THE FOUNDATION FOR SCIENCE AND TECHNOLOGY

DEBATE SUMMARY

Health, happiness and well-being: supporting the transition from adolescence to adulthood

Held at The Royal Society of Edinburgh on 26th October, 2016.

The Foundation is grateful to The RSE Scotland Foundation and The Royal Society of Edinburgh for supporting this debate.

The hash tag for the debate is #fsthappiness .
Audio files of the speeches are on www.foundation.org.uk .

Chair: **The Earl of Selborne GBE FRS**
Chair, The Foundation for Science and Technology

Welcome: **Dame Jocelyn Bell Burnell DBE FRS PRSE FRAS FInstP**
President, The Royal Society of Edinburgh

Speakers: **Dr Joanne McLean**
Research and Development Manager, Scotland, Mental Health Foundation
Dr Helen Sweeting
Reader, MRC/CSO Social & Public Health Sciences Unit, University of Glasgow
Professor Lord Layard FBA
Director, Well-Being Programme, Centre for Economic Performance, London School of Economics and Political Science

Panellist: **Catherine Calderwood FRCP**
Chief Medical Officer, Scottish Government

As a result of growing concern about the problems of vulnerable young persons between the age of 10 and 24, the RSE Scotland Foundation with the blessing of the Royal Society of Edinburgh had commissioned two studies. First, a study on the effectiveness of population based interventions, led by Dr Joanne McLean[1], and secondly a study on the effectiveness of individual interventions, led by Dr Kathryn Skivington from the University of Glasgow[2]. Dr Helen Sweeting presented the results of the second study as Dr Skivington is on maternity leave.

DR McLEAN outlined the work she and her colleagues had done on the systematic review of population level intervention. Adolescence was a difficult transitional period, subject to multiple risks. Health and behaviour patterns established then lasted throughout adulthood. The study aimed to review the research evidence on the impact of population interventions which were intended to improve well-being and reduce inequalities; would identify what works, where there were gaps, and how research policy and public debate might be altered. We examined the existing data, selecting reviews relevant to the project. We asked young people to prioritize their needs meeting in groups. Amongst the highest needs identified were support from friends and relatives and from adults and teachers. We found that there were common features of successful intervention when they contained multi components such as joint local and national policy, media and family help, together with whole school approach, skill building, duration and intensity of the intervention, and the utilization of peer group pressure. While there might be ways of reducing inequality, the evidence was insufficient to deduce how universal intervention might reduce it. But there was limited evidence that mentoring those in care or "being looked after" improved well-being. Practical help is valuable for the homeless and there was some evidence that Cognitive Behavioural Therapy (CBT) helped individuals or groups, who have been sexually abused; there was limited evidence about successful interventions in teenage pregnancy programmes.

The implications of the study were that we need to give more policy attention to these vulnerable groups, and relate initiatives in specific areas, such as education and housing, to mental health

[1] www.mentalhealth.org.uk/sites/default/files/health-happiness-wellbeing-adolescents-transitioning-adulthood-final-report.pdf

[2] www.sphsu.mrc.ac.uk/op026-health-happiness-wellbeing.pdf

issues. We must look beyond the academic research on mental health and find wider sources of evidence.

DR SWEETING described the results of the research into individual intervention in vulnerable adolescent groups undertaken by the second study. Mental health disorders start in adolescence - only 27% of adolescents described themselves as very happy . Inequalities in mental health persist and should be a key factor for intervention. "Vulnerability" is associated with social factors, such as hardship, prejudice, abuse, limited opportunities and social exclusion. Vulnerabilities are often clustered. We sought to synthesize the relevant literature to inform future work, which would lead to intervention based on evidence, while also revealing gaps. We looked at systemic reviews, RCTs (Randomised Controlled Trials) and the grey literature, seeking to limit biased views. We identified, vulnerable populations, those social groups with mental health related problems and with inequalities such as those in care, offenders, those living in deprives areas, the unemployed or out of school, teenage parents, young carers, ethnic minorities, asylum seekers, those suffering sexual or violent abuse.

We used 32 systemic reviews, and 20 RCTs, among the relevant reviews. We concluded from this evidence that there were no effective interventions for the unemployed or out of school or young carers; not enough evidence for asylum seekers, domestic violence, and deprived areas. There was some evidence that intervention helped the homeless, those in care or looked after, those who suffered sexual abuse and teenage parents. There was very little evidence on mentoring. The homeless were helped through practical support and CBT, young offenders and those sexually abused were helped with CBT. There was insufficient evidence about teenage parents to know which interventions would be effective.

In short there is insufficient evidence for intervention except for the homeless and the use in some cases of CBT. So there is no clear intervention model. More research is needed, but it should be more widely based than the evidence base we used. It needs to consider the social context of vulnerability and to use material derived from studies related to the contexts which are relevant to mental health.

LORD LAYARD, quoting Thomas Jefferson and Angela Merkel, said that the aim of the study he and his colleagues were conducting into "Well-being and Public Policy" was to maximize aggregate (not, as with Bentham, individual) happiness of the people and to measure life satisfaction. This measurement must be an individual's own evaluation.

Statistics on the probability of low adult life satisfaction showed that mental illness - not low income or poor education - was the most important factor. For 16 year olds it was poor emotional health, not academic or behavioural performance. 50% of mental illness manifested itself at 16. Poor primary and secondary education had the greater effect.

Key strategies must be both early treatment, and general prevention. Only 26% of those aged 5 to 16; and only 26% of 16 to 25 year olds with mental health problems were treated (compared with 75% of those with physical health problems). England now had a Programme for Improving Access to Physiological and Therapeutic Treatment for Children and Young Persons, which aimed to increase access to 33% by 2020 with National Institute for Health and Care Excellence (NICE) qualified treatments, and universal outputs measured. For adults the aim is to increase from 15% in 2015 to 25% in 2020. Digital treatment appears as effective as face-to-face treatment but with a quarter of the therapist's time.

Prevention needs to be tackled through schools, parents and work. Schools should have well-being as a goal as well as academic achievement. He outlined a life skills programme for 11 to 14 year olds. Every secondary school should have a trained specialist who could also act as a mentor for attainment in life skills. Parents should be offered universal courses at child birth on emotional aspects of child rearing and the impact on their relationship. In work, apprenticeships were a key to successful transition from school to work.

We need a cultural change in society for real progress. Fortunately this is starting to happen, led by women. Attitudes towards alleviating misery where possible, are more widely held. The enemy is the fear of people enjoying themselves - the old bugbear of Puritan beliefs.

DR CALDERWOOD opened the discussion. She said the Scottish Government was taking the problems of vulnerable adolescents very seriously. There were 34 different policies in Scottish Government at the moment with specific targeting at adolescents and young people. In the new mental health strategy £50m has been allocated over a five year period to improving mental health provision with an emphasis on mental health support for young people. However, funds were limited and tough choices of where to allocate health treatment resources had to be made.

Participants were concerned that the research had concentrated solely on a segment of young people - those defined as vulnerable. But it was important to consider the whole cohort of young people and not only a segment in order to judge whether problems were specific to the segment or whether some of them were shared with the whole. For example, no young person was likely to admit to an adult that he or she was happy - adolescence for anyone was likely to be worrying - so is it alarming if someone describes themselves as very unhappy? Treatment must concentrate on

the worst cases, but prevention must relate to the whole cohort. How would those not in the "vulnerable" categories receive the preventative measures suggested? It was important to understand their possible reactions, which could undermine the whole preventative programme if they were hostile, or only indifferent. Presentation of preventative programmes was crucial. Effort should be put into trying to find out what 15 year olds thought about matters and how they would design programmes. Moreover, had enough been done to involve those in the vulnerable groups, who might be subject to intervention, to involve them in both the development and application of the strategy. The British Medical Journal would not now publish articles concerning patients, unless the patients had been actively involved in the write up of the research.

Although the RSE Scotland Foundation had spent two years setting up the programmes, and the two teams had done work of great value, it was clear that they had not found in their reviews sufficient evidence on which effective intervention programmes could be built. This undermined the intent to construct a three phase programme, leading from the review of the literature, to emergence of research, which could lead to effective intervention policies. It was clear that the research base was too limited in that it saw research on mental health as separate from studies on different areas, such as housing and education, which might affect mental health. In short, as Lord Layard put it, we should not look at mental health apart from its context. Indeed, the proper context should be the whole of society; how would these young people relate to the adult world, find employment and form stable relationships? It was not only adolescents who had to prepare for these tasks, but society itself which needed to be willing to adapt and link with the emerging groups. It was miss-leading to look at only individual issues and groups.

Funding will always be a problem where new measures are required. But there are ways of using cost free initiatives, if care is taken to associate them with other social measures or using existing resources and staff in new ways. Greater use should be made of the voluntary sector, which not only has more intimate knowledge of personal or local problems, but can also deal informally with vulnerable adolescents, who will be more likely to have more trust with them than with official sources.

The significant points arising from the discussion were:

1. Widen the evidence base by examining contextual reports and studies in education, housing, training, justice and elsewhere. Look there for material which will indicate why mental health is not viewed as important as the contextual issue, and how it can be prioritized. Use the voluntary sector and informal relationships more.

2. Look at the problem of mental health in vulnerable adolescents, first in the context of the whole society and how they might become a valuable part of it; second, in relation to adolescents as a whole class; and third, devote efforts to those worst affected because of their vulnerability.

3. It must be recognized that, even if more material was found which gave evidence of effective interventions, it would be some time before sufficient positive outcomes became available so that politicians would agree to spending resources. Cultural change, too, was always gradual.

Sir Geoffrey Chipperfield KCB

Open this document with Adobe Reader outside the browser and click on the URL to go to the sites below.

Reports:

Health, Happiness and Wellbeing in the Transition from Adolescence to Adulthood: A Systematic Overview of Population Level Interventions, 2016

Report Authors:
Dr Joanne McLean, Dr Pauline Campbell, Dr Anna Macintryre, Dr Joanne Williams, Claire Torrens, Professor Margaret Maxwell, Hannah Biggs, Dr Alex Pollock and Amy Woodhouse

www.mentalhealth.org.uk/sites/default/files/health-happiness-wellbeing-adolescents-transitioning-adulthood-final-report.pdf

MRC/CSO Social and Political Health Sciences Unit, University of Glasgow
Health, Happiness and Wellbeing for Adolescents Transitioning to Adulthood: A Systematic Review of Individual-Level Interventions for Adolescents from Vulnerable Groups, October 2016

Report Authors:
Vojt G, Thomson H, Campbell M, Fenton C, Sweeting H, McQueen J and Skivington K

www.sphsu.mrc.ac.uk/op026-health-happiness-wellbeing.pdf

See the next page for useful URLs.

Useful Links:
Barnardo's – web based assistance portal
www.upsideonline.co.uk

Economic and Social Research Council (ESRC)
www.esrc.ac.uk

London School of Economics and Political Science (LSE)
www.lse.ac.uk

Mental Health Foundation
www.mentalhealth.org.uk

Medical Research Council
www.mrc.ac.uk

MRC/CSO Social and Public Health Services Unit, University of Glasgow
www.sphsu.mrc.ac.uk

NHS Scotland
www.scot.nhs.uk

Royal Society of Edinburgh
www.royalsoced.org.uk

The RSE Scotland Foundation
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