

Young people health risk taking: A brief review of evidence on attitudes, at-risk populations and successful interventions

Part of the contribution of the Department of Health (Children & Young People's Public Health programme) to the Ten Year Youth Strategy Review of the Department for Children, Schools and Families (DCSF)

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Introduction

According to a UNICEF report published in January 2007, young people in the UK are disproportionately engaging in behaviours that risk their health and wellbeing when compared to young people in other OECD countries. The prevalence of UK youth risking their health through smoking, drug and alcohol use, unsafe sexual activity and becoming parents in their teenage years, when taken together, far surpasses that of any other country in the OECD. In particular, among these countries, proportions of young people under the age of 15 reporting having been drunk and having had sexual intercourse, frequently without the use of a condom, are highest in the UK. Further, births to young women between the ages 15 and 19 happen most frequently in Britain relative to other OECD countries (UNICEF, 2007). Though these figures may only represent part of the picture of young people and health in the UK, these behaviours and outcomes are an immediate and long-term risk to the health and well-being of adolescents.

To aid in the process of developing strategies to curb these trends, this paper aims to highlight some of the underlying causes of risk taking behaviour and to identify young people most susceptible to engaging in unhealthy activities. A number of interventions have already demonstrated effectiveness in reducing the health risk taking behaviour in this population. Here, some of these interventions are described.

The information included in this paper has been collated from reviews of evidence and reports of academic research produced since 2000. This paper is not a comprehensive or systematic review of the evidence in this area, though it includes a number of reports using rigorous research designs. As such, its aim is to offer a brief summary of current knowledge about young people and risk and offers some suggestions for the direction of policy in relation to youth and health in order to ensure that the DCSF Ten Year Youth Strategy takes into account the health needs of young people.

What shapes young people's attitudes toward health and risk taking?

The development of attitudes or understandings about health and risk is largely influenced by aspects of an individual's social environment. Young people in the UK today grapple with a range of messages from their families, schools, communities, peers and the media that form their perspectives about their social lives and the actions that they take within it; including actions that impact upon their health (Margo *et. al.*, 2006).

Morrow's (2001) research with 12-15 year olds living in two communities in England, about 30 miles outside London, demonstrates how young people's attitudes about their health are shaped by their relationships to their communities and the social networks that develop as a result. Families and friends help to create a sense of identity and inclusion in a community and also provide important psychosocial support. However, the values and norms that define this community can encourage young people to develop attitudes and behaviours that compromise their health. For example, close ties to peer groups that provide social and emotional support but also advocate smoking can encourage young people identifying themselves as part of this group to also smoke (Morrow, 2001).

However, a sense of social belonging or connectedness is an important part of development and emotional health during adolescence. Research with Scottish youth living in rural settings illustrated

that young people themselves view their social relationships to be an important influence on their health. Though relationships and peer groups were viewed as possible sources of anxiety and emotional stress, they were also essential to a young person's ability to deal with physical illness, chronic depression or lack of self-esteem. Young people reported the ability to create and maintain good friendships and learning to manage their peer social groups as important elements of their development. Further, this appeared to be most important for young women who indicated a greater amount of impact on their self-confidence and emotional wellbeing when problems arose with their friends (Hendry and Reid, 2000). Though a key source of support and an indication of healthy social development, friendships are a strong influence on young people's attitudes to health and risk taking behaviour and in and of themselves impact upon emotional health and wellbeing.

However, traditional notions of peer pressure may misrepresent how interactions with peers lead to health risk taking behaviour. Research on smoking among young people described how social networks and friendships influence health risk taking behaviour. Research with 16-19 year olds in Scotland found that many young people viewed smoking as a part of their social world and of youth culture in general. Consequently, for them, smoking was custom. Many of the young people interviewed as part of this research discussed how their lives and friendship groups might change if they quit smoking and their concerns about feeling excluded from friendship groups where smoking was the norm (Amos, *et. al.*, 2006).

The meaning attached to risky behaviours, such as smoking, and how a young person defines themselves in relation to that behaviour may also affect motivations to take risks. Young people in this research held varying definitions of their smoking status and beliefs about their own smoking behaviour that shaped their intentions to quit. In this group of young people, smoking was often viewed as more of a habit rather than an addiction. Though many of the young people planned on eventually quitting smoking, they believed that as smoking for them was only a habit, they could easily stop when they were ready and did not respond to cessation activities that were aimed at people who believed they were addicted to smoking (Amos, *et. al.*, 2006).

Though peers are a significant influence on youth health risk taking behaviour, families and communities are also important. A review of research on the impact of families, peer groups, schools and neighbourhoods on achieving good outcomes for young people highlighted the importance of parents and parenting behaviour in determining young people's likelihood of engaging in risk taking behaviours. The report drew on literature emerging from countries such as Canada, the United States and the UK and found that above all other influences on young people, parents had the strongest independent and lasting impact on wellbeing. In particular, what was termed 'authoritative (nurturing)' parenting had the greatest positive impact upon young people. This type of parenting, characterised by reasonable and flexible discipline and a supportive and warm relationship with children, had the most positive emotional, social, behavioural and academic outcomes for young people. Where parents are less warm and supportive or particularly strict or neglectful young people often turn to their peers and thus friendships can become more influential. However, whereas peer support appears to only increase wellbeing when combined with parental support, parental support has a positive, lasting influence on its own (McClaren, 2002).

Though lower in impact, McClaren's report (2002) also indicated the importance of a combination of neighbourhood factors on young people's wellbeing. Some of the themes that emerged from research on neighbourhoods and young people's wellbeing included a sense of safety and stability, residents with increased economic and social resources, and positive interaction and community

involvement among neighbours. Such environments tend to increase positive academic, social, behavioural and emotional outcomes for young people and reduce health risk taking behaviours. However, neighbourhood factors are difficult to tease away from the other influences that make up communities, such as parents and peer groups. When researchers have attempted to consider the impact of neighbourhoods in isolation, they found that the type of neighbourhood accounted for only 5 percent of all the influences on children. From the findings of this area of research, it seems that children and young people from 'healthy' neighbourhoods, typically communities with access to warm and supportive schools and adults, have the best outcomes. Neighbourhoods that are lacking in services and facilities, where the population tends to be transitory, where community members do not support and protect one another and where there is a likelihood of violence and anti-social behaviour, yield the worst outcomes for young people. The mechanism for the impact of these factors on outcomes for young people is not clear, but as suggested by researchers, is likely to have two main characteristics: neighbourhood effects on young people are likely to be indirect and to function over an extended amount of time. For instance, neighbourhood characteristics are more likely to directly affect factors such as parental stress which, over time, may impact upon young people through their experience of parenting (McClaren, 2002).

As a key input to development, young people's experience of school is another important influence on their health risk taking behaviour. The review conducted by McClaren (2002) suggests that school climate, or the way teachers relate to students and the way students experience school, has a significant impact on outcomes for young people. The research collated argues that students who perceive their teachers as viewing them positively and providing support tend to display better mental health, increased enthusiasm for learning and perform better academically. Additionally, such positive outcomes were more likely to occur in smaller schools (generally less than 1000 students), schools that are free from bullying, schools where the focus is placed on individual development and not on competition and schools where students are placed into classes of mixed ability rather than streams (McClaren, 2002).

As part of a large, longitudinal survey on the impact of the school environment on health and wellbeing in Flanders, Belgium, Opdenakker and Van Damme (2000) found that school characteristics concerning instruction and understanding information were related to student wellbeing. In a similar study in Finland using data from over 80 000 children, Konu *et al.* (2002) found that factors related to the school context explained 17% of general subjective wellbeing for boys' and 20% for girls. Of the school context indicators, 'means for self-fulfilment' emerged as the most important. When combined with background characteristics, this explained 22% of the boys' and 25% of the girls' general subjective wellbeing. Indicators of school context showed that the strongest significant relationship to general subjective wellbeing for both boys and girls was means for fulfilment and social relationships in and out of school.

In further support of this argument, recent research by Bonell and colleagues (2005) found an association between dislike of school and subsequent risk of teenage pregnancy. In their analysis of longitudinal data from schools in southern and central England on sex education, a negative attitude toward school among young women was significantly related to risk of becoming pregnant, regardless of socioeconomic status, expectation of parenting, lack of expectation of education or knowledge about sexual health. In these data, approximately 15 percent of the over 4200 young women taking part reported disliking school. As a result of these findings, the authors advocate the development of interventions to increase young people's satisfaction with school and expectations for future education (Bonell *et al.*, 2005)

In addition to family, friends, schools and neighbourhoods, other societal messages about health behaviour can influence young people's attitudes about risk taking. Recent qualitative research with young people in Australia suggests that representations of smoking in television, movies and magazines gave young people between the ages of 13 and 16 the sense that smoking was a natural, normal and a part of everyday life. They also perceived it as way to relieve stress, as was often suggested by images in the media (Watson, *et. al.*, 2003).

The above provides some simple examples of the complex ways in which opinions about risk taking behaviours are shaped and the importance of those attitudes in setting in motion actual behaviours. However, there is evidence that an individual's personal values can safeguard against developing opinions that can lead to health risk taking behaviour. For example, young people who value their health have been shown to be less likely to abuse alcohol. Using a measure of health value, or the degree to which people consider it to be important to be in good health, research with young people ages 17-20 in New York tested the ability of health values to buffer the relationship between socio-environmental risk factors such as friends drinking, parent's alcohol abuse, parental monitoring and communication and alcohol misuse. Young people at risk for alcohol misuse who scored higher on a measure of health value were less likely to misuse alcohol (Reifman *et. al.*, 2001).

Young people's attitudes to health and risk are influenced by a number of factors. Any measures to curb health risk taking behaviours would benefit from taking these into account. However, it is also true that particular groups of adolescents are more likely to develop attitudes and understandings about behaviours or be involved in circumstances that increase their propensity to take health risks.

Which young people are most likely to engage in health risk behaviours?

A number of theories have been developed to try and explain why some young people exhibit a greater propensity to risk taking in general, or specific types of risks, than others. The most dominant is Problem Behavior Theory. The theory suggests that three aspects of a person's make-up determine their inclination towards risk taking: the personality system, perceived environment system and the behaviour system. The interaction between these three psycho-social influences determines an individual's propensity to take risk. This model has been successful in predicting risk behaviour for drug use, alcohol misuse and sexual activity in a range of empirical tests (Coleman, 2002).

In a summary of research and theory developed to understand and explain adolescent risk taking behaviour, Reyna and Farley (2006) found that the assumptions about rational decision making that are imbedded in theories such as the Problem Behavior Theory do not apply to all adolescents. They argue that traditional models that emphasise conscious behavioural intentions and expectations and ignore unconscious emotional and cognitive reactions to the environment can only apply to some young people. Young people who consciously weigh up the perceived benefits and consequences of risky behaviour are amenable to traditional models. However, there appears to be other young people who are able to quickly grasp an understanding of risky situations and avoid them and still others who take risks irrationally, under the influence of emotion. The latter group are described as sensation-seeking and generally not affected by interventions that attempt to illustrate increased consequences to risky behaviour (Reyna and Farley, 2006).

In addition to natural propensities to take risks, it is well documented that material circumstances for many young people either create opportunities for risk taking or emotional or psychological support needs through the experience of difficulty that is attended to through risk taking behaviour. In research with vulnerable young people becoming involved in substance use, a number of factors emerged that increase susceptibility to risk taking behaviour. Children and young people who start misusing drugs are also likely to have other health and social problems. Physical disabilities and psychological or behavioural problems, such as issues with mental health, peer rejection or alienation, increase risk of drug misuse. In social contexts where families or friends condone substance misuse, where there is instability and conflict or neighbourhood deprivation, young people are also more likely to engage in health risk behaviours (Evans and Alade, 2000).

In the increasingly heterogeneous population of the UK, particular groups of young people have been highlighted as being more likely to take part in some risk behaviours than others. A review of research on protective and risk factors for early sexual activity and contraceptive use among black and minority ethnic adolescents in East London between the ages of 11-18 shed light on the variability of risk taking around sexual activity and health among young people in Britain. For example, though White British youth were more likely to be having sex than ethnic minorities from largely Asian backgrounds, young men from Black Caribbean and mixed ethnicity background were more likely than White British youth to have started having sex. In an analysis of young people recently migrating to the UK, being born outside of the UK did not change a young person's likelihood of engaging in risky sexual behaviour, however speaking a language other than English in the home was associated with a lower risk of ever having had sex.

Support from extended family was important for these young people. Although most young people, across ethnicities, reported difficulty with discussing issues around sex with their families, this was particularly true for young people from Bangladeshi, Indian and Pakistani backgrounds. Though, the impact of this difficulty had varying results by gender. For example, young males that reported difficulty talking with their parents about sex were less likely to have started having sex, but young women were at higher risk. Also, young women across all ethnicities who experienced psychological distress, depression were more likely to initiate sexual activity before the age of 16 and those with low self-esteem were more likely to have unprotected sex (Jayakody *et. al.*, 2005).

Despite these findings, the authors emphasise that ethnicity alone cannot indicate an individual young person's sexual behaviour. Rather, such findings demonstrate the need for interventions that reflect the heterogeneity of young people in Britain and the unlikely utility of a one-size-fits-all approach (Jayakody *et. al.*, 2005).

Poor mental health, such as conduct disorder and oppositional defiant disorder, in childhood is linked to school failure and continued antisocial behaviour into adulthood. In the UK, rates are higher in lower social classes and in minority ethnic groups. There is increasing information on the risk and protective factors for mental illness in childhood that highlights important areas for intervention. Evidence suggests that universal, school- or community-wide, and targeted approaches are effective and complementary in addressing mental health. In controlled trials, school interventions that include identification and referral of young people exhibiting problem behaviour to targeted support services have been shown to be effective. However, interventions are most effective when the whole school is involved in improving quality of the relationships that take place in that setting. It is recommended that these interventions are instituted over an extended amount of time rather than for short periods to have the greatest impact. Interventions teaching parenting skills

and involving parents also demonstrate greater effectiveness in preventing or addressing mental health problems in young people. Further, as the impact of interventions to address mental health cuts across a number of outcomes for adolescents, it is recommended that funding and the development of programmes is made jointly, across government agencies (Stewart-Brown, 2005).

Though the specific characteristics of young people who take risks to their health can be different, there are some underlying commonalities across young people who take risks to their health. Much research has pointed to the increasing importance of the development of personal and social skills in aiding young people to navigate their complex lives. In particular, research has pointed to the salience of non-cognitive abilities that appear to be less available to young people from disadvantaged backgrounds. Young people from more affluent backgrounds are more likely to take part in activities that foster social and personal development. Another suggested explanation are the rapid changes in family and community structure and content over the past 30 years and the strained relationship between adults and young people in Britain that is more prevalent here than in other countries (Margo *et. al.*, 2006).

Interventions developed to reduce risky health behaviours among adolescents have taken into account the above notions about their susceptibilities to risk taking and sources of support and emotional and social development. Below, I discuss a few of the interventions that have demonstrated some effectiveness in reducing smoking, drug and alcohol misuse and teenage pregnancy.

Evidence for the potential for interventions to impact on young people's health risk taking

Smoking

Interventions for smoking prevention and cessation for young people have had mixed results. In general, there appears to be little evidence that interventions have an impact on the take up of smoking among children and young people, especially where adults are still smoking. However, some research has shown that school based or peer interventions can have an impact on smoking in adolescence.

Specific school or other social interventions appear to have an impact on reducing smoking rates among young people when they are designed using multiple strategies, rather than single strategies. For example, the combination of increasing knowledge about the consequences of smoking to physical health, a change in the perception that smoking is acceptable and increasing confidence and skill in refusing tobacco use and remaining a non-smoker is more effective than any one of these elements offered in isolation (Health Development Agency, 2004). Further, as one of the motivators for young people smoking is the perception that it is a societal norm, community-wide non-smoking campaigns aid in reducing this perception and can have an impact on smoking prevention and cessation among children and young people.

Little evidence exists on the impact of smoking cessation interventions on the reduction of smoking among young people specifically in the UK. However, activities such as, reducing the sales of cigarettes to under-16s, media campaigns and increasing the price of cigarettes may have some impact on the perceptions of smoking that hitherto have facilitated smoking uptake among young people. A restriction in the sale of cigarettes to young people under the age of 16 may reduce the

perception that cigarettes are relatively easy to obtain and thus may change smoking behaviour. Media campaigns appear to have been effective in impacting upon the knowledge attitudes and behaviours around smoking among 16-25 year olds through making the health risks personally relevant to this age group. Strong evidence from systematic reviews also demonstrates the effectiveness of increasing the cost of cigarettes in reducing use and consumption young people (Health Development Agency, 2004).

Alcohol misuse

In March 2005, an evidence briefing on the effectiveness of interventions to prevent and reduce misuse of alcohol was published by the Health Development Agency. The briefing was overwhelmingly focussed on interventions designed for adults, but also reported on the effectiveness of interventions designed for young people. It included the results of a systematic review, updated in 2002, of psychosocial and education interventions aimed at children, adolescents and young adults up to 25 years old where alcohol use was the only or one of a number of substance use outcomes reported. Fifty-six studies were included in the review and all except seven were conducted in schools. Though the findings failed to produce any review-level evidence for the effectiveness of interventions in reducing alcohol misuse, there was evidence that interventions designed to address alcohol misuse in families and communities has greater long-term impact than those solely focussed on youth (Mulvihill *et. al.*, 2005)

Drug use

A recent review of reviews on interventions for drug prevention among young people highlighted a number of approaches demonstrating effectiveness. Firstly, interactive approaches have been found to be more effective than non-interactive approaches in reducing drug-use in universal school-based and family-focused drug intervention programmes, particularly with groups with low socioeconomic status. Also, school-based drug education programmes led by peers showed some evidence of effectiveness and were in fact found to be superior to adult-led programmes in effecting a reduction in drug use. When peer leaders were combined with teacher-led programmes effectiveness was reduced, but adding a peer component to already effective programmes increased effectiveness (McGrath *et. al.*, 2006).

Young people and pregnancy

A recent systematic synthesis of research evidence on effective approaches to preventing teenage pregnancy linked to social exclusion found that pregnancy was more likely among young women who disliked school, came from poor material circumstances and unhappy childhoods, and had future expectations that were based on negative experiences in school or work, low expectations from people close to them and perhaps a positive perception of having a baby. In response to these findings, the authors made specific suggestions for the development of interventions to improve young people's experiences in school as a strategy for reducing the incidence of teenage pregnancy and social exclusion. Some of the suggestions included, increasing young people's involvement in the development and management of their school, equipping young people with skills for forming positive relationships with peers and resolving conflicts, and providing learning support for students who are falling behind in their studies. In particular, in line with other evidence emerging about the effectiveness of skills education and youth development approaches in addressing a range of

outcomes for young people, this research also pointed to the salience of the development of life skills in reducing teenage pregnancy (Harden *et. al.*, 2006; Mahoney *et. al.*, 2005).

Conclusions and recommendations for policy

- **Relationships with peers are a great influence on young people's health risk taking behaviour.** Young people may benefit from curriculum designed to develop skills related to identifying, forming and maintaining healthy and positive relationships with peers and to help them cope with the stresses of managing these relationships in the transition into adulthood.
- **Peer influence is important, but not more than parenting.** Both are central to social development in early childhood and adolescence. Young people may turn to their peers when they are experiencing low support in their home environment and thus friendships can become more influential. However, whereas peer support appears to only increase wellbeing when combined with parental support, parental support has a positive, lasting influence on its own. Parenting characterised by warm and supportive relationships with children and reasonable and flexible discipline is most likely to achieve positive outcomes and reduce health risk taking among young people.
- **Positive and healthy neighbourhoods, communities and schools provide the background for healthy social relationships.** Characteristics of communities and neighbourhoods are indirectly impact upon the health and wellbeing of young people. Neighbourhoods typified by poverty, violence, anti-social behaviour and lack of social cohesion increase parental stress and the amount of interaction with peer groups, which in turn have implications for health.
- **Positive experience in schools is key factor in the health and wellbeing of young people.** The school climate, which is characterised by students' relationship with their teachers and experience of the school environment, is linked to emotional, behavioural and social outcomes and health. Students who perceive their teachers as viewing them positively and providing support tend to display better mental health, increased enthusiasm for learning and perform better academically. Additionally, such positive outcomes were more likely to occur in smaller schools (generally less than 1000 students), schools that are free from bullying, schools where the focus is placed on individual development and not on competition and schools where students are placed into classes of mixed ability rather than streams.
- **The development of life skills and social and emotional development are effective at reducing negative health outcomes such as teenage pregnancy.** Such interventions address the mediators of health risk behaviours by improving young people's experiences in school, increasing parental involvement in education, broadening future expectations and providing targeted support for individuals experiencing difficult circumstances.
- **Evidence suggests that universal, school- or community-wide, and targeted approaches are effective and complementary in addressing mental health.** School interventions are most effective when the whole school is involved in improving quality of the relationships that take place in that setting. It is recommended that these interventions are instituted over an extended amount of time rather than for short periods to be most effective. Interventions can

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help parents to have better interactions with their children and are more effective when parents are involved. Further, as the impact of interventions to address mental health cuts across a number of outcomes for adolescents, it is recommended that funding and the development of programmes is made jointly, across government agencies.

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