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Square pegs in round holes: the mental health needs of young adults and how well these are met by services – an explorative study

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Abstract

Purpose – This research paper aims to examine the mental health needs of young adults and to discuss how well these are met from the vantage-point of the patients. Young adulthood is identified as an epidemiological risk for developing mental health problems and so the care provided during these developmental years is investigated to assess efficacy and experience.

Design/methodology/approach – After interviewing 35 young adults, it was found most people are aware of the genesis to their problems and have strong views about the level of support and types of treatments offered.

Findings – Like other writings, this research finds that many of the needs presented by young adults are unique to this transitional phase in life and administratively determined age structures on which current mental health care is configured do not adequately meet these needs.

Research limitations/implications – The small sample size (35) and the geographical region covered means caution should be exercised in drawing any generalisations. Further research on outcomes after the mid-20s by reflecting on service experience during the 18-25 transformational years would be a useful area for exploration.

Practical implications – This paper makes some powerful recommendations on why service provision must meet service user needs and how the recent equality legislation may provide impetus to this. All of this needs to start with examining the age boundaries on which mental healthcare is designed.

Originality/value – This work complements the existing literature in this field by giving a voice to the subjects of this research.

Keywords Young adults, Social inclusion, Pathways, Information, Transitions, Equality

Paper type Research paper

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Introduction

The period of transition from childhood to adulthood is a rite of passage that presents both opportunities and risks. The changing nature of youth and the associated pressures over the last two decades have been well documented in a number of studies (Pugh *et al.*, 2006; Rutter *et al.*, 2006). Family and community ties are more fluid, "job for life" securities are rare and jobs are increasingly only available for those with previous work experience. Young people now have more intense exposure to high-risk behaviour, including alcohol and drug use, availability of financial credit and sexual activity (Newell *et al.*, 2005). Whilst most people harness these freedoms and opportunities constructively, for some, this period can be difficult and risky.

This precarious time of “highs and lows” coincides with the peak period for the onset of mental health problems as a study by Kessler *et al.* (2005) in discussing the age of onset for DSM-IV disorders reported three quarter of cases, they studied emerged before the age of 25. And whilst there never really can be a suitable time in life for developing mental illness, the least welcome of all would be young adulthood as this is precisely when people try to establish their identity, personality and patterns for later life (Ghuman, 1999; McGorry, 2005; YoungMinds, 2006).

If we place this epidemiological prevalence alongside, the associated risks of material poverty (Dunn, 1999), unemployment (Boardman, 2010), homelessness (Mental Health Foundation, 2006a) stigma (Berry *et al.*, 2010) and other variables which fit under the rubric of social exclusion and disadvantage then we can see why finding a solution should escalate up the priority list as resolving one disadvantage may consequently lead to resolving others (SEU, 2005). Conversely, it could be argued that missed opportunities during young adulthood may well mark the first steps towards an adult life marked out with disadvantages and dependence (Office of the Childrens’ Commissioner, 2007; SEU, 2005). One of the most important features of disadvantage faced by young adults is that it rarely confines itself to a single domain; many young adults who face serious problems in their education, for example, will also face difficulties in the labour market (SEU, 2005), and are more likely to become involved in crime or anti-social behaviour (Rutter, 1988) or drug abuse (Newell *et al.*, 2005). The above circular relationship between youth, mental health problems and social exclusion will feature throughout this writing.

This work, though limited in the number of people interviewed and geographical areas covered, supports the idea of a misfit between what young people expect and need and what they find available from mental health services. It is argued that when attempts are made to place people into systems to which they do not appropriately fit, then such efforts could be likened to slotting square pegs in round holes. Missed opportunities and unmet needs are two good reasons for revisiting and rethinking the basis on which healthcare services are designed and delivered. This paper demonstrates this will be a useful starting point for many reasons, not least of which is to remain compliant with the equality legislation.

Research methodology and sample

A research application was approved by a NHS Ethics Research Committee to explore, through the use of semi-structured interviews, the nature and experience of young people’s contact with mental health services. Our central question at the time was this: how were young adults affected in terms of service experience and outcome by accessing statutory mental health services (i.e. NHS mental health services). More broadly, we were interested in hearing what was considered helpful or otherwise about a range of topic areas (discussed further) and how young people felt about the treatments they were offered when considering what may have been the genesis to their problems in the first place. The ultimate aim of this research was to explore the impact of existing systems in terms of both experience and outcome from young peoples’ perspective, but also to identify ways to improve services for this age group.

Semi-structured interviews seemed most appropriate for this explorative study. The key advantage served by this method is their flexibility in allowing investigators to ask by explaining questions whilst at the same time ensuring, there is a schedule to complete (May, 1994). Allowing respondents to talk with a generous amount of latitude proved very useful in developing a rapport and eliciting the more subtle views, which may have been difficult to elicit with a rigid format. In total, 35 interviews were conducted with young adults aged 18-25 who came into contact with mental health services in the previous two years. The sample was randomly selected with age and recent experience of service (in last two years) as the only criteria for inclusion. We were interested in hearing from people who could share experiences about a range of mental health conditions. The patients’ diagnoses covered a wide spectrum of psychiatric conditions such as psychosis, depression, bipolar disorder, personality disorder and anxiety disorders, but these are not systematically reported as part of the findings as many people were not provided a diagnosis. The most fruitful publicity for

recruitment purposes happened to be “word-of-mouth” systems employed by staff members. Although posters were displayed to attract interest, this only yielded three responses. Tables I-III present some demographic details about the young people.

It is difficult to determine whether or not the ethnic origin and gender (Pakistani male) of the interviewer contributed in any way to the sample composition as there appears a significant level of uptake by young Pakistani men and a disproportionately low level of participation by women across all ethnic groups. This finding is interesting for two distinct reasons. First, some public sector consultation exercises sometimes refer to minority ethnic groups as “hard to reach” or “seldom heard” (Brackertz, 2007); both of these terms were not realised here. The Asian population in the city concerned was estimated at around 20.5 per cent for the year 2006, of which 15.6 per cent is of Pakistani heritage (ONS, 2009). Our data (Table II) appear to show a higher level of participation than the above statistics would suggest is commensurate. This can be explained in two ways. First, the age profile of black and minority ethnic communities (BME) is unevenly spread in most cities with a higher proportion of people from the residing minority community situated in the younger age ranges (Nazroo, 1997). If we take ethnicity and youth collectively when discussing this sample then there is little statistical significance in the ethnic demographics. The second reason for a higher level of uptake may well be down to a higher proportion of people from the Pakistani community in the city using mental health services compared to other groups as there are complicated correlations to be found in ethnicity and predisposition to mental health problems (Fernando, 2002; Sashidharan and Francis, 1993). Space precludes any detailed discussion on any of these possibilities; however, it is worth stating there are very few note-worthy findings that are relevant to ethnicity or culture in this research. Any repeated or follow up study should consider including questions relating to ethnicity and culture with respect to youth and mental health as the sample may lend itself well to inform such research.

Table I Age profile

| <i>Age in years</i> | <i>Percentage</i> |
|---------------------|-------------------|
| 18 | 6 |
| 19 | 14 |
| 20 | 17 |
| 21 | 6 |
| 22 | 17 |
| 23 | 14 |
| 24 | 17 |
| 25 | 9 |

Table II Ethnicity profile

| <i>Ethnic origin</i> | <i>Percentage</i> |
|----------------------|-------------------|
| White British | 57 |
| Pakistani | 34 |
| Indian | 3 |
| Chinese | 3 |
| Mixed Race | 3 |

Table III Gender profile

| <i>Gender</i> | <i>Percentage</i> |
|---------------|-------------------|
| Male | 83 |
| Female | 17 |

On average each interview lasted 45 minutes and was conducted at a location where the young person felt they could talk. In most cases, this involved visiting people at their home address, but also meant some people were interviewed at various locations associated with their treatment centres (i.e. Community Mental Health Teams). I was particularly mindful of the confidentiality of our young interviewees. It was made clear at the outset that reports of danger or risk to either themselves or others would override any agreements on confidentiality, but in all other circumstances it would be preserved. Only on one occasion (to good effect) was this clause exercised. All interviews were conducted in complete privacy except when the young person requested a carer to be present. This happened on three occasions.

In what follows, it has sometimes been necessary to excise details from the responses in order to ensure confidentiality remains complete, but can assure this has not compromised the integrity of the data. The interview consisted of questions relating to eight areas considered to be of great significance to understanding the mental health needs of young adults. These were determined by a young adult project steering group, which was made up of a number of professionals including, amongst others, nursing staff, a psychotherapist, a clinical psychologist and two psychiatrists. The themes were determined by drawing on relevant literature and the findings from a conference at which delegates from a range of professional backgrounds were asked to consider the key areas for young people in respect of service experience and outcome. This provided a generous amount of data which, after careful consideration by the steering group, was reduced to the following:

- B reasons for first contact;
- B sources of support;
- B pathways into mental health services;
- B social inclusion through support in the community;
- B information from services whilst in treatment;
- B treatments and therapies;
- B transition towards adulthood; and
- B ideal service for young people.

All interview transcripts were recorded manually and then analysed using a grounded theory method (Strauss and Corbin, 1998). This approach ensured findings were not limited to a predetermined set of themes listed above, but also created room for other possibilities to enter the proceedings, which may have not been included or covered by the scoping exercises. Recording interviews manually is not without drawbacks and audio recording would have better captured the rich dialogues with various underlying messages and subtleties, which were difficult to note by jotter and pen. In presenting the findings, every effort has been made to let the young people speak for themselves by drawing directly on useful and succinct quotations gathered during fieldwork. In reporting the findings, I do so in the above order, however since some of the above themes interlinked and overlapped during the interviews it has sometimes been necessary to merge discussions on certain themes to facilitate the reader.

First contact and sources of support

The very first interview questions covered the reasons why young people believed they came into contact with mental health services. A great deal of leeway was allowed to ensure interviewees were able to express themselves. Interestingly, very few respondents reported clinical “mental health deterioration” or “mental illness” in isolation from other social and environmental problems. Most young people were able to identify a genesis to their mental distress and described either the association or the “cause and effect” between their circumstances and the onset of mentally ill health. Here, is what some young people informed us:

I was looking for a job but nobody would employ me. I got stopped and searched in the street so many times for no reason. I was just so fed up that I started smoking skunk and ended up mad. Lost two children, one after the other – started drinking heavily and then got psychosis. Had problems with brothers and sisters, always fighting each other and then I think someone cast a spell on me [. . .] black magic. Flashbacks of abuse started coming through during my teenage years and sent me mad. Nervous breakdown – took on 13 GCSE subjects and just could not cope. I really wanted to shine but ended up in a mess. Started hearing voices very soon after being raped. Completely broke down and lost control of my life for the next two years.

If we place the above “causal effects” next to the notion that young adults are more difficult to engage when it comes to accessing mental health services as they avoid help seeking behaviour (Mental Health Foundation, 2006b; YoungMinds, 2003) then it raises a question on what they do instead? Our respondents reported a number of different coping mechanisms. Some turned to drugs and alcohol, others to self harm and many of them did nothing in the hope that their problems would disappear without any intervention. Only 3 per cent reported turning to the voluntary sector (e.g. charitable organisations) as their first port of call. Most people were not aware of the help available from the voluntary sector when they first experienced their problems.

Respondents were then asked the same question about accessing voluntary services after receiving treatment from statutory services. This time, we found the number had jumped to 37 per cent. This finding does dismiss the idea that young people are avoidant of services; if anything, it points to a willingness to seek help and support if it appears appropriate and welcoming. A key consideration to be mindful of is noted by the Social Exclusion Unit (SEU, 2005, p. 70):

Some (young people) can feel that a service is not for them, or that the service is targeted at a specific group they do not identify with or want to identify with. More often young adults may turn away from services due to bad experiences and only make contact with services when they reach a crisis point and have no choice.

The growing evidence base for early intervention (Bertolote and McGorry, 2005) favours the idea of treatment and access to services being available well before someone reaches a crisis point as this not only avoids the more arduous path of coercion but also reduces the length of time to achieve recovery. Early intervention in psychosis services are often heralded as a success story for the positive impact they have made on young peoples’ lives and their carers (Mental Health Network, 2007). This model may provide a template to address a broader range of mental health conditions which equally have a tendency for onset during the formative years such as depressive disorders (Lewinsohn *et al.*, 2003), eating disorders (Rutter, 1989) and personality disorder (NIMHE, report 2003). Taken from a different angle, there is a growing body of evidence which implicates missed opportunities during youth with any mental health condition as a causal for more serious mental health problems in later life (Rutter *et al.*, 1996; NIMHE, 2003; McGorry, 2009) which invariably means increased dependence on services and a lengthier and more problematic journey towards recovery.

Pathways into mental health services

Any concerted effort to improve access for young people must be done so in a way which understands how young people currently enter the healthcare system. When young people were asked “how” or “through whom” they sought help from statutory mental health services, the services accessed are explained in Table IV.

Social support networks are an important method of accessing health services for young adults as manifested by the help seeking behaviour of our sample (Table IV illustrates friends, neighbours and parents account for 34 per cent). This notwithstanding, a considerable number entered through the “emergency hatch” (i.e. A&E and Police 31 per cent) whilst a significant portion also sought help from their GP (26 per cent). The importance of social

Table IV How were services accessed?

| <i>Contact through</i> | <i>Percentage</i> |
|------------------------|-------------------|
| Parents | 28 |
| Police | 20 |
| GP | 26 |
| Accident and emergency | 11 |
| Leaving care services | 6 |
| Friends | 3 |
| Neighbour(s) | 3 |
| School | 3 |

connections, particularly the family, is further reinforced when we look at the accommodation status of young people (Table V) as nearly three quarters were living with parents. This is consistent with the Office for National Statistics which found most young people continue to live this way well into their mid-20s as they lack the financial resources to purchase or rent their own property (*BBC article, 2007*).

Young people described the stress endured by family members as a result of their illness, particularly when they lived in the same household and suggested measures should be in place to help and support families to alleviate this. Some of the ways in which this may be achieved included the following:

We need family approaches because people who have to care for the mentally ill suffer a lot too.

They need help to sort out their problems.

Take carers into account to understand what they may want to say.

Parents need more help than just an invitation to a meeting.

Whilst the above findings are somewhat counter to the social policy assumptions about young adults achieving complete independence by their 18th birthday (HASCAS, 2008), it should not in any way, overstate the support families provide to mitigate adverse life events. In some cases it may well be the family which create or exacerbate mental health problem(s) (Katz *et al.*, 1999). Either way, in light of these findings and in support of research completed by Stratton (2005), service providers should ensure the inclusion of the family and the impact of family relationships on emotional health as an integral aspect during assessment and treatment.

Social inclusion through support in the community

The research participants were clearly aware of the negative connotations associated with mental illness and how this can have implications on other aspects of life. One area in particular which has received wide scale attention is meaningful activity, otherwise defined as employment, education or training (EET). Those not engaged in either of these are often described by the Department for Work as not in employment, education or training (NEET).

Table V Accommodation status

| <i>Accommodation</i> | <i>Percentage</i> |
|-------------------------|-------------------|
| Parental home | 74 |
| Living alone | 6 |
| Living with partner | 3 |
| Homeless | 6 |
| Supported accommodation | 8 |
| Living with friend(s) | 3 |

There are a number of studies which draw an inextricable link between mental well-being and employment (Boardman, 2010; Sainsbury Centre, 2010) and some institutions like the British Psychological Society go as far as saying “getting back to work has a greater positive impact than any other single factor on the outcome of mental illness” (Select Committee Fourth Report, 2006, p. 2). The poor labour market position of people diagnosed with psychosis is well researched and documented (Marwaha and Johnson, 2004; Perkins and Rinaldi, 2002) with findings suggesting they are less likely to be in employment and are at more than double the risk of losing their job compared to the general population (Boardman, 2010). Correlations are also to be found between other mental health conditions and unemployment for example Meltzer *et al.*'s (1995) study noted:

Adults with neurotic disorders were four to five times more likely than the rest of the sample to be permanently unable to work (Boardman, 2010, p. 149).

The epidemiological prevalence of mental health problems during young adulthood (18-25) discussed earlier unfortunately coincides with the same years when most people are planning on entering the labour market. And whilst mental health is a poor predictor of ability, it continues to be a fundamental reason for high levels of unemployment for service users (Mental Health Network, 2010; Boardman, 2010). The following statistics illustrate the level of the problem – “Between 10 per cent and 16 per cent of people with a mental health condition, excluding depression, are in employment. However, between 86 per cent and 90 per cent of this group want to work” (Mental Health Network, 2010, p. 1). To fuel further anxiety, a study by Pugh *et al.* (2006) estimated there is a 70 per cent chance of remaining unemployed at the age of 35 if one is unemployed at 23. Supported employment programmes such as the individual placement and support model (IPS) offer a great deal of hope in tackling such issues and increasing employability prospects for mental health service users (Bond *et al.*, 2008; Burns *et al.*, 2007), but this can only be realised when young people are informed about and encouraged to partake in such initiatives.

This research found very few young people discussed or planned employment and other variables related to social inclusion and citizenship as part of their support in the community. Most young adults reported their relationship with their care coordinator as being centred on receiving visits to monitor their health and to ensure compliance with treatment plans. Areas related to employment, housing, income and ambitions received only scant attention.

From our sample, 6 per cent of young people were employed and only 3 per cent were at college whilst the remaining 91 per cent were NEET. A great majority of these expressed their frustration at not being able to secure a job:

I just cannot get a job. They don't want to know people with mental health problems and staying at home makes me sick.

I don't have any experience – I've lost out on experience and can't get a job.

If they find out I've been in (hospital) they won't want to know me, they'll think I'm a freak or something.

The low economic downturn is likely to perpetuate the poor labour market position of people who use mental health services and so care-planning processes will need to step up efforts if young people are to avoid the prospect of long-term unemployment. This may well require a new way of working with significant changes in the values and ethos of care coordination. Shepherd *et al.* (2008) describe one possibility which will require a shift from:

Staff who are seen as remote, in a position of expertise and “authority”, to someone who behaves more like a personal coach or trainer – offering their professional skills and knowledge, whilst learning from and valuing the patient, who is an expert-by-experience (p. 3).

In essence, the aim of the professional would be to provide the young person with the necessary resources such as information, skills, networks and appropriate tailored support to allow them to make strides towards recovery by utilising the resources they believe are needed to live their lives in a fully inclusive way. In practice, it means mental health services need to firmly believe there is a correlation and not coincidence between social inclusion and well-being and the role of the professional must demonstrate this.

Information from statutory services whilst in treatment

We received a very mixed response to the questions relating to adequacy of information made available to people as part of their treatment. Nearly, a third of young people were content with the amount and quality of information made available to them (31 per cent). Another group (34 per cent) were either indifferent or could not remember how well informed they were; and this maybe down to the crisis at the time of contact which may have taken precedence over the “softer” issue of quality of information. Interestingly, 28 per cent out of the 34 per cent who fall into this group were sectioned under the Mental Health Act as part of their first contact with mental health services.

The remaining 34 per cent levelled a number of complaints on this subject. Common areas for concern were related to lack of engagement in the decision making process during care planning and precious little being shared with them or carers when it came to informing them about efficacy or side effects of treatments, purpose of interventions and alternative options. Below are just a few of the responses:

(Information) not clear, just had a load of medication chucked at me – not able to understand why.

I remember people were reading off bits of paper – I was so unsure about what we were doing there (in hospital); the process just drowned me [. . .] Staff asked me to take medication and not explaining why was really annoying.

I didn't realise how drowsy I was on the medication and no one told me that I would gain all this weight.

One young person, in particular, received some very confusing messages over several years:

As a kid I got told I had depression. During my teens I was told that I was schizophrenic. This later changed to border line personality disorder and now they are telling me that I might have Bipolar Affective Disorder. I have read books on all of these and they are so different to each other, I cannot understand how there could be a mix up.

Whilst it may well be scientifically plausible for one mental health condition to progress to another over time, it must never be assumed that people who use services will understand this in the absence of a proper explanation. Where treatment is progressed on the basis of limited and what may seem contradictory plans, this will inevitably erode any confidence in services and increase the likelihood of disengagement.

Treatments and therapies

Discussions on treatments revealed everyone was prescribed medication for their problems at some stage and for most people this remained to be the case at the time of the interview. A few people talked about problems with compliance and reported this would fluctuate from time to time. Only 6 per cent were complimentary when discussing the prescribed medication and reasons included it helped them “calm down”, “sleep” and “stopped the voices”.

Over a third (34 per cent) were not really able to offer thoughts on this topic as they were not aware of any treatments or interventions other than oral or intravenous medicine and, therefore, had little for comparison purposes. Nearly, two-thirds (63 per cent) were aware of the range of treatments, and given they were aware of what made them unwell in the first place, echoed a number of concerns about what they received:

Never been offered anything other than medication. Olanzapine was prescribed and I got a few bits of paper telling me what it was for. I just took it but I thought I was going to get more help than that.

All these tablets are useless – I've stopped taking them.

The tablets were rubbish – they screwed my mind up even more.

Although young people were able to comprehend resource constraints and how these affect healthcare delivery; however, many did assert these should never supersede their

healthcare needs. This issue seems to be widespread across a number of young people services as noted eloquently in the report prepared by the SEU (2005, p. 10):

Policy structures have tended to lag behind the reality of people's lives: the ways in which young people become adults has become more complicated and diverse but policies have generally failed to keep up with such changes. The age structuring on which many policies are based is often complex, inconsistent, and working against the principle of resources following need.

None of the above is to deny the usefulness of medication as clearly some people did believe the medicine ameliorated their symptoms. The problem, as noted by the findings is with offering medicine without other forms of support or without sufficient information on how it will work. A key finding from our interviews is very few people noticed the relevance of their treatment plans to what they believed to be the root cause to their mental health problems. The few people (9 per cent) who were offered psychological therapies, in addition to medicine, found these to be very helpful:

(Family therapy) made my very difficult Mum see things from my perspective. In the meantime, I got one-to-one support and when things worked out I thought mental health services do have their uses.

Group psychotherapy was amazing. There were people who were so shy and withdrawn. By the end of the last session the same people were full of beans.

Transition towards adulthood

Under this section, we covered a broad range of topics usually associated as a passage of rite during the transitional years (e.g. independence, identity, housing and relationships) (Ghurnah, 1999). Interview discussions were directed towards gauging progress made and any future ambitions.

Many young people reported their mentally ill health impeded progression and watching peers and siblings who appeared to have managed the transitional years with minimal upheaval raised their anxieties and frustrations. The following two comments typify just some of the sentiments:

I just want a fresh start, but I can't get anywhere to live. Hostels are full of drug users and the council won't give me anywhere. I'm really fed up.

Life has just come to a big halt. I live with parents and it looks like it will stay that way for a whilst.

Some young people said they started the difficult journey towards adulthood but found that mental health problems stopped them in their tracks:

I was on a very good degree course at university and had to drop it cause I got really ill.

I couldn't keep my job because my employer thought that I was a risk.

I was doing alright but then this happened you know (illness) and the brakes were on after that. Hopefully, I can go back to University and start all over again.

Unfortunately, too many young people felt they have never been able to get started and echoed feelings of regret. Some of the comments about reduced self-confidence alluded to the stigma associated to mental illness and the "sticky" nature of this label. It was clear that going through transitional years with mental health problems can be damaging to morale:

My mental health issues have really messed things up for me big time. I just haven't been able to get my life sorted if you know what I mean.

I don't have the confidence to apply for a job and sit for an interview; I just wish I could, but I can't.

I've never been able to get started. If I tried to get a job I wouldn't know where to start.

Some of this group placed the blame of social exclusion right on the doorstep of the services, as they believed more support should have been available. The complaints included the following:

After spending 6 months on a section I think I should have at least been helped with getting back to normal things like work and that.

It's been a right mess for me. I haven't got my future planned and nobody has really helped me with it.

Things have fallen apart but nobody has been able to help me put my life together again. My Brothers have all got jobs and places (to live), I'm still stuck here and can't move on.

Ideal service for young people

Having reflected on their personal journey through mental health services, young people were now asked to design an ideal-type service using their experience as a tool for reflection. The only instructions offered were to consider both service experience and outcome. Space precludes a detailed discussion on all the responses generated by this question, however, there were some points which were consistently repeated such as the need to ensure social inclusion and family friendly approaches. A recurring finding here was the different and distinct position of young adults compared to other age groups and the need to be treated as such. Consider the following:

Facilities need to be appropriate to age. Too many old people here (inpatient wards) – we need outdoor facilities – we need treatments that are more than just tablets.

Services for young people need to be just for young people and these need to be set up differently.

One young person went as far as meticulously working out the operations and functions of the ideal service. The idea was very interesting as this young man who experienced both inpatient and community care suggested a service should contain the following functions:

- B *Therapeutic centre.* With activities such as group work, sports and gym facilities and arrangements to go outdoors as part of therapy. Such a service would ameliorate issues associated with isolation and would offer support groups to people who may experience similar difficulties.
- B *Community based services.* Whilst improving mental health would be a primary aim of this function, it would do so through a “social model” of care by ensuring treatment plans are adhered to but also crucially providing support with, say job applications, seeking accommodation and welfare advice. Staff employed here would regularly liaise with a range of organisations to resolve issues such as debt and risk of losing employment or accommodation. Drop in advice for a range of problems such as substance misuse and sexual health, amongst others, could also be available here.
- B *Smaller inpatient service.* Young people's ward staffed by professionals who understand both young peoples' transitional issues and clinical needs. Treatments would be prescribed on the basis of a “quick-turnaround” so young people spend little time as possible in inpatient care and more time in the community making best use of social connections in order to achieve recovery. The ward should be designed in a “young people friendly way”, for example, by creating a sports area and internet room.

Other respondents focussed entirely on removing the negative facets from existing mental health operations rather than creating innovative services. Some of the key points raised were:

Inpatient services need to move away from locking people up towards making them feel better.

Services should not wait for people to breakdown and then put them in hospital and say it only happened because you took dope – things are more complicated than that.

One young person found the process of accessing services a major problem and against the ethos of providing help when it is most needed. An appropriate service must avoid sending young people down the pathway experienced by this young person:

At the A & E Department I was put on a kind of assembly line alongside people with all kind of problems but most of them were drunk or bleeding. I had to repeat time and time again what happened to me. I had to explain myself all over again when I got admitted to (psychiatric hospital). When you're suicidally low it's not good to put people through that experience.

If services are going to make it easier for young people to approach and access services then they must cut down the length of time and the number of steps it takes to get to the right person. A report by YoungMinds (2003) in describing a “young people friendly” service asserts the GP’s gate-keeping role to specialist services may be seen as a barrier to access and this opinion was echoed by a small number of our sample.

Increasing points of access, it seems, would reduce the chances of ending up in a crisis and going down the fast track and often most distressing route of compulsory admissions. Young people, however, did point out that there will always be a reluctance to attend services which over-emphasise the mental health nature of their business. Therefore, a service which contains multiple services that has a considerable flow of young people, including some attending non-stigmatising programmes such as recreation or support groups may go some way towards improving the appeal.

Conclusion and the way forward

In line with a number of other studies, young people who informed this research confirmed a close interface between mental health problems and social and economic problems such as unemployment (Sainsbury Centre for Mental Health, 2009), Identity and capacity for independence (Rogers and Pilgrim, 1999; Ghuman, 1999), and relationships (Pugh *et al.*, 2006). In the absence of appropriate support, issues such as these carry the potential to be precipitators for prolonged mental health problems with far reaching implications on both future prospects and overall quality of life (McGorry, 2009; Pugh *et al.*, 2006; Burns *et al.*, 2007).

The success story associated with early in intervention in psychosis (Mental Health Network, 2007), whilst a step in the right direction, has not had the ripple effect to include a broader range of mental health conditions. This study supports the idea that young people are willing to access and approach services as long as the service is perceptive, sensitive and skilled in communicating with and engaging youth. Equally, treatments and interventions must not be overly medical or illness orientated but should focus on the complex transitional needs young adults contend with during this period of development. As such it would seem prudent to design and commission a young people service in which mental health is a mainstream concern whilst developing a working partnership with a range of agencies and services that deal with other non-pathological issues (i.e. unemployment, training and homelessness). We found, like other studies (Stratton, 2005) family relationships for young people are inextricably linked to emotional well-being and should not be reduced to a “side issue”. The stress endured by family members as a result of their caring role was frequently mentioned and is one area that needs addressing for the sake of the young person as much as the carer(s).

Professionals and service providers need to understand young people better and develop age appropriate services tailored to the complex needs of the 18-25-year age group. The recent announcements about the “equality duty” which will make unjustifiable age discrimination unlawful for anyone over the age of 18 by 2012 (EHRC, 2011; Anderson, 2011) offers hope for this to be realised. The equality duty is extensive in what it covers and describes both direct and indirect discrimination as illegal. On the latter point in particular, Anderson (2011) notes:

Indirect discrimination occurs when a seemingly neutral provision, measure or practice has harmful repercussions for a person. It occurs when all age groups are treated the same without recognising different needs of a particular age group, who are then disadvantaged (p. 3).

Throughout this paper, it has been maintained that emerging adulthood and the associated needs presented during these formative years could be categorically distinguished from both childhood and absolutely independent adulthood. We have seen how treating people the “same” in respect of age can lead to perceptions of inequity and inequality and will, therefore, require providers of services to be mindful of the legal implications of maintaining the status quo. “How” and “in what ways” the equality duty will provide any impetus to improve services for this age group remains to be seen and will present a fertile

area for research, particularly in terms of comparative data exploring length of time in treatment and any measurable outcomes.

For now, services available to young adults are, in the main, similar or identical to those offered to everyone in the working age group (i.e. 18-65 years) and whilst these might be helpful to many people in such a wide age bracket, there is a mismatch when we consider the needs of younger adults. Metaphorically speaking, young people in such services are like “square pegs in round holes” as their age-related needs are not appropriately met by a one-size-fits-all approach. To achieve any meaningful improvement, services need to fit service users and not vice versa. As a starting point, we need to revisit the basis on which the administratively neat age based boundaries were determined.

High quality, accessible services are costly and difficult to commit to when financial pressures abound, but the cost of inadequate treatments and missed opportunities for young people are much greater. Social exclusion and prolonged use of services are two dangers facing young people who get trapped in the mental health net without appropriate care, treatment and interventions (SEU, 2005; McGorry, 2009; Berry *et al.*, 2010). Allowing people to break this cycle whilst also reducing demand for services in later life, provides us with sound moral, legal and long-term financial reasons for meeting the needs of young people.

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