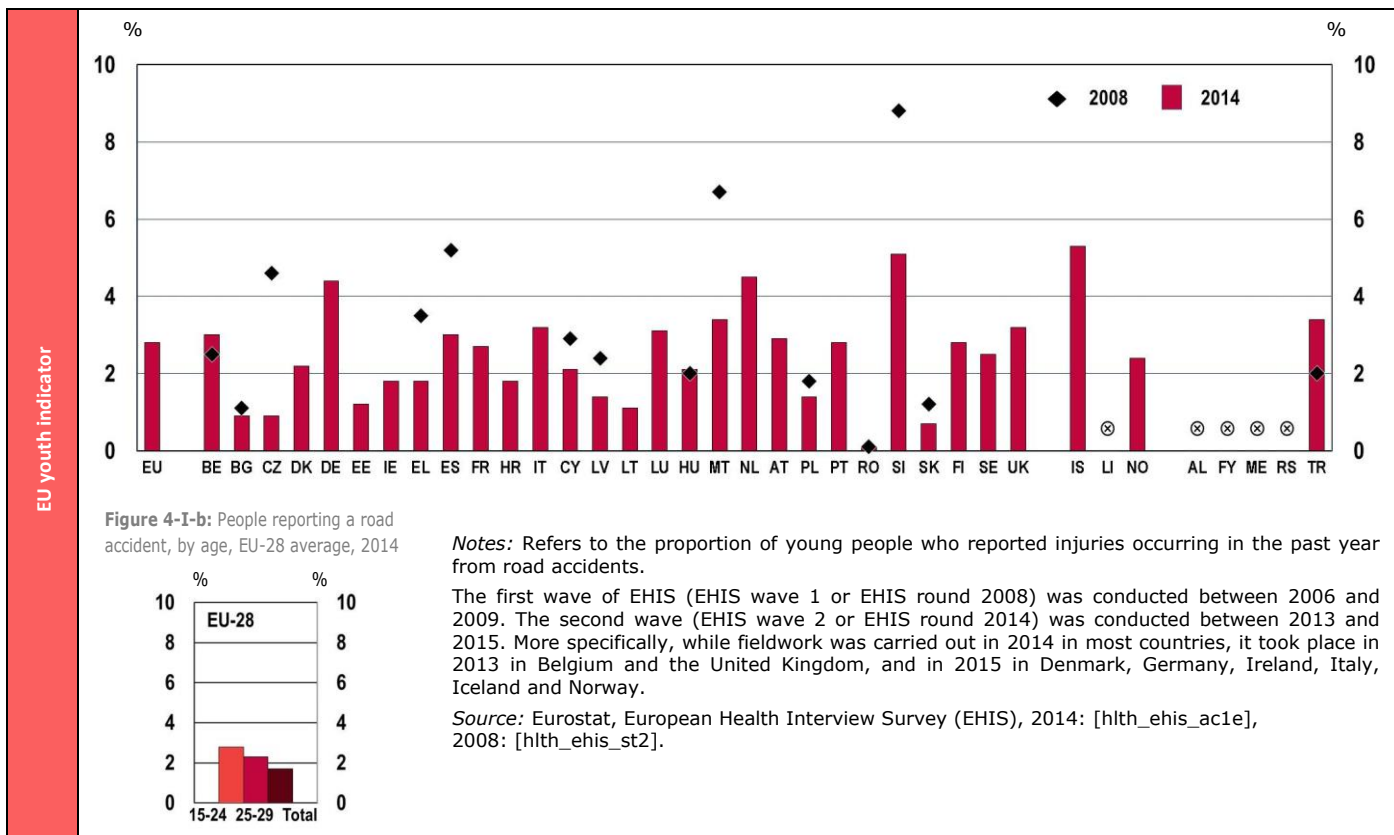
4.2.3. Road traffic accidents resulting in injury

Risk behaviours affecting young people include dangerous driving or driving without due care and attention. These can be operationalised by looking at road traffic accidents resulting in injury. Young people are much more prone to having such accidents than older generations, due to a mixture of different factors such as inexperience, more risk-taking, as well as having a tendency to drive at night, under the influence of drugs and alcohol, or letting themselves be distracted, for example by mobile phones⁽⁴⁷⁾. In fact, injuries resulting from road accidents are the leading cause of death and disability among young people⁽⁴⁸⁾. As Figure 4-I-b shows, in 2014, in the EU-28 on average, 2.8 % of young people aged 15-24 reported a road traffic accident resulting in injury, while this proportion is 2.3 % among 25 to 29 year-olds and only 1.7 % within the total population.

Though the proportion of young people involved in road traffic accidents decreased in many countries, they are still overrepresented among people reporting related injuries. Young men are more prone to risky behaviour than young women.

Young people's likelihood of being involved in road traffic accidents resulting in injury however varies quite substantially among European countries. While over 5 % of young people aged 15-24 reported such accidents in Slovenia and Iceland, this proportion remained below 1 % in Bulgaria, Czech Republic, Romania and Slovakia.

Figure 4-I: Young people aged 15-24 reporting a road traffic accident resulting in injury, by country, 2008 and 2014



Regarding the changes in reported road traffic accidents resulting in injury between 2008 and 2014, information is relatively limited as data is available only for 14 countries. Nevertheless, as Figure 4-I depicts, existing data

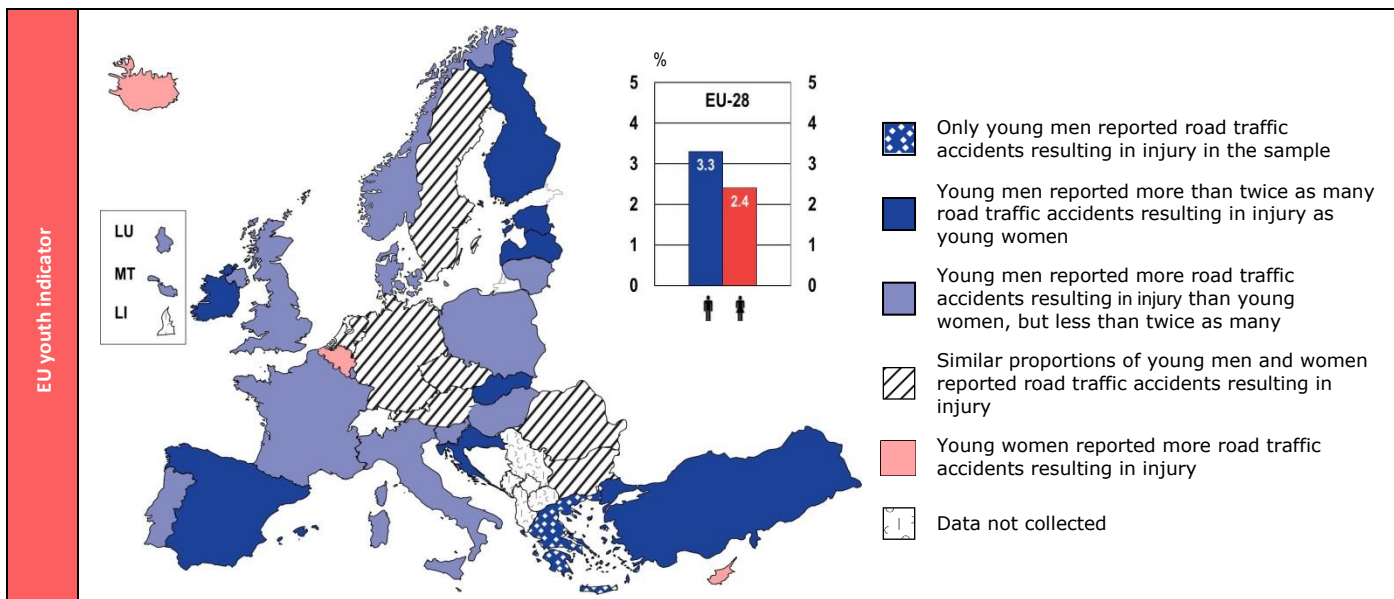
⁽⁴⁷⁾ European Commission, 2017i and 2017a.

⁽⁴⁸⁾ WHO Regional Office for Europe 2009, p. 36.

shows relatively large decreases in such accidents in a number of countries. The proportion of young people aged 15 to 24 reporting these types of accidents decreased by more than 3 percentage points in Czech Republic, Malta and Slovenia. However, in Slovenia, while the involvement of young people in such accidents decreased substantially in the 20-24 age group, it increased among the younger age group, the 15-19 year-olds⁽⁴⁹⁾. In addition, the proportion of road traffic accidents resulting in injury among young people aged 15-24 increased in Belgium and Turkey, mostly within the 20-24 age group.

As with substance abuse, gender patterns are relatively clear in this area (Figure 4-J). In general, young men are more involved in road traffic accidents resulting in injury than young women in European countries. In the EU-28, 3.3 % of young men aged 15-24 reported such accidents, in contrast to the 2.4 % of young women. As Figure 4-J shows, young men are twice or more likely to report road traffic accidents resulting in injury in eight countries, and no young women reported such accidents in Greece. Gender differences are the largest in Greece, Spain, Croatia, Latvia and Turkey. More young women reported these types of accidents in Belgium, Cyprus and Iceland. In fact, in Belgium and Cyprus, the gender gap reversed since 2008: in both countries, while the proportion of young men aged 15-24 decreased between 2008 and 2014, the proportion of young women reporting such accidents increased⁽⁵⁰⁾.

Figure 4-J: Gender differences among young people aged 15-24 reporting road traffic accidents resulting in injury, 2014



Notes: The second wave of EHIS (EHIS wave 2 or EHIS round 2014) was conducted between 2013 and 2015. More specifically, while fieldwork was carried out in 2014 in most countries, it took place in 2013 in Belgium and the United Kingdom, and in 2015 in Denmark, Germany, Ireland, Italy, Iceland and Norway.

The proportions of young men and women reporting road traffic accidents are regarded as 'similar' if the male/female ratio was between 0.85 and 1.15.

Source: Own calculation based on Eurostat, European Health Interview Survey (EHIS), [hlth_ehis_ac1e].

⁽⁴⁹⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Persons reporting an accident resulting in injury' [hlth_ehis_ac1e] and 'People reporting having had an accident' [hlth_ehis_st2]. Data extracted on 07/06/2017.

⁽⁵⁰⁾ Source: Eurostat, European Health Interview Survey (EHIS), 'Persons reporting an accident resulting in injury' [hlth_ehis_ac1e] and 'People reporting having had an accident' [hlth_ehis_st2]. Data extracted on 07/06/2017.

4.3. MENTAL WELL-BEING

The transition from childhood to adulthood and the societal and family pressures that young people face in such contexts also influence their mental health. Though mental and psychological distress are still less prevalent among young people than older age groups, special attention has to be paid to young people and the factors which increase their vulnerability. As with risk behaviour, mental health is also influenced by the socio-economic conditions of young people's lives – their level of social exclusion and degree of poverty ⁽⁵¹⁾. As this report also shows, young people can experience periods of unemployment and social exclusion in the current economic climate, which certainly influences their mental health and psychological well-being.

4.3.1. Psychological distress

The EU Dashboard of Youth Indicators ⁽⁵²⁾ includes an indicator on psychological distress to assess the mental health and well-being of young people. However, this indicator was not included in the 2014 round of the European Health Interview Survey (EHIS). Instead, for the first time, the EHIS survey included questions making it possible to evaluate the severity of respondents' symptoms of depression ⁽⁵³⁾. Depression is a mental illness, potentially a serious health condition. Depression is the leading cause of ill health and disability worldwide; at worst, it can lead to suicide ⁽⁵⁴⁾. Looking at the proportion of young people experiencing moderate to severe symptoms of depression therefore provides important input into understanding the mental health conditions of young generations.

Figure 4-K shows the proportion of the population that was experiencing moderate to severe symptoms of depression. In the EU-28, 4.9 % of young people (from both the 15-24 and 25-29 age groups) show moderate to severe symptoms of depression, while this proportion is 6.3 % within the total population. However, differences between countries are enormous: while more than 10 % of young people aged 15-24 report moderate to severe symptoms of depression in Germany (11.5 %), Ireland (13 %), Luxembourg (11.3 %) and Iceland (15.6 %), the proportions are below 1 % in Czech Republic (0 %), Greece (0.8 %), Croatia (0.7 %), Cyprus (0.3 %), Lithuania (0.5 %) and Slovakia (0.5 %).

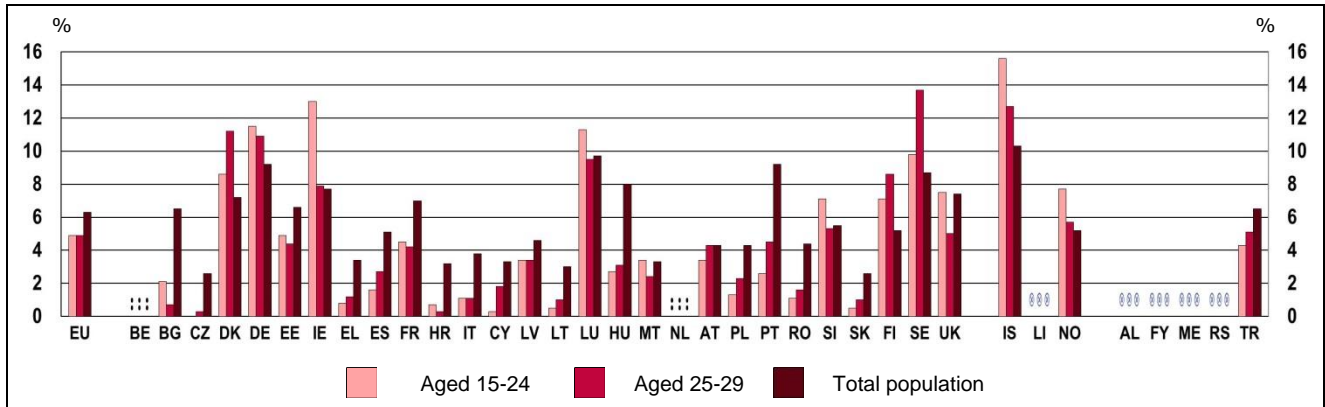
⁽⁵¹⁾ WHO and Calouste Gulbenkian Foundation, 2014.

⁽⁵²⁾ European Commission, 2011.

⁽⁵³⁾ Symptoms of depression are evaluated based on eight specific questions defined on the basis of the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV). Respondents had to evaluate how frequently they experience the following feelings: A. Little interest or pleasure in doing things; B. Feeling down, depressed or hopeless; C. Trouble falling or staying asleep, or sleeping too much; D. Feeling tired or having little energy; E. Poor appetite or overeating; F. Feeling bad about yourself or that you are a failure or have let yourself or your family down; G. Trouble concentrating on things, such as reading the newspaper or watching television; H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual (Eurostat 2013, pp. 51-53).

⁽⁵⁴⁾ WHO, 2017.

Figure 4-K: Proportion of population experiencing moderate to severe symptoms of depression, by country and by age, 2014



Notes: The second wave of EHIS (EHIS wave 2 or EHIS round 2014) was conducted between 2013 and 2015. More specifically, while fieldwork was carried out in 2014 in most countries, it took place in 2013 in Belgium and the United Kingdom, and in 2015 in Denmark, Germany, Ireland, Italy, Iceland and Norway.

The figure covers symptoms of varying degrees of severity: moderate, moderately severe and severe.

Source: Eurostat, European Health Interview Survey (EHIS), [hlth_ehis_mh2e].

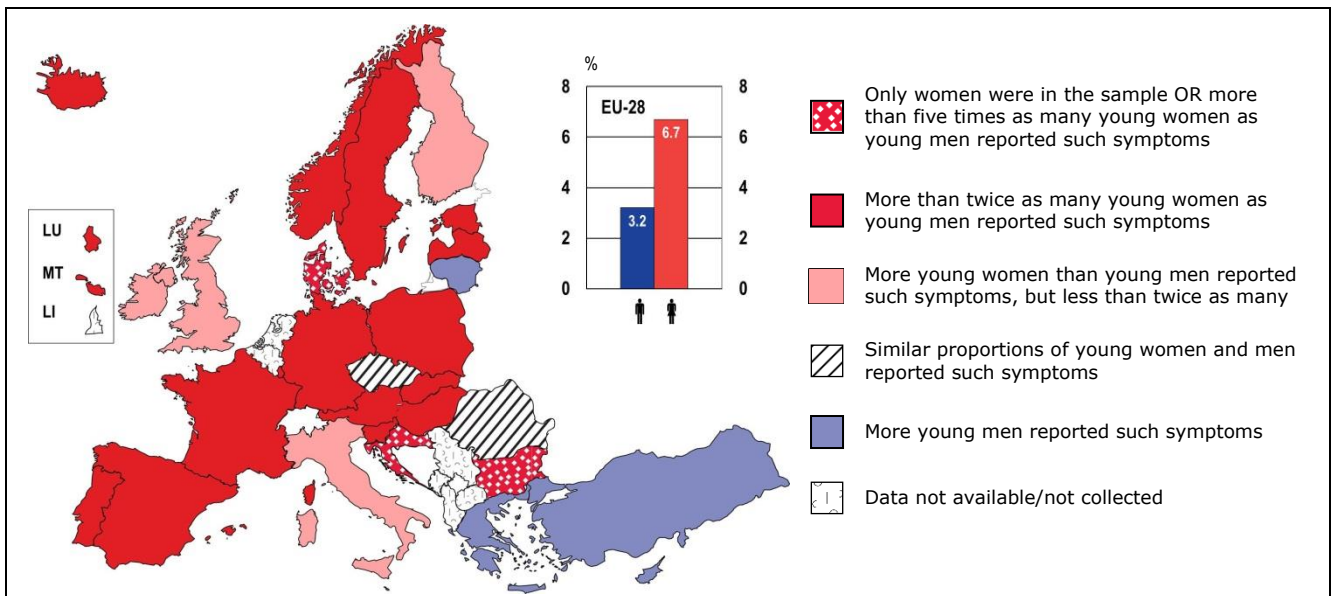
At EU level there is no difference between the younger and older youth cohorts in the proportions experiencing symptoms of depression, and both these groups suffer less in comparison to the total population. At the individual country level the picture varies, although some geographical differences do emerge: young people seem to be relatively more vulnerable than the general population in the Nordic countries (Denmark, Finland, Sweden, Iceland and Norway), as well as in Germany, Ireland, Luxembourg and Slovenia. As Chapter 7 will show, in most of these countries, young people (especially women) leave the parental household and start an independent life at a relatively early age, which can make them more vulnerable (Figure 7-A). On the other hand, the proportion of young people experiencing moderate to severe symptoms of depression is relatively low in some southern and eastern European countries, both compared to the European average and to the total population within the same country.

More than twice as many young women as young men report that they suffer from moderate to severe symptoms of depression in Europe. As Figure 4-L shows, this is also true for a large majority of European countries. In Denmark, for example, 15.6 % of young women aged 15-24 report moderate to severe symptoms of depression, while the same proportion among young men is 2 %. Yet, these differences could be partly due to men underreporting their symptoms⁽⁵⁵⁾.

More than twice as many young women as young men report that they suffer from moderate to severe symptoms of depression in Europe.

⁽⁵⁵⁾ Dallas, M.E., 2015.

Figure 4-L: Gender differences in the proportion of young people aged 15-24 experiencing moderate to severe symptoms of depression, 2014



Notes: The second wave of EHS (EHS wave 2 or EHS round 2014) was conducted between 2013 and 2015. More specifically, while fieldwork was carried out in 2014 in most countries, it took place in 2013 in Belgium and the United Kingdom, and in 2015 in Denmark, Germany, Ireland, Italy, Iceland and Norway.

The figure covers symptoms of varying degrees of severity: moderate, moderately severe and severe.

The proportions of young women and men experiencing moderate to severe symptoms of depression are regarded as similar if the female/male ratio was between 0.85 and 1.15.

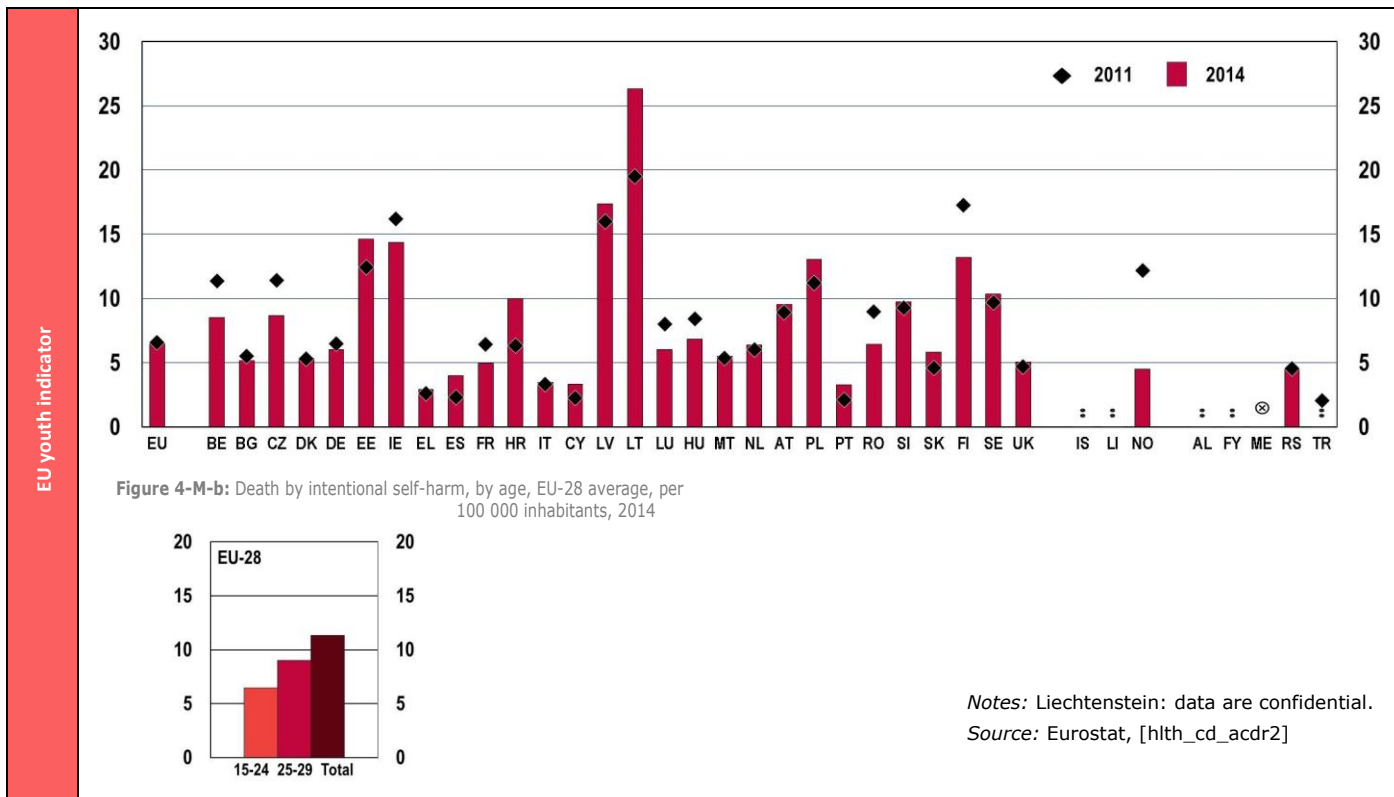
Source: Own calculation based on Eurostat, European Health Interview Survey (EHIS), [hlth_ehis_mh2e].

4.3.2. Suicide

The most serious outcome of mental suffering is suicide. After road accidents, suicide is the second leading cause of death among 15-29 year-olds⁽⁵⁶⁾. As with depression, however, the differences between countries are quite significant. Suicide rates are by far the highest in Lithuania, where every 26 in 100 000 young people aged 15 to 24 committed suicide in 2014 (Figure 4-M). Although suicide rates are more or less stable in the EU-28, with a rate around 6.5 per 100 000, Lithuania saw a relatively large increase in crude death rates by intentional self-harm among 15-24 year-olds between 2011 and 2014 (from 19.5 to 26.3 per 100 000 inhabitants). The other two Baltic States and Ireland also register comparatively high suicide rates. At the same time, suicide rates are relatively low (below 5 per 100 000 inhabitants) in southern countries such as Greece, Spain, Italy, Cyprus and Portugal. In addition, Norway, which was among the countries with relatively high youth suicide rates in 2011, now registers crude death rates by intentional self-harm comparable to southern Europe.

⁽⁵⁶⁾ WHO, 2014b.

Figure 4-M: Death by intentional self-harm among young people aged 15-24, crude death rate (per 100 000 inhabitants), by country, 2011 and 2014



As Figure 4-M-b illustrates, across Europe, suicide rates generally increase with age. However, there are a few exceptions. In Ireland, for example, crude death rates by suicide are higher in both the 15-24 and 25-29 age groups than within the total population; while in Estonia, Cyprus and Finland, young people aged 25-29 are more prone to commit suicide than older – or younger – groups⁽⁵⁷⁾. In these three countries, suicide rates among 25-29 year-olds were higher in 2014 than in 2011; in Estonia, the rate almost doubled in this period⁽⁵⁸⁾.

Despite depression being more commonly reported among women than among men, young men are much more likely to commit fatal suicide than young women (Figure 4-N). While only 2.7 in 100 000 women aged 15 to 24 died due to intentional self-harm in 2014, the rate is more than three times higher – 10 per 100 000 – among young men. As Figure 4-N depicts, female to male ratios are especially high in central and eastern Europe, where in many countries, young men are more than five times as likely to commit suicide as young women.

Young men commit suicide in larger proportions than young women. Suicide rates increased substantially among young men in Lithuania, while they decreased in Norway.

However, higher crude death rates by intentional self-harm among men does not mean that men are more likely than women to attempt suicide. In fact, data and estimates show the opposite: non-fatal suicide attempts are more common among women⁽⁵⁹⁾. One reason for such a difference is that men tend to choose more lethal suicide methods⁽⁶⁰⁾.

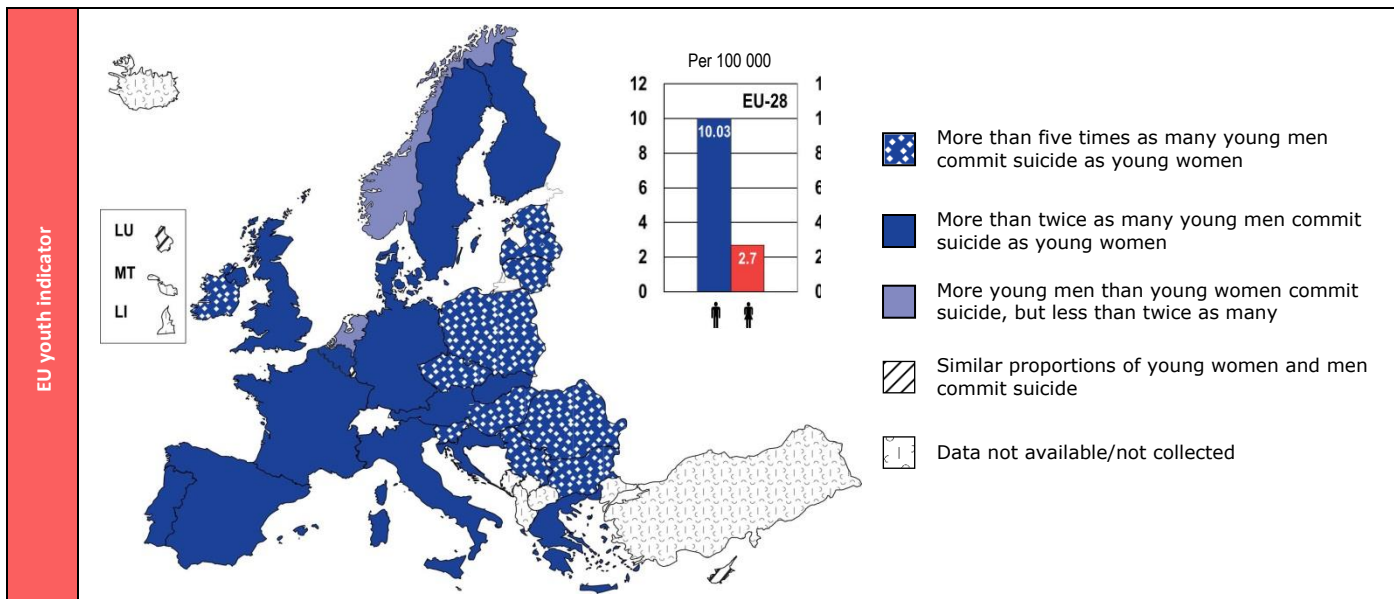
⁽⁵⁷⁾ Source: Eurostat, 'Causes of death (intentional self-harm) – Crude death rate' [hlth_cd_acdr2]. Data extracted on 07/06/2017.

⁽⁵⁸⁾ Ibid.

⁽⁵⁹⁾ See e.g. Mergl et al., 2015.

⁽⁶⁰⁾ Ibid.

Figure 4-N: Gender differences in the proportion of young people aged 15-24 whose death is caused by intentional self-harm, 2014



Notes: Malta and Liechtenstein: data are confidential.

The proportions of young women and men committing suicide are regarded as similar if the male/female ratio was between 0.85 and 1.15.

Source: Own calculation based on Eurostat, [hlth_cd_acdr2].

Gender differences are not only evident in crude death rates in a given year; changes over time are also more prominent among men. In fact in the countries where bigger changes took place, these changes occurred mostly among men: suicide rates increased primarily among men in Estonia, Croatia and Lithuania (in Estonia, suicide rates even decreased among young women aged 15-24); while they decreased principally among young men in Finland and Norway⁽⁶¹⁾. Fluctuations in suicide rates of young women are less pronounced.

CONCLUSION

This chapter has provided a snapshot of young people's health based on selected indicators of health risks and mental well-being. In many respects, it shows a reassuring picture: there is a decreasing trend in the proportions of young people smoking regularly, reporting recent incidents of intoxication or reporting road accidents resulting in injury. However, this is not true for obesity: the proportion of obese young people has increased in the majority of countries with available data. In addition, differences between countries are quite substantial for most health indicators, with some countries showing a relatively large proportion of young people at risk.

Young men are much more prone to risk-taking than young women⁽⁶²⁾. There are more young men among regular smokers and cannabis users; more of them report recent drunkenness; and more of them are involved in road accidents resulting in injury. When they attempt to take their own life, men are more likely to choose more lethal methods. The over-representation of young men among risk-takers tends to be particularly pronounced in southern and eastern Europe. However, differences between women and men are narrowing in several countries, especially when it comes to drinking or smoking habits.

While young men are more prone to risk-taking, young women are slightly more affected by obesity, and much more affected by mental health issues. More than twice as many young women as young men report suffering

⁽⁶¹⁾ Source: Eurostat, 'Causes of death (intentional self-harm) - Crude death rate' [hlth_cd_acdr2]. Data extracted on 07/06/2017.

⁽⁶²⁾ For potential explanations, see e.g. the meta-analysis by Byrnes, Miller and Schafer, 1999.

from at least moderate symptoms of depression in Europe. Young people are affected especially in countries where they are expected to start an independent life earlier. As Chapter 7 will show, this opens the door to vulnerability on several fronts, which in turn influences the mental well-being of young people.