Review Article

Young people’s views of UK mental health services

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Abstract

Aims and method: Adolescence is the period of highest risk for the development of mental illness, but also the age group least likely to seek help from mental health services. We undertook a systematic review of the published literature on the views of young people of mental health services in the UK and a thematic analysis of the findings to explore the reasons behind this to guide those developing services for young people.

Results: Thirty-one studies were identified, which captured the views of 13,605 young people including 625 young people who had experience of mental health services. Positive views to emerge were of qualities of mental health workers and encouraging self-reliance. Negative views were of stigma, lack of information, medicalization of their problems and a lack of continuity of care.

Conclusions: Young people have consistent views of the positive and negative aspects of mental health services, which could be helpfully incorporated in the design of services. The views of some groups of young people have not been well represented, however, and the views of minority ethnic groups and those who have disengaged from services in particular need to be actively sought.

Key words: adolescent, health attitudes, patient satisfaction, youth service.

INTRODUCTION

Adolescence is a key developmentally sensitive period when social, psychological and vocational pathways are being laid down. It is also the time of greatest risk of mental illness. The onset of most mood, psychotic, personality and substance use disorders occurs in a discrete time band from mid-teens to early 20s,1 75% of all mental disorders will occur by the age of 24. Mental disorders in youth are therefore associated with high rates of social disability including school failure, unstable employment, poor family support and social functioning.2 However, although this young group may have the greatest need for mental health services, they are also the least likely to seek help, and this is particularly the case in young men and ethnic minority groups. In response to this discrepancy, there are increasing calls to rethink traditional service designs (Child and Adolescent Mental Health and Adult Mental Health services (CAMH/AMH) with proposals for youth-focused mental health services (12–25 years) in their place. However, although these changes are proposed to address the lack of engagement with young people, there is a lack of robust evidence from the UK as to what underlies this lack of engagement and therefore whether the proposed service changes would make a difference.3,4 We therefore aimed to undertake a systematic review of the views of young people of mental health services, including both those with experience of services, and those without, to describe the barriers and facilitators to engagement with mental health services as experienced by young people in the UK.

METHODS

The review was conducted in two parts: a descriptive mapping of all published literature in this area followed by an in-depth review of the quality and findings of those studies.
The following databases were searched in May and June 2011 – PsycInfo, Medline, Embase, British Nursing Index, CINAHL, HMIC and the Social Science Citation Index. In addition, brief searches were conducted on the following databases – ERIC (for school-based interventions July 2011) and Social Care Online (see Table 1). The search terms we used were derived from our research question – ‘young people’ (youth, teenagers, adolescents), ‘mental health services’ (secondary care, primary care, psychiatric service), ‘attitudes’ (opinions, beliefs, views), and ‘accessibility/uptake’ (barriers, facilitators, access). Thesaurus terms for each database were used and combined with free text terms. The strategies were tested and refined. Limits were applied to retrieve references to papers published from 2000 onwards. This date was chosen as it corresponds with major service reorganization in the UK, following the publication of the National Health Service Plan. Any views of services after this date are therefore likely to be more relevant for those planning services today.

**Study selection (Fig. 1)**

As a result of the diffuse search terms used, the initial electronic database search returned a large number (n = 3998) of studies. Initial title screening excluded studies that were clearly irrelevant, resulting in 201 potentially relevant studies. An additional 13 studies were located through hand-searching the references of all review papers and other key papers identified through the systematic review. Full papers were then screened independently by two separate reviewers (two from BL, JP, KM and JW) against the following exclusion criteria:

- Paper published prior to 2000.
- Not English language.
- Book magazine or trade article or policy and guidance with no clear data sources (include published and non published material).
- Not based in the UK: Young people aged less than 12 years or over 25 years. Does not directly report young people’s views and attitudes in relation to mental health services or mental health service design.
- No original data, or re-analysis of original data (opinions, synthesis only, commentary, editorials, summaries).
- Insufficient details to identify reference or make an informed decision.

One hundred seventy papers fulfilled at least one of the above criteria and were excluded from the review. Any disagreements at this stage were resolved through discussion with a third rater. This resulted in a total of 31 studies for inclusion in the review (Table 1).

**Data extraction and quality assessment**

Each of the 31 studies meeting the inclusion criteria were independently coded for quality by two reviewers. Each paper was weighted for its overall contribution to answering the research question using Gough’s ‘weight of evidence’ criteria. Each paper was weighted as high, medium or low on three initial criteria, and then combined to give a fourth criterion of overall assessment.

1. Coherence and integrity of the evidence in its own terms. This is a non-review specific judgment about the quality of the execution of the study in its own terms – whether a qualitative or quantitative study. This is based on accepted criteria for evaluating the quality of different types of evidence (SCIE, Cochrane).
2. Appropriateness of the form of evidence for answering the question of the systematic review. This is a judgment about the method and design used and the fitness for purpose of that form of evidence for answering the review question.
3. Relevance of evidence for answering the review question. This is a review-specific judgment about the relevance of the focus of the evidence for the review, for example, the sample used, type of evidence gathered or analysis method.

The concordance between reviewers for the quality assessment was 74%, with all but one case of lack of concordance being between ratings of low and medium quality.
Data analysis

A thematic analysis process was undertaken by two reviewers (DK and KM) by reading the text, noting items of interest. An initial reading of the text using an inductive approach allowed themes to emerge and major issues were noted. All text was examined closely, identifying other data within the primary material. Themes emerged and were organized into related categories, which were developed in an iterative way through discussion and consensus as the analysis progressed. Axial coding was undertaken, with re-examining of the data to ensure that none was overlooked or contradictory. The final construct of each theme included all the material relating to it, focusing on the underlying meaning of the themes. Quotes were added to illustrate meaning. The number of papers mentioning each theme was counted.

RESULTS

Study characteristics

The flow diagram for the 31 included papers is shown in Figure 1.

Methodologies

Twenty-one of 31 (68%) studies including 3797 participants used qualitative methods. Nine studies, including 6804 participants, used mixed qualitative and quantitative methods, and one study used quantitative methods only (Biddle et al., with 3004 participants). Eight studies used focus groups, two of them in combination with questionnaires and two in combination with interviews. One focus group study used a control group. Fifteen studies were based purely on interviews. A further three studies combined interviews with other methodologies. Most of these used only qualitative analysis, with three mixing qualitative and quantitative methods of analysis. One small study (n = 4) combined interviews with a review of case notes, and a larger one (n = 154) used a case note survey. Four studies used questionnaires only, one study combining questionnaires with a diary log. Overall, questionnaires were used in nine studies, using both quantitative and qualitative methods of analysis.
<table>
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<th>Author and year publication</th>
<th>Setting</th>
<th>Age range</th>
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<th>Research methods used</th>
<th>Main findings</th>
<th>Weight of evidence† A/B/C</th>
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<td><strong>Weight of evidence – high</strong></td>
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<tr>
<td>O'Toole et al 2004</td>
<td>Mental health</td>
<td>17–49</td>
<td>12</td>
<td>Qualitative (focus group)</td>
<td>Early intervention Psychosis service better experience than inpatient ward or A and E</td>
<td>h/h/h</td>
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<tr>
<td>Randhawa and Stein 2007</td>
<td>School</td>
<td>13 to 16</td>
<td>95</td>
<td>Mixed (focus group, semi-structured interview)</td>
<td>CAMH not a visible service, school main source of info, confidentiality and accessibility important</td>
<td>h/h</td>
</tr>
<tr>
<td>Lester et al 2011</td>
<td>Mental health</td>
<td>14–35</td>
<td>63</td>
<td>Qualitative (interview)</td>
<td>Positives – youth focussed workers, flexibility, including family, community based. Negatives – telling story too many times, lack of continuity of care</td>
<td>h/h/h</td>
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<tr>
<td>Walsh et al 2011</td>
<td>Youth offending service</td>
<td>10 to 18</td>
<td>44 (6 interviews)</td>
<td>Mixed (self-report questionnaire, interview)</td>
<td>Accessibility main issue</td>
<td>h/h/m</td>
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<td>Buston 2002</td>
<td>Mental health</td>
<td>14–20</td>
<td>32</td>
<td>Qualitative (semi-structured interview)</td>
<td>Want to be listened to, not just be given medication, continuity of care, support for carers</td>
<td>m/h/h</td>
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<tr>
<td>Sinclair and Green 2005</td>
<td>General population</td>
<td>16–25</td>
<td>20</td>
<td>Qualitative (interview)</td>
<td>Want trusted staff, someone outside family but not secondary care. Want more help in A and E, more information. Mental health services limited impact for young peoples</td>
<td>h/h/l</td>
</tr>
<tr>
<td>Storey et al 2005</td>
<td>Accident and Emergency Department</td>
<td>16–22</td>
<td>74</td>
<td>Qualitative (interview)</td>
<td>Social networks important</td>
<td>m/l/m</td>
</tr>
<tr>
<td>Teggart and Lindon 2006</td>
<td>Mental health</td>
<td>14–20</td>
<td>30 (11 focus group)</td>
<td>Qualitative (questionnaire, focus group)</td>
<td>CAMH unhelpful</td>
<td>m/m/m</td>
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<td>Day et al 2006</td>
<td>Mental health</td>
<td>9 to 14</td>
<td>11</td>
<td>Qualitative (focus group)</td>
<td>Confidentiality, time to build relationships, trust</td>
<td>m/h/m</td>
</tr>
<tr>
<td>Biddle et al 2006</td>
<td>General population</td>
<td>16–24</td>
<td>22</td>
<td>Qualitative (interview)</td>
<td>Would not go to GP for mental health problems; seen as pill dispensers</td>
<td>m/m/m</td>
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<tr>
<td>Taylor et al 2007</td>
<td>Mental health – homeless</td>
<td>16–23</td>
<td>19</td>
<td>Qualitative (interview)</td>
<td>Integrated service provision seen as important</td>
<td>m/m/m</td>
</tr>
<tr>
<td>Fox and Butler 2007</td>
<td>School</td>
<td>11 to 16</td>
<td>415 (63 in focus groups)</td>
<td>Qualitative (focus group and questionnaire)</td>
<td>Counselling should be provided</td>
<td>m/m/l</td>
</tr>
<tr>
<td>Fortune et al 2008a</td>
<td>School</td>
<td>15–17</td>
<td>5293</td>
<td>Mixed (questionnaire)</td>
<td>Friends and family main support, barriers to seeking help</td>
<td>m/m/l</td>
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<tr>
<td>Fortune et al 2008b</td>
<td>School</td>
<td>15–16</td>
<td>2954</td>
<td>Qualitative (questionnaire)</td>
<td>School-based approaches important, proactive counselling. Little relevance of mental health services</td>
<td>h/m/m</td>
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<tr>
<td>Paul et al 2008</td>
<td>General population</td>
<td>14–16</td>
<td>1129</td>
<td>Mixed (questionnaire)</td>
<td>Under half would attend CAMH if referred. Want choice, final say, information before attending, generic name not mental health</td>
<td>m/m/m</td>
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<td>Woolfson and Harker 2008</td>
<td>Mental health, psychology service</td>
<td>12 to 15</td>
<td>8</td>
<td>Qualitative (focus group)</td>
<td>Want information sharing, patient information, self-referral</td>
<td>h/m/m</td>
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<tr>
<td>Greco et al 2009</td>
<td>Mental health</td>
<td>7 to 16</td>
<td>18</td>
<td>Mixed (interview)</td>
<td>Deaf services, telemedicine</td>
<td>m/m/m</td>
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<tr>
<td>Author and year publication</td>
<td>Setting</td>
<td>Age range</td>
<td>No. participants</td>
<td>Research methods used</td>
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<tr>
<td>Greco et al 2009</td>
<td>Mental health</td>
<td>7 to 16</td>
<td>18</td>
<td>Mixed (interview)</td>
<td>Deaf services, telemedicine</td>
<td>m/m/m</td>
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<tr>
<td>Rani et al 2009</td>
<td>Mental health</td>
<td>13–17</td>
<td>7</td>
<td>Qualitative (semi-structured)</td>
<td>Want to keep own environment, more practical help, better communication. Liked outreach and home-based treatment.</td>
<td>m/m/m</td>
</tr>
<tr>
<td>Neale 2009</td>
<td>General population</td>
<td>14 to 22</td>
<td>35</td>
<td>Qualitative (interview)</td>
<td>Like flexibility, outreach, technology in delivery, cultural competence. Current lack of trust, accessibility, not involving minority ethnic groups and young people.</td>
<td>m/l</td>
</tr>
<tr>
<td>Singh et al 2010</td>
<td>Mental health</td>
<td>17–18</td>
<td>154 (11 interview)</td>
<td>Mixed (interview, case note survey)</td>
<td>Joint working, flexibility, transition planning</td>
<td>h/m/l</td>
</tr>
<tr>
<td>Weight of evidence – low</td>
<td>Biddle et al 2004</td>
<td>General population</td>
<td>16–24</td>
<td>3004</td>
<td>Quantitative (questionnaire)</td>
<td>7.5% men and 8.9% women seek help from GP for mental health, less than 20% with suicidal thoughts go to GP, men higher threshold severity before seeking help</td>
</tr>
<tr>
<td>Rother and Buckroyd 2004</td>
<td>Mental health</td>
<td>to 28</td>
<td>6</td>
<td>Qualitative (semi-structured)</td>
<td>Accessibility, peer support, school info, GP not helpful, Counsellors nice but no help</td>
<td>l/l/l</td>
</tr>
<tr>
<td>Grealish et al 2005</td>
<td>Mental health</td>
<td>Not known</td>
<td>5</td>
<td>Mixed (questionnaire and diary log)</td>
<td>Telemedicine</td>
<td>m/l/l</td>
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<td>McKenzie 2006</td>
<td>Mental health</td>
<td>Not known</td>
<td>4</td>
<td>Qualitative</td>
<td>Problems with current service provision</td>
<td>l/l/l</td>
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<tr>
<td>Biddle et al 2007</td>
<td>General population and distressed young people</td>
<td>16–24</td>
<td>23</td>
<td>Qualitative (interview)</td>
<td>Stigma</td>
<td>h/l/l</td>
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<tr>
<td>Mullan et al 2007</td>
<td>Mental health</td>
<td>12 to 25</td>
<td>51</td>
<td>Mixed (focus group, interview)</td>
<td>Kids in care, continuity of care</td>
<td>l/l/l</td>
</tr>
<tr>
<td>Naylor et al 2008</td>
<td>Prison</td>
<td>mean 14.6</td>
<td>20</td>
<td>Qualitative (interview)</td>
<td>Genuineness of mental health worker, trust hard won, flexibility, outreach, explanations, proof of commitment</td>
<td>l/l/l</td>
</tr>
<tr>
<td>Gordon and Russo 2009</td>
<td>Mental health</td>
<td>7 to 17</td>
<td>15</td>
<td>Mixed (interview)</td>
<td>Information</td>
<td>l/l/l</td>
</tr>
<tr>
<td>Hardy et al 2009</td>
<td>Mental health</td>
<td>16–30</td>
<td>10</td>
<td>Qualitative (interview)</td>
<td>Social needs come first</td>
<td>l/l/l</td>
</tr>
<tr>
<td>O’Reilly et al 2009</td>
<td>Mental health – homeless</td>
<td>15 to 22</td>
<td>25</td>
<td>Qualitative (interview)</td>
<td>Stigma, barriers to engagement</td>
<td>m/m/l</td>
</tr>
<tr>
<td>Walker 2010</td>
<td>Mental health</td>
<td>Under 17</td>
<td>7</td>
<td>Qualitative (focus group)</td>
<td>New service</td>
<td>l/l/l</td>
</tr>
</tbody>
</table>

†Assessed using Gough’s weight of evidence framework. A = Coherence and integrity of evidence in its own terms. B = appropriateness of form of evidence for answering review question; C = relevance of the evidence for answering the review question; A and E, accident and emergency; CAMH, Child and Adolescent Mental Health service; GP, general practitioner; h, high; l, low; m, medium.
Young people’s views

Sample size

Over two thirds (n = 21) of studies had a sample size smaller than 50 participants, with seven studies of up to 10 participants. Six studies had between 50 and 1000 participants, and four studies over 1000 participants.

Sample selection

Fifteen of 31 studies were based on views of self-selected participants. A further seven studies used purposive sampling, mostly inviting known service users to take part in the study.

Participants

All but two studies had participants of both genders. One of these studies was based in an eating disorders setting and all six participants were female.27 Another small study with seven participants did not contain information about the gender of participants.36

Fourteen of the studies included were based on the views of adolescents under the age of 18, 15 studies covered the views of young people in their late teens and early twenties, that is, the period of transition from child to adult services. Only one study focused on young adults aged 18 and over.27

Two studies sought the views of young people from specific ethnic minority backgrounds,7,24 most studies (18 of 31) did not give information about the ethnicity of participants. Two studies had only white British participants,10,14 and nine had participants from mixed ethnic backgrounds.

Settings

Eighteen of 31 studies were based in a mental health service setting, with a combined number of 477 participants. Two further studies recruited participants from general hospital following deliberate self-harm.11,12 Five studied the general population of young people in the community, with a combined number of 4213 participants, and four recruited a total of 8757 participants through schools. Two further studies focused on clients of a Youth Offending Team and an assertive outreach service for young offenders, respectively.9,32 Overall, 625 participants from 22 studies had some experience of mental health services, and 12 990 participants from 10 studies were from schools or the general population, and are assumed to have no experience of mental health services.

Thematic analysis

Thematic analysis of all studies was carried out, generating themes of what young people wanted from and found helpful about mental health services (positive themes) and what they found unhelpful about mental health services (negative themes). The themes were broad, including groups of related, but distinct themes within each.

What do young people want and find helpful about mental health services?

Broad areas of information, accessibility of services, qualities of mental health workers and self-reliance were the main positive themes to emerge from thematic analysis of the studies identified.

Theme 1: information

Information was a key issue both in studies of young people with experience of mental health services (11 of 22 studies) and in studies that covered the general population (6 of 9 studies).

Six of the papers studying the general population or schools, which included the views of over 4000 young people, highlighted that young people thought they needed more information about mental health, about mental health services, and what to expect from these services.

A questionnaire-based study exploring the decision making of 1129 14–16-year-olds, of whether to re-attend CAMHS or not, highlighted the importance of the quality of the information young people received before attending appointments. Eighty percent of respondents said they wanted relevant information prior to attendance.20 The vast majority (1050 of 1129) thought that information about CAMHS should be given to all young people, not just those referred.

Young people with service experience commented that information about what to expect from mental health services would have been helpful prior to appointments:

- If they sent . . . a letter something or phoned (I) would have been more aware and like, think, could think, of the questions they would ask . . . and then think of the answers.14

Young people wanted services to be more visible and put forward ideas on how to make information about mental health services available, including websites, leaflets aimed at young people to be sent out before appointments, and interventions and information in accident and emergency (A&E) departments.11 Young people expressed a preference for information about local non-statutory groups
and agencies (i.e. not state-run health and social care services) enabling them to make a choice about services they access. Young people said their ideas of psychiatry were based on television series and documentaries. Using television, as well as school-based information and education, were suggested by young people as a way of raising people’s awareness of mental health, and tackling stigma.

**Theme 2: accessibility of services**

Accessibility was identified as an umbrella theme comprising sub-themes of accessibility in terms of location, timing, access without waiting list, as well as services being flexible in responding to young people’s needs, and services having an ethos and using a language that made young people feel at ease. Accessibility was the most prevalent theme in studies exploring the views of young people with experience of mental health services, featuring in 16 of these 22 studies, and in four of nine studies of young people without service experience.

Young people expressed the view that mental health services should be available in locations that they could easily access, and access independently, for instance having counsellors in their school, and being seen in community based services close to home. Services with an outreach approach were commented on favourably. Equally, home-based treatment was greatly favoured over hospital admission. Services being accessible at the appropriate time was important to young people, in particular having immediate access to help, and problems being addressed in a timely way before they became worse.

If I’ve got a problem I just phone them up and tell and they are out in an instant.

Several studies highlighted the importance of services being flexible and responding to young people’s preferences in terms of location and timing of appointments, as well as means of communication used (e.g. phoning, texting and email rather than letters).

Yeah, so, I just saw her like once a fortnight. But when I was going through my worst stages, she really helped me out like over the phone, […] In the evenings, she’d just ring me up when I went through a rough patch. Well, it’s a nice feeling, isn’t it, like have someone there for me (Charlie, 18 years old).

This quote is from a client of a new service called ‘Strong Minded’, a voluntary organization/mental health service for residents of Foyer Federation shelters for young homeless people. Participants liked the easy access, quick referral process and flexible but integrated approach, with the counsellor taking young people out of the foyer, for instance for a chat in local cafes or parks.

Flexibility and responsiveness were seen as validating and supportive:

- He was always asking me for when would be a nice time for the next meeting and he wasn’t telling me, ‘I’ll be coming back on this day and this day’.
- He wasn’t in a hurry all the time. He always made sure everything was alright for me . . . not alright for himself, like, ‘Oh I’ve got to go now.’

Similarly, a new mental health service for 11–18-year-olds, ‘The Junction’ aims to offer flexible interventions tailored to the needs of the young person. The service users were impressed with the speedy response, flexible working and range of interventions. Although these small-scale studies are surveys of particular services, they reflect recommendations from wider groups of young people, such as the National Advisory Council.

Help with practical problems was also valued highly and was essential to engagement for some young people, for instance, the clients of an early intervention in psychosis service. Meeting in a relaxed atmosphere, focusing on activities and building social support networks have been suggested as helpful especially for those who find engagement and trust difficult.

**Theme 3: worker qualities/skills**

Fifteen studies of young people with and without experience of mental health services highlighted the key qualities young people found helpful in their workers. They needed to be approachable, genuine, friendly, positive, warm and kind, as well as skilled and knowledgeable. The worker’s awareness of and ability to maintain confidentiality was highlighted in nine studies, for example:

I wanted to tell my doctor but then I was scared that he’ll tell my parents.

Two large, questionnaire-based studies of young people’s help seeking after episodes of self-harm identified ‘talking and listening’ as the most dominant theme when young people were asked to identify what would be or had been helpful to them.

‘People want to listen to their problems, give them confidence, be there for them, don’t let them down, show them you like them and want to help them.’

The relationship with the worker, and having someone to talk to and to listen were important
features for young person’s experience of early intervention in psychosis services, and child and adolescent mental health services. The best thing was that I could tell someone how I felt and what was bothering me.

A small, qualitative study of homeless young people, a particularly vulnerable and disadvantaged group, found that they highly valued having someone to talk to who they did not feel was prejudiced against them. Young people appreciated workers being positive and encouraging: ‘She’s helped me see in different ways. Instead of seeing the bad in everything, seeing the good things about life as well.’

Theme 4: self-reliance

Eight papers found that young people valued self-reliance, and taking control of their own lives.

In studies of those without service experience, this was expressed as not wishing to use services, or not having a need for services, with young people wanting to solve their problems themselves.

Young people with service experience also wanted mental health services to promote self-reliance. ‘When she helped with my problems I feel just like this dinosaur . . . I can go over my problems and solve them myself and she can help me and the appointments have helped me because I can tower over my problems and look at it another way.’

Young homeless people interviewed by Taylor et al. valued the support given by their mental health coordinator, which allowed them to become more independent in the long run: ‘I wouldn’t go to the doctor’s on my own, I couldn’t . . . and so she would come with me just to make sure, keep me at ease [. . .] That increased my confidence and made me able, like, to go to the doctors whenever now.’

What do young people find unhelpful about mental health services?

In young people with and without experience of mental health services, stigma of mental illness was a common theme, and a main barrier to accessing services, alongside lack of information or access. In studies of those with experience of mental health services, medicalization of their difficulties, especially by GPs and psychiatrists, was experienced as unhelpful, as was lack of continuity of care.

Theme 1: stigma

Stigma was an issue in 14 studies (6 of 9 studies of those without experience of mental health services, and 8 of 22 studies in mental health service settings), and cited as one of the main barriers to accessing mental health services. For instance, a study eliciting the views of a large, school-based group of adolescents on help seeking before and after episodes of self-harm, cited stigma as a reason not to seek help:

Because I didn’t want people to say I was a psycho.’ A respondent in another school-based study commented on the idea of going to see a school counselor: ‘Friends would probably take the mick if they found out.’

For those with experience of mental health services, negative beliefs about mental health services and the stigma attached to these were also cited as significant barriers to help seeking, and a reason not to identify themselves as having a mental illness: ‘I thought if I said anything to anyone, I thought I was going to end up at [the local psychiatric hospital] having electric shock treatment.’

‘I didn’t think I was mentally ill as such I just thought (.) mentally ill for me is like, that gives me a picture of someone who’s really screwy in the head. [. . .]’

The term ‘mental health’ itself was seen as negative by young homeless people: ‘someone who wuz a bit of a fruit loop that’s what it meant. That’s what I thought it meant’ ‘Yeah I think it’s jus’ scary sayin mental health cuz it doesn’t sound very nice really.’

Theme 2: lack of information/access to services

Young people are known to be low consulters of mental health services particularly in the age range of 16–24 years. In a paper exploring reasons why young people had not sought help from mental health services, Biddle pointed out that a lack of information about and awareness of mental health difficulties was a crucial factor, with one participant explaining: ‘. . . I didn’t think it was that bad. I didn’t think it warranted wasting their [the doctor’s] time.’

A study following up young people presenting to A&E following an episode of self-harm similarly highlighted a lack of awareness of mental health as a barrier to help-seeking: ‘It had in no way occurred to me that I might be ill. I hadn’t even thought of depression being involved, never crossed my mind [. . .]. Going to the doctor didn’t even enter my head’

Additionally, young people lacked information about services available to them ‘I didn’t know who
or how to get help. This was particularly highlighted in those from minority ethnic communities.

For young people involved with services, lack of information about service and treatment options was also a dominant theme. Frequently, young people were not aware why they had been referred to services, and what their choices were in terms of engagement with the service. Singh et al. highlighted the lack of information and preparation for young people making the transition from child and adolescent to adult mental health services.

In a few of the studies identified, young people commented on the lack of appropriate services available to them, for instance, Rother and Buckroyd report the lack of availability and access to specialized eating disorder services:

You are either bad enough to be put in hospital or left to your own devices.

One study of views of users of Child and Adolescent Mental Health Services found predominantly negative experiences of the services, highlighting the lack of public knowledge of child and adolescent mental health, insufficient service capacity with long waiting times and lack of access to services.

**Theme 3: medicalization of problems**

Nine of the studies highlighted young people’s feeling that they were not listened to when they sought help from health professionals, and were ‘fobbed off with medication.’ GPs were mentioned specifically in five of the studies.

Some young people felt that they were not taken seriously by their doctor:

Could not be arsed with a doctor saying nothing is the matter.

Being ‘fobbed off with medication’ was also a theme identified by young people following presentation at A&E after intentionally harming themselves, such as a young woman looking back on her GP consultation:

I was pleased that he had done something but really I didn’t want to be put on antidepressants. I would have preferred to have just been able to talk to somebody. I think that’s what I needed, rather than just take tablets or something.

Medicalizing emotional difficulties was a recurrent theme, expressed by a young woman about consulting her GP:

[...] I’ve sat in front of him before and sobbed because I was upset and he just did another blood test.

**Theme 4: lack of continuity of care**

A lack of continuity of care was raised as an issue in 8 of 22 studies that included young people with an experience of mental health services. For instance, a 17-year-old woman interviewed about her experience of accessing care in relation to repeated self-harm, explained that over the past 3 years, she had seen about 20 different counsellors, psychiatric nurses and doctors:

See someone, and then it stops. See another person. You need someone continuously or it’s not going to work.

Young people experienced frustration at the repetitive questioning associated with a lack of continuity of care:

Each change was disruptive. I was continually having to get to know different people and to tell my story, and it takes a whole load of time to build up trust in someone.

Singh et al. examined lack of continuity due to transition from child and adolescent to adult mental health services as a systemic issue, and found that optimal transition was a rarity at less than 5% of 154 cases studied.

**DISCUSSION**

We conducted a systematic review of all available studies exploring the views of young people of mental health services in the UK. A strength of the review is its inclusion of both quantitative and qualitative studies. A limitation is the inclusion of a large number of studies providing low-quality evidence in answering the research question.

Previous reviews have highlighted a lack of high-quality evidence available in this field with many studies failing to meet basic standards of methodological reporting. In this review, a high proportion of studies were reliant on highly selected samples (over two thirds), often using non-independent researchers and service settings. Although some studies included data from distressed non-help seekers, the views of important groups of young people, for instance, those who have disengaged from services, are not represented. Eighteen out of 31 studies provided no details of the ethnic status of their samples raising further questions regarding the representativeness of the views reported. A recent consultation exploring the mental health needs of young people (12–24 years) from ethnic minorities, some of whom were asylum seekers or refugees, reported low use of mainstream services as
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of services who did not see that feeling suicidal or distressed would warrant a visit to a doctor. Although young people identified stigma as a major barrier, they also expressed stigmatized views themselves against those with mental health problems, and the use of medication to treat emotional problems, for instance. This lack of mental health literacy demonstrated in young people in UK has been shown across age groups, and in a number of countries. Recent investigations of help seeking in mental health highlight the dynamic nature of this behaviour, and that those young people who do seek help may reach it through multiple complex pathways.

A recent report from Young Minds advocates for increased government campaigns around mental health and well-being and greater training for professionals working with young people (i.e. teachers, youth workers) around mental health promotion, the negative effects of stigma and ways of accessing help, as well as embedding teaching about good mental health and emotional resilience into school agendas. There are also increasing calls for mental health services to be mainstreamed and central to all services for children and young people and for as much emphasis on mental health as there is on physical health, as a way of challenging the prevailing negative views.

Other strategies that have shown to be effective in improving mental health literacy include individual training programs, such as mental health first aid training and school-based interventions such as MindMatters and Mental Illness Education.

In summary, young people have strong and consistent views of mental health services, both of the reasons for current poor engagement, and also how they could be improved. Engaging young people directly in service redesign as well as assessing the impact of service redesign on these barriers to engagement would be ways of ensuring that services are addressing the needs of young people, and are fit for purpose. Future research in this area should actively seek the views of those young people who have disengaged from services, whose views are not currently known, and who are the most vulnerable. This will be especially important to do to ensure services suit the needs of all young people.

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