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The casualties of transition: The health impact of NEET status and some approaches to managing it

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Abstract

Youth unemployment can be understood as a major public health risk. This paper explores the multi-disciplinary literature in this field, and its relevance to support for NEET (not in education, employment or training) young people. There is reason to believe that unemployment may have a scarring effect on future labour market prospects and on health, with lifelong consequences for individuals and for society. To the extent that illness has social causation, it may potentially have social remedies. Evidence for the effectiveness of mental health prevention with young people is limited, but there is persuasive recent research suggesting that moving people on from unemployment leads to health improvements. Schools, colleges, vocational training providers, and the welfare benefits system all have a role to play in reducing the impact of unemployment. Career guidance services are particularly well placed to reach potentially vulnerable young people both before and after leaving school, to provide support, and to enable them to access opportunities.

Introduction

This paper aims to add a public health dimension to the existing guidance literature concerning youth transitions and unemployment. It begins by highlighting the importance of the topic and outlining some issues of terminology. It moves on to explore the links between NEET status (not in education, employment or training) and health inequality. The issue of causality is then addressed. Adolescence is identified as a critical period in health development. The focus then shifts to considering young people as a target group for interventions, and the potential role of different agencies in those interventions.

Longstanding concerns about youth unemployment have been heightened in the years following the banking crisis of 2008 (Institute of Public Policy and Research [IPPR], 2014). Unemployment levels rose across Europe and youth unemployment rates are substantially

greater than those for adults. There are estimated to be over 4.6 million people in the age range 15-24 years who are unemployed, representing 20.4% of the youth population in the 28 member nations of the European Union (European Commission, 2016). The persistence of this problem has led the International Labour Organisation to talk in terms of ‘a generation at risk’ (ILO, 2013). Whilst there have been signs of an economic recovery, it is less clear that this is leading to strong reduction of unemployment (ILO, 2014a), and there remain concerns about whether hiring rates for young people are recovering (Wilson & Bivand 2014). Youth unemployment is unquestionably a major issue.

Any consideration of youth unemployment raises issues of how we define both youth and unemployment. The age range adopted in the literature for youth varies considerably. Unemployed status can be defined in a variety of ways (welfare benefit claims, worklessness, economic inactivity, availability for work, including or excluding students, and so on). The concerns brought up in this paper, are not exclusively with youth in the labour market (potential job seekers), so the term ‘NEET young people’ is adopted. This is an intentionally broad-brush characterisation. For the purposes of this argument, precise definitions are not required. The focus here is on young people who are not engaged with work or learning, and who may be at risk of experiencing some detriment as a result. It is important to acknowledge that the use of such a label is inevitably a gross simplification, and one that could obscure as much as it illuminates. For some young people NEET status may represent a positive life choice (e.g. young parents). NEET young people are diverse and heterogenous, and their situation is dynamic: NEET status is often transitory. Issues of labelling, policy and the experiences of NEET young people have been extensively explored elsewhere (e.g. Furlong, 2006; Hutchinson, Beck & Hooley, 2015; Hutchinson & Kettlewell, 2015; MacDonald, 2011; Maguire, 2015; Russell, 2016; Thompson, 2011). NEET terminology remains in current use in the academic literature, and in international policy discourse, so is adopted here as a shorthand. The term unemployed is used where this more accurately reflects the source under discussion.

Mental health is the main focus of the discussion as it represents the most important category of early onset health conditions, and frequently arises during the teenage or young adult life stages. For the purposes of this paper, mental health is best understood not in terms of dichotomy between the diagnosed and the healthy, but rather as a spectrum of intensity, duration and frequency of symptoms spanning the whole population. This approach is taken

by public health specialists (e.g. Keyes, 2002). Mental health conditions are more common in those with poor physical health, and multi-morbidity increases with age and socioeconomic deprivation (e.g. Barnett et al., 2012). Thus, a rigid separation between physical and mental health has some drawbacks, and public health discussions may encompass both.

Social inequality and health

Whilst recognising that NEET young people are highly diverse, NEET status is more common in lower socioeconomic groups, and less common among higher socioeconomic groups, largely as a result of participation in formal education (Thompson, 2011). An individual's chances of being NEET are strongly associated with low income; low qualifications; parents who are single, divorced or workless; and being in social housing (De Goede, Spruit, Maas, & Duindam, 2000; Duckworth & Schoon, 2012). Care leavers are an example of one group that is particularly at risk in the transition from being children in local authority care to adult independence (Akister, Owens & Goodyer, 2010; Stein & Dumaret, 2011).

Social inequality is deeply linked to health inequality, and careers are one domain where this is evident (Robertson, 2014). There are sound theoretical and empirical reasons to believe that unemployment impacts negatively on the mental health of adults (Warr, 2007) and young people (Reine, Novo & Hammarström, 2013; Winefield, Tiggemann & Winefield, 1991; Winefield et al., 1993; Winefield, 2002). The research base can be traced back to the 1930s (Fryer, 1997) and is now very extensive. For example, Kieselbach (2003; 2004) found unemployment in young people to be associated with poor health in several European countries. Pfoertner *et al.* (2014) found that the psychological health of older adolescents in European nations was linked to local levels of youth unemployment. Reine, Novo and Hammarström (2004) found the association between unemployment and psychological health to be stronger in young people than in adults. Health conditions are often acquired with age, and we would expect older workers to be more at risk than the young workforce. This is broadly true, but nonetheless there are substantive levels of ill health among young people (Beck & Quinn, 2012; Levin, Walsh & McCartney, 2014).

McLean et al. (2014) found that socioeconomic inequality was associated with multi-morbidity not just in older people, but from early adulthood onwards. Focusing on mental health, the most persuasive evidence comes from Reiss (2013) who conducted a systematic

review of the relationship between socioeconomic status and mental health in children and adolescents. Out of 55 studies meeting the inclusion criteria, 52 showed a lower status associated with substantially higher levels of mental health problems. Socioeconomic status interacts with demographic categories. For example, young women on the margins of the workforce may experience health problems, including depression. The issues they face may be inter-related with their ethnicity, and caring roles (Escott, 2012). Whilst recognising the crucial importance of gender and ethnicity, they are not the main focus of this discussion.

Some have argued that in post-industrial society, transitions from youth to adulthood have become less predictable, more individual (Roberts, 1997), and non-linear or circular (Du Boir-Reymond & Blasco, 2003) This argument is widely accepted (e.g. European Commission, 2015). With more complex pathways to adulthood, those with more resources and knowledge tend to be more able to navigate them, or help their children to do so. Thus, modern career patterns may accentuate the gap between higher and lower socioeconomic groups (Yates, Harris, Sabates & Staff, 2011). In their analysis of the British Cohort Study data, young people from the low socioeconomic status (SES) backgrounds were twice as likely to have misaligned or uncertain aspirations as those in high SES backgrounds. Where they were also NEET, the evidence suggested poorer long-term employment outcomes. Moreover, at least half of those with misaligned goals had ideas of achieving above their educational expectations: this suggested that low aspirations in NEET young people was not the main problem. The notion of low aspirations is also dismissed by Roberts and Atherton (2011). Whilst opportunities may be structurally determined, this evidence speaks to the need for support to individuals in navigating career pathways, and in clarifying attainable goals to aim for; therefore, a need for guidance.

The question of causality

The issue of causality in the relationship between socioeconomic status and health outcomes has attracted considerable attention. The consensus is to accept that unemployment is a major causal factor in poor health, primarily because it tends to deny access to psycho-social benefits of work (e.g. Waddell & Burton, 2006; Warr, 2007). The evidence from longitudinal studies of adults clearly supports this because it highlights the sequence of events: transition to unemployment is followed by a subsequent deterioration in mental health (e.g. Jefferis et al., 2011; Murphy & Athansou, 1999; Paul & Moser, 2009). Similarly, studies of school

leavers show clear differences in psychological well-being between unemployed and satisfactorily employed groups that are not evident prior to transition (e.g. Winefield, Tiggemann & Winefield, 1991).

The same applies to longitudinal studies focusing on re-employment, which typically find a subsequent improvement in well-being and a reduction in symptoms of mental ill health. A systematic review found this holds true across a variety of contexts (Rueda, 2012). Again, there is evidence this also applies to youth: Praise and Dooley (2001) found that any improvement in employment status seemed to improve depressive symptoms in young people. O'Dea *et al.* (2016) found that relieving symptoms of depression may help young people to function but is not associated with reducing their likelihood of NEET status.

The possibility of reverse causality, that is, health conditions as a risk factor for unemployment, must be also considered. Daly and Delaney (2013) have acknowledged that childhood psychological distress is a predictor of unemployment and later experiences of distress. But they are able to demonstrate that this cannot account for most of the impact of unemployment on mental ill health. Van der Wel (2011) and van der Wel, Dahl and Thielen (2011) presented evidence from a large longitudinal study in Norway showing that health problems had a more serious effect on young adults at the start of their career, most particularly those with lower qualifications and fewer employability resources to draw on. Similarly, Praise and Dooley (2001) found that elevated levels of depression reduced chances of later employment. Nonetheless, on balance there seems to be rather more evidence that unemployment leads to psychological distress than vice versa (Bjarnson & Sigurdardottir, 2003; Hammarström & Janlert 1997). The situation may be rather different for the less common but more severe and enduring mental health conditions: Lloyd and Waghorn (2007) have argued that psychotic episodes in youth can have long-term disruptive impacts on career patterns.

Sweeting *et al.* (2016) have reported a recent longitudinal study of health inequalities in the West of Scotland. They sum up their own findings and their reading of the literature in terms of a complex, bidirectional relationship between socioeconomic position and health. This may be the best way to characterise our current understanding.

Youth as a critical period

There are reasons to focus on youth: social and biological factors interact to make this a special period in the lifespan. It is a developmental period characterised by exploration, risk taking and frequent changes in education and work (Uthayakumar, Schimmack, Hartung & Rogers, 2010). There are suggestions that young adults' achievement of life tasks, such as career goals, feeds directly back into well-being (Roberts, Caspi & Moffit, 2003). It would be wrong to assume that career concerns were necessarily the only, or the dominant concern in young people's lives apparent in longitudinal studies (Borgen, Amundson & Tench, 1996), but their importance cannot be ignored.

NEET status can undermine the formation of an adult identity (Bynner & Parsons, 2002), and economic conditions may prolong the transition period. Arguably, barriers to entering the housing market and the associated delays establishing an independent adult lifestyle have become a widespread phenomenon, which individuals may attribute to their own failings rather than wider socioeconomic conditions. Furlong (2002) has suggested that the health risk factors facing young people are increased by a trend towards a prolonged and complex period of transition from youth to independent adulthood, during which unemployment is likely. He indicates that this has the potential to increase not only stress and mental health issues, but also risky health behaviours such as use of drugs, promiscuity, eating disorders and self-harm.

Van der Wel (2011) has argued that youth transitions are a critical period in the lifespan. This view is shared by public health specialists: "Adolescence is a life phase in which the opportunities for health are great and future patterns of adult health are established" (Sawyer et al., 2012, p. 1630). Furthermore, van der Wel et al. (2011) have asserted that the transition from school to work can be seen as a social equivalent to the biological process of birth. Exposure to risk at this time can have profound and long-lasting impacts on a range of important social, economic and health outcomes. Moreover, a critical period socially may coincide with a critical period biologically (Patton et al., 2016). Lifestyle factors in adolescence and young adulthood, such as education and work, may have a profound effect on health and well-being later in life (Foresight Mental Capital and Wellbeing Project, 2008). Experience of life stress in adolescence or young adulthood may bring about permanent neuro-biological changes in the brain. Monroe and Harkness (2005) have claimed that that the onset of depression renders a young person more vulnerable to further episodes by lowering the threshold of stress that can be tolerated.

In recent years youth unemployment has been described as having a ‘scarring’ effect on the future labour market prospects of young people, in terms of greater risk of social exclusion, job loss, poorer quality of jobs obtained, and suppressing wages (e.g. McQuaid, 2015; Bäckman & Nilsson, 2016). In a study across 11 European nations, Brandt and Hank (2014) demonstrated that early unemployment (over 6 months) has an economic scarring effect throughout the life course. They argue this impact can be considered permanent as it can be detected even close to retirement. Recent longitudinal evidence provides persuasive evidence that there is health scarring as well as economic scarring. The Scandinavian evidence is particularly interesting. Brydsten et al. (2015), Helgesson et al. (2012), Reine, Novo and Hammarström (2004, 2013), and Strandh, Winefield, Nilsson and Hammarström (2014) found youth unemployment to be associated with detriments to adult physical and mental health that persist into adulthood and can be detected in middle age. Swedish evidence also shows links between youth unemployment and elevated alcohol consumption in mid adulthood (Vitanen et al., 2016).

In USA, Mossakowski (2009) found that unemployment in the 15-year transition to adulthood was predictive of depressive symptoms at ages 29-39. In the UK, Wadsworth, Montgomery and Bartley (1999) used evidence from the National Child Development Study, a British birth cohort study, of people born in 1958. They found evidence of scarring in the relationship between the extent of unemployment (age 16 - 33) and both socioeconomic capital and health capital, the latter measured by an indicator combining body mass index, consumption of fruit, exercise, and smoking at the age of 33 years.

There is an emerging consensus that health scarring is a real phenomenon. Some caveats need to be highlighted. A feature of some of these studies is that the effects for women seem to be weak or absent; it is possible that youth unemployment presents a greater threat to male health. Moreover, Baggio et al. (2015) found only short-term mental health and substance use effects of NEET status in a Swiss longitudinal study; there were no long-term enduring effects. The evidence relating to long-term impact of adverse macro-economic circumstances, such as leaving school during a recession, is mixed (e.g. Brydsten, Hammarström & San Sebastian, 2016; MacLean, 2013; Virtanen, Hammarström & Janlert, 2016) but seems to suggest a detrimental effect. It remains unclear the extent to which young people can ameliorate the psychological effects of unemployment by proactive responses.

These might include engaging in activities that substitute for formal work, such as participation in the informal economy.

NEET young people as a target group for public health intervention

In recent years public health commentators have raised concerns about the consequences of high levels of youth unemployment as a result of recession (e.g. Lakasing, 2013; Leyland, 2013). Mental health conditions typically have their first onset in adolescence or young adulthood, and comorbidity is common (Kessler et al., 2005). Unemployment represents a risk factor. The consequences of common mental health conditions are not only serious, but also long-term. Early onset depression can recur throughout the lifespan, increasing the burden of the disease on society (Foresight Mental Capital and Wellbeing Project, 2008). The rise of NEET numbers across Europe during the recent economic downturn has only heightened the concerns of public health advocates.

Authoritative reviews of public health issues have argued for a joined-up approach to promoting mental well-being, with cross departmental co-ordination of policy to support young people's development (Black, 2008; Foresight Mental Capital and Wellbeing Project, 2008; Marmot, 2010; WHO, 2013). It would be all too easy to treat health issues as outside of the scope of education and employment policy. But if we accept that there is overwhelming evidence for social causation, then we must look to social measures to promote public health. The corollary of the 'scarring' argument is that, as Whitehead (2007) has suggested, there may be critical periods in the life course when interventions can have far-reaching life-long impacts on health. Adolescence may be one such period: if effective interventions can be delivered, then the lifelong impact and benefits to wider society could be great (Reiss, 2013; Patton et al., 2016). Friis, Wittchen, Pfister and Lieb (2002) identified family, education and work as key domains for the prevention of depression. Given the evidence that the health impacts of youth unemployment can be serious and enduring, it follows that work and learning for NEET young people must be of particular interest as a target for primary prevention (Allen, Hetrick, Simmons & Hickie, 2007; Beck & Quinn, 2012; Monroe & Harkness, 2005). For Patton et al. (2016), NEET rates represent a headline indicator of adolescent health status. One public health review suggests that "the most effective interventions are probably structural changes to improve access to education and employment for young people and to reduce the risk of transport-related injury" (Viner et al., 2012, p.1641).

Mental health specialists may believe the potential benefits of mental health promotion (without addressing education and employment transitions) are great for individuals and for society, but there is little proof of the effectiveness of such early intervention (St John, Leon & McCulloch, 2004). A systematic review of the literature found only limited evidence for the effectiveness of mental health promotion with young people (Harden et al., 2001).

Similarly, Morton and Montgomery (2013) in a systematic review of the literature on youth empowerment programmes found insufficient evidence that they improved self-efficacy and self-esteem. Perhaps this is not surprising. The social risks influencing the likelihood of NEET status are multi-dimensional so interventions that focus on one risk factor only are likely to be inadequate (Duckworth & Schoon, 2012).

The value of health promotion may be unproven, but it is not the only option. If NEET status tends to be detrimental to health, then moving people on from this status may be beneficial. We might reasonably expect that interventions that prevent youth unemployment, shorten its duration, or reduce its recurrence would tend to be good for health. Again, the evidence base is problematic. In their literature review, Lakey, Mukherjee and White (2001) complained of a near absence of evidence for the health effects of labour market programmes for NEET young people. Fortunately, recent evidence in this field looks more promising. Return to work seems to be good for the health of unemployed adults (Rueda et al. 2012). Similarly, Bjarnson and Sigurdardottir (2003) found that re-employment reduced levels of psychological distress in young people, although the level of the reduction was related to the quality of the new role (with full time employment better than part-time work).

These findings are broadly consistent with the logic of the Marmot (2010) review of health inequalities, which recommends improving access to learning in general, and work-related learning in particular. Effective interventions may also be cost effective to the state in terms of reduced medical and social care or welfare benefit costs. For example, Bruckner, Snowden, Subbaraman and Brown (2010) found that level of demand for youth mental health services in California was related to levels of unemployment.

Potential interventions to manage the public health impacts of NEET status

The role of secondary schools

Duckworth and Schoon (2012) identified protective factors that enable disadvantaged young people exposed to severe socioeconomic risk to avoid becoming NEET. These factors include prior attainment, educational aspirations and school engagement. They point to a preventive role for schools. Schools can seek to attenuate, rather than amplify socioeconomic status differentials (Thomas, 2014). Within the curriculum, career education, and personal, social and health education (PSHE) can help to build resilience for transition - a point that has not gone unnoticed in Dame Carol Black's *Review of the health of the working age population*:

“Many children already receive Personal, Health and Social Education at school. There is a great opportunity for the links between health, skills and work to be made clear as part of this curriculum...Schools and Further Education colleges should consider including the benefits of work in their health promotion for children and young people.” (Black, 2008, p. 105-106).

There is some evidence that effective careers programmes in school and colleges produce a more positive mindset (Blenkinsop, McCrone, Wade & Morris, 2006), and at least among those most at risk, may reduce psychological distress (Koivisto, Vuori & Nykyri, 2007; Peng, 2005). There are also some attempts (e.g. Kavanagh et al. 2009; Stallard & Buck, 2013) in schools to introduce psychoeducational approaches to manage mental health symptoms using approaches derived from cognitive behavioural therapy. It remains unclear if this approach can inoculate pupils against the stress of transitions, and post-school environmental pressures. More importantly, close relationships with support agencies and the range of post-school opportunity providers are vital to reduce the likelihood of NEET status.

Whilst schools provide an obvious platform for public health interventions (Rothi, 2006), they have the equally obvious drawback that they are poorly placed to help those who have already left the school system. NEET young people have by definition left school, so it is necessary to look elsewhere for potential interventions to reach them.

The role of further education and vocational training

The provision of training has been favoured by governments as a solution to youth unemployment. Indeed, offering a ‘youth guarantee’ or a promise of a place on a programme

to all unemployed young people represents a recommended policy option (European Commission, 2014; ILO, 2014b). This is pragmatic, but not entirely unproblematic in areas with chronic structural unemployment. Where work is hard to obtain, further education or training may represent a way of postponing unemployment rather than a way of developing the skills required in paid employment. Recent research on the impact of further education and vocational training on health and well-being is scarce. Further education and training will not provide as much income as paid employment and are inevitably temporary - bringing uncertainty about what happens when a programme is completed. This may limit their potential to provide enduring psycho-social benefits of work. Some have claimed that youth training is little better than unemployment in this respect (e.g. Dorling 2009). Recently, Standh, Nilsson, Nordlund and Hammaström (2015) have provided some intriguing longitudinal evidence from Sweden. At a 27-year follow-up in middle adulthood, those who participated in youth programmes at age 18-21 did not show the elevated levels of mental health symptoms of those who had been unemployed at the same stage. This suggests that the enduring health benefits of participation in youth training may have been underestimated due to lack of longitudinal research.

Some training interventions are short prevocational courses intended to promote employability. These may include elements specifically targeted at personal development. They tend to reach some of the most vulnerable groups of NEET young people who are not yet ready for occupationally-specific training. These programmes might represent a particularly good location to deliver psychoeducational input designed to help individuals retain any mental health gains they have made during a course.

The role of welfare systems

Whilst labour markets across Europe are tending to become more flexible, state welfare regimes differ in the way they handle youth unemployment (Cinalli & Giugni, 2013), although in general access to benefits is limited and conditional (Eichhorst & Rinne, 2014). Nonetheless, some regimes may limit the scarring impacts of unemployment better than others (Brandt & Hank, 2014; Jensen, Rosholm. & Svaver, 2003). This suggests that governments are not powerless to manage the health consequences of youth unemployment: welfare benefits represent a potential area for leverage. However, at this stage the evidence is not sufficiently clear to give unambiguous policy prescriptions.

The role of career guidance services

Robertson (2013a) argued that there is strong rationale that guidance interventions could impact on mental well-being via two mechanisms. The first is an indirect mechanism: by promoting participation in suitable work or learning, and thereby facilitating access to the health benefits of gainful occupation. The second is a direct mechanism: by providing emotional support in a counselling setting, albeit pragmatic rather than therapeutic in intent. Robertson (2013b) further suggested that career guidance may represent a potential public health intervention because state guidance services (such as those in Scotland and Wales) are uniquely placed in their ability to reach at-risk young people both before and after they leave school. They may have a specific remit to engage with NEET young people: this makes them an ideal platform for psychoeducational interventions with young people designed to promote positive mental health and re-engagement. They are able to provide a bridge from school to post-school opportunities. They facilitate access to further education and vocational training. They can provide emotional support and also pragmatic support, with issues such as accessing welfare benefits. Guidance can be embedded within other interventions and locating it within training programmes may enhance their supportive potential. This remains speculative. To date there appears to be no research isolating the long-term effects of career guidance on the health of NEET young people.

Conclusions

Social causation is accepted by public health experts as an important element in epidemiology. Structures in society that can prevent the onset of mental health conditions are our first goal. Failing that, to delay the onset of a condition, reduce its duration, and prevent its reoccurrence are also desirable goals. Unemployment is known to have harmful effects on mental health: the evidence base for this is strong. Youth unemployment has reached alarming levels in Europe in the early 21st century. Whilst accepting that NEET young people are a heterogenous and transient group, there is nonetheless reason to be concerned about the consequences of this development.

Young people are believed to be particularly susceptible to threats to their mental health, which may result in lifelong vulnerability. There is a credible evidence base suggesting that exposure to stress in adolescence can have enduring consequences for adult mental health. Also, patterns of risky health behaviour established in adolescence or young adulthood may

endure, resulting in a lifelong burden of disease, with costs to society beyond the distress of the individual. There is also an emerging evidence base indicating that there may be enduring health scarring effects from experiences of exclusion from work and learning in youth.

NEET young people could be considered vulnerable at a critical period in their biological maturation, at their socioeconomic ‘birth’ into the adult world. They are therefore a key target group for public health interventions. It is clear that the public health implications of NEET status are taken very seriously by the health professions (e.g. Scott et al., 2013). It is not clear that those educational and employment related agencies responsible for implementing policy responses to the ‘NEET issue’ have got this message. Rarely do they see it as their business to contribute to a health agenda. Effective prevention requires transcending the traditional policy silos of education, employment and health.

An important caveat to this argument is that the empirical evidence on the effectiveness of interventions is far from complete. The longitudinal evidence from Scandinavia suggests positive effects of active labour market programmes. It is not conclusive but is indicative that the possibility of enduring health and well-being impacts of employment related interventions on NEET young people merits further investigation.

Nonetheless there are reasons to believe that important contributions can be made by:

- Developing the preventive capacity of schools, whilst recognising this is unlikely to represent a complete solution. Exploring the links between work and well-being in the career and health education curriculum may be helpful, and close support in transition to post-school options is essential.
- Continuing use of further education and vocational training to reduce the amount of time spent in NEET status, and to explore the potential of embedding psychoeducational interventions in employability programmes for young people.
- Developing state welfare systems in such a way that they tend to ameliorate the harmful impacts of unemployment on young people.
- Recognising the central role of career guidance services in their work with school leavers and NEET young people, providing emotional and pragmatic support in transition and,

crucially, to reduce the likelihood and duration of NEET status.

These conclusions must be seen as tentative, given the inadequacies of the evidence base relating to the impact of interventions. Longitudinal studies of young people in transition to adulthood are required to identify which approaches, or combinations of approaches, provide the best protection against the potential long-term threat to health and mental well-being presented by NEET status. Empowering interventions, that recognise the goals of young people, rather than impose top-down policy driven solutions upon them, are particularly worthy of further exploration.

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