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Assessing the mental health of 16 – 17 year olds in Manchester

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Compulsory education in the United Kingdom ends at 16. This paper explores the challenges of attempting to find a representative sample of 16 – 17 year olds. The authors worked with Connexions, the careers advisory service and sent out a one stage postal questionnaire survey. Sixty young people returned questionnaires, information was also provided by parents and connexions workers. About 17% of young people identified that they needed professional help, as did a similar proportion of Connexions workers, while parents felt about 14% of adolescents needed professional help. Data from the Strengths and Difficulties Questionnaire identified that this sample had high levels of mental health needs.

Keywords: adolescent;mental health; needs assessment

1. Background

There is increasing awareness of the mental health needs of 16 - 17 year olds. Their voices can be heard in 'Pushed into the shadows' and inpatient provision now reflects their developmental needs and vulnerability. Furthermore, the needs of specific groups of adolescents; those Not in Education, Employment and Training, or young offenders from ethnic minority groups (Differences or Discrimination) have been highlighted. The Manchester Self harm Project concluded that as 'in previous reports, the group with the highest rate of self-harm was young women aged 15 to 19 years with a rate of 1211 per 100,000'.

A national survey (Singleton, 2000) found that 23% of 16 – 74 year olds had mental disorders. In 16 – 19 year olds, the prevalence was higher at 29% with 7% of 16 – 19 year olds having more than one disorder. The prevalence was highest in the Northwest, 29% compared to 23%. A survey of the mental health of young people in English local authority (Meltzer, 2003) found that 38.7% of 16 - 18 year olds had a disorder (37.8% for boys and 40% for girls). The National Service Framework for Children, Young People and Maternity Services emphasises the importance of understanding the local population. Manchester is a developing city; families have diverse cultures and resources. There are many first generation families and redevelopment has led to the recent redistribution of communities. The validity of the Strengths and Difficulties Questionnaire (SDQ) was established in 1999 (Goodman et al). The SDQ has been used in samples over the age of 16 (Meltzer, 2002).

2. Aims

To assess the prevalence of mental health problems in 16 – 18 year olds across Manchester.

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3. Method

Having obtained ethical approval, the full study examined children's centres, schools (nurseries, primary and secondary) 2 colleges and Connexions. Connexions is the national United Kingdom careers guidance service identifying all Year 9 pupils and monitoring school registers for newcomers. All 13 - 19 year olds can access support, and are tracked to ensure they are signposted to services if they need more support. Adolescents are classified according to the intensity of input that they need, and placed in one of three categories in the Connexions database. The database identified all 16 - 17 year olds in Manchester who contacted Connexions in the preceding 2 months, 100 adolescents from each category were chosen via a random number table. To maintain confidentiality, no identifiable data was obtained, and an opt-out consent method was used. Young people were allocated a unique identification number, the only means of identification taken out connexions.

Chosen adolescents received a letter from Connexions explaining the study and asking consent for parental and Connexions worker participation. Adolescents could opt-out via a tear-off slip, if they did not opt-out, they received the SDQ and a needs assessment questionnaire for themselves and parents or carers. Two pre-addressed envelopes were included for young people and parents to return the questionnaires independently. Connexions personal advisors (PAs) received information about the study, Teacher SDQs and a needs assessment questionnaire. Young people who did not opt-out but had not returned the questionnaire were sent a second question pack and offered assistance by their Connexions worker if they had any planned contact. PAs who had not returned the Questionnaire were sent a second then third copy and prompted to complete it. Guidance on scoring the SDQ can be found on the website. Adding together the first 4 subcategories provides an indicator of mental health need. Additionally the impact question, asks teachers to assess the impact of young people's mental health needs once again using the categories of normal, borderline and abnormal.

4. Results

From the 2001 Census Report, the projected number of 16 and 17 year olds in Manchester in 2006 was 10834. The Connexions database identified adolescents who had completed compulsory education (n=8600 or 79.1%). Of these, 15.8% (n=1357) received intensive support, 27.3% (n=2348) medium level support and 57.0% (n=4895) minimal support. Additionally, 70.9% (n=6096) were in full time education, 9.5% (n=816) in employment and 4.1% (n=350) in government supported training. A further 10.5% (n=906) were not in training or education but available and 2.7% (n=232) were not available for training or education (teenage parents, illness, young carers, custodial sentence). Of the 300 invited, 100 from each level of support, 28 opted out, 3 from minimum support, 13 from supported and 8 from intensive.

Questionnaires were sent to 276 adolescents, their parents and PAs. Sixty young person questionnaires and 59 parent questionnaires were returned (Table 1). PAs returned 231 questionnaires, 84 completed, 48 partly completed and 99 blank. Reasons given for not filling out the questionnaire were a lack of knowledge of the young person and ethical concerns.

Table 1: Completed questionnaires stratified by level of support

Responses	Adolescents	Parents	Personal Advisers
Minimum	28 (28.9%)	27 (27.8%)	30 (30.9%)
Supportive	14 (16.1%)	13 (14.9%)	28 (32.2%)
Intensive	18 (19.6%)	19 (20.7%)	26 (28.3%)
Total	60 (21.7%)	59 (21.4%)	84 (30.4%)

A full data set (young person, parent and PA) was available for 11 adolescents and 2 data sets were available for 43 (34 sets from young person and parent, 5 data sets for PA and parent and 4 sets for PA and young person). One data set was available on 84 young people. Finally, 203 completed questionnaires were available, providing information on 138 young people (50% of sample). A gap between the identification of the sample (April 2006) and

field work (June/July 2006) meant that a percentage of young people had reached their 18th birthday when they completed the questionnaire. Males are over-represented in the responder sample, more so than in the original sample.

Ethnicity data was available for over 90% of adolescents in all samples, composition was similar in the 3 groups and representative of the diversity of Manchester. Most young people were identified as 'white British', followed by a predominantly Pakistani south-east Asian ethnic minority and a black and African-Caribbean minority. Notably, 11.7% (7) of young people acknowledged drug misuse, and the same number reported drug use by family members, 73.3% (44) of adolescents denied drug use and 9 did not answer. Furthermore, 61.7% (37) reported no family drug use, 3.3% (2) did not know and 23.3% (14) did not answer. Advisors reported that 1 young person, 2 family members and 1 family and adolescent were using drugs. In 54% (46) of cases PAs thought there was no substance use and in 40.5% (34) they did not know or answer.

Notably, 43.3% (26) young people reported living with both parents, 28.3% (17) with their mothers and 15.0% (9) with 1 parent and a new partner. One young person (1.7%) reported living with a foster carer and 4 reported other living arrangements (step parent, grandparent, boyfriend and moving back and forth between two parents) 5% (3) did not answer. PAs identified that 31% (26) of adolescents were living with both parents, 14.3% (12) with one parent, 2 young people (2.4%) with a parent and new partner, 2 lived alone, 3 with another relative (2 with sister and one with grandmother), 1in a hostel, 1 homeless and in 1 care leaver accommodation. In 34.5% (29) of cases the advisor did not know who the adolescent was living with, and in 8.4% (7) the information was missing.

4.1. Results from the young people questionnaire

Sixty young people returned questionnaires, representing 20% of the sample, 65.0% (39) scored in the normal range on the summative score of the four subdivisions of hyperkinesis, conduct disorders, peer problems, and emotional problems, 15.0% (9) in the borderline range and 20.0% (12) in the abnormal range (Table 2).

Table 2: Mental health needs in 16-18 year olds as scored by young people

	Normal	Borderline	Abnormal	Total
Male	41.7% (25)	10% (6)	8.3% (5)	60% (36)
Female	20.0% (12)	5% (3)	8.3% (5)	33.3% (20)
Unknown	3.3% (2)	0	3.3% (2)	6.7% (4)
Total	65.0% (39)	15.0% (9)	20.0% (12)	100% (60)

Of the 60 young people in the sample, 20.0% (12) perceived themselves as hyperactive, 21.7% (13) had conduct problems, 6.7% (4) had peer problems and 16.7% (10) emotional problems. Summative scores provide information regarding behavioural symptoms, impact scores provide an insight into the impairment caused by these symptoms. Fifty eight percent of (35) adolescents scored normally, 6.7% (4) received borderline scores and 45% (27) of the young people received normal scores on the SDQ and impact criteria. Fifteen percent (9) of young people received an abnormal score on both the SDQ and the impact criteria.

In 21.7% (13) of cases adolescents reported that they had received professional help, while 73% (44) had not, and 5% (3) did not answer this question. Furthermore, 16.7% (10) of young people believed that their difficulties required professional help, while 50% (30) of the young people did not believe this. A further 20% (12) did not know, and in 13.3% (8) this question had not been answered. Young people were asked to identify the type of help that they needed. Child and Adolescent Psychiatry was identified most frequently, followed by educational psychology and General Practitioners. The young people were also asked to identify the types of help that would address their difficulties. Medication was identified most commonly followed by Behaviour Management Advice.

4.2. Results from the parent questionnaire

The parents of 59 young people returned questionnaires (Table 3), 13.6% (8) were perceived to be hyperactive, 18.6% (11) had conduct problems, 20.3% (12) had peer problems and 22.0% (13) had emotional problems.

Table 3: Mental health needs in 16-18 year as scored by parents

	Normal	Borderline	Abnormal	Total
Male	35.5% (21)	6.8% (4)	10.2% (6)	52.5% (31)
Female	22.0% (13)	6.8% (4)	5.1% (3)	33.9% (20)
Unknown	5.1% (3)	3.4% (2)	5.1% (3)	13.6% (8)
Total	**62.7% (37)**	**16.9% (10)**	**20.3% (12)**	**100% (59)**

Looking at the information from parents, it can be seen that 69.5% (41) young people scored normally, consisting of 22 males and 15 females. In four young people the gender was not known. Only 1.7% (1) of the young people received a borderline score, he was male. Finally 25.4 % (15) of young people were identified as falling in the abnormal range, consisting of 6 males, 5 females and one young person of unknown gender. Additionally, 54.2% (32) of young people received normal scores on both the SDQ and the Impact criteria while 15.3% (9) received an abnormal score on both the SDQ and the impact criteria.

In 25.4% (15) cases, parents reported that adolescents had received professional help, while 64.4% (38) of parents said they had not and 10.2% (6) of parents did not answer. Furthermore, 13.6% (8) of parents believed their child's difficulties required professional help, while 55.9% (33) of parents did not believe this and 13.6% (8) of parents did not know whether their child's difficulties required professional help. In 16.9% (10) this question had not been answered. Parents were then asked to identify the type of help that they felt their child needed. Input from the Behavioural Support Team was identified the most frequently, followed by educational psychologist and GP. Support from teachers, child clinical psychologist, voluntary services and Youth Access Team were the third most common choice. Parents were also asked to identify the types of help that would address the child's difficulties, the most common choice was behaviour management advice. Other types of help that were requested were medication, diet advice and educational support. One parent identified 'all options available'.

4.3. Results from the Personal Advisors questionnaires

Eighty-four Personal Advisors returned a fully completed questionnaire representing 28% of the sample (Table 4). Furthermore, 66% (n=55) scored in the normal range on the summative score, 17% (n=14) scored in the borderline range and 18% (n=15) scored in the abnormal range. Furthermore, 13 (15.5%) where perceived by the Personal Advisor as having emotional problems, 9 (10.7%) as having conduct problems, 6 (7.1%) as hyperactive and 11 (13.1%) as having peer problems.

Table 4: Mental Health needs of 16 and 17 year olds as scored by the Personal Advisors

	normal	borderline	abnormal	total
Male	27 (32.2%)	5 (6.0%)	9 (10.7%)	41 (48.8%)
Female	25 (28.6%)	9 (10.7%)	6 (7.1%)	40 (47.6%)
Unknown	3 (3.6%)	0	0	3 (3.6%)
Total	55 (65.5%)	14 (16.7%)	15 (17.9%)	84 (100%)

Looking at the impact information provided by the Personal Advisors 64 (76.2%) young people scored normally, 17 (20.2%) had a score in the borderline range and 3 (3.6%) had an abnormal score. In 13.1% (11) of cases it was reported that they had received professional help. No help was received in 38.1% (32) of the cases. 46.4% (39) of advisors did not know and in 2.3% (2) the question was not answered. Sixteen (19.0%) young people were considered to be in need of help and 39 (46.4%) as not requiring professional help. In 20 young people the advisor was not sure whether help was needed, and for 9 (10.7%) young people the information was missing.

Advisors were asked to identify the type of help they felt the young person required. Child & Adolescent Psychiatrists were named most often, followed by help from Behavioural Support and teachers. When asked what type of help they felt was needed. Behaviour Management was identified most commonly, followed by confidence building, motivation and emotional support.

5. Conclusions

If the borderline and abnormal scores are viewed together as a crude indicator of unmet need, the combined percentages from the young people and also the parent data can be seen to be slightly higher than the results from Singleton. However it is of note that Singleton examined 16 – 19 year olds. Although data from the connexions advisers placed slightly more young people in the 'normal' range, there is relative consistency across the three groups in this small study. Although return rates are low and may not be representative, the fact that 60 young people chose to complete the study may illustrate that they are keen to communicate their unmet need.

Roughly17% of young people felt that their difficulties required professional help; Child and Adolescent Psychiatry, Educational Psychology and general practitioners were listed most commonly as the person whose help was required. This may reflect the fact that before 2007 there was no specific 16 – 17 year old mental health team. Furthermore, many young people in Manchester start living away from parents and carers at the age of 16 and access to primary health care can become difficult to navigate. A surprisingly large number of young people felt they needed pharmacological treatment for their difficulties, followed by Behaviour Management. Based on parental responses, roughly 14% of young people needed professional help. The Behavioural Support Team, Educational Psychology and general practitioners were identified most often and the type of help requested was nearly exclusively behaviour management advice. Personal Advisers identified the highest proportion of young people as requiring help at 19%. The most commonly identified professionals were Psychiatry, Behavioural Support Teams and Teachers and the types of help requested behaviour management, confidence building and social skills training.

This data was fed back to the commissioners and Connexions staff and a dedicated service, the Emerge 16 – 17 Community Mental Health Team now works across the city accepting referrals from young people, connexions, education, youth justice and of course healthcare. Furthermore, this team offers training to connexions and other agencies working with older adolescents.

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