



## 16-25 years

### Missed opportunities: children and young people's mental health

Adolescence and young adult years are considered a peak age for the first onset of adult mental illness. Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24 (Kessler, *et al.*, 2005; McGorry, *et al.*, 2007). Diagnosable conditions which occur at this age produce high levels of enduring impairment which can snowball over time and increase the odds of suffering life course disadvantage – this includes school failure, unstable employment, poor family and social functioning (McGorry, *et al.*, 2007). There is now strong evidence that common mental health conditions that first emerge in adolescence have a higher chance of persistence into young adult years if not quickly treated and contained – particularly for women. For example, around half of young men and two-thirds of young women went on to have at least one further episode in young adult years after suffering an episode of adolescent diagnosable depression and anxiety. However, for those with a single episode in

their teens lasting less than six months, persistence into adult years was much lower than those with longer lasting illness or recurrent episodes of ill health (Patton, *et al.*, 2014). This study points to the critical importance of containing and reducing any period of illness during adolescence through prompt and reliable early intervention and also of preventing the recurrence of episodes of illness during this important time.

Evidence suggests that 60% of disability experienced by those aged 15-34 years is caused by mental illness; as such, it represents a major burden of disease for this age group and should be a health improvement priority (Halfon, *et al.*, 2012; Whiteford, *et al.*, 2013). International evidence from high income countries also points to a broad increase in young adult psychological distress and depression during the recession between 2008 and 2011 (Collishaw, 2015) although we are currently lacking up to date data on trends over time for this age range.

The weight of evidence indicates that it is not too late for interventions to have a positive effect during teenage and young adult years; intervening early in the course of many mental illnesses can significantly reduce life-course impairment (Patel, *et al.*, 2007). Yet very few young adults get early help that has the best chance of making a difference and on average it will be 10 years after the first onset of symptoms before they access help (Kessler, *et al.*, 2005). This points to significant missed opportunities to change the trajectory of mental health outcomes and alter the life chances of vulnerable adolescents.

Services for teenagers and young adults also create gaps and involve imperfect handovers between child, adolescent and adult systems. This can result in young people losing support at a time when they face the greatest risks in terms of their wellbeing, mental health and risk taking and need the most help (McGorry, *et al.*, 2013). Furthermore, gaps in support at this time mean that services back away from young people at the time that they are also least likely proactively to seek help from services (McGorry, *et al.*, 2013).

Overall, at any one time around 20% of young people in this age band experienced a diagnosable mental illness during mid adolescence to young adult years (McManus, 2007). However, studies also suggest that around 60% of 9-21 year olds are likely to fulfil criteria for one diagnosable mental health condition at some point during this entire age range (Copeland, *et al.*, 2011).

## Prevalence of mental health problems

### *Depression and anxiety*

The adult psychiatric morbidity survey completed in 2007 indicated that 16% of young people aged 16-24 met the criteria for diagnosis with a common mental health condition such as depression and anxiety (the peak period for presentation with such conditions was between 45 and 54 years) (McManus, *et al.*, 2009). Data also highlighted that:

- Women were more likely than men to present with diagnosable common mental health conditions during this age band (21% versus 12%).
- There was little variation between males from white, black and south Asian communities; however, women from south Asian communities were noted to have a higher likelihood of presenting with a diagnosable common mental health problem (although small sample sizes made it difficult to draw reliable conclusions).
- People living in households with the lowest level of income had a higher likelihood of having a common mental health condition compared with those living in the highest income brackets (McManus, *et al.*, 2009).

### **Post-traumatic stress disorder (PTSD)**

The overall prevalence rate for a diagnosis of PTSD among adults was 3% (McManus, *et al.*, 2009). However, it was much higher in young people and adults aged 16-24 years with 5% of young men and 4% of young women likely to screen positive for PTSD (McManus, *et al.*, 2009).

These high levels were attributed to evidence that young men in this age band were more likely to have exposure to violent assault, an occurrence associated with higher likelihood of developing PTSD symptoms (Nicholas, *et al.*, 2007; McManus, *et al.*, 2009).

Men and women of all ages from black communities were more likely to have experienced trauma, to have a higher likelihood of PTSD symptoms and to screen positive for current PTSD. And black men were much more likely to screen positive for PTSD than women (McManus, *et al.*, 2009). The reasons underpinning this finding were not explored but may again be related to a higher likelihood of men from BME communities living in urban and more deprived settings with higher risk of experiencing victimisation and violent assaults. There has been no reliable breakdown of prevalence for those with migrant or refugee experiences in the last national adult psychiatric survey.

## Self-harm

Reports of self-harm were highest for young people of both sexes in the 16-24 age group ranging from 9% disclosure in face-to-face responses and 12% in self-completed responses. The overall average across all age ranges was 5%. Half of those who had self-harmed also said that they had attempted suicide at some point in their life (McManus, *et al.*, 2009). Figure 1 shows the number of hospital admissions in England for self-harm among 15-19 year olds between 2011 and 2014.

Trends over time for this age group suggest that while hospital admissions for self-harm have remained largely stable for young males between 2011 and 2014, female self-harming has increased by around 30% in the same period with the largest jump occurring between 2012/13 and 2013/14.

Fewer men (35%) than women (53%) received psychological help after self-harming. In a qualitative study of this age group, young people generally talked about a 'conspiracy of silence' which locked them into isolated distress searching among a maze of variable sources (often online) for help (YoungMinds & Cello, 2010). They talked of experiencing high levels of stigma and wanting more open dialogue with, and less negative judgment from, family, friends, educational staff and professionals. GPs, teachers and parents also talked of having high levels of nervousness about how to open up conversations safely and support young people appropriately with addressing self-harming behaviour (YoungMinds & Cello, 2010).

## Suicidal thoughts

13% of 16-24 year old men and 22% of young women in the most recent national adult psychiatric morbidity survey reported suicidal

thoughts with around a third reporting that they had attempted suicide at some point. Reported rates of suicidal thoughts in the last year were higher for young men and women in this age band than in any other age group during adult years (McManus, *et al.*, 2009).

Suicidal thoughts were more commonly disclosed by white men and women and least common among South East Asian men. Men were more likely than women to take their own lives. Suicide was twice as likely in households with low income compared with those in households with the highest income (McManus, *et al.*, 2009). The national suicide prevention strategy identified unemployment as a known risk factor for suicide (Department of Health, 2012).

National statistics (2016) on completed suicides in 2014 indicate that 4.2 in every 100,000 15-19 year olds and 9.2 in every 100,000 20-24 year olds took their own lives in 2014. Overall, these rates represented a very marginal increase compared with 2013 rates for both age ranges. Suicide remained much more common among young men than among young women. Although suicide rates had remained largely stable for young men when comparing trends during 2013 and 2014, rates for females in both age ranges appeared to have increased (although from conclusions on trends are difficult due to the small numbers of young women affected). Suicide represented a leading cause of death for both men and women aged 20-34 in England and Wales) (Office for National Statistics, 2015).

On a more positive note, young adults were the most likely of all age groups to have sought help after a suicide attempt (70% compared with 50%). There had also been a notable improvement in rates of help seeking since 2000 among young men – pointing to the significant potential to achieve improvements in help seeking among this age group (McManus, *et al.*, 2009).

**Figure 1: Hospital admissions for self-harm for 15- 19 year olds between 2011 and 2014**

2011-2012		2012-2013		2013-2014	
Male	Female	Male	Female	Male	Female
4,405	12,010	3,745	12,600	4,189	15,515



Confusingly, in the 2007 national survey (McManus, *et al.*, 2009), women reported more lifetime suicide attempts than young men (which runs counter to what we know about completed suicide events which are more common among males). The explanation offered for this contradictory finding is that men are more likely to be successful in their first suicide attempt (McManus, *et al.*, 2009).

Groups at higher risk of suicide include:

- Men;
  - Those in lower income groups;
  - Young people in the criminal justice system;
  - LGBT young people;
  - Young people with a history of self-harm;
  - Young people with a history of abuse;
  - Young people with untreated depression;
  - Young people with a history of early conduct problems;
  - Young people with a family member or peer who have died from suicide;
  - Those with painful or physically disabling illnesses, including chronic pain;
  - Those misusing alcohol or drugs.
- (McManus, *et al.*, 2009; Department of Health, 2012).

High risk events are noted as:

- The loss of a job;
- Debt;
- Living alone, becoming socially excluded or isolated;
- Bereavement;
- Family breakdown and conflict including divorce and family mental health problems;
- Imprisonment;
- Harassment.

It can often be a combination of these factors that leads to suicide (Department of Health, 2012).

### **Psychosis**

Psychoses represent a group of major psychiatric conditions characterised by significant disturbances and alterations in

people's perceptions, thoughts, mood and behaviour. They include conditions such as schizophrenia, affective psychosis and bipolar disorder. Young people in this age band are less likely to meet the criteria for a full diagnosis with psychosis compared with older age groups. However, this age band is the peak period for first onset of psychotic symptoms. During early onset years, symptoms are more subtle and easier to miss. However, there is good evidence that early treatment at this stage can change the severity, level of impairment experienced, likelihood of recurrence and course of the illness (Bottlender, *et al.*, 2003) (Harrigan, *et al.*, 2003). Early intervention can also prevent later crisis and costs (Knapp, *et al.*, 2011).

Some young people are at higher risk of developing psychotic illnesses. These include those:

- With a relative suffering from psychosis;
- Using cannabis during adolescence;
- Who experienced certain childhood and adult adversity (such as sexual, physical, emotional abuse, bullying and neglect);
- With reduced household income;
- Living in highly urban environments;
- With migration histories.

(Arseneault, *et al.*, 2004; McManus, *et al.*, 2009).

Psychotic illnesses are more common among men in the 16-24 age group than women. Conditions are also more prevalent among men from black communities than men from white communities with black African Caribbean males being around five times more likely than average to present with the symptoms of psychosis.

### **Adult attention deficit hyperactivity disorder (ADHD)**

ADHD was previously considered a condition solely affecting children and mostly boys. However, long term studies have shown that around one in six children will continue with symptoms impairing their day to day functioning in adult years (Faraone & Biederman, 2006; McManus, *et al.*, 2009).

National surveys of adults also suggest that ADHD may be more visible among young adult women in this age group than in childhood/early adolescence (McManus, *et al.*, 2009). Symptoms are also most visible between the ages of 16 and 24 and decrease (or get easier to manage) with age.

During adult years, symptoms appear slightly different with hyperactivity decreasing but inattention, disorganization, and impulsivity affecting functioning both at home and at work. People who are 'economically inactive or unemployed' are more likely to screen positive for ADHD (McManus, *et al.*, 2009). Adult ADHD can result in failure in education and college, high job turnover, higher car accidents, increased likelihood of poor relationships and divorce and higher reliance on substances (McManus, *et al.*, 2009). Those with ADHD frequently have higher rates of other disorders including anxiety, substance misuse and personality disorders. Eight out of ten will have two other co-existing disorders, yet the same proportion of people with adult ADHD are not in contact with treatment or support services (McManus, *et al.*, 2009).

Specialist mental health services for adults with ADHD are now increasing but knowledge of what works is still emerging. For example, many ADHD medications have not yet been licensed with adults. Other recommended interventions include support for co-existing conditions and psychosocial interventions helping sufferers understand and manage the impact of their symptoms on their lifestyle thus reducing instability. Cognitive behavioural interventions and family therapy appear promising (McManus, *et al.*, 2009).

### **Eating disorders**

Eating disorders rank among the 10 leading causes of disability among young women (Mathers, *et al.*, 2000) and anorexia nervosa has the highest mortality rate of all mental health conditions (Millar, *et al.*, 2005; Zipfel, *et al.*, 2000). There is mounting evidence of increasing demand on high cost crisis placements when young people slip into crisis as a result of eating disorders (Health and

Social Care Information Centre, 2014); by the time they enter inpatient settings there is also evidence of significant impairment to their day to day lives with recovery taking longer (Pro Bono Economics & Beat, 2012).

Eating disorders exist across a spectrum. When severe and persistent, they reach the threshold for mental health diagnosis and include conditions such as anorexia nervosa, bulimia or non-specific eating disorders (eating disorders which are severe but do not share clear common characteristics with anorexia and bulimia). Non-specific eating disorders and anorexia almost always start in teenage years and are most commonly identified in young people between the ages of 16 and 24 years. Bulimia starts slightly later (Fairbairn & Harrison, 2003; McManus *et al.*, 2009).

Eating disorders are noted as being between three and ten times more common among young women than men (Health and Social Care Information Centre, 2014). In the last adult national psychiatric morbidity survey, very severe symptoms were observed in 5% of young women and 2% of young men (McManus, *et al.*, 2009). Unlike other mental illnesses, there is much less of an association between eating disorders and low household income.

British data indicate that only two out of ten people with diagnosable level needs were receiving treatment and support (McManus, *et al.*, 2009). This is worrying as there is good evidence that conditions tend to worsen with age and that later presentation for help worsens outcomes – particularly for anorexia.

Risk factors for eating disorders include:

- Being female;
- Being adolescent or in young adult years;
- Living in a western society;
- A family history of:
  - depression
  - eating disorders
  - substance misuse
- Family discord (particularly low contact, high expectations, high conflict);
- A history of sexual abuse;
- Critical comments about body image;

- Occupational/recreational/social pressure to be thin (e.g certain sports or professions where there is pressure to self-evaluate through weight);
  - Low self-esteem;
  - Perfectionism (particularly for anorexia);
  - Anxiety;
  - Early menarche;
  - Obesity (especially for bulimia).
- (Fairbairn & Harrison, 2003).

Evidence increasingly points to a combination of genetic susceptibility together with exposure to environmental risk driving the development of eating disorders (Fairbairn & Harrison, 2003). However, the genetic branch of eating disorders research is in its infancy. More research is required to understand the interplay between genetics, environmental risk factors and more recently identified early neurodevelopmental risks linked to birth complications and trauma during pregnancy and childbirth.

Environmental risk factors are considered to include social norms about thinness and the importance that women pursue beauty (instead of or as well as securing interpersonal or vocational success) to affirm their sense of femininity (Rodin, *et al.*, 1985). Both the yearly Girlguiding's Girls' Attitudes Survey (covering girls and young women aged 7-21 years) and the Good Childhood Survey (collecting data on young people up until the age of 18) point to worrying increases in girls' preoccupation with appearance as well as pressures to be perfect or thin (Girls' Attitudes Survey, 2014 & 2015) in recent years.

## Personality disorders

Personality disorder is an umbrella term for a range of mental health conditions. It describes a rigid and enduring pattern of personality traits which deviate markedly from those accepted in an individual's culture, which persist across a range of different contexts, which can severely impair the social, interpersonal and occupational functioning of those affected and which often cause distress to others. These patterns often start early.

Generally personality disorders can result in:

- People feeling overwhelmed by stress and negative feelings leading to unpredictability, emotional volatility (including excessive anger and sometimes intimidation), self-harming, high demands, overdosing, anxiety or substance misuse to manage emotions;
- An inability (in the case of antisocial personality disorder) to acknowledge and respect the rights and boundaries of others;
- Avoiding or prompting rejection from other people, creating social isolation;
- Difficulties feeling empathy and building stable relationships with others including families, children, peers and professionals.

Because of the lack of agreement over the definition of personality disorders, national studies often struggle to reliably identify prevalence rates. Furthermore, the label 'personality disorder' is controversial and not always clearly defined, often covering a series of diagnoses. Not everyone accepts their existence or their legitimacy as diagnoses. For many years, these conditions were deemed untreatable, although greater confidence has now emerged as to how people can be supported to live with and manage their conditions in the longer term.

Two examples of well-known personality disorders include antisocial personality disorder and borderline personality disorder.

### **Antisocial personality disorder**

Antisocial personality disorder is characterized by a long-standing pattern (starting in youth) of disregard for other people's rights, often involving violation of those rights. Those with antisocial personality disorder can present as arrogant, have unrealistic perceptions of their potential achievements and often lack empathy and remorse concerning the rights, feelings, and suffering of others. Symptoms often significantly impair the lives of those affected as well as causing damage to others, including:

- Failure to conform to social norms;
- Persistent deceitfulness;

- Impulsivity or failure to plan ahead;
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- Reckless disregard for safety of self or others;
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.

Antisocial personality disorder (ASPD) has been identified in 1.7% of young adult men. (McManus, *et al.*, 2009). There is some evidence that these young men are more likely than average to end up in the criminal justice system and particularly in custody (Singleton, *et al.*, 1998). However, the relationship between ASPD and crime is not straightforward with broader community studies estimating that only 47% of people with the condition had significant arrest records. Instead, those with this condition often experienced histories of aggression, school failure, unemployment, unstable interpersonal relationships, and substance reliance (Robins & Regier, 1991; The National Collaborating Centre for Mental Health, 2010). Such experiences often lead to a lack of stability and experiences of multiple crises. Adults with ASPD have lower than average life expectancy, including higher levels of suicide (The National Collaborating Centre for Mental Health, 2010).

Some continuity is observed between children presenting with early starting conduct disorders (and also with severe forms of disorganised attachment associated with severe maltreatment) and the development of later ASPD (Fergusson, *et al.*, 2005; National Institute for Health and Care Excellence, 2013). Around 25-40% of children with early starting conduct disorder go on to experience ASPD during adult years (Zoccolillo, *et al.*, 1992), and indeed current diagnostic criteria for antisocial personality disorder require a conduct disorder diagnosis before the age of 15. However, diagnostic guidance advises strongly against labelling young people with a personality disorder before the age of 18 years partly because adolescence can be a period of such dramatic emotional, behavioural and neurodevelopmental change. However, neither is it helpful to children, young people, families

and communities to adopt a policy of providing no support (purely watching and waiting to see what happens) when behaviours, distress and harm associated with emerging personality disorders are left to fester, impairing young people's lives during critical years and often resulting in later damaging and expensive crises. In practice, many of the behaviours that prompt later diagnosis during young adult years have been persistent and distressing beforehand, with children, parents and victims frequently struggling to get early intervention. In these early stages of adolescence the condition is often referred to as emerging personality disorder.

### **Borderline personality disorder**

Borderline personality disorder (BPD) is four times as likely to be diagnosed in the 18-34 age band compared with other adult age groups. It is also more commonly diagnosed in women aged 18-34 years (1.4%) as opposed to men (0.3%) (McManus, *et al.*, 2009). It is characterised by high levels of personal and emotional instability and self-destructive behaviour which seriously undermines people's ability to forge and maintain healthy relationships and achieve stability in their day to day lives (Skodol, *et al.*, 2002; McManus, *et al.*, 2009). Self-harm and suicidal behaviour is common with 60-70% attempting suicide at some point in their life and an estimated suicide rate of around 10% for those experiencing the condition (Oldham, 2006). As well as the severe impairments faced by the person affected by BPD, the diagnosis is also associated with significant financial costs to the NHS, social services and wider society. The annual cost of personality disorders to the NHS was estimated at approximately £61.2 million in 1986 (Smith, *et al.*, 1995).

Most people diagnosed with borderline personality disorder no longer meet the criteria for diagnosis five years later. There is some evidence that they get better at managing the impact of their symptoms over time. However, a small number of young people will face ongoing and serious impairment throughout their life as a result of the condition (National Institute for Health and Clinical Excellence, 2009).



Borderline personality disorder emerges from a complex interrelationship between genetic predisposition and exposure to environmental risk (National Institute for Health and Clinical Excellence, 2009). Many young people with borderline personality disorder have experienced some form of childhood trauma or serious attachment difficulty with their care-givers. Histories often include exposure to physical abuse (71%), sexual abuse (68%), parental substance misuse and witnessing serious domestic violence (62%) (Herman, *et al.*, 1989). Indeed, some have argued that BPD should be seen as a delayed form of PTSD. The unstable, non-nurturing family environment is considered a key mediator of abuse and for the development of later personality disorders (Zweig-Frank, *et al.*, 1991; Bradley, *et al.*, 2005).

Women with borderline personality disorder often take multiple pathways from early experiences of abuse and trauma towards generally unstable lives and vulnerability in society, often remaining under the radar until they slip into crisis (McNeish & Scott, 2014). Crises and vulnerability can include self-harming, substance misuse, victimisation through interpersonal violence, prostitution etc. Estimates suggest that around a fifth of women in prison fulfil criteria for borderline personality disorder (Singleton, *et al.*, 1998).

## Substance misuse

### Alcohol use

The most recent national survey focusing on the drinking patterns of 16 to 24 year olds pointed to an overall decline in alcohol consumption between 2005 and 2013 with most of the change being driven by changes in young adult behaviour (Office for National Statistics, 2013). In 2013, young adults (aged 16 to 24) were just as likely to be teetotalers as those aged 65 and over (27%). Between 2005 and 2013 there was a rise of over 40% in the proportion of young adults who said that they did not drink alcohol at all. In contrast, when young adults did drink they remained the most likely group to have binged. Four out of ten young adults who drank alcohol in the week before interview exceeded

eight units for men and six units for women on at least one day. Women were more likely to be teetotalers than men although the steepest rise in teetotal behaviour had been among men in this age group (Office for National Statistics, 2013).

### Drug use

Young people aged 16-24 years were the most likely age group to have used an illegal drug in the last year with around 19% reporting use. This is more than double the average rate of use among all other age bands. Between 2012/13 and 2013/14 there had been an increase of roughly 3% in the numbers of young people reporting using drugs in the last year. There was also a slight increase in frequent drug use. However, these figures were both lower than in 1996. Overall, cocaine, ecstasy, LSD and ketamine use had increased between 2012/13 and 2013/14. Levels of use of any illicit drug more than once a month on average in the last year were higher among men than women, among those who went to pubs or nightclubs more often and among those who lived in more deprived areas (Office for National Statistics, 2013).

The number of drug related deaths by poisoning had marginally decreased for under 20 year olds (from 53 to 46) and remained largely stable for 20 to 29 year olds (from 413 to 415) compared with the previous year. There had been a fourfold reduction in drug related deaths for under 20 year olds since the late 1990s and a halving of rates for those aged 20-29 years whereas drug related deaths in older age groups were continuing to rise (Office for National Statistics, 2014).

## What works?

### Depression and anxiety

Common mental health conditions such as depression and anxiety should be managed through a process of good quality initial assessment to determine risks, and through stepped care. Evidence suggests that less complex conditions, where risk of harm is low, can be supported through evidence-based psychological therapies provided through



Improving Access to Psychological Therapies (IAPT) services (now available from 16 years onwards), self-help CBT support, physical activity groups (in the case of depression) or group and individual CBT. Young people in this age range are often less happy to approach highly 'clinical feeling services' (DH, 2015). They may, therefore, favour seeking psychological support and counselling from Youth Information Advocacy and Counselling services (YIACs) as highlighted by the recent CAMHS Taskforce Review (Department of Health, 2015).

For young people with more persistent or severe problems, more intensive CBT and/or medication (for over 18 year olds) should be available. Referral to specialist mental health services would normally be for young people with depression who are at significant risk of self-harm, have psychotic symptoms, require complex multi-professional care, or where an expert opinion on treatment and management is needed (National Institute for Health and Care Excellence, 2005; National Institute for Health and Care Excellence, 2009; National Institute for Health and Care Excellence, 2013; National Institute for Health and Care Excellence, 2014).

### ***Post-traumatic stress disorder (PTSD)***

As for under-16 year olds, Eye Movement Desensitisation Therapy and trauma focused CBT is effective for teenagers and young adults (Washington State Institute for Public Policy, 2015). A meta-analysis of studies also points to the effectiveness and good value of PTSD Prevention Following Trauma – an intervention which is delivered in the first weeks and months after a trauma, before a diagnosis of PTSD can be made. Interventions involve five to ten hours of individual therapy combining education on effects of trauma, relaxation, and exposure (Washington State Institute for Public Policy, 2015).

The last adult survey indicated that just under 30% of those screening positive with PTSD were in receipt of treatment – however, most were receiving medication rather than interventions likely to promote recovery (McManus, *et al.*, 2009).

### ***Suicide prevention***

More research and development are needed to establish effective preventative initiatives and treatment for young people at risk of suicide. Depression is one of the most important risk factors for suicide. Early identification followed by prompt, compassionate and effective treatment of depression is particularly important and has a major role to play in preventing suicide across the whole population (Department of Health, 2012). Reducing reliance on substances is also critical. Good crisis management plans should involve families and should facilitate swift access to crisis care in the event of any escalation of poor mental health (Department of Health, 2012).

Multi agency post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, and health and care settings (Department of Health, 2012).

Men are much more likely to hide emotional problems and avoid seeking help for emotional distress than young women (Rickwood, *et al.*, 2007). They are also much less likely to approach primary care services (Department of Health, 2012). This presents a major challenge when seeking to prevent suicide. Supporting wider awareness in non-clinical settings among those in contact with young men (for example in educational, employment or job centre settings and through raising awareness in friends and partners) or encouraging more creative and more male-friendly ways of accessing help is an important developmental piece of work.

### ***Psychosis***

Early identification continues to be important at this early adult stage. Effective early intervention approaches involve medication but also holistic care from multi-disciplinary teams supporting broader psychosocial recovery (Knapp, *et al.*, 2011). For those recovering from psychosis, placement in employment backed up by specialist mental health support during this transitional adjustment (Individual Placement and Support schemes) has also proved to have a positive effect on people's mental health as well as representing good value for money (Washington State Institute for Public Policy, 2015).

### **Borderline personality disorder**

The core effective principles of working with young people with borderline personality disorder include:

- Placing a premium on flexible engagement and developing an optimistic and trusting relationship;
- Adopting a multi-disciplinary approach to supporting the young person according to their needs;
- Working in partnership with young people; supporting them actively to problem solve, find solutions and co-create crisis management, recovery, multi-agency and holistic plans;
- Paying especial attention to managing transitions and endings in relationships carefully; this includes transitions from youth to adult services as well as internal changes in support workers and exit planning.

(National Institute for Health and Clinical Excellence, 2009).

A number of treatment interventions show early stage promise for people with BPD including:

**Dialectical Behaviour Therapy (DBT)** is a NICE-guidance recommended cognitive behavioural therapy-based intervention for those with BPD at particular risk of self-harm (Dimeff & Linehan, 2001). It seeks to reduce the incidence of unwanted behaviours and improve regulation of emotions. It includes mindfulness skills, taken from Buddhist meditation practice. DBT has also been extensively researched and has a proven efficacy.

**Mentalisation-based treatment and related approaches** were developed by the Anna Freud Centre and are informed by early attachment theory recognising how problems experienced in relationships with carers in infancy and childhood can over stimulate neural stress responses with long lasting effects on people's destructive and self-destructive behaviours, and their ability to regulate their mood and emotions. Strong relationships with workers aim to help those affected improve the quality of their relationships and their understanding of other people's internal states and feelings, work

towards life goals and help regulate responses in the face of negative responses and stress. It has been evaluated and is demonstrating promising early results (National Institute for Health and Clinical Excellence, 2009; Durcan, 2015).

**Adolescent Mentalisation-Based Integrative Treatment (AMBIT)** is an adolescent version recognising the particular challenges faced by young people with conduct and emerging personality disorders in vulnerable groups who have often accumulated multiple challenges across the life course. Rather than offering a health clinic-based approach (unpopular with this group and resulting in low engagement with support) it seeks to skill up workers in day to day contact with these young people (youth offending workers, probation, youth workers, substance misuse workers) to deliver mentalisation-based approaches providing background supervision and consultation and, if things get stuck and if the young person agrees, three way problem solving sessions involving a consultant therapist (Durcan, 2015).

**Structured Clinical Management (SCM)** involves regular counselling sessions, practical support, advocacy and case management. Like MBT it has been shown to be effective with people diagnosed with BPD. It has been evaluated and is demonstrating promising early results (Durcan, 2015).

**Multi Systemic Therapy and Functional Family Therapy (MST)**, for those under the age of 18 years meeting the criteria for conduct disorder and with emerging personality disorder, is an intensive in-home programme aimed at families with children and young people aged 12-17. It seeks to empower parents with the skills and resources needed to address the difficulties that arise in raising teenagers and to empower young people to cope with family, peer, school and neighbourhood problems. Functional Family Therapy is a family intervention targeting young people aged 11-18 years at risk of entering youth justice settings. It assesses the behaviours in families which sustain problematic behaviours, supports more effective family negotiation and communication, and helps families set clear boundaries and skills.

## Antisocial personality disorder

The evidence for treatment of antisocial personality disorder in adult life remains limited, outcomes of interventions are modest (NICE, 2010) and the work can be challenging for practitioners. There is emerging evidence for a multi-agency approach with practitioners supported via local expert networks and focusing on helping young people manage the knock-on effects of their condition to maintain stability. Effective management of and work with young people with antisocial personality disorder includes the following activities:

- Developing an optimistic and trusting relationship;
- Good quality assessment by staff specifically trained in managing risk and supporting people with ASPD;
- Paying attention to frequently missed secondary mental health conditions and ensuring access to proven interventions;
- Delivering group based cognitive behavioural interventions which address impulsivity, interpersonal difficulties and antisocial behaviours;
- Using approaches which incentivise improvements in substance use through positive rewards and reinforcement (contingency management approaches);
- Good quality supervision and consultation for staff supported by regional forensic expert networks;
- Brokering multi agency care;
- Ensuring that there is effective continuity of support (placing a premium on effective handover and transitional engagement).

The most effective interventions, however, are those offered at an earlier stage to help children and young people with conduct disorders, such as Functional Family Therapy, Multisystemic Therapy and (for younger children) teaching parents positive parenting techniques (Khan, *et al.*, 2015; National Institute for Health and Care Excellence, 2013).

People with ASPD are small in number and easy for local commissioners to overlook when considering the broader local population's

requirements. However, when people with personality disorders escalate into crisis the costs can be very high. But because these costs are poorly tracked and affect multiple agencies, intensive projects seeking to reduce people's chances of escalating into crisis often receive inconsistent funding particularly when budgets are under pressure.

## Eating disorders

The evidence base for what works to reduce the risk of young people developing eating disorders and for intervening early remains in its infancy. In particular, interventions seeking to prevent the development of eating disorders have shown very inconsistent results. At best some programmes have been able to demonstrate a positive impact on reducing risky attitudes associated with eating disorders; however, it has not been possible to track whether interventions actually have any knock-on effect to prevent later high risk behaviour. This is mainly because programmes have been targeted at universal female populations (Pratt & Woolfenden, 2002). As we understand more about groups at higher genetic risk for eating disorders, there may be some benefit in targeting and evaluating the impact of interventions more specifically for those at greater risk.

Family Therapy, particularly the Maudsley Family Therapy approach, appears the most promising intervention for adolescents with a diagnosable eating disorder (National Institute for Health and Care Excellence, 2004b). Despite a recent review of the evidence generally pointing to no notable improvements at the immediate conclusion of family-based therapy, moderate improvements in recovery did emerge six months after treatment had concluded compared with comparison groups (Couturier, *et al.*, 2013). More research is required to develop the reliability of this intervention with longer term follow up.

Self-help resources and CBT delivered over six months are considered effective for adults with bulimia with an adapted version recommended for under 16 year olds (National Institute for Health and Care Excellence, 2004b).



Given the significant impairment that often follows the development of a diagnosable eating disorder, more research is required to understand who may be at greater genetic risk of developing disorders. This research needs to go hand in hand with efforts to develop and test out preventative programmes with higher risk groups.

## Groups at higher risk of poor mental health

Some young people in this age band face higher risk of poor mental health compared with their peers.

### Care leavers

Every year around 10,000 16-18 year olds leave foster or residential care in England. Local authorities must support care leavers until they are 21 years old (or 25 if they are in education or training).

Young people in care have often had difficult lives. Without comprehensive wraparound support they can face greater likelihood of multiple poor outcomes as adults. For example:

- 62% of care leavers were originally taken into care because of neglect or abuse.
- Only half of children in care have emotional health and behaviour that is considered normal and this has changed little in recent years.
- Care leavers are five times more likely to self-harm in adult years (National Audit Office, 2015).
- 25% of those who are homeless have been in care at some point in their lives.
- 22% of female care leavers became teenage parents.
- 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience.
- In 2013-14, 41% of 19 year old care leavers were not in education, employment or training (NEET) compared with 15% for all 19 year olds.
- Only 6% of care leavers were in higher education compared with one third of all 19 year olds.

(National Audit Office, 2015).

## Transitions between child and adult services

Young people and young adults are at most risk of developing mental illness at the point when they are most likely to experience multiple gaps and a lack of continuity between youth and adult mental health and social care systems (Department of Health, 2009) (McGorry, *et al.*, 2013).

For young men, adolescent years are also the time when they are least likely to approach services and acknowledge vulnerabilities (Chandra & Minkovitz, 2007). One study tracking people from child mental health services to adult services noted that up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care (Singh, *et al.*, 2010). In many cases, adult mental health services were not vigilant in looking for, or being responsive to, the less clear cut, more subtle and less crisis orientated emerging mental health problems synonymous with young adults' needs. This is worrying given that there is still good evidence at this age of the benefits of intervention during the very early stages of presentation with early symptoms.

Better designed services and commissioning systems which minimise service gaps at this crucial time are urgently required and are now being piloted in some local areas (e.g. Birmingham and Norfolk & Suffolk). Youth Information, Advice and Counselling Services (YIACS), provided by the voluntary sector (e.g. Youth Access) also seek to straddle gaps in transitional mental health care in local health and social care services (Department of Health, 2015).

Despite facing greater life challenges than young people who have not been in care, care leavers often failed to get the support they needed to help them negotiate critical transitions to adult independence. For example, while half of young people in the UK were living with their parents at the age of 22 in 2013, a third of young people aged 16 or over left care before their 18th birthday. Many care leavers felt that they left care too early despite the introduction of legislation supporting continued support up until the age of 21. Care leavers also wanted:

- Support from personal advisors up to the age of 25, whether or not they are in education or training;
- More support for those in prison;
- Better housing, employment training and financial support;
- More access to apprenticeships for care leavers.

(The Care Leavers' Association, 2013).

### ***Young people not in employment, education and training***

The most recent Youth Index 2015 (The Prince's Trust Macquarie, 2015) highlights that young people not in employment, education and training have poorer wellbeing than other young people in this age band. The survey also suggested that young people's confidence in the future (often linked to employment and the successful adoption of adult responsibilities) was at its lowest point for seven years. Furthermore, a University and College Union study (2014) found that:

- A third of young people not in education, employment or training had suffered from depression.
- Young people out of work and training also had higher levels of anxiety than other young people in employment.
- Nine out of ten wanted to work or be in education or training but a third felt they had 'no chance' of ever getting a job and 40% felt that they had 'no part in society'.
- 37% rarely left their home.

- More than 70% said that with the right support they could contribute a lot to the country although they needed advice and support about their options and help to boost their confidence.

(Simmons, *et al.*, 2014).

Furthermore, the most recent Joseph Rowntree Foundation (2015) poverty report noted that families with children, as well as young people and young adults, were most likely to have been affected by recent housing benefit, housing market and welfare changes. Although marginal overall increases in poverty were noted in the UK over the last year, this younger age group was thought to be facing significantly more straitened financial circumstances increasing their social exclusion (Joseph Rowntree Foundation, 2015).

### ***Young adults in the criminal justice system***

The peak years both for developing mental illnesses and for offending span mid-adolescence to the mid-twenties (McGorry, *et al.*, 2013; Centre for Mental Health, 2014). Adolescents and young adults in the criminal justice system have poorer mental health than other age groups who offend (Singleton, *et al.*, 1998).

Nearly all young adults in the criminal justice system face multiple social, educational, psychological, health and economic challenges (Social Exclusion Unit, 2002). Many have experienced cumulative social and psychological stress and adversity, maltreatment, violence, trauma and poor attachments with parents and carers (Bretherton, 1992; Revolving Doors Agency, 2010).

From the age of 16 onwards, these young people face multiple transitions, disrupted support worker attachments and many barriers which prevent successful rehabilitation, undermine recovery from poor mental health and hamper independent living (Centre for Mental Health, 2014).

In terms of their mental health:

- Nine out of ten young people in custody have been found to suffer from a diagnosable mental health condition and eight out of ten suffer from at least two (Singleton, *et al.*, 1998).
- Young adults in custody aged 18 to 20 account for 18% of all self-harm incidents although they represent 9% of the population in custody (Ministry of Justice, 2013).
- 52% of newly sentenced prisoners were permanently excluded from school (Stewart, 2008).
- 40% of young women in custody and 25% of imprisoned young men reported having suffered violence in the home (Stuart & Baines, 2004).
- 29% of young women in custody reported having been sexually abused in childhood (Farrant, 2001).
- A quarter of young adults thought they would leave prison with a drug problem (HM Chief Inspector of Prisons for England and Wales, 2011).
- Fewer than half of young people in custody knew where to get help with accommodation, drug treatment or continuing education when they left prison (Centre for Mental Health, 2014).

Criminal justice systems tend to be organised around the needs of predominantly male offender populations rather than catering for the needs of females. Yet females in the criminal justice system have been noted to have more severe and broad ranging vulnerabilities with backgrounds frequently characterised by trauma (Scott and McNeish, 2014).

### **Homelessness and social housing**

Over half of all people seeking help with homelessness are under 25 years old. However, official figures only capture a fraction of actual need with many young people temporarily staying in other people's homes, in insecure settings or living rough. In 2011, the University of York published an estimate of the scale of youth homelessness in the United Kingdom (based on 2008/9 data) which was felt to amount to roughly 80,000 16-24

year olds (Quilgars, *et al.*, 2008). Although estimated rates of youth homelessness decreased nationally between 2006 and 2009, improvements have not been sustained since and there is some indication that rates have been rising since the last estimate in 2013 (Platts, 2015). For example, in the last four years the number of young people sleeping rough in London has more than doubled (CHAIN, 2014). Recent changes to benefit allowances and shortages of affordable housing for young single people have particularly affected younger people.

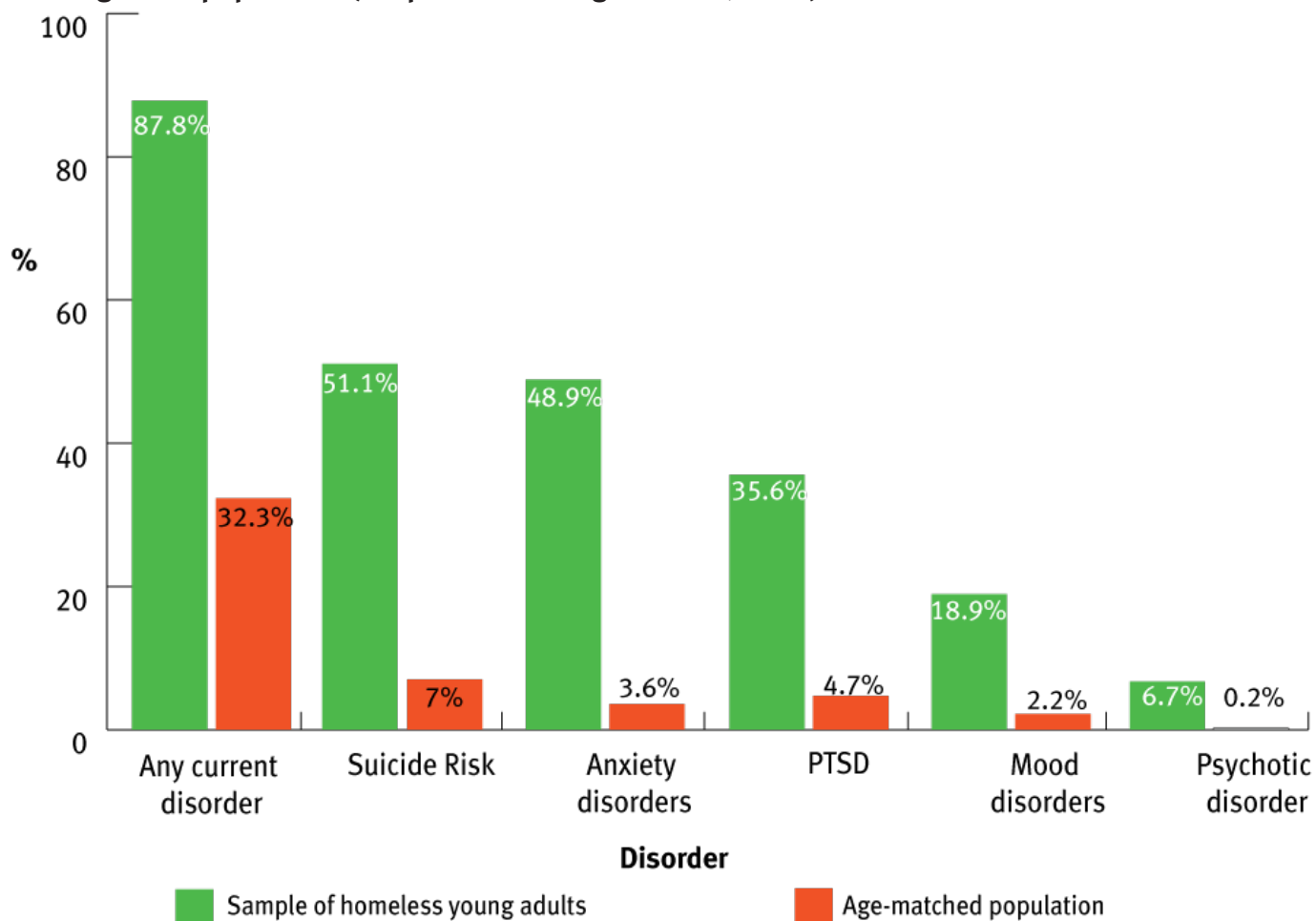
Homelessness is highly stressful. Studies generally show large variations in the proportion of homeless people who have mental health problems. However, most studies indicate that homeless young people have much greater likelihood of suffering from mental illness compared with other young people (see Figure 2) (Hodgson *et al.*, 2014). Studies also suggest that between four and nine out of ten young homeless people meet the criteria for a diagnosis (Hodgson, *et al.*, 2013). Mental health problems sometimes precipitated young people's homelessness; but homelessness also undermined mental health and wellbeing. Homeless young people were also more likely to be reliant on substances (Hodgson, *et al.*, 2013).

One study also noted that only 30% of homeless young people had accessed any form of mental health service and only 10% accessed substance misuse services. This was despite two thirds having visited their GP in the three months prior to one survey and a quarter having been to A&E (Hodgson, *et al.*, 2013).

Overall one in five young people who became homeless had been forced to leave their family home (CHAIN, 2014). The risk of becoming homeless was greatest for those who had experienced multiple disadvantage including disrupted family background, trauma, violence in the home, institutional history, poor socio-economic status and poor health (Social Exclusion Unit, 2004). Young women were more likely to declare themselves as being statutorily homeless and were also more likely to be homeless as a result of physical or mental



**Figure 2: Prevalence of psychiatric disorders among homeless people compared with the general population (adapted from Hodgson *et al.*, 2014)**



illness or after fleeing violent relationships. Young men were less likely to be declared statutorily homeless and more likely to cite relationship breakdown, substance misuse and leaving an institution such as care, prison or hospital as a trigger for homelessness (Quilgars, *et al.*, 2008).

Among those facing greater risk of homelessness are care leavers, drug and alcohol users, asylum seekers and refugees, and lesbian, gay, bisexual or transgender (LGBT) people. In a survey of 16-22 year olds who were LGBT one third became homeless because of non-acceptance by their family. Often the full extent of their need was 'invisible' in homeless settings due to insufficiently sensitive screening for sexuality (Dunne, *et al.*, 2002).

Trusting relationships with key staff who supported access to resources which facilitate independent living and skills was identified as

important for homeless young people (Quilgars, *et al.*, 2008). However, those providing services for homeless young people talked of low confidence in providing basic emotional support for young people within the generic housing and homelessness sector, and struggles in accessing specialist mental health support due to waiting times or gaps between child and adult services. A lack of integration between services also meant that many young people fell through the gaps between multiple sectors and between child and adult services.

There are significant gaps in knowledge of what works well for young homeless people (Quilgars, *et al.*, 2008). There is generally considered to be insufficient investment in pre-crisis prevention activities such as conflict resolution or parenting initiatives. Inadequate emergency accommodation and affordable 'move-on' housing are often lacking. Even when available, emotional and practical support may

be poorly coordinated. Evidence suggests that young people experiencing homelessness need high quality relationships with a significant adult, support from ‘floating workers’ offering life skills, tenancy management/budgeting skills and opportunities to access employment to support recovery (Mental Health Foundation, 2006; Quilgars, *et al.*, 2008). There may also be some benefit in testing out with young people a promising approach known as ‘Housing First’ which is beginning to show positive results with adults with poor mental health (Boardman, 2016). Housing First sees stable accommodation both as an essential human right and as a core health intervention. The consistent principles of the Housing First model also include:

- Providing immediate housing without the need to go through a series of intermediary stages to prove ‘housing readiness’;
- An emphasis on choice and on permanent housing;
- Providing access to flexible, respectful, voluntary, person-centred and open-ended support as part of the core offer.

(Boardman, 2016).

Finally, there is some indication from research tracking trends in child and adolescent mental health over time of increasingly powerful links between adolescent emotional difficulties and living in social housing. The association between family poverty (and to a lesser extent neighbourhood poverty) and child/youth mental health is strong (Huston, *et al.*, 2003; Akee, *et al.*, 2010; Morrison Gutman, *et al.*, 2015). Observed increases in emotional problems among adolescents living in social housing were thought to be related to higher rates of exposure to environmental stress and adverse events; increased maternal distress and family stress; and income inequality among those without opportunities for social mobility (Langton, *et al.*, 2011). Some Arm’s Length Management Organisations have recognised these higher needs and the benefits to landlords of supporting child and parental mental health (Centre for Mental Health, 2012).

## Young people in the Armed Forces

Young people in the Armed Forces community experience mental health problems at broadly the same rate of prevalence as other groups. They are most likely to experience depression, anxiety and particularly alcohol misuse problems (Fear, *et al.*, 2009; Iversen, *et al.*, 2009). Recently there has been greater focus on the prevalence of post-traumatic stress disorder (PTSD) among UK military personnel, although prevalence rates among those returning from Iraq appear relatively low (between 4–6% compared with 8–15% experienced by US counterparts) and are broadly comparable with community rates. Similar rates of mental illness are also found between ex-Service personnel and their still serving equivalents (Sundin, *et al.*, 2010).

However, some particular patterns, problems and challenges are noted in the literature outlining the particular experiences of those with mental health needs in the Armed Forces community and their patterns of access to mental health interventions.

Based on a comparison involving small samples, overall UK veterans appear no more likely than non-veterans to have mental health difficulties (Iversen, *et al.*, 2010; Iverson, *et al.*, 2011). However, female veterans in one study appeared more likely to present with suicidal thoughts and male veterans were more likely to present with violent behaviours than non-veterans (Woodhead, *et al.*, 2011). Relative to other service personnel, the following groups have been identified with poorer mental health in the Armed Services community:

- Early service leavers;
- Those deployed to Iraq or Afghanistan with pre-Service vulnerabilities;
- Those exposed to high levels of combat in Iraq or Afghanistan;
- Reservists;
- Younger male ex-Service personnel (under the age of 24 years); this age group has higher rates of suicide than their general population equivalent.

(Iversen, *et al.*, 2009; Fear, *et al.*, 2010; Harvey, *et al.*, 2011; Buckman, *et al.*, 2012; Woodhead, *et al.*, 2011a; Woodhead, *et al.*, 2011b).

Early service leavers have been particularly noted to have poorer mental health than others in the Armed Forces (Buckman, *et al.*, 2013). There was evidence that common mental health problems, PTSD, fatigue and multiple physical symptoms were more prevalent compared with other veterans after adjusting for other influential variables. Early Service Leavers were also more likely to be younger, female and to have higher rates of exposure to childhood adversity (Buckman, *et al.*, 2013).

Having mental health problems is also acknowledged as a recognised risk factor for leaving service early. Military personnel with mental health problems are more likely to leave service compared with those with no problems or with physical health problems, and are at risk of poorer post-service outcomes (Garvey Wilson, *et al.*, 2009; Fear, *et al.*, 2009; Buckman, *et al.*, 2013).

In terms of stigma and seeking help there is evidence that:

- Armed Service personnel do not always know where to go (Iverson, *et al.*, 2011).
- Stigma and lack of trust or confidence in providers of mental health services represent significant barriers to seeking help in serving personnel (Britt, 2000; Langston, *et al.*, 2007; Rona, *et al.*, 2004; Greene-Shortridge, *et al.*, 2007). For example, admitting a psychological problem was experienced as much more stigmatising than admitting a physical health problem among soldiers returning from Bosnia (Britt, 2000). Some stigma has been associated with a reluctance to disclose vulnerability in a profession which sets great store by physical and psychological resilience in the face of adversity. Some stigma is also linked to fears of being blamed by their employer and that disclosure may have a negative impact on careers (Britt, 2000; Langston, *et al.*, 2007; Iverson, *et al.*, 2011).
- There are mixed findings regarding the likelihood of those in the Armed Services seeking help. One study noted an overall treatment rate of 13% for a sample of UK Armed Forces personnel, around half that found for the general population (Iverson,

*et al.*, 2010). However, other studies indicated that serving personnel and veterans were no less likely to seek help than non-veterans, although there were some indications of personnel delaying seeking appropriate help and treatment thereby reducing opportunities for early intervention and better recovery (Iversen, *et al.*, 2010; Iverson, *et al.*, 2011; Woodhead, *et al.*, 2011a). Just under a quarter (23%) of personnel with alcohol problems had sought professional help, compared with 50% among those suffering with depression and anxiety (Iversen, *et al.*, 2010). Common treatments included medication and counselling/psychotherapy (Iversen, *et al.*, 2010).

- When Armed Forces personnel with a mental health problem seek help, there is evidence that they prefer informal support through a spouse or friend (between 73–85%). Regulars and Reservists did not differ in their help-seeking behaviours.

### ***BME young people***

There is longstanding evidence of persistent mental health inequalities affecting young adults and adults from some BME communities (Keating, *et al.*, 2002; Street, *et al.*, 2005; Afiya Trust, 2011) – particularly young African Caribbean men. This is despite cross cultural prevalence studies suggesting that rates and patterns of diagnosable mental health problems are broadly comparable and stable across different ethnic groups and evidence that children largely start on a level playing field in terms of their mental health (Weisz, *et al.*, 1997). In the past, poor quality prevalence data on BME children and adolescents has hindered understanding of mental health trends among these populations over time – sample sizes for national prevalence studies have been too small to draw reliable conclusions (Green, 2005). A recent analysis of eleven year old children in the Millennium Cohort (which oversampled those from BME communities) sheds some light on patterns of mental health over time indicating that at this age, white boys and mixed heritage young people are most likely to present with diagnosable difficulties closely followed



by boys classified as black. For girls, those classified as being of mixed heritage were most likely to present with a diagnosable difficulty. Indian boys and girls were least likely to have diagnosable difficulties (Morrison and Gutman, 2015).

However, by the time children from some UK BME communities reach adult years, sizeable increases can be observed in prevalence of some mental health diagnoses (particularly PTSD and psychosis diagnosis rates), in the severity and length of mental illness and in the way that formal mental health and other systems respond to those from some BME communities compared to white British counterparts (Keating, *et al.*, 2002; McManus, *et al.*, 2009). Despite lower rates of diagnosable conduct disorder than white adolescent males, they were also much more likely during teenage years to be over represented among higher risk populations (e.g. in local authority care settings, those excluded from school or in the youth justice system) and to access mental health care through criminal justice pathways rather than via primary healthcare (Keating, *et al.*, 2002; Afiya Trust, 2011).

The drivers for these persistent inequalities remain the subject of ongoing debate and are attributed to a medley of factors including greater exposure to persistent economic deprivation, social exclusion, institutional racism, misinterpretation of cultural differences and social cues, cultural insensitivities, poor design of mental health services, high stigma and fear preventing early intervention and leading to greater likelihood of presenting in crisis (Keating, *et al.*, 2002; Afiya Trust, 2011).

Over the years, many initiatives have attempted to drive changes in the system and improve mental health outcomes for BME communities. However, these have so far failed to result in system-wide sustainable and culturally sensitive adaptations. Culturally sensitive initiatives for young people focused on early intervention and prevention therefore remain patchily available, and have failed to attract investment in research and development to build their evidence base and scalability. And yet, there is evidence that good quality early support can both prevent poor mental

health and life chances as well as promote more effective recovery (Patel, *et al.*, 2007). Creating less stigmatising, more culturally acceptable, better branded and more accessible strength-based early support for at-risk BME communities must be a central priority as well as ensuring that such services are routinely available on a national scale.

Other groups covered in earlier age bands and who continue to possess higher risk of poorer mental health at this stage include:

- Young people in gangs;
- Migrants and refugees;
- Young Carers.

## Seeking help

Teenagers and young adults are most likely to develop mental health problems but least likely to recognise that they have a problem that might benefit from treatment (Jorm, 2012).

As young people pass through adolescence they become incrementally less reliant on parents and have greater need for autonomy and independence. At this time in their life, they are more likely to believe that they should be able to handle problems themselves (Wilson & Deane, 2001; Wilson, *et al.*, 2005) with between a third and just under a half of those with serious mental health difficulties in some studies believing this to be the best course of action (Andrews, *et al.*, 1999; Gould, *et al.*, 2004).

Furthermore, studies suggest that the particular mental health difficulties more commonly experienced by adolescents and young adults (e.g. depression, anxiety and substance misuse) tend to increase social withdrawal, making it more likely that a young person will keep their distress to themselves. This is particularly the case with suicidal behaviour where studies of young adults and adolescents found that the more suicidal a person felt the less likely they were to seek help (Deane, *et al.*, 2001; Wilson, *et al.*, 2005).

Likelihood of seeking help at this age is also influenced by:

- Lack of belief that seeking help will make a difference;
- Lack of faith in formal services;
- Previous poor experiences of help;
- Fears about confidentiality.

(Rickwood, *et al.*, 2007).

Young adults are most likely to seek help from those they trust and know (Rickwood, *et al.*, 2007). As with younger teenagers, friends continue to be an increasing source of support for those in late adolescence (Booth, *et al.*, 2004) (Rickwood, *et al.*, 2007). However, some studies have indicated that peers were least likely to encourage linkage with professional support for those suffering from potentially serious conditions such as depression (Kelly, *et al.*, 2006; Dunham, 2004).

There were mixed results concerning the role of the internet in supporting mental health for this age group. Some studies highlighted the importance of online information, websites, social media sites, blogs etc. (Burns, *et al.*, 2009; YoungMinds, 2012), while other studies have suggested that face to face support still remains the preferred mode of help for young people (Bradford & Rickwood, 2014).

For young adults, intimate relationships become an important source of support – particularly for men – with partners often exerting a strong influence on men to seek professional support (Cusack, *et al.*, 2004).

Furthermore, although adolescents and young adults are increasingly self-reliant, the influence and views of parents still remain important even among this age group. Most students still identified parents as a source of support (Rickwood, *et al.*, 2007). Other studies have also pointed to the impact that negative parental reactions or stigmatization can have on help seeking at this age, particularly for men (Cohen, *et al.*, 2009). This study found that while some parents of 17-24 year olds were supportive of their children with mental health conditions, others discouraged or actually prevented young people from getting the help they needed (Cohen, *et al.*, 2009). These family responses were related to a lack of understanding of mental health issues, negative

attitudes about mental health treatment, and concerns about the part of people outside the family. Finally, surveys of young people that use case scenarios show that accurate recognition increases rapidly from early adolescence to the mid-20s and is associated with their parents' ability to recognise correctly (Wright, *et al.*, 2005; Wright, *et al.*, 2007).

### ***Gender, mental health literacy and help seeking***

Men were generally noted to have lower mental health literacy than women as well as being less sensitive to peer wellbeing and less likely to air their problems with peers (Wilson & Deane, 2001; Burns & Rapee, 2006; Rickwood, *et al.*, 2007; Mojtabai, 2007). Men were also noted to experience higher levels of self-stigma concerning mental health and emotional wellbeing. More traditional views on masculinity and concerns about showing vulnerability were seen to be in direct conflict with help seeking (Galdas, *et al.*, 2005; O'Brien, *et al.*, 2005). Young adult men have also been particularly noted to have less positive attitudes to mental health treatment (Rickwood & Braithwaite, 1994; Gonzalez, *et al.*, 2005; Chandra & Minkovitz, 2007) than women. In an Australian study of 3,092 young adults aged 15-24 years, 39% of males and 22% of females reported low intentions to seek help from formal services for personal, emotional or distressing problems and 30% of males (compared with only 6% of females) reported that they would not seek help from anyone at all (Donald, *et al.*, 2000). In practice, adolescent and young adult males are also significantly less likely to actually seek professional help (including psychological therapies) than females (Chandra & Minkovitz, 2007; Bowers 2013). Low help seeking rates for males at this age are particularly worrying given their comparatively higher rates of suicide. However, young women are more likely during this age group to experience poor mental health (McManus, *et al.*, 2009).

The capacity for self-referral was seen to develop over adolescence, as independence and autonomy from parents increased, although parents do continue to play a significant role, particularly until young people are financially independent. Parental attitudes have also been

associated with gender differences in patterns of help seeking. One study found that more boys and young adult men cited perceived parental disapproval as a reason why they might be more unwilling to use mental health services (Cohen, *et al.*, 2009). The same study found that older adolescents who did turn to parents for mental health issues were more likely to seek formal mental health support than those who turned to friends.

## Key messages

- In young adulthood, there is a significant increase in self-harm, depression, anxiety and eating disorders, all of which for the first time begin to affect young women more than young men. It is also at this time that we first begin to see more severe mental health diagnoses emerge such as psychosis and personality disorders.
- Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24. Poor mental health represents a major disease burden for this age group and should be a health improvement priority.
- Teenage and young adult years continue to provide vital opportunities for intervention among those facing or living with poor mental health. Intervening early in the course of many mental illnesses can significantly reduce life course impairment. Yet very few young adults get early help that has the best chance of making a difference and they are the least likely to seek help – particularly males.
- For young adults with common mental health problems (depression and anxiety), cognitive behavioural programmes have the best evidence of supporting recovery. CBT is also effective for young adults who have suffered trauma. For young people with emergent psychoses, early identification and holistic intervention supporting recovery is highly effective.
- Women are the most likely to have an eating disorder and only one in five are likely to be in receipt of treatment; this is despite the fact that poor outcomes have been associated with later presentation to services for anorexia nervosa. The evidence base for effective responses to eating disorders is also still developing.
- A small proportion of young adults are affected by a group of mental health conditions known as personality disorders. While these are rare and highly controversial diagnoses, people living with them can feel overwhelmed by stress and negative feelings, have difficulties in forming relationships, end up in frequent, distressing and costly crises and become very isolated.
- Support for young adults with personality disorders needs to be based on building trusting and optimistic relationships, on working in partnership with young people, and on managing transitions to maximise continuity (for example at age 18).
- Young people who have been in the armed forces have a similar prevalence of mental health problems to other groups, but they face particular challenges in seeking help, for example because of stigma, fears about reduced career progress or a lack of knowledge of where to go for support.
- Young adults as a whole are the most likely age group to develop mental health problems but the least likely to recognise that they have a problem that might benefit from treatment. Their difficulties are less likely to be spotted by parents or teachers.
- Where young adults do seek help, it is often from peers, parents or online information rather than from formal services. Young men are particularly unlikely to seek help, sometimes with tragic results.
- There is good evidence that you can reduce the impact and burden of poor mental health during adult years if, during adolescence, you intervene to reduce the duration of episodes of mental illness and to prevent its recurrence during these vital years.





## Missed opportunities

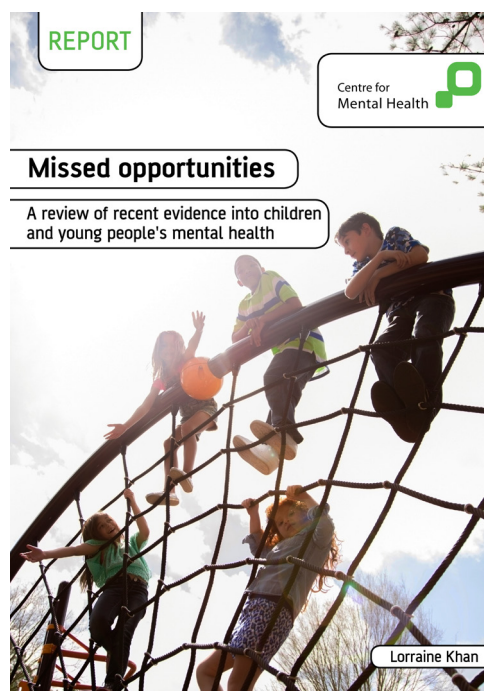
This is a chapter from the report **Missed opportunities: a review of recent evidence into children and young people's mental health** by Lorraine Khan. For the full report, or the reference list, please visit [www.centreformentalhealth.org.uk/missed-opportunities](http://www.centreformentalhealth.org.uk/missed-opportunities)

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