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Audit of family support of 16-17 year olds with mental health needs

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Abstract

Introduction
Mental health problems occur commonly and impact on quality of life. It is important to understand causal factors.
Aims
To understand parental support available for 16-17 year olds with mental health needs.
Method
An audit of all case notes open to an adolescent mental health team in June 2010
Results
Notably 59.1% adolescents had family support and 40.9% lacked support. More males had family support than females, but more females had parental support. Case note documentation of family involvement is variable.
Conclusion
Family support should be explored for each referral. Documentation of family involvement should to be improved.

Keywords: adolescent; parental support, mental health

1.1. Introduction

Mental health problems impact on quality of life, learning and ability to work, affecting society as a whole. Such disorders are common, with a prevalence of around 10% in the UK childhood population (Green et al 2004), difficulties often appear in adolescence (Steinberg 2001). There is a correlation between the mental health needs and family disruptions (DH 2004). Meltzer et al 2000 found that within healthy families, 7% of children had mental health disorders, yet within more unstable families, the prevalence was 18%.

The National Service Framework for Children, Young People and Maternity Services stipulates: "Child and adolescent mental health services are able to meet the needs of all young people including those aged sixteen and seventeen" (DH 2004). Emerge 16-17 Community Mental Health Team aims to provide such support. If familial discord is a risk factor for developing mental health needs, a deeper understanding of the correlation between parental support and adolescent mental health is paramount. Furthermore, 16-17 year olds are transitioning from childhood to adulthood and are of an age where parent-child discord is commonplace. To enhance the efficacy of

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interventions, there is a requirement to understand the relationship between parent support and mental health needs of adolescents.

1.2 Aim

To understand the family support and involvement available to 16-17 year olds with mental health needs.

1.3 Method

The audit was approved prior to commencement with the Trust Clinical Audit Department. All cases open to Emerge in June 2010 were analysed. Notes with insufficient information for the purpose of the audit were excluded. Data was collected regarding; gender, ethnicity, referrer, priority, presenting complaint and family support status. Family support status was determined from the notes by examining the patient's perception of the support shown by family and whether they supported young people to reach appointments or attended consultations. The audit also ascertained if patients had told their family they were using Emerge, other services involved, living situation and employment status. Data was entered into the Statistical Package for Social Science (SPSS).

1.4 Results

Of the 182 cases open to Emerge, 33 files had insufficient information to audit e.g. new referrals or non attendance. Thus, 149 files were analysed, 88 (59.1%) individuals had family support and 61 (40.9%) did not. Mothers most commonly supported young people, 48 (32.2%) were supported by their mothers, 23 (15.4%) were supported by both parents and 4 (2.7%) were supported by their fathers alone. More males 63.8%, had family support than females (55.0%). More females had a parent acting as their family support than males. Of those with a mother as family support, 25 (52.1%) were female and 23 (47.9%) were male. Of those with a father as their support, 3 were female compared with 1 male and where both parents acted as the family support, 12 (52.2%) were female and 11 (47.8%) were male.

Reassuringly, 113 (76%) young people allowed their family to know they used Emerge, 22 (15%) kept Emerge private, and in 14 (9%) cases this information was unknown. Overall, 84 (56.4%) young people were seen alone by Emerge and 64 (43.0%) were seen with a member of family, the information was unknown in 1 (0.7%) case. In total, 55 (36.9%) lived with both parents, 31 (20.8%) lived with mother only and 9 (6.0%) lived with father only. Of all the open cases, 69 (46.3%) were male and 80 (53.7%) were female.

Overall, 121 (81.2%) young people were White British, and 7 (4.7%) were Asian British. General Practitioners provided 70 (47.0%) referrals while only 3 (2%) referrals were made by parents, all for young females. Low mood was the commonest presenting complaint, affecting 60 (40.3%) individuals. Of these, 32 (53.3%) had family support and 28 (46.7%) did not. All cases presenting with sleep problems, bereavement or ADHD had family support. A presenting complaint of self harm was the only group in which there were fewer individuals [14 (53.8%)] with family support than those without [(12 (46.2%)].

Most cases, 75 (50.3%), were rated as concerning, needing to be seen within 4 weeks. There were 63 (42.3%) individuals considered to be routine in priority. More urgent referrals were not as common, with 10 (6.7%) considered urgent and 1 (0.7%) emergency. In 77 (51.7%) cases, no other services were involved. Connexions, the careers advisory service, were the only other agency working with 14 (9.4%) cases and the voluntary sector 12 (8.1%) cases.

Of the individuals with family support, 34 (38.6%) were using other services and 54 (61.4%) were not. For individuals with no family support, other services were involved with 38 (62.3%) young people compared with 23 (37.7%). Most young people, 102 (68.5%) were at college, 1 (0.7%) was employed and 46 (30.9%) were not in employment education or training. Additionally, 13 (8.7%) young people had a child and 136 (91%) did not. Of the young people with a child, 6 (46.2%) had family support and 7 (53.8%) did not. Of the young people without children, 82 (60.3%) had family support and 54 (39.7%) did not.

1.5 Conclusion

No significant correlation between family support and the mental health needs of young people could be found. However a higher percentage of young males were found to have family support than females, which echoes Colarossi and Eccles 2003. It was also found that mothers most often provided support, followed by both parents. Colarossi and Eccles 2003 found that maternal support resulted in a decrease in depression in young people more than other social support. Power et al 2009 suggest that parental support decreases mental health problems and aids in treatment of mental health disorders. The largest number of referrals from any one sector was from general practice (GP), possibly because most people have a GP. However, most young people were noted to be at college while only a small percentage of referrals came from this sector. Possibly suggesting a lack of knowledge from schools is regarding mental health.

The only presenting complaint where there were more individuals with no family support was the “self harm” group. Among some of the common reasons for adolescent self harm is a feeling of loneliness or alienation (Laye-Gindhu and Schonert-Reichl 2005). The lack of family support amongst those presenting to Emerge with self harm may actively result in a presenting complaint of self harm. Green et al 2005 found that young people aged 11-16 were more likely to report self harm than their parents. However, the reporting rates were higher at 19% for parents of young people with emotional disorders. This could indicate that parents are less likely to be aware of self harm if it does not already correlate with a known mental health problem. The results of all the young people presenting to 16-17 CMHT with self harm having a lack of parental support may be due to a lack of realisation on the part of the parent.

As only the notes were examined, information is limited. A further limitation is the definition of family support. Studies show that factors such as parenting styles affect the child’s development (Dwairy 2007). This audit could not elicit whether the support provided by family members was ideal or adequate. Furthermore, the audit failed to determine whether family support was present before or after the young person developed mental health problems. It is therefore not possible to comment on whether a young person’s mental health is affected by family support, or whether the young person’s mental health stipulates how much family support is received. Finally, the sample size was small.

The audit suggests that Emerge should develop specific criteria to establish if family support is present. Clinicians could determine degree of family support and establish the potential benefit of the family support of the individual. A re-audit should complete the audit cycle and demonstrate enhanced documentation. Finally, further attention should be directed towards how parental support or lack thereof affects onset of mental health needs and the effects of increased parental support on prevention and management of mental health needs.

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