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“Nobody really gets it”: A qualitative exploration of youth mental health in
deprived urban areas

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ABSTRACT

Aim: To explore and describe the experience of mental health and addiction for young people living in urban deprived areas in Ireland.

Method: Semi-structured qualitative interviews were conducted with 20 young adults attending health and social care agencies in two deprived urban areas, and analysed using thematic analysis.

Results: Five main themes were identified: experiencing symptoms, symptom progression, delay accessing help, loss of control/crisis point, and consequences of mental health and substance use issues. As young people delayed help, symptoms disrupted normal life progression and they found themselves unable to engage in every-day activities. Living in deprivation made it harder to avoid developing problems: many had added stressors, less familial support and early exposure to violence, addiction and bereavement.

Conclusion: Young people in urban deprived areas are vulnerable to mental health and addiction issues. Early identification is necessary to halt this progression to improve their chances of achieving their potential.

Key words: adolescence, mental health, substance addiction, qualitative research, early medical intervention

Introduction

In Ireland, youth mental health and substance use is a major population health challenge ^{(1) (2)}

⁽³⁾. However, services struggle to identify mental health issues in young people: a ten year follow-up study of school children from the Dublin area found that while one fifth had symptoms indicative of a probable psychiatric condition, only a minority had received any formal medical/psychiatric intervention ⁽⁴⁾. Furthermore, young people often do not present to mental health services for treatment ⁽⁵⁾.

While it is known that areas of social deprivation which are associated with increased risk of developing a mental health or addiction issue ^(6, 7), evidence has shown that akin to Hart's Inverse Care Law ⁽⁸⁾, as social deprivation rating scores for an area increase along with the prevalence of psychological distress, average consultation times in practice decrease due to demands on services ⁽⁹⁾. In essence, those who are most in need of longer consultation time and improved care, are less likely to receive it. Therefore, a cycle exists where burden and poverty are reinforced by the failure to receive necessary services ⁽¹⁰⁾. Irish services are also structured to prioritise those with serious mental health diagnoses ⁽¹¹⁾, meaning most are left without help until the problem is harder to treat.

As addressing and treating youth mental health is a 'best buy' ⁽¹²⁾, efforts need to be made to change how current services operate. General practice has the potential to play a large role in early intervention, due to its ongoing nature and acceptability as a place of treatment ^{(13) (14)}, although currently young people and even GPs themselves do not associate general practice with youth mental health ^{(15) (16)}. In developing a general practice-based complex intervention to promote early identification and treatment of youth mental health in deprived urban areas, this paper aims to explore the lived experience of mental health and addiction issues from the

perspective of young people in socio-economically deprived urban areas in Ireland.

Understanding ill-health behaviours and their interventions is incomplete unless we take into account the subjective reality of those who are experiencing illness, especially for populations such as young people who have limited representation in determining health care practice and research ⁽¹⁷⁾.

Method

We conducted 20 semi-structured interviews with young people (aged 16-25 years) attending a range of healthcare settings and community agencies from Limerick City and South Inner City Dublin, two areas in Ireland associated with extreme social deprivation ^(18, 19). Recruitment was facilitated by healthcare professionals at each service, who identified young people who met the study inclusion criteria (aged 16-25 years, attended the service for a mental health or addiction problem, able to provide informed consent). Each participant was provided with information and a consent form prior to participation, with parental consent needed if the participant was under 18 years. A description of the study population is in Table 1.

All interviews were conducted using an interview guide. Interviews were audio-recorded, transcribed, stored, then organised using Nvivo 9. Coding was conducted by the research team using a thematic analysis approach ⁽²⁰⁾ similar to other research ^(21, 22) i.e. data driving the coding and constant collaboration used to ensure codes created were accurately reflective of the data. Three researchers (DL, ES, CA) coded the interviews individually and corroborated themes with the principal investigator (WC) to reach consensus. The data reported here relates to the lived experience of mental health and addiction problems, with previous and

future published reports addressing the role of context, the role of the GP and treatment experiences.

The study was approved by the Research Ethics Committees of the Irish College of General Practitioners.

Results

We identified five themes outlining the experience of living with a mental health or addiction issue: experiencing symptoms, symptom progression, delay accessing help, loss of control / crisis point, and consequences of mental health and substance use issues.

Experiencing symptoms

The young people interviewed were dealing with a range of symptoms. Many had feelings of sadness and worthlessness, with social withdrawal common. Participants felt better when alone, but unable to engage with activities of daily living:

So I just kind of withdrew from the world, and even if I needed stuff from the shop I would get family members to do it. (*Participant 6*)

Others described the negative impact of panic attacks on their daily functioning; disturbing and frightening them on a regular basis:

I think that is one of the worst things that can happen to you that you have a panic attack; it is just terrifying. You can actually feel like you are having a heart attack... people just say it is a 'panic attack' and you will scream and say that it is not a panic attack, that you are actually dying but you are not...It was very frequent last year. It was like every day last year. (*Participant 20*)

Symptom progression

As symptoms deteriorated, the young people developed issues which exacerbated their problems. Many turned to substance use, or were frequently getting into trouble for angry outbursts or behavioural problems:

I just ran to drink straight away...I was so angry all the time and the smallest thing would go wrong and I'd be lashing out, like hitting wardrobes and digging and kicking things. *(Participant 4)*

Those already engaged in substance use found themselves becoming addicted and dependent:

I was getting really in a state. My Mam didn't know I was drinking. I was going down a hole. I was keeping my lunch money and buying the cheapest drink...*(Participant 12)*

Self-harming was used as a coping strategy to manage intense emotional pain. This could be through eating disorders or substance abuse, but on some occasions involved cutting with sharp implements:

I used to cut myself and just think like 'ok if I can actually feel the pain physically it's going to go away', but it never did. Yet I still didn't learn the lesson and I still cut because for those few seconds it helped. It relieved some of the pain. *(Participant 4)*

Delay accessing help

Despite increasing distress, participants found it difficult to reach out for, or accept help. When many did open up, it was after long periods of hiding symptoms from others out of embarrassment or a genuine inability to talk about their problems:

You learn to hide it well. And it is like when you are with other people, you put on a brave face and then when you go home, you are like “Oh, not this again.” It is that sort of thing. At the same time you can’t really go up to people and ask. They will just say they are grand. That is all I ever said to anyone “I am grand.” *(Participant 11)*

Refusing help offered was also common:

I have had plenty of opportunities but I wasn’t ready to come out of it, I wasn’t ready to come off drugs....I don’t think you can really force it (treatment) on someone...if you don’t want it, you are not going to go and get it. You are just going to push people away. *(Participant 7)*

Loss of control / crisis point

With relationships breaking down, addiction becoming a full-time occupation, and their negative thought processes becoming overwhelming, participants felt themselves losing control. Nearly half had serious suicidal ideation, with four participants having attempted suicide:

I sent a text to my mother two years ago I think. I basically asked her would she rather me kill myself than live an everyday life, since I am making life so bad for her *(Participant 20)*

Due to their illnesses, and the protracted time spent dealing with the problem alone, many felt it was not possible to get better, with needed others to convince them to get help and keep living.

...(my friend) said “Why don’t you want to get help?” And I am like, “The thing is I do”.
But, you know, when you get to that stage where you are just so... you hate yourself so much that you would rather die, it is a scary stage. (*Participant 19*)

Consequences of mental health and substance use issues

Participants felt ashamed and embarrassed about needing treatment or disclosing problems to others. There was also lack of understanding and empathy about their situations, making them feel isolated when they needed help most.

I don’t talk to my friends in school anymore. They stopped talking to me because I haven’t been in school in ages and they didn’t keep in touch with me or anything to see how I was. They don’t seem to get – they think that I wasn’t actually sick. They just think “Oh, she is doing [it] for attention...” They don’t really get it; nobody really gets it unless they have been through it. (*Participant 11*)

A large majority of our participants had also left school at a young age and were unhappy with their current employment options. Some found it difficult to work when dealing with a mental health problem:

At the moment I’m floating around through life. I don’t really have an actual job that I love to get up to go to every day it’s 12 hours a week and I actually hate going in there but it’s something that keeps me going. Some days I really struggle to get up and go but I have to...I mean 12 hours really if you think about it...is nothing when you think about it compared to 40 hours a week but it’s a start I suppose and in another few months I’ll be able to do more. I am struggling but I’d rather struggle than not even try. (*Participant 4*)

Others also had legal issues over behaviour that had happened whilst drunk or high:

...going back when I was 16/17 I got into a lot of trouble especially by drinking like, with the law and things like that, and I ended up in court for things I did that I can't even remember. (*Participant 2*)

It is then difficult for the young person to see themselves in employment or for employers to employ them, especially in times of recession. Many found themselves receiving social welfare and struggling to engage with society.

Notably, these young people experienced the above themes within the context of urban deprivation. Many described troubled families, stressful life circumstances as the norm, and localities where it was difficult to distance themselves from a drug-taking culture. This exacerbated problems and made them more difficult to cope with.

Discussion

Our findings demonstrate that as symptoms progress, it becomes harder for the young person to reach out to others for help. Many become socially isolated, whilst also fearing stigmatisation. As treatment was delayed, normal life progression was disrupted affecting school, work, and social activities. These findings are similar to previous qualitative work, which show the experience of mental health issues in youth tends to progress from bad to worse without intervention, eventually leading to crisis point⁽²³⁾. Interventions for identification and treatment of mental and substance use disorders in young adults should have acceptability and availability as core elements e.g. 'headspace', which offers interventions in less-stigmatising environments and targets people with earlier stages of illness development, has increased engagement with and effectiveness of services⁽²⁴⁾. This is encouraging for general practice as a less-stigmatised location for interventions, which can also question young people on mental health when they present for other reasons.

Living in socially deprived urban areas means developing mental health and addiction problems is somewhat inevitable, and has been noted in previous research ^(6, 25, 26).

Participants in this study described how mental health and substance use problems pushed them further away from normal social and educational development, severely restricting their potential for successful lives. Coupled with the high rate of suicidal ideation in our sample, it becomes all the more important to focus research and resources to these areas to ensure these young people have a chance at a better life.

While this research sampled participants from a number of different services in each area, thus capturing diverse experiences and data saturation was achieved, we acknowledge some potential sources of bias. Ethical considerations made it difficult to recruit people aged under 18, and we were also unable to recruit participants with severe mental illness. Thus these key groups' perspectives were not fully expressed in our data.

Conclusion

While youth mental health and substance use are problems that should be addressed through socio-economic policy and changing health systems, they are also very personal and distressing issues for many young people. Our findings highlight why early intervention is not just a 'best buy' in terms of reduced costs to public expenditure, but also in improving the lives of those who struggle daily with emotional pain, high anxiety, and debilitating addiction. It is important to move forward with changes to current systems to ensure that young people in urban deprived areas who are known to be at-risk of developing problems, do not have to wait until they are a danger to themselves before they receive help. General practice can take up this

role due to its availability and familiarity with disadvantaged young people and their communities, as well as its ability to target young people who present for physical rather than mental health problems. However, future research should aim to increase awareness of the services it can offer, and define the role the GP can take in identification and treatment.

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