

RIGHThere

Literature Review

Young people aged 16 to 25: The promotion of mental health and well-being and the early intervention in mental health problems



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Abstract

This paper reviews the literature related to promoting young people's mental health and early intervention in mental health problems. It begins by looking at how mental health and mental health problems are defined, the numbers of young people experiencing problems and the potential impacts of both poor mental health and mental health problems.

Risk, protective factors and resilience can have an effect on mental health. Examples are given of those factors as well as strategies that can promote mental health and resilience. The importance of stigma and discrimination is discussed and evidence explored in relation to how best to tackle these issues. Finally, the paper focuses on the vital need for meaningful young person participation in developing new projects and programmes and in creating change within services and organisations.

The review leads to a number of general conclusions which is hoped will assist future work in this field:

- There needs to be an increased focus placed on mental health.
- It is important to develop early intervention in detecting and treating mental health problems, as well as promoting mental health.
- Strategic frameworks for the promotion of mental health and resilience need to operate to strengthen both individuals and communities, and reduce structural barriers to mental health.
- The development of fully-evaluated action plans that promote the mental health and resilience of young people during times of transition is needed.
- There is a need for the implementation of action plans to tackle stigma and discrimination that target young people and ensure young people participation in their development.
- All organisations need to address the challenges inherent in ensuring meaningful young people participation.

Glossary of terms

General terms

Early intervention

In this literature review, early intervention refers to action being taken in the early stages of someone having mental health problems, regardless of their age.

Prevalence

The number of people with a certain condition (e.g. diagnosed mental health problem) in the population at a given time.

Statutory sector

The statutory sector is comprised of services such as the National Health Service, Social Services, education and housing. They have a legal obligation to provide a service to those who are eligible under their criteria.

Voluntary sector

Voluntary sector organisations are self-governing and independent of government, are established for the good of the community (are 'value-driven') and are not set up for financial gain.

Young people

The term 'young people' is used to cover different age ranges by different research reports and policies. In this report, the term 'young people' refers to 16 to 25-year-olds unless otherwise stated.

Mental health problems

Anxiety

Anxiety is a universal human emotion, regarded as a mental health problem when it is severe and persistent.

Depression

Depression describes a range of moods, from the low spirits that we all experience, to a severe problem that interferes with everyday life, often referred to as 'clinical depression'.

Self-harm

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases, self-harm remains a secret behaviour that can go on for a long time without being discovered. Self-harm can involve cutting, burning, scalding, banging or scratching one's own body, breaking one's bones, pulling one's hair, or ingesting toxic substances or objects.

For further details and information on the above and other mental health problems, issues and treatment options, please go to the Mental Health Foundation's Mental Health A – Z: www.mentalhealth.org.uk/information/mental-health-a-z/

Introduction

This literature review has been undertaken as part of the Right Here programme, which is a joint Mental Health Foundation (MHF) and Paul Hamlyn Foundation (PHF) initiative. The scope of this literature review is wide, but has as its overall focus the mental health and well-being of 16 to 25-year-olds, including both mental health promotion to this age group, and early intervention when problems arise. The 16 to 25-age-range can be a time of significant change and transition. All young people will leave school and face a number of challenges, such as making decisions about their future, commencing work or higher education, leaving home, starting families of their own, forming new social networks, and many others. The Right Here programme aims to build on other work, such as the MHF's Listen Up! Project, to develop a significantly better understanding of how to promote mental health for young people going through this period of major change, and to develop early interventions which work for them.

The onset of adulthood is often categorised, including by mental health services, as taking place between the ages of 16 and 19, but in reality, reaching adulthood is more of an individual process or developmental milestone. This review therefore looks at evidence relating to both adolescents and adults.

Literature searches for this review involved a variety of sources including peer-reviewed journals, trade publications, reports, policy documents and unpublished literature. In addition, searches were made of a number of websites such as those of health-related organisations. Where possible, the review explores research conducted within the last five years. To keep it as relevant as possible to forthcoming projects within the Right Here programme, the literature searches were primarily concentrated on the UK, although reference is made to international research where it is thought to have particular bearing.

The final section of the review outlines general conclusions. It is hoped this will help highlight areas where further work should be considered.

1. Mental health and mental health problems

1.1 Mental health and well-being

There is much more to mental health and emotional well-being than the absence of problems. The World Health Organization (WHO) (2008a) defines mental health as:

... a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

The Mental Health Foundation and Office of Health Economics (2005) describe mental health for children and young people as underpinning their ability to:

- develop psychologically, emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
use and enjoy solitude
- become aware of others and empathise with them
- play and learn
- develop a sense of right and wrong
- resolve (face) problems and setbacks and learn from them.

The promotion of good mental health and well-being is similarly not just about avoiding mental health problems. Mental health promotion is defined as:

... both any action to enhance the mental well-being of individuals, families, organisations and communities, and a set of principles which recognise that how people feel is not an abstract and elusive concept, but a significant influence on health.

Friedli, 2000

Mental health promotion charity Mentality (2003) looked at ways of measuring positive mental health and well-being and concluded that this was a 'considerable challenge' because the emphasis has been on detecting mental health problems rather than good health. There is a range of tools used to measure well-being, including the Psychological Wellbeing Scale and General Health Questionnaire, as well as quality of life indicators that include looking at the community and environment, economic well-being, social networks, safety etc (Mentality, 2003; Audit Commission, 2005). The key elements of these tools and indicators have been divided into three categories, as follows:

Individuals: Feeling safe, feeling in control, trusting unfamiliar others, confiding relationships, access to social networks, financial security.

Communities: Access to resources and services, support for parents, opportunities for lifelong learning, cultural life, friendly physical environment, robust local democracy.

Quality of life indicators: Equity, control, involvement, safety, lifelong learning, cultural assets.

Mentality, 2003

Keyes (2007) argues that we should see mental health as one continuum and mental illness as another, which means that a person can have poor mental health without being mentally-ill, and vice versa. Complete mental health is described as 'flourishing' whilst poor mental health is described as 'languishing' and 'moderate' mental health is a state of neither flourishing nor languishing (Keyes, 2007). The signs of mental health against which people can be measured are placed into three main categories (Keyes, 2007):

- "positive emotions" (for example, "mostly or highly satisfied with life overall")
- "positive psychological functioning" (for example, "positive attitudes to self")
- "positive social functioning" (for example, "a sense of belonging to, and comfort and support from, a community").

Keyes (2007) found that only 17% of adults were completely mentally healthy, while languishing adults without mental illness had the same functioning as those with mental illness who had moderate or flourishing mental health, and those with mental illness who were languishing fared the worse of all¹. The case for promoting mental health whether someone does or does not have mental illness is made clear:

Languishing and moderate mental health are associated with high limitations in daily living, more reductions in work productivity due to cutbacks and lost days of work, more chronic physical disease and poorer psychosocial functioning.

Keyes, 2007

1. Study based in the United States.

1.2 Mental health problems

The term 'mental health problem' is a broad term that is used to cover a wide range of problems that impact on a person's ability to cope with his or her everyday life. These can be short- or long-term and can be categorised as being mild, moderate or severe. Formal diagnosis of problems using the World Health Organization's ICD-10 (2007a) often involves grouping together symptoms and/or behaviours which are then classified as a type of 'mental disorder'. For example, 'mood disorders', which includes depression, are one type of mental disorder under this system (for further details, see: www.who.int/classifications/apps/icd/icd10online/). The other main classification system used is the DSM-IV which is produced by the American Psychiatric Association.

The most common forms of mental health problems are depression and anxiety, and most people with a mental health problem will be seen by their GP or primary care team (Department of Health (DH), 1999). However, the World Health Organization (2008a) states that as many as one in four people who visit a health service are experiencing a mental health problem that is neither diagnosed nor treated.

1.3 Numbers of young people experiencing mental health problems

Children and adolescents

The Office for National Statistics (ONS) 2004 survey covering England, Scotland and Wales found that one in ten children and young people aged between 5 and 16 had a clinically-recognisable mental health disorder, with one in five of those having more than one of the main types of disorder (Green et al, 2005). The percentage of children experiencing mental disorders increased from childhood into adolescence. Mental health disorders were more common in boys than girls, with 13% of boys aged 11 to 16 having a disorder, compared to 10% of girls in the same age group. The two most common disorders in the 11 to 16 age range were found to be conduct disorder² and emotional disorder (anxiety and depression)³. Conduct disorders were more common in boys (8.1%) than girls (5.1%), whereas emotional disorders were more common in girls (6.1%) than boys (4.0%). It is noteworthy that the category of conduct disorder only applies in childhood, but it is argued that 'a substantial proportion of children and adolescents with conduct disorder grow up to be antisocial adults, leading impoverished and destructive lifestyles' (Scott, 2005). Kim-Cohen et al (2003) suggest that childhood conduct disorder is also associated with many major mental health problems in adulthood.

The Department of Health (2004a) states that overall there are specific groups of young people that have higher rates of mental health problems. These are young people who: are looked after by a local authority; are in young offender institutions; have a learning disability; or are unaccompanied refugees and asylum seekers.

2. Defined in the WHO ICD-10 as being characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct.States.

3. The larger sub-categories within this disorder include separation anxiety, specific phobia, social phobia, generalised anxiety disorder and depression (Green et al, 2005).

Young adults

The Office for National Statistics found that approximately one in six adults aged 16 to 74 were assessed as having a neurotic disorder (such as anxiety and depressive disorders) (Singleton et al, 2001).

The Royal College of Psychiatrists (RCPsych) (2003) report that the stresses of higher education (such as financial pressures, homesickness and loneliness) may lead to the exacerbation of mental health problems in students and make others more vulnerable to problems. They also found that excessive alcohol consumption and drug misuse were common (RCPsych, 2003). A survey conducted in 2006 found that 20% of students aged 16 to 19 in sixth form or further education colleges admitted experiencing emotional or psychological problems in that current term and 36% stated that they had in the past (Schools Health Education Unit, 2007).

Youth Access (Wilson, 2001/2) surveyed young people's information, advice, counselling and support services (YIACs) across England and found that some of the main reasons that young people aged 13 to 25 wanted to have counselling were:

- low self-esteem
- family problems
- difficult and aggressive behaviour
- self-harm
- drug and alcohol misuse
- depression
- eating disorders
- sexual abuse
- sexuality
- and bullying.

Drugs and alcohol

The negative impact of alcohol and drug misuse on well-being and health is well-documented (see for example: HM Government, 2008; Reitox, 2007; MHF, 2006a; Royal College of Psychiatrists, 2006a). Daily guidelines on alcohol consumption state that men should drink no more than three to four units in a day and women no more than two to three (Information Centre, 2007). It is acknowledged that binge drinking is difficult to define but the most widely-used measure is that of drinking over twice the recommended daily maximum: over eight units on one day for men and six units on one day for women (Information Centre, 2007). In 2006, it was found that 30% of men aged 16 to 24 in England, Scotland and Wales had drunk more than eight units on at least one day in the previous week and 25% of women in the same age range had drunk more than six units (Goddard, 2008)⁴. In 2006, it was found that 9% of men aged 16 to 24 in England, Scotland and Wales had drunk in excess of 50 units a week, and 7% of women in the same age range had exceeded 35 units a week (Goddard, 2008).

It has been reported that across the UK illicit drug use overall is significantly higher in young adults aged under 35, and that cannabis is the most widely-used drug across all ages (Reitox, 2007). In England and Wales, the 2006/7 crime survey found that 23.3% of young people aged 16 to 19 and 24.8% of those aged 20 to 24 had used one or more illicit drugs in the last year (Murphy and Roe, 2007). In Scotland, the highest percentages of adults who reported having taken drugs in the last year were among the 16 to 19-year age range (34.6%) followed by the 20 to 24-year age range (28.3%) (Brown and Bolling, 2007). In the 2006/7 Northern Ireland crime survey, 22% of 16 to 24-year-olds reported having used at least one type of illicit drug in the last year (Ruddy and Brown, 2007).

Self-harm

At least one in 15 young people in the UK are thought to self-harm, most commonly by cutting (MHF and Camelot Foundation, 2006). The national inquiry looked specifically at the 11 to 25 year old age group and identified that self-harm was a symptom of an underlying problem 'an emotional or psychological trauma' (MHF and Camelot Foundation, 2006). More recently, a survey of 818 11- to 19-year-olds across the UK found that as many as 22% self-harmed (Affinity Healthcare, 2008). Reasons given by survey participants included depression (43%), feeling angry (17%), stress (10%) and relationship problems (10%) (Affinity Healthcare, 2008).

Suicide

Globally, suicide is one of the three leading causes of death in 15- to 44-year-olds (WHO, 2008b). The 2006 figures for the UK show the lowest rates of suicide for men and women since 1991 (Office for National Statistics (ONS), 2008). Suicide rates overall are higher in men, with the highest rates, as at 2006, occurring within the 15- to 44-age-range (ONS, 2008). Research has found that young people aged 16 to 24, and particularly men, are reluctant to seek help, and only 7.5% of men and 8.9% of women who had suicidal thoughts had contacted their GP for help (Biddle et al, 2004). In prisons in England and Wales, it was found that young men aged 15 to 17 were 18 times more likely to commit suicide than men in the general population of the same age, and those aged 18 to 20 were six times more likely (Fazel et al, 2005).

4. Based on figures calculated using updated methods of converting volumes drunk to units.

1.4 The impact of mental health problems on young people

Mental health problems continuing into adulthood

There is a growing body of evidence to show that childhood mental health problems can be the precursors of adult mental health problems (WHO, 2005a). Kessler et al (2005) conducted a study in the US, and in a sample of 9,282 people aged 18 or above found that “half of all lifetime cases start by age 14 years and three fourths by age 24 years”. This echoed the findings of Kim-Cohen et al (2003) in New Zealand; in their sample of 976 26-year-olds, who met the criteria for a diagnosable mental health problem, half first had a diagnosable mental health problem between the ages of 11 and 15, and three-quarters by the time they were 18. However, they go on to suggest that effectively treating children and young people experiencing ‘psychiatric disorders’ may result in as many as half of the cases being prevented in adults (Kim-Cohen et al, 2003). They point out the need for detecting problems in childhood and emphasise the importance of aiming preventative measures “early in life” (Kim-Cohen et al, 2003).

The range of impacts on young people’s lives

There are many possible impacts of mental health problems on young people’s lives, some potentially far reaching. They range from immediate effects to much longer-term ones. The National Service Framework (NSF) for Children, Young People and Maternity Services in England identifies the broad sweep of potential impacts:

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

DH,2004b

1.5 Examples of specific impacts

Education and employment

The 2004 ONS survey found that many children with mental health problems were more likely to be absent from school and have difficulties with areas of education such as reading than those without mental health problems (Green et al, 2005). Employers are placing an increasing emphasis on social and emotional skills, for example, communication skills and team working (HM Treasury and DfES, 2007a). People with mental health problems are less likely to be employed and only 21% of people with a long-term mental health problems are in work (Sainsbury Centre for Mental Health, 2007).

Young offenders

The Prison Reform Trust (2008) states that “mental health problems, drug and alcohol abuse are common amongst young people in prison” and that young people in prison are more likely to have mental health problems than adults. The ONS state that many of the characteristics that predict that a young person may commit crime – for example, poor family relationships and lifestyle factors such as drug and alcohol use – overlap with those that predict that a young person may develop mental health problems (Maughan et al, 2004).

Homelessness

Recent research found that the majority of young homeless people aged 16 to 25 had mental health problems, which either preceded homelessness or were a result of it (MHF, 2006b). Mental health problems were found to be one of the reasons that young people were forced to leave the family home (MHF, 2006b). It was therefore recommended that early intervention work with families should be undertaken to prevent the breakdown of family relationships (MHF, 2006b).

Physical health problems

Recent research suggests that ‘languishing’ adults (those with poor mental health) have more chronic physical conditions (Keyes, 2007). Other research has shown that people with mental health problems, particularly severe mental health problems, are also more likely to suffer from higher rates of physical health problems (Scottish Government, 2008; Seymour, 2003; Phelan et al, 2001). Seymour (2003) suggests that some of the links between mental health problems and physical health problems relate to socioeconomic factors such as living in poverty and homelessness; and unhealthy behaviours such as poor nutrition, alcohol and drug misuse and smoking. In addition, physical health problems may not be given the same priority as mental health problems and there can be unwanted, even severe side effects from medication prescribed to treat mental health problems (Seymour, 2003, Phelan et al, 2001).

2. Risk and protective factors and promoting resilience

2.1 Risk factors

Certain factors can have an impact on mental health and well-being in young people. Factors which have a positive impact are known as protective factors, and those which have a negative impact as risk factors. "Social adversity, poor parenting, low intelligence, poor achievement, impoverished social networks and threatening life events" can all reduce the likelihood of someone "developing into a mentally healthy, emotionally stable, coping adult" (Mental Health Foundation (MHF), 1999). It is not possible to eliminate risk from a young person's life completely; nor is it desirable if they are to learn coping mechanisms (Newman, 2004a). However, risk factors can be cumulative and this is where the impact of risk becomes increasingly problematic (Newman, 2004a). The relationship between risk factors and the outcome for a child is not simple, and whilst it is more likely that a child will experience poorer outcomes if they are exposed to more risks, the outcome is not inevitable (Department for Education and Skills (DfES), 2007a). It is important "not to adopt a fatalistic approach" (Jenkins et al, 2002) as there may be other factors that help "to mitigate any negative influences to which the child is exposed" (DfES, 2007a).

It can be useful to look at risk factors in the context of health inequalities. The World Health Organization (WHO) (2006) points out that there are social and economic factors that will influence health, including poor housing, poverty, social exclusion and unemployment. The WHO (2007b) states that mental health promotion has a role in reducing the risk of mental health problems as well as "contributing to social and economic development". Walker et al (2005) state that:

... a comprehensive approach to promoting mental health would ideally address the socioeconomic conditions that exacerbate poor mental health such as low income, low literacy, limited education, insecure employment, stressful work conditions or unemployment, poor quality housing, violent and run-down neighbourhoods, and social and political disenfranchisement.

Risk factors for children up to 16

Data taken from the Office for National Statistics (ONS) survey which was carried out in Great Britain in 2004 (Green et al, 2005) identified many different factors that increase the prevalence of childhood mental health problems. The age range investigated was 5 to 16 and the countries covered were England, Wales and Scotland. All figures below are quoted from this report.

Socio-economic factors appear to play an important role in increasing the prevalence of children experiencing mental health problems. Examples included:

- Families where neither parent work (20% as opposed to 8% in families in which both parents worked)
- Low family income (16% among children whose families had a weekly income of less than £100, compared to 5% where the weekly income was more than £600)
- Living in areas classed as 'hard-pressed' (15% compared with 6% in areas deemed to be 'wealthy achievers', and 7% in areas of 'urban prosperity').

Other family factors appeared to have an influence, such as:

- Lone parent families (16% compared to 8% in two parent families, with boys at even greater risk (18% compared to 13% of girls))
- Interviewed parent had no educational qualification (17% compared to 4% of those whose parent interviewed for the survey was educated to degree level).

The survey included questions addressed to parents to find out about the relationship between other aspects of children's lives and mental health problems. The findings showed that children with mental health problems found it harder to make and keep friends, and had a lower ability to empathise compared to other children. Children with mental health problems were also more likely report smoking, taking drugs and drinking alcohol.

The ONS survey did not cover Northern Ireland, but the British Medical Association (BMA) (2006) suggests that, given the higher percentage of children there, the higher levels of socio-economic deprivation, and the higher percentage of adults with mental health problems (compared with the rest of the UK), it is likely that figures for child mental health problems would be at least the same if not higher.

There are many other risk factors for children and young people and examples include being in local authority care, being a refugee or asylum seeker, having chronic physical health problems, having been physically or sexually abused, and having parents who misuse drugs and alcohol (Green et al, 2005; BMA, 2006).

Risk factors for adolescents and young adults

The WHO defines the age range for adolescence as the period between the ages of 10 and 19, and identifies this is a time when "many life lasting health behaviours are formulated" (2007c) and as a time of "exploratory, sometimes risky, behaviours" (2005b) such as alcohol and drug misuse. It has specified several key risk factors for mental health problems in adolescents, but acknowledges there are more than these:

- poverty
- social exclusion
- violence
- peer rejection
- isolation
- lack of family support.

WHO, 2007b

Newman (2004a) suggests that points of transition in young people's lives can be both "threats and opportunities". Young people aged 16 to 25 can find that their lives change "rapidly and dramatically in a number of areas" (Office of the Deputy Prime Minister (ODPM), 2005). Support and guidance from families through the transition process to adulthood is thought to be important, but not all young people have this, which may leave them vulnerable (Morrow and Richards, 1996). It is argued that "the transition to adulthood for some young people can be a culmination of everything that has come before – whether positive or negative" (ODPM, 2005). Some young people face disadvantage or multiple disadvantages (for example, unemployment, homelessness and mental health problems), and for those most disadvantaged, the transition to adulthood can be "complex, disordered, and involves several repeated cycles of progress and backtracking" (ODPM, 2005). MHF (1999) state that "interventions for those at risk have to be available at key transition points" and must be "based on an understanding of their lifestyles and networks".

2.2 Protective factors and resilience

There are some young people who do not develop mental health problems even though it would seem likely given the risk factors. The impact of risk factors "can be reduced by strengthening factors known to protect mental well-being" (Jenkins et al, 2002). Protective factors can "increase the likelihood of positive life outcomes", which in turn can boost resilience (HM Treasury and DfES, 2007a). Resilience is defined as "patterns of positive adaptation or development manifested in the context of adverse experiences" (Masten and Gewirtz, 2006).

To put it simply, "resilience is a word that describes what someone has who copes well when bad things happen to them" (Royal College of Psychiatrists, 2007). Resilience allows the individual to: manage current adversity well; recover well from adversity; and develop "the capacities likely to help manage future adversities" (Hill et al, 2007).

The DfES in England (HM Treasury and DfES, 2007) has identified three key protective factors for children in addition to higher household income: high attainment; good social and emotional skills; and positive parenting. Social and emotional skills are identified as being:

- self-awareness
- the ability to manage feelings
- motivation
- empathy
- social skills (enabling children to relate to others).

HM Treasury and DfES, 2007a

It is argued that the development of social and emotional skills supports “educational achievement, employment and earnings, and relationships in adulthood”, as well as playing a part in reducing engagement in risky behaviours and promoting resilience (DfES, 2007a).

The WHO (2007b) reports that the key protective factors for mental well-being in adolescents (10- to 19-year-olds) are:

- empowerment
- positive interpersonal interactions
- social cohesion (this includes participation, services and support, and community networks).

WHO, 2007b

Yates and Masten (2004) argue that in adolescence some of the key issues are: forming identity; seeking autonomy; forming of ‘romantic’ relationships; and occupational contexts (such as those relating to work, vocational training etc.). Below are strategies identified by Newman (2004b) as being particularly important in promoting resilience in adolescents and young adults aged 13 to 19 years:

- strong social support networks
- the presence of at least one unconditionally supportive parent or parent substitute
- a committed mentor or other person from outside the family
- positive school experiences
- a sense of mastery and a belief that one’s own efforts can make a difference
- participation in a range of extra-curricular activities
- the capacity to re-frame adversities so that the beneficial as well as the damaging effects are recognised
- the ability – or opportunity – to ‘make a difference’ by helping others or through part-time work
- not to be excessively sheltered from challenging situations that provide opportunities to developing coping skills.

It is argued that what is needed overall for young people are interventions that address “self-esteem, communication and negotiation skills, media influences, social, cultural and gendered norms” (Mentality, 2003). The range of possible interventions is enormous and many of them serve both to promote mental health and help with existing mental health problems. Examples include: talking therapies; exercise and diet programmes; self help and support networks and volunteering; arts and arts therapies; complementary therapies; access to green areas such as community gardens etc. (MHF, 2007a; Mentality, 2003) (see appendix). There are also a number of interventions targeting specific issues including self-harm; bullying; alcohol and/or drug misuse; and smoking.

Individual, community and structural levels

In developing a strategic framework for mental health promotion, Jenkins et al (2002) argue that what is needed is “to achieve a balance between reducing risk factors and strengthening protective factors, which can enhance the ability of communities to cope with and survive difficulties”.

Those factors can be identified at “individual, community and structural” levels (Department of Health, 2001a; Jenkins et al, 2002). These involve:

- **Strengthening individuals** or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- **Strengthening communities** – this involves increasing social support, social inclusion and participation; improving community safety and neighbourhood environments; promoting childcare and self-help networks; developing health and social services which support mental health; and promoting mental health within schools and workplaces e.g. through anti-bullying strategies and mental health strategies.
- **Reducing structural barriers to mental health** – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

Department of Health, 2001a

These initiatives can be addressed:

- at different stages in life [this could include early adulthood]
- in different settings [this could include colleges, youth centres etc.]
- at different levels (such as locally, regionally or nationally).

Jenkins et al, 2002

3. Stigma and discrimination

Stigma and discrimination have been found to be major problems for people with mental health problems, which can help to impede recovery, make symptoms worse and stop people from getting help when they need it (World Health Organization (WHO), 2008c). Link and Phelan (2006) state that:

When people are labelled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them.

This means that people with mental health problems can be marginalised in society, affecting their quality of life and their ability to participate fully in society. Stigma may also be internalised (self-stigma), as negative attitudes are 'absorbed', resulting in a loss of self-esteem and self-worth (WHO, 2008c). Experiencing mental health problems may lead to a cycle of "social exclusion, including unemployment, debt, homelessness and worsening health" (Office of the Deputy Prime Minister (ODPM), 2004). This is confirmed by statistics that show, for example, that people with mental health problems have some of the lowest rates of employment, with stigma and discrimination identified as barriers (Sainsbury Centre for Mental Health, 2007).

3.1 People's perceptions of mental health problems

Overview

A recent survey of attitudes revealed a marked lack of knowledge among the general public about mental health problems, with 63% of people describing people who are mentally ill as 'suffering from schizophrenia' and 56% believing someone mentally ill has to be kept in a psychiatric hospital (TNS for Shift, CSIP, 2007). In a survey conducted by the Mental Health Foundation (MHF) (2000), 70% of participants had experienced discrimination either in response to their own mental health problems or those of someone else.

While many families and friends are supportive when mental health problems arise, others are not, and can act in a "strongly avoidant way", leading to stigma and discrimination in the home and within personal relationships (Thorncroft, 2006a). In a survey in Scotland, 4% of those who reported having experienced a mental health problem had suffered verbal abuse from within the family, and 11% were discouraged from taking part in social activities (Braunholtz et al, 2007). It is therefore perhaps less surprising that in an MHF survey (2007b), 44% of people said that they did not want their friends to know about their mental health problems, with the main reason given as feeling ashamed of what they might think.

Media

There is evidence from around the world that media portrayals of mental health problems, through film, television, newspapers and children's programmes, are predominantly negative, focusing largely on negative attributes especially links with violence (Thorncroft, 2006b). The WHO (2008c) suggest that, given the role the media is thought to play in stigmatising mental health problems, the reverse could be achieved by enlisting the media to provide a more positive function. Fortune et al (2008) state that more research is required to understand the role of different media, including magazines, television, music and the internet, in raising mental health awareness in young people.

Multiple discrimination

Thornicroft notes a lack of research evidence in the area of multiple discrimination and a lack of knowledge regarding the specific impact of this (2006a). Multiple discrimination occurs when a person is subject to more than one form of discrimination. Young people who are particularly at risk of multiple discrimination include those who are lesbian, gay, or bisexual, and those from black and minority ethnic groups (BME) (Mind, 2008a; 2008b). The national inquiry into self-harm found that young people from those groups were among those more at risk of self-harming (MHF and Camelot Foundation, 2006). YoungMinds (2005a) reported that young people from BME groups could face a number of barriers to receiving the help they needed, such as a lack of interpreting services and a lack of understanding of different cultural and religious needs.

Young people, stigma and discrimination

There is some evidence to suggest that young people may be subject to negative stereotyping. According to a recent survey, 70% of young people aged 16 to 25 said they were 'tarred with a negative image' (OnePoll for V, 2008). This negative stereotyping can include the concept of the 'dangerous youth', particularly relating to young men (Clements, 2007). Last year, the Children's Commissioner for England (2007) commented on the "demonising" of young people, and the Department for Education and Skills (2006) acknowledges that young people's "good work often goes unnoticed or is overshadowed by anti-social behaviour of a small minority".

Young people can themselves display negativity towards those with mental health problems. Pinfold et al (2003) found that young people had as many as 270 words and phrases to describe people with mental health problems, and that most were derogatory. Another survey found that whilst 80% of young people aged 16 to 24 thought having a mental health problem would lead to discrimination, 61% admitted that they themselves used derogatory language to describe mental health problems (Department of Health, 2001b).

3.2 Tackling stigma and discrimination

Thornicroft (2006a) suggests that the concept of stigma is best seen as three problems, described in detail by the WHO (2008c):

- Ignorance:** the problem of knowledge. Most people do not know very much about mental health problems, and much of what they do know – or think they know – is inaccurate.
- Prejudice:** the problem of negative attitudes. People fear and avoid other people with mental health problems; people with mental health problems anticipate and fear avoidance from other people.
- Behaviour:** the problem of discrimination. People act towards people with mental health problems in ways that are unjust and unfair.

Thornicroft (2006a) argues that, to date, much research has focused on attitudes towards mental health problems, and that it may be advantageous to concentrate more on discrimination and taking action to fight social exclusion. By focusing on discrimination (behaviour rather than attitudes), it means moving from “intentions to actual behaviour”; for example, “not if an employer would hire a person with mental illness, but if he or she does” (Thornicroft, 2006a). This approach also: requires attention to be given to injustice, human rights and anti-discrimination legislation; shifts the viewpoint “from that of the person within the ‘in-group’ to that of the person in the ‘outgroup’” (i.e. those with mental health problems); and can include interventions aimed at changing behaviour (Thornicroft, 2006a).

A number of studies from around the world looking at programmes targeted at school pupils to reduce ignorance, prejudice and discrimination have shown positive results (Thornicroft, 2006a). Thornicroft (2006a) states that:

Such changes may have very important implications as we know that among the factors which make young people with mental health difficulties reluctant to seek help are low levels of information and negative feelings about mental illnesses.

One of the most important factors in tackling stigma and discrimination has been found to be the direct contact with someone who has experienced mental health problems and who can relate the experience to others (WHO, 2008c; Thornicroft, 2006a). The evaluation of mental health awareness programmes aimed at both children and adults found that, for young people aged 14 to 15, personal experience of mental health problems, either their own or those of members of their family or friends, was the most likely to have a greater positive change in terms of their knowledge and attitudes (Pinfold et al, 2003; 2005). This was not the same for the adult groups; adults reported that it was, instead, testimonies from service users, describing their experiences of mental health problems and of using services that had “the greatest and most last impact on the target audiences in terms of reducing mental health stigma” (Pinfold et al, 2005).

Two of the larger health promotion programmes have taken place in New Zealand and Scotland. In New Zealand, the ‘Like Minds, Like Mine’ campaign to reduce stigma and discrimination against those with mental illness started in 1997. A study comparing people’s attitudes from 1997 to 2004 found that overall there had been a number of positive improvements in both young people’s (15- to 19-year-olds) attitudes and behaviour towards people experiencing mental health problems (Fearn et al, 2006).

In Scotland, the See Me campaign was launched in 2002. This was followed by a campaign specifically targeting young people in 2005⁵. An evaluation of the impact of this targeted campaign found that there had been an increase in mental health knowledge and awareness and the impact of the campaign had been “greatest where stigmatising attitudes lead to negative behaviour” (See Me, 2006).

The National Institute for Mental Health in England (NIMHE) (2004) concluded that there was sufficient evidence to gain an understanding of what worked in tackling stigma and discrimination. Based on their review, six key recommendations were made:

1. Users and carers are involved throughout the design, delivery, monitoring and evaluation of anti-discrimination programmes.
2. National programmes that support local activity demonstrate the most potent combination for efficacy.
3. Programmes should address behaviour change with a range of approaches.
4. Clear consistent messages are delivered in ways to target specific audiences.
5. Long term planning and funding underpins programme sustainability.
6. Programmes should be appropriately monitored and evaluated.

NIMHE, 2004

5. The age of the children/young people is not specified in the See Me literature.

The WHO (2008c) states that recent research has indicated that the most effective programmes for long-term change in tackling stigma, discrimination and social exclusion use a number of tactics on different levels. They therefore suggest that when programmes are being set up, providers should look at: what tactic/s to take (e.g. influencing public opinion, developing projects etc.); what level/s to aim at (e.g. individual/family, local level etc.); which group/s is to be targeted (e.g. young people); in relation to which mental health problem/s; and using what model/s (e.g. social inclusion, human rights) (WHO, 2008c). The WHO (2008c) suggests breaking down action plans for tackling stigma and discrimination using the following questions:

- What do you want to achieve?
- Why do you want this outcome?
- When do you want to achieve it?
- How will you go about making it happen?
- Who has the power to make it happen?
- Where are you now and where do you want to be?

Thornicroft (2006a) calls for evaluation to support all projects and suggests that they assess positive changes with regard to:

1. knowledge about mental illnesses
2. negative emotions and attitudes towards mentally ill people
3. negative discriminatory behaviour towards people with mental illness.

4. Young people participation

There has been widespread acknowledgement of the necessity for children and young people to have a say. This is enshrined in Article 12 of the UN Convention on the Rights of a Child, which gives children the right to express their views and for those views to be taken into account. Subsequent legislation and policies for England, Wales, Scotland and Northern Ireland have echoed this.

The term participation does not have one single definition and is often used interchangeably with involvement and consultation (Day, 2008). Participation Works, a consortium of six national and British children and young people organisations set up to provide information on participation to the statutory and voluntary sector, uses the following broad definition:

Participation is the process by which children and young people influence decision making which brings about change in them, others, their services, and their communities.

Participation Works, 2005 – 2008

A lack of clear definition can mean that in understanding and in practice, the idea of participation can be interpreted according to “individual ideologies, circumstances and needs” (Fudge et al, 2008). Kirby et al (2003) argue that, whilst many organisations aim to facilitate different participatory activities with children and young people, they do not focus enough on how the organisations themselves need to change their culture and ethos. This is echoed by Wright et al (2006), who argue that a ‘whole system’ approach to participation needs to be used by organisations, in developing:

- a culture
- a structure
- effective practice
- effective review systems.

A recent report concluded that, although in 2003, public sector and voluntary sector organisations had signed up to the policy of young people participation, there was still a gap between policy and practice (Carnegie UK Trust, 2007). Exploring available evidence, the report identified that the “breadth” of young people involved in participation was limited; that participation lacked “depth” which could lead to a lack of “fundamental reform”; and that, despite increasing commitment by organisations, there was uncertainty about participation and support was required including training (Carnegie UK Trust, 2007).

4.1 Types of participation

There are a huge variety of ways in which young people can actively participate within organisations and projects. To ensure that participation, there needs to be a flexible and creative approach within the right environment so that the participating is a positive activity (Day, 2008; Mental Health Foundation (MHF), 2007a; Wright et al, 2006). Wright et al (2006) urge that aims, objectives and outcomes are agreed at the outset, in particular making clear what will be changed or achieved. Being transparent and honest with young people about how far they can be involved in making decisions is also identified as being important (MHF, 2007a; Wright et al, 2006; Connexions, 2001). If this is not done, young people may have unrealistic expectations e.g. agree on something that is not possible to fund.

Some organisations opt to have a 'champion', such as a specialist participation worker to promote young people participation, and they can work with young people to discuss different ways that young people can be involved (MHF, 2007a; Wright et al, 2006). Appointing such a worker can drive participation forward, but needs to be part of a whole organisational shift towards participation to be effective (Wright et al, 2006).

The list below is not definitive but seeks to illustrate some of the many ways young people participated within the organisations involved in the Listen Up! project (MHF, 2007a) and provides examples of what can be done.

- Taking part in surveys, suggestion boxes, focus groups and individual feedback sessions.
- Being a member of a youth advisory board.
- Taking part in formal panel board meetings alongside senior management.
- Informing the development of the environment and design of organisations.
- Marketing, promoting and campaigning including radio and magazine interviews.
- Assisting with the development of publications and producing young person-friendly information.
- Planning and organising events and social activities.
- Undertaking research and evaluation.
- Undertaking work experience within organisations including administrative work, assisting with running groups or drop-ins etc.
- Being involved in staff recruitment and induction programmes.
- Taking part in internal events such as 'open days' and art exhibitions.
- Taking part in external events such as conferences and workshops.
- Training staff in other agencies.

Partnerships and links with other organisations can open up ways of undertaking participation. For example, a partnership with a university can provide young people with the support and expertise they need to take part in carrying out research/evaluation of programmes, for a service which could not provide that expertise in-house (MHF, 2007a). Partnerships can also help to ensure that young people's holistic needs are met rather than focusing on the agenda for a particular organisation, as well as exposing organisations to new ways of working, sharing knowledge and capacity (Kirby et al, 2003).

4.2 Benefits of participation

The Children and Young People's Unit (2001) outlined three main benefits of involving children and young people in the provision of government services:

- better services
- promoting citizenship and inclusion
- personal and social education and development.

Organisations and services

The main benefits for organisations are:

- services become more responsive to the needs of young people
- can begin to challenge presumptions about the needs of young people
- become more accessible
- become more efficient as they are providing a more effective service to young people.

Wright et al, 2006

For example, young people involved in research may provide a different perspective and think of different research questions than professional researchers (Kirby, 2004). In addition, young people may be able to put their peers more at ease and use language that is clear to them (Kirby, 2004). Involving young people in the design and layout of a service and decisions on opening times can mean that it becomes more welcoming to young people and therefore more accessible (MHF, 2007a).

Funders

Funders can benefit from young people participation as they can see how organisations are identifying gaps in services and what they are doing to resolve them, as well as gaining a good understanding of young people's satisfaction with services (Vasiliou-Theodore and Penketh, 2008; YoungMinds, 2005b).

Community

It is also suggested that there are broader benefits to the community, as young people become empowered, leading to an increased likelihood of them making a "positive contribution to society" (YoungMinds, 2005b; Mumby, 2001). Kirby et al (2003) concur with this idea, arguing that young people participation recognises that young people are "active and competent citizens".

Young people

Recent evidence garnered from interviews with young people aged 16 to 25 illustrated the wide range of benefits that were gained from participation, including:

- personal development such as feeling empowered and in control, more independent, and more confident in decision making
- gaining transferable skills ranging from giving presentations to coping strategies that could help them progress in other areas of their lives such as employment or relationships
- acquiring communication skills, specialised knowledge and language which could improve their ability to network, engage with professionals, help their peers, and navigate through services
- influencing change and making a difference at many levels
- raising awareness of young people's mental health and reducing stigma and discrimination
- giving something back to the service that had supported them.

Vasiliou-Theodore and Penketh, 2008

Participation can also provide opportunities for young people to have their contribution recognised and to meet new people, both in their own age group and older adults (Kirby, 2004), thereby expanding wider social and community networks.

4.3 Challenges to achieving participation

Representation

There are difficulties in ensuring that young people's participation is representative of the young people using the service. Ensuring that certain 'hard-to-reach' groups are represented can be a particular challenge (Carr, 2004; Connexions, 2001). Recognising that young people can participate in a number of different ways, at different levels, and encompassing a range of interests and skills can be helpful in tackling this (Connexions, 2001). One of the specific issues of working with young people in the 16 to 25-age-group is the amount of change occurring in their lives (MHF, 2007a). This can mean that committing to any long-term participation may not be possible and organisations need to work around this (MHF, 2007a).

Tokenism

Tokenism occurs when young people are asked to be involved in a way that is not meaningful; this could include being asked to comment on something that has already been developed (Henwood, 2007). Young people participation can be used to provide 'legitimacy' to the views of those running services, rather than being a vehicle to provide a real voice for young people (Day, 2008). Young people involved in the ListenUp! project said that the main barrier to participation was tokenism and they reported having found this a problem particularly with statutory sector consultations (MHF, 2007a). The young people described this as feeling that were not listened to or taken seriously, and that their views would not influence any change (MHF, 2007a). Consultation 'fatigue' occurs when young people become disillusioned by being frequently consulted without anything ever seeming to change as a result (YoungMinds, 2005b). A study conducted in children and adolescent mental health services (CAMHS) concluded that one of things needed to instigate a cultural shift was:

Clear education for all stakeholders about the potential benefits of service user involvement in care and treatment, and in service improvement initiatives. This might usefully come from national organizations (like the Mental Health Foundation and Mind).

Mind, 2006

Time and resources

Setting up young people participation can have implications for organisations in terms of time and resources. If participation is to be on-going rather than one-off, then "structures and processes" need to be put in place for responding to young people's views (MHF, 2007a). Organisations with a strong ethos of participation still identified time and resource difficulties in ensuring that this remained a priority throughout the lifetime of projects and was not just an exercise conducted at the start of new developments (MHF, 2007a). Getting young people participation off the ground can take time, as young people may need to build up trust with professionals, groups or organisation (MHF, 2007a; YoungMinds, 2005b). There are other issues such as the cost of events; young people's expenses; the cost and time investment of training staff and young people; the cost of providing information and support to young people; the cost of setting up protocols and charters etc. (Vasiliou-Theodore and Penketh, 2008; Wright et al, 2006).

Resistance to meaningful participation

One potential barrier to meaningful participation is resistance by senior professionals (Hasler, 2003; Kirby et al, 2003) including uncertainty among clinicians about relinquishing authority and autonomy (Day, 2008). Support and encouragement through change and shifts of power may be ways of addressing this, as well as firm commitment to participation by senior management (Wright et al, 2006).

4.4 Impact of participation

There have been a number of recent calls for more rigorous evidence to show the benefit of participation (Fudge et al, 2008; Day, 2008, Community Care, 2008). Research on the impact of participation is limited and often relates to the process rather than the outcome of participation (Carr, 2004). There is often a focus on how service users experience the process of being involved, but there is lack of monitoring of the actual changes that occur as a result of this participation (Carr, 2004), and of any improvements in service quality (Fudge et al, 2008).

Wright and Haydon (2002) suggest that reviews of young people participation should be based on outcomes that are 'realistic', 'measurable' and 'specific'. Kirby and Bryson (2002) argue for more research to explore a whole range of potential impacts including how young people participation affects the attitudes of adults; whether there is any lasting impact within organisations and their participation practice following a young person participation programme; how young people perceive positive outcomes, such as whether the important thing is being listened to or whether it is actual change; and whether participation in one area has an affect on other aspects of young people's lives.

General conclusions

This literature review shows that the case for promoting mental health and early intervention in mental health problems is clear. Poor mental health and mental health problems have the potential to impact on a number of areas of young people's lives, from schooling through to employment, physical health and relationships. Times of transition in young people's lives can be both "threats and opportunities" (Newman, 2004a). Between the ages of 16 to 25, young people will inevitably experience change such as leaving school, but changes are likely to occur in many other aspects of their lives too. This may therefore be a time when young people are in particular need of support, and during which the early identification of problems and the promotion of mental health and resilience are vitally important.

Identified below are general conclusions that are drawn from each section of the review and are aimed at informing the development of action plans within the Right Here programme and other work targeting young people:

1. Mental health is more than the absence of mental health problems. Research has shown that poor mental health can affect the quality of life in a number of areas for both those with and without mental health problems. Whilst data on mental health problems is highly valuable in understanding the extent and type of problems, there is little data available on mental health.

Conclusion: there needs to be an increased focus placed on mental health. This should include further research and measures of young people's mental health to ensure that their mental health needs are met.

2. There are many serious and wide-ranging potential impacts of mental health problems and longer-term implications for young people, as outlined in this review.

Conclusion: it is important to develop early intervention in detecting and treating mental health problems, as well as promoting mental health. The aim of this will be to prevent problems from worsening or becoming embedded.

3. Mental health is important for the whole of society and every member of it, and the reduction of risk factors and the promotion of protective factors should be enshrined as part of a wider strategic framework.

Conclusion: strategic frameworks for the promotion of mental health and resilience need to operate to strengthen both individuals and communities, and reduce structural barriers to mental health. These can then be addressed at different times (such as early adulthood), in different settings (such as youth centres, colleges and others) and at different levels (such as locally, regionally and nationally).

4. There is a growing and substantial body of evidence on risk and protective factors for young people. Transition periods, including the pathway to adulthood, are shown to be times when interventions to promote mental health and resilience are key.

Conclusion: the development of fully-evaluated action plans that promote the mental health and resilience of young people during times of transition is needed. These plans should take into account the lifestyles and networks of young people and provide choice by offering a broad range of interventions.

5. A strategic framework for mental health promotion needs to incorporate ways of tackling stigma and discrimination. It is helpful to understand stigma and discrimination as three problems: ignorance; prejudice; and behaviour.

Conclusion: there is a need for the implementation of action plans that target young people and ensure young people participation in their development. These plans should be fully evaluated and measure positive changes with regard to young people's knowledge of mental health problems; their attitudes to mental health problems; and their behaviour towards those with mental health problems.

6. It is essential to ensure young people participation in the development of projects/services that are targeted at young people. The potential benefits for services, funders, communities and young people themselves have been outlined in this review.

Conclusion: all organisations need to address the challenges inherent in ensuring meaningful young people participation. This will include reviewing the ethos, culture and practices of organisation/s to ensure that participation policies are in place and fully implemented. Young people participation should be fully evaluated and include the measurement of outcomes (beyond solely those of the experience of participation), such as whether/how services have improved.

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Appendix

Examples of interventions

Education

- **Full Service Extended Schools (FSES) and their equivalents**

The aim of full service extended schools is to bring together a “comprehensive range” of services in one place, to include health services, community activities, adult learning, study support and child care (Cummings et al, 2007). Evaluation of FSES sites shows some positive impacts on the attainments of pupils as well as impacts on other outcomes including “engagement with learning, family stability and enhanced life chances” (Cummings et al, 2007).

- **Healthy Schools approach**

The World Health Organization (WHO) published a review of evidence to see the effectiveness of the healthy schools approach and within that explored the results of 17 studies that had reviewed interventions relating to mental health promotion or preventing a form of mental illness (Stewart-Brown, 2006). Interventions included both small-scale programmes and larger and longer-term ones. The conclusion of the review was that there was evidence to support interventions in programmes that:

... adopted a whole school approach and included key elements of the health promoting schools approach, such as changing the school environment, developing personal skills in class, involving parents and the wider community, and actively involving the school.

Stewart-Brown, 2006

In addition, there was evidence to suggest that programmes aimed at promoting mental health rather than preventing mental illness and which ran for a year or more on a continuous basis could still be effective even where the whole school approach was not fully adopted (Stewart-Brown, 2006).

- **The Social and Emotional Aspect of Learning (SEAL) programme**

The SEAL programme, formerly introduced into primary school pilots, is now being rolled out in secondary schools in England. It is based on the understanding that social and emotional skills are necessary for emotional health and well-being for pupils and staff as well as impacting on areas such as learning, behaviour and attitudes (Department for Education and Skills (DfES), 2007b). An evaluation of the primary school programme showed that teachers had perceived positive changes in the children in terms of their “confidence, social communication, negotiating skills and attitudes” (Hallam et al, 2006). Teachers also reported personal benefits from the programme, such as helping them to understand their pupils more, but it was more difficult to interpret and analyse response data from children themselves (Hallam et al, 2006).

Psychological therapies

Psychological therapies include a range of different types of approach which involve a person being able to talk about their issues and being listened to, often by someone specifically trained. Examples of talking therapies include counselling and cognitive behavioural therapy (CBT) (for further information see www.mentalhealth.org.uk/information/mental-health-a-z/talking-therapies/). Psychological therapies can be offered in a range of settings such as within primary care or specialist mental health services, schools and universities or at community-based organisations such as voluntary sector organisations. The benefits of these therapies are summarised as follows:

Talking to someone provides people with an opportunity to explore their thoughts and feelings and how they relate to behaviour, mood and psychological well-being ... Having a greater understanding of how they think and feel can help people find ways to change their lives for the better, by acting and thinking in a more constructive or positive manner.

Mental Health Foundation (MHF) et al, 2006

Often the therapies are on a one-to-one basis, but group therapy can also be offered. Other approaches recommended by the National Institute for Clinical Excellence (NICE) include computerised CBT for depression which is aided by a computer package, and bibliotherapy which uses books, leaflets and other written materials - both are forms of self-help and treatment. There are strong concerns about the lack of availability of therapies, waiting times and a lack of regulation of standards (MHF et al, 2006).

Some services, particularly those in the voluntary sector, offer a combination of counselling, information and advice (Wilson, 2007), and this can also include group work that addresses issues for young people such as life skills, self-harm or anger management (MHF, 2007a). In addition, some services offer drop-in sessions where young people can turn up without appointments and be offered both emotional and practical support (MHF, 2007a; Wilson, 2007).

Arts therapies

Art, drama, music and dance movement therapy are other forms of therapy that use the arts as a method of communication as an alternative to verbal communication. These therapies entail working with a trained arts therapist. Overall, there is a lack of sufficient evidence to show the effectiveness of arts therapies (Maratos et al, 2008; Crawford and Patterson, 2007; MHF, 2006c). However, there is some emerging evidence which is promising, including a finding that arts therapies can help with the negative symptoms of schizophrenia such as "feelings of depression, lack of energy, and reduced motivation" (Crawford and Patterson, 2007). In addition, a small-scale study conducted in Scotland involving children, young people and adults showed that art therapy can improve mental health and social functioning (MHF, 2006c).

As well as formal arts therapies, some services offer arts programmes or facilities to undertake arts work. Recent research has shown these programmes and facilities can have some promising results, particularly on the user's empowerment, mental health and social inclusion, but the research identified that longer-term studies were required (Secker et al, 2007).

Exercise and diet

There is a substantial body of evidence to show the link between exercise and mental well-being (MHF, 2005; DH, 2004c). Clinical guidance for health professionals on working with both children and young people with depression and with adults with depression states that the benefits of exercise should be explained, and regular exercise encouraged (NICE, 2005; 2004). A recent review of research looking at whether exercise specifically reduced anxiety and depression in young people (up to age 20) found that evidence was too scarce to draw firm conclusions, but that there were some trials that

indicated this did occur (Laren et al, 2006). Findings from a study by the MHF (2005) showed that apart from mental health benefits there are other benefits such as its potential to improve physical health and promote social inclusion. Young people from the consultation sites in the National Inquiry into Self-Harm suggested a number of ways of exercising that they thought could help those who self-harm, but emphasised the need for each individual to find out what worked for them (MHF and Camelot Foundation, 2006).

There is now some evidence to show that diet has a role to play in mental health (MHF, 2006d). In addition, the links between diet and obesity are well documented, and the BMA (2005) suggests that obesity has psychological and social effects as well as physical ones, such as low self-esteem and depression, and that for young women in particular, it “can have a negative impact on life satisfaction and . . . future life aspirations”.

Complementary therapies

In consultations with young people aged 16 to 25 to find out what they wanted when they were experiencing mental health problems; some requested access to complementary therapies such as acupuncture and reflexology (MHF, 2007a; MHF, 2001). Where complementary therapies were offered, interview evidence revealed that:

Young people explained that having different types of support brought them into contact with more people, helped them to form relationships and build trust, and provided them with a wider range of support mechanisms.

MHF, 2007a

Other interview evidence suggested that complementary therapies helped to alleviate stress and had been used as a form of early intervention when young people had felt that their mental health was deteriorating (MHF, 2007a).

The Prince's Foundation for Integrated Health, with project partners MHF, Mind and the Royal College of Psychiatrists are currently establishing a set of guidelines relating to mental health and integrated health which involves mainstream as well as other therapies such as aromatherapy, yoga, exercise, reflexology etc. (www.fih.org.uk/information_library/mental_health.html). These guidelines will encompass a literature review to show available evidence.

Spirituality

Expressions of spirituality found to be most helpful for mental health are those that “encourage personal empowerment, that affirm and embrace diversity and that promote the importance of emotions such as hope, forgiveness and purpose” (MHF, 2006e). Spirituality and religion are “interlinked but are not the same” (MHF, 2007c). Expressions of spirituality can include belonging to a faith and practising its beliefs, but it can also be expressed in a wealth of different ways such as through arts, yoga, meditation or engaging with nature (Royal College of Psychiatrists, 2006b). People have different spiritual needs and these may also be influenced by different cultures and ethnic backgrounds (MHF, 2007c).

Volunteering

Research into volunteering suggests that this may have a role in promoting mental health and emotional well-being. Recent research showed that volunteering may have a positive effect on happiness levels (Borgonovi, 2008). A study looking at young people aged 11 to 25 found that volunteering had a number of positive effects, such as “increased confidence and self-esteem, improved communication skills” and, in some cases, “improved relationships with their families or communities” (National Youth Agency (NYA), 2007).

Peer support

Peer support largely started as a means of helping to tackle bullying, and for the school setting it is defined by the MHF (2002) as:

... a form of student help. It builds on students’ natural willingness and ability to turn to their peers to discuss concerns, worries and problems.

There are different forms of peer support, including: peer mentoring; peer listening; peer mediation; and peer support/education (MHF, 2002; MHF and Camelot Foundation, 2006; Cowie and Wallace, 2000). Peer support shares many of the benefits of young person participation and in addition it may also:

- increase young people’s willingness and ability to listen and take in information by presenting this in a different way;
- provide a ‘bridge’ between young people and the professionals working with them.

YoungMinds, 2005b

Peer support is not exclusive to schools and is used to varying degrees in a range of settings such as universities, mental health services, prisons, voluntary sector organisations and via the internet. Webb et al (2008) advise that research is needed to gain a better understanding of “unsupervised forums and chat rooms” (those without trained moderators) on the internet to see if they are effective, and to understand what potential dangers there may be for young people in using these for early intervention into mental health problems.

Peer support does not have to be formally set up and having, for example, group activities for young people to attend, can lead to the development of short- and longer-term friendships thus reducing isolation (MHF, 2007a). Young people aged 15 to 16 reported that friendships and “peer interactions” (as well as family and school) were important sources of help in helping to prevent them from self-harming (Fortune et al, 2008). This was echoed in a recent survey, which found that when people were experiencing mental health problems, out of all the people helping them including their doctor and family, the majority reported gaining the most support from their friends (MHF, 2007b). However, nearly half of those friends reported that they felt they did not know enough about mental health, and the survey indicated the need for more support and information for those helping friends with mental health problems (MHF, 2007b).

RIGHThere

Right Here is an ambitious five-year project from the Paul Hamlyn Foundation and the Mental Health Foundation. It aims to revolutionise the prevention of mental health problems among people aged 16-25. It will also tackle the stigma attached to mental illness that often stops young people asking for help.

Right Here will invest in partnerships between public and voluntary sector organisations across the UK. These will pilot new ways of working to protect young people's mental health.

For more information about the project visit
www.right-here.org.uk or email info@right-here.org.uk

 Paul Hamlyn
Foundation

Mental Health Foundation

Right Here is a collaboration between Paul Hamlyn Foundation, a company limited by guarantee registered in England and Wales (no. 5042279) and a registered charity (no. 1102927) whose registered office is at 18 Queen Anne's Gate, London SW1H 9AA, and the Mental Health Foundation, a company limited by guarantee registered in England and Wales (no. 2350846) and a registered charity (no. 801130) whose registered office is at Sea Containers House, 20 Upper Ground, London SE1 9QB.