Scottish Needs Assessment Programme

Mental Health Promotion among Young People

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SCOTTISH NEEDS ASSESSMENT PROGRAMME

Mental Health Promotion among Young People

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FOREWORDS

Mental health is not the absence of mental illness. Health is more than simply not being ill – and being mentally healthy means so much more than merely being free of a mental disorder. It is mental health in this broad sense that is the focus of this report.

At ChildLine Scotland we get a real insight into how children and young people feel. It is then that the meaning or experience of mental health becomes a real rather than an abstract concept. We must as adults, as friends, as parents, as professionals, listen to what they have to tell us.

When we think of mental health problems, what often comes to mind is suicide, self-harm, eating problems and depression. Studying our ChildLine records, it becomes clear that these problems are more often a symptom of distress rather than the actual cause of it.

At ChildLine, we hear from children and young people in their thousands every day. They are experiencing difficulties and stress at school, bullying, fears about the future. I could extend this list much further to include family problems, racism, loneliness, homelessness, pregnancy, poverty, bereavement, problems with friends, and the list goes on. We do hear from children who have suicidal thoughts, who have attempted suicide, who self-harm or have eating problems. At ChildLine, we also hear chilling accounts of physical, sexual and emotional abuse – hidden horrors that are outwith the scope of this report.

Sometimes what is needed to help them deal with their lives is what we at ChildLine can provide – a service and people who will listen, who accept, who care. Calling ChildLine may also be a first step towards help for a youngster whose problems are more serious. ChildLine is not the whole solution. There needs to be available more, not fewer, high quality services offering support, help and therapeutic work.

If we do not respond to the needs of young people and invest our resources in their mental health, not just their mental illness, the damage in the future will be considerable. The promotion of mental health must start with the children and young people of today, who will be the adults – and the parents – of tomorrow.

This SNAP report provides a foothold for meeting this continued challenge. By providing a picture of where we are now, this report shows that we have a considerable task ahead of us. By presenting evidence on what works, this report is particularly welcomed in pointing us in the right direction so that we can build on good practice and take further steps to improve the mental health of young people. It would be good to think that, by all playing our part in this agenda, there could ultimately be fewer children and young people who need a service like ChildLine.

Anne Houston
Director, ChildLine

Social Work Services in Glasgow welcome this report.   In particular, we are pleased to see that the recommendations are arranged in a way, which suggests a collaborative and holistic approach to the planning and delivery of mental health promotion services to young people.

Mental Health Promotion requires to be integrated into the strategic planning of all mental health services to young people, in the context of joint planning for all children and family services.   The recommendation to incorporate the planning of services within the current joint planning arrangements is fully endorsed and should assist a collaborative approach to mental health promotion.

Our specific interest is in the planning and delivery of a mental health promotion programme to vulnerable and excluded young people, and the recommendation for further research in this area is fully supported by ourselves.   The recent research completed on the mental health needs of young people "looked after" provides a good planning tool for intervention with vulnerable young people in Glasgow, also offering good models of joint working and training.   The outcome of this research should be considered alongside the recommendations in this report to ensure the delivery of effective mental health promotion.

In addition, social work units should be a central focus for mental health promotion given the vulnerable nature of young people we work with, and the likelihood that they do not attend mainstream facilities, e.g. school, community centres.   Further, there is much interest in the research on effective interventions, and this knowledge and information would be invaluable for staff constructing intervention programmes with young people, e.g. in our community support projects.

The benefits of joint working in this area of service planing and delivery cannot be overemphasised, and social work services look forward to working with colleagues from a range of agencies in the implementation of the recommendations in this report.

Suzanne Miller
Planning Officer – ChildLine Family Services
On behalf of
Glasgow City Social Work Services

<u>ACKNOWLEDGEMENTS</u>

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EXECUTIVE SUMMARY

1. The remit of the SNAP Group was to examine the mental health of young people aged 12-18 yrs and to consider implications for general mental health promotion in the enhancement of emotional well-being among this age group.

    Specific objectives for the SNAP Group were:

*   to define mental health promotion;

*   to examine epidemiological data in mental health among young people, broadly defined in both quantitative and qualitative accounts;

*   to review the literature on effective interventions in mental health promotion among young people;

*   to provide recommendations for practice in mental health promotion among young people;

*   to provide recommendations for strategic planning;

*   to recommend specific mental health promotion initiatives.

2. Mental Health Promotion actively fosters good mental health through increasing mental health promoting factors and decreasing those factors which are known to damage or reduce good mental health. Interventions in mental health promotion combine both population-based and high-risk group approaches. Practice, which includes elements of health education, protection/maintenance of well-being and prevention of disorder is directed across "levels" from the cultural and structural to the individual. In United Kingdom, in common with generic health promotion, a number of principles are used both to define mental health promotion, at a theoretical level and to inform practice: equity, participation, empowerment and collaboration (WHO, 1986).

3. In considering mental health among young people, **mental health problems** are described as difficulties or disabilities which may arise from a number of factors and include a wide range of emotional and behavioural difficulties; **mental health disorders** are distinguished by their persistence or severity (HAS, 1995).

4. Quantitative data suggests that approximately 20% of young people experience **mental health disorders.** There is, however, a contrasting pattern for males and females. For example, rates of depression are twice as high among young adolescent females as young adolescent males and rates of suicidal thoughts and behaviour are also much higher in females than in males. By contrast, males outnumber females in completed suicides.

5. Qualitative studies suggest that adolescents consistently identify a number of **mental health problems**, broadly characterised as worry and concern. However, as young people are not a homogenous group, there are differences and variations in their worries and concerns as a function of age, gender, family composition and whether or not both parents are employed (Ghate and Daniels, 1997). However, the effects of socio-economic status in this population are not entirely clear (West, 1990).

6. There is evidence to suggest that interventions aimed at both the general population (e.g. bullying/victimisation) and high-risk groups (e.g. young people undergoing particular life transitions) are effective. The majority of published interventions studies are focused on the individual as opposed to the wider social system in which the individual exists and among these interventions, behavioural or cognitive-behavioural methods (modelling, role-playing followed by peer feed-back and reinforcement, self control strategies) have been the most prevalent (Diguiseppe and Cassinove, 1976). Durlack and Wells (1997) have noted that information-only programmes are virtually ineffective.

7. In the literature on bullying, there are also examples of small-scale systems models of promotion/prevention (reflecting concerns with structural factors in the social system) with proven efficacy (Olweus, 1992).

8. There is a disproportionate amount of work in promotion/prevention conducted among younger age children, in particular children aged 7-11 years. The needs of adolescents and teenagers are relatively neglected in research. Furthermore, existing studies with this older age group focus predominantly on addictions, which may reflect prevailing social concerns with drug and alcohol use to the exclusion of both possible underlying predictive psychological factors for addiction (e.g. self-esteem, communication, conflict resolution, etc.) and broader socio-political and cultural issues.

9. The overwhelming majority of published intervention studies are U.S.-based. Given the differing socio-cultural environments, there is an important question regarding the generalisation of this work to a U.K. context. Replication studies of these interventions and further research development in the U.K. in mental health promotion among young people is clearly required.

10. Recommendations made within this Report, based on a systematic review of the literature and consultation with professionals working with young people, are presented under four headings: Strategic Recommendations (systems-level recommendations), Specific Recommendations (person-centred recommendations), Research Recommendations and Project Development and Evaluation Recommendations. It is recommended:

- that all economic and social policies be designed to ensure positive mental health impact and the attainment of the goals outlined in the White Paper (Towards a Healthier Scotland, SODOH, 1999);

- that mental health promotion be fully integrated with Health Board Mental Health Framework strategic planning;

- that mental health promotion be explicitly integrated into the spectrum of mental health services available to young people;

- that support be provided for professionals working in direct contact settings (Teachers, Care Workers, parents and others) to assist them in developing greater awareness of mental health needs among young people;

- that two further SNAP Groups be convened in mental health promotion: the first should be commissioned to consider mental health promotion among children and the second group should consider mental health promotion among the adult population;

- that interventions with proven efficacy in mental health promotion with young people be established across Scotland, including: interventions aimed at the prevention of bullying, which have utilised a multi-modol approach including individual and systems-level interventions (Olweus, 1973; 1984; 1992), interventions aimed at the promotion of emotional well-being of children of divorce, which have, again, employed a multi-modol approach including interventions aimed at assisting children/young people in identifying and communicating feelings regarding divorce, a skills-building component designed to teach conflict resolution/ anger management skills and a component designed to enhance self-esteem (Pedro-Carroll and Cowen, 1985; Stolberg and Garrison, 1985) and interventions aimed at those young people facing school-transitions which have attempted to reduce levels of anxiety and increase available interpersonal support (Durlak, 1997).

- that appropriate pilot programmes be developed to pre-test protocols derived from U.S.-based studies;

- that the development of interventions reflects appropriate gender, class and ethnicity perspectives;

- that the national research agenda specifically consider the mental health promotion needs of young people considered "at risk" of mental ill-health, the specific needs of young people in care and a broader population-based approaches;

- that research protocols seek to investigate both systems-level and person-centred approaches to mental health promotion among young people;

- that SIGN should consider mental health promotion for young people as a topic for development of evidence-based guidelines for practitioners;

- that a national Task Group, composed of Health Promotion Specialists, mental health professionals, academics and researchers be convened to develop a suitable framework for project development of mental health promotion in Scotland and to select suitable evaluation review indicators.

1 INTRODUCTION

1.1 Why do we need a SNAP Report on Mental Health Promotion Among Young People?

There is a common assumption that young people are a healthy group who, apart from mild adjustment difficulties, experience few mental health problems (West and Sweeting, 1996). However, two sources of evidence appear to question this assumption:

- In the recently published "A Framework for Mental Health Services in Scotland", (SODOH, 1997), it is stated that up to 20% of young people aged 14/15 yrs. experience significant emotional/ behavioural disorders; that the 15-25 yr. age range is the most common time for the onset of severe mental disorder; that in the age group 14-19 yrs., 400 young people per 100,000 attempt suicide.

- Further, there is evidence to suggest that young people's perceptions of their emotional well-being differ considerably from adult perceptions (parents/teachers) of young people's emotional well-being: young people themselves rate their own emotional well-being more negatively than do adults. In a recent study in which self-report measures of emotional well-being were taken among 4,000 young people aged 11-16 yrs. in the West Of Scotland (West and Sweeting, 1996), significant proportions of the respondents indicated feelings of anxiety, unhappiness, and depression. It was also reported that 20% of this sample expect to be unemployed. As noted by West, MacIntyre, Annandale and Hunt (1990), any rose-tinted belief regarding the well-being of young people "...is rapidly being shaken both by the evidence concerning the health of young people themselves and by a broader concern with the social and economic conditions they face as they enter adulthood" (p.673).

Evidence regarding the emotional disequilibrium experienced by young people (defined as both mental health problems and mental health disorders) suggests imperatives for both mental health services and other non-health based services which support this population. Clearly, mental health promotion must be integrated into the development of these services. In "A Framework for Mental Health Services in Scotland" (SODOH, 1997), the requirement for mental health promotion among young people has been explicitly recommended, as part of the development of comprehensive mental health services. This SNAP Report has been written to assist in this process.

1.2 Remit of the SNAP Group on Mental Health Promotion among Young People

The remit of the SNAP Group was to examine the mental health of young people aged 12-18 yrs and to consider implications for general mental health promotion in the enhancement of emotional well-being among this age group.

Specific objectives for the SNAP Group were:

- to define mental health promotion;

- to examine epidemiological data in mental health among young people, broadly defined in both quantitative and qualitative accounts;

- to review the literature on effective interventions in mental health promotion among young people;

- to provide recommendations for practice in mental health promotion among young people;

- to provide recommendations for strategic planning;

- to recommend specific mental health promotion initiatives.

1.3   Methods

This report was written after a period of extensive discussion on issues surrounding the mental well-being of young people and the broader issues of mental health and mental health promotion. Expert advice was sought and literature reviews were undertaken to ensure that the report reflects the best available evidence base. In order to gain a further understanding of current issues in the provision of mental health services for young people and in order to provide recommendations reflecting views of multi-agency/multi-disciplinary professionals, a consultation exercise was conducted.

1.4   Conclusion

This report provides information about the scale of mental health problems among young people and provides recommendations on evaluated mental health promotion interventions.   We hope that the report will be a useful resource and one which will inform joint planning processes including Children's Services Plans led by Local Authorities, Joint Mental Health Plans and Health Board Mental Health Strategies. Further, we hope that this report will assist the growth of pro-active mental health initiatives in Scotland.

2   WHAT IS MENTAL HEALTH PROMOTION?

This section will consider the definition of mental health, will offer a definition of mental health promotion, will briefly consider the theoretical framework for mental health promotion, and finally will consider the relationship between mental health promotion and prevention of disorder.   The theoretical perspectives included in this Section have been used to inform and guide the tasks of this SNAP Group.

2.1   Defining Mental Health

In United Kingdom, the conceptualisation of mental health remains a dominant theme in mental health promotion (Tudor, 1994; Trent, 1997; Money, 1997), but there has, as yet, been little broad consensus. Increasingly, in the British literature on definitions of mental health, there is a tendency to replace the concept of mental health with the concept of emotional well-being. MacDonald and O'Hara (1998) argue that emotional well-being can be considered across three key areas:

- **Emotional well-being depends on our needs being met**. These include basic needs such as adequate food and shelter, security, social support and freedom from environmental hazards, unnecessary stress and any form of exploitation. Well-being is also dependent on the satisfaction of higher needs, such as rewarding relationships, self-respect and fulfillment (Maslow, 1968; Albee, 1982).

- **Emotional well-being involves skills**. Such skills, or competencies, are wide ranging and include the ability to manage change, to communicate thoughts and feelings, to make and maintain relationships and to manage stress (Bandura, 1992).

- **Emotional well-being involves feelings and beliefs**. Well-being involves feelings that one has rights, purpose and power. It also involves feeling positive about oneself and others. However, well-being is also about understanding and accepting that emotional problems do occur for most people at some stage in life. This perspective is consistent with the concept of self-esteem, which is a common theme in this literature (Mrazek and Haggerty, 1994).

With specific reference to young people, the Health Advisory Service (1995) has suggested that mental health is also defined through an individual's ability to *develop* psychologically, emotionally, intellectually and spiritually and to use psychological distress in such a way that it does not hinder development.

The Health Education Authority (1997) has incorporated these concepts into a working definition of mental health:

"*Mental health is the emotional and spiritual resilience which enables us to enjoy life and to survive pain, suffering and disappointment. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth (p.7).*"

There have been several attempts to describe relationships among biological/psychological/social determinants of mental health/well-being (Albee, 1982; MacDonald and O'Hara, 1998; Health Education Authority, 1997). In each model, mental health/well-being is conceptualised as influenced by genetic inheritance, socio-economic circumstances and experience with **social structures** (including economic/cultural structures), a **social world** (including social networks) and the **inner self** (including self-esteem, cognitive/behavioural coping competencies). Each model makes an attempt to identify, within these parameters,

sets of factors which appear to promote or demote mental health. Although none of these models is empirically derived, all three have pragmatic utility. For that reason, the model by MacDonald and O'Hara (1996), as an example of these models, is presented in Appendix One.

2.2 A Working Definition of Mental Health Promotion

"Mental health promotion includes any activity which actively fosters good mental health, through increasing mental health promoting factors, such as meaningful employment and decreasing those factors which damage or reduce good mental health, such as abuse and violence." Health Education Authority, 1997, p. 9)

Interventions in mental health promotion, based on a variety of methods of needs assessment, including standard epidemiological data, lay perspectives, social/educational/environmental/policy diagnoses, are demonstrated through a combination of population-based and high-risk group approaches.

2.3 A Theoretical Framework for Mental Health Promotion

Mental health promotion explicitly relies on a psycho-social model of mental health (Tudor, 1996). At both a theoretical level and in practice, interest is focused on the interaction between personal experience and socio-economic, environmental and cultural determinants of mental health/well-being (Tudor, 1996). Practice, which includes elements of health education, protection/ maintenance of well-being and prevention of disorder, is directed across levels from the cultural and structural to the individual. In United Kingdom, and in common with generic health promotion, a number of principles are used both to define mental health promotion, at a theoretical level, and to inform practice: equity, participation, empowerment and collaboration (WHO, 1986). As is to be expected in a developing field, there are a number of theoretical tensions within mental health promotion which continue to attract significant debate (Mauthner et al, 1999).

2.4 Strategic Values in Mental Health Promotion

The implementation of mental health promotion initiatives relies on broadly accepted strategic values:

1. In order to ensure that mental health promotion needs of all young people are met, strategic planning and programme development in mental health promotion should target both the maintenance of well-being among the general population of young people and the reduction ill-health among high-risk groups.

2. Planning processes should be multi-agency/multi-disciplinary and should explicitly recognise complementary roles played by this variety of stake-holders in the mental health of young people.

3. In addition to the analysis of epidemiological data and explicit recognition of the perceptions of young people regarding their own mental health, needs assessment should include analysis of the social contexts in which young people live, with particular reference to risk/protective factors for mental health in community, school and other youth settings and the effects on mental health of social policies/organisational structures within these settings.

4. Programme development in mental health promotion for young people should incorporate multi-level (international/ national/ regional/ community/

family/individual) and multi-component (advocacy/media campaigns/ social support /competency skills programmes) interventions.

5. Programme evaluation should attempt to actively involve young people in the evaluation process and should ensure that the results are disseminated back to the young people involved.

2.5   Promotion and Prevention

At a theoretical level, the role of prevention of disorder within a mental health promotion framework has been an area of contention within the field (Hosman & Veltman, 1994; Ross and Stark, 1996; Money, 1997). However, in practice within the National Health Service, both the promotion of well-being and the prevention of disorder are identified goals for mental health promotion and are delivered through activities and interventions which are both health and non-health based. "*Good housing, having a job, access to services and buildings, activities which are directed to promoting health generally, such as family planning, sexual health and CHD programmes, as well as services directly targeted at the primary prevention of mental health problems are all able to deliver benefits for mental health*" (Health Education Authority, 1997, p.9)

Traditionally, prevention in mental health was classified across primary, secondary and tertiary levels of activity. However, the Committee on Prevention of Mental Disorders (U.S.A.) has recently presented an alternative model of classification (Mrazek and Haggerty, 1994). This model identifies prevention as part of a spectrum (including treatment) of interventions for mental disorders. In this model, prevention is defined under three headings:

- **universal preventative interventions:** interventions targeted to the general public/whole populations and not just people who may be considered "at risk" for some reason (e.g. : programmes aimed at preventing emotional distress among young people);

- **selective preventative interventions:** interventions targeted to individuals/sub-groups of the population whose risk of developing mental disorder is considered higher that average on the basis of psychological, social or biological risk-factors (e.g. : programmes aimed at young people in socially deprived communities).

- **indicated preventative interventions:** interventions targeted at high-risk individuals with minor symptoms of mental disorder (e.g.:programmes for young people identified as exhibiting emotional problems/disorders).

2.6 Conclusions

Mental health promotion is, in practice, composed of elements of health education, protection/maintenance of well-being and prevention of disorder. Through a focus on the interaction between personal experience and broader environmental factors, mental health promotion seeks to empower individuals and communities in their pursuit of optimum health. With young people, who are engaged in an important developmental trajectory, mental health promotion has an important contribution to make to both emotional well-being and the prevention of mental health problems.

3   MENTAL HEALTH NEEDS OF YOUNG PEOPLE

3.1   Introduction

This section will consider epidemiological data on the mental health of young people in Scotland. A range of sources of data will be examined, including accounts of young people themselves taken from qualitative studies (e.g. Gordon and Grant, 1997).   There has been a growing call on researchers, practitioners and policy-makers to take young people's views and experiences into account when planning programmes and initiatives aimed at meeting their needs. This position is consistent with the Children Scotland Act (1995), and Article 18 of the United Nations Convention on the Rights of the Child (Committee on the Rights of the Child, 1994).

As well as presenting young people's views, it is important to present the scale of mental health problems and disorders in young people. to understand some of the risk factors for mental health problems and to describe the type of difficulties which young people experience. The purpose of this section is to provide an overview and context for the rest of the report.

3.2   Definitions

3.2.1   Mental Health and Young People

"Together We Stand" (HAS, 1995) attempts to differentiate between mental health problems and mental health disorders:

mental health problems are described as difficulties or disabilities in the able areas which may arise from a number of factors and include a wide range of emotional and behavioural difficulties; **mental health disorders** are distinguished by their persistence or severity.

3.3   Sources of Information

There are a variety of available sources on which to estimate the prevalence of mental health problems and mental health disorders of young people in Scotland. These include :

- young people's perspectives;
- knowledge of risk factors for mental health problems;
- published epidemiological studies;
- Service Activity Data;
- General Register Office data on suicides;
- local studies examining prevalence of psychological morbidity of young people.

3.3.1   Young People's Perspectives

This section of the report draws on recent survey, questionnaire and interview-based work which has set out explicitly to gather young people's own views on their emotional and psychological well-being (Aggleton et al, 1996; Kelly, 1996; Gallagher and Millar, 1996; Gordon and Grant, 1997; Gate and Daniels, 1997).

The quotations presented below have been taken from Gordon and Grant (1997) and are based on a sample of young people in Secondary Three. While it is important to recognise that young people cannot be considered an homogenous

group, the common themes which young people identify as adversely affecting their mental health include the following:

- Many young people report feeling "fed-up" or bored but this is more commonly reported by boys than girls.

  "I feel very lonely and bored but I don't know why and I feel angry but that's just me and I feel confused but I don't know why" (female)

  "Every day I wake up and get ready for school. go to school come home   then go to bed etc. I want a change, something different. I'm bored with my life" (female)

- Girls more commonly report feelings associated with low self esteem and depression, often related to body image.

  "I really hate myself 'cause I'm fat and ugly. I feel like killing myself sometimes 'cause I hate myself so much no-one loves me" (female)

- Performance at school is associated with self esteem.

- For boys, performance in sport is also associated with self esteem.

- Feelings of "stress" and "depression" feature prominently in young people's reports.

  "*Sometimes I feel stressed out and when people come close to me I want to punch them. I only feel stressed when I have a lot of homework to do or the family are arguing. I get annoyed easily "* (male)

  "I feel depressed and unliked. Sometimes I feel suicidal. It is on a rare occasion when I smile. Only when I take stuff" (male)

- Girls are more likely than boys to say they were worried about bullying, as were children in lower socio-economic groups

  "*Today will be no different from any other day. I will either get punched or kicked, get called names like "nae pals" or be just bored at school all day long" (*male)

  "The people in school are calling me names again. I really feel like pulling the plug on my life. I can't cope with it. What really bugs me is that they don't even know me" (male)

- Many young people have concerns and anxiety about their future, especially about future employment and the possibility of unemployment.

  "I feel depressed because I want to have a good job and a good future to support my family. I am scared in case I won't get a good job...." (male)

- Relationship difficulties with peer groups can cause considerable distress.

"My friend is being bitchy to my best friend. She takes days about. One day it's me she's bitchy to and the next it's my friend. She really does my nut in" (female)

"Today I had an argument with friends. This makes me feel really down, but now I am much better because I am much better because I am talking to them again" (female)

- Family life including concerns about the welfare of family members are common worries.

"*Being a teenager is hard. Your parents are always on at you and if you don't do well you feel as if you have let them down. Everyone is on at you to be nice and to do what is right. You've not to do anything wrong but it is hard sometimes. It's hard to always do what your parents want you to do. You have to try things out for yourself, not to be told don't do this because you need to try things. It feels as if everyone is always putting pressure on you and are taking control of your life......*" (female)

ChildLine Scotland

ChildLine Scotland, set up in 1990, provides a free, confidential telephone counselling service for any child or young person with any problem. Over 20,000 children and young people contact ChildLine annually. In 1998, more than 915 children and young people (aged between 7 years and 18 years) discussed suicide, self-harm, eating problems or depression.

Bullying accounts for the largest proportion of calls received (approximately 1 in 4 calls), with younger children (aged 9 years to 12 years) most commonly represented among these callers. Additionally, statistics for 1998 indicated that 4,500 children called to report physical, sexual or emotional abuse as a primary difficulty.

Although this information is useful is alerting services to some of the sources of distress for young people, it does not, obviously, provide information on the prevalence of these difficulties in the population.

3.3.2 Risk Factors

Risk factors, in this context, are defined as *"...characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random form the general population, will develop a disorder" (Mrazek and Haggerty, 1994, p.127).*

In a comprehensive review of the research investigating rising levels of psychosocial disorder among young people over the last fifty years, Rutter and Smith (1995) have drawn several important conclusions about risk factors, which will be presented below. It should be noted, however, that the focus of their work is on *psychosocial disorders*: crime, suicide and suicidal behaviour, depression, eating disorders and substance abuse (both alcohol and drugs). Although these findings should not be automatically generalised to the wider issues of mental health problems and emotional well-being among young people, the issues raised provide a useful summary of psycho-social risk factors for mental ill-health among this population. Rutter and Smith (1995) suggest that:

- social disadvantage is associated with many psychosocial disorders at any one point in time and social circumstances can *indirectly* affect disorder through associated risk factors such as family break-down;

- unemployment creates psychosocial risk for *individuals;*

- poor physical health is a risk factor for mental health;

- although there is a lack of clarity of the role of parental divorce as a risk factor for psychosocial disorder, it appears that the main risk stems from discord rather than family break-down per se;

- it may be that factors associated with the elongation of the period of adolescence (as evidence by the gap between the falling age of puberty and the rising age of completing education) carry risk and increase psychosocial stress;

- young people's expectations for the future, coupled with difficulties in achieving these aspirations, may increase the risk of disorder.

In synthesising the research, Rutter and Smith (1995) also conclude that the evidence suggests that different factors may underpin and explain increases in the prevalence of different disorders: increased availability of drugs will play a part in increasing misuse of drugs and in turn such misuse may be linked to suicide; enhanced opportunities for crime will at least partly explain rises in delinquent behaviours. Once again, this observation indicates the important interaction among individual psychological factors and social factors in well-being and disorder.

Although a detailed analysis of developmental theory among young people is outwith the scope of this report, it is essential that any discussion regarding the mental well-being of young people be placed within a developmental context. There are a number of developmental challenges faced by young people, particularly during early adolescence (usually defined as ages 10-15 years). Significant biological changes (the effects of puberty) and environmental changes (usually associated with the shift from primary to secondary schools) lead to subsequent changes in friendship patterns and the peer group, changing interactions with parents and other family members and changing self-concepts (Petersen, 1987). As noted by Rice et al (1993), "…Adolescence is a period of the life course involving extensive change. For some young people, these changes stimulate further growth. For others, the changes may be overwhelming and lead to developmental decline or problems" (p 235).

Challenges faced by young people may be considered in terms of the type, number and the timing of these challenges and gender differences in their effects must be noted. Types of challenges include normative life events (events experienced by the majority of individuals at roughly the same time point in the life course), non-normative life events (events less commonly experienced like parental death) and hassles (defined as frequently occurring stressors). There are potential psychological interactions among these types of challenges: non-normative events may be moderated or adversely amplified by the effects of normative events and the resulting cumulative effects of these events may increase or decrease daily hassles experienced by individual young people. Rice et al (1993) suggest, for example, that "…parental divorce not only changes the adolescent's relationships with each parent and perhaps siblings, it may alter the school attended, peer relationships,

opportunities to participate in extracurricular activities and the regularity of daily life" p 238).

Further, there is evidence to indicate that adolescence is a life-stage during which there are an almost overwhelming number of changes and it has been argued that the sheer volume of change can impact on developmental outcomes (Newcomb et al, 1986; Simmons et al, 1987). Research has suggested that girls experience a greater number of conflicting challenges during adolescence than boys and, as such, it has been noted that "…adolescence is likely to be more stressful for girls than boys because it is more likely to impose on girls significant value and role conflicts" (Rice et al, 1993, p 239).

In addition to the type and number of challenges faced by young people, the timing of these challenges may influence psychological well-being. Pubertal development occurring either early or late has been associated with negative outcomes, especially among girls. Early development in girls, for example, has been associated with poorer body image and more conflictual relationships with parents (Tobin-Richards et al, 1983; Petersen, 1987). The effects of developmental challenges to young people will be moderated by a number of external resources (parental and peer support) and internal resources (intelligence, perceived control and adaptive coping responses) (Rice et al, 1993).

3.3.3 Published Epidemiological Studies

"Together We Stand" (HAS, 1995), which examined the commissioning, role and management of child and adolescent mental health services, provided a useful summary of the epidemiology and nature of child and adolescent mental health problems. The report concluded that epidemiological studies give fairly consistent estimates of the prevalence of mental health disorders and problems.

This overview of some of the commonest disorders in young people is clearly relevant to clinical practice. It also has theoretical implications for health promotion in relation to early detection and prevention of disorders. Health promotion will have a part to play in these activities to a greater or lesser extent depending on the nature of the disorder. There is no evidence that any one single intervention will in itself prevent a mental health disorder and the role of health promotion is likely to be greater in the prevention of non-psychotic disorders such as emotional disorders or depression. Health promotion also has a crucial role to play in the provision of information about conditions to those experiencing mental health disorders and to parents and carers of young people.

A brief summary of the epidemiology of some of the more common disorders, based on published research, is taken from the HAS Report (1995) and from a recent Maudsley Discussion Paper (Goodman, 1997).

- Emotional and conduct disorders are found in approximately 20% of adolescents.

- The prevalence of depression increases rapidly in adolescence. The report quotes Graham and Hughes (1995) estimate of 1 in 20 secondary school pupils being seriously depressed each year. Major depressive disorder is found in about 2 to 5% of young people in mid-adolescence.

- The prevalence of obsessive compulsive disorder in adolescents is in the order of 1%-4% (1% among adolescents aged 11-15 yrs.; 4% among adolescents aged 16-17 yrs.).

- Severe eating disorders including Anorexia Nervosa occur in about 0.2% of 11-15 year olds reaching a peak incidence (approximately 1% among girls) at 16/17 years. Bulimia Nervosa has a greater prevalence but with a later peak incidence. Both disorders are more common in females than in males.

- Psychotic disorders occur from puberty onwards, with an estimated prevalence 0.5/10,000 to age 15 yrs. and 15/10,000 among those ages 16/17 yrs.

- Definitions vary but it has been reported that autism is found in 3-8 children per 10,000 and only 10-15% of these may be able to lead an independent life.

- The estimated prevalence of Attention Deficit Disorder is 1% among those aged 5-15 yrs.

3.3.4   Service Activity Data

Hospital activity information is of limited value in estimating the prevalence of psychological ill-health among young people as it identifies only a small proportion of young people with mental health needs (those young people attending psychiatric services as inpatients or outpatients). In 1998, 1125 episodes of in-patient care for young people aged 12 years to 18 years occurred in psychiatric wards in Scotland. The male to female ratio was 6:5. Of these admissions, 324 individual patients were admitted to psychiatric wards as first admissions. The principle diagnostic groups were neurotic disorders (20%), depression (20%) and alcohol/drug misuse (17%). Eating disorders accounted for 6% of first admissions. In the same year, there were 3119 new psychiatric outpatients attendances (excluding young people with learning disabilities). Of these attendances, 55% were female.

3.3.5   Suicide and self-harm

During 1996, SMR1 discharge data identified 1997 episodes (71.5% female/28.5% male) with a diagnosis of suicide, self-inflicted injury or intentional self-harm (excluding deaths) in the age range 12-18 years. The Registrar General death data for 1998 indicated that there were 178 deaths of young people from all causes. Of this number, 13% were as a result of suicide or self-inflicted injury (with a higher number of females represented than in previous years). The incidence of suicide remains greater among young men than among young women. An increase in parasuicide has occurred in both sexes but more markedly in men with the effect that the female:male ratio has been greatly reduced (Platt et al, 1992; Hawton et al, 1998).

3.3.6   Local Prevalence Studies

Over a number of years, West and Sweeting of the MRC Medical Sociology Unit at the University of Glasgow have conducted longitudinal studies of a sample of young people in the West of Scotland (West, et al, 1990; West and Sweeting, 1996). Their work is based mainly on the Twenty-07 study of young people aged 15, 18 and 21 years (West, et al, 1990). This study, which commenced in 1987, involves a cohort of 1000 young people at 15 years of age, living in the Central Clydeside conurbation. The study attempts to investigate the differences in health in relation to social factors and has analysed a wide range of information from questionnaires and interviews of the young people and their parents.

The study utilises a range of measures of physical health (blood pressure, etc.) and self reported measures of psychological health, including the General Household Survey (GHS) (Office of Population Census and Surveys, 1996), and the General Health Questionnaire (GHQ) (Goldberg, 1978), which examines psychological morbidity.

West and Sweeting's work (West and Sweeting, 1996; West, 1997) may not readily identify conduct disorders, a problem particularly associated with males. The implication of this is that the Twenty-07 studies may underestimate the prevalence of mental health problems among this population. In a related study the addition of a combination of a computer-based psychiatric interview affords the opportunity to investigate prevalence of specific conditions (West, 1999, personal communication)

Table One demonstrates the prevalence of psychological morbidity at the different ages, using GHQ caseness (cut-off 2/3).

<div align="center">

Table One
Psychological morbidity (per GHQ Caseness) at 15, 18 and 21 years

</div>

	Total Number	GHQ Case (%)	
		Males	*Females*
at age 15	942	10.7	18.6
at age 18	883	33.3	41.8
at age 21	794	30.5	37.2

A number of conclusions emerged from this study (Bryce, 1995 [unpublished manuscript]):

• A substantial number of young people experience psychological morbidity which meets the GHQ "caseness" criteria (symptomatology thought to warrant intervention by mental health services).

• The level of psychological morbidity rises sharply from the age of 15 to 18.

• In relation to family life, family conflict and psychological stress among 15-18 year olds are associated   (Sweeting and West 1995)

• At age 15, and on the evidence obtained per the GHQ, psychological well-being or malaise is not class differentiated, in contrast to later life.

- In contrast to childhood when psychological problems are more common in males than females, female adolescents are more likely than male adolescents to suffer psychological morbidity, particularly neurotic disorders.

- The 18 year olds who were unemployed or who *expected* to be unemployed had poorer mental health than either students or those in work, as evidenced by higher levels of psychological distress, suicidal thoughts and attempted suicide.

- The level of psychological morbidity is higher in females than in males, particularly as identified in neurotic disorders.

Sweeting and West (1996) suggests that the shift in male:female ratio in psychological disturbance from childhood to adolescence may be due to a relative lowering of female self-esteem, greater stress among females and a societal norm which allows greater tolerance of emotional expression among females.

3.4   Conclusions

1. Quantitative data suggest that approximately 20% of young people experience mental health disorders, defined as both emotional disorders and conduct disorders. Further, there is a current increase in parasuicides among both sexes (but more markedly for young men) in this population.

2. While mental health problems, including depression, parasuicide and suicide, become much more common during adolescence, there are contrasting patterns for males and females. Rates of depression are twice as high among girls as among boys. Rates of suicidal thoughts and behaviour are also much higher in girls than in boys. By contrast, males outnumber females in completed suicides (Fombonne, 1998).

3. Qualitative studies suggest that adolescents consistently identify a number of mental health problems, broadly characterised as worry and concern, including: issues around school performance, schoolwork and examinations; issues around friends and peer groups; issues around their family and home life; issues around their self-esteem, self-perceptions and self-concept; and issues around their employment future and prospects, and in particular the possibility of unemployment.

4. Young people are clearly not a homogeneous group. There appear to be differences and variations in young people's worries and concerns, in particular according to age; gender; social class; family composition; whether both parents are unemployed (Ghate and Daniels 1997).

5. The effects of socio-economic status in this population are not entirely clear (West, 1997). Research by West and Sweeting (West and Sweeting, 1990) presents relatively little difference among young people from different social classes on most dimensions of health. However, it appears that family life has an important impact on adolescent physical and mental health independent of social class factors. For example, the Twenty-07 Study indicated that young people in conflict with their parents were more likely to have poor mental health (West and Sweeting, 1996). West and Sweeting (1996) have argued that we need to broaden our view of cultural influences in the inequalities debate as family functioning is a major way in which these influences operate.

6. Increasing prevalence rates for mental health disorders and the wide-spread existence of mental health problems among young people have obvious implications for both mental health services and mental health promotion (Rutter and Smith, 1995).

4 A LITERATURE REVIEW OF EFFECTIVE MENTAL HEALTH PROMOTION INTERVENTIONS AMONG YOUNG PEOPLE

The purpose of this section is to provide examples of effective interventions which we believe indicate the vitality of the field, which could be easily replicated by the NHS and partners and which provide models for future intervention research. For this review, Medline/Psychlit databases were searched from 1980 onwards using the following keywords: mental, psychological, emotional, health, children, young people, youth, interventions, health promotion, prevention. We selected evaluated studies (which appeared in peer-reviewed journals), specifically targeted to young people aged 12 yrs. to 18 yrs., which had been based within both health and non-health settings (e.g. schools).

Studies focusing on addictions (e.g. drugs, smoking, alcohol) and studies addressing conduct disorders were excluded. The reasons for excluding these studies were two-fold: first both these areas are worthy of separate discussion and analysis and secondly, with specific regard to conduct disorders, the antecedents for these disorders appear to exist in early childhood. This suggests that mental health promotion is required for conduct disorders at that developmental stage. The importance of early intervention with children and families has been recognised in many successful early education and family support programmes (and a complete review of these interventions, with specific reference to conduct disorders and delinquency, is provided by Yoshikawa [1995]). This Report, while attempting to demonstrate the importance of mental health promotion programmes specifically targeted at adolescents, acknowledges that the mental health of young people will often be predicated on effective interventions for young children and families.

Durlak and Wells (1997) recently completed a meta-analysis of 177 child and adolescent mental health prevention/promotion interventions. Selected for analysis were "...interventions intentionally designed to reduce the future incidence of adjustment problems in currently normal populations as well as efforts directed at the promotion of mental health functioning" (p.117). Their results indicated that the majority of interventions achieved positive effects (with mean effect sizes ranging from 0.24 to 0.93). Durlak and Wells (1997) noted that these intervention effects "...are higher in magnitude than those achieved by many other treatment and preventive interventions in the social sciences and medicine" (p.138). This includes, for example, well-established preventive treatments like the use of aspirin to treat heart attacks, which have effect sizes estimated as 0.07 (Rosenthal, 1991).

In compiling this review, we have cited randomised controlled trials drawn, almost exclusively, from a *prevention* paradigm. As noted in Section Two, the prevention of disorder is regarded as a component part of mental health promotion in United Kingdom and preventive interventions are included here under the general heading of mental health promotion. Interestingly, in the American literature, interventions from the prevention and promotion paradigms are included under the general heading of primary prevention (Durlak and Wells (1997). In spite of differing typology, the fundamental issue, as stated by Kazdin (1993), remains unchanged "...A comprehensive model of adolescent mental health requires the promotion of positive adaptive functioning and the prevention and treatment of dysfunction" (p.128). This section will examine disorder-specific interventions (depression), interventions directed toward specific transitional periods, bullying interventions, interventions based on psycho-educational skills training and suicide prevention.

4.1   Primary Prevention of Depressive Symptomatology

Clarke et al (1993) have described adolescent unipolar affective disorders, (major depression/dysthmia), which are the most prevalent mental health disorders for young people, as a "significant public and mental health problem" (p.183). Estimates suggest that approximately 3% of older adolescents will experience unipolar depressive disorders at any one point in time, with 20% of adolescents reporting at least one diagnosable episode by age 18 (Clarke et al, 1993, p. 183). Given the high co-morbidity observed between adolescent depression and substance abuse, delinquency and suicide and the fact that the association between childhood and adulthood depression is greater than for other psychiatric disorders, adolescent depression has become an important issue for researchers, clinicians and policy-makers (Rutter, 1983, Kovacs et al, 1988; Clarke et al, 1993). Unfortunately, there have been few rigorous efforts to develop preventative interventions for unipolar depression among adolescents and many of those interventions which have been well-designed have failed to yield significant treatment effects (Clarke et al, 1993).

For example, Clarke et al (1993) designed two schools-based preventative interventions for depression. The first was a brief educational intervention and the second was a behavioural skills-training intervention. They reported that "...Neither of the two interventions had any effect on depression knowledge, attitudes toward treatment or actual treatment seeking" (Clarke et al, 1993, p.183). In the first intervention, 14/15 yr. old adolescent males and females were randomly assigned to either an experimental condition (n=361) or a control condition (n=261). Participants in the experimental condition were given three consecutive 50-minute sessions, consisting of three structured lectures and two videotapes, describing symptoms, causes and treatment of depression. The participants were also encouraged to increase rates of daily pleasant activities in order to "...help prevent the onset or exacerbation of depressive mood" (Clarke et al, 1993. p.186). The principle measurement index was the Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) administered pre/post intervention and at twelve weeks follow-up. Results indicated a "short-term" effect of intervention on depressive symptomatology for boys only. This finding did not persist at follow-up.

In the second intervention, a further sample of 14/15 year old adolescent males and females were randomly allocated to an experimental condition (n=190) or a control condition (n=190). Participants in the experimental condition were provided with five 50-minute sessions, consisting of an introductory lecture and videotape on causes, symptoms and treatments for depression and four subsequent sessions in which behavioural training, aimed at increasing daily rates of pleasant activities, was provided. Again, the principle measurement index was the CES-D (Radloff, 1977), administered pre/post intervention and at twelve week follow-up. There were no significant effects of the intervention observed. In discussing their findings, Clark et al (1993) suggested that both the brevity of their intervention and reliance on the CES-D (Radloff, 1977) as a principle measurement index may been limiting factors. With regard to the length of intervention, Connell et al (1985) have suggested that 30-40 hours of contact time may be the minimum amount necessary to yield long-term preventative effects in adolescent health.

However, using a selective intervention, Gilham et al (1995) reported a reduction in symptoms of depression among 11/12 year old participants over a two-year follow-up period. In this study, (n=118 young people), participants demonstrating caseness scores on the Children's Depression Inventory (Kovacs, 1985) and the Children's Perception Questionnaire (Emery and O'Leary, 1982) were randomly allocated to an intervention group (n=69) or a control group (n=49). Participants in the intervention

group met in groups of 10/12 young people for 1.5 hr. sessions over a period of 12 weeks. The programme, led by a Clinical Psychologist group leader, included two major components: a cognitive component (based on work by Beck, 1967) and a social problem-solving component (based on work by Leon et al, 1980). Evaluation was conducted two-weeks pre-programme, one week post-programme and at six month intervals during the two year follow-up. In reporting results, Gilham et al (1995) noted that: "Two years after the program ended, children who participated in it reported fewer depressive symptoms, on average, than children in the control group. Moreover, children in the program were only half as likely as children in the control group to report symptoms in the moderate to severe range" (p.348).

4.2   Mental Health Promotion During Transitional Periods

a)   School Transitions

The School Transitions Environment Project (STEP) "... simultaneously attempts to reduce stress levels and increase interpersonal support for high risk students..." . (Durlak, 1997, p.36). The project is conducted through creating fundamental changes in the school system: new students are assigned "homerooms" where they remain with the same core of 20/30 students for at least four subjects during the school day and homeroom teachers adopt expanded roles which include advisory and counselling functions. Evaluations

have indicated that STEP "...prevents deterioration in grades, attendance and levels of self-concept..."(Durlak, 1997, p.37). Further, teacher ratings of classroom behaviour and adjustment were superior for STEP, as were student self-report ratings of general stress, depression and anxiety (Felner et al, 1993). Four year follow-up demonstrated that drop-out rates for STEP participants were 56% lower than for control participants.

b)   Children of Divorce

A range of cognitive (self-blame, feeling different from peers), affective (feelings of sadness, heightened sensitivity to interpersonal incompatibility), behavioural (deficits in prosocial behaviour, high frequencies of acting out/aggressive behaviours with associated deficits in academic achievement) and psychophysiological difficulties (more frequent diagnoses of serious illness than peers from intact families) have been reported among children of divorce (Kurdek, 1981; Guidubaldi et al, 1984; Stolberg et al, 1984). There is, however, evidence to suggest that children/young people vary in their ability to adapt to parental divorce and the degree of risk is apparently mediated by three classes of variables: a) parental/family factors (pre-divorce marital hostility, parenting skills, custodial parents' adjustment to divorce), b) environmental/extra-familial factors (environmental change), and, c) individual factors (age/sex of child and emotional predisposition) (Kurdek, 1981; Emery, 1982; Stolberg et al, 1984). In an attempt to minimise psychological risk to children undergoing this life transition and, equally, to enhance adaptation, a number of preventative interventions have been developed.

An early small-scale intervention by Guerney and Jordan (1979) lacked methodological rigor and findings rested on "...impressionistic evaluations" (Alpert-Gillis et al, 1989, p.583). Kalter et al (1984) designed an eight-session intervention which, although described favourably by clinicians, achieved few statistically significant changes in objective pre/post evaluation. However, significant effects of experimental selective preventative interventions have been reported for the school-based Children's Support Groups (Stolberg and Garrision, 1985; Stolberg and

Mahler, 1994) and the Children of Divorce Intervention Program (CODIP) (Alpert-Gills et al, 1989; Pedro-Carrol and Black, 1993).

In the initial study by Stolberg and Garrison (1985), the Children's Support Groups (CSG), which were part of a larger initiative (The Divorce Adjustment Project), "...were expected to directly facilitate children's adjustment by teaching cognitive-behavioural skills and providing emotional support" (Stolberg and Garrison, 1985, p.113). Participating children (aged 7-13 yrs.) and custodial mothers were allocated to one of three intervention groups or a no-treatment control group: a) school-based CSG only, b) concurrent involvement by the child in the CSG and the mother in the Single Parents' Support Group (SPSG), or, c) involvement by the mother in the SPSG only. The CSG was described as a "...12 session psychoeducational program designed to help children meet behavioural and affective demands on them associated with parental divorce" (Stolberg and Garrison, 1985, p. 116). Each session was divided into two sections, with the first section devoted to discussion and the second section devoted to teaching, modelling and rehearsal of specific cognitive-behavioural skills (including anger control, communication and relaxation). In the SPSG, a twelve week support group for the divorced mothers, the focus was on "....the development of participants both as individuals and as parents" (Stolberg and Garrison, p.116). Measurement indices were chosen to reflect those process variables expected to be altered by the interventions: parenting skills (Single Parenting Questionnaire, Fisher, 1978), adult post-divorce emotional/social adjustment (Fisher Divorce Adjustment Scale, Fisher, 1978) and child adjustment (Child Behaviour Checklist, Achenbach, 1981). Data was collected pre/post intervention and at five-months post-intervention.

In describing their results, Stolberg and Garrison (1985) stated that there were no significant effects observed in the combined CSG/SPSG condition (when compared to the non-treatment control condition). However, "...The CSG-alone condition resulted in substantial increases in children's self-concept at the end of intervention and yielded increases in adaptive social skills at follow-up. The SPSG-alone condition prevented deterioration in parents' adjustment which was found in the other groups at post-testing, and in fact strengthened adjustment for its participants" (Stolberg and Garrison, 1985, p.120). In more recent studies (Stolberg and Mahler, 1994), in which an explicit attempt was made to identify effective intervention components in the CSG, and in which support-alone and support and skill-building conditions have been compared, ",,,The skills and support condition yielded the most immediate gains, specifically in reductions in internalising and externalising behaviour and total pathology in the home" (Stolberg and Mahler, 1985, p. 154). Interestingly, children who entered the intervention with significant psychological difficulties, demonstrated greatest benefits (as observed at follow-up) from the support-alone condition.

The Children of Divorce Intervention Program (CODIP), (Pedro-Carroll and Cowen, 1985), was defined by three major components: a) an affective component designed to assist children/young people in identifying and communicating feelings regarding divorce, b) a skills-building component designed to teach conflict resolution/ anger management skills, and, c) a component designed to enhance self-esteem. In an early evaluation study, participating 8-13 yr. old children/young people were included in either an intervention group (n=54) or a matched comparison group (n=78) of children from intact families. In the intervention group, small groups of children met for eleven weekly one-hour sessions within their schools. Measurement indices included the Parent Evaluation Form (Pedro-Carroll and Cowen, 1985), the STAIC (Spielberger, 1973) and the Multidimensional Measure of Children's Perceptions of Control (Connell, 1985). Pedro-Carroll and

Cowen (1985) reported that their intervention "...resulted in significant adjustment gains for participants, measured from the perspectives of teachers, parents, group leaders, and the children themselves" (Pedro-Carroll et al, 1986, p.286). In subsequent studies (Pedro-Carroll and Black, 1993), the intervention has been found to be effective with children/young people from a variety of ages (5-14yrs.) and populations (urban/suburban).

Stolberg and Mahler (1994) have described limitations in the children of divorce intervention literature: the use of idiosyncratic rating scales lacking demonstrable reliability and validity; the definition of adjustment gains through uni-dimensional scaling, hampering an overall assessment of intervention impact and a lack of clarity regarding the clinical relevance of statistical improvements. In spite of these legitimate concerns, the available evidence does appear to suggest that short-term improvements (at least) on measures of social competence, school adjustment and child/parent relationships can be observed in these interventions.

4.3   Mental Health Promotion and Bullying

Although bullying among schoolchildren is an old phenomenon, it was not until relatively recently that systematic attempts have been made to study it. Significant research in the field is attributable to the work of the Scandinavian researcher, Dan Olweus (Olweus, 1973; 1984; 1992). Olweus (1992) suggests that bullying or victimisation occurs when a child "...is exposed, repeatedly and over time, to negative actions on the part of one or more other persons" (p.101). In turn, negative actions are defined as the intentional infliction, or attempts to inflict injury (for example, through physical contact, words, "making faces") or discomfort upon another. Olweus notes that it is useful to distinguish between *direct bullying or victimisation* (relatively open attacks upon an individual) and *indirect bullying or victimisation* (social isolation/exclusion from a group) (Olweus, 1992).

Research has indicated that victims of bullying are often more anxious and insecure than peers, that they are lonely in the school environment and generally report that they do not have a single good friend. As stated by Olweus (1992), the passive or withdrawn victim can be characterised by "....an anxious reaction pattern combined (in the case of boys) with physical weakness" (p.103). A smaller sub-group, the provocative victim, is characterised by "....a combination of both anxious and aggressive behaviour patterns" (p.103). Bullies are characteristically aggressive toward peers, and additionally, toward teachers, parents and siblings. Contrary to received wisdom, bullies are not noticeably more anxious or insecure than peers, nor are they likely to experience poorer self-esteem (Olweus, 1992). Follow-up studies have suggested that while former school bullies demonstrate a "...fourfold increase in the level of relatively serious, recidivist criminality" (Olweus, 1992, p.104), former victims demonstrated a below average of criminality in early adulthood (Olweus, 1992).

The prevalence of bullying in schools has been reported at 15% (approximately one in seven students) in Norwegian schools (Olweus, 1992) and at similar or higher rates of prevalence in Sweden (Olweus, 1986), Finland (Lagerspetz et al, 1982) and the USA (Perry et al, 1988). A recent British study (Salmon et al, 1998), the largest bullying survey in the United Kingdom to date (n=904 pupils aged 12-17 yrs), indicated that 10% of the sample reported that they had been bullied on an occasional basis during the school term, with 4% reporting being bullied on a weekly basis. In this survey, the male to female ratio of bullies was 3:1, a decrease on the 4:1 ratio reported by Olweus (1994). Salmon et al (1998) argue that differences in these ratios may indicate that current interventions are having a greater impact on

the direct bullying practices more commonly manifest by boys and less impact on the indirect bullying more common among girls.

There have been a variety of mental health promotion interventions aimed at bullying (Strong, 1996) and a range of anti-bullying interventions and policies are widely in place in Scottish primary and secondary schools. An explicit universal prevention intervention designed by Olweus (1991), which was, in fact, a national campaign in Norway (n=2,400 students), demonstrated significant reductions from baseline in bully/victim problems at eight-month and twenty-month follow-up, reductions in self-reports of anti-social behaviour (defined as vandalism, theft and truancy) and increases in self-reports of satisfaction with school life.

It must, of course, be noted that the exclusive reliance on self-report data in this study poses a significant methodological limitation. However, in spite of this caveat, the intervention is worth considering in some detail. The goals of the intervention were twofold: to reduce current levels of bully/victim problems and to prevent the development of new problems. Specific objectives for the intervention were: a) to increase knowledge/ awareness of bully/victim problems, b) to actively involve teachers and parents in bully-victim issues, c) to develop rules concerning bullying behaviour, and, d) to support/protect victims of bullying. Olweus (1992) states that "...It is considered important to try to create a school (and, ideally, also a home) environment characterised by warmth, positive interest, and involvement from adults on one hand and firm limits to unacceptable behaviour on the other" (P.116). In this intervention, then, there was a clear orientation toward both the larger social environment (school/family systems) and the individual. As noted by Olweus (1992), the programme is "... directed toward the school as 'system' and works simultaneously at several levels: the school, the class and the individual..." (p.120). Programme components included the provision of written information to school personnel regarding the nature of bullying problems and prevention strategies, the provision of similar information to all parents of school-age children, and the production of a video on the lives of bullied victims.

4.4 Psychoeducational Skills Training

a) Assertiveness Training

Rotherham et al (1982) developed a universal intervention aimed at promoting assertiveness skills among young people. In this intervention, participants (n=343 young people aged 10/12 years) were provided with twenty-four sessions (approximately one hour in length) over a twelve week period. Sessions involved both group discussion and role-play (with peer feed-back). The intervention was school-based and at outcome, young people in the intervention sample (n=110) were rated in teacher ratings as more popular and as demonstrating better classroom behaviour and higher academic achievement than young people in the control sample.

b) Behavioural Training

In a second schools-based project, Bry (1982) developed an indicated intervention for adolescents demonstrating low academic motivation and frequent disciplinary referrals. Participants (n=66 young people aged 15 yrs.) attended weekly group sessions, over a two year period, where teacher-rated progress (attendance, discipline referrals) was discussed and behavioural options for improvement were considered. Points were awarded for positive behaviours and accumulated points resulted in school-trips chosen by the participants. At one-year follow-up, the

frequency of serious school-based behavioural problems were significantly lower for intervention group participants.

c)   Peer Counselling

Programs that provide training for adolescents to work as "peer counsellors" have been identified anecdotally as "...important vehicles for promoting psychological well-being and enhancing personal, interpersonal and educational growth..." (Silver et al, 1992, p.111).   Diverse benefits to adolescent helpers have been reported including increased personal growth, improved self-acceptance and confidence, improved social interaction and improved communication skills (Silver et al, 1992). It has been argued that benefits arise both from the training to become a counsellor and the actual peer counselling activity (Campbell, 1983). In spite of general agreement about the mental health promoting value of peer-counselling training, there has been little evidence of specific psychological benefit. However, in a recent study with inner-city adolescents aged 14-17 years, Silver et al, 1992, reported that "...Evidence from the present study appears to lend further support to claims that interpersonal skills training programs can have important mental health benefits for some adolescents, including both increased psychological maturity and decreased psychiatric symptoms " (p.126).

In their study, Silver et al (1992) aimed to examine the psychological effects of a peer-counselling training intervention (defined as an interpersonal skills training program, incorporating listening, communication and peer counselling skills) among adolescents, a significant proportion of whom had a variety of serious, chronic health problems (including asthma, diabetes mellitus, heart disease and epilepsy). In the intervention group there were thirty-two participants (eighteen of whom had health problems); there were twenty-eight adolescents in the control sample. The intervention training consisted of thirteen ninety-minute sessions held weekly over a three month period. In the sessions, conducted by experienced group leaders, lecture and role-play methodologies were employed. At a process level, "success" in the training intervention was judged by completion of a minimum of 10 of the 13 sessions and satisfactory skills attainment as rated by the group leader. Standard measures included the Peabody Picture Vocabulary Test (Dunn and Dunn, 1981) and the Wide Range Achievement Test (Jastak et al, 1978) completed at baseline and the SCL-90-R (Derogatis, 1977) (a brief psychiatric assessment tool) and the Loevinger Sentence Completion Test of Ego Development (Loevinger and Wessler. 1970) completed at both baseline and post-test assessment. At follow-up, it was noted that those adolescents who had been judged as adequate counsellors and who later accepted to invitation to become peer-counsellors demonstrated greatest change on the Loevinger Test. Silver et al (1992) noted that "...Only those adolescents who both demonstrated the motivation and persistence to complete the entire training program and who opted to practice their acquired communication skills by working as peer counsellors in the hospital demonstrated significant ego development gains and reduction of psychiatric symptoms. Thus, this type of intervention may not be appropriate for all adolescents, but it appears to a be a valuable mechanism for enhancing psychological adaptation in some groups of high-risk adolescents" (p.126).

4.5   Suicide Prevention

There is evidence to suggest that suicide among adolescents in the international community, including United Kingdom, has increased dramatically over the past thirty years (Recklitis et al, 1992; Fombonne, 1998). Malley et al (1994) noted that suicide is now the second leading cause of deaths (after accidents) among

American adolescents and, even more alarmingly, there has been a suggestion that cases of adolescent suicide are often under-reported and "disguised" as accidents (Capuzzi and Golden, 1988). In United Kingdom, "..there has been a clear increase in suicide in 15-19 year old males between 1970-1990" (McClure, 1994, p.513). In examining Scottish statistics, Platt (1997) reported that suicide deaths among males aged 15-24 increased by 169% between 1971/73 and 1993/95. McClure (1994) noted that increases in suicide among young men were associated with increases in hanging and self poising with vehicle exhaust gas. In examining the prevalence figures in New Zealand, Disley (1994) identified a range of predictive factors for adolescent suicide, including: high rates of depression and alcohol/drug use, histories of conduct disorder and histories of family dysfunction (including sexual abuse). This range of predictive factors serve to place suicide within a broad context of emotional distress and led Disley (1994) to argue for wide-ranging programmes of suicide prevention, including "...wider public awareness of adolescent depression, more adequate mental health and primary health programmes for young people, better identification and support of young people with emotional and conduct disorders and better support and counselling for families in distress" (p.11).

Specific adolescent suicide prevention programs, which are often schools-based, must, according to Malley et al (1994), be both comprehensive and systematic. "...Comprehensive and systematic school-based suicide prevention and intervention programs are those that address preventing suicides from a point before a potential suicide, during suicidal crisis, and following a completed suicide" (p.131). Interestingly, this schools-based approach to suicide prevention includes universal, selected and indicated prevention perspectives. The literature acknowledges the ethical, moral and legal importance of written formal suicide policy statements in schools (including procedures aimed at addressing the needs of at-risk adolescents, staff training, prevention classroom discussions and program evaluation methods). The recent survey by Malley et al (1994) of American schools (n=325 schools) indicated that schools with written policies "...were considerably more comprehensive and systematic in their approach...."(p.135).

Steele (1992) notes that where adolescents commit suicide, there is "... a minimum of three peers who are so affected by this violent death that the resulting trauma claims their lives by burdening them with such intense reactions that they suffer cognitively, socially, psychologically and emotionally" (p.469). To address the needs of peers, school-based post-suicide crisis interventions have been developed. These interventions are referred to as postvention, defined as "..a process, after a suicide, during which an individual and/or family works toward emotional and psychological recovery and readjustment to healthy living and ...the provision of interventions combining education and treatment to prevent bereavement complications for individuals, families and groups left behind" (Mauk et al, 1994). The efficacy of postvention programmes has been identified in studies by Mauk (1993) and Mauk and Rodgers (1994).

4.6   Non-Research Based Projects in Mental Health Promotion in the UK

Mental health promotion is in embryonic development in the United Kingdom (Mauthner et al, 1999). As such, a considerable amount of work in the field is currently represented by non-research based projects which rarely, if ever, are published in peer-reviewed journals. However, in a recent publication by the Health Education Authority (HEA, 1998), information regarding a range of community-based projects, focussed across the life-span, has been collated. As noted by the HEA, "… The projects are examples of people in partnership with other local people, offering support, social contact, knowledge and expertise based on experience, and

the chance to develop confidence and self-esteem" (p.3).   Five of the projects in the publication have been specifically designed for young people, and these initiatives will be briefly described here.

4.6.1   The A.F.R.I.C.A. Project (All Foundations Rise in Community Awareness)

The A.F.R.I.C.A. Project "… works to raise achievement, create a positive attitude to education and employment, and promote mental health with African Caribbean young people…" (HEA, 1998, p.17).   A joint initiative, with funding provided by both voluntary and statutory agencies, the impetus for the Project came from census data, published in 1991, which indicated that low numbers of African Caribbean young people were academically achieving and/or gaining training and employment opportunities.   The Project aimed to assist this population through encouraging and developing literacy skills, creating positive attitudes to education and employment and promoting mental health through "… developing confidence, image, expectations and self-esteem" (HEA, 1998, p.19).   Importantly, the Project aimed to assist parents, teachers and young people themselves to work co-operatively in the pursuit of these objectives.   A number of activities, including individual support, classroom-based interventions, the provision of a "drop-in" facility and summer activity programmes were established.   In evaluating the effectiveness of the Project, the authors reported that there was a fifty per-cent increase in attendance of African Caribbean parents at parents' evenings in the schools involved and that participating young men achieved training places or avoided exclusion as a result of participation in the Project.

4.6.2   Anti-Racism and Anti-Bullying Strategies in an Inner-City School

This project was developed in an inner-city, multicultural school and community college where forty-three per-cent of the pupils are from minority ethnic communities.   Based on similar principles to those described by Olweus (1991), the project aimed to provide individual pupils with strategies to prevent bullying or to effect prompt action in the event of bullying behaviour and to create a school climate where the reporting of bullying was acceptable and where attitudes to bullying were addressed through the school curriculum.   Activities introduced through the project included ensuring a rapid response to bullying incidents, the development of assemblies on bullying and related issues and the active support of teachers and parents in project development and maintenance.   In considering the project effectiveness, it was reported that "… Since the programme began, reported complaints of bullying and anti-social behaviour have dropped significantly" (HEA, 1998, p.28).

4.6.3   Mentoring Programme for High Schools

As described "… Mentoring is a process where one person acts as a support and guide for another and this scheme, run by Manchester Education and Business Partnership (EBP), provides mentors for 14-16 year-olds in Manchester schools, from private firms, the public sector and educational establishments" (HEA, 1998, p.89).   Participating pupils, both male and female (n=approximately 220 per year), many of whom were described as disaffected, underachieving and living in dysfunctional families, were matched with mentors (including graduate trainees in business, University students and local professionals).   Mentoring, provided through one-to-one discussion and the provision of workplace experiences, was provided in schools and supplementary visits to business environments were also arranged. "Potential signs of effectiveness" were described: improved attendance,

punctuality and appearance, improved relationships with peers and improved academic performance.

4.6.4   Young Lesbian, Gay and Bisexual Peer Support Project

This project developed through a voluntary organisation, Lesbian and Gay Youth Manchester began in 1996 and was initially funded for a three-year period.   Based on evidence reporting extensive bullying (including violent attacks) perpetrated on young lesbians and gay men (Mason and Palmer, 1996; Rivers, 1996), the project provides training to young people to allow them to offer support and information to peers.   The target group for the project (both users and supporters) was 14-20 year-old lesbian, gay men and bisexuals in the ten boroughs of Greater Manchester. Three sources of peer support were available through the project: "The Young Phoneline", which operated one evening weekly, "The Peer Support by Post Project", which provided an opportunity for isolated young people to correspond with a peer and an e-mail address and web-site.

4.6.5   Young People's Media Arts Project

This project, which was established with a small group of young people aged 10-16 years (n=8; six girls and two boys) with a history of mental health problems, was a "… six-month media arts project aimed at building the self-esteem of young people with mental health problems, through their involvement in the production of a series of posters and postcards" (HEA, 1998, p.106).   The aims of the project were to promote emotional well-being through empowering the participants through their work on a photographic and graphics initiative and to provide specific skills and experience through active involvement in tasks and skills development (including design, photography, art and drama techniques).   Materials were designed and produced and local distribution has taken place.   Anecdotal evidence suggested that the involvement in the project was of benefit to the participating young people.

4.7   Conclusions

1. This review (in common with other reviews by Hosman and Veltman, 1994; Hodgson et al, 1996 and Tilford et al, 1997) demonstrates the potential for mental health promotion among young people. There is evidence to suggest that interventions aimed at both the general population (e.g. bullying/ victimisation) and high-risk groups (e.g. young people undergoing particular life transitions) are effective.

2. The majority of interventions presented here have been person-centred (focused on the individual as opposed to the wider social system in which the individual exists) and among these interventions, behavioural or cognitive-behavioural methods (modeling, role-playing followed by peer feedback and reinforcement, self-control strategies) have been the most prevalent. Diguiseppe and Kassinove (1976), Thompson and Hudson (1982) and Durlak and Wells (1997) have previously observed the superiority of cognitive/ cognitive-behavioural strategies over non-behavioural (counselling and group discussion) strategies. Further, Durlak and Wells (1997) have recently noted that information-only programs are virtually ineffective. They have stated "...Programmes that rely on informational strategies to change behaviour have not been effective in any area of prevention in which they have been tried. In fact, the evidence is overwhelming that such programmes do not significantly change behaviour" (Durlak and Wells, 1997, p.192). It has also been noted by Trickett (1997) that even successful interventions are rarely embedded into the environmental setting (school, community, etc.) in such a way that continuation of the intervention would be assured after the departure of researchers.

3. Although the majority of interventions presented here have been person-centred, there are also examples of small-scale systems models of promotion/prevention (reflecting concerns with structural factors in the social system) indicating effectiveness (Olweus, 1992). One of our conclusions, formed on the basis of this review, is that the mental health promotion needs of young people require multi-disciplinary and multi-agency collaboration in the development of both person-centred and systems-level interventions.

4. Further, the majority of interventions presented here have been schools-based. However, it seems likely that time and resource implications may prove to be real barriers to their large-scale replication in Scottish schools. As Clarke et al (1993) note in relation to their work on depression : "…schools may be unwilling to devote such time resources to the prevention of depression" (p.197). Conceivably, schools might be more willing to invest their finite resources into mental health promotion activity if the potential effects of such activity on school performance were better communicated and understood. Arguably, further research is required in identifying other appropriate settings for interventions and it is vital that health promotion officers responsible for mental health promotion in this population develop and foster initiatives in close collaboration with other social and educational providers.

5. Additionally, there is a noticeable absence of work addressing large-scale structural and socio-economic factors (e.g. employment, educational opportunity, deprivation, etc.). While health providers cannot solely accept responsibility for these areas of concern, they have, through Public Health Departments and Health Promotion Units, an enviable opportunity to advocate on behalf of young people on these issues, particularly in light of recent Scottish

Office perspectives (SODOH, 1998) on precipitants for mental health and well-being.

6. In compiling this literature review, we have observed that there is a disproportionate amount of work conducted among younger aged children, in particular 7 - 11 years, and that the needs of adolescents/older teenagers are relatively neglected in research. Furthermore, existing studies with this latter age group focus predominantly on addictions. This may reflect prevailing social concern with drug and alcohol use to the exclusion of both possible underlying predictive psychological factors for addiction (e.g. self-esteem, communication, conflict resolution, etc.) and broader socio-political and cultural issues.

7. Finally, studies reviewed here have been almost exclusively US-based. Given differing socio-cultural environments, there is an important question regarding the generalisability and applicability of this work within a UK context. The requirement for UK-based replication studies of these interventions and further research development in the UK in mental health promotion among young people is clearly identified.

8. The non-research based projects described in this Section have indicated the value of a wide-range of partnerships in the growth of mental health promotion initiatives. These community-based projects, aimed at addressing the needs of a variety of young people experiencing social exclusion, have demonstrated further potential sources of intervention.

5 RECOMMENDATIONS FOR MENTAL HEALTH PROMOTION AMONG YOUNG PEOPLE

5.1 Introduction

The prevalence of psychological distress among young people in Scotland, defined as both "mental health disorders and "mental health problems" has been identified throughout this report. While available quantitative data suggests that approximately 20% of young people experience mental health disorders, available qualitative data demonstrates a broad range of mental health problems among this population. In mental health services for young people, a spectrum of interventions is required, interventions ranging from the promotion of well-being and prevention of initial onset of disorder through to traditional treatment and rehabilitation programmes. Both the "Framework for Mental Health Services in Scotland" (SODOH, 1997) and the recent White Paper (SODOH, 1999) explicitly support this position. With a new emphasis on promotion and prevention, defined through both systems-level and person-centred approaches, and the integration of these interventions with treatment and rehabilitation models of care, the potential for improved mental health among young people is, at least theoretically, enhanced (Kazdin, 1993; Ross, 1998). Mental health promotion alone is not a panacea, but should be considered as a necessary component part in the development of comprehensive and responsive mental health care services.

Mrazek and Haggerty (1994) have noted that "…Although there are excellent reasons to target an intervention for a specific age or stage of life, and for a particular disorder or problem, there is usually no single intervention at a single point in time that accomplishes comprehensive goals of prevention for a lifetime" (p.298). This statement has particular resonance for this report. The mental health of young people is significantly affected by their experiences in infancy and early childhood (Rutter and Smith, 1995) and, therefore, as noted earlier, mental health promotion interventions must begin prior to adolescence. However, recommendations for mental health promotion among younger children will require a separate report.

5.1.2 Mental Health Promotion and the Context of the Current NHS in Scotland

As described in Section Two, mental health promotion depends on a psycho-social model of mental health: at both a theoretical level and in practice, interest is focussed on the interaction among multiple determinants (including a range of personal experience, socio-economic, environmental and cultural factors) for health and well-being. Described in complementary terms from a prevention perspective, Mrazek and Haggerty (1994) have noted that "…The ultimate goal to achieve optimal prevention should be to build the principles of prevention into the ordinary activities of everyday life and into community structures to enhance development over the entire life span. This would include promoting consensual community values and norms " (p.299).

This concept of interactive influences for health among life circumstances and lifestyles is fundamental to the recent White Paper "Towards a Healthier Scotland" (SODOH, 1999). The White Paper states: "…Social disadvantage, emotional strain and family disruption can lead to mental health problems in childhood, adolescence and early adulthood. Children at particularly high risk of mental health problems are those living in poverty, showing behavioural difficulties or living in families undergoing divorce or bereavement" (p.31). It appears, therefore, that the knowledge base out of which recommendations in this report are made is co-

terminus with the current health policy context. Recommendations made in this report will, therefore, reflect the endorsement of this SNAP Group for those aspects of the White Paper.

5.1.3 Recommendations for Mental Health Promotion Among Young People: Key Practice Issues and Values

The recommendations presented in this Report are predicated on both key practice issues in health promotion and values reflected in national and international consensus documents on the rights of young people (United Nations Convention of the Rights of the Child, 1989; Children [Scotland] Act). These key practice issues and values suggest the following :

1. Young people require access to resources that support mental health: basic physical needs (including adequate protection and freedom from any form of exploitation) and "higher" psychological and social needs. This range of needs must be considered in strategic policy (both health and non-health related).

2. The needs assessment process which informs the development of mental health promotion strategy and service provision for young people should, in addition to traditional methods of needs assessment, address issues identified by young people themselves and, where possible, should accommodate diverse needs relevant to gender, social class and ethnicity.

3. The Health Impact Assessment process ("…a method of evaluating the likely effects of policies, initiatives and activities on health at a population level and helping to develop recommendations to maximise health gain and minimise health risk" [SODOH, 1999, p.42]) should, where possible, consider the implications for mental health in strategy and policy development at national and local levels.

4. The processes inherent in the development of mental health promotion strategies for young people and subsequent programme delivery should incorporate the principles of empowerment, equity, participation and accountability (WHO, 1986).

5.2 Recommendations

The recommendations for action made by this SNAP Group, based both on a systematic review of the literature and consultation with professionals working with this young people (See: Appendix Two), will be presented under four headings: Strategic Recommendations (systems-level recommendations), Specific Recommendations (person-centred recommendations), Research Recommendations and Project Development and Evaluation Recommendations. In making specific recommendations for further research and project development in mental health promotion among young people, we are attempting to identify the importance of establishing a suitable infra-structure for further development in the field.

5.2.1 Strategic Recommendations

1. This SNAP Group endorses the co-ordinated approach to better health, with specific reference to tackling health inequalities, improving life circumstances and attacking poverty, advocated in the White Paper (SODOH, 1999). Further, we specifically endorse the mental health promoting components of the "Starting

Well" Health Demonstration Project and endorse proposals for the Health Education Board for Scotland and Health Boards to work in conjunction with partners to safeguard and promote mental health. We recommend that all economic and social policies be designed to ensure positive mental health impact in the attainment of these goals.

2. Development in mental health promotion has largely been focussed on person-centred initiatives. Structural (or "systems-level" approaches) have been under-represented both in research and practice (Health Education Authority, 1997). The White Paper presents a number of structural potentials for mental health promotion among young people through multi-agency initiatives like Social Inclusion Partnerships, Healthy Living Centres and Community Schools. We recommend that, where possible, the mental health needs of young people be explicitly considered within these social environments.

3. We recommend that Local Authority-led Children's Services Planning should incorporate planning for mental health promotion and should be fully integrated with Health Board's Mental Health Framework strategic planning.

4. Throughout the preparation of this report, we have recognised the importance of effective multi-disciplinary and multi-agency co-ordination in the planning and implementation of mental health promotion initiatives for young people. We recommend that mental health promotion be explicitly integrated in the spectrum of mental health services available to young people and acknowledge the training and development implications of this recommendation for both mental health service providers and mental health promotion specialists.

5. We have observed that mental health is multi-faceted and is influenced by structural, interpersonal and intra-personal factors. We recommend that all services for young people (schools, residential care settings, primary care services, etc.) integrate mental health promotion into their core service delivery. We also recommend that support (resource packs, appropriate training, etc.) be provided for professionals working in primary care settings, teachers, care workers, parents and others to assist them in developing greater awareness of mental health needs among young people.

6. Finally, we recommend that SIGN should consider mental health promotion for young people as an appropriate topic for the development of evidence-based guidelines for practitioners.

7. In compiling this report, we have frequently noted the importance of the school environment in young people's lives: the overwhelming majority of young people spend a significant amount of time in school settings. We recommend that all schools develop, implement and monitor mental health policies using the health promoting school framework to identify mental health needs in relation to the school's physical environment, ethos, curriculum, relationships to health and community services and staff health.

8. While recognising the pervasive detrimental effects of child sexual abuse on young people and adults, we also recognise that there is very little research on effective promotion and prevention in this area. Therefore, we recommend the development of a research programme in this area.

9. We recommend that two further SNAP Groups be convened in mental health promotion. The first group should be commissioned to consider mental health

promotion among children and the second group should consider mental health promotion among the adult population.

5.2.2 Specific Recommendations

1. In Section Four, research evidence was presented which indicated the effectiveness of a variety of mental health promotion interventions among young people. Several conclusions, which will be reiterated here, are available on the basis of the research evidence.

- Successful studies are characterised by a focused approach to mental health among young people.

- There is evidence to suggest that interventions aimed at either the general population or "at-risk" sub-groups are effective.

- The superiority of cognitive and/or cognitive-behavioural strategies over non-behavioural strategies (counselling and group discussion) has been observed. Further, there is evidence to suggest that information-only programmes are virtually ineffective.

- Small-scale "systems-level" strategies established in conjunction with person-centred approaches in social settings frequented by young people have been effective.

- Studies have been largely US-based.

2. We recommend that interventions of proven efficacy in mental health promotion with young people be established across Scotland. We specifically recommend that interventions aimed at the prevention of bullying, at the promotion of emotional well-being of children of divorce and those facing school-transitions, and psycho-educational skills training initiatives be established.

3. We recommend that, as in the work by Olweus (1973; 1984; 1992) on bullying, structural determinants demoting mental health and those person-centred objectives specifically addressed in an intervention protocol be addressed simultaneously, where possible.

4. We recommend that where initiatives are established based on models developed in America, that pilot programmes be developed to pre-test protocols and, where necessary, the use of written materials, etc. However, we also recommend that in all replication studies, fidelity and integrity of implementation is carefully observed (Mrazek and Haggerty, 1994).

5. We recommend that the development of interventions reflects an appropriate gender, class and ethnicity perspective.

5.2.3 Research Recommendations

As noted by Hodgson and Abbasi (1995) "….. successful studies have a long history of development, often ten years or longer, involving needs assessment, pilot studies and formative evaluations leading to further improvements" (p.25). There is a pressing need for further research development in mental health promotion among young people in Scotland and it is essential that a co-ordinated research agenda be implemented.

1. We recommend that a national programme of research in mental health promotion among young people be commissioned.   It is conceivable that a research agenda could be developed across Health Boards, working in collaboration with academic institutions, the Health Education Board for Scotland and the Chief Scientist Office.   Further, we recommend that the research agenda specifically consider the mental health promotion needs of young people considered "at risk" of mental ill-health, the specific needs of young people in care and a broader population-based approaches.

2. As noted in Section 4, a significant proportion of existing research in mental health promotion among young people has been established within the school context.   There is little evidence to indicate the effectiveness of intervention in other community-based settings.   We recommend, therefore, that intervention studies based in community settings be developed.

3. In Section Three of this report, it was noted that some recent studies (West and Sweeting, 1995) have failed to show a consistent socio-economic gradient for psychological malaise among young people in their mid-adolescence. It is recommended, therefore, that further research investigating the effects of socio-economic factors on the mental health of young people be conducted.

4. We recommend that long-term outcomes (of at least one year) in intervention studies be routinely assessed.

5. Further, we recommend that research protocols seek to investigate both systems-level and person-centred approaches to mental health promotion among young people.

5.2.4   Project Development and Evaluation Recommendations

As noted in Section 5.2.3, the research cycle depends on appropriate project development. Effective project development and rigorous evaluation are essential basic components in the development of a reliable research base.

1. We recommend that a national Task Group, composed of Health Promotion Specialists, mental health professionals, academics and researchers be convened for two specific purposes :   (a)   the development of a suitable framework for project development in mental health promotion in Scotland, and (b) the selection of suitable evaluation and review indicators.   As examples of previous work in this area, we cite the "Quality Framework for Mental Health Promotion" developed by the Health Education Authority (1997) and Intervention Mapping (Bartholomew et al, 1998).

AFTERWORD

<u>SNAP REPORT ON MENTAL HEALTH PROMOTION AND YOUNG PEOPLE</u>

This report challenges professionals working with young people in Scotland to examine existing practice in mental health promotion. It provides important definitions of mental health and its promotion and suggests a framework against which agencies might compare existing policy and practice. It examines the needs of young people from various perspectives, including that of the young people themselves. It draws on a wide range of research evidence and gives a useful summary of relevant research findings and other literature. It evaluates specific interventions and makes a number of extremely important recommendations.

The report contains two messages of the utmost significance for all agencies working with young people. The first is that interventions do make a difference. This is not a new message but it is a message which needs constant updating and reinforcement. Young people's mental health can be affected positively, and by definition, negatively, by the policies, procedures and practices of the agencies with whom they come into contact. Secondly, it highlights the need for all agencies with responsibilities towards young people to collaborate in the interests of providing a coherent, 'joined up' service and achieving Best Value in the deployment of scarce resources.

The messages and challenges contained in the report are no less relevant to the education service than to its partner agencies. It is possible to take heart from the fact that a great deal of good practice is already in evidence. Concepts such as the health promoting school place health, mental and physical, at the heart of the education process. The new community school concept, which is still in its pilot year, brings together a range of relevant services under one roof, surely the starting point for encouraging a genuine collaboration and the breakdown of rivalries among these services. Similarly, it is worth noting that many of the principles and strategies recommended as contributing to mental health promotion are well established in practice. A few examples serve to illustrate this point:

♦ major anti-bullying initiatives have been ongoing in Scottish education throughout the 1990s – although the largest official survey of bullying in the UK was based on a sample of 904 pupils aged 12-17 years, the former Strathclyde Regional Council sought the views of almost 17,000 young people aged 5-18 years, on the basis of which workshop materials were developed and are still used widely with pupils, teachers and parents;

♦ the recent expansion in early years education is in recognition of the impact (identified by Rutter and Hersov, 1985) of the experiences of early childhood on later development;

♦ guidance structures backed by extensive staff development programmes ensure that teachers are aware of the importance of high quality pastoral care for all young people and are trained in a range of helping techniques including basic counselling approaches;

♦ personal and social education programmes using commercially produced 'life skills' type materials embody the skills based, experiential approaches recommended in the report and address such themes as relationships, coping with transitions, behaving assertively, resolving conflict, saying no to drugs, communicating effectively and expressing feelings constructively;

♦ peer helping, often in the form of 'buddy' systems, operates in many schools;

♦ the link between high self-esteem and a range of positive factors, such as attainment, social adjustment and the ability to resist negative influences is firmly established. The principle underpins staff and curriculum development and is at the heart of good teaching and personal and social education.

This list represents only a fraction of the structures and practices designed to promote pupils' affective development. There is, however, no room for complacency. Although the above represents best practice, it does not represent universal practice.

Whilst the messages from the research are not new to education, the collation of research findings and the summary of conclusions will make the report an extremely useful source against which to evaluate and review best practice and ensure that mental health remains high on the agenda. Moreover, as the SNAP Report contends, there is a significant shortfall in Scottish based research evidence and the rationale for many of these approaches is rooted in the assumption that what is good for children in North America will apply equally to their Scottish counterparts.

The report will stimulate teachers and policy makers within the education service to direct resources towards ensuring that best practice becomes normal practice. It throws down a gauntlet to any who still fail to see mental health promotion as fundamental to raising standards of attainment and nurturing the psychosocial development of young people. On the other hand, the report's assertion that "schools might be more willing to invest their finite resources into mental health promotion activity if the potential effects of such activity on school performance were better communicated and understood" says more, perhaps about the extent to which one agency is familiar with the work of another than about the state of awareness and the commitment to mental health promotion which exists in education. The issue is not one of understanding but of competing resources. If the view is taken that positive interventions cannot, for practical reasons, be replicated on a large scale in Scottish schools, then the sixteen thousand hours that young people spend in school would represent a lost opportunity. Moreover, to be effective in the long term, interventions must not be seen as 'bolt-on', but must permeate the experiences of young people and the training and practice of those who have responsibilities towards them.

Of the recommendations made in the report, the most telling is the need for closer collaboration between agencies. The Children's Service Plan is the blueprint for the co-ordination of services to children and young people, but there remain structural and organisational barriers to ensuring that resources are deployed to maximum effect. Pooling of resources, particularly financial resources, is difficult to co-ordinate. At a more basic level, each agency tends to have its own modus operandi, its own structures and its own ethos. Decisions about when to collaborate, with whom and to what extent often lie with individual managers. At an even more basic level, departments and agencies often do not find out about the good practice that exists in sibling departments with responsibilities to the same client group. Some local authorities, in recognition of this fact, have already created children's departments, bringing social work and education together. Whatever the best solution, there is no doubt that, as Best Value reviews probe more deeply into the quality of service delivery, the issues highlighted in the SNAP Report will require to be addressed.
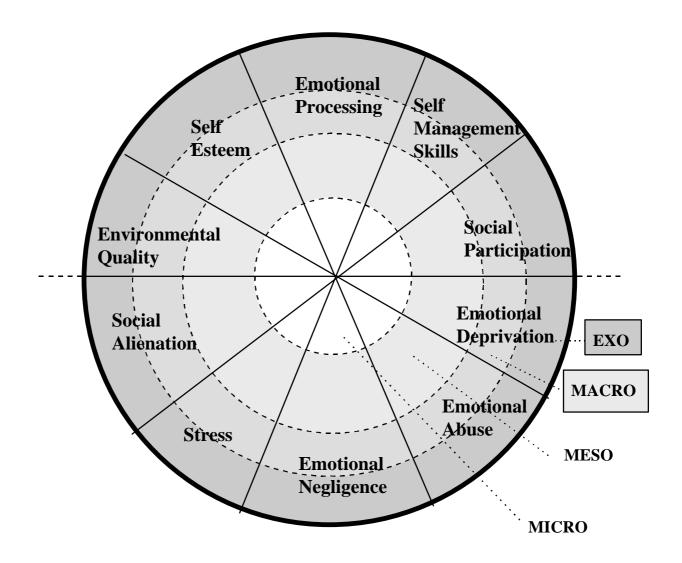
An obvious and necessary way forward, so far as mental health promotion is concerned, is to take forward the suggestion that a national Task Group be set up. It is vital, however, that the membership of such a body contain not just health professionals and academics, but experienced practitioners from education, social work and other agencies as appropriate. Mental health promotion is too important to be the exclusive domain of mental health specialists and academics!

Loretta Scott (Adviser in Guidance/PSD),
Glasgow City Council,
November 1999

A MAP OF ELEMENTS OF MENTAL HEALTH, ITS PROMOTION AND DEMOTION

(MacDonald and O'Hara, 1998)

In this model, MacDonald and O'Hara (1996) suggest that mental health can be *promoted* by increasing or enhancing those factors above the horizontal dotted line or by decreasing or diminishing those elements below it.

The model delineates various *levels* of activity: **micro**, **meso, macro and exo.** Mental health can be promoted at the level of individual needs and preferences (**micro**), family and community needs (**meso)** at the level of local and regional policies (**macro**) and at national and international levels (**exo**).

MacDonald and O'Hara (1996) suggest that the model provides a useful tool for plotting current mental health promotion activity and for the planning of future activity. The model or "map" enables location of current activity within a particular domain, and the identification of potential for future development, through either expansion to different **levels** within the one element (e.g. from micro to meso), or through lateral expansion to other elements (e.g. from the enhancement of social participation to enhancement of self-management skills).

It is also important to note the lateral dependence which can operate between segments in the map. The status of one domain can have implications for others. It follows that inter-relationships must be accommodated in the development of mental health promotion activity. For instance, it may be inappropriate and naive to attempt to teach coping skills without, at the same time, addressing a related domain like self esteem.

Brief descriptions of each of the individual elements are outlined below:

Environmental quality refers not only to the absence of adverse environmental influences (such as environmental deprivation), but also encompasses positive environmental factors (such as good housing, amenities, and aesthetically pleasing surroundings.) The antithesis of environmental quality is **environmental deprivation,** which the model indicates as a mental health *demoting* factor. The model suggests that those strategies employed to enhance environmental quality can impact positively on mental health: mental health can be promoted through strategies targeted at reducing poor housing, exposure to danger and poor amenities.

Self esteem is dependent on feelings of worth and significantly influences behaviour (MacDonald and O'Hara, 1996). Conversely, **emotional abuse** refers to infringements of the right to be emotionally fulfilled. It can be seen as a systematic denial and destruction of self esteem through destruction of the sense of worth either directly (e.g. mental torment/physical or sexual abuse) or indirectly (e.g. systematic criticism).

The term **emotional processing** describes one's awareness that how we feel matters, and to similar awareness and respect for the feelings of others. It requires the development and use of a sophisticated vocabulary to share feelings. As such, skills in this domain will be dependent on the extent to which affective experience is encouraged and nurtured. **Emotional negligence,** a form of emotional abuse, is a disregard for the legitimacy of feelings and emotions.

Self management skills are broader and more varied than the coping skills which they encompass. They reflect a more proactive approach to stress, enabling individuals to handle or address stressful or adverse circumstances. **Stress** is accepted as a demoting factor and successful programmes to reduce stress must be rooted in an understanding of the individual experience . As in other domains, the model highlights the fact that activities to reduce stress can be targeted at various levels (meso/macro). It may be, as suggested by the model, more ethically and pragmatically favourable to attempt to reduce stress within the wider environment than to focus a strategy exclusively at the individual.

Social participation involves both social responsibility and social rights - a process of active involvement, of give and take. It includes social support which is well recognised as fulfilling both a buffering role from stress and exercising a general effect in enhancing mental health (REF.). Conversely, the experience of **social**

alienation, or exploitation, (based on, for example, age, gender, race, class) leads to demoted mental health (MacDonald and O'Hara, 1996). As in the earlier example regarding stress, the moral and necessary strategy approach will often be to address the exploitation itself, requiring policy intervention at the meso, macro or exo levels.

APPENDIX TWO

Consultation Exercise

As part of the preparation of this Report, a Consultation Exercise was held at the Central Hotel, Glasgow, in October 1998. The purpose of this event was to explore our progress on the Report to that date with professionals (from a variety of statutory and voluntary settings) working closely with young people. Invitations were sent to a representative sample of professionals and approximately fifty delegates attended the Exercise.

Ms Ann Houston, Director of Childline Scotland, provided a keynote address and the purpose of this SNAP Group and the structure and content of a preliminary draft of the Report were discussed. Opportunities for both small and large-group discussion were offered. Specifically, delegates were asked to consider whether or not the Report met established objectives, to comment on obvious omissions in the Report (either in terms of literature or practical initiatives) and to offer further recommendations for inclusion in the Report. Comments from the Exercise (in addition to written comments provided by delegates unable to attend the event) were collated and used to inform further development of the final Report.

The following organisations were represented at the Consultation Event :

Aberdeen City Council Aberdeen	Archdiocese of Scotland Glasgow
Ayrshire & Arran Health Board Ayr	Borders Health Promotion Department Melrose
Child & Family Centre Paisley	Child & Family Clinic Motherwell
Child & Family Services Ayrshire & Arran Primary Care NHT Trust Irvine	Clydebank Social Work Department Clydebank
Community Education Camelon	East Renfrewshire Social Work Dept Glasgow
Fife Healthcare NHS Trust Cupar	Forth Valley Health Board Stirling
Glasgow City Council (Education) Glasgow	Greater Glasgow Health Board Glasgow
Health Promotion Department Edinburgh	Health Promotion Department Fife
Health Promotion Department Motherwell	Health Promotion Service Irvine

North Lanarkshire Council
Motherwell

Notre Dame Centre
Glasgow

Nuffield Centre
University of Glasgow

Penumbra Youth Project
Galashiels

Psychological Services
Dumbarton

Psychological Services
Glasgow

Social Work Department
Dumbartonshire

Social Work Services
Bo'ness

Tayside Health Promotion Centre
Dundee

Young People's Unit
Royal Edinburgh Hospital

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