June 2015

Health Inequality and Access to Justice: Young People, Mental Health and Legal Issues

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Young People's Health Partnership

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June 2015

Published by:
Youth Access
1 & 2 Taylors Yard
67 Alderbrook Road
London SW12 8AD
Telephone: 020 8772 9900
http://youthaccess.org.uk

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Abstract

This report presents findings from new analysis of English and Welsh Civil and Social Justice Panel Survey (CSJPS) data, of the relationship between mental illness and social disadvantage among young people, with a particular focus on the experience of those facing legal issues. Our findings indicate that while young people, in general, are least likely to experience mental illness those not in education, employment or training (NEETs) are far more likely to do so than other young people, and somewhat more likely than those aged 25 to 59. Our findings also indicate that the experience of social welfare related legal issues (and legal issues in the round) is associated with higher rates of mental illness. Importantly, we found that NEET's who experience legal issues are associated with particularly high rates of mental illness. 'Social isolation' (whether or not young people had an adult aged 25 or over in their household), when looked at in place of NEET status, was also found to be associated with mental illness. However, the likelihood of mental illness among isolated young people was similar to that of 25 to 59 year olds in general. Young isolated NEETs reporting legal issues had the highest incidence of mental illness, though numbers were small. On the basis of model simulation this group was predicted to have 45% mental illness prevalence, rising to 49% when social welfare law related issues were reported. Finally, analysis of change in mental health between waves of the CSJPS indicated that mental health deteriorates as new legal issues emerge. There were some indications that deterioration is particularly severe for disadvantaged young people, though the numbers of respondents was too small to draw conclusions with confidence.

Introduction

Health inequality in a justice context

Across Europe, tackling health inequalities has become "an overarching aim" of public health policy (Crombie et al 2005, p.4).[1] Informing the policy response in England, the report of the *Independent Inquiry into Inequalities in Health* observed that "the weight of scientific evidence supports a socioeconomic explanation of health inequalities." This led Sir Donald Acheson to emphasise, in the report's Preface that "it has become clear that the range of factors influencing inequalities in health extends far beyond the remit of the Department of Health and that a response by the Government as a whole will be needed to deal with them" (Acheson et al 1998). A whole-system approach was therefore embodied in the Department of Health's subsequent Programme for Action on tackling health inequalities (Department of Health 2003), which incorporated commitments from 12 government departments. These commitments included specific support for children and young people, including a commitment to bring about a 10% reduction in the number of 16-18 year olds not engaged in education, employment or training within 2 years. Stress on the need to support disadvantaged children and young people was also later echoed in the 2010 Marmot Review, which underscored that "inequalities in health arise because of inequalities in society" (Marmot et al 2010, p.16). Again, young people not in education, employment or training were singled out as a target for coordinated action. More recently still, the importance of coordinated young people's services was stressed in Public Health England's (2015) framework for improving young people's health and wellbeing. A specific whole-system approach has also been developed in relation to mental health, predicated on the notion that "mental health is everyone's business" (Department of Health 2011).

Alongside these developments in the health field, evidence in the legal field has increasingly suggested inequality of experience of legal issues.[2] For example, the 2001 English and Welsh Civil and Social Justice Survey (CSJS) exposed both heightened vulnerability to legal issues among disadvantaged groups (both in general and, particularly, in relation to social welfare issues such as housing, health, employment, debt and welfare benefits[3]) and processes through which legal issues bring about or worsen disadvantage, thereby contributing to its perpetuation (Pleasence et al 2004a).[4] Recognition of this led government to emphasise legal services outreach into disadvantaged communities, the role for legal services in reducing

[1] In England, the 2012 Health and Social Care Act introduced duties concerning the reduction of health inequalities on the Secretary of State, the National Health Service and clinical commissioning groups.

[2] For an overview of this evidence, see Pleasence, Balmer and Sandefur 2013. For ease of reference we use the term 'legal issues' to refer to 'justiciable issues' as defined by Genn (1999). She defined a justiciable issue as "a matter experienced by a respondent which raise[s] legal issues, whether or not it [is] recognised by the respondent as being 'legal' and whether or not any action taken …[involves] the use of any part of the civil justice system" (p.12).

[3] These include, for example, issues around provision of services by a landlord, housing disrepair, harassment by a landlord, eviction/repossession, homelessness, being sacked or made redundant, rights at work, being unable to pay debts, entitlement or level of assessment of welfare benefits.

[4] It has consequently been suggested that legal issues "may partly define the dynamics that create and perpetuate poverty" (Currie 2005, p. 2).

the risk of 'social exclusion'[5] and the importance of collaboration in addressing crosscutting concerns (e.g. Lord Chancellor's Department & Law Centres Federation 2001, Legal Services Commission 2005).

Research in both the health and legal fields has demonstrated widespread associations between the experience of legal issues and morbidity (e.g. Pleasence et al 2004b, Zuckerman et al 2008, Tobin Tyler et al 2011, Coumarelos et al 2013). Indeed, Zuckerman et al's (2008, p. 1616) commentary in *The Lancet* declared that "virtually all legal needs (ranging from housing issues to domestic violence) are directly or proximally connected to health status." And Lawton and Sandel (2014, p.30) have recently observed that "the world is full of examples in which health and law collide." While patterns of association between legal issues and morbidity are various and complex, it is clear that legal issues can both follow on from and bring about or worsen ill-health. For example, Tobin Tyler et al (2011, p.236) have pointed to a vicious circle of vulnerability involving health problems, inability/disruption to work, loss of income, non-payment of rent, eviction and homelessness (Figure 1).

In light of these associations, Parmet, Smith & Benedict (2012, p. 21) have argued that:

> *"Law is one of the most important social determinants of health. It helps establish the framework in which individuals and populations live, face disease and injury, and eventually die … Law is one factor that helps determine other social determinants."*

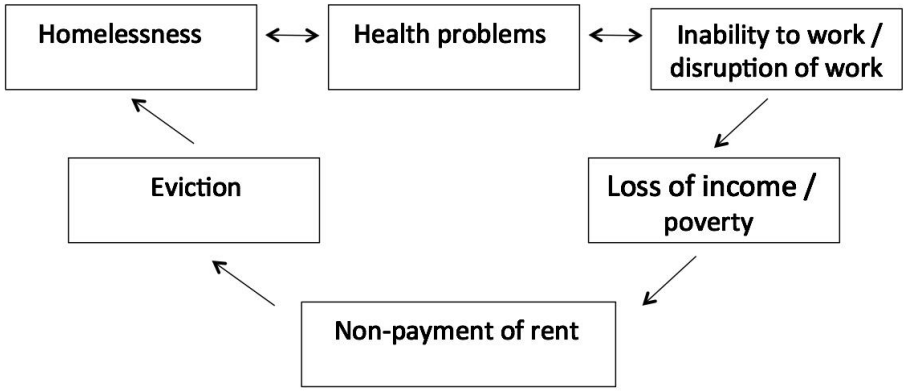

Figure 1. Example vicious cycle of legal issues and morbidity

[5] Social exclusion was defined by the Social Exclusion Unit in 2001 as the "shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown" (Social Exclusion Unit 2010, p.10). The concept and definition were contested, but the Social Exclusion Unit's definition provided a framework for much of government policy over the following decade. The argument that legal services can reduce the risk of social exclusion centred on their being able to "prevent people's problems escalating, becoming more numerous and complex" (Legal Services Commission 2005, p.37).

And, around the world, these associations – between "adverse social condition[s] with a legal remedy" (Lawton & Sandel, p.31) and morbidity – allied to repeated findings that "individuals often seek legal advice from non-legal sources and frequently from health professionals" (Gyorki 2014, p.16), have led to a proliferation of collaborations between legal and health services (e.g. Noone 2007, Pleasence et al 2008, Noble 2012, Coumarelos et al 2013, Gyorki 2014). In the United States, there are now more than 250 medical-legal partnerships (MLPs) in healthcare institutions,[6] including MLPs focused on the needs of children and young people (such as the very first MLP, which grew out of the Paediatric Department of Boston Medical Center) and on the needs of mental health patients (Zelhof & Fulton 2011). There are also movements to institute MLPs and other forms of legal-health collaboration in Australia (e.g. Noble 2012, Gyorki 2014, Pleasence et al 2014) and Canada (where, again, the first partnership was focused on the needs of children and young people),[7] building on the experience of pioneer collaborations, such as between West Heidelberg Community Legal Service and Banyule Community Health (Noone 2007).

In the United Kingdom, Citizens Advice has, as one of its charitable objectives, "the protection and preservation of health" (Citizens Advice 2014, p.3) and, in 2006, announced that it provided outreach information and advice services in more than 1000 health settings (Citizens Advice 2006). Collaboration has also been documented between Law Centres and other legal advice services and health services (e.g. Pleasence et al 2008, Low Commission 2014, Gyorki 2014), with funding coming from both the legal and health sectors. For example, the Low Commission report on advice and health detailed that until their abolition in 2013, many NHS primary care trusts (PCTs)[8] in England, and all Local Health Boards in Wales, "have commissioned advice agencies to provide advice in GP surgeries, as well as in hospital settings" (Low Commission 2014, p.1). However, as the Low Commission noted, against this, the replacement of PCTs with Clinical Commissioning Groups (CCGs) has represented a disruption to legal-health collaboration. As also have cuts to legal aid and public services more generally.

Young people, mental health and the experience of legal issues

Using data from England and Wales, New Zealand and Australia, Pleasence and Balmer (2009), Balmer et al (2010) and Coumarelos et al (2013) identified particularly strong associations between legal issues and psychiatric morbidity. The implications of this are "particularly pronounced" (Pleasence & Balmer 2009, p.123). Mental ill-health represents around 23% of the total burden of ill-health in the United Kingdom (WHO 2008) and 2010 estimates put the cost of mental health problems in England at over £105 billion (Centre for Mental Health 2010). Common forms of mental illness may affect up to one in six people in the

[6] http://medical-legalpartnership.org. Accessed on 14 January 2015.
[7] The partnership between Sick Kids and Pro Bono Law Ontario, launched in 2009. http://www.sickkids.ca/AboutSickKids/Newsroom/Past-News/2009/Family_Legal_Health_Program%20. Accessed on 14 January 2015.
[8] Their function has now been taken on by and Clinical Commissioning Groups (CCGc).

United Kingdom at any given time (Singleton et al 2001) and such illness is enduring for many (Singleton & Lewis 2003).

While, in general, children and young people – along with older people – may experience lower rates of mental illness than others[9] (Mental Health Foundation 2004, Green et al 2005, Singleton et al 2001), and there has been less attention paid to the social determinants of health for children and young people as distinct from the general population (Hagell et al 2015), the association between legal issues and psychiatric morbidity is no less profound for this age group (Pleasence & Balmer 2009, Balmer et al 2010, Coumarelos et al 2013).[10] Indeed, in New Zealand, the association was found to be strongest for the youngest respondents (Pleasence & Balmer 2009), with 70% of people aged under 25 and with mental health problems reporting legal issues, compared to 28% of others aged under 25.[11]

Moreover, a study of the clients of youth advice agencies found that the young people surveyed exhibited very high rates of mental illness; much higher than any comparison cohort identified through CSJS data. Around two-thirds scored four or more on the GHQ-12, a commonly used cut-off to identify cases of mental illness.[12]

In this report

In this report we use data from both the 2010 and 2012 English and Welsh Civil and Social Justice Panel Survey (CSJPS) to explore the extent to which the experience of legal issues and disadvantage are determinants of mental health, with a specific focus on young people.

[9] Around one in ten children have a mental health problem at any given time, and one in five in any given year.
[10] In New Zealand the association was strongest for those aged under 25, in New Zealand those aged 25 to 34 and in Australia 35 to 44. However, for those experiencing both mental and physical ill-health/disability the association was strongest for those aged under 25 in Australia.
[11] In England, 65% of those aged under 25 and with a mental health problem (but no physical health problem) reported legal issues, compared to 65% for those with a physical health problem alone and 75% for those with both mental and physical health problems.
[12] GHQ-12 is a screening device for the detection of common mental illnesses in the community and non-psychiatric clinical settings (Goldberg & Williams 1991)

Investigating the experience of legal issues, disadvantage and mental health

Measuring mental health in the CSJPS

Both waves of the CSJPS employed the Mental Component Summary (MCS) of the SF-12 health survey (Ware et al 2007), commonly used in epidemiological research as a measure of health and functioning (Ware et al 1996).[13] The MCS-12 can be used to discriminate between the presence and severity of mental disorders (Ware et al 1996) and as a screening instrument for depression and anxiety in the general population (Gill et al 2007). Gill et al (2007) have calculated cut-off points for the MCS-12 to screen for common mental disorders or anxiety disorders (≤ 50) depression (≤ 45) and severe psychological symptomatology and/or impairment (≤ 36). For the majority of analyses reported in this report an MCS score of 45 or lower was used as indicating mental health problems. Overall, 18% of survey respondents had an MCS score of 45 or lower.[14]

Measuring disadvantage among young people

We used two simple measures of disadvantage among young people (aged 16 to 24) derived from CSJPS data. The first was a standard measure of disadvantage among young people,[15] whether or not young respondents were in education, employment or training (NEET). The second was whether or not they had an older adult (aged 25 or older) living in the household. We refer to this as 'social isolation' (or 'isolation'). This categorisation was used successfully in previous work exploring young people's experience of legal issues (Balmer et al 2007). Of the 484 young respondents to the CSJPS, 117 could be classified as NEET (24%), 109 as 'isolated' (23%) and 45 (9%) could be classified as both NEET and isolated.

Analysis[16]

First, we explored broad legal issue and social welfare related legal issue prevalence overall, for young survey respondents and for young disadvantaged survey respondents (using the definitions of disadvantage above). Second, we explored the relationship between legal issues and mental health (as highlighted above). Third, we fitted a series of statistical models to explore the relationship between age, disadvantage, legal issue experience and (binary) [17] mental health. Details of the models and comprehensive output are set out in the statistical appendix.[18] Finally, to exploit the longitudinal design of

[13] The MCS is calculated from the SF-12 using item weights derived using factor analysis (Ware et al., 1996; 1997).
[14] Models were also fitted using alternative cut-off values as well as absolute MCS score, with some of these presented for comparison later in the report. Findings and conclusions remained very similar regardless of the choice of cut-off or absolute MCS score.
[15] Its spread in use attributed to a report by the Social Exclusion Unit (1999).
[16] As analysis used data aggregated from waves 1 and 2 of the CSJPS, some findings may differ slightly from figures reported elsewhere (for example, civil justice problem prevalence).
[17] A binary measure of mental health was used (whether or not respondents reported and MCS score of 45 or less).
[18] We also repeated the statistical analysis using alternative MCS cut-off values and absolute MCS scores. Findings were comparable to those set out below, and some examples of the outputs of these models are presented in the statistical appendix for comparison.

the CSJPS, we examined change in MCS score, and the extent to which this was driven by the experience of legal issues. All statistical models were fitted using MLwiN.[19]

The experience of legal issues (among young people)

Overall, across the two waves of the CSJPS, 1,599 of 5,113 respondents (31%) reported legal issues and 1,011 of 5,113 (20%) social welfare related legal issues. For young respondents the figures were 194 of 601 (32%) and 131 of 601 (22%), respectively. However, the figures varied with age, even within the 16 to 24 age group. For example, only 24% of 16 to 19 year olds reported legal issues compared to 41% of 20 to 24 year olds (and 38% of 25 to 59 year olds). A comparable pattern could also be observed for social welfare related issues (13% of 16 to 19 year olds, 31% of 20 to 24 year olds and 27% of 25 to 59 year olds).

The percentage of disadvantaged young people reporting issues was substantially greater. For example, 52 of 177 (44%) 16 to 24 year olds NEETs reported legal issues and 42 of 117 (36%) social welfare related legal issues. Similarly, 58 of 109 (53%) isolated 16 to 24 year olds reported issues and 43 of 117 (39%) social welfare related issues. Percentages rose still further for the small number (45) of isolated young NEETs (56% any issue and 47% any social welfare issue). Disadvantaged young people were also more likely to report multiple issues.

Legal issues and mental health problems (MCS <= 45)

As with previous surveys, there was a strong and highly significant association between the experience of legal issues and mental health. Thus, while 495 of 3,350 (15%) respondents who reported no issues had mental health problems, the figures were 394 of 1,570 (25%) for respondents who reported issues. Looking only at social welfare law issues yielded a similar pattern, with 608 of 3,923 (16%) of those with no issues having mental health problems compared to 281 of 997 (28%) of those with issues. The number of issues reported was also associated with mental health. So, 21% per cent of those who reported one issue had mental health problems, rising to 28% of those reporting two issues and 34% of those reporting three.

Age, legal issues and mental health problems (MCS <= 45)

Before introducing disadvantage to the analysis, the likelihood of mental health problems was lowest for the youngest survey respondents (particularly those aged 16-19).

[19] MLwiN was used to correctly account for the hierarchical data structure in the CSJPS (with respondents not independent, but nested within households)(Rasbash et al 2009).

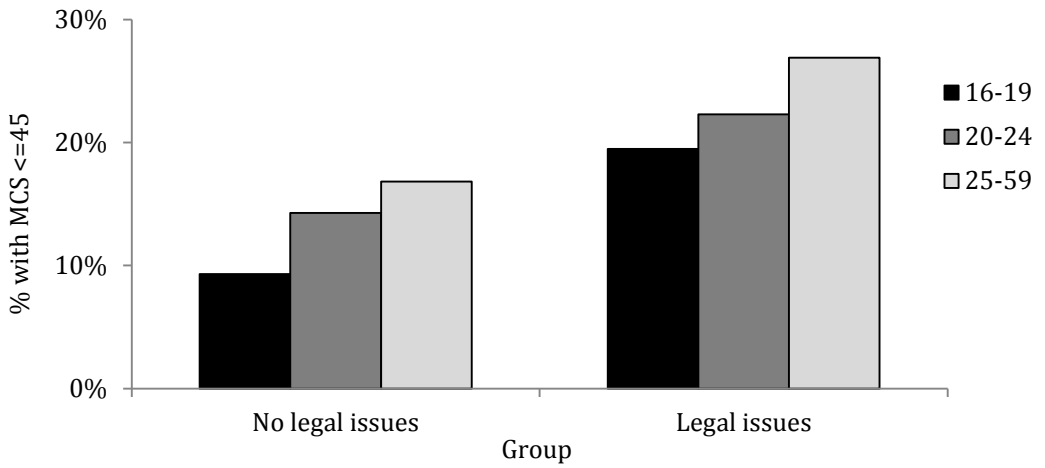

Figure 2 Percentage of respondents with an MCS score of 45 or less by age group and legal issue experience (simulated from regression analysis)

This is illustrated by Figure 2 (derived from the statistical output in Table A1 in the statistical appendix). Mental health was also strongly linked to legal issue experience, with those reporting issues having a far greater likelihood of mental health problems. The experience of a legal issue was associated with a somewhat higher increase in mental ill-health for the youngest respondents (compared to other groups), though overall the interaction was non-significant.

Figure 3 (derived from the statistical output in Table A2 in the statistical appendix) presents similar findings for social welfare law related issues. As can be seen, younger respondents were again the least likely to have mental health problems, and in the case of the youngest respondents, (most unusually) the likelihood of mental health problems did not appear to increase with the experience of legal issues.

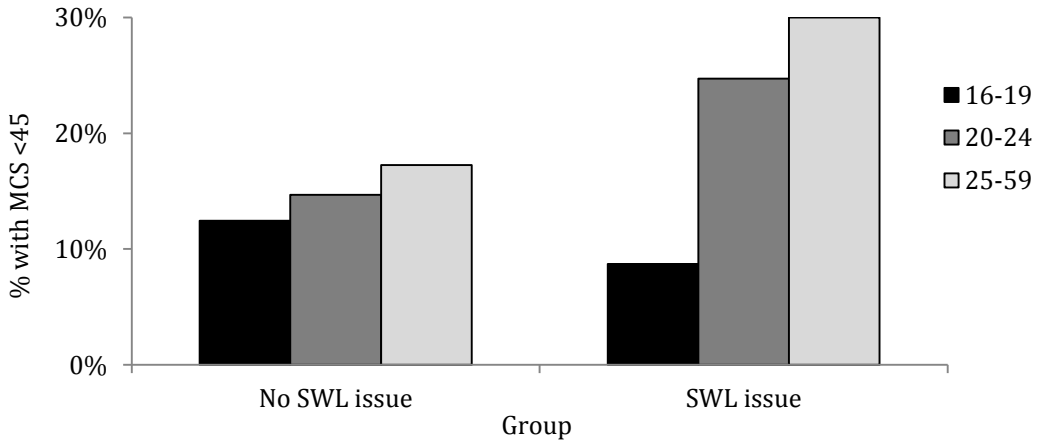

Figure 3. Percentage with an MCS score of 45 or less by age group and social Welfare related legal issue experience (simulated from regression analysis)

Disadvantage, age, legal issues and mental health problems (MCS <= 45)

Not in education, employment or training (NEET)

Figure 4 (derived from the statistical output in Table A3 in the statistical appendix) illustrates the modelled likelihood of mental health problems on the basis of age, legal issues and NEET status. As can be seen, whether or not young people were NEETs was strongly related to mental health. Young NEET respondents were more than twice as likely to have mental health problems, with the difference particularly stark for those also reporting legal issues. Indeed, they were also more likely than those aged 25 or older to have mental health problems, whether or not they reported legal issues.

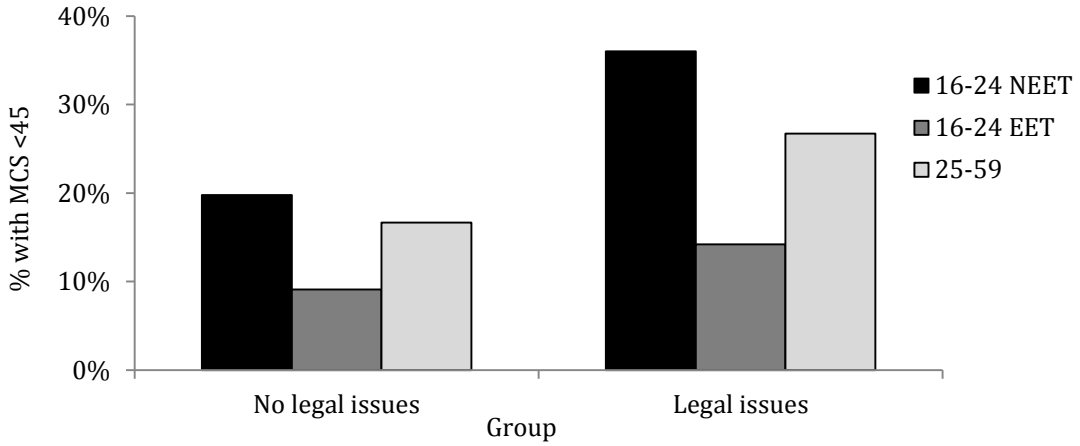

Figure 4. Percentage with an MCS score of 45 or less by age group/NEET status and legal issue experience (simulated from regression analysis)

Experience of legal issues was also related to a substantial increase in the likelihood of mental health problems for all three groups.

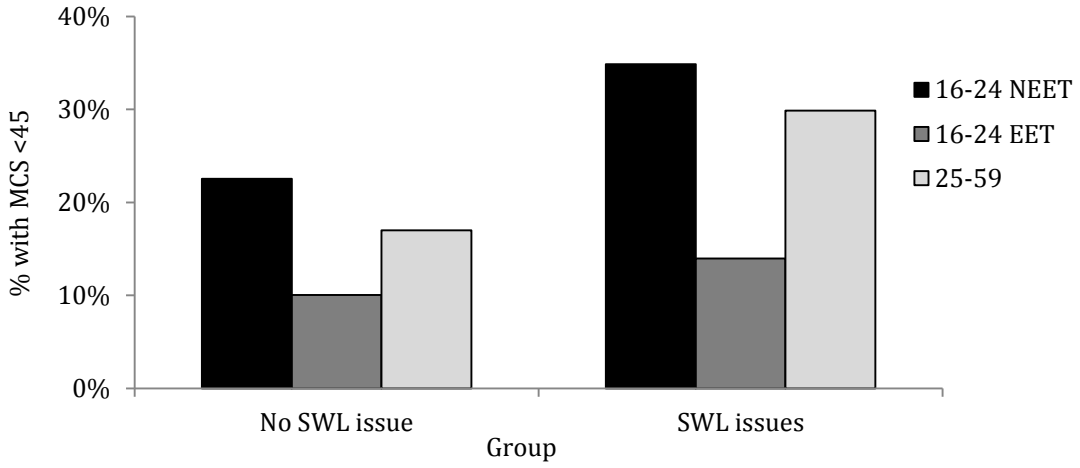

Figure 5 Percentage with an MCS score of 45 or less by age group/NEET status and social welfare related legal issue experience (simulated from regression analysis)

Figure 5 (derived from the statistical output in Table A4 in the statistical appendix) presents equivalent findings for social welfare law issues. A similar picture emerges, with problem experience relating to an increase in the likelihood of mental illness across all groups, and NEET status relating to a dramatic increase in the likelihood of mental health problems for young people.

Again, experience of legal issues was also related to a substantial increase in the likelihood of mental health problems for all three groups.

'Social isolation'

Figure 6 (derived from the statistical output in Table A5 in the statistical appendix) illustrates the likelihood of mental health problems on the basis of age, legal issues and 'social isolation' (whether or not young people had an adult aged 25 or over in their household). As can be seen, whether or not young people were isolated was strongly related to mental health. Young isolated respondents were significantly more likely to have mental health problems, irrespective of they reported legal issues. However, 'isolated' young people were associated with comparable rates of mental illness to 25 to 59 year olds (with or without problems).

As before, experience of legal issues was related to a significant increase in the likelihood of mental health problems across the board.

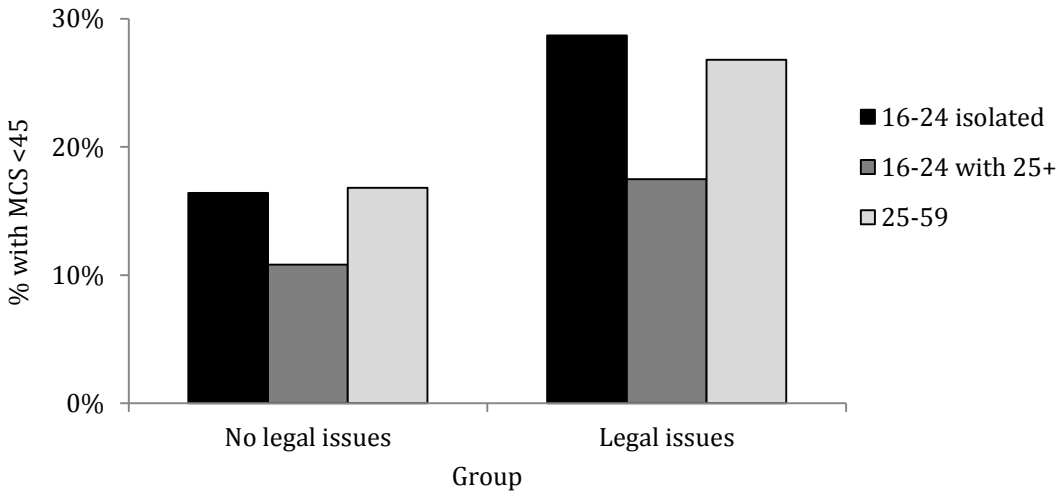

Figure 6. Percentage with an MCS score of 45 or less by age group/'isolation' and legal issue experience (simulated from regression analysis)

Figure 7 (derived from the statistical output in Table A6 in the statistical appendix) presents equivalent findings for social welfare law issues. A similar picture emerges, with problem experience relating to an increase in the likelihood of mental illness across all groups, and isolation relating to a significant increase

in the likelihood of mental health problems for young people. When adults were present in a young person's household the increase was more modest.

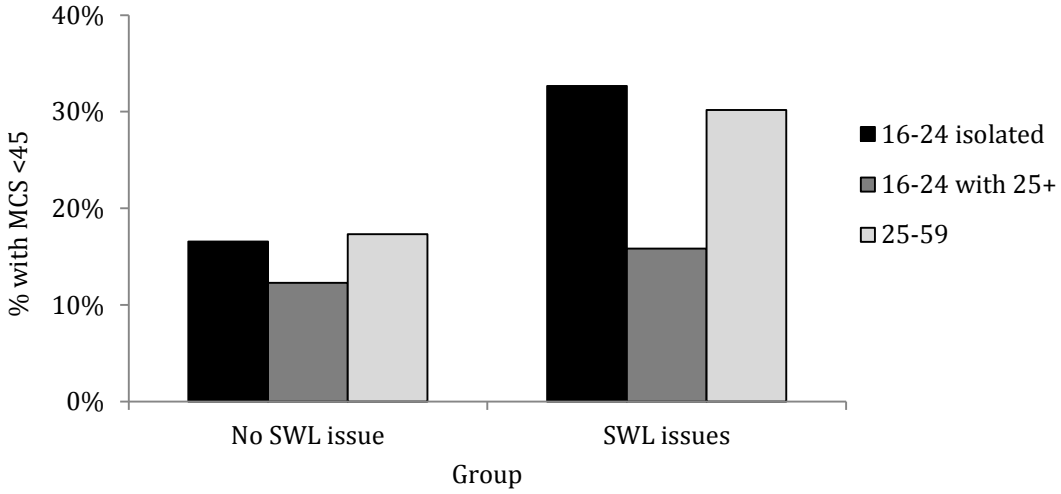

Figure 7. Percentage with an MCS score of 45 or less by age group/'isolation' and social welfare related legal issue experience (simulated from regression analysis)

Multiple disadvantage, age, legal issues and mental health (MCS <= 45)

Figure 8 (derived from the statistical output in Table A7 in the statistical appendix) illustrates the likelihood of mental health problems on the basis of age, legal issues, NEET status and 'social isolation'.

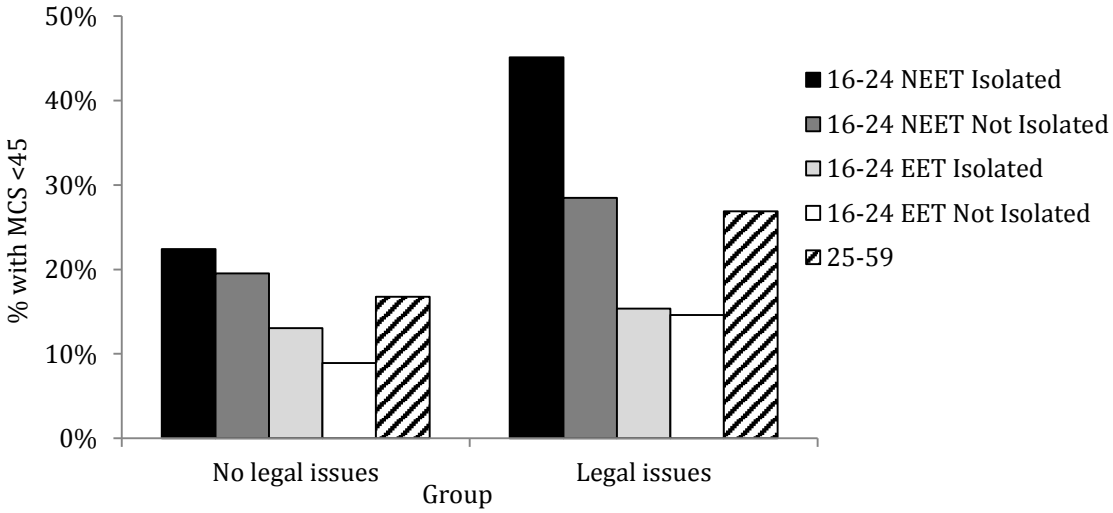

Figure 8. Percentage with an MCS score of 45 or less by age group/NEET status/'isolation' and legal issue experience (simulated from regression analysis)

Again, legal issue experience was strongly associated with mental illness, as was disadvantage. However, despite relatively small numbers in some age/disadvantage categories, mental health varied significantly with form of disadvantage. Those young people who were both in education, employment or training and lived with an older adult had the lowest likelihood of mental illness. Then came isolated, but non-NEET, young people. Then, substantially more likely to have mental health problems came non-isolated NEETs,

followed by isolated NEETs. For the last group, the increase in likelihood of mental illness associated with problem experience was particularly noticeable.

Figure 9 (derived from the statistical output in Table A8 in the statistical appendix) presents equivalent findings for social welfare law issues. A similar picture emerges, with problem experience relating to an increase in the likelihood of mental illness across all groups, and disadvantage – particularly being NEET – relating to a significant increase in the likelihood of mental health problems for young people. Again, the increase in the likelihood of mental illness associated with problem experience was particularly noticeable for isolated NEETs. This group was associated with 49% mental illness prevalence.

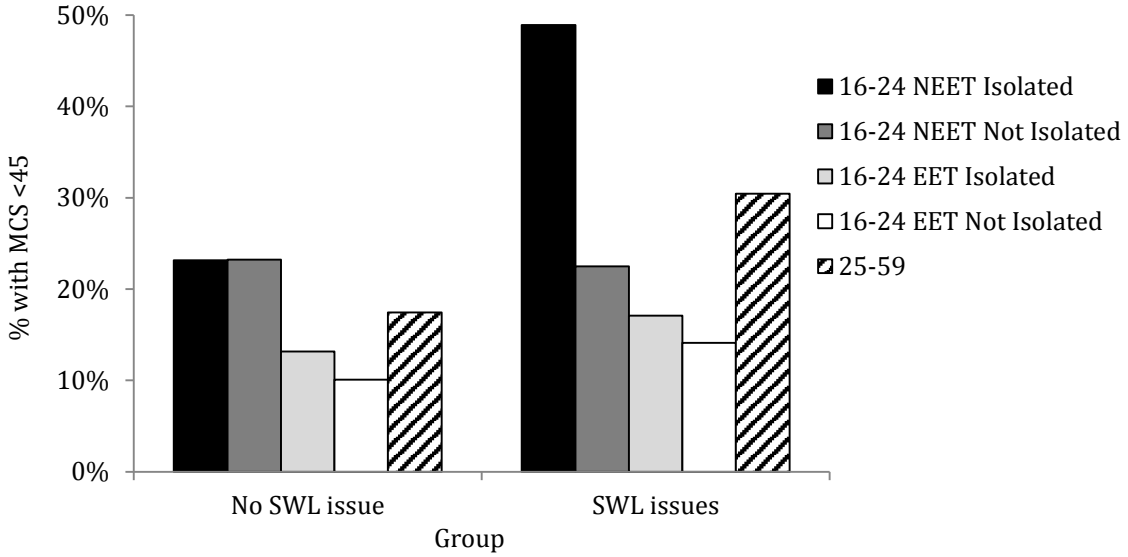

Figure 9. Percentage with an MCS score of 45 or less by age group/NEET status/ 'isolation' and social welfare legal issue experience (simulated from regression analysis)

Multiple disadvantage, age, multiple legal issues and mental health (MCS <= 45)

Figure 10 (derived from the statistical output in Table A9 in the statistical appendix) illustrates the likelihood of mental health problems on the basis of age, *multiple* legal issues, NEET status and 'social isolation'. The number of legal issues reported was a key predictor of mental illness, with the likelihood of an MCS score of 45 or less increasing significantly with number of problems. And again, while numbers were small in some age/disadvantage groups, especially once split by number of problems (for example, there were 45 NEET 'isolated' young people, 20 with no problems, 6 had one, 7 had two and 12 had three or more), there was some indication that mental illness was at its highest for young people facing multiple disadvantage and multiple problems.

Numbers were too small to repeat analysis for only social welfare related legal issues.

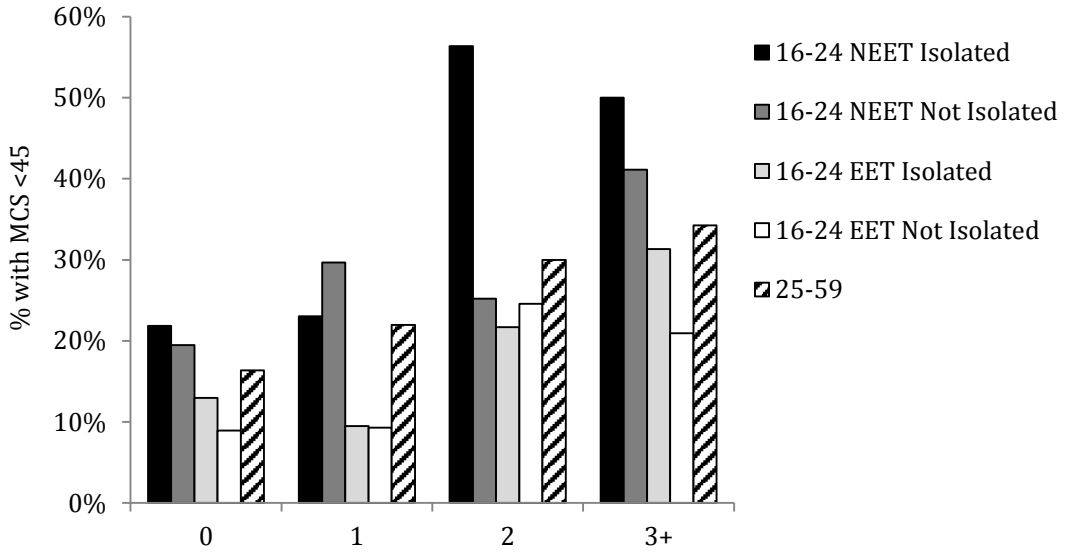

Figure 10. Percentage with an MCS score of 45 or less by age group/NEET status/'isolation' and number of civil justice problems (simulated from regression analysis)

Changes in (mental) health

The longitudinal panel design of the CSJPS allowed some examination of changes in MCS score between wave one and wave two of the survey. Three models were fitted, all of which are presented in Table 1.

The first model (Model 1 in Table 1) examined change in MCS score between wave 1 and 2 by whether or not a new legal issue was reported at wave 2. As can be seen, reporting a new issue at wave two was associated with a fairly small yet statistically significant worsening of mental health.

The second model (Model 2 in Table 1) also included legal issue experience at wave one and the interaction between issue experience at wave one and wave 2. As can be seen, the greatest increase in mental illness (a significant reduction in MCS score of 1.32) was observed where respondents did not report an issue at wave 1, but did at wave two.

Finally, the third model (Model 3 in Table 1), which included only wave 2 issues also included disadvantage (NEET status), along with the interaction between wave 2 issue experience and age/disadvantage. As can be seen, young NEET respondents reported worse levels of mental health when they experienced new legal issues at wave 2, but the difference fell well short of statistical significance (likely due to numbers of respondents in the model).

Table 1. Models of change in MCS score between wave 1 and wave 2 on the basis of whether or not a new legal issue was reported at wave 2 (model 1); legal issue experience at wave 1, wave 2 and their interaction (model 2); and legal issue at wave 2, age/NEET status and their interaction (model 3)

Variable	Level	Model 1		Model 2		Model 3	
		Est	SE	Est	SE	Est	SE
Constant		-0.54	0.24	-0.54	0.27	-0.47	0.33
New problem at wave 2	No	0.00	-	0.00	-	0.00	-
	Yes	-0.84	0.42	-1.32	0.56	-0.53	0.53
Problem at wave 1	No			0.00	-		
	Yes			-0.02	0.51		
Age/NEET status	16-24 NEET					0.93	1.67
	16-24 EET					-0.59	1.01
	25-59					0.00	-
Interaction terms	W1 x W2 issue			1.01	0.86		
	16-24 NEET x W2 issue					-2.27	2.96
	16-24 EET x W2 issue					0.07	1.75
Person level var.		19.37	3.02	19.26	3.01	21.14	3.86
Household level var.		67.35	3.15	67.37	3.15	66.61	3.96

Discussion

The findings

Before the introduction of aspects of disadvantage, in line with previous studies, the above findings presented a picture of young people being the least likely to experience mental health problems. While the experience of legal issues generally related to an increase in mental health problems for young people (with the exception of social welfare law related issues and the youngest respondents), their likelihood of having mental health problems remained below other age groups. Young people were also associated with lower legal issue prevalence, though the prevalence of issues was higher among those aged 20 to 24.

However, whether young people were in education, employment or training, was a very strong predictor of mental health problems, with young NEETs far more likely to report mental health issues than other young people, and somewhat more likely than 25 to 59 year olds. Accounting for NEET status, legal issue experience continued to relate to a far higher likelihood of mental health problems across age/disadvantage groups.

'Social isolation', when looked at in place of NEET status, was also a predictor of mental health problems. However, the likelihood of mental health problems among isolated young people was similar to that of 25 to 59 year olds.

When NEET status and isolation were looked at in combination, young isolated NEETs were found to have high incidence of mental illness, and particularly high incidence if they also reported legal issues. Overall, despite relatively small numbers, young 'isolated' NEET respondents reporting legal issues (n = 25) had the highest incidence of mental illness. On the basis of model simulation this group was predicted to have 45% mental illness prevalence, rising to 49% when social welfare law related issues were reported.

Throughout all of the results, the experience of legal issues was a key predictor of mental illness. However, when the number of legal issues reported was introduced to the analysis, this was also found to be a key predictor, with the likelihood of mental health problems increasing significantly along with number of problems. And again, while numbers were small, isolated NEETs reporting multiple legal issues were most likely to have mental health problems.

Finally, our analysis of change in MCS scores between waves of the CSJPS indicated that mental health deteriorates as new problems emerged. There were some indications that deterioration was particularly severe for disadvantaged young people, though the numbers of respondent was too small to draw conclusions with confidence.

The implications

The 2003 Department of Health Programme for Action set out a whole-system approach to talking the broader social determinants of health inequality, with cross-departmental support for children and young people an important component (Department of Health 2003). While the social determinants of the health of young people, as a specific group, are less well understood then those of the general population, and there is some evidence that health inequalities may narrow during adolescence and widen again in early adulthood, our finding concerning the high rate of mental illness among young (particularly isolated) NEETs facing social welfare related legal issues is startling; and even more so when the rate is seen to increase along with the number of legal issues faced. The long-term impact of such a high level of mental illness is also profound. Kessler et al (2007), for example, detail how three-quarters of cases of mental illness in adults commence before the age of 24.

Given the multiple disadvantage associated with NEETs, combined with the higher than general incidence of both legal issues and mental illness found among (particularly isolated) NEETs, the strong association between legal issue experience and mental illness among disadvantaged young people makes clear the potential benefits of integrating legal and health services directed towards them. As we have argued before

(Pleasence & Balmer 2011, p.137), it is evident that legal issues and mental illness "need to be treated not in isolation, but in the context of the evident links between them." As Coumeralos et al (2013, p.16) have noted, this should also be "irrespective of paths of causation," as integrating legal and health services helps to maximise both "the opportunity for life problems to be spotted and addressed within the human services sphere," and the long-term savings of timely and appropriate intervention. Integration can also (generally[20]) act to make services more accessible to young people, who – as with others – will "not usually perceive their problems as single entities" (Noone 2012, p.27). This is important in the case of both legal and health needs, where young people have been found to frequently fail to access services (e.g. Pleasence & Balmer 2014, Green et al 2005). Furthermore, integration is a policy goal, "championed" by Public Health England (2015, p.8), to move towards "services that meet needs holistically and that are centred on young people" (p.6). It is also part of the path of change heralded by report of the work of the Children and Young People's Mental Health and Wellbeing Taskforce (Department of Health 2015, p.14):

> *"Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries."*

Of course, service integration is difficult to realise and can be highly resource intensive (e.g. Huxham & Vangen 2005); a fact well illustrated in the context of increasing attempts to the proliferation of collaborations between legal and health services that we referred to at the outset of this report (see, for example, Noone 2007, Noble 2012, Coumarelos et al 2013, Gyorki 2014, Pleasence et al 2014). There can also be "tension between concerns about, on the one hand, holistic client-centred service delivery and, on the other hand, service quality and increasingly specialist professional practice" (Pleasence et al, p.67).

Thus, further movement towards integration must be based on proper evaluation of both service benefits and costs. This is a matter of some difficulty in the context of disparate outcomes influenced by multiple services and multifarious external factors. Nevertheless, models of assessing potential economic benefits exist, and it remains the case that only negligible impact on health on the part of relatively inexpensive young people's legal advice services could justify their operation within the health domain (Balmer & Pleasence 2012). Moreover, there are already existing examples of integrated legal and health services aimed at children and young people. For example, the report of the work of the Children and Young People's Mental Health and Wellbeing Taskforce (Department of Health 2015, p.43) detailed the key role

> *"for the voluntary and community sector to encourage an increase in the number of one-stop-shop services, based in the community. They should be a key part of any universal local offer, building on the existing*

[20] There are occasions on which integration can – through, for example, impacting on privacy – act as an inhibitor to access, but careful service design should be able to mitigate such problems (Pleasence et al 2014).

network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment."

In conclusion, therefore, this report provides further evidence of the overlap between legal and mental health needs and the potential value of further integration of children and young people's legal, health and broader services. This value will not be easily realised, as "It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together" (Department of Health 2015, p.14). Nevertheless, there is now broad acceptance of the fact that "improving young people's health is a collective endeavour between young people, their families, local leaders, commissioners and providers across the statutory and voluntary sectors" (Public Health England 2015, p.21). And, political support – an essential ingredient of public services integration (Huxham & Vangen 2005) – provides hope of new progress.

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Appendix 1: Statistical appendix

We first fitted a series of multilevel binary logistic models of mental health (whether or not respondents reported and MCS score of 45 or less) by age, legal issue experience (in general and in relation to social welfare) and disadvantage using data from the 2010 and 2012 waves of the CSJPS. The models were fitted using MLwiN to account for data structure. Aspects of disadvantage were progressively introduced, with the initial models considering only age group and problem experience, before the introduction of disadvantage and then multiple disadvantage. The relatively small number of young people reporting multiple disadvantage in the CSJPS placed some limitations on the conclusions which could be drawn. Finally, the number of legal issues experienced was introduced, through substitution of a binary issue experience variable with a count variable. Model outputs are detailed in Tables A1 to A9 below. Of note throughout are the significant household level variance terms. This indicates that MCS scores clustered by household. So if one household member had a score of 45 or less, it was more likely that other household members would also have scores of 45 or less.

We then fitted further series of models using different MCS cut-off scores and MCS absolute value. Results were comparable. Example model output is set out in Table A10 onwards.

Table A1. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group, legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.89	0.08
Age group	16-19	-0.78	0.29
	20-24	-0.24	0.27
	25-59	0.00	-
Legal issues	No	0.00	-
	Yes	0.69	0.11
Interaction terms	16-19 X Yes	0.27	0.45
	20-24 X Yes	-0.07	0.38
Random household level variance		1.00	0.17

Table A2. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group, social welfare law problem experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.91	0.07
Age group	16-19	-0.46	0.24
	20-24	-0.24	0.26
	25-59	0.00	-
Social welfare legal issues	No	0.00	-
	Yes	0.86	0.12
Interaction terms	16-19 X Yes	-1.47	0.77
	20-24 X Yes	-0.10	0.40
Random household level variance		1.19	0.19

Table A3. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/NEET status, legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.95	0.08
Age group/NEET status	16-24 NEET	0.22	0.38
	16-24 EET	-0.81	0.29
	25-59	0.00	-
Legal issues	No	0.00	-
	Yes	0.71	0.16
Interaction terms	16-24 NEET X Yes	0.31	0.52
	16-24 EET X Yes	-0.15	0.44
Random household level variance		1.22	0.19

Table A4. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/NEET status, social welfare related legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.94	0.08
Age group/NEET status	16-24 NEET	0.39	0.34
	16-24 EET	-0.72	0.26
	25-59	0.00	-
Social welfare legal issues	No	0.00	-
	Yes	0.88	0.12
Interaction terms	16-24 NEET X Yes	-0.13	0.53
	16-24 EET X Yes	-0.48	0.50
Random household level variance		1.29	0.20

Table A5. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/'isolation', legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.97	0.08
Age group/isolation status	16-24 'isolated'	-0.10	0.52
	16-24 with 25+	-0.61	0.26
	25-59	0.00	-
Legal issues	No	0.00	-
	Yes	0.72	0.12
Interaction terms	16-24 'isolated X Yes	0.19	0.64
	16-24 with 25+ X Yes	-0.07	0.41
Random household level variance		1.29	0.20

Table A6. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/'isolation', social welfare related legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.95	0.08
Age group/isolation status	16-24 'isolated'	-0.11	0.47
	16-24 with 25+	-0.49	0.23
	25-59	0.00	-
Social welfare legal issues	No	0.00	-
	Yes	0.89	0.12
Interaction terms	16-24 'isolated X Yes	0.23	0.62
	16-24 with 25+ X Yes	-0.56	0.47
Random household level variance		1.37	0.20

Table A7. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/NEET status/'isolation', legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.96	0.08
Age group/NEET/isolation status	16-24 NEET 'isolated'	0.33	0.69
	16-24 NEET with 25+	0.18	0.45
	16-24 EET 'isolated'	-0.50	0.77
	16-24 EET with 25+	-0.85	0.31
	25-59	0.00	-
Legal issues	No	0.00	-
	Yes	0.72	0.12
Interaction terms	16-24 NEET 'isolated' X Yes	0.65	0.84
	16-24 NEET with 25+ X Yes	-0.12	0.69
	16-24 EET 'isolated' X Yes	-0.46	1.01
	16-24 EET with 25+ X Yes	-0.10	0.50
Random household level variance		1.24	0.20

Table A8. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/NEET status/'isolation', social welfare related legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		-1.94	0.08
Age group/NEET/isolation status	16-24 NEET 'isolated'	0.35	0.63
	16-24 NEET with 25+	0.41	0.40
	16-24 EET 'isolated'	-0.52	0.68
	16-24 EET with 25+	-0.75	0.28
	25-59	0.00	-
Social welfare legal issues	No	0.00	-
	Yes	0.88	0.12
Interaction terms	16-24 NEET 'isolated' X Yes	0.63	0.83
	16-24 NEET with 25+ X Yes	-1.00	0.79
	16-24 EET 'isolated' X Yes	-0.55	1.03
	16-24 EET with 25+ X Yes	-0.49	0.57
Random household level variance		1.31	0.20

Table A9. Multilevel logistic regression modelling mental illness (MCS score of 45 or less) on the basis of age group/NEET status/'isolation', number of legal issues and their interaction.

Variable	Level	Estimate	SE
Constant		-1.97	0.08
Age group/NEET/isolation status	16-24 NEET 'isolated'	0.33	0.68
	16-24 NEET with 25+	0.21	0.45
	16-24 EET 'isolated'	-0.48	0.76
	16-24 EET with 25+	-0.82	0.31
	25-59	0.00	-
Number of legal issues	None	0.00	-
	One	0.43	0.15
	Two	0.93	0.18
	Three or more	1.17	0.17
Interaction terms	16-24 NEET 'isolated' X One	-0.57	1.47
	16-24 NEET with 25+ X One	0.21	0.83
	16-24 EET 'isolated' X One	-1.13	1.50
	16-24 EET with 25+ X One	-0.48	0.71
	16-24 NEET 'isolated' X Two	1.08	1.14
	16-24 NEET with 25+ X Two	-0.64	1.07
	16-24 EET 'isolated' X Two	-0.41	1.55
	16-24 EET with 25+ X Two	0.42	0.75
	16-24 NEET 'isolated' X Three+	0.48	0.98
	16-24 NEET with 25+ X Three+	0.06	1.48
	16-24 EET 'isolated' X Three+	0.20	1.26
	16-24 EET with 25+ X Three+	-0.10	0.75
Random household level variance		1.18	0.19

Table A10. Multilevel logistic regression modelling mental illness (absolute MCS score) on the basis of age group/NEET status/'isolation', legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		51.76	0.24
Age group/NEET/isolation status	16-24 NEET 'isolated'	-0.45	2.14
	16-24 NEET with 25+	-1.24	1.36
	16-24 EET 'isolated'	2.36	1.86
	16-24 EET with 25+	2.77	0.66
	25-59	0.00	-
Legal issues	No	0.00	-
	Yes	-2.95	0.37
Interaction terms	16-24 NEET 'isolated' X Yes	-3.43	2.84
	16-24 NEET with 25+ X Yes	2.10	2.26
	16-24 EET 'isolated' X Yes	0.81	2.49
	16-24 EET with 25+ X Yes	0.91	1.22
Random person level variance		63.31	2.46
Random household level variance		25.57	2.56

Table A11. Multilevel logistic regression modelling mental illness (absolute MCS score) on the basis of age group/NEET status/'isolation', social welfare related legal issue experience and their interaction.

Variable	Level	Estimate	SE
Constant		51.68	0.23
Age group/NEET/isolation status	16-24 NEET 'isolated'	-0.20	1.99
	16-24 NEET with 25+	-2.34	1.28
	16-24 EET 'isolated'	2.13	1.62
	16-24 EET with 25+	2.60	0.62
	25-59	0.00	-
Social welfare legal issues	No	0.00	-
	Yes	-3.85	0.40
Interaction terms	16-24 NEET 'isolated' X Yes	-4.05	2.90
	16-24 NEET with 25+ X Yes	6.93	2.43
	16-24 EET 'isolated' X Yes	1.58	2.59
	16-24 EET with 25+ X Yes	1.92	1.37
Random person level variance		62.45	2.43
Random household level variance		24.61	2.54

Table A12. Multilevel logistic regression modelling mental illness (absolute MCS score) on the basis of age group/NEET status/'isolation', number of legal issues and their interaction.

Variable	Level	Estimate	SE
Constant		51.85	0.24
Age group/NEET/isolation status	16-24 NEET 'isolated'	-0.36	2.13
	16-24 NEET with 25+	-1.36	1.35
	16-24 EET 'isolated'	2.28	1.84
	16-24 EET with 25+	2.67	0.65
	25-59	0.00	-
Number of legal issues	None	0.00	-
	One	-1.36	0.46
	Two	-4.62	0.63
	Three or more	-5.15	0.59
Interaction terms	16-24 NEET 'isolated' X One	1.42	4.22
	16-24 NEET with 25+ X One	-0.08	2.77
	16-24 EET 'isolated' X One	0.18	2.88
	16-24 EET with 25+ X One	0.98	1.50
	16-24 NEET 'isolated' X Two	-4.43	4.14
	16-24 NEET with 25+ X Two	5.01	3.47
	16-24 EET 'isolated' X Two	2.05	4.17
	16-24 EET with 25+ X Two	0.90	2.23
	16-24 NEET 'isolated' X Three+	-3.31	3.51
	16-24 NEET with 25+ X Three+	3.03	5.33
	16-24 EET 'isolated' X Three+	1.07	3.93
	16-24 EET with 25+ X Three+	0.90	2.21
Random person level variance		62.58	2.42
Random household level variance		24.69	2.51

Appendix 2: Mental health prevalence – tables

MCS 50 or less * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
MCS 50 or less	.00	Count	448	1839	2287
		% within Age group - two groups	77.1%	66.9%	68.7%
	1.00	Count	133	908	1041
		% within Age group - two groups	22.9%	33.1%	31.3%
Total		Count	581	2747	3328
		% within Age group - two groups	100.0%	100.0%	100.0%

MCS 45 or less * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
MCS 45 or less	.00	Count	498	2180	2678
		% within Age group - two groups	85.7%	79.4%	80.5%
	1.00	Count	83	567	650
		% within Age group - two groups	14.3%	20.6%	19.5%
Total		Count	581	2747	3328

		% within Age group - two groups	100.0%	100.0%	100.0%

MCS 36 or less * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
MCS 36 or less	.00	Count	546	2491	3037
		% within Age group - two groups	94.0%	90.7%	91.3%
	1.00	Count	35	256	291
		% within Age group - two groups	6.0%	9.3%	8.7%
Total		Count	581	2747	3328
		% within Age group - two groups	100.0%	100.0%	100.0%

MCS 30 or less * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
MCS 30 or less	.00	Count	562	2614	3176
		% within Age group - two groups	96.7%	95.2%	95.4%
	1.00	Count	19	133	152

	% within Age group - two groups	3.3%	4.8%	4.6%
Total	Count	581	2747	3328
	% within Age group - two groups	100.0%	100.0%	100.0%

Self-reported mental health * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
Self-reported mental health	No mental health problem	Count	539	2361	2900
		% within Age group - two groups	89.7%	82.7%	83.9%
	Mental health problem	Count	62	493	555
		% within Age group - two groups	10.3%	17.3%	16.1%
Total		Count	601	2854	3455
		% within Age group - two groups	100.0%	100.0%	100.0%

Treated mental health problem * Age group - two groups Crosstabulation

			Age group - two groups		
			16-24	25-59	Total
Treated mental health problem	No treated mental health problem	Count	546	2426	2972
		% within Age group - two groups	90.8%	85.0%	86.0%
	Treated mental health problem	Count	55	428	483
		% within Age group - two groups	9.2%	15.0%	14.0%
Total		Count	601	2854	3455
		% within Age group - two groups	100.0%	100.0%	100.0%

MCS 50 or less * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
MCS 50 or less	.00	Count	236	212	1839	2287
		% within Age group - three groups	80.8%	73.4%	66.9%	68.7%
	1.00	Count	56	77	908	1041
		% within Age group - three groups	19.2%	26.6%	33.1%	31.3%
Total		Count	292	289	2747	3328
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

MCS 45 or less * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
MCS 45 or less	.00	Count	258	240	2180	2678
		% within Age group - three groups	88.4%	83.0%	79.4%	80.5%
	1.00	Count	34	49	567	650
		% within Age group - three groups	11.6%	17.0%	20.6%	19.5%
Total		Count	292	289	2747	3328
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

MCS 36 or less * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
MCS 36 or less	.00	Count	281	265	2491	3037
		% within Age group - three groups	96.2%	91.7%	90.7%	91.3%
	1.00	Count	11	24	256	291
		% within Age group - three groups	3.8%	8.3%	9.3%	8.7%
Total		Count	292	289	2747	3328
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

MCS 30 or less * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
MCS 30 or less	.00	Count	286	276	2614	3176
		% within Age group - three groups	97.9%	95.5%	95.2%	95.4%
	1.00	Count	6	13	133	152
		% within Age group - three groups	2.1%	4.5%	4.8%	4.6%
Total		Count	292	289	2747	3328
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

Self-reported mental health * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
Self-reported mental health	No mental health problem	Count	273	266	2361	2900
		% within Age group - three groups	91.9%	87.5%	82.7%	83.9%
	Mental health problem	Count	24	38	493	555
		% within Age group - three groups	8.1%	12.5%	17.3%	16.1%
Total		Count	297	304	2854	3455
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

Treated mental health problem * Age group - three groups Crosstabulation

			Age group - three groups			
			16-19	20-24	25-59	Total
Treated mental health problem	No treated mental health problem	Count	273	273	2426	2972
		% within Age group - three groups	91.9%	89.8%	85.0%	86.0%
	Treated mental health problem	Count	24	31	428	483
		% within Age group - three groups	8.1%	10.2%	15.0%	14.0%
Total		Count	297	304	2854	3455
		% within Age group - three groups	100.0%	100.0%	100.0%	100.0%

This report has been produced with support from **The Legal Education Foundation** and the **Health and Care Voluntary Sector Strategic Partner Programme**

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