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Public services

Inequalities in the access of young people to information and support services

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Eurofound project: Access of young people to information and support services (170802)

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

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Introduction

Young men and women are the future of European societies. However, there are concerns at EU and national levels that the combined stresses from school, expectations from parents, and peer and societal pressures can create challenging transitions to adulthood and have a long-lasting impact. There are also concerns about inequalities of opportunities and resources, including those for coping with social or health problems. To reduce inequalities, ensuring access to key services is vital.

This report sets out to review inequalities in young people's access to information and support services and how these inequalities can be overcome. It focuses on the 12–24 age group; where possible, information is provided separately for ages 12–17 and 18–24.

Policy context

In May 2018 the European Commission proposed a new framework for cooperation on youth for the period 2019–2027, which emphasises partnership and cross-sectoral work. The strategy points to cooperation between schools, youth workers, health professionals and sports organisations to ensure better access to opportunities.

The importance of public services is highlighted in the European Pillar of Social Rights, which includes a focus on using services to support education, training and lifelong learning, equal opportunities, gender equality and active support to employment.

Key findings

Issues around mental well-being affect many young people in Europe. Data for 2016 show that 14% of Europeans aged 18–24 were at risk of depression. Young people in Sweden were most at risk of depression, followed by those in Estonia, Malta, the Netherlands and the United Kingdom (UK). The proportion of young people who are chronically depressed is lower, but still of great concern. Data for 2014 show that 4% of Europeans aged 15–24 were chronically depressed. The highest rates were in Ireland (12%), followed by Finland (11%), Sweden (10%) and Germany (9%).

Socioeconomic status has a strong impact on whether young people are at risk of depression. Those living in households in the lowest income quartile are more likely to be at risk. There is also a strong gender dimension to issues of mental health, with young women (15–24 years) being more prone to depression.

The incidence of both bullying and cyberbullying are on the rise in several countries, with the highest prevalence in the Baltic states and the French-speaking community in Belgium.

Given that issues around health and mental well-being are among the most prominent problems affecting young people, access to relevant services is key to addressing associated risks. Yet a significant proportion of young people have difficulties in accessing services. Regarding health care, the most important access issues are delays in getting an appointment and long waiting times on the day.

There are considerable inequalities among young people in Europe in terms of accessing healthcare. The most obvious differences can be seen by country. For example, cost is a problem for nearly three-quarters of those aged 18–24 in Cyprus. In Austria, Bulgaria, Cyprus, Latvia and the UK, deterioration was reported on most dimensions of access between 2011 and 2016, while in Italy and Slovakia some improvements can be seen. Overall, in the EU, young people with disability or chronic illness are more likely to report difficulties in accessing healthcare – especially in terms of delays, waiting time and finding time to get to the doctor.

Some success factors underpinning efforts to reduce inequalities in access include:

- adaptability – services and professionals need to adopt new tools in line with trends among young people
- guidance – some young people may not be in a position to immediately know what type of service they need
- high degree of knowledge of and familiarity with the issues of concern to young people
- empathy with young people and an understanding of their needs, which translates into greater involvement of young people themselves as service providers through, for example, peer-to-peer support

Policy pointers

Policy pointers for service providers

Service providers should:

- respect and protect the privacy of young people needing help (as well as the privacy of parents)
- consider the differences among young people and tailor services to individual situations
- take into account emerging issues such as cyberbullying and rising levels of homelessness
- consider going beyond a simple concept of 'hard to reach' and invest in understanding the causes of inequalities in access to services in order to provide solutions
- be flexible, without putting unnecessary pressure on young people to use certain services for further referrals

- involve young people as a potential gateway to others, particularly those who are more difficult to reach

Policy pointers for policymakers

Policymakers should:

- ensure the availability of a network of services to cater for the social and health needs of young people, with the help of public and non-governmental providers that have the competencies and experience to deliver such services

- examine young people's environments at home and in school so new and emerging risks, such as rising levels of cyberbullying, can be detected early

- promote closer cooperation between mainstream services and schools to provide more school-based interventions: for example, around mental health issues (understanding of mental health disorders, mental health literacy)

- put in place and support initiatives grounded in national programmes to improve the coverage and quality of social and health services for young people

- when establishing eligibility criteria for services and allowances, pay attention to the age range 12–17 (who are covered by child protection policies) without forgetting those aged 18–24 (or even up to age 29)

Policy pointers for the EU

The EU should:

- through its Youth Strategy, explicitly mainstream youth into the European Pillar of Social Rights and related initiatives – in relation to employment and education, and in terms of social protection and access to essential services

- support the provision of more comparative data on access to social and health services in the Member States

- promote and support research on the causes and consequences of inequalities between young people in their experience of health and social problems and access to services as well as on the impact of various initiatives to increase access

- provide budget to organisations that facilitate access to information and support for young people beyond the mainstream environment, especially social enterprises or non-governmental organisations engaged with or providing services

Introduction

In recent years, the impact of the recession and its aftermath on young people as well as on families with children has been a prominent feature in policymaking at the EU and at national level, with a range of policy initiatives having been put in place to address the challenges faced by these groups. While economic growth is being experienced by many in the Member States, some young people and particularly some families with children do not seem to be benefiting from improving economic conditions.

While the majority of policy initiatives focus on issues of young people's inclusion in the labour market – the most notable being the Youth Guarantee – a range of studies, including those by Eurofound, suggest that policymakers should take a broader, more holistic view that focuses on issues beyond employment and draws on a life-course perspective. This perspective takes into account the social, economic and cultural contexts of people's lives; applied to young people, this acknowledges that the transition into adulthood may be more problematic for some due to global and societal challenges, including the consequences of rising social and economic inequalities and growing polarisation or feeling of disenchantment.

Concerns have been raised in many countries about the health status of young people and, in particular, their mental health. Similarly, efforts are being made to support households with children and young people. Yet there are ongoing concerns with issues around in-work poverty, inadequate support for working parents and lack of affordable housing – issues that affect many in society but to which young people are especially exposed.

If not managed properly by policymakers, these challenges may have long-lasting negative consequences not only for the individual but for society as a whole. Empowering and equipping young people so that they are able to contribute to society and economy requires a clear and comprehensive vision that is supported by a sound strategy to achieve its objectives – a strategy that translates into national priorities and, crucially, essential services that ensure the effective implementation of initiatives and programmes.

Young people may need help to cope with a range of health and social problems. These are 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. Groups of vulnerable young people, such as those experiencing unemployment, poverty or social exclusion, may be prone to more serious problems related to their physical and mental health. Moreover, behaviours considered to affect young people's health, such as smoking, alcohol consumption, drug use, unhealthy eating, physical inactivity and unsafe sexual practices, often cluster together and reinforce each other (Jackson et al, 2012). In turn, these behaviours are influenced by social factors such as deprivation and social exclusion, poor access to education or health services, as well as family issues and school and living environments. Finally, not only do these behaviours have a strong impact on young people's health and well-being at the time they occur, but they also have lifelong effects (Sawyer et al, 2012). If action is not taken, there is a risk that inequalities between the different groups will grow even greater.

The overall risk factors and their impacts also mean that some young people may find it difficult to access and make use of relevant public services. Access to services may be particularly challenging for disadvantaged young people, precisely those who may need support the most.

Some young people need support to find and follow their path into adulthood, to maintain or establish a social network (including family and friends) and to be included and respected and be able to contribute in community and society. This means that it is important that young people have access to key services and that service providers are aware of and have the capacity to serve their needs (in the right ways and at the right times).

This report focuses on reviewing and analysing the provision of information and support services to young people to address needs related to health and social inclusion. Public services are understood broadly to cover health and social services in general use (which may be delivered by public, private or non-governmental organisations – NGOs). The report looks specifically at inequalities in young people's access to information and support services and how these can be overcome. The Eurofound research reported here covers the 12–24 age group. Where possible, information is provided separately for those aged 12–17 and those aged 18–24, as it is recognised that there are differences in both the prevalence of problems and the types of support needed by these two groups.

The research examines several issues:

- the most common social and health problems facing today's young people
- characteristics of young people facing the greatest difficulties in accessing social and health services
- the types of services relevant to addressing social and health problems
- the main challenges for young people in accessing appropriate information and support
- strategies employed by service providers to reach young people in need of support
- innovative approaches being employed to address inequalities in accessing information and support services

EU policy context

The EU has a long track record of introducing policies and strategies aiming to foster social inclusion and tackle social exclusion, and it has recently focused more of its resources specifically on fostering the social inclusion of young people.

Fostering the social inclusion of young people and combating poverty and social exclusion feature prominently in the Europe 2020 strategy put in place in 2010. The setting of an anti-poverty target was first achieved in the framework of this strategy, which aimed at reducing by 20 million the number of people in or at risk of poverty and social exclusion by 2020 (European Commission, 2010a). In monitoring achievements in poverty reduction, specific attention has been paid to child poverty, although not equally so to poverty among young people as a specific age group.

The European Commission in its *Reflection paper on the social dimension of Europe* (European Commission, 2017a) underlines the challenges that young people face related to depression, isolation and loneliness as well as the capacity of public authorities, public services and welfare systems to respond and adapt and to manage complex transitions during a person's lifetime. While young people (those aged 12–24) may need extra help and assistance to cope with health and social problems, they may often find it challenging to access and make use of relevant public services.

Both the European Commission's *Annual Growth Survey 2019* and *Joint employment report 2018* – while acknowledging the overall improvement in, for example, the number of people at risk of poverty – highlight that there is still a large number of young people (up to age 17) living in households that are at risk of poverty. Moreover, both reports call for more investment in different types of services that centre around the young person's ability to make a successful transition into adulthood, not only in terms of employment but also in relation to broader social and living conditions (European Commission, 2017b). Another issue, not mentioned so explicitly in European Commission policy documents but which has received a lot of attention from a number of international organisations, is mental health and in particular the mental health of vulnerable groups, including young people. Recent warning comes in the OECD report *Health at a glance 2018*, which notes that the growing issues of mental health pose a heavy burden not only for the individuals concerned but also for society, including increased spending on social and health services. The report calls for more investment in timely and preventive social and health services, both universal in nature but also targeting children and young people so that they are not scarred by mental health issues throughout their adult lives (OECD, 2018).

The EU Youth Strategy for 2010–2018 had two main objectives: (1) to provide more and equal opportunities for young people in education and the job market and (2) to encourage young people to actively participate in society. These objectives were pursued through a dual approach, involving:

○ specific youth initiatives targeted at young people to encourage non-formal learning, participation, voluntary activities, youth work, mobility and information

○ 'mainstreaming' cross-sectoral initiatives that ensure youth issues are taken into account when formulating, implementing and evaluating policies and actions in other fields with a significant impact on young people, such as education, employment or health and well-being

The EU Youth Strategy focused on eight priority areas, including employment and entrepreneurship, social inclusion, participation and health and well-being. While certain areas (most notably employment and entrepreneurship) received much attention and dedicated funding, others (such as health-related issues) are still works in progress.

In May 2018 the European Commission proposed a new framework for cooperation on youth for the period 2019–2027. The proposal will undergo the regular legislative process of consultation. Its main aim is to empower young people and build their resilience by focusing on three areas of action:

○ the engagement of young people in civic and democratic participation

○ connecting young people across the EU to promote solidarity, intercultural understanding and opportunities to learn, work and volunteer abroad

○ the support of youth empowerment through boosting innovation, quality and recognition of youth work

While employment remains one of the top priorities, the renewed strategy puts an emphasis on partnership and cross-sectoral working by addressing the needs of young people in different EU policy areas and developing specific youth initiatives. For instance, the strategy stresses cooperation between schools, youth workers, health professionals and sports organisations to ensure better access to opportunities. It also highlights the importance of youth information and counselling in encouraging social inclusion and well-being of young generations (European Commission, 2018).

The importance of public services is highlighted in the European Pillar of Social Rights. In Chapter I of the pillar, there is a focus on services to support education, training and lifelong learning, equal opportunities, gender equality and active support to employment. Chapter II emphasises employment conditions and protection, wages and secure employment. Chapter III focuses on childcare and support, social protection, healthcare, housing assistance, inclusion of people with disabilities and access to essential services. These focus areas can all be addressed in services targeting disadvantaged young people (European Commission, 2017c). The Pillar's overall principles also reflect the broad objective of the Sustainable Development Goals of timely access to affordable, preventive and curative healthcare working towards good health and well-being (United Nations, 2015).

Structure of the report

Chapter 1 outlines the most common social and health problems facing young people today as well as examining the characteristics of those who face most difficulties in accessing relevant services. It presents some of the latest evidence on a broad range of topics, including changes over time and comparisons with general populations where available. The chapter exposes inequalities based on age and gender and reveals pockets of disadvantage in EU countries. The chapter covers young people aged 12–24, but where possible (given the availability of data) the 12–17 age group is highlighted. It starts by sketching demographic changes in Europe, then provides an overview of broad socioeconomic and health determinants (including poverty, deprivation, homelessness and living conditions) to provide a solid overview of the current situation of young Europeans. The chapter then covers issues related to households or the family unit (family background, family support). Based on this broad context, the chapter concludes with a description of the outcomes resulting from the individual problems or challenges (mental well-being, feeling of social exclusion, risky behaviours, bullying). This chapter is based on the research carried out by IRS for Eurofound.

Chapter 2 provides an overview of the main types of services available to young people in EU countries. It then provides some evidence, based on Eurofound's European Quality of Life Survey (EQLS), on inequalities in access to services, including access to healthcare and difficulties in affording psychology services. The chapter concludes with an overview of the main barriers to accessing services in Europe today (personal, structural, institutional, cultural and societal). In describing these barriers, the chapter uses material from 15 initiatives based in five countries (a brief description of the initiatives is provided in Table 1).

Chapter 3 presents findings on what types of initiatives and approaches are relevant to address the barriers that young people experience in accessing appropriate information and support services, and how service providers ensure they reach those who are in need of their support. Findings are based on case studies in five EU countries. The case studies were carried out by Ecorys.[1] The chapter describes how the service providers ensure they reach those who are in need of their support and the innovative ways of providing information and support services to challenge inequalities in access to these services.

Chapter 4 presents results of a consultation with European, national and local providers of support services to young people with regards to their main issues in the provision of services. The consultation aimed: to identify problems faced by service providers both in reaching target groups and in implementing services in order to find common sources for the above problems; to find solutions for easing the inequalities in access that could be shared across different European organisations; and finally to formulate conclusions and pointers for EU and national-level policymakers in improving provision of services for young people. The questionnaire that was used (which was available in 15 languages) is included in the Annex. The development of the questionnaire was supported by a range of European umbrella organisations. Eurofound is grateful for their time and support in improving and making the consultation possible.[2]

The report finishes with conclusions and policy pointers for a range of stakeholders: service providers, policymakers and the EU.

Selection of case study initiatives in five countries

Five EU countries were selected for inclusion in the review of initiatives. The geographical dimension was taken into account as well as the mix of the welfare systems. In addition, various social exclusion and health indicators (people at risk of poverty and social exclusion, severe housing deprivation, people with a long-standing health problem, school-related anxiety and bullying) were considered, and selection was based on the prevalence of these problems and how they affect young people. The five countries chosen were Bulgaria, Estonia, Finland, France and the UK.

In each country, three case studies of services that target information and support towards young people in general were selected. Particular attention was paid to case studies that targeted disadvantaged young people: for example, young people with disabilities or mental health problems, or transgender or homeless young people. While the selected services cater to persons aged 12–24, particular attention was paid to young people aged 12–18.

Three semi-structured interviews were conducted per case study. The interviewees were chosen to represent the different perspectives of service directors or managers, staff involved in service delivery and service users.

Table 1 provides a brief description of the 15 initiatives that were selected. These are categorised according to the main issues tackled by the organisation: health and well-being, mental health and housing-related issues. The main problems dealt with in these case studies are teenage pregnancy, crime victims and bullying, mental health problems, homelessness and drug abuse.

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1   Details are available on request from Eurofound (email: information@eurofound.europa.eu).
2   The following EU and national-level organisations were consulted in developing the questionnaire and supported participation in this consultation: Council of European Municipalities and Regions (CEMR), European Association of Service Providers for Persons with Disabilities (EASPD), European Youth Information and Counselling Agency (ERYICA), European Social Network, Eurochild, European Federation of National Organisations Working with the Homeless (Feantsa), Mental Health Europe, National Youth Council of Ireland, National Network for Children Bulgaria, and the Association of Estonian Open Youth Centres.

Table 1: Description of the case studies

Issues	Description	Country
Health and well-being	The Young Parenthood Programme is a peer-to-peer education scheme active in selected London schools for pupils aged 12–19. The scheme is run by Coram, an NGO. Young parents visit schools to talk to students about their experiences. Discussions are interactive and include information on the realities of being pregnant, financial situations, housing and relationships. Discussions also cover sexual health and consent.	UK
	Life by the Kilo is an initiative aiming at the prevention of eating disorders among students aged 12–18. The goal is to provide young people with appropriate and understandable information so that they can recognise the factors leading to eating disorders and react adequately in risk situations.	Bulgaria
	Instants Santé Jeunes offers young people a general health check-up by a family doctor. In order to increase take-up by young people, MSA (the social security agency for the agricultural sector) offers a voucher worth €30 to be spent on sports-related products and services for young people who attend a medical consultation.	France
	Fil Santé Jeunes provides remote health services, prevention and support, to young people aged 12–25, especially those in rural areas. It runs a hotline service provided by a team of adults with complementary professional expertise (physicians and psychologists). There are also forums moderated by professionals where young people can interact with each other.	France
	The Estonian Sexual Health Association (ESHA) is an organisation aiming to develop and provide information and services for young people related to sexual health. It provides online sexual health counselling and information resources about sexual and reproductive health via the web platform Amor.ee. All services and information are free of charge and available in both Estonian and Russian.	Estonia
	The municipality of Inkoo's contraceptive care service is a consulting service where young men and women (up to the age of 25) can get answers to their questions about contraceptive care. The service also offers advice about how to start a family, sexually transmitted diseases, sexual difficulties and pregnancy.	Finland
Mental health	The Single Step Foundation was established in order to provide support services to LGBTQI (lesbian, gay, bisexual, transgender, queer and intersex) young people and their families and friends while the young person is in the process of recognising, accepting and affirming their sexual orientation and gender identity. The services provided include online chat, a hotline, an LGBTQI community centre and awareness-raising campaigns.	Bulgaria
	The Prevention and Information Centre on Drug Addictions is a specialised centre which focuses on preventive activities (educational programmes, workshops, counselling and a website) related to the use of narcotic substances. Services are available for the whole population of Sofia, but reach out specifically to vulnerable groups such as students between 12 and 15, young people from specialised institutions and marginalised young people from ethnic minorities.	Bulgaria
	TORE is a youth association specialising in the promotion of friendly, safe, supportive and tolerant school environments. It trains 'support students' – young people aged 12 and over – who offer peer-to-peer assistance to schoolmates suffering from bullying or exclusion. They also intervene to stop conflicts at school and conduct seminars and activities to prevent bullying, drug use and other problems.	Estonia
	Carita Eesti provides support to young mothers and fathers (aged up to 24) to improve their parenting skills, further their personal development and cope better with daily tasks as well as motivating them to continue in education or look for a job. The services include individual assistance for young parents, childcare, lectures, food aid and the Young Mother's School.	Estonia
	Victim Support Finland (RIKU) is a service for young people who are victims of crime, consider themselves potential victims, have attempted a crime or are aware of crimes being committed. A website is available for victims who need counselling or legal advice. RIKU offers both practical advice and psychological support for victims.	Finland
Housing	Centrepoint provides support for homeless young people aged 16–25. Accommodation is available for up to two years, after which support continues to be available for a further six months to aid independent living. Alongside accommodation, other services are offered, such as health support (e.g. counselling) and development of life skills (e.g. one-to-one basic maths and English lessons, help with budgeting, work experience opportunities and advice to facilitate (re-) entry to education, training or employment). There is also information online for young people who are homeless or at risk of homelessness.	UK

Table 1: Continued

Issues	Description	Country
	The Albert Kennedy Trust is a youth homelessness charity aimed at young people aged 16–25 who identify as LGBTQI. The trust provides support to stay safe in a crisis, find emergency accommodation, access specialist support, develop skills and identify and achieve life goals. The main service is Purple Door, an early action service wherein LGBTQI young people can come to an emergency safe house where they are helped to access longer-term housing along with support related to employment, training and debt management in the hope that they will be able to live independently and be reunited with their parents.	UK
	AIVS (Agences Immobilières à Vocation Sociale) promotes access to privately owned rental housing for those with low income by offering a range of accompaniment services to tenants, which also serve to reassure landlords.	France
	La Fondation Abbé Pierre is an agency that focuses on supporting access to affordable housing for young people (all ages). Furthermore, the agency supports initiatives such as co-housing (in which young people get access to shared rental housing in exchange for conducting social animation activities in the neighbourhood) or intergenerational rentals (where young people are hosted by elderly people in exchange for help with daily chores).	France

1 | Social and health problems of young people

This chapter outlines the most common social and health problems faced today by young people aged 12–24 years. As very different problems can be found within this broad age group, efforts have been made to break down information according to two age cohorts: 12–17 and 18–24. This allows a more nuanced examination of the social and health issues experienced by young people, as these vary due to their stage of physical, cognitive and social development and, in turn, may require different interventions or support. For example, a 12-year-old is likely to cope differently with being bullied or having family problems than someone who is 24; thus, their support needs will also be different.

The chapter starts with a brief description of demographic changes in Europe, followed by an overview of socioeconomic and health determinants to give a picture of the current situation of young Europeans. The chapter then covers issues related to the household and the family unit. Based on this broad context, the chapter concludes with a description of the characteristics of young people who face the greatest social and health problems as well as inequalities in access to relevant services to address these problems.

Demographic changes

The EU population aged 12–24 declined by 10 million between 2011 and 2016, when it was approximately 72 million (Eurostat, 2016). The decline in the youth population applied to the majority of Member States during this period, with the largest fall in Poland (2.8 million), followed by Romania (1.9 million) and Spain (1.3 million). The exceptions were Denmark and the Netherlands, where the youth population slightly increased, and Austria, Luxembourg, Sweden and the UK, where the youth population remained stable (Figure 1). Looking separately at the two age groups for all EU countries in 2016, there were around 39.4 million young adults (18–24) while the younger cohort (12–17) was smaller at around 32.7 million.

There is a wide-ranging set of factors that have an impact on population change. One of the contributing factors may have been the impact of the economic crisis. The aftermath of the crisis made it difficult for many young people to gain economic independence – in some countries more than others. Consequently, some young people made use of their mobility to improve their

Figure 1: Youth population (12–24), by country, 2011 and 2016 (%)
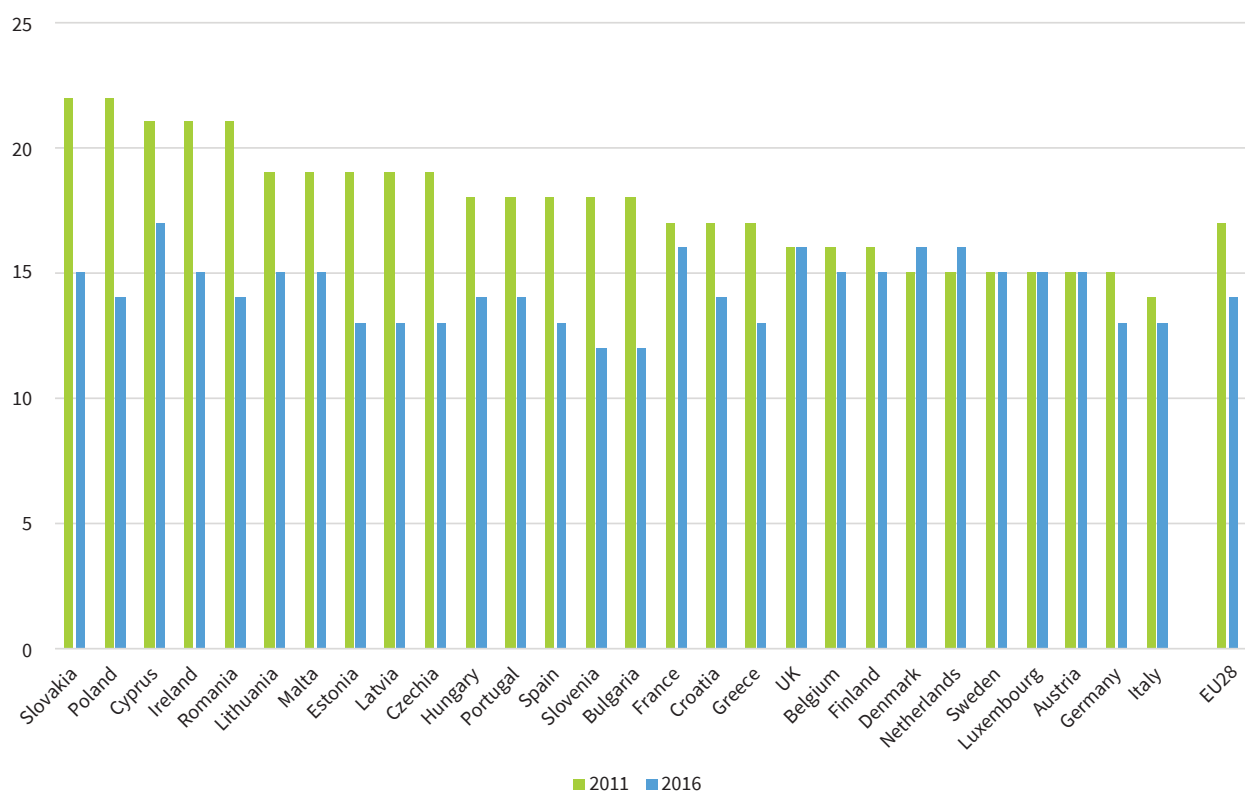
Source: Eurostat [demo_pjan]

socioeconomic status by moving to another EU country. It might be for this reason that receiving countries like Denmark and the Netherlands have had net gains in their youth populations.

Common social and health issues

When identifying common social and health issues among young people, it is important to keep in mind that these are often multifaceted and interlinked. For example, a person may experience social exclusion and poverty at the same time as they experience discrimination or marginalisation. Furthermore, whether or not an individual has the financial and social resources to obtain needed support may influence mental and physical health status, and vice versa.

Poverty, deprivation and social exclusion

Experience of poverty and deprivation has an impact on quality of life and is linked to a number of social and health problems facing young people. Social exclusion relates to the feeling of being disempowered and marginalised from participating in activities which are considered the norm in the mainstream. Experience of poverty, deprivation and social exclusion results in unequal participation in social, economic, civic and political spaces. Moreover, the type and extent of support young people need to overcome their social and health problems depends on factors such as experience of discrimination, education level, housing conditions, residence or legal status, poverty, health status and family background (Eurofound, 2015).

Young people's needs related to emotional or financial support can be addressed, at least partially, by family, friends or community members; other needs may require more formal assistance. In the latter case, the availability of information and support services and having the opportunity to access these services are crucial to the well-being and personal and social development of the young person. While aiming to avoid stigmatising young people on the basis of certain characteristics, it is important to understand the linkages among various determinants.

According to Eurostat, in 2016 in the EU, 29% of the younger cohort (those aged 12–17) were at risk of poverty and social exclusion. The figure for the older cohort (18–24 years) was higher still – 31% (Table 2). There were large national differences. The younger cohort was most at risk in Romania (52%) and Bulgaria (48%) and least at risk in Finland (12%) and Denmark (16%). The older cohort was most at risk in Greece (50%), Romania (46%) and Denmark (45%) and least at risk in Czechia and Malta (both 17%).

A related measure is the share of young people experiencing severe material deprivation. As with the risk of poverty and social exclusion, there are large differences between countries. For 2016, the lowest rates of severe material deprivation were reported in Austria, Denmark, Finland, Germany, Luxembourg and the Netherlands (both age groups in each country having rates under 5%), and the highest rates were reported in Bulgaria (39% for the younger group and 35% for the older group). It was also in Bulgaria where the gap between the two cohorts was greatest (Figure 2).

Being at risk of poverty and social exclusion and living with severe material deprivation are indicators of harsh living conditions. However, in order to comprehensively review the main social and health problems facing young Europeans, it is important to also take into account their subjective views on social exclusion.

Between 2011 and 2016 the perception of being socially excluded decreased among those aged 18–24 in the EU. The greatest improvements were noted in Cyprus and Estonia; in addition, in 2016, perceived social exclusion tended to be lower than the EU average in northern and western European countries (14 in total) (Figure 3).

Much has been written about the ongoing social and employment impacts of the economic crisis on young people in particular, as this group has been disproportionally affected by the economic downturn. The Youth Eurobarometer in 2016 asked young people aged 16 to 30 whether they felt marginalised by the economic crisis. Figure 4 shows that in 20 Member States more than half the people surveyed felt marginalised by the economic crisis. The highest levels were reported in Greece (93%), followed by Portugal (86%), Cyprus (81%), Spain (79%) and Croatia (78%), all countries which experienced severe recession. Feeling marginalised by the economic crisis might foster the perception of a less prosperous future with limited possibilities; in turn, this impact on life aspirations and attitudes may lead to poorer mental well-being and unhealthy lifestyles.

Homelessness

One of the key challenges of the Europe 2020 strategy is to provide housing for everyone – a challenge that a large number of Member States are grappling with. The European Commission's 2010 report on social protection and social inclusion acknowledges that being without a roof or having to live in emergency shelters or temporary accommodation are the most extreme forms of poverty and social exclusion (European Commission, 2010b). According to a recent European Parliament study, 'homelessness is no longer the fate of middle-aged men with long-standing social problems, but also affects families, young people and migrants' (European Parliament, 2016, p. 1).

There are no comparable statistics for all EU countries regarding homelessness among young people, but the limited data for some countries available from the European Federation of National Organisations Working with the Homeless (Feantsa) shed some light on the topic (Table 3).

A number of factors are deemed to have played a role in the rise of youth homelessness (see Table 4). In the context of this study, key factors include: the aftermath of the financial crisis of 2008; cultural factors, such as leaving the parental home at an earlier stage of life; and deregulated housing markets.

In relation to housing markets, often young people with low monetary resources do not possess the necessary means to compete and many struggle to find affordable housing. For those young people who are in precarious work, paying market rents may be a challenge, and

Table 2: Young people at risk of poverty and social exclusion, by country and age group, 2011 and 2016 (%)

	2011		2016	
	Age 12–17	Age 18–24	Age 12–17	Age 18–24
Austria	18	18	19	24
Belgium	23	20	23	26
Bulgaria	53	49	48	44
Croatia	30	35	31	28
Cyprus	25	25	31	30
Czech Republic	22	18	18	17
Denmark	17	39	16	45
Estonia	29	29	26	22
Finland	15	31	12	31
France	25	29	25	29
Germany	21	24	20	24
Greece	34	40	45	50
Hungary	42	37	36	33
Ireland	38	42	31	32
Italy	34	34	36	36
Latvia	46	44	30	27
Lithuania	39	38	35	33
Luxembourg	22	21	26	30
Malta	32	21	27	17
Netherlands	19	27	20	29
Poland	34	29	29	29
Portugal	35	27	33	29
Romania	50	45	52	46
Slovakia	27	23	24	22
Slovenia	19	17	17	20
Spain	36	31	39	40
Sweden	18	28	22	33
UK	28	29	28	28
EU28	**29**	**30**	**29**	**31**

Source: *Eurostat [ilc_peps01]*

Figure 2: Severe material deprivation rate, by country and age group, 2016 (%)
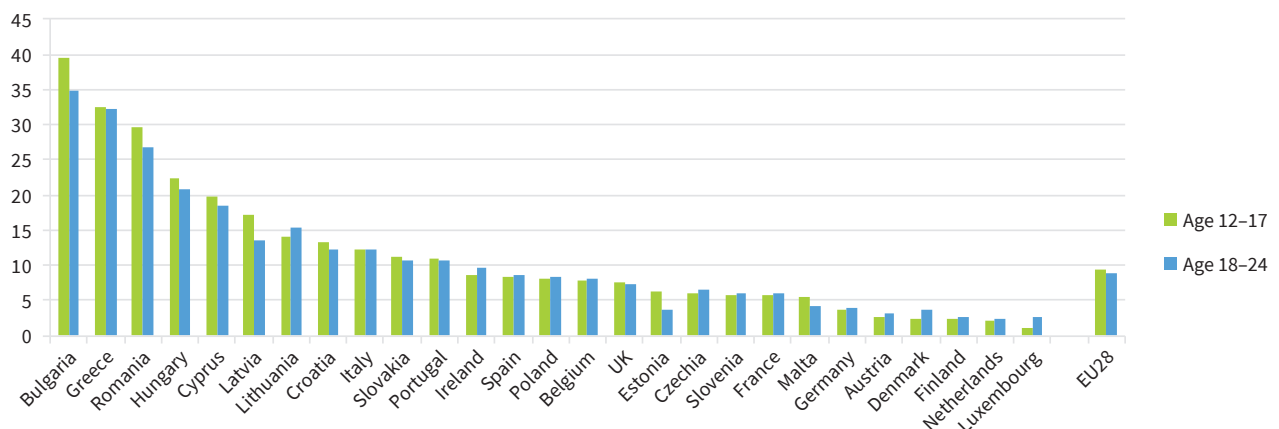
Source: *Eurostat [ilc_mddd11]*

Figure 3: Perceived social exclusion index, 18–24 years, by country, 2011 and 2016

Source: *EQLS 2016*

Figure 4: Feeling of marginalisation due to economic crisis, 16–30 years, by country, 2016 (%)
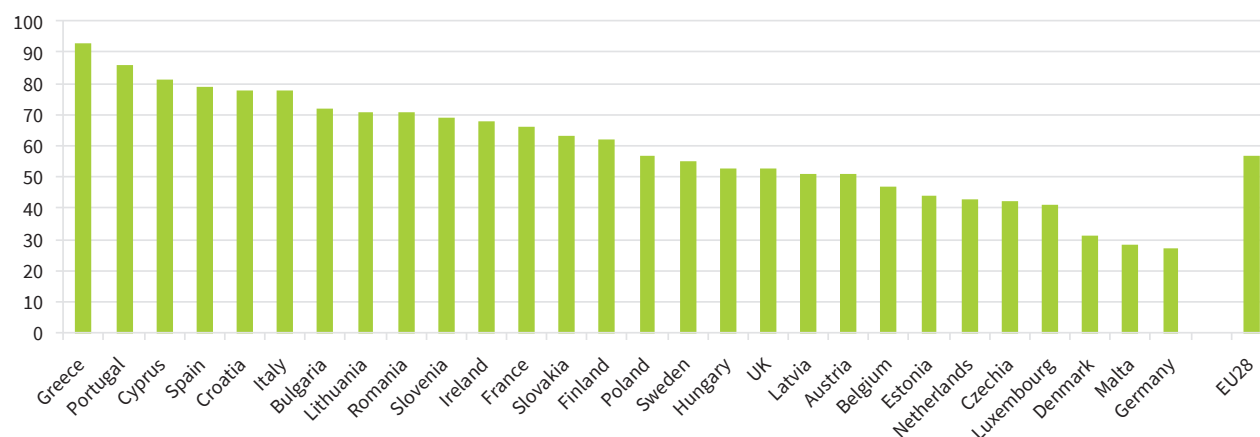
Source: *European Youth Eurobarometer 2016 (85.1), QA5.*

interruption of housing contracts by landlords can in some cases lead to homelessness.
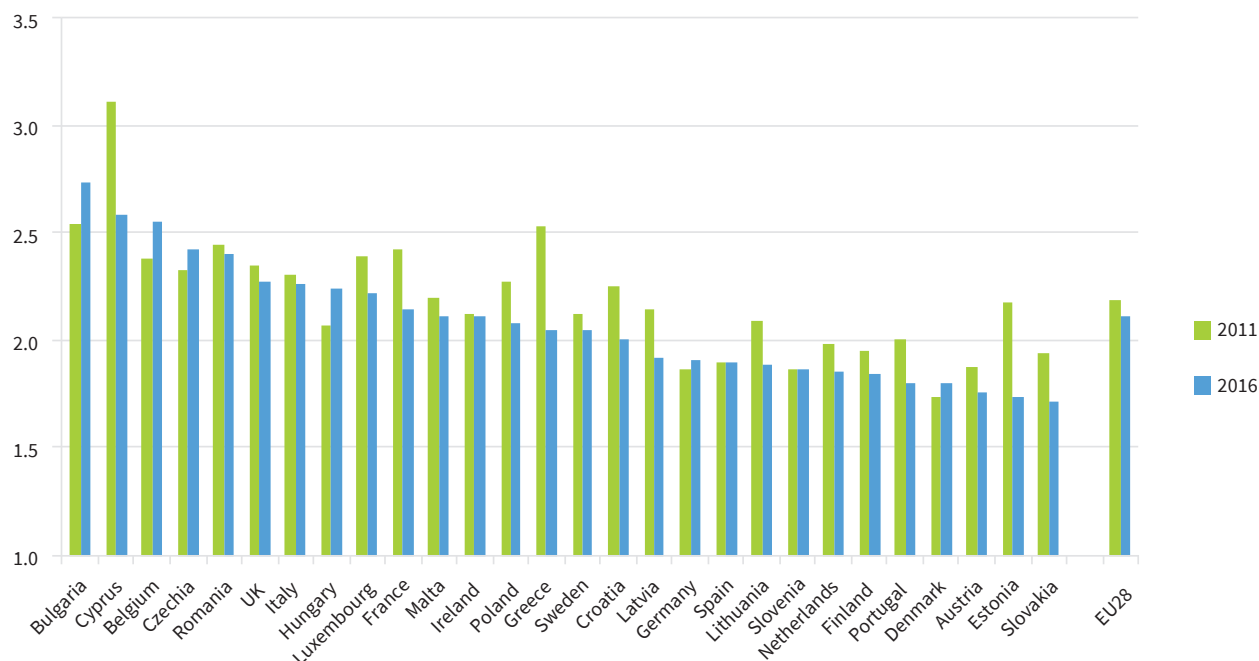
Another important cause of young people becoming homeless is lack of strong family ties. This may happen for different reasons: lack of family network support because of the death of parents or their addiction or alcoholism; dysfunctional families where parents have difficulties supporting young people in their growing up; or family ruptures that lead to expulsion from the family home, which may involve violent or problematic behaviour by the young family members (Markovic et al, 2015). Particularly exposed to such situations are young LGBTQI people who are not accepted by their families.

Similarly, young people who have grown up in care institutions are quite vulnerable, especially when they reach adult status and lose the protections granted to children.

A serious problem associated with young people sleeping rough is that they are often affected by mental health issues, which may become more severe with the prolongation of this living situation (Young, 2010). It is also the case that support is not always available to young people affected by or at risk of homelessness: according to UK research, up to one in three young people asking for help from local councils were turned away, often due to austerity cuts (The Independent, 2016a).

Table 3: National statistics and issues regarding youth homelessness

Country	Increase in youth homelessness	Issues related to homeless children (under 18 years)
Denmark	There was an 85% increase in homelessness among the 18–24 age group between 2009 and 2015	
France		There were 30,000 homeless children registered in 2012; 30% of people in homeless accommodation were children, making this the largest age group
Ireland	There was a 78% increase in homelessness among the 18–24 age group between 2016 and 2018	More than one in three homeless people is a child.
Netherlands	There was a 50% increase in homelessness among the 18–30 age group as counted in the 2016 census compared to 2015	There were 4,000 children registered homeless with local authorities in 2018, a 60% increase compared to 2013.
Sweden		Between 10,000 and 15,000 children were homeless in April 2017; there was a 60% increase in children in emergency accommodation between 2011 and 2017.

Source: *Feantsa and Fondation Abbé Pierre (2018)*

Table 4: Main risk factors and triggers for youth homelessness

Risk factors	Triggers
Family disputes and breakdown	Leaving the parental home after arguments
A history of state care	Leaving care
Sexual or physical abuse in childhood or adolescence	Leaving prison
Offending behaviours and/or experience of prison	Increase in alcohol or drug misuse
Lack of social support networks	Eviction from rented accommodation
Debts, especially rent arrears	Family breakdown
Drug or alcohol misuse	
School exclusion and lack of qualifications	
Mental health problems	
Poor physical health	

Source: *Maycock et al (2010), pp. 4–6*

Inadequate family and social networks

Family, friends and social networks have significant influence on a young person's behaviour and life opportunities. The quality of these relations are important factors for the young person's well-being, their perception of their own life and their experience of being socially integrated as well as their social and emotional development (Ikesako and Miyamoto, 2015). The social components of feeling accepted, understood and supported are central here. Equally significant is the extent of financial, emotional and informational support in the social setting. Growing up with strong family ties allows the development of coping strategies to handle stressful situations and furthers communication skills, enabling the young person to express a need for support if it is needed. Receiving advice from someone who is trusted about serious personal or family matters may be vital to feeling accepted, supported, understood and socially included. Therefore, it is evident that lack of strong family and community ties may jeopardise self-esteem and social confidence, which are essential for the maintenance of mental health and well-being.

The types of social networks young people turn to when seeking advice differ across the EU. The EQLS 2016 provides some findings for 18- to 24-year-olds regarding this source of support. If they needed advice about serious problems, the majority of young Europeans (65%) sought support from their immediate families rather than from a friend, neighbour or other relative. Family support was most important in Slovakia (87%) and Lithuania (83%). On the other hand, in Germany younger people felt more comfortable seeking support from someone outside the family (53%). On average across the EU, only 1% of young people said they had nobody to turn to for advice; this was most common in Czechia (8%).

Furthermore, the type of advice a young person is seeking may determine the person they would turn to. The young person may not wish to discuss certain personal or family matters with someone they are close to; for instance,

sensitive issues related to gender identity or sexual orientation (see Chapter 2 for further findings on sources of support). In such cases, public service provision may be vital to fill support or information gaps. Peer-to-peer support might be particularly effective as peers can share similar experiences.

In addition to having someone to turn to when advice is needed, the extent to which the young person feels supported and taken care of is important. The need for family support varies over the teenage years, and where there are good family ties, based on trust and emotional closeness, family members might respond more flexibly to the young person's changing circumstances. Alternatively, fragile and insecure family relations might cause tensions in the teenager–family relationship. Findings from research by the Programme for International Student Assessment (PISA) in 2015 show how 15-year-olds perceived their parents' support in terms of education and confidence (Figure 5). Overall, the majority of these young people felt supported by their parents, with 90% reporting that their parents encouraged them to be confident and 94% reporting that their parents supported their educational efforts and school activities. In 15 of the 25 Member States represented in this survey, the share of 15-year-olds with parental support in relation to confidence was below the EU average. The lowest proportion was found in Latvia (with 82% reporting support), followed by Czechia (83%) and Estonia (85%). At the opposite of the scale were the Netherlands, Ireland and Portugal (all 95%).

Psychological well-being and physical health

Becoming an adult means coping with many changes, physically and psychologically. Fundamentally, the

ways in which young people adjust to these changes influence their development of self-esteem, their degree of intellectual and emotional independence and their self-concept (Steinberg, 2005). Many factors influence an individual's health status. These include quality of living conditions, income and education levels as well as health behaviours and social relationships.

In relation to young people's health, some issues are specific to young people, as in the case of eating disorders, with anorexia and bulimia particularly affecting young girls. Others are common to all age groups but are of particular concern when they impact on young people, who are in a transition phase of life, characterised by instability.

Psychological well-being

Mental health concerns the degree to which an individual is capable of handling life stressors (WHO, undated). Topics discussed earlier, ranging from demographic shifts to being at risk of poverty and social exclusion or living in a socioeconomically deprived context, can cause feelings of insecurity (towards personal, housing, employment and income situations) and affect mental well-being (Eurofound, 2017). The reported increase of psychosomatic symptoms related to poor mental health, such as anxiety, sleep disruption, drowsiness or other stress-related warning signs, as well as the rising numbers of young people in hospital for depression illustrate a growing problem (The Independent, 2016b).

One extreme coping mechanism involves self-harming. In the UK a recent Children's Society survey covering 11,000 14-year-olds found that one-quarter of girls and nearly 1 in 10 boys had self-harmed in the previous year. Experts attributed the behaviour to a combination of pressure from school, gender expectations and austerity.

Figure 5: Perceived parental support, 15 years, by country (%)
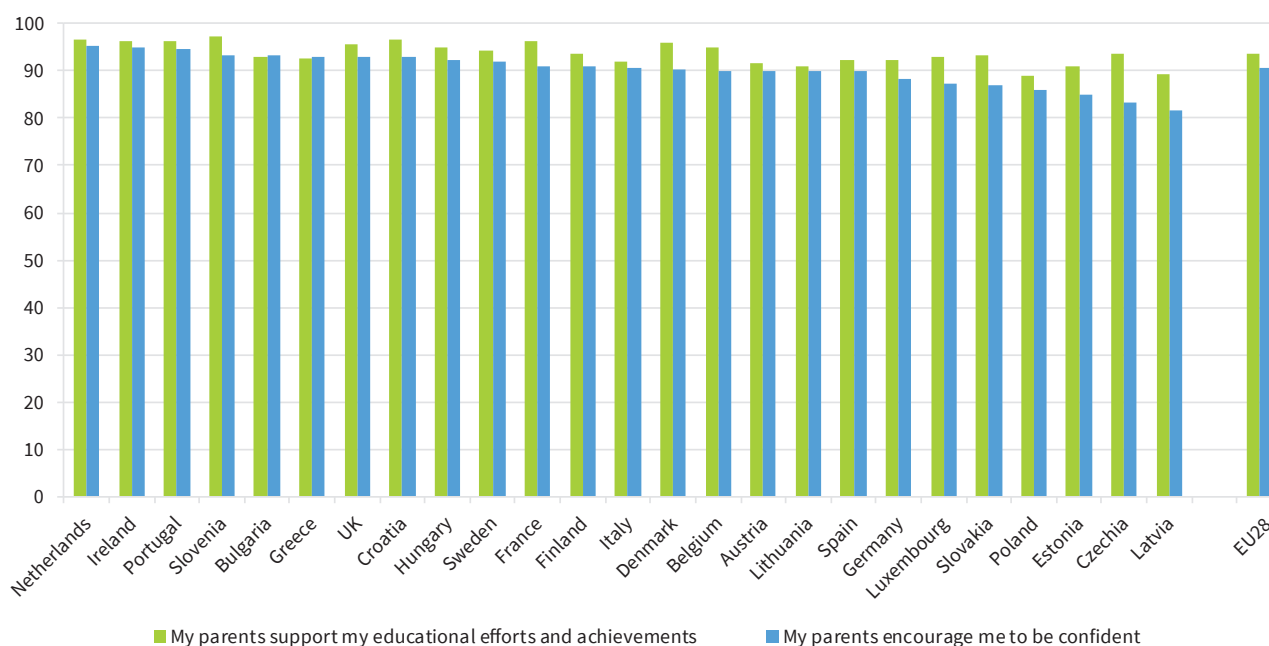
Note: *Cyprus, Malta and Romania were not included in the survey.*
Source: *OECD (2017)*

The charity also analysed data from the Millennium Cohort Survey, carried out by researchers from University College London, which follows children born in the UK in 2000–2001. Nearly a quarter (24%) of this sample reported hearing jokes or comments about other people's bodies or looks all the time, while more than a fifth (22%) of those in secondary school said jokes or comments were often made about people's sexual activity. Both made girls feel much worse about their appearance and less happy with their life as a whole, but this pattern did not apply to boys (Children's Society, 2018). Figure 6 presents results from two surveys, one relating to risk of depression among young people aged 18–24 (EQLS 2016) and the other relating to experience of chronic depression among young people aged 15–24 (European Health Interview Survey – EHIS – 2014).

Data for 2016 indicates that 14% of Europeans aged 18–24 were at risk of depression. Across the EU, young Swedes were most at risk of depression (41%). It is interesting that Sweden was the only country where young people (18–24 years) were less likely than older citizens to report optimism about their future (EQLS 2016). The second-highest proportion of young people at risk of depression was found in Estonia (27%), followed by Malta (22%), the Netherlands (21%) and the UK (20%).

As would be expected, experience of chronic depression among young people was lower than the rate of being at risk of depression. Data for 2014 shows that 4% of those aged 15–24 were chronically depressed. The highest proportion of young people reporting chronic depression was found in Ireland (12%), followed by Finland (11%), Sweden (10%) and Germany (9%).

Gender is an important factor in depression, and Figure 7 shows that in the majority of Member States young women aged 15–24 were more likely to suffer from depression than young men. The greatest gender gaps were in Denmark, Germany, Ireland and Sweden. Only in Cyprus, Greece and Lithuania were there higher percentages of young men with depressive symptoms. There are also indicators that young women are more likely to handle upsetting events internally – a factor linked to depression. These include higher rates of self-harm and eating disorders such as anorexia or bulimia among this group compared to young men.

Young people's risk of depression is strongly linked to socioeconomic status. Figure 8 shows that during 2011 and 2016 young people living in households in the lowest income quartile were more likely to be at risk of depression than those in higher quartiles (though this was not the case for 2007, when risk was highest in the second-lowest quartile). However, the differences in risk in the top three quartiles for 2011 and 2016 were not that large; nor are they easy to explain. The data also show that the overall proportion of young people at risk of depression increased from 16% to 19% between 2007 and 2011 (in the surveys before and after the economic crisis). There was an improvement between 2011 and 2016, from 19% to 14%, taking the risk level to below pre-crisis levels. This was the case for risk in all quartiles apart from the lowest, which saw improvement from 2011 but with risk remaining higher than the pre-crisis level.

Physical health

PISA 2015 looked at the frequency of participation in moderate and vigorous physical exercise outside school among 15-year-olds (Figure 9). Young people in Denmark and Poland participated in vigorous physical activity outside school most frequently (on 4.6 and 4.4 days per week, respectively). At the other end of the scale, young people in Austria, France and the UK were involved in vigorous physical activity least often (on fewer than 3.5

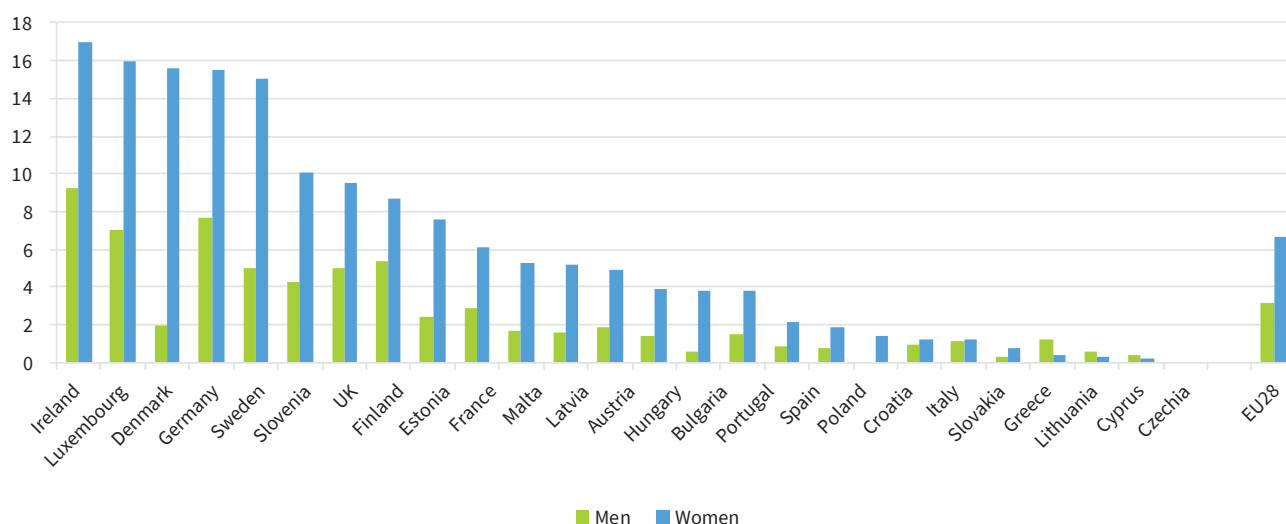### Figure 6: Risk of depression (18–24 years, 2016) and reported chronic depression (15–24 years, 2014), by country (%)
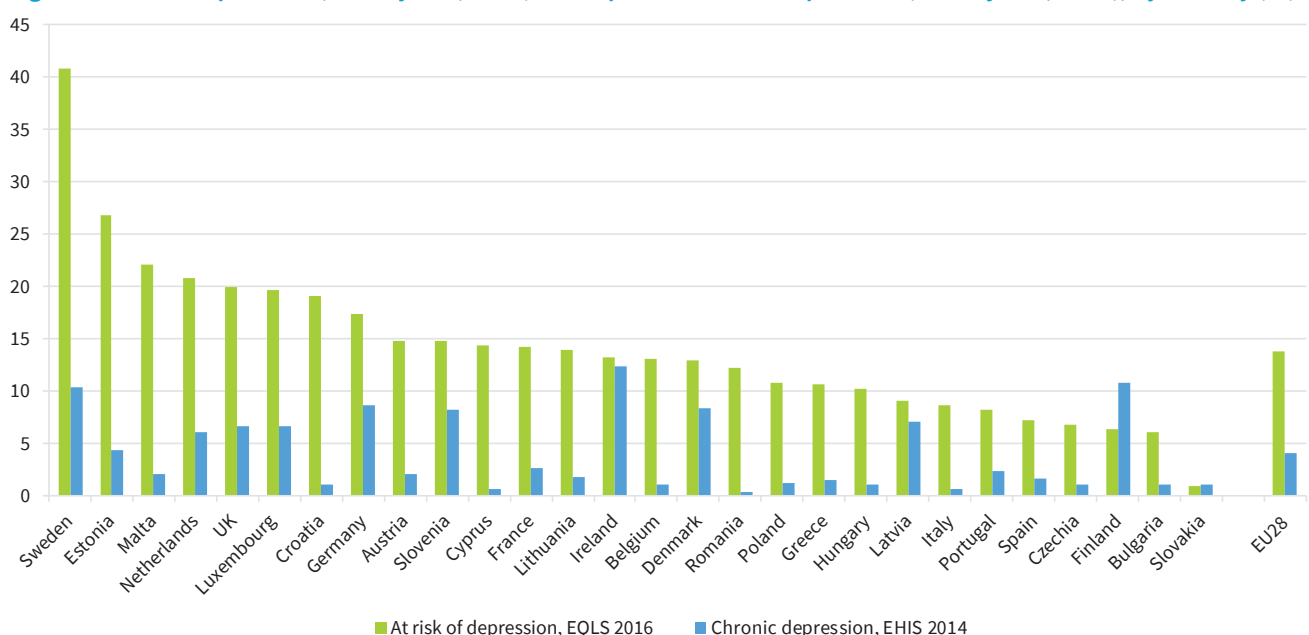
Note: *'At risk of depression' is based on the WHO-5 index in EQLS 2016 (ages 18–24). (The index is a self-reported measure of current mental wellbeing). 'Reported chronic depression' is in the EHIS 2014 (ages 15–24).*
Source: *EQLS 2016, Eurostat [hlth_ehis_cd1e]*

Figure 7: Incidence of moderate to severe depressive symptoms, by country and sex, 15–24 years, 2014 (%)

Source: *Eurostat [hlth_ehis_mh2i]*

Figure 8: Risk of depression by income quartile, 18–24 years, 2007, 2011 and 2016 (%)
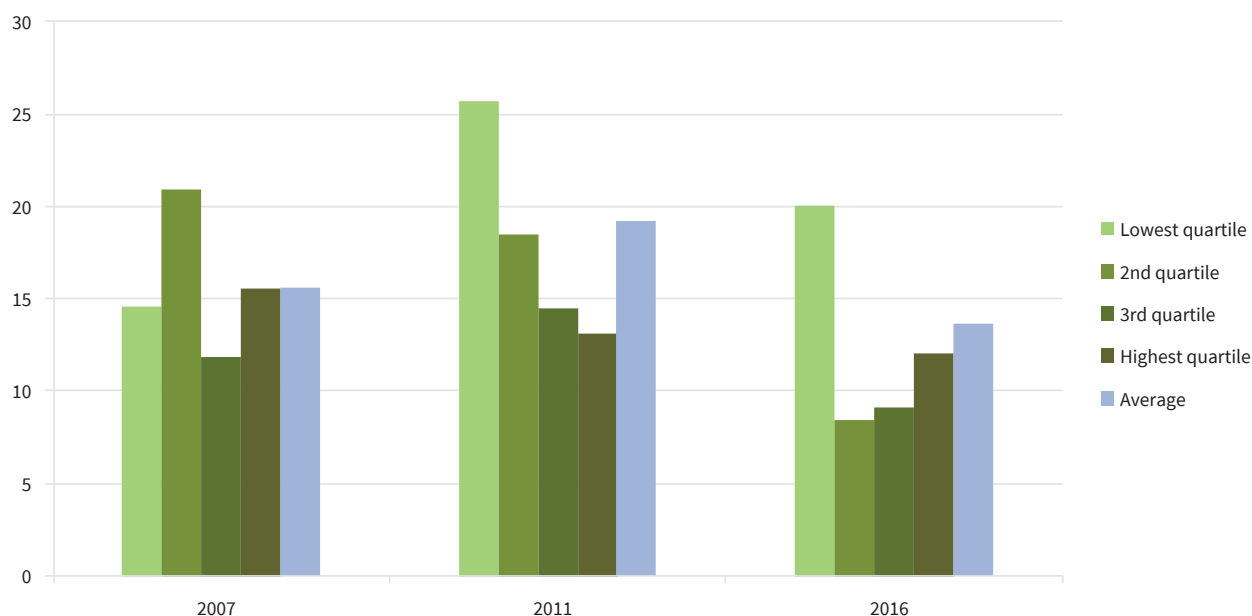
Note: *'At risk of depression' is based on the WHO-5 index in EQLS 2016.*
Source: *EQLS 2016*

days per week). In terms of moderate activity, young people were most often active in Denmark, Germany, the Netherlands and Poland (on 5.6 days).Moderate activity was undertaken least often by young people in Greece, Luxembourg, Portugal and Spain (on fewer than 4.5 days).

Obesity is a health issue of growing concern, particularly as it is more common among young people from less affluent families (OECD, 2018). According to the World Health Organisation (WHO) survey on Health Behaviour in School-aged Children (HBSC) in 2014, 6% of Europeans aged 15 were overweight or obese. The highest levels of obesity were observed in Bulgaria, Greece, Malta and Wales (in the UK). There were clear gender differences too, with young men having higher rates of obesity compared to young women in all participating countries (Figure 10).

The greatest gender gaps can be observed in Bulgaria, Greece, Hungary, Italy and Poland.

Serious eating disorders, such as anorexia and bulimia, are traditionally more common among young women. However, increasingly, boys and young men are being affected by these disorders (Micali et al, 2013). The symptoms of both disorders include social isolation, low self-esteem, sexual apathy and other problems related to physical and mental health. In the worst cases, these disorders can lead to death, and anorexia has the highest mortality rate among all psychiatric disorders for young people (European Youth Portal, 2013).

Sexual health among young people has multiple dimensions. While sexual health encompasses the positive development of sexual behaviour and identity, it also takes

Figure 9: Physical exercise outside school, 15 years, by country, 2015 (number of days per week)

■ Moderate physical activities for at least 60 minutes per day

■ Vigorous physical activities for at least 20 minutes per day that made you sweat and breathe hard
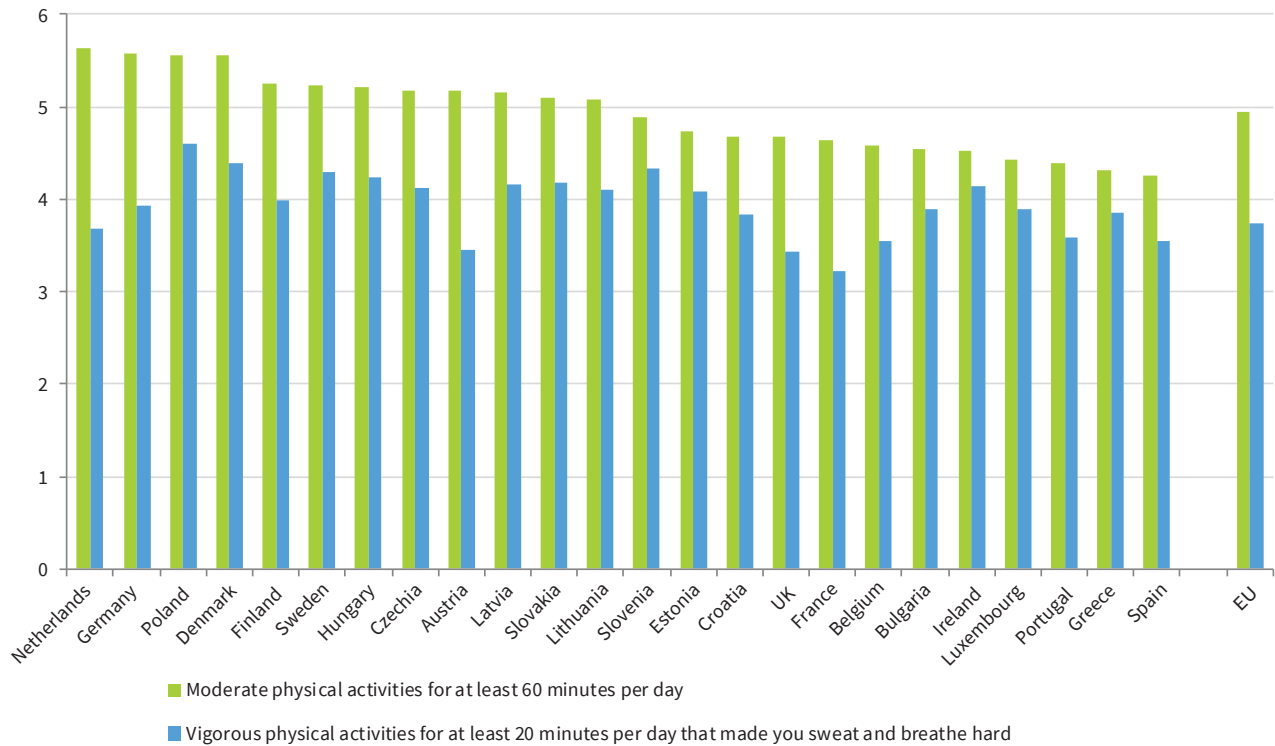
Note: *Cyprus, Italy, Malta and Romania were not included in the survey.*
Source: *OECD (2017)*

Figure 10: Incidence of overweight or obesity, 15 years, by country, 2014 (%)

■ Women ■ Men
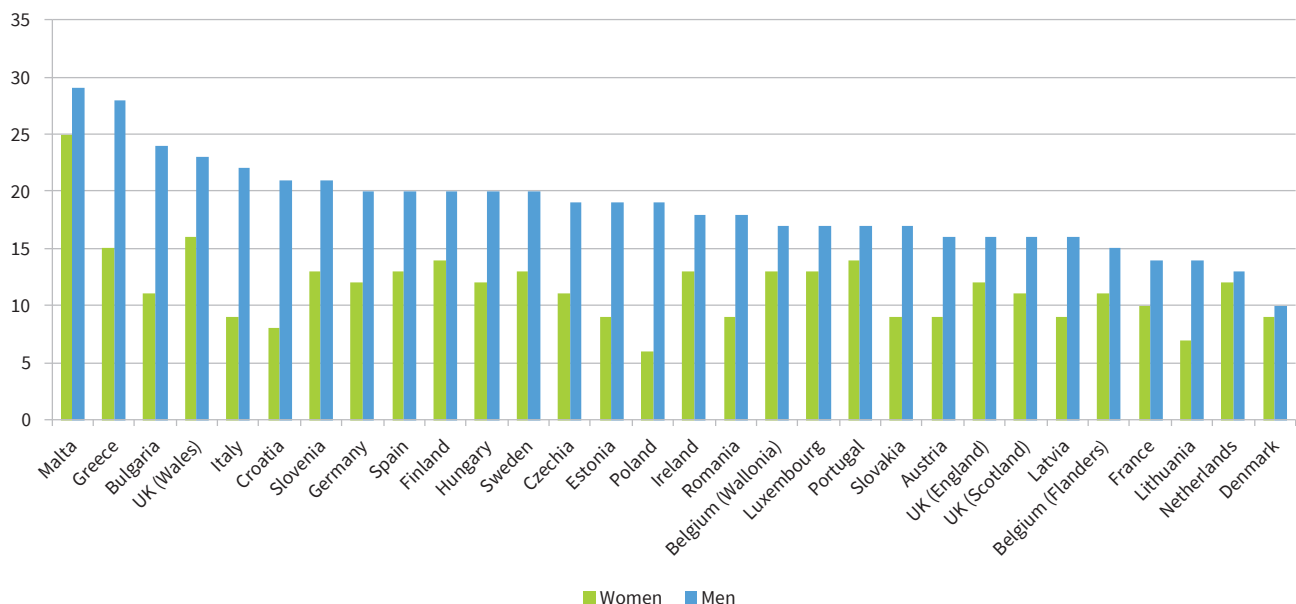
Source: *HBSC 2014*

in a range of problems. One issue is lack of knowledge of, for example, the dangers associated with sexually transmitted diseases and teenage pregnancy.

Teenage pregnancy bears high costs for the young people involved. It is associated with a range of adverse health and social outcomes: teenage mothers are less likely to complete secondary school; they more frequently access

social benefits and are at higher risk of poverty and social exclusion; and they may have physical health issues or psychological difficulties, including behavioural issues (Markovic et al, 2015).

Eurostat data for 2015 shows that the highest rates of teenage pregnancy (among those aged 15–19) were recorded in Bulgaria and Romania (3.9% and 3.5%,

respectively), with these countries having a prevalence three times higher than the EU average of 1.1% (Figure 11). Pregnancy rates were also highest in these two countries for young women aged 20–24. As Figure 11 shows, teenage pregnancy was also notably above the EU average in Slovakia (2.4%) and Hungary (2.3%).

Most EU countries have witnessed declines in teenage pregnancy since 2010, the exceptions being Bulgaria, Czechia, Hungary, Latvia, Lithuania and Romania. An interesting case is the UK, which had the highest teenage pregnancy rate in Europe in the 1990s. Between 2000 and 2014, the rate has halved. This is due to a range of factors including young people staying in education longer and better access to contraception, but also a new strategy and a media campaign on sex education that was launched in 2000. In particular, more money was spent on tackling this issue in more deprived areas, which then saw the greatest declines. This is clear evidence that policy can play a particularly effective role in reducing teenage pregnancy; even so, this issue still does not seem of particular importance in national policymaking in many EU countries.

A separate issue related to sexual health involves gender identity issues. Despite growing awareness, there is still a lack of adequate service provision for transgender persons. Although facing greater risks in relation to social isolation, depression, bullying and self-harm, young transgender people are often excluded and misunderstood by mainstream health services. The need for sex education is also likely to be greater for this group.

Bullying

Bullying and cyberbullying can have severe consequences, both acute and long-term, for young people – for the victims as well as for the aggressors. These behaviours often occur among peers in settings with minimal adult surveillance (WHO HBSC Survey, 2013). Bullying is not a clearly defined concept but can be described as reoccurring psychological or physical harm caused by

tyrannical behaviour of a powerful person over a weaker person (Farrington, 1993). Being bullied implies being at risk of developing emotional and/or behavioural problems, which may trigger feelings of hopelessness and loneliness, impair ability to make friends, lead to underachievement in school or dropping out of school, or increase physical health symptoms or substance abuse.

Figure 12 shows findings from the HBSC surveys in 2010 and 2014 on the prevalence of bullying among young people aged 10–16. Bullying was most common in the Baltic states and among the French-speaking community in Belgium. Notably, in the four years between these surveys, there was an increase in bullying in Latvia, though small decreases were found in Estonia and the French-speaking community in Belgium (Lithuania has data for 2010 only). The largest increases in bullying were reported in the UK (in Scotland and Wales, specifically). Meanwhile, bullying was comparatively uncommon in Czechia, Italy and Sweden, and the most significant decrease took place in Romania.

Overall, boys and girls experience bullying at similar rates, with boys just slightly more likely to experience regular bullying than girls: this was reported by 12% of young men and 10% of young women in 2010, and 11% of young men and 10% of young women in 2014. However, there were greater differences in some countries. In the French-speaking community in Belgium, 25% of young men experienced bullying regularly compared to just 16% of young women. Similarly, young men were bullied more often in Austria, Malta, Poland, Romania and Slovakia. On the other hand, Scotland was the only country where young women were more likely to be bullied than young men (15% compared to 12%).

Related to bullying is the growing issue of cyberbullying. Data are still scarce, but some insight is provided by the Net Children Go Mobile project carried out in eight countries, co-funded by the European Commission. A total of 3,500 children (aged 9 to 16) were asked about access,

Figure 11: Rate of pregnancy among young women, by age group and country, 2015 (%)
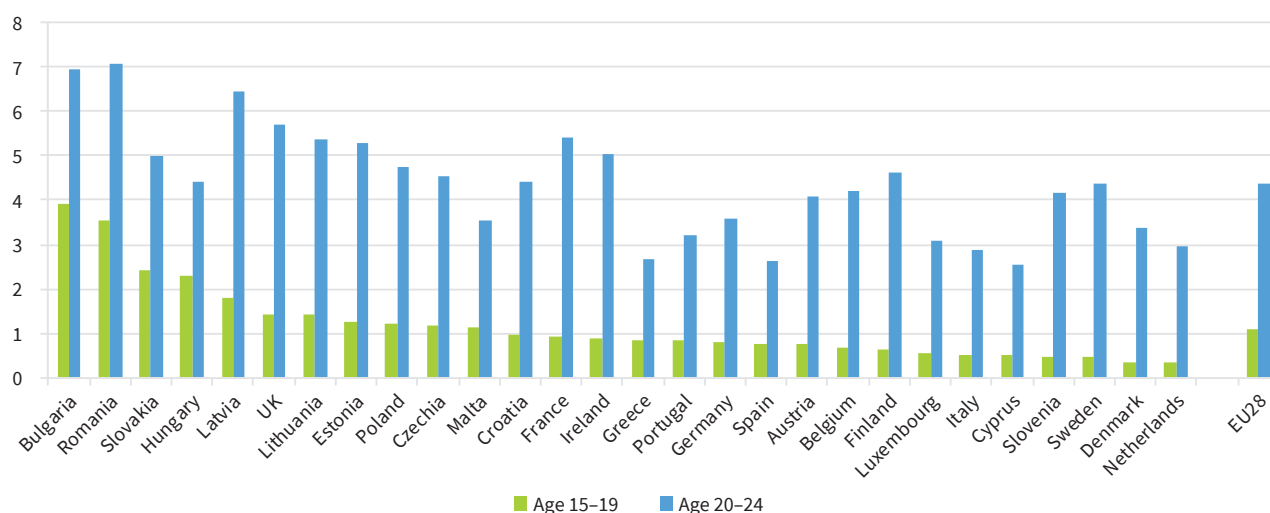
Source: *Eurostat [demo_frate]*

Figure 12: Experience of regular bullying, 10–16 years, by country, 2010 and 2014 (%)
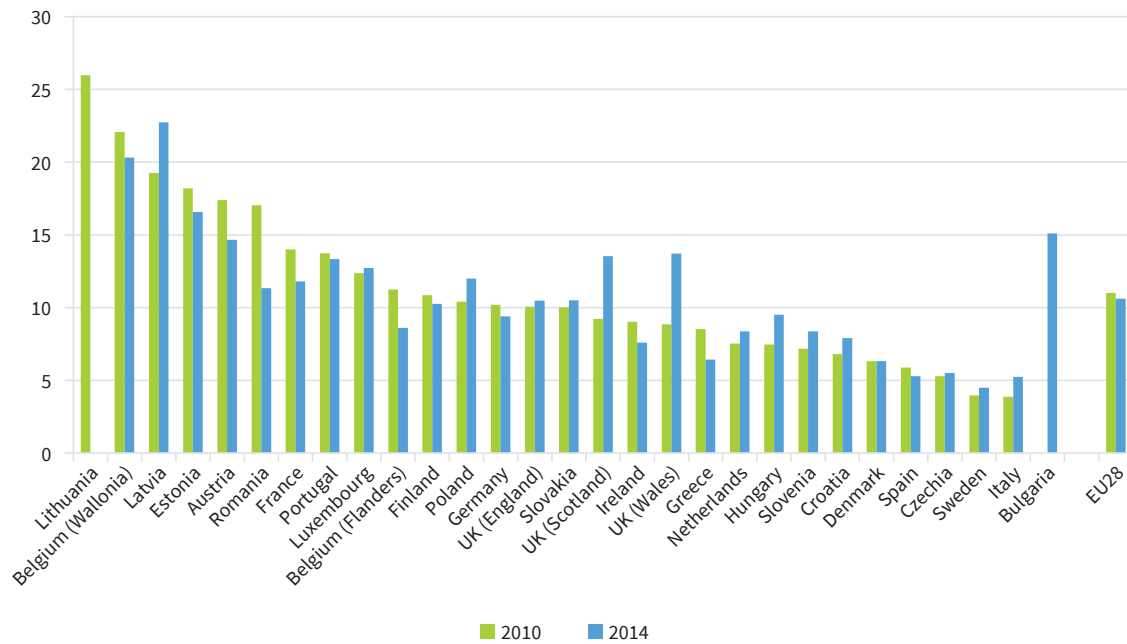
Note: *Percentages indicate the prevalence of bullying experienced in the two months prior to the survey.*
Sources: *HBSC 2010, 2014; Eurofound calculations*

use, opportunities and risks of smartphones for children. Findings indicate that between 2010 and 2014 there was a rise in those being cyberbullied from 7% to 12%. (Discussion of self-harm also increased, as did the posting of hate messages.) There was a strong gender dimension, with girls much more exposed to cyberbullying than boys (15% vs 8%).

The HBSC survey introduced a question on cyberbullying in 2014. Only 4% of young people overall reported regular cyberbullying. The highest rates were found in some eastern European countries as well as the UK and Ireland. While this survey found little difference overall between young men and women, there were exceptions in the UK and Ireland, where young women were cyberbullied more often (in line with the findings of a University of Sheffield survey), and in Bulgaria and Spain, where young men experienced more of this form of bullying.

Finally, the HBSC survey explored the risk of being bullied and of bullying others. Table 5 summarises the findings.

Young people who are being bullied are at increased risk of mental health problems, especially depression and anxiety, and more likely to undertake risky behaviours such as substance abuse. Those who bully others

Table 5: Risk of being bullied and of bullying others among young people aged 10–16

	Risk of being bullied	Risk of bullying others
Age	Being bullied reduces with age – the highest rate (12%) was found at age 11, decreasing to 8% by age 15	Bullying others was highest at ages 13 and 15 (both 8%)
Gender	Overall, young men and women were bullied at similar rates (11% and 10%, respectively)	Young men were more likely to bully others (10% vs 5% of young women)
Family financial security	Young people with a financially poor family background were more prone to being bullied across all countries and regions (18% vs 10% of those with greater family financial security)	Overall, young people with a financially poor family background were more prone to bullying (9% vs 7% of those with greater family financial security), though there was no such difference in 11 countries
Relationship between being bullied and bullying others	Those who were bullied were more likely to say they bullied others in the two months prior to the survey (25% vs 5% of those who were not bullied)	

Sources: *HBSC 2013/14: 197–205; own calculations*

are also at risk of long-term consequences, such as underachievement in school and criminal convictions. At greatest risk of mental health issues and of later substance abuse are those who have been bullied and have also bullied others, known as reactive victims (Smokowski and Kopasz, 2005).

Risky behaviours – drugs, alcohol and tobacco

Adolescence and young adulthood are seen by many as the time when young people may try new substances but do not necessarily become addicted to them in later life (Peele, 2007). Risky behaviours frequently occur together and, according to the literature, 'are all influenced by the same social factors: the level of deprivation and social exclusion, access to education, as well as living environment' (Raffo et al, 2007).

Figure 13 shows findings from the European Social Survey (ESS) 2014 on smoking and drinking among the 15–16 age group. Alcohol was commonly used, and the consumption motives ranged from wishing to create bonds with peers, peer pressure or coping with stress or negative emotions. Rates of binge drinking, involving consumption of large amounts of alcohol, were particularly high in Ireland (32%), the Netherlands (29%) and the UK (27%), while the lowest rates of binge drinking were found in Finland and Estonia (both 9%) and Hungary and Slovenia (both 10%). Frequent alcohol use (several times a week) was most common in the Netherlands and the UK (17% and 16%, respectively).

The European School Survey Project on Alcohol and Other Drugs (ESPAD) found that tobacco use among young adults decreased between 1995 and 2015 (ESPAD, 2016, p. 76). Nonetheless, it is of concern that tobacco consumption seems to be higher among young people from disadvantaged backgrounds (Hisock et al, 2012). Figure 13 shows that among countries participating in the ESS 2014, French respondents were most likely to smoke daily (25%); a similar proportion of Austrian, Dutch, German and

Hungarian participants were daily smokers (all 24%). Daily smoking was least common among Swedish respondents (9%) and Czech respondents (8%).

Drug use is a complex topic and should not be viewed as a single issue. It seems there is a correlation between the consumption of illicit drugs and tobacco use. Cannabis is regarded as a potential gateway to other types of illegal substance and is the most frequently used illicit drug among young people in Europe. Heavy consumption may lead to a drop in school performance, social isolation or increased risky behaviours. Data for 16-year-olds from ESPAD (2016) shows the great variation of cannabis use across EU countries (Figure 14). The highest levels of lifetime use of cannabis were in Czechia (37%) and France (31%), and the lowest levels were in Sweden and Romania. Overall, young men were more likely to consume cannabis, with the exception of Czechia, where young women were slightly more likely to have tried cannabis by age 16, and Malta, where equal percentages of boys and girls had done so.

Summary: Common health and social problems faced by young people

This chapter highlights that perspectives on and experiences of social and health problems vary greatly among Europeans aged 12–24. Having examined a wide range of issues, it is clear that certain social and health issues are more prevalent than others. Moreover, some issue are specific to young people, whereas others are common to all age groups but are of particular concern when they affect young people, who are in a transition phase of life, characterised by instability.

In the transition phase from childhood to adulthood, mental well-being is influenced by many pressures, including those created by one's own needs and expectations, but also those introduced by family and society. Young people

Figure 13: Incidence of smoking and drinking, selected countries, 15–16 years, 2014 (%)
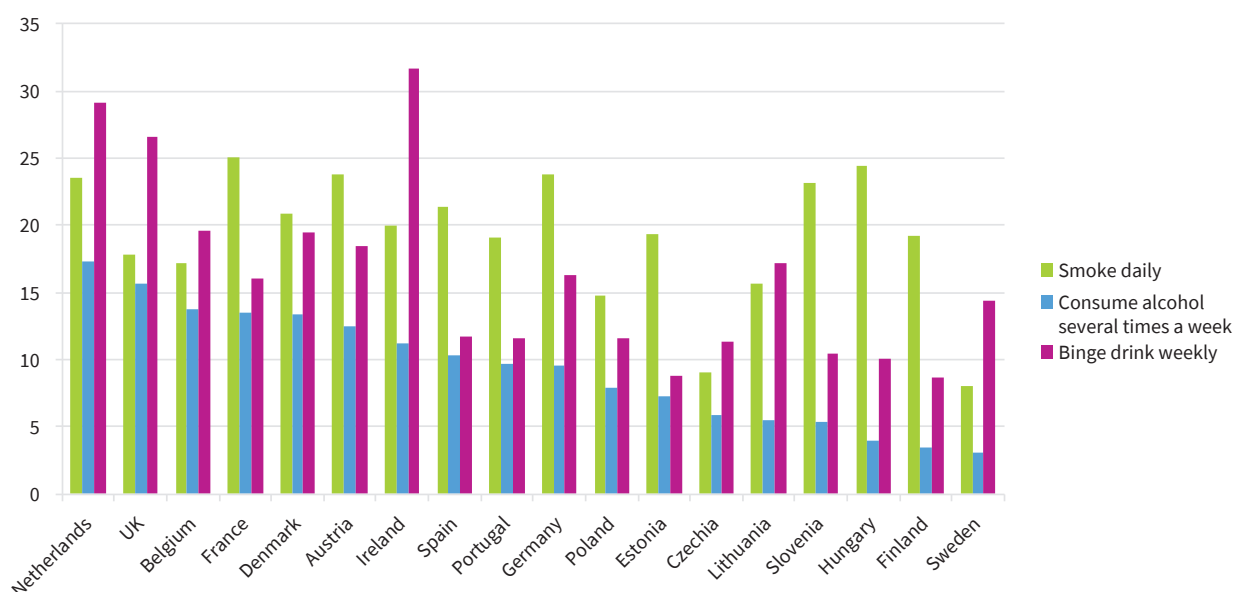
Note: *Bulgaria, Croatia, Cyprus, Greece, Italy, Latvia, Luxembourg, Malta, Romania and Slovakia were not included in the survey.*
Source: *ESS 2014*

Figure 14: Use of cannabis by 16-year-olds, by gender, selected countries, 2015 (%)

Note: *Germany, Luxembourg and the UK were not included in the survey.*
Source: *ESPAD (2016)*

experience extreme consequences, such as suicide and homelessness, at a much higher rate than adults.

In some respects, this chapter offers a reassuring picture in terms of the health behaviour of young people, with the proportions of young people smoking regularly or reporting recent incidents of intoxication decreasing.

Despite the improved economic situation, young people are still feeling the economic and social impact of the economic downturn. In 2016 m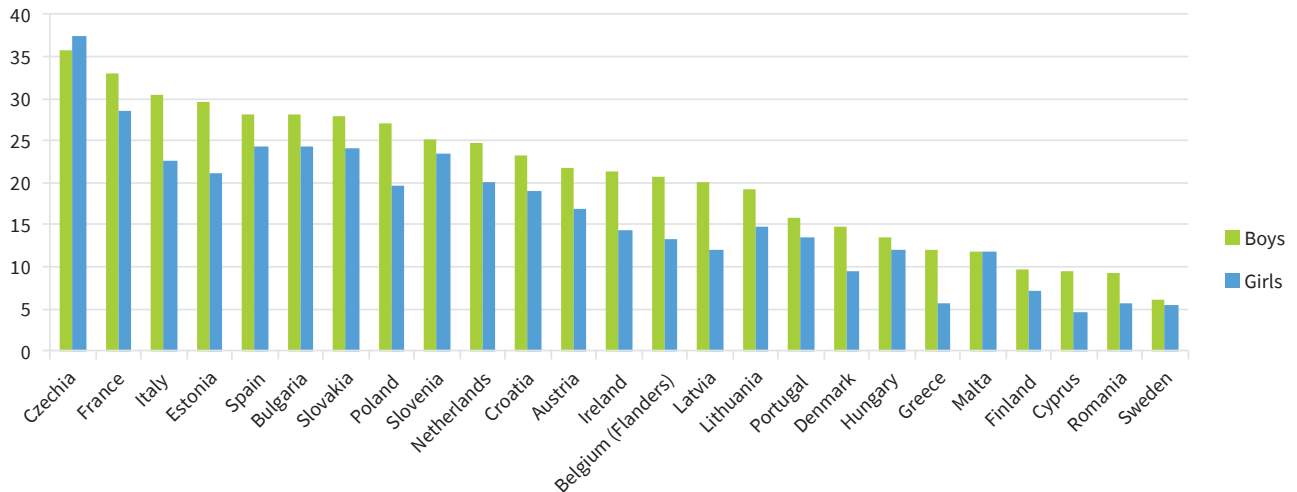ore than half (57%) of young Europeans felt marginalised by the economic crisis. The highest levels were reported in Greece (93%) followed by Portugal (86%), Cyprus (81%), Spain (79%) and Croatia (78%), all countries that battled a severe recession. Poverty and deprivation continue to impact young people, particularly those living in eastern and southern European countries as well as young people leaving the parental home at an early age in northern European countries. Living in deprived and remote areas with limited access to basic services (healthcare, social services and education facilities) is one aspect of poverty and may represent a key factor in social exclusion.

This chapter confirms that issues related to health and mental well-being affect many young people in Europe and continue to be a major challenge in many countries.

Data for 2016 shows that 14% of young Europeans aged 18–24 years were at risk of depression. The second-highest share of young people at risk of depression is recorded in Estonia, followed by Malta, the Netherlands and the UK. The rate of young people being chronically depressed is much lower, but still of great concern. Data for 2014 shows that 4% of those aged 15–24 were recorded as chronically depressed. The highest proportion of young people with chronic depression was in Ireland (12%), followed by Finland (11%), Sweden (10%) and Germany (9%).

There is a strong gender dimension, with young women (15- to 24-year-olds) more likely to suffer moderate

to severe symptoms of depression across the EU. The greatest gender gap was in Denmark, Germany, Ireland and Sweden. Only in Cyprus, Greece and Lithuania are the percentages of young men with current symptoms of depression higher than those for young women.

But there are also concerns around young people's physical health – in particular, high and growing rates of obesity. The highest levels of obesity can be observed in Bulgaria, Greece, Malta and the UK. There are clear gender differences, with boys having higher rates of obesity than girls.

The incidence of both bullying and cyberbullying are on the rise in several countries. The prevalence of bullying was highest in the Baltic states and the French-speaking community in Belgium. The largest increases in bullying were reported in Scotland and Wales (in the UK). Meanwhile, regular bullying was comparatively uncommon in Czechia, Italy and Sweden, and the most significant decrease was found in Romania. There is a relationship between being on the receiving end of bullying and becoming a bully.

Finally, the limited data of the prevalence homelessness or being at risk of it shows that increasingly young people are finding themselves in this situation.

Naturally, not all young people are exposed to risks to the same degree, and some young people are more prone to health and social problems. This includes: those with disabilities; those with weak family ties; those leaving care and moving from one institutional set-up to another; and those living in rural areas or from an ethnic minority or a migratory background, who often experience discrimination in addition to being at higher risk. These are the young people who may be in particular need of information and support services, and it is key that service providers are able to reach out to those groups that are in greatest need and provide relevant services. The next chapter provides an overview of the barriers and inequalities in access to services experienced by young people.

2 | Barriers to and inequality of access to services

Most of the approximately 72 million Europeans aged 12–24 are healthy and socially well connected. However, as Chapter 1 showed, there are various common social and health issues faced by young people across EU countries, and some groups of young people are more likely to experience these problems. Some young people may experience several different problems at the same time. While some problems may not be acute, they should still be addressed to prevent them becoming serious health or social issues.

Appropriate and timely information and support services can have an impact on a young person's ability to cope with social and health issues. Barriers to information and services for young people are related to personal aspects (age, gender, disability, sexual orientation and identity), socioeconomic aspects (social networks, poverty, membership of a specific group, language) and cultural or geographical aspects (across the EU and between Member States; e.g. legal status), all of which can be seen as challenges for service providers in deciding how to best reach all young people in need. An additional complexity involves the different ways services are organised in different countries. This chapter introduces the main types of services available to young people in EU countries to address common social and health issues. It then provides some evidence on inequalities in access based on the EQLS. Finally, it summarises the main barriers to accessing services in Europe today.

Services addressing young people's social and health issues

This section summarises the main information and support services available to young people in health and social fields in Europe. As outlined in the Introduction, this report does not focus on mainstream education and employment services, although schools and, later on, workplaces may be key sources of help and support. Therefore, the classifications below refer only to the health and social fields.

Individual and collective services

Individual services target each young person independently, aiming to ensure social inclusion by improving their skills and motivation. Also called micro-level services, these are related to young people's everyday lives and support them in dealing with obstacles and risks. These services usually target specific groups through counselling as well as social and health services.

Collective or structural services address the infrastructure available to support young people, often aimed at young people from poorer socioeconomic backgrounds and with lower levels of education and less access to support. These services may target specific groups – for example,

promoting the social inclusion of young people in marginalised rural Roma communities.

Preventive and compensatory services

Preventive services are aimed at preventing the development of problems by addressing key determinants. In the context of this study, these services usually involve education about a particular topic, such as healthy behaviours, sexual health or substance abuse. Other preventive services may be aimed at improving family circumstances that affect young people indirectly.

Compensatory services are aimed at young people who already experience some form of disadvantage. Examples include services to help young people with disabilities achieve their full potential, treat mental illness, address substance abuse or support teenage parents.

Eurofound's consultation with service providers (see Chapter 4) includes a third option: services aimed at acute, current problems that are neither strictly preventive nor compensatory. These may include crisis support services, such as: helplines for young people suffering abuse; emergency contraception; or women's shelters. Furthermore, in its consultation with service providers, Eurofound made a distinction between organisations providing services to general populations where young people are one of the constituents and organisations offering services specifically to young people.

Type of provider

Informal support provided by families and parental groups, as well as friends and other peers, is fundamental to both prevention and management of the health and social problems of young people. However, serious issues such as abuse and mental illness cannot be solved solely within the young person's personal environment. Therefore, access to formal services is important, especially for young people experiencing multiple disadvantages or those who have no access to informal support.

Formal health and social services are delivered by the public sector, often with the help of private organisations in public–private partnerships. NGOs have an important role in supplementing public services and improving access for specific groups; for instance, providing services for young people with specific circumstances or addressing access for young people living in remote regions having poor formal provision. These organisations, in turn, often receive public funding or financial support from private companies.

Needs addressed

Services can be grouped according to the specific needs they address within the health and social fields. Based on the main issues faced by young people in Europe,

described in Chapter 1, Table 6 provides a summary of the types of services addressed in this study and the various needs they focus on.

Many of these services are closely interrelated, as are the issues they are trying to address (see Chapter 1). For example, a young person with family issues may be in need of legal assistance, psychological support and housing services, or a pregnant teenager may need health services, counselling and mediation. A challenge for service providers is to enable all young people in different, often very individual, situations to access each of the services they need simultaneously without being passed from one service provider to another due to administrative reasons. A separate challenge relates to lack of relevant services in rural or remote areas. In this case, a young person may be referred to a particular service simply because there is no relevant service available locally; that provider may then need to expand provision to cover the specific need.

Inequality of access to services: Data from the EQLS

In general, there is relatively little information available about the problems young people face in accessing services for health and social problems. This is especially true when it comes to identifying which young people in which countries have most difficulty obtaining services. While EQLS 2016 included a set of questions on access to and quality of public services, this survey only covers people aged 18 and over.

Although young people make less use of healthcare services than older people, this survey found that in the year prior to the survey over half (54%) of those aged 18–24 used family doctor services at least once, 20% used hospital services and 11% used emergency healthcare. A significant proportion of young people reported difficulties in accessing healthcare services (Table 7), the most important access issues being long waiting times

on the day (mentioned by 49%) and delay in getting an appointment (44%), both of which were less of an issue with older age groups. This may be explained in part by the fact that young people experience less severe or urgent issues than older groups. Finding time to go to the doctor was mentioned by 32% while cost was an issue for 20% and distance was a problem for 18%.

There are considerable inequalities among young people in Europe in terms of accessing healthcare. The most obvious differences can be seen by country. For example, cost is a problem for nearly three-quarters of those aged 18–24 in Cyprus, and it is also an issue in Malta, Greece, Ireland and several other countries. In some of these this is due to lack of universal healthcare provision (as in Ireland), while in other countries (such as Bulgaria, Hungary and Romania), this may be related to informal payments (European Commission, 2015). Distance is a more important issue in Cyprus, Greece, Lithuania and Romania than elsewhere. Appointment and waiting time issues exist in many countries with universal healthcare, such as Austria, Bulgaria, Romania and the UK. The separate problem of finding time to get to the doctor is related to work–life balance, care responsibilities and studying. This issue is especially prevalent in France and Romania (both 52%).

Since the previous survey (EQLS 2011), there was a decrease of 9 percentage points in reporting of cost issues by young people in the EU, but problems to do with delays in getting appointments increased by 8 percentage points and issues with waiting times increased by 5 percentage points. The increase in delays in getting appointments were found in 12 countries, most notably in Bulgaria, Malta and the UK (all increasing by 30 percentage points or more). The issue of long waiting time on the day of the appointment increased in 13 countries, especially in Austria, Bulgaria and Czechia. Overall, in Austria, Bulgaria, Cyprus, Latvia and the UK, young people reported deterioration on most access dimensions, while in Italy and Slovakia more improvements were experienced.

Table 6: Summary of types of services examined and different needs addressed

Type of service	Needs addressed
Social support (living conditions, social exclusion) Housing, legal assistance, financial assistance, compensatory services, information services, mediation	Poverty, social exclusion, risk of homelessness, abuse, extreme vulnerability or multiple disadvantage, family problems, problems settling into school
Health support (physical and psychological well-being) Psychiatric, emotional and psychological support services, sexual health services, care for young mothers, health services for young people with disabilities	Mental illness, suicide risk, eating disorders, sexually transmitted diseases, teenage pregnancy, chronic disease or disability
Services addressing adverse social and health outcomes Counselling, school psychosocial support, helplines, online support services, support to young offenders, rehabilitation, treatment of addiction and substance abuse	Bullying, cyberbullying, antisocial behaviour, substance abuse, social media abuse, gaming and gambling addictions
Services for particular groups Homeless intervention and support, support for LGBTQI youth, services for young people with disabilities, aftercare, specific services for refugees or marginalised communities	Homelessness, disability, issues specific to LGBTQI young people, young people in care, unaccompanied refugee minors, young people in marginalised communities

Table 7: Main problems in accessing healthcare services, 18–24 years, by country (%)

	Distance	Appointment delay	Waiting time	Cost	Finding time
Austria	30	59	73	21	25
Belgium	17	39	43	33	42
Bulgaria	21	65	74	44	48
Croatia	24	38	33	22	20
Cyprus	42	27	48	72	47
Czechia	31	32	81	21	39
Denmark	16	37	35	7	25
Estonia	27	54	34	24	24
Finland	6	49	39	24	20
France	16	49	57	32	52
Germany	16	46	60	7	35
Greece	41	52	70	56	31
Hungary	18	47	44	16	29
Ireland	19	22	34	46	38
Italy	13	35	28	26	22
Latvia	26	53	60	44	35
Lithuania	39	45	56	26	36
Luxembourg	14	30	50	45	32
Malta	13	67	82	61	29
Netherlands	5	11	32	7	21
Poland	25	35	31	21	26
Portugal	11	47	54	18	23
Romania	36	58	74	44	52
Slovakia	8	23	32	6	15
Slovenia	25	48	51	5	17
Spain	7	28	26	4	10
Sweden	18	51	33	16	33
UK	20	69	64	14	40
EU28	**18**	**44**	**49**	**20**	**32**

Source: *EQLS 2016*

Apart from country differences within the EU, regional inequalities in access also exist within countries. A simple rural–urban area distinction (based on the respondent's own classification of whether they live in the open countryside, a village, a large town or a city) reveals significant disparities in access to healthcare. The main difference was in terms of distance of travel to services, with 24% of young people in rural and 13% in urban areas finding this to be a problem.

Income inequalities in access to healthcare for young people were also prevalent. Household income can impact the ability to pay for services; it may also have effects related to distance from services and ability to pay for travel. In addition, young people who have to take on work have less free time to attend services. Young people living in households in the lowest income quartile were more likely than others to report problems; the following were especially reported:

○ finding time to go to the doctor (8 percentage points higher than the average)

○ waiting times on the day (7 percentage points higher)

○ cost (5 percentage points higher)

○ distance and delays in getting an appointment (4 percentage points higher)

Altogether, 32% of those aged 18–24 said that it would be difficult for them to cover dental costs, and one-quarter said the same about hospital care. These affordability issues were more commonly reported by those in the lowest income quartile: difficulties with dental costs were reported by 38% and affordability of hospital care was reported by 30%.

Inequalities related to chronic illness or disability were also present in accessing healthcare. Young people with a disability or chronic illness were more likely to report

difficulties on all five access dimensions (Figure 15), which is especially concerning as these young people are likely to be heavy users of healthcare services.

Looking specifically at social support, the EQLS asked respondents who they would turn to (1) in case of feeling depressed and needing somebody to talk to and (2) when facing a serious personal problem. As shown in Figure 16, family and friends were the most common sources of support cited by young people (by 72% and 52% of respondents, respectively). Family was the primary source of support for at least one of these two issues in nearly all EU countries, but it was especially important in France, Hungary, Lithuania, Malta and Slovakia. Germany and Sweden were the only countries where most young people turned to their friends rather than family being the main support for either of these issues.

Overall, only 2% of young people said that they would turn to a service provider when feeling depressed or when facing a serious personal problem. Acknowledging that this is probably dependent on the seriousness of the problem, it is interesting to see the large differences between countries in terms of the proportion that would turn to a service provider: 12% in Finland, between 5% and 10% in Czechia, Denmark, Ireland, the Netherlands and Sweden, and 0% in 10 other EU Member States.

Part of the explanation is the availability of and preference for family and friends as a source of support. However, in certain cases, families may not be the natural source of support and so availability of formal support services is of key importance; for example, in cases of substance abuse or where the young person is dealing with issues around identity.

Young people also have needs related to mental health, and it is important that services are equipped to help young people in those difficult times. Yet when asked how difficult it would be to afford psychological or psychiatric services, 30% of young people in the EU said it would be

'difficult' or 'very difficult' (Figure 17). In countries where this form of support is deemed least affordable, such as Cyprus, Greece and Slovenia, young people would not consider turning to support services for mental health issues.

Interestingly, young women were approximately twice as likely to say that they would turn to a service provider for these issues (3.2% vs 1.6% of young men). This is despite them being more likely to struggle to afford psychology or psychiatry services: 35% of young women said it would be difficult for them to afford these services, compared to 26% of young men.

Barriers to accessing services

It is clear that young people do not have equal access to different services, and inequalities exist both across countries and regions as well as across different social groups. But what are the main causes of limited access for certain groups? This section summarises the main access barriers, focusing specifically on support and information services for young people.

There are many ways of grouping barriers to accessing services. This report, including consultation with service providers, addresses four types of barriers, as summarised in Table 8.

These barriers are outlined in more detail below. The service providers that recognise and seek to address the barriers are shown in brackets along with the country where they are based.

Personal barriers

The young person's individual situation may prove to be a barrier to accessing services. Personal barriers may stem from the young person's psychological condition, their legal or socioeconomic status or simply from their dependency on adults.

Figure 15: Difficulty in accessing healthcare services for young people with chronic illness or disability, 18–24 years (%)

Legend: ■ Aged 18–24 with no chronic illness or disability   ■ Aged 18–24 with chronic illness or disability
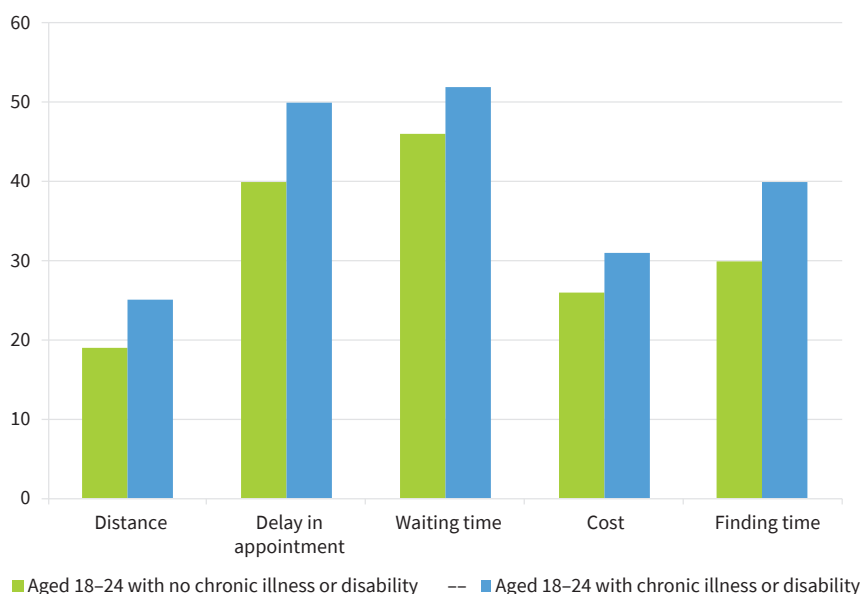
Source: *EQLS 2016*

Figure 16: Sources of support when facing a serious problem or feeling depressed, 18–24 years (%)
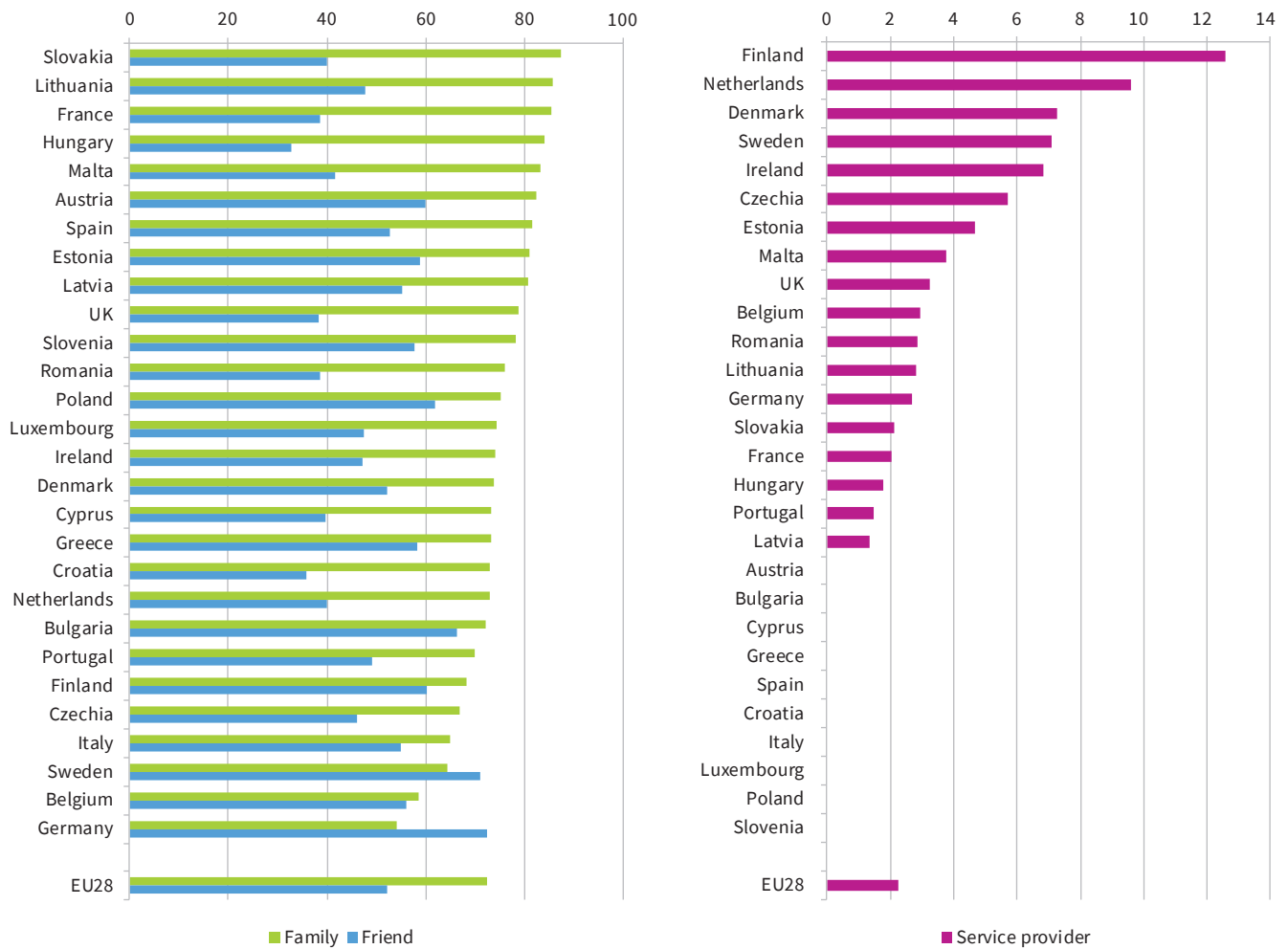
Source: *EQLS 2016*

Figure 17: Difficulty in affording psychological or psychiatric services, 18–24 years, by country (%)

Source: *EQLS 2016*

Table 8: Main barriers to accessing services for young people

Personal barriers	Structural and institutional barriers
- Lack of information - Stigma – reluctance to ask for help - Poor mental well-being (e.g. anxiety, introversion) - Social attitudes (e.g. gender stereotypes) - Family problems, parents' intervention - Lack of knowledge regarding one's rights	- Physical accessibility (e.g. location, opening hours, access for people with disabilities) - Administrative burden (e.g. referrals, ensuring privacy and anonymity) - Legal restrictions (e.g. age limit, citizenship) - Lack of funding - Staff issues (e.g. lack of staff qualified in youth issues) - Lack of availability - Cost
Cultural and societal barriers	Operational barriers
- Religion - Belonging to certain kinds of community (e.g. in sparsely populated rural areas) - Discrimination, prejudice (associated with certain services) - Attitudes towards certain issues (e.g. drug use) - Language problems	- Method of delivery, communication tools - Design of services - Referrals, waiting lists - Competence of staff - Facilities, equipment - Anonymity, privacy - Young people's involvement and agency - Capacity to measure outcomes and impacts

Mental health issues such as anxiety, depression and severe introversion often result in young people being reluctant to ask for he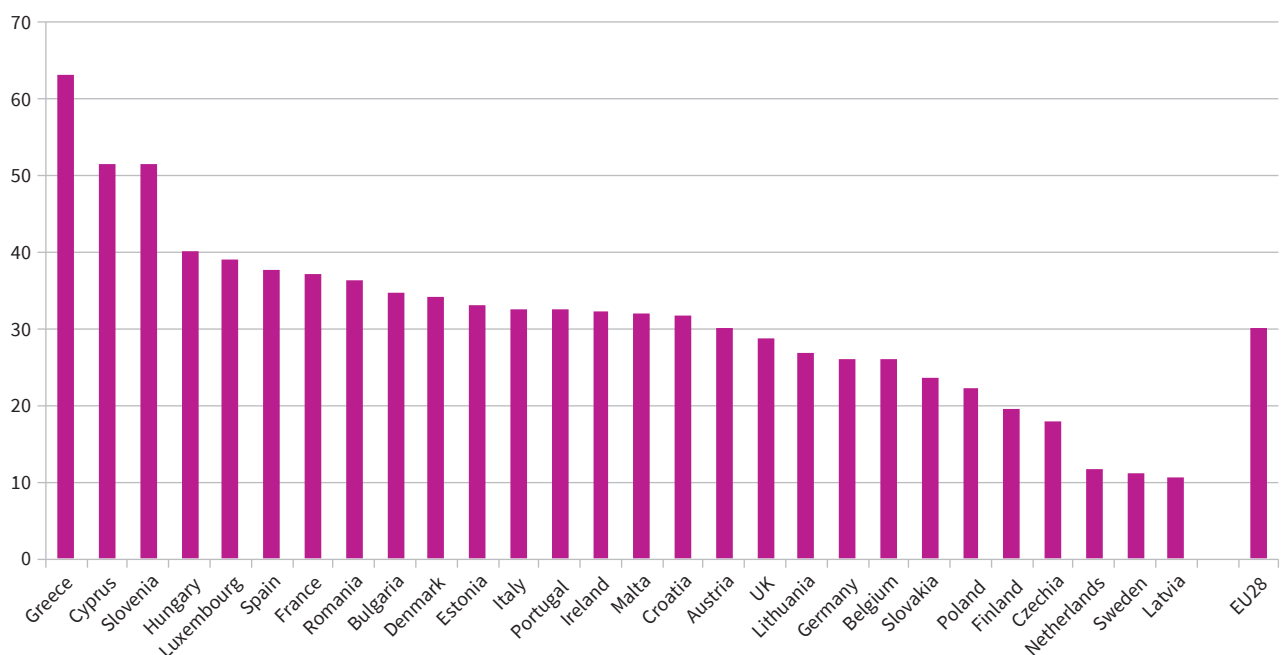lp even when it is available. This is especially an issue if use of a certain service is associated with social stigma. For example, young people experience fear and embarrassment in discussing sex and relationships (ESHA – Estonia; Young Parenthood Programme – UK) and find it difficult to talk with parents on subjects such as sexuality and contraception, psychological issues and eating disorders (Instants Santé Jeunes – France). These are subjects that are personal, private and sometimes taboo and, therefore, difficult to address face-to-face (Fil Santé Jeunes – France).

Lack of open and honest communication with parents, friends and partners not only can lead to ill-informed decisions (Young Parenthood Programme – UK) but also has consequences for access to health and social services. In fact, such access is often mediated by parents. Young people may be reluctant to talk about their concerns to a specialist at school, a family doctor or a gynaecologist in the hospital because they do not want their parents and acquaintances to find out about their visits (ESHA – Estonia). Moreover, asking for help may be even trickier if young people are surrounded by people with negative attitudes or prejudices towards some of the services. This is certainly the case when it comes to subjects such as crime and illicit drugs. Young victims of crime who need psychological, social or legal assistance depend on help from parents. Yet telling parents about a crime may be difficult for young people. Young victims of crime may be

scared or feel ashamed if they were involved in some way or if they were doing something illegal themselves when the crime took place (like using drugs). Talking about drugs with parents in general is difficult, which makes the availability of services important and also reinforces the need for privacy within services (YAD – Finland). Ensuring anonymity and privacy can help to improve access; however, this is not always possible if the service requires registration with a name and other personal data or even authorisation from a parent or a teacher in order for the young person to participate. A separate issue involves cases where one or both parents are responsible for committing a crime; the types of support required by young people here are, of course, quite different (Victim Support – Finland).

It must be noted that not all young people experience fear and embarrassment to the same extent when seeking support. Gender differences and stereotypes about masculinity come into play. In Estonia, young men are less likely to turn to a specialist concerning personal problems and prefer to use online counselling rather than visiting clinics. Service user statistics for ESHA (Estonia) show that young men represented 20% of those using internet counselling but only 5% of those visiting youth clinics.

Loneliness, hopelessness and isolation affect particular groups of vulnerable young people to a greater extent; for example, LGBTQI young people or teenage parents. LGBTQI young people may have low self-esteem, lack clear self-concept and feel marginalised and powerless

(Single Step – Bulgaria). In Estonia, many young mothers, especially those who do not have family support, feel helpless and trapped; they do not go out often and increasingly live in isolation. After childbirth, young parents often leave school. Within this group, young parents with intellectual disabilities are a particularly vulnerable subgroup (Caritas Eesti – Estonia).

Homeless young people do not readily approach organisations that can provide them with assistance, and services need to reach out to them instead (Centrepoint – UK). Furthermore, being young and not having experienced independence as part of adult life can be an obstacle for young homeless people when they are offered housing assistance by local authorities, as they may not have developed the life skills to live on their own in private accommodation. In addition, they fall into debt easily and are often unable to pay their bills. Mental health issues are often associated with homelessness, and this represents a further barrier to accessing services, especially for those young people who are living on the streets (Centrepoint – UK).

Lack of awareness of one's rights is often a factor underlying poor rates of access to health and social services by particular groups of young people. For instance, in the UK young men are less likely to be aware of their rights as fathers (Young Parenthood Programme – UK). Young LGBTQI people are often unaware of their right not to be discriminated against (Albert Kennedy Trust – UK). Young people in Finland often lack awareness of the types of crime that exist and what type of help is available for victims; for example, cyberbullying or sexual intimidation are generally not recognised as crimes by young people (Victim Support – Finland).

Cultural and societal barriers

Personal barriers often reflect societal barriers based on negative attitudes towards service use or towards particular groups.

Certain services, for instance psychological and psychiatric services, still have stigma attached to them. In the absence of support that ensures confidentiality, young people may be especially sensitive to a perceived stigma, especially when having to ask their parents to arrange consultations (Fil Santé Jeunes – France). Sexual and reproductive health services are subject to stigma in certain more conservative environments, as they are seen as opposing religious values (Young Parenthood Programme – UK).

Often, living in closed and sparsely populated areas (e.g. islands, counties with small populations), where people tend to know each other, creates a barrier to accessing services. For example, in Estonia, there is little anonymity in such areas, and young people prefer to visit youth clinics in larger towns (ESHA – Estonia). Living in closed communities also means more limited access to information flows, resulting in lack of awareness. This is the case for some Roma communities in Bulgaria regarding drug-related health risks (Prevention and Information Centre on Drug Addictions – Bulgaria).

For some groups, access to mainstream services may involve the risk of being discriminated against. According

to promoters of programmes for young mothers, they will have experienced disapproval from teachers or school principals and being stared at and commented on while travelling on public transport or waiting in the reception areas of women's clinics (Caritas Eesti – Estonia; Young Parenthood Programme – UK). Discriminatory attitudes towards LGBTQI people are another example (Single Step – Bulgaria). As mentioned previously, intrusion by parents is a major barrier to accessing services. If a young person contacts their family doctor, they may be unsure whether or not this will get back to their parents (Fil Santé Jeunes – France). This is particularly stressful for LGBTQI young people. One of the biggest challenges faced by this group is the risk of abuse once they let friends and family know about their sexuality. This can lead to physical harm, low self-esteem or mental health problems, and it also increases the risk of homelessness (Albert Kennedy Trust – UK).

Societal attitudes also feed in to use of services related to drug use. The view held by some that addiction is about choice rather than an illness can result in feelings of shame among young people experiencing drug-related problems. In Finland, some young people with drug problems do not seek help because they feel ashamed (YAD – Finland).

Aside from societal attitudes, unprofessionalism on the part of child protection officers or other officials may cause young people to lack confidence in their ability to cope with difficult situations. For instance, one case study in Estonia reported that many young mothers have a serious fear that they are not coping as parents and that their children will be taken from them. They are afraid that they will do something wrong and will, therefore, be bad mothers (Caritas Eesti – Estonia).

Lack of awareness of health risks along with lack of a culture of prevention result in a societal barrier that affects general populations but which young people may be especially prone to. The habit of going to the doctor for prevention purposes is less widespread among young people due to their limited exposure to health information (Instants Santé Jeunes – France).

Often parents themselves are not educated about certain health risks young people may be exposed to. A service provider in Bulgaria (Life by the Kilo) noted parents' lack of awareness about eating disorders and neglect of related symptoms. Also in Bulgaria, specialists described how parents would not easily admit that drug abuse is something that could affect their children.

Finally, language and cultural barriers constitute an obstacle in reaching out to young people from ethnic minorities. In Estonia, there are difficulties in informing Russian-speaking young people in the north-eastern part of the country about sexual and reproductive health services, and they are also less willing to come to youth counselling (ESHA). In Finland, young asylum seekers are not easily reached through workshops, posters and leaflets at school or via events like festivals. Furthermore, young people with different cultural backgrounds might have specific needs (YAD).

Structural and institutional barriers

Another important set of barriers relates to the organisational set-up of services.

In some cases, the main structural barrier is simply lack of specialised services that tackle issues of importance to young people. In Bulgaria, there is a shortage of specialised services dealing with eating disorders or addressing LGBTQI issues. Standardised school-based drug prevention protocols are also rare. Even when a specialist centre exists, there may be lack of coordination with mainstream services due to the absence of national policies and strategies. Sometimes services do not serve groups equally; for instance, availability of specialist provision in sexual health may be better for young women than young men (ESHA – Estonia).

In other cases, services designed mainly for adults may not be appropriate for the needs of younger users. One example is of a service for pregnant teens which involves attending lectures on pregnancy, motherhood and childcare held at hospitals in Estonia. The target group for these lectures is adult women whose pregnancies were planned, and teens often feel uncomfortable attending (Caritas Eesti – Estonia).

Even when provision of services is good, the complexity of administrative systems can introduce major barriers to access. The welfare system may have strict and complicated eligibility criteria that are difficult to understand, especially for young people (AIVS – France; Centrepoint – UK). Furthermore, requirements for formal referral to certain services creates additional administrative hurdles (Centrepoint – UK).

Age restrictions and lack of continuity of care across age groups allow young people to fall through the cracks in the system. In the UK, young people over 18 are not entitled to emergency housing. For those under 26, less financial support is available, the premise being that most young people can live at home and receive financial and/or in-kind support from their families (Centrepoint – UK). In France, child psychiatric services cater for up to age 16 only. This creates a gap for young people over 16, who are referred to general adult services despite the need for specialised age-relevant services. In Estonia, there are some anti-bullying programmes for students in primary schools, but no programmes for students attending grades 7–9 and gymnasium (TORE – Estonia). Another eligibility criteria that can penalise young people involves proof of income. Difficulty of demonstrating income prevents certain groups of young people – those who are unemployed or in precarious employment as well as those who are homeless – from accessing rental housing (AIVS – France).

Various economic and financial barriers exist for young people accessing services. For instance, a service provider in France noted that access to housing is hampered by unaffordable private sector rental prices for young people. At the same time, the French network of hostels, the Foyers des Jeunes Travailleurs, represents an insufficient response to the need for affordable housing for young people below 30 who need privacy (AIVS – France). Some other services have a cost associated for the young person, and even if this is relatively small, some may not be able to meet it. In Finland, contraceptives are not free, and young people often cannot afford them (Inkoo).

The uneven distribution of services throughout a territory is also a source of inequality among young people. For instance, the more limited availability of health and social services in rural areas is an obstacle for young people living there (Instants Santé Jeunes – France). In the very northern part of Finland, there are currently no street teams for reaching out to addicted youth (YAD). In the UK, LGBTQI community groups are less common in rural areas (Albert Kennedy Trust).

Practical barriers include opening hours, which are often short and coincide with school hours, and poor disabled access to buildings. Legal restrictions can also prove to be a barrier to access; for example, use of a service may be dependent on citizenship.

Operational barriers

The fourth category of barriers is associated with operational aspects of the services that are on offer. Factors such as poor service design, inadequate staffing and quality of service delivery discourage uptake by young people.

One barrier that discourages young people from making use of mental health counselling services is the length of waiting lists for public sector services, with users sometimes having to wait longer than six months (Centrepoint – UK). Since psychology and psychiatry services in the private sector are expensive, young people are left with little choice (Fil Santé Jeunes – France).

Sometimes service design does not consider privacy issues. A provider in France (Fil Santé Jeunes) noted that the requirement to register a personal profile in order to access online services had been a barrier to service use; this was rectified with the introduction of an anonymous online chat service. In another example, in some counselling centres in Estonia (e.g. the Children's Mental Health Centre located in Tallinn), it was established that parents should be informed whenever children who are legally still minors visit the centre and are offered services. However, this practice inhibits young people's willingness to ask for help (ESHA – Estonia). Another important aspect of service design concerns whether young people have any say in how services are provided to them – whether they are informed about what will happen and/or consulted about what they would like to happen.

Technical barriers are often overlooked, or new ones arise due to technological and social developments. For instance, while many young people now only access the internet via their smartphone, online services may have been optimised for use on desktop computers and laptops (Fil Santé Jeunes – France).

Another operational barrier concerns the training, knowledge and skills levels of (mainstream) service professionals in relation to youth issues. This is important for teachers, health professionals, especially family doctors, and police officers. A lack of specialised knowledge and skills to deal with sexual orientation and

gender identity issues was observed for social and health service staff in Bulgaria (Single Step), especially in small towns outside the capital (Prevention and Information Centre on Drug Addictions). In addition, among school psychologists there is a lack of specialised skills related to substance abuse (Prevention and Information Centre on Drug Addictions). In Finland, teachers are not trained to give information on substance abuse (YAD). Also in Finland, teachers may be ill-equipped to provide sex education; according to one service provider, they mainly present information to students without any interaction, as they do not feel comfortable leading an open dialogue (Inkoo). Still in Finland, it was reported that police and other service providers are not trained specifically to deal with the potential crimes young people face (such as bullying) and/or the legal aspects of those crimes (Victim Support). Elsewhere, when it comes to bullying, it is also the case that young people often do not approach teachers due to lack of trust; large age gaps between teachers and students do not help (TORE – Estonia).

Another barrier that was observed is lack of resources leading to the offer of superficial initiatives or those that are not operationally well supported. In Bulgaria, drug prevention activities in schools tend to be one-off events with brief lectures, which provide insufficient support or may even have the opposite effect of generating curiosity about drug use among students. It is a challenge to find locations within schools for more structured programmes (Prevention and Information Centre on Drug Addictions – Bulgaria).

Finally, to ensure that service provision is of good quality, it should be monitored in some way. However, some providers lack the means to measure relevant aspects such as user participation, outcomes and impact. Furthermore,

it may only be possible to gauge the impact of the service long after the young person has left.

Conclusions

As outlined in this chapter, there are multiple considerations when identifying inequalities in access to social and health services and the barriers leading to them, and when trying to develop the solutions for overcoming these access issues for different groups in different countries. Reviewing the barriers, it can be noted that, just as with exposure to problems, barriers to access affect different groups of young people to different degrees. The overlapping of different types of barrier also contributes to varying degrees of inequalities of access.

Some barriers apply to the general population – or at least the middle-lower income segment – not just young people. These include restrictive housing markets; stigma associated with the use of mental health services; lack of a culture of preventive health; and lack of knowledge (of the seriousness of a problem or of the existence of services that may help to address it). Other barriers are mainly relevant for young people: dependency on parents; shyness in dealing with emotional and sensitive issues related to health, sexuality and addictions; and low self-confidence in navigating bureaucratic systems.

Finally, some barriers are particularly acute for certain vulnerable groups of young people, either because of forms of discrimination that affect both young and adult members of a particular group (e.g. LGBTQI people; Roma people) or some specific types of vulnerability among young people (e.g. absence of parental support having grown up in a care institution; going through teenage pregnancy; and having dropped out of school).

Figure 18: Examples of barriers to which adults and/or young people are exposed

ALL YOUTH
Dependency on parents
Shyness
Limited abiility to navigate bureaucracies

SOME YOUTH
Teenage pregnancy
Leaving care institutions
Dropping out of school

ALL ADULTS AND YOUTH
Lack of prevention culture
Lack of services in rural areas
Tight housing market/lack of social housing

SOME ADULTS AND YOUTH
Discrimination against the Roma population
Mental health issues
Disability
Discrimination against the LGBTQI community
Conflict with law/detention

3 | Addressing barriers and inequalities

In response to concerns about the health issues and social exclusion of young people, most Member States have taken measures to support youth in general or disadvantaged young people in particular. The main issues, reflecting key problems that young people are grappling with, are illustrated here with examples from selected case studies. These issues are: teenage pregnancy, crime and bullying, homelessness, health issues and drug abuse.

Main issues identified

Teenage pregnancy

Within the UK, there has been considerable progress in reducing levels of teenage pregnancy. In England and Wales, for example, the under-18 conception rate is now at its lowest since comparable statistics were first produced. In 2018, there were 18,076 births to under-18s in England and Wales, which is a decrease of 11 percentage points since 2015. Notably, the under-18 birth rate has now declined by 55 percentage points compared with 2001 (ONS 2016). In Estonia, in 2015, the birth rate for women aged 15–19 was 12 births per 1,000, somewhat higher than the average for the EU (10 births per 1,000) (World Bank, undated).

Victims of crime and bullying

The prevalence among young people of being victim to crime and the number of young people that have witnessed a crime remain, for the most part, unclear. In Estonia, the proportion of young people aged 16–18 who have experienced sexual violence (10%) has remained the same since 2003. In Estonia it was found that 13% of girls and 19% of boys aged 13 had been bullied at school, and 7% of young people had been absent from school due to fear of being bullied (WHO, 2016). Though one has to be careful when looking at the data regarding bullying, as different sources reveal rather different pictures, both PISA and HBSC found high levels of bullying in both Estonia and France. PISA 2015 data indicates that in France, 29% of students aged 15–16 suffered from anxiety issues at school and 17.9% had experienced bullying (OECD, 2017). In Finland, it was observed that cybercrime is becoming more common among young populations: 5% of those aged 15–24 reported being victims of cyberbullying in the three years prior to the 2013 survey (Oksanen and Keipi, 2013). In the UK in 2017, 45% of young people aged 11–19 were bullied at school for being LGBTQI. Half of these young people feel that homophobic, biphobic and transphobic bullying has had a negative effect on their plans for future education. In addition, LGBTQI young people who are disabled, and those who receive free school meals, are at heightened risk of being bullied and experiencing poor mental health (Bradlow et al, 2017).

Homelessness

Access to decent housing is difficult for many young people. While sources vary, one study found that every year more than 80,000 young people (aged 16–25) in the UK are homeless (Clarke et al, 2015). In France in 2013, 7% of young people aged 15–24 suffered from severe housing deprivation (Fondation Abbé Pierre, 2014). Only a quarter of young people under 30 were living in social housing, and this figure was falling. Just over half (53%) of young people lived in private rental accommodation and were therefore hit hard by rent increases.

Health issues

In France, nearly 15% of young people aged 16–24 were affected by some long-standing illness, and 10% suffered from a depressive episode. Difficulties in accessing health services and affordable housing are a key concern in French youth policy. In 2013 one-third (33%) of students did not make use of health services as they could not afford them.[3] In Bulgaria, the mental and emotional health of young people is especially concerning. In the past two years, over 150,000 cases of anorexia and bulimia have been recorded, most of those affected being teenagers.

Drug abuse

According to data from the European Monitoring Centre for Drugs and Drug Addiction, young Bulgarians aged between 15 and 24 are the most vulnerable to drug use. In Bulgaria, the most commonly used drug (by 8% of these young adults) is cannabis, followed by MDMA ('ecstasy', 3%), amphetamines (1%) and cocaine (0.3%). Although drug abuse is below average in Finland, the popularity of cannabis is growing. According to a 2014 study on drug use, while in 1998 just under a fifth (19%) of those aged 15–24 said they had tried cannabis, this grew to 23% by 2014.

Case studies – national contexts

Within the UK, physical and mental health services for young people are provided by the National Health Service (NHS) which is free, being supported through general taxation. Health policy is devolved to each UK nation. Services are planned and delivered by public sector bodies, local authorities, NGOs and private sector organisations.

In France, a range of publicly funded health and social services offering information and support, often run by NGOs, have been established to address the specific needs

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3   Information gathered by Ecorys (report available on request)

of young people. The approach is quite systematic and standardised in terms of names and types of services, although concrete offers may vary from one department to another.

In Estonia, management and supervision of the healthcare system and development of health policy are under the scope of the Ministry of Social Affairs and its agencies. Publicly owned hospitals and private primary healthcare institutions provide health services. All individuals under 19 are covered by health insurance, and most healthcare services are free for all. Also covered by health insurance are pregnant women and basic or secondary education students up to the age of 24.

Most social and health services for young people in Bulgaria come under the remit of national government. This is the case for most services directed at young people, including those from ethnic minorities, those with disabilities, homeless young people or those living in poor housing conditions, those not in education, employment or training, those living in institutional care or leaving specialised institutions and early school leavers. The Human Resources Development 2014–2020 programme is one of the main sources of funding for social and health services for young people.

Social and healthcare in Finland consists of a highly decentralised, three-level, publicly funded healthcare system and a much smaller private sector. Although the Ministry of Social Affairs and Health has the highest decision-making authority, the municipalities (local governments) are responsible for providing care to their residents. The statutory National Health Insurance scheme covers all Finnish residents, and it is run by the Social Insurance Institution through approximately 260 local offices across the country.

Analysis of the initiatives

The initiatives make use of several tools in order to reduce barriers to access for young people:

- tailored support for different age groups and training for professionals
- confidential services to provide a safe space
- online support to facilitate access
- personalised guidance in navigating the system
- proactive campaigns, social media and/or workshops to raise awareness of health and well-being

Tailored support for different age groups and training for professionals

This category includes services that tailor their support to the specific needs of different groups of young people and/or focus on the training of professionals. In terms of tailored support, a distinction can be made among initiatives focusing on: the assessment of specific needs; learning life skills; mentoring; support packages; and support centres and counselling services. The health professionals involved in these tailored support services have all been trained to work with young people – a key issue since inadequate training has been identified as one

of the main barriers in access to services. Whether such a tailored approach is successful is difficult to estimate due to the lack of data on impacts. However, limited data from the case studies show that young people are satisfied with the services received.

Assessment of specific needs

Often, the success of an intervention or a service depends on the young person having undergone timely and accurate assessment, enabling the organisation to tailor support to the individual's specific needs. This assessment can focus on a variety of different topics. For example, it may concentrate on health issues (mental and/or physical) or education needs, but also on work-related issues or lifestyle. The assessment can be done using online questionnaires or during face-to-face sessions with professionals. An advantage of an online assessment is that it can reach out to a larger group of young people than face-to-face assessment, including those in rural areas, at relatively lower costs. An advantage of face-to-face assessment is the opportunity to discuss the young person's potential needs directly with them. An assessment can be preventive or compensatory in nature. For example, an online assessment questionnaire might be aimed at a large group of young people in order to evaluate their knowledge on certain topics and their associated needs. Alternatively, this tool can be used where young people have already reached out to a specific service.

A proper assessment is key, especially when dealing with young people with multiple and complex issues that may require a wide range of services to be offered simultaneously. An example of this approach can be found in Centrepoint – UK. In order to provide young people with the necessary help and support, professionals conduct a comprehensive assessment that covers information on health (mental and physical), education needs, employment needs and other factors (e.g. cooking skills, financial management) that can impact a young person's chances of living independently. Following the health assessment, young people can be directed towards: short- or long-term counselling to deal with the stresses and strains of homelessness; healthy living workshops to help them learn how to take care of themselves; cookery and nutrition workshops to prepare them for independence; and/or more general emotional support from Centrepoint staff to help build confidence. Following a learning assessment, young people can be directed to: one-to-one sessions that help them improve basic skills (such as maths and English); life skills training to help them budget and pay bills; work experience; or expert advice and/or job skills workshops to prepare them for a career. This approach means that services can be tailored to a wide range of young people, including single parents, care leavers and those escaping violence and abuse.

Another example of needs assessment, this time used in a preventive way, is Instants Santé Jeunes (France) that seeks to improve poor health outcomes for rural youth, who often fall through the cracks in terms of preventive services. The objective is to encourage young people to make use of a free medical check-up scheme. Young

people, including 16-year-olds who have just received their health pass (Carte Vitale), are invited to visit a website and fill in a questionnaire preparing for a medical consultation. The questionnaire for 16- to 19-year-olds asks about: alcohol, eating habits, relationships, smoking, perceived health status and information needs. The questionnaire for 20- to 25-year-olds expands to include items on work and work-related accidents, sexual behaviour and contraception, sexually transmitted infections, depression and sleeping patterns, use of alcohol, physical exercise and perceived hearing or sight problems. Young people can print out a summary of their main concerns to bring with them to their consultation. In order to increase the take-up of this scheme by young people, MSA offers young people who attend the medical consultation a voucher worth €30, which can be spent on sports-related products and services.

Learning life skills

Young people need to learn a set of life skills in order to be able to live independently. Being young and not having experienced independence of adult life is the primary barrier that is addressed by life skills programmes. There are different types of life skills that may be enhanced, and support can focus on a general youth population or a specific group of young people, such as young parents or LGBTQI young people. This type of service can be preventive or compensatory. For example, by proactively reaching out to young people at schools by means of education programmes, young people can learn skills to deal with a variety of issues, such as bullying or the temptation to use drugs.

An example of using compensatory measures to equip young people with life skills is the approach taken by Centrepoint (UK) with young homeless people. The organisation offers a holistic approach by providing the individual with accommodation as a crucial first step but also offering tools to build resilience and become independent when moving on to their own accommodation. Workshops are offered on topics such as healthy living, cookery and nutrition, budgeting and job skills. These sessions seem effective: Centrepoint's records show that 88% of young people they have accommodated moved into their own homes or reconnected with their families, got their first jobs or went to university (Centrepoint, undated). As discussed earlier, LGBTQI young people are particularly at risk of homelessness. The Albert Kennedy Trust, also in the UK, provides support to this group. Their early action service Purple Door offers these young people the opportunity to go to an emergency safe house where they are helped to access longer-term housing but also support for employment, training and debt management in the hope that they will be able to live independently and be reunited with their parents. In addition to this, the trust offers a digital support service that allows young people to speak directly to trained mentors. Mentors are available to communicate about developing skills via online chat, messaging, video calls or audio calls.

Another group of young people who may need assistance to develop skills to help them adapt to a new situation

is young parents; they may need help to improve their parenting skills, facilitate personal development or cope better with daily tasks as well as motivation to continue in education or look for a job. One example from a service in Estonia involves individual assistance for young parents, childcare, lectures, food aid, and the Young Mothers' School. The service offers individual counselling and a support group for pregnant teens or young women who have had a baby. Topics such as pregnancy, childbirth, raising a child, family relationships and other issues are discussed in the group. Skills for coping independently (e.g. cooking, self-efficacy) are taught. Young fathers (or partners) are also welcome to participate in the support group activities.

Mentoring

Mentoring for a period of time is an effective tool to help young people facing continuing challenges. Mentoring can be provided online (by means of chat) or face-to-face. Furthermore, mentoring can be both preventive and compensatory; it can be provided to young people already experiencing certain issues, such as homelessness or gender issues, but it can also be the case that those being mentored are able to identify other young people at high risk of social exclusion, who can then be given the opportunity to receive mentoring.

TORE in Estonia provides mentoring to young support students, who in return identify and support other young people at their schools who are being bullied. Support students receive basic training from their mentors. Following this, they meet regularly with their school mentor to talk about difficulties and ways of approaching other young people.

In some cases, mentoring is quite immersive; for example, the Albert Kennedy Trust's (UK) mentoring for homeless young people involves the individuals staying in the mentors' own homes.

Support packages

Support packages bundle different types of support. These tend to be primarily compensatory measures addressing economic and financial hardships faced by certain groups of vulnerable young people, including young parents or LGBTQI people who are not accepted by their families. These support packages can include food, clothes and furniture as well as financial support. In the UK, the Albert Kennedy Trust's Rainbow Starter Pack helps young people move into their first tenancy by offering financial support (e.g. their deposit and first month's rent), furniture and food for the duration of their first week of independent living. In Newcastle, the Purple Door programme offers young people an opportunity to live independently in self-contained flats or units. The trust additionally provides up to six months of advice and support to young people during their first tenancies. An aftercare package is also offered, through which the trust or other specialist services provide time-limited support and advice.

In Estonia, Caritas Eesti (an NGO) provides food aid to young parents through its food bank. If necessary, young parents are also provided with furnishings and clothing (provided by donors) for themselves and their children.

The association also helps young parents obtain legal assistance where required.

Support centres and counselling services

Support centres and counselling services can be preventive or compensatory. They offer a safe space for young people who are already facing certain problems as well as for young people that may have questions. Support centres and counselling services tackle a range of barriers, compensating for lack of specialised public services. The staff working at these support centres have specialised competencies to deal with particular topics, such as gender identity, substance abuse or crimes among young people, that are often missing among mainstream service professionals. In most cases services at these centres are provided by different health and social professionals, such as psychologists or social workers, who cover a variety of topics and issues. A common topic addressed by counselling services is problems related to drug addictions.

The Prevention and Information Centre on Drug Addiction in Bulgaria implements preventive awareness raising and educational activities, programmes, training sessions and seminars related to the use of narcotic substances. It also has a multidisciplinary team of psychologists, adolescent psychologists and social workers as well as administrative staff. The support provided is related both to physical health and emotional/psychological needs.

Broad issues around sexuality and sexual health are also commonly addressed by support centres and counselling services. While Inkoo's initiative is primarily a support centre providing contraceptive care (for both girls and boys), it also provides information to young people about sexuality, sexual health, pregnancy and sexual transmitted diseases.

Counselling may also be provided by lawyers and/or other legal professionals. This is the case in RIKU support centres in Finland, where young people can get further personal support when they have been a victim of a crime. As well as legal help, psychological support is provided by professionals who are specialised in working with young people.

Different types of support services

Confidential services to provide a safe space

One of the issues relevant to accessing services highlighted in Chapter 2 is the importance of anonymity. One major barrier is the involvement of parents as gatekeepers to certain services. Young people might be embarrassed to talk with their parents about certain topics (such as sex and mental health issues) or they may be afraid of being punished should parents considered that they have done something wrong. By guaranteeing anonymity, a number of services have successfully reached out to young people. For example, the provision of support through anonymous online chat services has increased extensively in recent years. In addition, the number of young people attending remote services has steadily increased, which could

indicate that young people feel more comfortable with an online service that provides guaranteed anonymity.

The École des Parents et des Éducateurs d'Île-de-France (EPE-IDF) runs the Fil Santé Jeunes hotline and website. The Fil Santé Jeunes initiative offers anonymous contact through website, online chat and telephone services to overcome the perceived stigma of contacting a psychological or psychiatric service. It is not necessary to submit documents or complete any paperwork. The service explicitly chooses not to respond to parents' queries to avoid the risk that they 'invade' a space that is meant to be for young people.

In Estonia, ESHA services provide anonymous support to young people who do not want to talk about their concerns to a specialist at school, a family doctor or a gynaecologist in the hospital. Anonymous support may also be useful to young people who have witnessed a crime being committed or have themselves been victim of a crime and who, for whatever reason, prefer to maintain anonymous. RIKU in Finland provides an online chat function for such cases. No personal information is collected during the chat. Only in the case of serious crimes are young people asked to talk to a professional (by phone). Parents are not informed that their son or daughter has contacted RIKU. However, in the case of serious crime (such as sexual violence), RIKU is required to inform the police.

Online support to facilitate access

As outlined earlier, provision of support online can help to address several barriers; this allows for greater privacy when sharing concerns on sensitive matters (like sexual and reproductive health) and helps to overcome geographical distance and reach more young people. Moreover, online support can be helpful addressing the stigma of using psychological and psychiatric services. There is certainly a shift toward providing services online. Most of the case studies reviewed are increasingly capitalising on the benefits of online support. In terms of the main tool, online chat seems to be most widespread in reaching out to young people of different ages. However, one must take into account different pitfalls associated with online support. The most obvious is the fact that not all young people have equal access to the internet, and in some cases the most in need may have greatest difficulties in accessing this form of support. For example, asylum seekers or homeless people might have difficulties in accessing online support.

There are a number of examples of case studies utilising online support as means of delivering their services. In the UK, the Albert Kennedy Trust offers an online space via the Inter-AKT service. This is aimed at vulnerable young LGBTQI people who can receive support from a digital mentor on a range of topics, including: housing and homelessness; skills development; coming out to friends and family; bullying and abuse; well-being; and referrals to local services and groups. One of the key features of the programme is that it can help young people prepare to come out to friends and family. This enables them to better plan for all eventualities, such as becoming

homeless. In offering this service, the trust can help overcome individual barriers to accessing services, such as lack of knowledge about the services available, perceived stigma of being LGBTQI or lack of awareness about rights and opportunities. The service can be accessed via computer, laptop, tablet or smartphone from any location. While e-mentors are not available 24 hours a day, there is an emergency contact number available for when young people need urgent support.

The French initiative Fil Santé Jeunes is a national service providing remote prevention and support on health matters to young people aged 12–25, especially those in rural areas. It includes a hotline run by a team with complementary professional expertise (physicians and psychologists), who answer young people's health-related questions daily from 09:00 to 23.00 through a dedicated website and a live chat. There are also forums moderated by professionals where young people can interact with each other. As observed by the director of EPE-IDF, young people speak more easily of personal things such as sexuality, contraception and relationships on an anonymous phone line or web chat.

In Estonia, ESHA offers a web platform, through Amor.ee, that provides online sexual health counselling to young people. The website includes exhaustive information on topics such as puberty and body development; intimate relationships and sexual intercourse; sexual identity, including LGBTQI issues; pregnancy, contraception and abortion; sexually transmitted diseases; rights, sexual violence and healthy and safe intimate relationships. The anonymous and free-of-charge web-based counselling service allows young people to ask questions and discuss issues. The website also runs a forum where young people can discuss, and ask questions about, sexuality and reproductive health. The forum is run by an administrator and an advisor.

In Finland, RIKU has a web chat function where individuals can interact with social workers who specialise in youth crime. In the case of a serious crime, the social work professional or volunteer will try to talk to the young person by phone (if a phone number has been given).

Personalised guidance in navigating the system

Chapter 2 showed that navigating through what is often a complex system may be a barrier to accessing services in a timely manner. Every country has different bureaucratic procedures, and consequently young people might experience difficulties when accessing certain support services. In three case studies, specific guidance is provided in order to support young people in navigating the system effectively. In two of these case studies, guidance is provided face-to-face, and in one case by means of a digital mentor.

The system as the main barrier is clearly illustrated by the main challenge faced by young people at risk of homelessness in the UK: the welfare system has strict and complicated eligibility criteria. Young people can be discouraged from taking up benefits that are difficult

to understand, or it may be that they are not eligible for support services. For example, local authorities are currently only required to provide emergency housing for individuals under 18. In addition, the current benefits system provides less financial support to individuals under the age of 26. Overall, the severity of the issue of homelessness among young people coupled with the inability of the system to tailor support to the specific needs of this target group means that there are increasing numbers of initiatives trying to address this.

In France, the Fondation Abbé Pierre is a national organisation engaged in addressing the issue of homelessness and supporting access to affordable housing for young people. It has started advocating for greater use, and dissemination, of the *Agences immobilières à vocation sociale* (AIVS) system among local youth. The AIVS is a group of non-governmental agencies that promote access to privately owned rental housing for low-income people by offering a number of accompanying services to tenants, which also serves to reassure landlords. Normally, young people do not know about the existence of these agencies, and the agencies are more focused on an older target group. Another challenge for young people is accessing housing allowance, which requires multiple bureaucratic steps. For that reason, the Brest Alma AIVS focuses specifically on guiding disadvantaged young people through this system, collecting the necessary information to get approval by an owner as well as the social assistance which pays a large part of the rent.

Use of proactive campaigns and social media to raise awareness

The majority of the case studies reach out proactively to young people, especially those that face additional barriers in accessing services, and many are also trying to raise awareness on certain health and well-being issues. Preventive approaches in raising awareness vary greatly, using a variety of tools and strategies. Some common tools can be distinguished: young ambassadors, interactive workshops, public events and peer-to-peer support. The one barrier each of these aims to address is lack of awareness of health risks. This might be among the general population or, specifically, young people, parents, teachers, policymakers, etc.

Young ambassadors

In two case studies, young ambassadors are engaged with the objective of reaching out to wider groups of young people. In both cases, young ambassadors attend various events and festivals. In YAD (Finland), young volunteers also organise their own activities locally. Furthermore, in both case studies, young ambassadors are active on social media to promote their initiatives and attract other young people. In the UK, the Albert Kennedy Trust engages in a range of activities to promote a positive message and exchange of information and experiences within the LGBTQI community. Their young ambassadors are a team of ex-service users who represent the trust, delivering key messages at events and via the media.

Interactive workshops

In various case studies, interactive workshops are provided in order to proactively reach out to young people and raise awareness about certain topics. These topics relate to sexual health, young parenthood, eating disorders, substance abuse and how to identify crimes such as cyberbullying. These workshops are provided by trained young volunteers, health professionals or social work professionals. Some initiatives are provided as part of national mainstream services. Furthermore, some workshops invite parents to attend the events or provide separate workshops for parents. Most workshops are organised at schools, but in two cases, workshops take place at the initiative (Prevention and Information Centre on Drug Addictions – Bulgaria; Young Parenthood Programme – UK). The main barriers addressed with this tool are lack of awareness of health risks and poor knowledge or lack of confidence among parents in providing education.

In Bulgaria, the Life by the Kilo programme was initiated in an effort to increase awareness about eating disorders. The team organises monthly meetings with students in secondary schools. These are organised in three stages. In the first stage, the main topics are the students' role models and the way they see themselves. In the second stage, meetings aim to teach students how to recognise various emotions and how to deal with them. The relationship between emotions and eating habits is discussed, as well as looking for comfort through food in cases of negative experiences or when lacking positive experiences. The third stage of meetings introduces students to the risks, signs and consequences of the main types of eating disorders. The tools used in the meetings are fully interactive: exercises, games, informal conversations and discussion of specific cases. This approach stimulates young people not only to accumulate information but also to experience and understand the essence of the problem.

Also in Bulgaria, the Prevention and Information Centre on Drug Addictions organises preventive awareness raising and educational activities, training and seminars related to the use of narcotic substances. Finally, in Finland, RIKU provides workshops at local schools to educate young people about what is a crime and how to recognise a crime as well as when and where to get help.

Public events

Similar to workshops but on larger scale, a lot of initiatives use public events as a vehicle for their messages to raise awareness about certain topics, such as young parenthood, eating disorders, bullying and drug abuse. Some initiatives target the general population, whereas others focus solely on young people or health and social professionals and policymakers. The main barrier addressed with this strategy is lack of awareness of health risks among the general population. In addition, initiatives try to break down certain stereotypes through raising awareness at events – for example, that addiction is a choice rather than an illness.

The Single Step Foundation in Bulgaria participates in various events and activities in order to reach out to young people and to raise awareness among the general public

about LGBTQI issues. For example, the team took part in an adult-oriented event at a children's museum, focusing on the topic of taboo. The event featured exhibits based on the theory of learning through play and applied activities. Through interactive lectures, Single Step aimed to battle prejudice associated with LGBTQI people.

In a similar approach, Life by the Kilo in Bulgaria participates in open events in order to reach out to the general public. For example, the team also participated in an adult-oriented event in a children's museum, based on the theory of learning through play and applied activities. Through interactive lectures, Life by the Kilo aims to raise awareness on causes, symptoms and health risks of eating disorders. To improve access and uptake, Life by the Kilo has encouraged exchange of information between schools through word of mouth. As the message is now transmitted within a network of school psychologists, many of the psychologists have recommended the initiative to their colleagues. As a result, there has been a rise in the number of schools interested in the programme.

Peer-to-peer support

Peer-to-peer support is increasingly popular among service providers that aim to have more user involvement in the delivery of their services. A peer-to-peer model has been introduced by two case studies. In one, this concerns young parents, and in the other, support focuses on students. In the first case, the peers involved actually have experience of the topic of interest (young parenthood) while the young people who are targeted do not. In the UK, the Young Parenthood Programme uses a peer-to-peer model which enables young people to hear directly from others of a similar age about their experiences of being a young parent. Almost three-quarters of young people surveyed reported that they preferred hearing about a range of topics from people who have personal experience (Coram, undated). The face-to-face contact and co-productive design of the sessions offer young people the opportunity to hear personal stories first-hand and ask about the impact of having a child at a young age. The interactive nature of sessions is critical, creating a safe and familiar space for discussions and support around the issue of young parenthood.

In Estonia, the TORE initiative engages young people in supporting other young people who may be at risk of being bullied. The young peers have not necessarily been bullied, but they do identify and support young people that are being bullied or that are of high risk of being bullied. They offer a range of activities, including; individual peer-to-peer support to isolated schoolmates, victims of bullying and young people in trouble; intervention in conflicts at school (e.g. a conflict class); conducting thematic training and seminars (e.g. on bullying or drug issues) for other students; providing assistance to and cooperating with teachers and social pedagogues (e.g. involvement in solving a bullying case).

Both initiatives take place at schools and are mainly preventive, although TORE is also compensatory since young people that are bullied are supported as well. The barrier overcome by provision of peer-to-peer support is reluctance of young people to talk about certain issues,

such as young parenthood, to parents, specialists at school, family doctors or other professionals.

The experiences of these initiatives show that young people are better informed when making choices; have greater awareness of certain topics; and have increased empathy and higher levels of self-reflective thinking. The initiatives also raise awareness about personal responsibility; help young people to foster a long-term view of their lives and raise their aspirations; and help them feel supported.

It is difficult to conclude whether such models are more effective than non-peer models, as the impact of these two case studies has not been evaluated. However, many schools are interested in such programmes. For example, in Estonia, 62 schools are currently running the Parenthood Programme. As for the TORE initiative, there are currently over 80 mentors in schools (on average 1–2 mentors per school). To date, thousands of young people have undergone TORE basic training. In 2018 there were 627 TORE mentors (mostly support students). These numbers have steadily increased since the initiatives began, indicating that models such as these are successful in reaching young people.

Key success factors in case studies

Sustainability and transferability

Similar to mainstream health and social services, services provided by NGOs are also subject to cuts in welfare expenditure in many Member States. Many initiatives discussed in this report rely heavily on public funding, either directly or indirectly through use of publicly funded services or benefits and allowances. The differences between countries in the generosity of the welfare system affect transferability of good practices from one Member State to another. When welfare is secure and services are available to support young people, good practice can simply consist of giving advice to help navigate the system or setting up very specific and tailored services for particular groups not yet covered by statutory services. Where public services are more scarce and where welfare is less generous, partnerships with the private sector can still refer young people to a network of services; however, the offer is more scarce for the general population and it is more likely that initiatives for young people will be of the awareness-raising, 'soft' type and based on funding of particular projects. The sustainability and impact of such initiatives is more uncertain as they depend on ad hoc funding.

Groups that remain hard to reach

The initiatives presented in this report have enabled providers to better reach out to different groups of young people. Nonetheless, by their own admission there are still groups of young people that remain hard to reach. Sometimes the limitation comes from the need for referral by local authorities and local social services. Young people without a residence permit, young people in conflict with the law and others who do not feel at ease with or cannot contact public authorities can hardly be reached out to in this case. Young asylum seekers are another group that is often not reached by the initiatives. Initiatives that target schools do not reach out to young people with particularly low attendance, who are at risk of dropping out or who have already left education. Also, in many cases, young people with disabilities (e.g. young people with hearing impairments, young parents with intellectual disabilities) have very specific needs in terms of accessibility, which are not catered for by initiatives. At times, young people from a particular language minority (e.g. Russian speakers in Baltic countries) cannot be reached by services, despite efforts to remove the barriers. Overall, it can be said that the process of making health and social services inclusive and responsive to the needs of young people requires a never-ending effort, and success in reaching certain groups brings new challenges of including other groups.

Key success factors

While diverse approaches and a variety of tools are used by the case studies, some aspects of service delivery have emerged as key success factors.

First of all, flexibility is critical in service delivery. Services need to adapt their delivery to evolving trends among young people – being able, for example, to transform a hotline into an online chat service or replace a web page with an app that can be used from a smartphone. There is also need for flexibility in opening hours and in acceptance of cases where, for instance, not all the administrative documents are ready. Flexibility also means dealing with multiple disciplines, because young users are not always able to identify by themselves which type of professional or service they need.

Another success factor concerns the level of knowledge and specialisation of professionals on issues specific to young people. Tailoring support to young people implies knowledge of the particular problems that this target group encounters. However, in specialised services, staff may tend to rely on their own professional networks rather than interacting with mainstream services such as family doctors. In a few cases discussed in this report, cooperation with family doctors was, in fact, established, and this allowed staff to inform family doctors about youth-specific issues.

Having empathy with young people and understanding of their needs is another key success factor. This can be achieved through professional training, but it can also be encouraged by involving young people themselves via peer-to-peer support. The often patronising attitude of parents, teachers and health professionals is neutralised when young people have the opportunity to learn something from others of the same age or to receive help from other young people who have experienced similar circumstances. Mobilising peers does not imply less engagement from professionals; on the contrary, professionals need to maintain a discreet presence to make sure that the right messages are put forward and scientifically supported knowledge is provided.

4 | Perspective of service providers

This chapter presents the results from a web-based survey with providers of services that focus on health and social inclusion issues for young people. Organisations from the 28 EU Member States were invited to participate. The full questionnaire and information on methodology can be found in the Annex. The chapter gives an overview of the common challenges faced by service providers as well as ways of improving services and thus reducing inequalities in young people's access to services.

Characteristics of service providers

Operational set-up

The vast majority of respondents are based in NGOs (77%). Governmental organisations are less well represented, with just 14% of participants describing their organisation as a public service provider. Whereas combinations of public, NGO and private ownership characterise 8% of the participating organisations, hardly any providers are strictly private (0.5%). As described in previous chapters, the social or health issues that young people are grappling with are often complex and interrelated. In order to effectively address these issues, active cooperation among different organisations and services is essential. The consultation indicates the following:

- nearly all organisations (92%) cooperate with municipal, local or other governmental authorities
- more than half collaborate with other service providers for young people (67%), schools or universities (68%) and NGOs (77%)

Moreover, some problems experienced by young people, such as poor mental health, might not be immediately apparent and are only detected over a longer period of interaction. In those cases, schools and universities – places where young people strive on a daily basis – might play an essential role in identifying need for support or preventive services.

Staff

In providing their services, organisations rely on a combination of full-time staff (36 per organisation on average), part-time staff (21) and, in certain cases, on-call staff (16). The involvement of users and volunteers varies considerably depending on the organisation. While certain organisations have more than 1,000 volunteers and/or users who can aid in providing services, other organisations have only a handful.

Target groups

Half (50%) of the organisations surveyed provide services to all young people, or general services, rather than aiming at a specific target group. For the organisations that do focus on specific groups of young people, the most prominent target groups are young people experiencing (or at risk of) poverty and social exclusion (27%) and those

experiencing homelessness (21%). In addition, almost one in five (18%) organisations specifically target young people with mental health problems, providing services related to depression and anxiety. This is an important finding: mental health issues represent one of the biggest challenges faced by young people (see Chapter 1); in addition, a large number of young people experiencing a problem struggle to afford psychological services (see Chapter 2). In the majority of organisations (59%), services were used by more than 500 individuals aged 12–24 in the year prior to the survey, just over a quarter (26%) of these organisations reaching more than 1,000 young people.

Types of service

As outlined in Chapter 1, the most common social and health problems for young people (aged 12–24) are multifaceted. The need for a comprehensive approach seems to have been taken up by many service providers, as the majority reported being involved in several types of youth services.

The most common practice is to organise events or activities aimed at young people (65% of the organisations do so for those aged 12–17; 58% for those aged 18–24).

The second most common type of service is to provide education or information on health (46% of the organisations do so for those aged 12–17; 44% for those aged 18–24) as well as information on social issues (45% for those aged 12–17; 53% for those aged 18–24).

Finally, more than 4 out of 10 provide mental health services, addressing conditions such as depression and anxiety (44% of organisations do so for those aged 12–17; 43% for those aged 18–24).

Provision of services

In order to understand how service providers can overcome barriers for young people in accessing services and reduce inequality of access, it is important to examine how young people are introduced to services and what tools are effective in the delivery of services.

Most typically, young people access services via other young people or approach services by themselves (66% of young people reporting each of these). Peer-to-peer introduction to services requires that the young person is associated with a social network and has good relations with their peers in order that they are able to open up and share their experience or express a need for support. The finding that young people's peer networks are so important in introducing new users highlights the significance of individual barriers to accessing services, especially for young people at risk of social exclusion who may lack strong social ties with other peers. When the young person approaches a service provider themselves, this requires the young person to be in a position to reach out for help or support; for example, having access to the

internet or the means to travel to the service provider's premises. These issues mean that young people who experience or are at risk of social exclusion may be at a double disadvantage in accessing services: not having the necessary means to access support and not being encouraged by peers to make use of services.

Attending locations where young people are likely to be present, such as schools or youth clubs, was reported by survey respondents as being useful for introducing new users. Also mentioned was referral by other institutions such as social services (61%) or schools (56%).

Lastly, service users were introduced to a service through attending events (52%). The importance of this form of introduction is in line with the finding that organising events is a common practice among youth service providers.

With regard to methods of service delivery, organisations typically use a mix of different approaches. Face-to-face contact plays a prominent role, with 73% of the organisations having face-to-face meetings with young people at their premises, 62% offering face-to-face services at schools, youth centres or other public spaces used commonly by young people, and 59% relying on group work. Such contact requires that the provider's premises are located conveniently for the target group, which is a problem in some cases (discussed further in the section on barriers). In addition to face-to-face delivery, printed leaflets, books or posters constitute a key method of delivery among the organisations surveyed (60%), as do web- or app-based services and social media (59%). These findings suggest that groups of young people who face barriers to accessing face-to-face services, such as young people living with disabilities, rely more strongly on alternative methods of provision, like services delivered via the internet. However, young people who cannot travel to a service location and do not have access to the internet are not benefiting from some of the information or support that they are entitled to.

The timing of support and information provision can be key in easing challenges occurring during the transition into adulthood, which are often severe and sometimes have lifelong effects. The vast majority of organisations (84%) are involved in prevention; that is, providing preventive support and/or information services or education. A large proportion (78%) are involved at the point where the young person is coping with a problem. However, since most organisations focus on education and information provision, somewhat fewer organisations (55%) are involved in providing services that are compensatory rather than preventive. Reasons for this may be that some serious health or social problems may require intervention by more specialised staff. Dealing with life-endangering matters such as eating disorders requires medical and psychological expertise. Likewise, problems such as homelessness may require structural and strategic operational support.

Barriers to accessing service provision

When identifying barriers to accessing services, it is helpful to distinguish between barriers associated with the internal operation of services and those which are associated with the users themselves.

Identifying the barriers

Survey participants were asked to rate the severity of a range of access issues on a scale from 0 (not an issue) to 10 (a very serious issue). Ratings indicate that several of the most serious access problems were related to the operation of services: securing financial resources (with an average rating of 6), managing administrative burdens (5) and meeting large demands with limited resources (5) (see Table 9). In relation to the need to improve management capacity, one respondent commented on the problem of recruiting and retaining staff with the right skills and qualifications:

> The main challenge is the pay in the field of youth work. The salaries are too low and the expectations are too high. Youth workers are expected to work around the clock; it's not a normal 8–5 job. Because of this, people tend to go to more secure jobs with normal office hours, less work and higher pay.

Half (50%) of the organisations consulted target their services to young people with specific characteristics. One issue faced by these organisations involves unsuitable referral from other organisations due to lack of availability of more appropriate services locally. This can be a consequence of inadequate financial and professional capacities; staff may be specialised in supporting specific needs but not complex health or social problems, such as drug addiction or mental health diseases.

Achieving and maintaining contact with young people was also flagged up by survey respondents. Approximately one in four organisations perceived reaching their specific target group as a serious issue, 22% rating this 7 or higher on the severity scale. Respondents in Lithuania gave higher ratings of severity to this problem than those from other countries. In relation to keeping in touch with young people after they leave the service, 26% rated this issue 7 or higher.

Identifying hard-to-reach groups for service provision is one of the key objectives of this research. Table 10 shows that almost 40% of the service providers who took part in the survey reported no access problems among specific target groups. However, some groups of young people seem to face greater difficulties accessing the support and information they need. The views of survey respondents on three of these groups – namely, young people without access to the internet, young people living with disability and young people in rural areas – are discussed below.

Lack of internet access

Internet access is still not evenly available across the EU due to a range of factors including coverage and high telecommunication charges as well as challenges related to digital literacy. Young people with little disposable income and those with intellectual disabilities are prone to digital exclusion and, therefore, at greater risk of not receiving the support or information they need. Young people without internet access were identified as difficult to reach by 26% of organisations in the survey, which is not

Table 9: Rating for a range of access difficulties (severity scale; 0–10)

	Average rating	Percentage giving a score of 7 or higher
Securing financial resources, in terms of the necessary amount at the right time	6	54
Administrative burden or bureaucracy associated with operation	5	28
Being unable to meet a large demand for the service with existing time and resources	5	25
Need to improve management capacity (e.g. strategic planning, communication, partnership building)	4	26
Recruiting staff with the right skills or qualifications	4	22
Young people not in the service provider's target group are referred to them because no specific services are available in the area	4	20
Reaching the target group of young people	4	22
Keeping in touch with the young person after they leave the service	4	26
Stigma associated with using the service	3	14
Reaching or retaining contact with a specific group of young people within the target group	3	15
Retaining young people (avoiding dropouts)	3	16
Retaining staff	3	11
Other challenges	3	8

Note: *Difficulties were rated on a scale from 0 (not an issue) to 10 (a very serious issue). Multiple options could be selected; therefore the sum exceeds 100%.*

Table 10: Target groups with problems accessing services provided (%)

	Percentage
No target group has problems accessing services	40
Lacking access to the internet	26
Having physical or intellectual disabilities	25
Living in rural areas	24
Aged 12–17	19
Experiencing homelessness	18
Left school early or not currently in school	16
Over the age of 18	15
Belonging to an ethnic minority group	13
In care	13
Immigrants or refugees	10
Having a specific religion	8
Experienced family conflict and/or rejection	7
LGBTQI	4

Note: *Multiple options could be selected; therefore the sum exceeds 100%.*

surprising given that a large proportion (42%) offer their services via the internet (web- or app-based support).[4] Unsurprisingly, organisations that have direct contact with users (e.g. as part of face-to-face meetings) were less likely to report access problems for young people having no access to the internet (18% of organisations). Young people with an ethnic background who have no internet access or those from the LGBTQI community without access were perceived as being particularly hard to reach. Lack of internet access was more likely to be considered a problem for accessing services that target LGBTQI young people (60% of organisations reporting this) than those targeting young people from an ethnic minority background (41%). Since each of these hard-to-reach groups cope with sensitive issues linked to identity, they would find it especially useful to have anonymous contact online with service providers.

Young people with disabilities

Young people with disabilities are more likely to face social or economic problems than their peers living without disability. Yet one in four organisations indicated that living with a disability impacts ability to access their services. Respondents in Portugal were especially likely to perceive disabilities as problematic for young people seeking to access to their services: every second organisation flagged that additional measures are required to ensure access by young people with disabilities.

Physical disabilities can limit mobility, making it more difficult to attend events or activities – an important approach for youth service provision. This is borne out by the responses of providers involved in organising events

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[4] For all bivariate analyses, specific proportions are compared to the proportion within the entire sample (in this case 26.2%). All reported proportions differ significantly from the proportions in the entire sample (p < 0.05).

or activities, who were most likely to indicate that young people with physical or intellectual disabilities had access problems: 38% of providers organising events or activities for those aged 12–17 and 33% doing so for those aged 18–24.

In addition, for those living with an intellectual disability, dependence on carers can be a decisive factor in access to public services. For example, action by the carer may be essential to establishing contact between the young person with intellectual disability and the service provider. As one respondent from a Maltese organisation stated in regard to mental health issues:

> Usually the biggest challenge is not the young people themselves but the parents who tend to keep the young people with mental health issues very protected, which limits [their access] to experiences which might help them.

Young people living with disability are perceived as a hard-to-reach group by sex education and family planning service providers for young people aged 18–24 (49%) as well as those using web- or app-based services or social media (35%). This latter finding could be due to poor results when using electronic means of service delivery to reach young people with intellectual disabilities.

Young people living in rural areas

Service providers rely in large part on young people being able to attend their events and visit their premises. However, this may be more difficult for young people living in rural areas. Almost a quarter (24%) of the organisations in the survey reported that young people in rural areas have problems accessing their services. This was most commonly reported by organisations offering sex education for young people aged 18–24 (37%), information on social issues for those aged 12–17 (34%) and emotional or psychological support for those aged 12–17 (34%) and 18–24 (33%). For young people using these types of services, anonymity is important; but this might not be guaranteed in rural areas where youth services are sparse.

Access problems for young people living in rural areas were found to be most prevalent in Croatia (83%), Lithuania (54%), Portugal (50%), Bulgaria (46%) and Hungary (44%). A youth service provider from Croatia stated:

> Our location where we provide services is often out of reach for young people who have little or no means of public transport. This is a serious issue within rural areas where we provide our services, and we have trouble finding young people who can travel to our location.

Access problems for youth in rural areas were most common in organisations targeting young people with an ethnic minority background (42%) and those at risk of dropping out or leaving school early (39%).

Age as a barrier to access

The age of the young person in need of support also matters. In total, 19% of the organisations indicated

that teenagers aged 12–17 had problems accessing their services. These problems were most common in organisations targeting young people with mental health problems (reported by 36% of organisations in the survey).

With regard to young people aged 18 and over, 15% of organisations indicated that this group had problems with access. Organisations targeting LGBTQI people were most likely to report access problems for this specific age group (35% of these organisations). This finding suggests that LGBTQI individuals may be more difficult to reach after they leave secondary school.

Issues affecting access to services

The organisations were asked about issues that impact on young people's access to their services. Nearly half of the organisations consulted (48%) mentioned 'lack of awareness of the service or entitlement' as a particular issue. This problem is not specific to a certain type of service, but exists across the range of health, mental and social services included in the survey. Nevertheless, providers working on substance abuse for young people aged 18–24 were least likely to report access issues due to lack of awareness or entitlement (20%). In terms of specific target groups, this issue was most prevalent in organisations targeting LGBTQI young people (89%).

In addition to awareness and entitlement issues, 36% indicated that 'lack of interest' negatively affects access. This was reported most frequently by organisations that use 'other media, such as television, radio or newspapers' (58%), possibly due to young people increasingly using the internet rather than more traditional media. Furthermore, lack of interest is a common concern for organisations that engage in prevention (42%). The latter suggests that without an acute need for support, young people lack interest in preventive services. While this may be partly a reflection of poor communication by services on the importance of prevention, this, like all of the above-mentioned access issues, is a personal barrier deriving from the individual young person. However, as described in Chapter 3, individual barriers may be an adverse outcome of societal barriers.

Other factors impacting access are related to the organisation itself – and they are in line with the issues identified in the previous sections. These include institutional or structural barriers such as a lack of resources (37%), the physical location of the provider or transport issues (24%) and lack of staff with relevant skills (21%). Cultural and societal barriers, such as stigma associated with accessing a service (27%), also play a role.[5] This issue is particularly prominent in organisations offering foster care or family placements for young people aged 18–24 (57%). It is also common in organisations that provide services aimed at re-engaging young people experiencing social exclusion (42% of organisations addressing this issue with young people aged 18–24 and 42% working with the 12–17 age group). For organisations dealing with sensitive issues such as these, stigma associated with using a service may be especially prominent.

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5   This specifically assesses the impact of stigma on *accessing* a service as opposed to stigma as a *general* difficulty for youth service providers, which is reported in Table 9.

Finally, cultural and societal barriers such as language issues were noted as a problem by 24% of the service providers. Language issues were most common in organisations providing support related to teenage pregnancy or crisis pregnancy in young people aged 18–24 (50%) and those offering housing services for the same age group (38%).

Overcoming the barriers and improving services

Case study findings (see Chapter 3) provided some insight into strategies and tools to overcome access barriers and inequalities. The case studies revealed that successful approaches to reducing access barriers include confidential services providing a safe space for young people to open up as well as proactive campaigns to raise awareness. These findings are echoed in the survey of service providers. They were asked whether they have taken measures over the last few years to improve access for young people and reduce inequality in access among this group. The most prominent actions are related to the promotion of their services.

Measures taken to improve access

The measures taken to improve access for young people include promotional efforts using leaflets, websites or street advertisements (66% of organisations) as well as face-to-face information sessions or presentations in schools (51%) (see Table 11). These promotional efforts may contribute to raising awareness and increasing interest in services, two key barriers to access. Face-to-face promotion in schools is most common among organisations that provide teenage pregnancy/crisis pregnancy support for those aged 18–24 (carried out by 91% of organisations). This is also common in organisations offering services aimed at re-engaging with youth that experience social exclusion (80%) and services related to physical or sexual abuse (79%) for the 12–17 age group. Promotion efforts may be especially important for these services because providers may aim primarily to prevent such problems before they arise or address them at an early stage.

Significant effort has also been put in to making services available online or via telephone (50%). This is most commonly mentioned by organisations providing support in case of teenage or crisis pregnancy for young people aged 12–17 (91%) and 18–24 (89%), followed by organisations offering mental health services to those aged 12–17 (78%). In these cases, web-based and telephone communication allow young people to receive support more easily and get in touch with organisations without having to involve their parents or teachers. The development of these channels could also contribute to raising awareness as well as easier access for young people living in remote regions or those who perceive a stigma in using certain services.

Furthermore, efforts have been made to reach out to specific subgroups who have limited access to services and are difficult to reach (e.g. ethnic minorities). In total,

41% of the organisations in the survey reached out to specific groups of young people with limited access. This was particularly common among organisations providing teenage or crisis pregnancy support for those aged 18–24 (89%), services related to foster care or family placements for young people aged 12–17 (80%) and services related to antisocial or criminal behaviour for young people aged 18–24 (74%). These services have in common the fact that they address sensitive topics and issues, which can explain why additional efforts are required in order to reach the target groups.

In addition, measures have been taken to reach out to caretakers (families or teachers) by 48% of organisations. This strategy is particularly common for organisations dealing with family-related issues, such as teenage pregnancy or crisis pregnancy support for young people aged 18–24 (88%) and services related to foster care or family placements for young people aged 12–17 (86%). Youth service providers might get in touch with family members directly to resolve the conflict. Moreover, when family problems arise, schools might facilitate access to appropriate services by referral of the pupil to the provider. Reaching out to caretakers is also common in organisations providing legal aid or mediation for young people aged 12–17 (80%). This strategy is also used to attract new users: in 66% of organisations, new users are introduced through parents or other family members, and in 61% users are introduced through schools.

Another measure to improve access (and reduce inequality of access) involves ensuring additional funding; for example, from NGOs, via parents or through tendering. In total, 44% of the organisations indicated that they had secured additional funding. As would be expected, among organisations that indicated a lack of resources, the majority (62%) had taken measures to secure additional funding. This measure was most commonly used in organisations providing services related to physical or sexual abuse (63%), health education and information (56%) and emotional or psychological support (54%) – all for young people aged 18–24.

A particular strategy to improve access is to involve existing users of the service. In total, 41% of the organisations involved existing users in activities to reach out to other young people. This strategy is more common in organisations providing services related to mental health (71%), physical or sexual abuse (70%) and existing substance abuse (65%) – all for young people aged 18–24. Having left secondary school, this age group may rely more on their peers in dealing with issues related to health and well-being. Involving users could be a useful strategy for increasing awareness that avoids having to increase staffing or budgets.

User involvement

To assess user involvement, the survey participants were asked whether service users are involved in various stages of provision. User involvement is most common during the needs assessment stage, with 61% of organisations involving users here. One Croatian respondent noted:

Table 11: Measures taken to improve access and reduce inequality of access (%)

	Percentage
Other promotion activities, such as leaflets, websites, street advertisements	66
Running face-to-face information sessions or presentations in schools to promote the service	51
Making services available online or via telephone	50
Reaching out to families or teachers	48
Ensuring additional funding (e.g. from NGOs, via parents, through tendering)	44
Reaching out to specific groups of young people with limited access (e.g. ethnic minorities)	42
Involving young people using the service to help reach others	41
Travelling to various towns or rural or remote regions to provide information face-to-face	38
Engaging in advocacy to promote the service to users	37
Simplifying procedures for accessing or using the service	32
Involving young people using the service to act as peer-to-peer providers	27
Making the service available in additional languages	20
Other measures	17
No measures were taken in the last few years	6

Note: *Multiple options could be selected.*

Before starting a new cycle of workshops, we ask young people about their needs and wants regarding our workshops. At the end of our cycle we always carry out an oral and written evaluation with the users.

The prevalence of young people's involvement in needs assessment highlights the organisations' concern with matching their services to the demands of young people. Achieving this match increases the likelihood that when the user does find their way into the service, relevant services are on offer. Other stages where users are involved include monitoring or evaluation (in 55% of organisations) and promotion or outreach (54%).

It is less common for users to be involved in delivering a service (38% of organisations) or in service design (38%). One explanation might be that organisations prefer to have *experts*, rather than users, provide information on health or social issues. Users are, nevertheless, very likely to be involved at some stage. Only 9% of organisations did not involve users at any stage at all.

To assess the potential impact of user involvement, organisations were asked whether this resulted in change/improvement to aspects of their services. As shown in Table 12, the improvement mentioned most commonly by respondents was increased awareness among young people of their organisations' services (57%). This is most likely the result of user involvement in promoting the services and reaching out to other young people. A related outcome is the increase in use of a service due to user involvement (41%). These results suggest that user involvement may be an effective strategy for countering the barrier of limited awareness of availability of services. Additional improvements relate to the content of services: for instance, the planning of future services (54%) and the

Table 12: Aspects that have changed or improved as a result of user involvement (%)

	Percentage
Increase in awareness of the service	57
Improvement in planning of future services	54
Improvement in service quality	52
Increase in trust in service providers	48
Improvement in monitoring of use, quality or outputs	43
Increase in attendance or use of the service	41
Improvement in access to the service for certain groups	34
Reduction in stigma associated with the service	25
No aspect has changed or improved as a result of users' involvement	10
Other outcomes	8

Note: *Multiple options could be selected.*

quality of services (52%) were both perceived as being improved as a result of user involvement.

Around one-third of respondents (34%) indicated that user involvement has aided in reaching particular subgroups of young people, and one-quarter (25%) reported that user involvement helped to reduce stigma associated with their services. The fact that these issues were mentioned less often than increasing awareness and improving service content is likely due to lack of relevance for some organisations: not all services aim to reach subgroups or have to deal with social stigma.

5 | Summary and conclusions

Young men and women are the future of European societies. When young people are engaged and empowered, they not only fulfil their own dreams and opportunities but they also contribute positively to society. However, despite unprecedented opportunity for young people to access information and support systems, there are concerns at both EU and national levels that the combined stresses from school, expectations from parents, and peer and societal pressures often create challenging transitions to adulthood that have a long-lasting impact through adult life. There are also concerns about the differences among social groups in terms of risk of health and social problems as well as inequalities of opportunity and resources to cope with problems when they do arise.

This report set out to review inequalities in access of young people to information and support services and how these inequalities can be overcome. This involved, first, in-depth assessment of the most common health and social problems young people face today; second, identifying the most pronounced barriers preventing young people from finding help or advice (i.e. inequalities in access); and, third, reviewing the tools and approaches that aim to reduce those inequalities. Eurofound's research focused on those aged 12–24. Where possible, information is provided separately for two groups: young people aged 12–17 and young people aged 18–24.

Most of the around 72 million Europeans aged 12–24 are healthy and socially well connected. Indeed, the report provides a reassuring picture in terms of certain risky behaviours; for instance, there are decreasing trends in rates of young people smoking regularly and being involved in recent incidents of intoxication.

Even so, many young people in Europe face a range of health and social problems. Despite improved economic circumstances, young people still feel the economic and social impact of the economic downturn. As recently as 2016, more than half (57%) of young people still felt marginalised due to the aftermath of the economic crisis. Within the EU, the highest levels of feeling marginalised by the economic crisis were reported in Greece (93%), followed by Portugal (86%), Cyprus (81%), Spain (79%) and Croatia (78%), all countries that battled severe recession. The lowest level (27%) was for young Germans aged 16–30. Poverty and deprivation continue to impact many young people, particularly those living in eastern and southern European countries as well as young people in northern countries who leave the parental home at an early age. Living in deprived and remote areas with limited access to basic services (healthcare, social services and education facilities) is one aspect of poverty and may represent a key factor in social exclusion.

This report confirms that problems related to health and mental well-being affect many young people in Europe, and this continues to be a major challenge for policymakers to address.

Key factors and concerns

Mental health of young people is of particular concern across the EU. Data for 2016 indicate that 14% of Europeans aged 18–24 were at risk of depression, with young Swedes having the highest level of risk (41%).[6] (Interestingly, Sweden is the only country where young people (18–24) were found to be less optimistic than older citizens about their future, as shown in the EQLS 2016.) The second-highest share of young people at risk of depression was recorded in Estonia, followed by Malta, the Netherlands and the UK.

While the rates of young people actually suffering from chronic depression are much lower (4% of those aged 15–24 were chronically depressed in 2014), this is still of great concern. The highest proportion of young people with chronic depression was found in Ireland (12%), followed by Finland (11%), Sweden (10%) and Germany (9%).

Socioeconomic status has a strong impact on young people's risk of depression. Young people living in households in the lowest income quartile were more likely to be at risk of depression than those in the higher quartiles. Even though there was a significant improvement in the proportions at risk between 2011 and 2016, the gain for those in the lowest quartile was rather small compared to the better-off groups.

There is also a strong gender dimension to issues of mental health. Across the EU, young women (15–24) were more likely to suffer moderate to severe depressive symptoms. The greatest gender gaps were in Denmark, Germany, Ireland and Sweden. Only in Cyprus, Greece and Lithuania was the percentage of young men with current depressive symptoms higher than that of young women. This may be due to the tendency among young men to handle stressful situations via behavioural responses, such as engaging in fights or drinking, whereas young women tend to have more emotional responses, which may lead to psychosomatic issues (WHO HBSC 2018). There are some indicators of young women's negative handling of upsetting events, including comparatively high rates of eating disorders, such as anorexia or bulimia, and self-harm. On the other hand, when young men attempt suicide, it is more likely to be fatal than young women's suicide attempts.

There are also concerns around young people's physical health and, in particular, high and growing rates of obesity. The highest levels of obesity were observed in Bulgaria, Greece, Malta and the UK. There are clear gender differences too, with boys having higher rates of obesity than girls. Childhood obesity has lasting, often lifelong, consequences. In addition to early onset of chronic diseases and lower life expectancy, obese children

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6   The risk of depression is indicated by the WHO-5 index, a self-reported measure of current mental wellbeing.

and young people will likely experience bullying and poor attainment at school, lower productivity and less rewarding careers (WHO, 2014).

The incidence of bullying is on the rise in several European countries, as is the rate of cyberbullying. The prevalence of bullying was found to be highest in the Baltic states and among the French-speaking community in Belgium. The largest increases in bullying were reported in Scotland and Wales (in the UK). Meanwhile, reporting of regular bullying was comparatively uncommon in Czechia, Italy and Sweden, and the most significant decrease was measured in Romania. It is also noted that a relationship exists between the experience of being bullied and becoming a bully.

Discrimination is a key factor in young people's risk of social exclusion. This may be linked to cultural issues such as membership of a minority ethnic group, but it may also result from being perceived as different, as in the case of young LGBTQI people. The limited data on the experience or risk of homelessness show that young people are increasingly finding themselves in these situations.

It is important to note that not all young people are exposed to risks in the same way. Certain groups of young people are more prone to experiencing poor health or mental well-being and related challenges. These include young people with disabilities, those with weak family ties, those leaving care and moving from one institutional set-up to another, those living in rural areas or those from minority ethnic or migrant backgrounds (who, in addition to being at risk, may also experience discrimination). These groups may be in particular need of information and support services, and it is key that service providers are able to reach out to them and provide relevant services.

This report highlights that issues around health and mental well-being are among the most pressing problems affecting young people; access to services in social and health fields is key to addressing the associated risks. However, there is relatively little information available about the problems young people face in access to relevant services. An exception is data from the EQLS, which shed light on accessibility of healthcare services. A significant proportion of young people aged 18–24 reported some difficulties in accessing healthcare services; the most important access issue for them was long waiting times on the day (mentioned by 49%) and delays in getting an appointment (44%); both these issues are less significant for people in older age groups.

There are considerable inequalities among young people in Europe in terms of accessing healthcare. The most obvious differences can be seen by country. Cost, for example, is a problem for nearly three-quarters of those aged 18–24 in Cyprus, and it is also a considerable problem in Greece, Ireland and Malta. Distance is more of an issue in Cyprus, Greece, Lithuania and Romania than elsewhere.

Since the previous survey in 2011, cost issues have decreased by 9 percentage points for young people in the EU overall, but problems with delay in getting an appointment have increased by 8 percentage points and with waiting time by 5 percentage points. In Austria, Bulgaria, Cyprus, Latvia and the UK, more young people

reported difficulties in 2016 on most access dimensions, while in Italy and Slovakia some improvements were seen. In addition to country differences across the EU, regional inequalities in access exist within countries. A simple rural–urban distinction reveals significant disparities in access to healthcare. The main difference is in terms of distance, which was an issue for 24% of young people in rural areas but only 13% in urban areas. Inequality related to disability is also present in access to healthcare. Young people with a disability or chronic illness were more likely to report difficulties in accessing healthcare services. This is especially concerning as these young people are likely to be heavy users of healthcare services. There appears to be barriers in terms of the affordability of particular types of healthcare services, such as psychological or psychiatric services (which may be required to deal with more severe mental health problems). Among young people in Europe, 30% reported that they would find it 'difficult' or 'very difficult' to pay for these services. In countries where affordability is especially an issue, such as Greece, Cyprus, and Slovenia, young people would not consider accessing these services.

Of course, formal support structures are not the only option for young people reaching out for help. Family and friends continue to be the most common sources of help. When asked (as part of EQLS 2016) about support if feeling depressed or when facing a serious personal problem, in nearly all EU countries family was reported as the primary source for at least one of these issues; family was especially important in Slovakia, Lithuania, France, Hungary and Malta. Germany and Sweden were the only countries where family was not the main support for either of these issues, most young people turning instead to their friends.

Only 2% of young people said that they would turn to a service provider either when feeling depressed or when facing a serious personal problem. Acknowledging that this is probably dependent on the seriousness of the potential problem, it is still interesting to see the large differences between countries in terms of the proportion that would turn to a service provider: 12% in Finland and between 5% and 10% in the Netherlands, Denmark, Sweden, Ireland and Czechia, while it is 0% in ten other EU Member States. Part of the explanation for this is the availability and preference of family and friends as a source of support. However, in certain cases – for instance, when the issue is related to substance abuse or gender identity – families may not be the natural or the best source of support. Here, the availability of formal support services is key.

Overcoming barriers

The report makes a distinction between four types of barrier: personal; societal and cultural; structural; and operational. The evidence shows that each barrier poses different sets of challenges. These may be interrelated and reinforce each other. For instance, societal prejudices towards a certain group can result in a personal sense of powerlessness for a young person belonging to that group. These barriers and circumstances create different degrees

and forms of inequality in access to support and services, which initiatives discussed in this report seek to address.

Awareness among service providers of the needs of different groups of young people is critical so that they can identify particular groups not being reached and understand the factors underlying barriers to access as well as be able to implement effective solutions.

The majority of organisations discussed in this report provide services to all young people; when they do target specific groups, this is most commonly groups of young people that are at risk of social exclusion, those at risk of finding themselves homeless or those with mental health problems. This fits with the finding that issues related to mental health and, to a lesser extent, homelessness are the most prevalent among young people in Europe.

When it comes to young people's introduction to services, most commonly they are either introduced through peers (highlighting the importance of social ties) or they approach services themselves. The latter means that young people must be aware of their need for help and have the capacity to identify a resource and to use it.

Service providers identified specific groups of young people with access issues. Most notable were young people without internet access, young people living in rural areas and young people with disabilities. Young people with disabilities are of particular concern as they were more likely themselves to indicate that they have difficulties accessing healthcare services. Finally, the younger age cohort (those aged 12–17) was also mentioned as having particular problems accessing services.

The various initiatives discussed in this report illustrate some of the ways in which health and social service providers (or other organisations) attempt to overcome barriers to access. One way is to tailor services to groups of young people more effectively. In some cases, it is about conducting a thorough assessment of what the young person needs. In others, it is about teaching life skills that are missing. Sometimes it is about providing a drop-in centre where legal, psychological or practical advice can be obtained without having to complete paperwork, so that privacy is assured, while at other times it is about providing shelter to those young people at risk of being marginalised, like LGBTQI young people, and putting them in contact with others in the same situation or with social workers who really understand their problems.

It should be acknowledged that young people are less able to deal with bureaucratic systems than adults. Paperwork is a challenge for everyone, but young people have less experience of this task. Help with applications or identifying the right services, or the right professionals, is important, especially in those countries where allowances, subsidies or services are available to young people in principle, but not fully used.

A widespread approach to increasing young people's access to services is to make better use of technologies that address psychological and practical barriers. Online services are increasingly used to bring young people in to services offered by doctors, psychologists or social workers.

Such services provide interactive tools such as live online chats, both individual and group-based. These channels are successful because they allow for greater privacy when sharing concerns on sensitive matters (like sexual and reproductive health) and because they overcome geographical distance or travel problems. However, one must keep in mind, as noted by some service providers, that not all young people have access to the internet, and care should be taken to ensure that no one is excluded.

The extent to which social workers and other professionals actively reach out to young people varies. In some cases, they limit themselves to offering a safe space (an online space or a physical space), lowering thresholds and removing barriers to access. Young people may call, go online, or drop-in, if they want and whenever they want. Some services deliberately choose this passive kind of approach in order to respect the independent decision-making of young people. In other initiatives, rather than waiting for young people to contact them, professionals go to places commonly used by young people. For example, they might organise workshops and meetings in schools or other places young people visit, or they might hold events at youth festivals. This approach is especially common for preventive services and when information and awareness-raising is directed to all young people.

Evidence from the case studies

In the overwhelming majority of case studies included in this report, the providers were NGOs rather than mainstream services. This raises several questions regarding these initiatives: Are they sustainable? Are they reaching the young people who are most in need? Can services offered by NGOs deal with the specific, severe issues that young people face? This section reflects on the links between the case studies and mainstream health and social services. Moreover, as several of the case studies involve cooperation with schools (for example, some of the interventions happen in schools), this section also briefly touches upon the education sector.

Statutory or mainstream health services provide a wide range of services relevant to young people. However, in many cases, statutory health and social services do not address issues in ways that are specific for young people. Common operational barriers to access for young people include limited organisational capacity and resources and lack of targeted support for young people or specific vulnerable groups. One example in the UK involves a lack of local authority housing and other targeted statutory care for the LGBTQI community. This means that this vulnerable group may not receive needed support. Both Centrepoint and Inter-AKT launched their initiatives for this reason. In contrast to statutory services, these initiatives provide online information about housing and LGBTQI issues. Furthermore, they provide online advice and counselling to lower barriers to early access to services.

In another example from Estonia, pregnant teenagers had to use services, including lectures on pregnancy, motherhood and childcare, alongside adult women because only mainstream services were available. The

teenagers reported feeling uncomfortable. Therefore, Caritas Eesti, an NGO, introduced free services targeting young parents.

In Finland, in response to a lack of organisations that deal with issues around crime (being a victim of a crime or witnessing a crime) and how this may affect young people, the RIKU initiative introduced specialised online support (mainly chat) and face-to-face support for this issue.

Another potential problem with statutory health services is the cost to users. For example, in Finland, although some young people can get contraceptives from the public healthcare system, in many parts of the country, young people have to pay for contraceptives themselves. For this reason, the Inkoo initiative (whose coordinating authority is the municipality of Inkoo) provides free contraceptives.

Most statutory services deliver mainly compensatory services and are not focused on prevention. The Social, Economic and Environmental Council in France has recommended an extension of the MSA incentive (health insurance provided to 400,000 young people aged 16–30, representing 12% of affiliates to the agricultural social security regime) as a measure to increase use of preventive services, especially among rural young people. (A shortfall in provision may result in a failure to provide such young people with services.)

In Bulgaria, the Prevention and Information Centre on Drug Addictions in Sofia (a specialised municipal institution under the governance of Sofia municipality) is responsible for the implementation of a local drug prevention programme and proactively raises awareness of drug-related health risks by means of education programmes, workshops and online information.

Finally, it has been shown that young people express themselves more openly, especially about personal issues such as sexuality and contraception, when communicating through an anonymous phone line or online chat. These are subjects that are personal, private and sometimes taboo, which can be difficult to address in face-to-face situations. Statutory health services are primarily delivered face-to-face, and therefore initiatives have been set up that provide digital support.

In most EU Member States, in addition to offering the curriculum, schools are also places where professionals organise support sessions on topics that are relevant to young people, such as sex education and information about risks of drug taking, bullying, etc. In some countries, these have even become a compulsory part of the national education curriculum. There are, however, various issues that have been flagged, such as lack of relevance to the reality for young people and incomplete coverage of topics relevant to young people. To counter these challenges, several initiatives have been set up. For example, in the UK it was observed that sex education in schools lacks relevance to the reality of young parenthood. For that reason, Coram (an NGO) introduced the Young Parenthood Programme. The main difference between the existing sex education lessons in schools and the Young Parenthood Programme concerns the involvement of young parents, who provide their own perspectives based on their actual experiences.

In Bulgaria, standard lessons on health-related topics do not cover eating disorders or LGBTQI issues. NGOs such as Single Step and Life by the Kilo stepped in to cover these topics. In Estonia, even though mainstream sex education has improved and has also become more standardised, there are still topics that are omitted. Although schools generally cover topics that are easily taught in a lecture format (e.g. sexually transmitted infections and HIV, puberty, contraceptive methods), more difficult themes such as personal relationships or violence are dealt with less successfully. The Estonian Women's Health Survey showed that 21% of girls aged 16–17 considered school sex education insufficient. To address this deficiency, the Estonian Sexual Health Association (ESHA – an NGO) offers extra sex education lectures for students.

The availability of drugs within the EU is an ongoing challenge that many services deal with. In most Member States, traditionally, the topic of drug abuse has been addressed in schools. However, mainstream services confront difficulties in terms of keeping in touch with the ever-changing nature of drugs and their effects on young people. For example, in Finland, it was discovered that the traditional anti-drug measures and information services, provided exclusively by statutory authorities and through the public education system, had been failing to give young people the type of support they needed. Indeed, drug abuse and addiction have increased over the last years. In reaction, public policy sought to increase peer support for young people who are users or who are at risk of using drugs. This type of support was considered more conducive to convincing young people to seek help, but also reaching out to young people who could offer first-hand experience was viewed as beneficial. As a result, policy encouraged the creation and funding of numerous voluntary associations and NGOs that provide drug information and support to young people. For this reason, public policy supports initiatives such as Youth Against Drugs.

Finally, issues around bullying have always been present within the school environment, and, traditionally, the education system has put initiatives in place to tackle this problem. In recent years this topic has received more attention, and young people have been encouraged to speak out and seek support. However, with technological advancements, the nature of bullying has been changing, and concerns have been raised in many countries about cyberbullying. Also of concern is bullying affecting different ages. Several of the case studies in this report illustrate services that take place in schools but go beyond existing statutory provision. For example, in Estonia, there are some statutory anti-bullying programmes for students in primary schools, such as the KiVa school programme and the VEPA Good Behaviour Game, both designed for younger children. But there are no anti-bullying programmes for students attending lower secondary school and gymnasium. For this reason, TORE (an NGO) provides bullying prevention and intervention services related to bullying for all school students.

Success factors identified

Despite the diversity of tools and approaches applied in the various case studies, several success factors underpinning the range of approaches can be identified.

Adaptability: Services and professionals need to adopt and master new tools in line with trends among young people – for example, transforming a hotline into a more proactive online chat service. Other changes may involve altering opening hours or being more flexible with formal requirements for access to the service (for example, needing to provide particular documents).

Flexibility: This means working with multiple disciplines, as some young people may not be in a position to know what type of service they need. Flexibility also implies that service providers should make concerted efforts to reach out, in different ways, to groups that are especially difficult to reach. This means understanding the factors underlying barriers to access in order to implement effective solutions.

Knowledge and familiarity: A high level of knowledge of and familiarity with the issues that are of concern to young people is important. The organisations that are successful in their work are often centres of expertise on adolescence and youth in their countries.

Empathy: Having empathy with young people and understanding their needs also translates into higher involvement of young people themselves through, for example, peer-to-peer support. The risk of patronising attitudes on the part of parents, teachers and health professionals can be counterbalanced if young people can learn from others who have gone through similar experiences. Mobilising peers does not necessarily imply less engagement from professionals; on the contrary, they need to maintain a discreet presence to make sure that the right messages are put forward and scientifically supported knowledge is provided.

Policy pointers

Policy pointers for service providers

Various service providers are involved in social and health services for young people; among these are teachers, doctors (especially family doctors), police, the judiciary, social workers, counsellors and youth workers. Service providers should do the following:

- respect and protect the privacy of young people needing help, and that of their parents

- consider differences among young people and tailor services to individual situations and to new issues such as cyberbullying or rising levels of homelessness

- consider the fact young men and women may be exposed to and experience issues differently and that services should take this into account

- consider going beyond a simple concept of 'hard to reach' and invest in understanding the causes of inequalities in access to services to provide solutions

- cooperate with agencies that incentivise young people to access health promotion services

- be flexible, without setting barriers and also without putting excessive pressure on young people to use certain services for further referrals

- undertake training on the particular needs of young people within a general area (such as mental health) and on the best ways to communicate with young people

- use language that is understandable for young people, and request help from professional communicators if necessary

- involve young people as potential gateways to others, particularly those who are more difficult to reach

Policy pointers for policymakers

Policymakers at national, regional and local levels in charge of planning health and social services can create services that better reach out to young people. Policymakers should:

- ensure the availability of a network of services to cater for the health, practical and psychological needs of young people, involving public, non-governmental and private providers who have the competencies and experience to deliver such services

- ensure a mix of generalist referral services and specialised services that address particular issues and problems among young people

- systematically consult young people on their needs and experiences of social and health services through surveys or focus groups in schools or other locations where young people meet

- examine young people's home and school environments so that new and emerging risks, such as cyberbullying, can be detected early and support made available for young people and families, to prevent problems from developing further

- promote closer cooperation between mainstream services and schools to provide more school-based interventions – for example, around mental health issues (understanding of mental health disorders, mental health literacy)

- put in place and support initiatives grounded in national programmes to improve the coverage and quality of social and health services for young people (especially those who are more likely to face health and social problems) in order to achieve clearly defined outcomes

- promote and actively support initiatives and organisations that engage with schools, parents and the wider community in tackling inequalities in access to services

- address the needs of young people who are hard to reach, such as young people not in education or employment, young people with disabilities, migrant youth, young people from ethnic minority backgrounds and LGBTQI young people; this can be

done by providing tailored services and by making general services more inclusive and open

○ systematically evaluate access to and quality of services

○ when establishing eligibility criteria for services and allowances, pay attention to the 12–17 age group (who are covered by child protection policies) without forgetting those aged 18–24 (and even up to age 29); in the former group, transition to adulthood may represent a risk for vulnerable young people, whereas the latter group might be too easily assumed to be part of the adult population despite not yet having the financial means, knowledge or experience to deal successfully with services

Policy pointers for the EU

EU institutions have an important role in supporting and complementing Member States' policies with respect to young people, especially policies for social inclusion and social protection as well as health policies. The European Pillar of Social Rights includes the principle of equal opportunities and promotes access to goods and services and social protection irrespective of gender, racial or ethnic origin, religion or belief, disability, age or sexual orientation. Initiatives targeted at reducing barriers for young people or specific groups of young people in accessing services can be considered part of this effort to reduce discrimination and inequalities. In any case, the EU, by virtue of its Youth Strategy, should explicitly mainstream youth into the European Pillar of Social Rights and associated initiatives, not only in relation to employment and education but also in relation to social protection and access to essential services.

On a programming level, the EU institutions and the Commission should:

○ support the use of the European Social Fund under the inclusion priority to ensure access to high-quality, affordable services by young people, not only in the fields of employment, education and vocational training but also in the fields of housing advice

○ focus on groups of young people who experience discrimination and marginalisation

○ support the provision of more comparative data on access to social and health services in the Member States

○ promote and support research on the causes and consequences of inequalities among young people both in terms of experience of health and social problems and access to relevant services

○ support innovation and evaluation of the impact of various initiatives to increase access to services

○ provide financial support to organisations that facilitate access to information and support services for young people beyond the mainstream environment, especially social enterprises or NGOs engaged with or providing services

○ collaborate with organisations representing young people and service providers to develop policies and programmes addressing the social and mental well-being of young people (those aged 18–24)

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Annex: Questionnaire targeting service providers

As part of this research, a web consultation was carried out among national and local service providers for young people. In total, 151 organisations participated in the consultation. The questionnaire (see master questionnaire below) was translated into 15 languages.

The following EU and national-level organisations were consulted during the development of the questionnaire and were supportive of participation in the consultation:

- Council of European Municipalities and Regions (CEMR, www.ccre.org)

- European Association of Service Providers for Persons with Disabilities (EASPD, www.easpd.eu)

- European Youth Information and Counselling Agency (ERYICA, www.eryica.org)

- European Social Network (ESN, www.esn-eu.org)

- Eurochild (www.eurochild.org)

- European Federation of National Organisations Working with the Homeless (FEANTSA, www.feantsa.org)

- Mental Health Europe (www.mhe-sme.org)

- National Youth Council Ireland (www.nyci.ie)

- National Network for Children Bulgaria (www.nmd.bg)

- Association of Estonian Open Youth Centres (www.ank.ee)

Questionnaire

The first questions are about the services your organisation provides, your target groups and everyday operation.

Q1a. Which of the following services do you provide for young people aged 12–17 and 18–24? Please select all of those services that your organisation provides.

		Age 12–17	Age 18–24
Health or mental health services	Mental health services (addressing conditions such as depression, anxiety and others)		
	Emotional or psychological support		
	Family planning, contraception		
	Teenage pregnancy/crisis pregnancy support		
	Sex education		
	Substance abuse prevention		
	Services related to existing substance abuse		
	Health education/information provision		
Other social or youth services	Information provision on social issues		
	Legal aid or mediation		
	Organising events/activities for young people		
	Housing services		
	Homeless interventions and supports		
	Aftercare services (support for young people leaving care)		
	Services related to physical or sexual abuse		
	Services related to bullying or harassment		
	Parenting issues or family conflict		
	Services related to foster care or family placements		
	Services related to antisocial or criminal behaviour		
	Services aimed at re-engaging with youth that experience social exclusion		
Other services			

Q1b. Please specify the services you provide, whether they are included in the categories above or if you provide other services that are not listed *(open question)*.

Q2a. For which of the following groups of young people do you provide services? Please select all of those groups of young people that are specifically included in your target group. If you provide services for all young people, please choose the last category.

- Young people with physical or intellectual disabilities
- Young people with mental health problems
- Young people in care or care leavers
- Young offenders/young people with antisocial or criminal behaviour issues
- Young people at risk of school drop-out/early school leaving
- Young people at risk of poverty or social exclusion
- Young people experiencing, or at risk of, homelessness
- Young refugees or immigrants
- Young people with ethnic minority background
- Young people with a specific religion
- LGBTQI young people
- Girls or young women
- Boys or young men
- All young people (general services)

Q2b. Please specify your target group of young people if not mentioned above.

Q3a. How are young service users introduced to your organisation or how do they enter into the system of the service your organisation provides? Please select all methods of entry that apply.

- Referred by schools
- Referred by medical professionals
- Referred by other social services or bodies (e.g. child protection or welfare office, courts)
- Recommended by youth organisations
- Through parents or other family members
- Through other young people
- Young people may come to the service by themselves
- Outreach or information events
- Street outreach
- Other methods

Q3b. Please provide more specific information on how young people become involved with services provided by the organisation.

Q4a. Approximately how many young people aged 12 to 24 used your services in the past year?

- 1–10
- 10–50
- 50–100
- 100–500
- 500–1000
- Over 1000
- Other – please comment below

Q4b. Please provide more information on the number of young people using your organisation's services (e.g. if you know the specific number, or have comments on fluctuating numbers, or no information available/information only available about website visits or calls).

Q5. Which of the following methods of service delivery does your organisation use? Please select all methods used.

- Face-to-face meetings at service provider's premises
- Face-to face, at young people's homes
- Face-to face, at school, youth centre or other public space young people attend
- Group work
- Telephone services
- Web or app-based services or social media
- Other media, such as television, radio, newspapers
- Printed leaflets, books, posters
- Financial assistance or grants
- Provision of space or equipment
- Other methods not mentioned above

Q6. At what stage does your organisation provide services in relation to when the problem appears? Please select all that apply.

- Before (preventive support and information services, education)
- At the time the young person is dealing with the problem (e.g. helping in crisis, solving acute problems)
- After (dealing with outcomes, compensation)

Q7. Which of the following categories is closest to how you describe your organisation as a service provider for young people?

- Public service provider
- Private service provider
- Non-governmental organisation or non-profit organisation
- A combination of those above, such as a public-private partnership

Q8. Approximately how many of the following types of staff/volunteers does your organisation employ? In case of a large organisation, please refer to the section that is involved in service provision for young people. If none in a category, please type 0.

Categories of staff/volunteers	Approximate number
Full-time staff	
Part-time staff	
Staff on demand (e.g. in a specific season)	
Volunteers	
Users (young people) involved in service provision	

Q9. Does your organisation have any of the following monitoring or evaluation activities in place? Please select all that apply.

○ Official evaluation by public organisations (government, municipal or local authorities)

○ Self-evaluation within your organisation

○ Evaluation by users (young people): user surveys, focus groups, other feedback

○ Evaluation by parents, teachers or other service providers

○ Evaluation by donors

○ Regular monitoring of the number and type of users reached

The next few questions are about challenges faced by your organisation, issues with access and possible solutions.

Q10a. Has your organisation faced any of the following difficulties regarding services delivered to young people in the past few years? Please rate each challenge on a scale of 0 to 10, where 0 means this has not been an issue at all and 10 means this has been a very significant issue.

Issue	Not an issue at all for our organisation						Very serious issue for our organisation				
	0	1	2	3	4	5	6	7	8	9	10
Recruiting staff with the rights skills or qualifications											
Retaining staff											
Securing financial resources, in terms of the necessary amount at the right time											
Reaching the target group of young people											
Retaining young people (dropouts)											
Reaching or retaining a specific group of young people within the target group											
Administrative burden/bureaucracy associated with operation											
Problems with location or facilities (such as distance from users, size, accessibility etc.)											
Problems with or lack of suitable equipment											
Being unable to meet a large demand for the service with current time and resources											
Need to improve management capacity, e.g. strategic planning, communication, partnership building											
Young not in your target group are referred to you because no specific services are available in your area											
Stigma associated with using the service for young people											
Low visibility (young people cannot find the service)											
Relationship problems with other organisations											
Measurement/monitoring of quality											
Keeping in touch with the young person once they leave the service											
Other challenges											

Q10b. Please provide more specific information on the above listed challenges or any others that have not been mentioned above *(open question)*.

Q11a. In your opinion, which of the following target groups have problems accessing the services your organisation provides? Please select only those that are in the target group but have more difficulties to access.

○ Teenagers aged 12–17

○ Young people over the age of 18

○ Young people in rural areas

○ Young people without access to internet

○ Young people in care

○ Young people with physical or intellectual disabilities

○ Young people experiencing homelessness

○ Young people who have left school early/not currently in school

- Young people belonging to an ethnic minority group
- Young people with a specific religion
- Young immigrants or refugees
- Young people of a specific gender
- LGBTQI young people
- Young people who have experienced family conflict and/or rejection
- Other specific groups of young people
- None of the above groups

Q11b. Please specify the target groups that have issues with accessing your services *(open question)*.

Q12. In your opinion, have any of the following issues had an impact on accessing the services you provide for young people? Please select all that apply.

- Lack of awareness of the service or entitlement
- Cost of the service or associated cost (e.g. travel)
- Prior appointment is necessary or there is a waiting list
- Too far from home for young people/transport issues
- Lack of interest
- Stigma associated with using the service
- Discrimination against certain population groups (e.g. in referral, school, etc.), reducing their ability to access the services
- Legal restrictions
- Low internet penetration/no access to internet for certain groups
- Complexity of using the service (either for certain groups or for all young people)
- Language issues
- Incorrect assessment in referrals
- Lack of staff or staff with the relevant skills
- Lack of other resources (equipment, facilities, financial resources)
- None of the above

Q13a. Have you taken any of the following measures to improve access for young people and to reduce inequality in accessing it in the last few years? Please select all that apply.

- Travelled to various towns within the country or to rural or remote regions to provide information face-to-face
- Gave face-to-face information sessions or presentations in schools to promote the service
- Other promotion activities such as leaflets, website, street advertisements
- Ensured additional funding (e.g. from NGOs, parents, through tendering)

- Engaged in advocacy to promote the service to service users
- Reached out to specific groups of young people with limited access (e.g. ethnic minorities)
- Reached out to families, relatives or teachers
- Used young people involved in the service to help in reaching others
- Used young people involved in the service to act as peer-to peer providers
- Made the service available in additional languages
- Made the service available online or via telephone
- Simplified procedures for entering or using the service
- Other measures

Q13b. Please provide more specific information on how you improve young people's access to your services, either on the methods mentioned above or others *(open question)*.

The last few questions are about user involvement and cooperation with other organisations.

Q14a. Are service users involved in any of the following stages of providing the service? Please select all that apply.

- Needs assessment
- Design
- Promotion/outreach to other young people
- Service provision/delivery
- Monitoring or evaluation
- Other type of involvement
- None of the above

Q14b. Please provide more details on how users are involved in the provision of your organisation's services for young people *(open question)*.

Q15a. If users are involved, has any of the following aspects of the service changed/improved as a result of users' involvement?

- Increase in awareness of the service (for young people, parents, teachers or others)
- Reduction in stigma associated with the service
- Increase in attendance/use of the service
- Increase in trust in service providers
- Improvement in service quality
- Improvement in access to the service for certain groups
- Improvement in monitoring of use, quality or outputs
- Improvement in planning future services
- Other outcomes
- None of the above
- Users are not involved in service provision

Q15b. Please specify how user involvement impacts service provision *(open question).*

Q16a. Does your organisation have any formal or informal cooperation with other organisations? If yes, please select the types of organisations this applies to.

- Public bodies, such as governmental, municipal, local authorities
- Other service providers for young people
- Schools or universities
- Healthcare services (GPs or hospitals)
- Non-governmental organisations
- Private companies
- Youth organisations
- Parent organisations
- Other types of organisations
- None of the above

Q16b. Please specify your cooperation with other organisations *(open question).*

Q17. Finally, please give some examples of achievements your organisation is proud of in reducing inequality in access to services for young people, either those mentioned above or others.

Many thanks for participating in this consultation. If your organisation has a website, please add a link below, if you wish.

Website:

If you would like your organisation to be named in our final report and/or you agree to be contacted again for follow-up by Eurofound regarding this research, please add the precise name of your organisation, your name, email address and phone number below.

Organisation:

Name:

Email:

Telephone:

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In recent years, concerns have been expressed at EU and national level that the combined stresses arising from school, parental expectations and societal pressures can make the transition to adulthood difficult for young people – with the risk of a long-lasting negative impact. One way of easing the transition is to provide appropriate information and support services during these critical life-changing years. However, it appears that not all young people have access to such services. This report describes the characteristics of the young people who face most difficulties in accessing social and health services, the types of services most relevant to them and the main challenges they face in accessing information and support services. It also looks at what service providers can do to ensure they reach young people in need of their support and presents innovative examples of how to tackle inequalities in access to services.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.