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IMPROVING MENTAL HEALTH IN YOUNG PEOPLE

Helen Herrman, Rosemary Purcell, Sherilyn Goldstone & Patrick McGorry
Orygen Youth Health Research Centre, Centre for Youth Mental Health, The University of Melbourne, Australia

SUMMARY

The gap between unmet need and access to care for mental ill-health is wider for adolescents and young people aged 12-25 years than any other age group worldwide. This age group is the peak time of onset for many mental disorders including mood, substance abuse and psychotic disorders. Effective interventions in primary or specialist care are likely to be most cost-effective at this age. Yet in most countries there are few opportunities for young people and their families to gain access to treatment and care for mental ill-health and preventive interventions. This is especially important for young people exposed to trauma and adversity. Few countries give sufficient attention to safeguarding and improving the mental health of young people and few have developed policies and programs to support this.

Policy and practice changes suitable for each country have two essential starting points: improved understanding of youth mental health within communities; and involving young people and their families in decisions that affect them. Using information technology to assist care is another desirable feature of modern service development suitable for any environment. New directions and models of care to respond to better awareness and help-seeking and new approaches to health promotion are being developed in several countries, and psychiatrists have a central role in supporting these developments.

Key words: *adolescents - mental health promotion - mental health services – prevention - substance abuse*

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INTRODUCTION

Young people aged between 12 and 25 years make up a quarter of the world's population, with most (90%) living in the low and middle income countries (WHO 2009). Improving mental health in young people requires each country to consider several types of changes. Accessible help for treatment and prevention of mental ill-health in this age group is needed (Moris et al. 2011), as well as mental health promotion through a range of public health actions in the health and non-health sectors.

There is a shift in the global public health agenda towards addressing the health concerns most prominent in this age group: mental ill-health, sexual and reproductive health, injury, obesity and chronic physical illness (Resnick et al. 2012). It has become apparent that the health of young people overall has improved far less than that of infants and children over the last 50 years. The health of today's young people determines the health and prosperity for future generations worldwide. Patterns of many health-related behaviours are initiated and become established in this age group. Sexual activity, physical activity, and use of tobacco, alcohol and other psychoactive substances are examples. These behavioural patterns are intimately linked to determinants of health throughout adulthood, influencing a range of health outcomes across the lifespan (Sawyer et al. 2012).

THE EPIDEMIOLOGY OF MENTAL ILLNESS

Mental ill-health is now the main health concern for young people across the world, contributing 45% of the overall burden of disease (Gore et al. 2011). Depression and alcohol use are prominent contributors to the burden in all regions. The incidence of mental illness in young people is well documented (Insel & Fenton 2005), and is the highest of any age group. The US National Comorbidity Survey Replication indicated that 75% of people with a lifetime psychiatric disorder have experienced its onset by 24 years of age. The onset of most of the adult forms of mental illness occurs in the age group 15-25 years, peaking in the early twenties (Kessler et al. 2005). Furthermore, the full lifetime risk for mental disorders approaches 50% (Kessler et al. 2007b, Kessler et al. 2005). Other evidence supports this estimate, including large prospective cohort studies such as the Great Smoky Mountain Study in the United States (Copeland et al. 2011), and a large cohort study in New Zealand (Gibb et al. 2010).

Good evidence now reveals that the pattern of the age of onset of mental and substance use disorders is virtually the mirror image of that seen in the chronic physical disorders (Kessler et al. 2007a). Mental disorders can be considered to be the chronic diseases of the young (Insel & Fenton 2005). Mental disorders are often multiple, and often co-occur with health and social problems as well. Suicide, harmful use of alcohol and drugs, unsafe sex, reckless driving, offending and mental illnesses are frequent co-occurrences. The timing of the onset of ill-health during the developmentally critical adolescent and early adulthood years adds to the likelihood of adverse impact on the young person and the society in which he or she lives. These realisations spur policy and planning for primary prevention, the prevention of secondary disorders, and early intervention, with strategies for timely and cost-effective actions (McGorry et al. 2011).

MENTAL ILL-HEALTH AND THE LIVES AND DEVELOPMENT OF YOUNG PEOPLE

There are complex biological and social reasons for the vulnerability of young people to mental illness and its adverse consequences. The physiological activation of the HPA and HPG hormonal axes and the oxytocin system has a significant influence on behaviour and emotional functioning (Patton & Viner 2007). The resulting changes in affect and the increased capacity for abstract thinking that occurs during early adolescence create a mismatch between physical and intellectual maturity and psychosocial maturity. This, together with the brain maturational processes that occur across this age period (Paus et al. 2008), creates a 'window of vulnerability' to the onset of mental illness. This vulnerability is further accentuated by the increasingly complex demands from the young person's social environment as he or she begins the process of transition to independent adulthood. Young people are defining their individuality and autonomy, which includes establishing and negotiating their own social networks, beginning sexual relationships, completing their education and moving into employment (Arnett 2004). Successfully negotiating these developmental challenges is crucial for a productive adult life; and thus for the health and economic well being of each society (World Bank Development Report 2007).

As health improves worldwide, children reach puberty at an earlier age. At the same time, rapid changes in social, economic and technological environments in many societies tend to delay the entry of young people into mature social roles. They may be marrying later or needing to stay longer in education or training. Others experience attachment disruptions due to family disruptions and dysfunction; and the mental health of a significant proportion of children and young people is significantly compromised by neglect, maltreatment and other adversities (Read & Bentall 2012). The growth of the internet, social media and telecommunications has profoundly altered life for adolescents in most countries. For example, it reduces the influence that families and communities have traditionally maintained over young peoples' lives and their entry into adulthood. Young people are making the transition to independent adulthood in increasingly complex, and often conflicting, social environments (Sawyer et al. 2012).

Mental illness, even when brief and relatively mild, can disrupt this developmental trajectory and limit a young person's potential. Mental ill-health in young people is all too often associated with ongoing disability, with impaired social functioning, poor educational achievement, unemployment (and under-employment), substance abuse, violence and victimisation, and unhealthy lifestyles and risk of ill health, leading to a cycle of dysfunction and disadvantage that can be difficult to break (McGorry 2007). In a large and rigorous cohort study, Gibb and colleagues (Gibb et al. 2010) have shown that 50% of young New Zealanders had experienced a diagnosable mental disorder between the ages of 18–25 years, and that these disorders had a significant impact on young people's economic and social outcomes at age 30.

The World Health Organization has estimated that the peak age for the maximum negative social and economic impact of a disabling illness is 22 years (Murray & Lopez 1996). Mental illness, precisely because its onset peaks in emerging adulthood and has subsequent impact on the most productive years of life, has recently been calculated to pose the greatest threat to the GDP of all nations over the next 20 years, equal only to cardiovascular disease among the non-communicable diseases (Bloom et al. 2011).

IMPROVING MENTAL HEALTH IN YOUNG PEOPLE

Improving mental health in young people requires two types of actions in parallel. To reduce the burden of mental disorders, lessen the associated suffering and improve productivity across the adult years, requires the development of accessible, stigma-free, and effective systems of care for children and young people worldwide (McGorry 2007, Patton et al. 2007). As is the situation with physical illness, where in most places access to care, early diagnosis and appropriate treatment are considered crucial, greater emphasis on prevention and early intervention is especially important. Early intervention, targeting the initial clinical stages of emerging disorders in stigma free settings, offers a valid and achievable starting point.

The second set of actions has a focus on mental health in health promotion. The Ottawa Charter (WHO 1986) outlines five platforms of action for health promotion, which are equally applicable to physical and mental health. These are: (i) public policy, (ii) supportive environments, (iii) community action, (iv) personal skills, and (v) the reorientation of health services. In terms of mental health promotion, a spectrum of approaches is needed, from the promotion of good mental health and prevention of mental illness through to treatment approaches and service provision for those who do develop a mental illness.

REORIENTING HEALTH CARE SYSTEMS: JUSTIFYING A SPECIFIC FOCUS ON YOUTH MENTAL HEALTH

Young people are reluctant to seek help from mainstream health services. As they are usually in good physical health, they rarely need to visit primary care and other health practitioners, even in places where these are available to them. When they do, they find it difficult to mention emotional concerns (Rickwood et al. 2007). At the service level, problems with accessibility, culture, confidentiality and cost, as well as the

organisation of the services available, are critical barriers to engaging young people (Tylee et al. 2007).

To improve access, a new approach to youth mental health is required. Specific mental health services for young people are appropriate for two main reasons: first, because young people who develop mental ill-health tend to have varying and clinically uncertain illness trajectories. In the early stages of a mental illness they tend to present with blends of co-morbidities of variable intensity, particularly substance abuse and challenging personality traits and coping responses, which require an integrated model of care. Trust and engagement are critical issues which mainstream health care typically fails to address. In Australia, only 13% of young men and 31% of young women with a diagnosable mental disorder in the previous year had sought help from a health service for these problems (Sawyer et al. 2000). Thus, services that specifically acknowledge the complex and evolving pattern of morbidity and symptom fluctuation seen in this age group are needed. Second, developmentally and culturally appropriate approaches are essential for the management of emerging disorders; young peoples' individual and group identity and their help-seeking needs and behaviours need to be central to any service model. The available evidence shows that youth-specific services should be provided in an accessible, community-based, non-judgmental and non-stigmatising setting, where young people feel comfortable, have a say in how their care is provided, and can feel a sense of trust (McGorry 2007, McGorry 2009).

Different service levels that cover the entire spectrum of need among young people are required: from services that can benefit the entire community, through to primary care services for those with mild-to-moderate mental ill-health, then specialised services for those with complex presentations or more severe illness (Purcell et al. 2011). These include:

- Services that improve community capacity to deal with mental health difficulties in young people by providing education, mental health first aid training, e-health, and self-care initiatives;
- Primary care services, provided by front-line service providers such as general practitioners, teachers, school counsellors, community health workers, and other youth workers;
- Enhanced primary care services provided by general practitioners working with co-located specialist mental health service providers in a multi-disciplinary service centre;
- Specialist youth-specific mental health services providing comprehensive assessment, treatment, and social and vocational recovery services.

Designing culturally and socially appropriate systems of care is crucial, and contextual differences will determine the model to be adopted. Each service level in this model can be adapted to fit the local context after careful consideration of local needs and available resources. Over the last few years this reform in the delivery of youth mental health services has been gaining ground in Australia, Ireland and the UK (Illback & Bates 2011, McGorry 2009, McGorry et al. 2007, Purcell et al. 2011), and several successful programmes have been established in low and middle income countries (McIntyre 2002). Early indications suggest that these new service models are well accepted by young people, and that they improve access to mental health care.

YOUTH-SPECIFIC MENTAL HEALTH SERVICES TO INCREASE ACCESS AND ENHANCE ENGAGEMENT

As an example of innovation and service reform, recent developments in Australia have led to the construction of a series of policy frameworks and new programmes. headspace, the National Youth Mental Health Foundation, was established in 2006, to promote and support early intervention for young people with mental health problems (McGorry et al. 2007). A major part of the headspace mandate is to establish youth-friendly, highly accessible centres that target young people's core health needs by providing a multi-disciplinary enhanced primary care structure with close links to locally available specialist services and community organisations. Currently, there are 40 headspace centres across Australia, with a further 50 centres due to commence services throughout 2013–15. Each centre aims to promote and support early intervention for mental and substance use disorders through a 'one-stop shop' with four core service streams: mental health; drug and alcohol services; primary care (general health); and vocational/educational assistance. Each centre is led by a key agency on behalf of a local consortium of organisations who take responsibility for the coordination and delivery of the four core streams with linkage to other elements of care. This approach is designed to provide a central platform and trusted and secure base which also facilitates cooperation between existing local services that are already working well within the region. As well as providing clinical services within the core service streams, each centre also delivers local community awareness campaigns to encourage young people to seek help, to enhance the capacity of families and local service providers to identify emerging mental health concerns, to build capacity to contain and respond to simpler and transient issues, and to strengthen referral pathways into the service. Each centre also provides education and training programmes in order to strengthen local mental health, primary care and other workers' understanding and use of evidence-based approaches in mental health care for young people. Headspace also operates school-based programmes and rapidly expanding internet-based interventions through e-headspace.

A similar initiative, Headstrong, has been established in Ireland, and currently has five centres operating with a further five to ten sites under development. High rates of suicide and self-harm have created a sense of alarm and deep concern about the mental health and well-being of young people in Ireland. Headstrong, the National Centre for Youth Mental Health was founded through the One Foundation as an autonomous Irish charitable organisation with the intent of promoting change through a public–private partnership (llback & Bates 2011). Despite difficult economic times it is now attracting increasing support from the Irish government.

Programmes like headspace and Headstrong address early intervention, particularly for the high prevalence mental health problems, but a 'back-up' specialist system is necessary for young people with complex presentations or more severe conditions, who typically require intensive, specialised treatment and a longer tenure of care. Orygen Youth Health (OYH), established in 2002, is Australia's largest youth-specific mental health organisation and comprises an integrated research and clinical programme (Purcell et al. 2011) focussing on early intervention for psychosis (McGorry et al. 2008), mood disorders and borderline personality disorder in young people. OYH provides both acute and intensive care, as well as specialised streams of continuing care in the community, with client services designed to be comprehensive, flexible and responsive to the phase and severity of illness. The interventions include case management, individual support and therapy, and consultation-liaison with general health care and other agencies. The psychosocial recovery program supports the young person's recovery and return to optimal functioning as soon as possible. OYH also has a 16-bed youth-specific inpatient unit which focuses on acute care, emphasising brief admission in order to prepare the young person for community support. The Australian government has funded the main building block of this specialist system through a plan to create 16 Early Psychosis Youth Centres nationally by 2015 to comprehensively treat early psychosis in young people. It is hoped that these centres will ultimately evolve into fully-fledged OYH-style cross-diagnostic specialist youth mental health services.

Recent initiatives such as headspace, Headstrong and OYH provide examples of how to address the need for reform in mental health service provision for young people. These changes need advocacy and policy work for which psychiatrists and other practitioners, ideally in partnership with service users and family carers, can offer strong support (Wallcraft et al. 2011). Specialist practitioners have a key role in training and supporting primary care and community care workers to assist the integration of mental health care into routine primary health care in all settings. This is particularly necessary where there is no specialised structure available for young people at greatest risk, as is the case in 90% of the world (Patel et al. 2007).

PROMOTING THE MENTAL HEALTH OF YOUNG PEOPLE

Evidence now exists to support the local adaptation and evaluation of a range of policy and practice interventions to promote mental health in young people (Herrman et al. 2005, Barry & Jenkins 2007, Friedli 2009). The DataPrev project financed by the European Commission summarises the evidence available about effective interventions for promoting positive mental health in young people as well as other age groups: through parenting, at schools, at work, and in older age (Jane-Llopis et al. 2011). The results show that psychosocial interventions overall are promising in the promotion of mental health. There are several examples of effective interventions in each of these areas that range from simple low cost practices to more complex interventions requiring significant investment and planning. Much of the work is done outside the health sector. Psychiatrists and other mental health practitioners have important roles as advocates and advisers to introducing the policies and programs (Saxena et al. 2006)

Parenting is identified as the single most important factor contributing to a healthy start in life and hence to mental health and wellbeing, and health and function throughout life. The evidence suggests that simple parenting support could improve mental health in childhood and adulthood for the general population. At the same time, more complex interventions could assist the significant proportion of children whose mental health is compromised by neglect, maltreatment and other adversities. Poor mental health in childhood increases the likelihood as a young adult of low educational achievement, reduced productivity, criminality, and violence, as well as adult mental disorder, unhealthy lifestyles, and risk of ill health (Jane-Llopis et al. 2011).

The school is now seen as a community resource to promote mental, emotional, and social well-being. Schools worldwide are engaging in a range of initiatives and policies related to mental health, many of which address mental health and non-communicable diseases. The characteristics of effective interventions include: focusing on positive mental health; balancing approaches that are universal and targeted to children with identified problems; starting early with the youngest children and continuing with older ones; operating for a lengthy period of time; and embedding work within a multimodal, whole-school approach that includes changes to school ethos, teacher education, liaison with parents, parenting education, community involvement, and coordinated work with outside agencies (Jane-Llopis et al. 2011).

Evidence exists for promoting mental health through other domains such as work, justice, urban and rural planning, and business. There are important needs for information and support for reproductive health in young people in many societies, especially where there is a tradition of limited conversation on these topics between the generation (Zulcic-Nakic et al. 2012). Actions are also needed for reduction in risky activities

in other domains such as unsafe driving with automobiles or motorcycles. A recent domain of activity is understanding and using the internet as a setting for promoting mental health among young people, as well as support for young people in trouble (Young & Well Cooperative Reseach Centre, Burns et al. 2007).

The published evidence on cost-effectiveness of a number of these interventions is growing, particularly from the UK (Friedli & Parsonage 2007, Knapp et al. 2011). Many interventions have a broad range of benefits within the public sector and more widely. These occur for example through better educational performance, improved employment and earnings, fewer unwanted pregnancies, fewer road traffic accidents and associated illness and disabilities, and reduced crime. In some cases the pay-offs are spread over many years. Overall the evidence can be assembled to provide encouragement and examples for non-health and health sectors to promote mental health for mutual benefit (Beddington et al. 2008).

Respect for and protection of all dimensions of rights (civil, cultural, economic, political, and social dimensions) is fundamental to promoting mental health. The close interaction between mental health and human rights is illustrated by the role of mental health and psychosocial support (MHPSS) programs in protecting human rights during an emergency. The MHPSS programs now commonly integrated in humanitarian assistance programs include many elements that are designed to promote the population's mental health or do so as a desirable side-effect (IASC 2007, Herrman 2012). They are designed to improve fairness, dignity and participation of the local population. For example, providing life skills and livelihoods support to women and girls may reduce their risk of having to use survival strategies such as prostitution with added risks of human rights violations.

Other social interventions outside the health sector that are relevant in humanitarian settings include: (re)starting schooling; organising child friendly spaces; family reunification programs; economic development initiatives and involving existing cultural and religious resources. Future research needs to examine more closely the extent to which these broad social interventions influence individual and communal recovery from traumatic stress reactions and prevent more sustained morbidity. Research is also needed to identify more accurately the personal, social, and cultural factors that encourage natural recovery from immediate stress reactions and those that predict chronicity and disability (Silove & Bryant 2006, Tol et al. 2011). This agenda requires good alignment between researchers and practitioners, attention to the perspectives of affected populations, and sensitivity to their situation.

CONCLUSIONS

Policy and practice changes suitable for each country have two essential starting points: improved understanding of youth mental health within communities; and involving young people and their families in decisions that affect them. Using information technology to assist care is another desirable feature of modern service development suitable for any environment. New directions and models of care are being developed in several countries, and psychiatrists have a central role in supporting these developments.

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Correspondence:
Professor Helen Herrman, MD, MBBS, BMedSc
Orygen Youth Health Research Centre, Centre for Youth Mental Health,
The University of Melbourne,
Locked Bag 10 (35 Poplar Road), Parkville, VIC 3052, Australia
E-mail: h.herrman@unimelb.edu.au