VIEWS AND EXPERIENCES OF YOUNG PEOPLE (11 – 16 years) TOWARDS MENTAL HEALTH SUPPORT IN A SCHOOL AND COMMUNITY SETTING IN THE UK

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SCHOOL OF ENVIRONMENT, EDUCATION AND DEVELOPMENT

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LIST OF ABBREVIATIONS

BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CMHS	Community Mental Health Services
CMHT	Community Mental Health Teams
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
CPN	Community Psychiatric Nurse
CYP IAPT	Children & Young People's Improving Access to Psychological Therapies
DfE	Department for Education
DH	Department of Health
ECM	Every Child Matters
GP	General Practitioner
HC	The House of Commons
HCPC	Health and Care Professions Council
IPPR	Institute for Public Policy Research
LA	Local Authorities
LGBT	Lesbian, gay, bisexual and transgender
MHL	Mental Health Literacy
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OFSTED	Office for Standards in Education
ONS	Office for National Statistics
OT	Occupational Therapist
PFC	The Prefrontal cortex
PP/PPG	Pupil Premium / Pupil Premium Grants
PSHE	Personal, Social, Health and Economic Education
RCPSY	Royal College of Psychiatrists
SBC	School-Based Counselling
SDQ	The Strength and Difficulties Questionnaire
SEAL	Social and Emotional Aspects of Learning Programme
SEN	Special Educational Needs
SENCO	Special Educational Needs Coordinator
TA	Thematic Analysis

UK	United Kingdom
WHO	The World Health Organisation
YP	Young People

DEFINITION OF TERMS

Adolescence - Refers to a life developmental stage of every human following the onset of puberty during which a young person develops from a child into an adult. Also referred to as teenage years, teens, youth, young adulthood, young days, early life, pubescence, puberty, juvenescence, and juvenility.

Young Person/People – Refer to individuals who are in the process of transitioning from a child into an adult. *Synonyms:* adolescent, teenage, teenaged, pubescent, youthful, young, juvenile, *informal* teen. In this study, the term young person/people is used to describe individuals in the age group from 11 to 16 years.

Wellbeing – Stable wellbeing refers to a state when "individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. When individuals have more challenges than resources, the see-saw (balance) dips, along with their wellbeing, and vice-versa" (Dodge et al., 2012, pp. 230).

Mental Health - For the purpose of this study, mental health is regarded as "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her own community" (WHO, 2001a, p.1).

Community Mental Health Services [CMHS] also known as **Community Mental Health Teams [CMHT]** - Refer to a system of care that provides support and/or treatment to individuals with mental disorders or mental health difficulties in their community instead of a psychiatric inpatient facility (Bentley, 1994).

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ABSTRACT

Background & Aim: This study set to explore what young people [YP] think of the wellbeing and mental health [MH] support available to them in their school and community as such views are currently underrepresented in the literature. It aimed to contribute to our understanding of young people's psychological needs and preferences of mental health services including its delivery and performance.
Study Design: YP (11 to 16 years) were invited to take part in semi-structured interviews to discuss their experiences of MH and wellbeing support available to them. Twenty-one participants from a secondary school based in the North of the UK took part in the study. A representative sample with the following characteristics was recruited: YP with experiences of past MH issues; long-term health conditions; no known MH issues or other conditions. A comparable gender and age representation was ascertained in the sample.
Data Analysis: The participants' interviews were transcribed and further analysed through the use of thematic analysis (Braun & Clarke, 2006).
Results & Discussion: The findings suggest that YP are an informed consumer group of wellbeing and MH provision and were aware of the benefits of psychological support. They identified the need for more services and voiced strong views on helpful and unhelpful features of support that was available at their school and community, both on an interpersonal and service-user level. This study contributed to the literature on help-seeking and psychological coping in young people. It was observed that help-seeking was mediated by the perceived need for support, self-confidence and individual differences. Identified barriers to accessing support were lack of services and perceived stigma.
Conclusion: The findings showed that young people favoured a person-centred approach to care (Ahmad, Ellins, Krelle & Lawrie, 2014). They wanted to feel valued, respected, listened to, be a part of collaborative planning and involved in the decision-making and management of their mental health care.

Keywords: Young people, mental health, wellbeing, support, views, school, community.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

To my husband Philip for your love, support and encouragement.
Thank you for all you are, what you give to me and your unreserved belief in me.
I would not have done this without you.

To my sister Jana who witnessed the start of this journey but sadly not its completion.
You are my best friend.
I miss you every day.

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CHAPTER 1.

INTRODUCTION

1.1 Introduction

This chapter presents the key issues that form the basis for this study. Firstly, it discusses young people in relation to mental health issues and stresses why this area deserves our attention. Secondly, it provides an overview of the child and adolescents' mental health services that are currently operating in the United Kingdom and evaluates their performance. Finally, the importance of young people's opinions and experiences of mental health services is introduced and discussed. Following this, the main concepts are summarised in the rationale for this study, including the research questions. Also, a positioning statement in relation to the role of counselling psychology and mental health support for young people is discussed here. The chapter concludes with an overview of the structure of the thesis to provide direction and facilitate clarity.

1.2 Young People and Mental Health

Adolescence has been identified as a time of increased risk for the emergence of many mental health problems (Giedd, Keshavan & Paus, 2008). Amongst others, these include anxiety and mood disorders, psychosis, eating disorders, personality disorders or difficulties linked to substance misuse. It also has been recognised as a life stage that is susceptible to "specific challenges in treating disease and promoting health" (Christie & Viner, 2005, p. 301). According to Weare (2005) the prevalence of mental health issues amongst children and young people indicates that:

> 1 in 10 children and young people have a clinically diagnosed mental health disorder and emotional and behaviour problems. These are often the same children, and around 1 in 7 have less severe problems that interfere with their development and learning. (p. 2)

A survey conducted by the Office for National Statistics [ONS] in 2004 yielded estimated numbers of 850,000 children and young people aged 5-16 years having a mental health disorder (Department of Health [DH], 2015), of which 340,000 were children aged 5-10 and the remaining 510,000 were young people aged 11-16 years. Amongst the most prevalent diagnoses were anxiety, depression, conduct disorder and hyperkinetic disorders. These statistics are the most recently available (DH & Department for Education [DfE], 2017). However, only 30% of children and young people who experience such problems

are diagnosed in time (Mental Health Foundation, 2015). Increasingly, young people receive appropriate treatment only when their mental health deteriorates to such level that it causes significant disruption to their functioning (Giedd et al., 2008).

The ONS further reported self-harming habits in 2% of children and young people between ages 5 to 16 (DH, 2015). However, the risk of self-harm is higher in children with an emotional disorder, indicating a prevalence of 14%-28%. The prevalence of mental health difficulties varied across age, gender and ethnicity, with a 4% increase in 11-15 years old. Mental health difficulties were observed more commonly in boys (11%) than girls (8%) and in those with a white ethnic background (DH & DfE, 2017). High risk of suicidal ideation, self-harm and substance misuse was found in children and young people of all ages who identified as lesbian, gay, bisexual and transgender [LGBT]. It was observed that children and young people living in care were at particular risk of developing mental disorders: an estimated 45% were affected.

Furthermore high rates of mental illness, as well as behavioural difficulties, were observed in young people involved in gangs, indicating 40% of gang members in comparison with 13% of young people in the justice system. Mental health problems affect children and young adults from all social classes (Patel, Flisher, Hetrick & McGorry, 2007). However, it has been indicated that socio-economic inequality, such as deprivation and poverty, has been associated with the increased prevalence of mental illness (Mental Health Foundation, 2015). The ONS highlighted that mental illness and substance misuse occur more commonly in young people who are not in education, employment or training (DH, 2015). Their poor mental health was linked with socio-economic disadvantages, likely resulting from low employment prospects, low wages and dissatisfaction with life.

Good well-being and mental health are essential for young people's optimal development and learning. It equips them with the ability and skills to deal with everyday experiences, relationships, and the challenges of daily life. Well-being is considered stable when individuals possess skills and resources that are necessary at times of psychological, physical and social challenges. It is negatively affected when such challenges exceed an individual's skills and resources, causing distress and disharmony (Dodge, Daly, Huyton, Sanders, 2012). Individuals that are open to challenging and stressful situations for a prolonged period may develop physical and mental illness. Numerous factors enhance an individual's well-being such as their sense of purpose, good physical and mental health, positive interpersonal relationships, stable and rewarding employment, optimal socioeconomic status, active engagement with the community, and stimulating present and future environment (Dodge et al., 2012).

The relationship between physical health and mental health has been a focus of public health in the last 20 years. The World Health Organisation [WHO] stated "There is no health without mental health" (2004, p.4) and defined health as: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2001, p.1). Further, mental health was characterised as "A state of well-being in which the individual realises his or her own abilities can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (WHO 2001a, p.1).

However, despite the numerous efforts to improve public well-being in the last 20 years, mental health problems are becoming increasingly prevalent in today's society (Mental Health Taskforce Strategy, 2016). They have devastating effects on people's lives, on their communities and pose a growing burden on the economy. In the United Kingdom [UK], mental health problems account for the most substantial disease burden (28%), in comparison to cancer care (16%) or heart disease (16%) (Mental Health Foundation, 2015). One in four people will experience mental health problems in any given year, yet, only one quarter will receive appropriate treatment. Access to mental health care is reportedly insufficient across children, young people and adult mental health services (Care Quality Commission [CQC], 2017; Dubicka & Brent, 2017).

Currently, child and adolescent mental health services are struggling to accommodate the growing demand of young people who require support (House of Commons, 2014). This is mainly due to the budget cuts that resulted from the recent economic crises, which have engulfed Europe since 2008 (Karanikolos, Mladovsky, Cylus, Thomson, Basu, Stuckler, Mackenbach & McKee, 2013). Moreover, the increases in mental health problems may itself be due to the economic issues and its associated deprivation and poverty. The next section provides a brief overview of the current landscape of mental health services available to young people in the UK. Chapter 2 reviews the literature in more detail to substantiate these points.

1.2.1 Mental Health Support for Young People in the United Kingdom

The existence of mental health support for young people in the UK dates back to the 1920s. At first, it was dominated by medicalised psychiatric care (Wolpert, Harris, Hodges, Fuggle, James, Wiener, McKenna, Law, York, Jones, & Fonagy, 2015) and although the emphasis was put on preventative treatment and well-being enhancement, mental illness was only treated in inpatient facilities and asylums. In recent years there has been a dramatic shift in the treatment of the mentally ill that has shaped the organisation of mental

health services present today (Porter, 2004). The main effort was to move the treatment of severe mental illness from institutionalised psychiatric care to individuals' communities. The movement also known as *deinstitutionalisation* emerged in response to advocacy for more humane and individualised care for those treated in psychiatric hospitals. Britain was one of the first countries to embrace these changes when the Minister of Health Enoch Powell initiated the *Care in the Community* application in 1961. At present, the majority of mental health services are community-based and provided by the National Health Service [NHS] paid by the UK central government funding (NHS England, 2017). CMHS is organised by local authorities [LA] and may vary in size and supply according to the arrangements of each local governmental area. Other services are funded by the private or voluntary sectors.

Community mental health services [CMHS] refer to a system of care that provides support and treatment to individuals with mental disorders or mental health difficulties in their community instead of inpatient psychiatric facilities (Bentley, 1994). CMHS, also known as community mental health teams [CMHT], provide outpatient psychiatric care in a domiciliary setting to individuals that are not hospitalised but remain in their homes and access their treatment in the community. Community services vary according to their geographical area and include primary care medical services, day centres, supported housing, psychiatric wards of general hospitals, community mental health centres, self-help and support groups. CMHS is provided by a range of mental health professionals such as psychiatrists, community psychiatric nurses [CPN], social workers, occupational therapists [OT], psychologists, pharmacists, team managers, approved mental health professionals, outreach workers, mental health workers, benefit workers, support workers, recovery workers, vocational therapists, art therapists, counsellors, psychotherapists, speech and language therapists and physiotherapists (HC, 2014).

Primary care medical services are usually the first point of contact for individuals with mental health needs (WHO/Europe, 2004), where a health care provider, such as a general practitioner [GP], a nurse or a pharmacist would coordinate their care and refer them to other specialist services if necessary. These include secondary care or tertiary care. Secondary care is usually associated with acute and specialised psychiatric care that could be either outpatient or inpatient. These services are typically based in the hospital and require a referral from primary care. Tertiary care is commonly administered in specialised inpatient facilities for advanced medical investigation or treatment (Johns Hopkins Medicine, 2019). This study scope was interested in young peoples' views and experiences of ALL mental health services, including outpatient community mental health services,

inpatient psychiatric services, mental health support that was offered at their school, and other profitable or non-profitable organisations that provided mental health care to young people. Further details of the range of these services are provided in the literature review.

In the UK, mental health services that specialise in young people's mental health are collectively termed Child and Adolescent Mental Health Services [CAMHS]. They provide support with psychological difficulties and preventative care, including management of risk to young people who expressed antisocial and exploratory adult behaviours, such as smoking, substance misuse or early engagement in sexual relationships (Wolpert, 2009; Wolpert et al., 2015).

Similarly to CMHS, CAMHS comprises a multidisciplinary team of mental health professionals such as psychiatrists, clinical or educational psychologists, art therapists, speech and language therapists, paediatricians, social workers and other mental health practitioners trained in the assessment and management of emotional, behavioural and mental health problems in young people. Their collective aim is to support all young people and their families with mental health problems. The competencies of these professionals vary as well as their specialist skills and intervention range. CAMHS professionals are based across various settings. Commonly, these are schools, inpatient and outpatient services, social care, GP practices and youth centres.

Historically, CAMHS received limited funding, and their application was under-represented within the wider healthcare sector (The Royal College of Psychiatrists [RCPsych], 2016). Further, the effectiveness of CAMHS was hindered by differences in the adopted language and metaphors, values, philosophies and poor coordination efforts across services and management agencies in the wider system. The significance of these difficulties and the inadequacy of CAMHS has been recognised in the last two decades. To articulate the needs of children and young people into the national agenda, the government compiled the *Every child matters* framework (HM Treasury) in 2003. This framework committed to addressing children and young people's emotional well-being and mental health needs and promised to invest substantial government funding in CAMHS.

As discussed above, this research situates itself in the particular economic and social climate that has been significantly impacted by the major economic crises (Karanikolos et al., 2013). To counteract the financial deficit of the UK economy that was caused by this crisis, the government adopted by their definition, 'necessary' austerity measures. These measures had a direct impact on public services such as the National Health System [NHS] that provides health care and support for people with physical and mental health needs. According to Blyth (2013) "Austerity is a form of voluntary deflation in which the

economy adjusts through the reduction of wages, prices, and public spending in order to restore competitiveness which is (supposedly) best achieved by cutting the state's budget, debts, and deficits" (p.12). The adopted austerity measures resulted in a reduction of funding for many public services. Most areas of CAMHS experienced dramatic financial cuts (DH, 2015; Faulconbridge, Law & Laffan, 2015). CAMHS include community mental health services that are publicly funded, as well as private and charitable organisations that are subsidised by local authorities [LA]. For instance, the government budget, which is allocated to such services, has decreased by almost £60 million per year since 2010 (DH, 2015). As a result, services have been forced to reduce staff levels or downgrade their provisions despite the growing need for well-being and mental health services.

Preventative and early intervention services - that specialised in identification and management of early signs of psychological distress - were particularly affected. In order to manage demand, CAMHS were forced to prioritise and focus on children and young people with severe psychological presentations or those at crisis point, leaving young people with less severe difficulties waiting longer or often untreated. Increased demand for psychological help, as well as staff reductions, contributed to strains on already limited services, and further delayed treatment to those individuals in need (Faulconbridge et al., 2015). The DH (2015) also reported that well-being and MH services, including adult services, lack clear leadership, accountability, and have poor coordination across other services that are involved in individuals' mental health care (e.g. schools, social services, LA).

CAMHS shortcomings are still evident today and many young people receive inadequate support (DH & DfE, 2017). In recent years it has been identified that young people's mental health "has never been of greater concern" (RCPsych, 2016, p.2). A recent review looking at quality and accessibility to of mental health services (Care Quality Commission [CQC], 2017; CQC 2018) showed that services are fragmented and disjointed and offer poor care to young people. These concerns have recently attracted national interest and been reviewed in the Future in Mind report (DH, 2015), that formulated concrete steps and solutions to improve mental health care for young people. The Future in Mind agenda was developed individually for mental health services in England, Scotland, Wales and Northern Ireland to reflect their local laws and was studied by the UK's government. Proposed initiatives were agreed and ensured improvements in public policy, health-care provision and service delivery. A comprehensive five-year programme was proposed to deliver these changes with the aim to transform CAMHS services, also addressed as the *transformation agenda*. In detail, these initiatives agreed to deliver

improvements in public literacy on mental health issues young people face with the intention to tackle stigma and discrimination. The emphasis was placed on timely access to mental health services such that they would be accessible to young people when required.

To aid the transformation agenda, it was proposed that mental health provisions would replace the old model of service delivery with a new model, more fitting to the needs of young people. The old, 4-tier model of mental health services was replaced by the THRIVE Model. Both models are discussed in detail in the literature review, section 2.3, to provide more insight about the structure, approaches and philosophy of current CAMHS. Further, every mental health service is expected to apply evidence-based treatments and use outcome measures to monitor rigour and ensure the quality of services. A successful transformation programme that has been tested and demonstrated rigour is the Children & Young People's Improving Access to Psychological Therapies [CYPIAPT] and has the potential to be rolled out nationally.

The transformation agenda put a lot of emphasis on the importance of effective communication between all agencies that are involved in young peoples' care at any given time. They argued that improving communication between professional services would ensure straightforward and visible access to services as well as in relation to referral pathways, assessment and psychological treatment.

Additional support should be given to vulnerable children and young people that have experienced abuse or exploitation. Further, the availability of specialist support and comprehensive assessment that is tailored to the needs of these individuals is to be ensured. The agenda argued that access to evidence-based interventions and support should also be increasingly available to parents. Additional funding was allocated for programmes targeting parenting and early years health services, focusing on positive attachment, behaviour, and resilience. Improved provision for timely crisis intervention and treatment that is local and easily accessible would reduce unnecessary in-patient admissions. Police detentions of young people with mental health issues were criticised and it was argued that detention does not function as a place of safety, but rather contributes to the deterioration of mental health and perpetuates stigma.

Lastly, the agenda highlighted the importance of integration of mental health specialists into schools and the need for implementation of clear evidence-based pathways for community-based care. The government has aspired to transform child and young people's mental health care by 2020 and its aims and objective have been regularly reviewed and updated. For instance, the recent Green Paper (DH & DfE, 2017) builds on Future in Mind (DH, 2015) and sets to expand the mental health provision funded by the NHS and updated

some of the aims listed above. These updates are discussed in more detail in the literature review.

The transformation agenda adopts a whole-system approach that aims to improve the transparency and accountability of services and commissioning agencies. Outcome measures, a collection of access information and waiting times would allow services to evaluate and survey their performance more readily and effectively. Adequate training and support should be provided for all professionals who work with children and young people as well as regular evaluation of their performance. The whole-system approach requires collaboration and coordination within the wider system, including the healthcare sector, social care, schools, voluntary sector, communities, and families (RCPsych, 2016). The navigation of multi-agency services is not without its challenges. For instance, schools face increased pressure to support pupils' emotional well-being as well as their academic goals. However, they often lack the time and resources to support the psychological needs of young people with mental health needs (Hanley, Winter & Burrell, 2017; Thorley, 2016).

1.2.2 Young People's Views

Despite the active engagement in promoting awareness and supporting young people with mental health issues within the whole-school approach, it has been estimated that 200,000 children aged 10-17 in the UK face multiple disadvantages that are affecting them on emotional and economic levels (The Children's Society, 2017). Emotional neglect, fear of crime or assault and financial struggles were amongst the most common problems. "Children and young people's happiness with their life as a whole is at its lowest since 2010" (The Children's Society, 2017, p.3). School children reported surprisingly low scores on their subjective well-being and their satisfaction with life at school in comparison with fourteen other countries around the world (The Children's Society, 2015). Specifically, children aged 10 to 13 years old scored "particularly poorly in terms of their feelings and perception of themselves and also their life at school" (p. 62). Dissatisfaction with school life was not observed in children in other countries that participated in the survey. The Good Childhood Report (2015) also indicated gender differences, showing that girls in the UK are less satisfied with themselves than girls in a range of other countries, particularly in subjective feelings towards appearance or self-confidence. Financial deprivation and inequality were also identified as contributing factors to young people's poor subjective well-being. Individuals that were particularly affected were young people in residential or foster care. Subjective well-being has been identified as a reliable measure of societal progress and an indicator of the overall quality of life. However,

research into the subjective well-being of young people aged 14 years and above is limited (The Children's Society, 2015). Subjective well-being tells us how young people perceive what is important to them and what they like and do not like in relation to themselves, their relationships and environments.

The Good Childhood Report (The Children's Society, 2015) raised concerns that the agencies responsible for delivery and distribution of young people's mental health services in the UK are not focusing on young people needs and well-being. Instead, they are predominantly interested in young people's academic attainment or behaviours that are disrupting typical academic progressions, such as substance misuse, teenage pregnancy or anti-social behaviours. They further highlighted the need to widen the well-being debate to young people and include their perspectives and experiences. This would inform the service aims and objectives that are currently being shaped predominantly by the concerns and decisions of adults.

In 2005 The Children's Society initiated a research programme to balance this debate by involving children and asking their views about well-being with the aim of understanding their perspectives and priorities and focusing on all aspects of their lives rather than just negative behaviours (The Children's Society, 2008). Their recommendation in respect of addressing disadvantages amongst children and young people in the UK stated:

> Listening to children and giving them a say in decision-making is the best way to make sure that policy and practice solutions deliver positive outcomes for young people. Council plans should, therefore, be produced in collaboration with children and young people living in the local area (The Children's Society, 2017, p.18).

This study aims to build upon the above findings and contribute to the body of research that promotes the views of young people in relation to mental health and well-being. Further, it supports young people's involvement in service delivery and planned to explore their thinking on current mental health support. The next section summarises the main points raised above and outlines the rationale for this study.

1.3. The Rationale for the Study

As discussed above many young people are at increased risk of developing severe mental health difficulties (Giedd, Keshavan & Paus, 2008) due to their vulnerability associated with changes experienced in adolescence (Christie & Viner, 2005). Additionally, young people are often unable to receive adequate support for their mental health difficulties as services are presently struggling to accommodate the growing

demand (HC, 2014; Faulconbridge et al., 2015). Like many other public services, CAMHS experienced severe cuts to their resources due to the economic crises that affected the UK since 2008 (Karanikolos et al., 2013). As this study started to take shape in 2015, it became apparent that mental health support for young people was inadequate and insufficient (Mental Health Foundation, 2015). The Future in Mind report (DH, 2015) had just been released and highlighted many areas of potential improvements. One such area was to widen the debate to young people and ask their opinions on the matter. This study - in aiming to contribute to this debate - offered a platform to a small group of young people to express the views, attitudes and experiences they had of the mental health support available to them at their schools and communities. Schools are now increasingly acting as a gatekeeper to mental health support (Thorley, 2016); therefore, approaching young people within their school context was deemed appropriate.

As reviewed above, there has been a number of developments within the last three years in relation to mental health support for young people. Notably, the proposal of the influential 'transformation agenda' to the UK Parliament highlighted an urgent need for significant changes in children and young people's mental health provision (DH & DfE, 2017). This study reviewed literature in relation to the current discussion on the 'transformation agenda' of CAMHS services to contextualise current thinking in the field. The data were collected between May and June 2017 and potentially reflects some of the changes and initiatives that were proposed in the agenda. The specific aims of this study were, however, independent of this. The aim was to explore whether young people know what help is available to them when they need support with mental health difficulties and whether they find mental health support useful and easily accessible. The usefulness of some support that is available to students, such as school-based counselling, has been extensively evaluated (Cooper, 2013; Cooper, Fugard, Pybis, McArthur & Pearce, 2015). However, this study was interested in all forms of support, formal and informal, that young people could access either at their school or community. This study aimed to go beyond a single service evaluation and offer young people the opportunity to express their views towards *all* mental health provisions available to them inside and outside of their school. Such perspectives are currently missing from the literature and can inform us how young people perceive and utilise support. Such knowledge could facilitate change in mental health services and enhance our understanding of young people's psychological needs. Our understanding of these issues can further assist in the development of personalised care, and aid tailoring services, treatments and interventions that are suitable for, and preferred by, young people.

1.3.1 Research Question

In light of the above evidence, this research set out to explore young people's views and experiences of the well-being and mental health support that was available to them at their school and community. This study was interested in young people aged 11 to 16 years. Participation was random and selected from a school based in the North West of the United Kingdom. The research question explored:

What are young people's (11-16 years) views and experiences of well-being and mental health support at their school and community in the UK?

Specifically, it focused on areas related to:

- The availability of well-being and mental health support to young people at their school and community;
- the accessibility of well-being and mental health support to young people at their school and community and
- the usefulness of well-being and mental health support to young people at their school and community.

1.3.2 Positioning Statement: Young People and Counselling Psychology

Counselling psychology could play a crucial role in supporting young people because, as a discipline, it is interested in the well-being and mental health of individuals (Gelso, Williams, & Fretz, 2014). Furthermore, training in counselling psychology educates professionals in key areas of mental health support, such as how to recognise early signs of distress, assess individuals' psychological needs, devise and deliver interventions and treatment plans. The training in the UK is rigorous and extensive and requires professionals to complete a PhD programme. Trainees are required to complete competences and a certain amount of clinical practice that provides them with essential tools and strategies to support individuals with mental health needs within various applied fields, including health, forensic, educational, occupational and voluntary settings that are based in either public or private sector.

Programme philosophy and teaching style differs from University to University and could not be generalised across the practice of all counselling psychologists in the UK. This study is informed by the philosophy and teaching taught at the University of Manchester where the researcher completed her training (Manchester Institute of Education [MIE], 2014). The programme's therapeutic and philosophical base is strongly aligned with the pluralistic framework for counselling and psychotherapy (Cooper &

McLeod, 2011) and adheres to the scientist-practitioner model of professional practice (Lane & Corrie, 2006). Further, it adopts humanistic values that are the main features of person-centred counselling and acknowledges that a one-size-fits-all approach is inadequate. Specifically, it accepts that every individual deserves to be treated with dignity and respect and with consideration of their personal characteristics, idiosyncrasies and circumstances. It embraces diversity and pays attention to individuals' phenomenological experiences, needs, beliefs and wishes.

In relation to the mental health support, the pluralistic stance acknowledges the benefits, variability and appropriateness of multiple therapeutic approaches that are available to young people in clinical practice. Having such a varied skills base could assist counselling psychologists to use approaches eclectically and tailor mental health support to young people's needs and preferences more readily.

1.4 Overview of the Thesis

This thesis contains six main chapters as well as references and appendices. The chapters are as follows:

Chapter 1. Introduction;
Chapter 2. Literature Review;
Chapter 3. Methodology;
Chapter 4. Data Analysis;
Chapter 5. Discussion of Findings and
Chapter 6. Conclusion.

To ease navigation through the thesis the following briefly summarise the content of each chapter.

Chapter 1. **The introduction** sets the context for this study and presents an overview of the key concepts that provide the rationale for the study. It outlines the research question and the researcher's positioning in relation to the studies objectives. The importance and the role of counselling psychology in mental health support for young people are also highlighted here.

Chapter 2. Literature Review provides an overview of the existing literature in the area of mental health support that is available to young people in the UK. The aims were to contextualise this study within the current climate and provide theoretical underpinnings. Further, this section evaluates the limitations and highlights the gaps in the literature. This study hopes to provide evidence to bridge these gaps.

Chapter 3 Methodology details the methodological approach and provides specifications of current research design with consideration of its ontological and epistemological stance. The researcher's reflexivity statement is included here.

Chapter 4. Data Analysis describes the themes that were constructed via the means of Thematic Analysis (Braun & Clarke, 2006) and capture the key findings of this study. Vignettes of young peoples' views and experiences are provided here to represent their beliefs and preferences in the most authentic state.

Chapter 5. Discussion of Findings presents the outcomes of the present study in relation to the research question and existing literature, together with implications for clinical practice.

Chapter 6. The conclusion summarises the key aspects and findings of this study and highlights the contribution to knowledge. Limitations and directions for further research are also outlined here.

CHAPTER 2.

LITERATURE REVIEW

2.1 Introduction

This chapter outlines the research scope of the present study. The literature on young people's views and experiences of the UK's mental health and well-being provision is limited and provides only a partial understanding of the issue. Therefore, the intention of this literature review is to evaluate relevant research and present an overview of the main arguments in relation to three key areas: young people's views and experiences of mental health provisions; mental health difficulties in young people and, lastly, mental health services available to young people in the UK. It is beyond the scope of this thesis to provide an exhaustive account on the issue but rather, it focuses on the most recent research to keep the present study relevant and up-to-date.

An inductive approach was used to conduct a literature review to preserve the integrity of the data (Goddard & Melville, 2004). Generally, the inductive approach is associated with the literature review used in qualitative research (Dudovskiy, 2019). It integrates, evaluates and interprets findings of qualitative and quantitative studies. It usually starts with the observations of the phenomenon in question and with the definition of research questions. These consequently narrow the scope of the study. Therefore, the literature review could be completed after the data collection and data analysis. Following this, the outcome of the data analysis form bases for the study's theoretical assumptions. As indicated in the introduction, the landscape of the mental health provision for young people is always changing. This literature review firstly wanted to capture the most recent and relevant changes to inform the reader of the challenges that both young people and service providers face within mental health care. The discussion chapter builds on this inductive process and provides a further introduction of literature that was relevant to the findings of this study.

The search strategy that identified relevant research for this literature review was performed via the use of various search databases and engines including Science Direct, PsycINFO, PsycARTICLES, PubMed, Google Scholar, EBSCO, MEDLINE. The search targeted three subject areas:

- Young people and mental health;
- Young people's views, experiences of mental health services and
- UK's school and community mental health services.

Synonyms of key words were also considered, such as adolescents, youths, mental health provision, support, well-being. Primary and secondary sources of literature were considered that provided high to medium level of detail (Dudovskiy, 2019a), including published journals, books, theses, government publications, and reports. Additionally, relevant literature was identified from the article references or associated articles identified by the search engines.

In light of the above, this literature review is organised into three discrete sections. The first section provides an overview of the current research on young people's views and experiences in respect of the UK's mental health services. Section 2 focuses on young people in relation to their mental health. Specifically, it describes how young people are defined in this study and introduces adolescence as a vulnerable period of change that has been associated with the emergence of many common mental health illnesses. Furthermore, it provides an overview of risks and facilitators that frequently occur in adolescence and contribute to poor mental health and well-being. This section highlights the importance of adolescence and why this life stage deserves our attention. This is followed by section 3 that outlines the current landscape of mental health services that are available to young people in school and community settings in the United Kingdom. This chapter ends with a summary of the key points pertinent to this study.

2.2 Young People's Views and Experiences of the UK's Mental Health Services

A systematic review of the literature on young people's views and experiences of mental health services reveals that the sources are sparse. This is especially true in relation to research dealing with recent efforts to transform young people's mental health services. To date, the most recently available systematic review of young people's views of UK mental health services was published by Plaistow, Masson, Koch, Wilson, Stark, Jones and Lennox in 2014. It examined thirty-one studies and captured views of 13,605 young people, of which 625 had experiences of mental health services. The review focused on high-quality UK-based samples, including quantitative and qualitative studies, and reflected the particular structure of mental health services in the UK. However, an adequate representation of specific ethnic and difficult to reach groups or individuals who have disengaged from services was lacking. The studies included captured research from 2000 to 2011 and reflected the old, Tier-4 structure of services.

The review reflected young people's views and experiences of mental health services and categorised them according to what young people found helpful and unhelpful. The helpful aspects of mental health services related to information, accessibility of services,

qualities of mental health workers, and self-reliance. Young people favoured positive relationships with staff that were characterised by trust, confidentiality, and responsiveness. Plaistow et al. (2014) further highlighted the importance of social support. Their findings were consistent with research conducted worldwide. Young people expressed a preference for services that were flexible, more visible and offered information that was transparent and easily accessible, for instance, on leaflets and websites. Young people wanted appropriate and factual information that would enable them to make their own choices and decisions regarding the mental health support they access. Interventions that fostered self-reliance were highly valued amongst young people. It was observed that services often hindered the encouragement of young people's agency and preferred addressing their difficulties with medicalised treatment across mental health services, A&E departments and GPs. Self-reliance interventions were more visible in community-based services.

The unhelpful aspects related to stigma, lack of information and poor access to services, an emphasis on the medicalisation of mental health difficulties and, lastly, poor continuity of care. The inconsistency in care was characterised by the lack of continuity by health care professionals when accessing on different occasions. Young people found it frustrating and unhelpful having to explain problems to new people all over again: "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" (Plaistow et al., 2014, p. 20). Lack of continuity was also evident in the transition from child and adolescent services to adult mental health services (Singh, Paul, Ford, Kramer, Weaver, McLaren, Hovish, Islam, Belling, & White 2010). Repetitive questioning, multiple assessments and poor transition to adult services were also associated with accentuation of pre-existing barriers, such as stigma, The researchers identified that stigma was amplified by the lack of mental health literacy, often preventing young people from recognising their difficulties or discouraging them from seeking help.

Lastly, the review reported effective strategies that could lead to improvements in service provision. For example, suggestions included augmentation of services, increase in governmental campaigning around mental health, training opportunities for healthcare professionals and school staff on promotion, preventative measures and stigma awareness. Focus on good mental health literacy and practices around self-resilience should be firmly embedded in the curriculum.

Davison, Zamperoni and Stain (2017) examined experiences of vulnerable young people towards child and adolescent mental health services, namely the Children and

Young People's Improving Access to Psychological Therapies [CYP-IAPT]. CYP-IAPT is underpinned by evidence-based clinical practice and involves service users in active participation in planning, design and evaluation of service provision (DH, 2015). The study employed a mixed method design and looked at outcomes of self-report Experience of Service Questionnaire [CHI-ESQ] and semi-structured interviews of thirty-two vulnerable participants. Findings showed a prevalence of mixed or negative experiences of young people towards their local CAMHS service. Consistent with findings reported in Plaistow et al. (2014), the stigma associated with mental health, continuity of care and limited literacy on mental health prevented participants from effectively engaging with services.

On the contrary, participants' help-seeking behaviours were enhanced when they felt supported, listened to, and cared for. In more detail, their findings indicated that staff's ability to understand and relate to them helped participants to feel supported. One participant regarded it as helpful when staff had personal experiences of mental health difficulties, as they could relate better. The staff that listened and respected participants' views in a non-judgmental, empathic manner, made participants feel valued, understood and accepted. Not being taken seriously was perceived as unhelpful as well as support that was insufficient. In one instance a participant noted: "They were just getting told that they've just got to change their thought and they'll be okay [...] they were brushed off I think very easily" (Davison et al., 2017, p. 101). Help-seeking behaviours were negatively impacted by inconsistent contact, when for example; mental health professionals frequently changed, cancelled or were late to their appointments. This evoked feelings of unimportance and disregard in participants. In relation to access to services, participants reported a need for early intervention, reflecting their negative experiences of waiting for appointments for up to several months. Timely care was more likely to be ensured in urgent cases for young people with high levels of risk associated with self-harm and suicide attempts. Lastly, stigma was identified as the main barrier to seeking help. Young people were worried that they would be mistreated and looked down on if they admitted to their difficulties. Further, they expressed worries about being judged for 'attention seeking', or they perceived mental illness as something negative and not concerning them.

Davison et al. (2017) cautioned that low satisfaction with services might have been due to population differences. It was reported that their small sample of vulnerable adults was likely to be disadvantaged in relation to access, treatment outcome and service involvement. Suggestions for improvement included strategies to sustain engagement between young people and services. For instance, mental health professionals should strive to build a strong therapeutic relationship by engaging in active and non-judgmental

listening, being genuine, ensure consistency in contact and appointment keeping, and increase their flexibility in appointment allocation by offering choices in dates, times and location. Emphasis was also placed on the environment, suggesting buildings have an attractive appeal to young people and that they should be conveniently positioned. Use of games and activities should also be encouraged. Lastly, opportunities for service user involvement and feedback should be offered.

The importance of young people's views towards mental health provision has been gaining research attention in recent years (Coates & Howe, 2014; Coates & Howe, 2016; Kendal, Milnes, Welsby, & Pryjmachuk, 2017). It has been consistently argued that their *voice* should be prioritised and embedded in service values and public policy. Young people's involvement from start to finish improves research quality and therefore it is of high priority that "we listen carefully to what young people have to say" (Kendal et al., 2017, p.263). The involvement of service users is attracting more interest due to its potential to improve the care and quality of services, increase financial sustainability and, more importantly, it is an identified legal duty (NHS, England, 2017). Section 14U of the National Health Service Act 2006 specifies: "The duty requires CCGs and NHS England to promote the involvement of patients and their carers and representatives in decisions about their own care" (NHS England, 2017, p.28). Furthermore, service users' involvement is associated with improved well-being and health and contributes to a reduction of inequalities (Viner & Barker, 2005).

The NHS recently funded and supported a programme called *Amplified* to facilitate the participation of children and young people in every aspect of mental health, including commissioning, design and delivery of services as well as decision making about their care and treatment. Other goals included building professionals' knowledge, confidence and skills that could be utilised across the mental health services in relation to service user participation (Young Minds, 2018). Increased participation was aimed at an individual, organisational, community and national level. This initiative was in response to young people's expressed interest to participate in their own mental health care and delivery of mental health services:

> We have the motivation and knowledge to play an important role in shaping our communities, so that they are places that really help us achieve what matters to us in life. We believe we can improve the services we use by getting involved in planning and designing processes. We want more chances to take part in these decisions, and to get clear feedback on how our input has made a difference. (Young Minds, 2018, p.7)

The amplified report collated findings from three surveys directed at young people, parents, carers and professionals. 1,498 young people, 658 parents and carers and 414 professionals completed the survey. The young people that took part were from London, South East and South West (67%) and the Midlands; North West and North East of England (20%). 13% did not disclose their demographical location. The age groups included were 11-13 (27%), 14-15 (29%), 16-17 (24%), 18-21 (12%) and 22-25 (7%). The sample consisted of mixed gender and sexual orientation: 56% were male, 39% were female and 61% were heterosexual (the remaining 39% expressed themselves as being variously: bi, gay, lesbian, other and 'prefer not to say'). Professionals were from universal settings. 122 professionals were based at early years, child and family social services, local authority services, local and national charities, and youth services funded by local authorities. 120 worked in specialist mental health settings such as inpatient and outpatient CAMHS and adult mental health services. Seventy-nine professionals worked in educational settings, including primary and secondary school, sixth forms, colleges and universities.

The key findings highlighted the willingness of young people to be an active part of the service delivery. Young people expressed a need to be better informed and actively involved in their well-being care: "We know there is already information out there, but it isn't always created with the needs of young people in mind" (Young Minds, 2018, p.7). Young people were aware of the existing lack of clarity in relation to referral pathways and mental health treatment. They requested clearer and quicker access to information and services and the availability of more support at schools. They also highlighted the need to challenge stigma around mental health and their role in it: "We believe we have the most important role to play in achieving these changes, so we need to be involved in decision making at a national level" (p. 7).

Young people rated professional support as important as being enabled to have input in their own care, treatment and recovery. Therefore, the importance of self-reliance was highlighted: "We want to be more involved in the decisions made about our mental health care, and better informed about who might be able to find out what we say in our appointment*."* Young people voiced a preference for trained professionals in mental health who would respect their views and experiences as well as offer confidential support.

Lastly, a need for an individualised and person-centred approach to care planning and service delivery was identified, even in cases where young people are too unwell to decide for themselves. Young people favoured a role for themselves in decision-making and equal opportunities: "We want every one of us to have an equally good experience of services

and want to have a role in making that happen" (Young Minds, 2018, p.7). Parents and carers also expressed interest in service involvement and believed it would enable them to support their children better. A way to facilitate involvement is to offer young people and their parents/carers regular and consistent opportunity to express their views and provide an evaluation of their experiences.

This research aims to continue the engagement of young people in this dialogue and provide them with the opportunity to express their opinions on mental health services available to them. It was interesting to see how young people perceived their environment at school and in their community when their mental health has been negatively affected. The aim was to contribute to the existing literature and evaluate young people's response to current changes to children and young people's services posed by the 'transformation agenda' (DH & DfE, 2017; DH, 2015).

2.3 Mental Health Difficulties in Adolescence

Adolescence has been characterised as a period that follows the onset of puberty during which a young person develops from a child to an adult (Eccles, Templeton, Barber & Stone, 2003). It is marked by rapid and dramatic changes across psychological, physical and social domains (Bailey, 2003; Christie & Viner, 2005; Eccles et al., 2003). During adolescence, young people utilise the skills they acquired in childhood. On their journey, they transition from dependence on their parents and carers to an interdependent adult state through learning and strengthening self-reliance. The quality of this transition is reflected in young people's relationship with themselves, and with others. It also partly determines their well-being, future professional satisfaction and translates into parenting of their own children (Eccles et al., 2003). Most adolescents navigate through adolescence successfully by becoming well equipped and adjusted to their environment. However, the dramatic changes, as well as other external factors, could have a negative impact on their well-being, mental health and overall satisfaction with life. These factors are considered next in this section.

The understanding of causes and predictors of poor mental health in young people is complex and not without its challenges. There are multiple contributing factors such as the individuals' biological makeup, characteristics, home and social environment. These factors are interactive in nature and are of long-standing interest in social sciences. Engel firstly proposed a theoretical conceptualisation of the interplay of biological and environmental factors in 1977 as an alternative to the biomedical model that dominated medical practice at the time (in Lehman, David & Gruber, 2017). Engel highlighted the

importance of social context and psychological studies. Further, Bronfenbrenner (1979) emphasised the significant role of timing in a child's development and incorporated Sameroff's transactional model from 1975 that proposed that a child's development is continuous, constantly changing and is affected by the mutual interaction between the individual and their environment. Bronfenbrenner's Ecological Model of Child Development model (1979) (*see* Figure 2.1) reflects these dynamic developmental properties that are present across an individual's lifespan and contribute to their unique make-up. Furthermore, it considers the importance, impact and role of other social constructs that are present in an individual's life impacting on their identity and behaviours. Social constructs considered were, for example, schools, social welfare services, health services, legal services and media in respect of their influences on the individual.

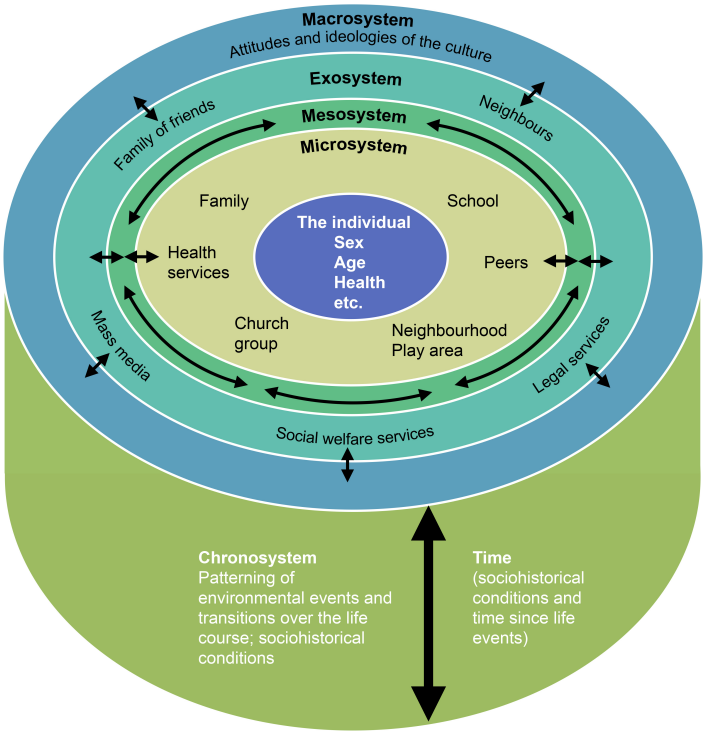

Figure 2.1 Ecological model of child development (adapted from Mooney, 2015).

Bronfenbrenner (1979) positioned an individual at the centre of the model within four systems that he or she interacts with. These are microsystem, mesosystem, exosystem and macrosystem. The microsystem represents face-to-face interactions and experiences with the family unit, school, friends and local services. The exosystem consists of societal structures such as social and legal policies, political and banking systems, community organisations, social services, etc. Lastly, the macrosystem comprises culture, ideology, societal beliefs and attitudes. The mesosystem enables communication between micro and

exosystem. These systems are organised and interact through communication to ensure control and agency.

Recently Lehman, David and Gruber (2017) reviewed Bronfenbrenner's (1979) biopsychosocial model and argued that the biological, psychological, interpersonal and contextual effects should be perceived as dynamic forces that could also affect individuals' health over time (see Figure 2.2). These dynamics could result in either positive or negative effects on mental health. Each dynamic can cause a shift and result in imbalance or instability in individuals' health and functioning. Thus, to account for these complexities, each domain should be considered in relation to each individual's microsystem, mesosystem, exosystem and macrosystem, as well as a subject of change over time.

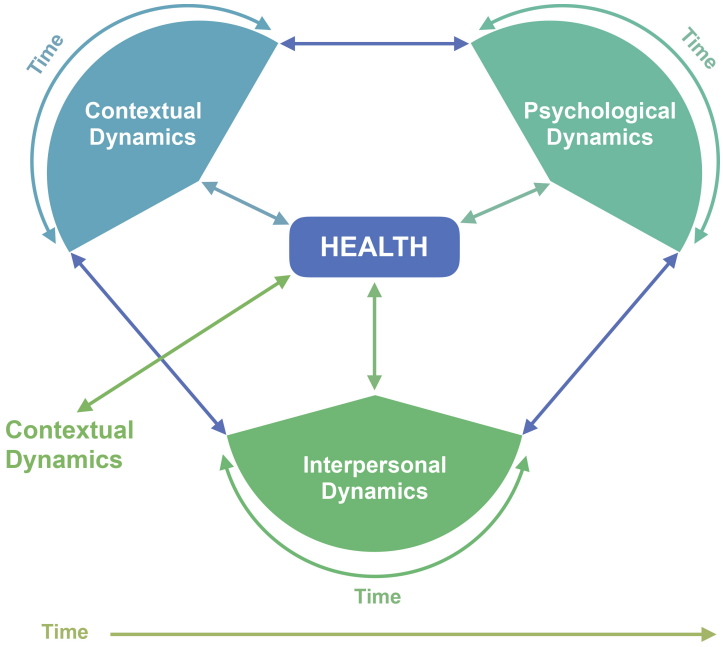

Figure 2.2 The dynamic biopsychosocial model of health (adapted from Lenham et al., 2017).

The adapted Biopsychosocial model (Lenham et al., 2017) will be further considered in the discussion chapter to support the conceptualisation of present findings. The following section focuses on the transitional nature of adolescence and the extent of biological, psychological and social changes. Secondly, it outlines protective and risk factors that have been established as contributors to poor mental health.

2.3.1 The Transitional Nature of Adolescence

Adolescence is an important life stage of human development. It is a distinct period - often described as ‘teenage years' or ‘growing up phase' - that has been legally defined as “That age which follows puberty and precedes the age of majority; it commences for males at fourteen, and for females at twelve years completed, and continues till twenty-one years complete” (Bouvier, 1856, p.76). Nonetheless, a precise definition that accurately portrays this important life stage is currently lacking. Many attempts have been made to characterise this dynamic and complex period. For instance, Eccles, Templeton, Barber and Stone (2003) adopted a developmental perspective and described adolescence as a variable period of change and progression that is experienced by all children when moving into adulthood. The onset of adolescence is marked by the end of childhood, where children are still highly dependent and governed by their parents or caregivers. By the end of adolescence, most young people are becoming largely independent adults with fully functioning bodies and minds. Considering that a young person achieves normal stages of development, their learning is also continuous from birth to adulthood. However, recent advances in neuroscience show that learning is life-long and even the adult brain can grow new cells and make new connections and is flexible, modifiable and reparable (Blakemore & Frith, 2005).

The age of a young person deserves important consideration as it can determine legal milestones and also, can be an indicator of social and cultural positioning. In England and Wales, a young person that reaches the age of 16 is deemed able to consent to sexual activity, marry or join the army (House of Commons, 2015). The age which marks the end of adolescence and the onset of adulthood has been a subject of recent debates. Arnone (2014) argued that nowadays young people reach adulthood later than their predecessors: around the age of twenty-five. Reflecting on young people’s ever-changing needs and lifestyle, it has been observed that they often stay longer in education and the parental home. Young people also settle down, marry or have children in their late twenties to mid-thirties. Arnone (2014) reviewed neuroscientific research and concluded that the brain continues to develop until the age of twenty-five, specifically the prefrontal cortex that controls cognition, executive functioning, emotional maturity and self-image. The accuracy of the transition from adolescence to adulthood is not imperative for this study as the targeted population was young people between the ages of 11 to 16. However, it illustrates the complexity of this life stage that is not only associated with individual changes and development but also determined by the environment and socio-political

climate in which they live. The following sections focus on the changes across the biological and social domains.

In the UK early adolescence is considered to be between the age of 10 to 13 years old, middle adolescence between 13 to 16 years old and late adolescence between 16 to 19 years of age (Christie & Viner, 2005). Transitions between these stages are not necessarily marked by a particular occasion and each individual experiences these transitions uniquely. However, there are common denominators associated with biological, psychological and social development, which are experienced by all adolescents equally.

Early adolescence is set in motion by the biological changes due to the development of a number of the body's systems (Eccles et al., 2003), such as the Hypothalamic-Pituitary-Gonadal [HPG] Axis (Hoehn & Nicpon, 2007) and the synergistic actions of growth hormone, thyroid hormone and androgens (Steinberg, 2008). The HPG axis controls development, reproduction and ageing. The growth of thyroid hormones, together with the steroid hormone androgens, is essential for optimal weight and height of an adolescent and the development of their reproductive systems. As a result, the adolescent's body undergoes considerable physical development - commonly referred to as puberty - that is characterised by body spurt, menarche, and sexual maturation. The girls experience breast budding, pubic hair growth and the onset of menstruation. The boys will experience changes in genital growth and testicular enlargement due to spermarche, the development of sperm. On average pubertal changes start 18 months earlier in girls than in boys; nonetheless, changes are also determined by individual differences (Blythe, 2016). The adolescent's brain also undergoes considerable structural changes that result in remodelling of the brain. Changes occur, namely, in the increased number of neurons in the prefrontal cortex (Giedd, Blumenthal & Jeffries, 1999), myelination of axons and synaptic pruning. Changes in the prefrontal cortex [PFC] are largely due to the growth of myelin. Myelin - a lipid-rich substance that surrounds the axon - speeds up nerve conduction and, therefore, allows the brain to operate faster and more efficiently. The PFC controls important and complex cognitive functions, such as problem solving, decision-making, personality expression, language, memory, emotional expression, and sexual behaviours (Science of Psychotherapy Experts, 2017). The PFC also facilitates attention span, motivation and forward planning. It is also the last part of the brain to myelinate and its development continues until around 18 to 25 years of age.

Synaptic pruning has been recognised as a necessary developmental process of specialisation of the brain circuitry in adolescence (Willis, 2006). It is a process that eliminates synaptic connections from the brain. It allows the brain to function more

efficiently by reshaping and reorganising neural networks that are necessary and carve away the unused neuronal connections that were acquired during an intense period of learning in childhood (Willis, 2006). Siegel (2014) metaphorically equated this robust process of neuron elimination to trimming down an overgrown garden following a period of intense growth of information gathering in childhood. The image below (*see* Figure 2.3) shows a network of neural connections in the brain at birth, during childhood and in adolescence. The synaptic pruning is visible on the right, where the reduction of neuronal density is visible in the adolescent brain in comparison to childhood (in the middle).

Figure 2.3 Neuronal density at birth, childhood & adolescence (adapted form Shore, 1997).

Adolescents' brains also undergo development of the limbic system that is responsible for a variety of functions including emotions, long-term memory, motivation and olfaction (Morgane, Galler & Mokler, 2005). The limbic system develops faster than the PFC and therefore the adolescent brain is more susceptible to impulsive decision-making, poor concentration and seeks reward and pleasure (Steinberg, 2007). Latent development of the PFC in young people also increases responsiveness to reward-seeking behaviours as well as their chances to engage in substance misuse, sexual behaviours or violence because their impulse control is underdeveloped (Casey, Getz & Galvan, 2008). These are discussed in more detail in the last part of the next section.

The biological maturation also alters adolescents' psychological state and determines changes in their social functioning. Psychological changes, also referred to as cognitive changes, are characterised by the development of an adolescent's sexual identity and orientation, reassessment of body image, attitude formation, identification with values and development of social capital (Eccles et al., 2003). Individuals aged 9 to 13 years typically display concrete thinking and adopt early morality concepts. They show morality to avoid punishment or gain reward. However, they also start to experiment with exploratory behaviours such as smoking, drinking or being antisocial.

In mid-adolescence individuals start to shift from concrete to abstract thinking, yet the concept of self is still solid. Their morality is determined by social rules and laws and they uphold them for their own sake. In mid-adolescence one starts to explore adult behaviours and seeks autonomy, identity, questions the status quo and forms worldviews, that are increasingly independent or divergent from those of their parents or caregivers (Viner & Barker, 2005). These views inform their behaviours, choices and adherence to their well-being and physical health. Psychological changes go hand in hand with social changes. These are manifested in gradual separation from parents and the development of social autonomy. Adolescents experience changes in relationships with family and peers. Emotional dependence on parents is replaced with strong peer identification and planning of their own future (Christie & Viner, 2005).

Late adolescence starts with the end of puberty (Christie & Viner, 2005). Boys gain muscle mass and continue to grow body hair. Young people are capable of complex abstract thinking and can identify and differentiate between law and morality. They often adhere to personally valued ethical principals. Identity continues to develop and it is common to conform to or reject religious or political ideology. In late adolescence, social autonomy and intimate relationships are also developed. Young people pay attention to the pursuit of education and vocational careers and strive for financial independence (Christie & Viner, 2005).

2.3.2 Risk Factors in Adolescence

This section will outline some of the risk factors associated with biological, psychological and social changes in adolescence. Some biological changes and psycho-social changes contribute to individual's environment and socio-economic structures (e.g. Eiland & Romeo, 2013; James & Amato, 2013; Mental Health Foundation, 2015; Pickett, James & Wilkinson, 2006; Siegel, 2014).

The diverse tapestry of these changes exposes young people to the vulnerabilities of mental illness, such as thinking disorders, mood disorders or other psychiatric difficulties. The risks associated with the dynamic period of adolescence are discussed next: firstly, in relation to biological changes, then, regarding psychological changes and, lastly, in relation to social changes identified above. Moreover, risks connected to parenting styles are also included at the end of this section. There is an abundance of research concerning risks in adolescence representing the potential of hazards to the physical and psychological health of young people. However, the following are only indicative findings due to the restrictive parameters of this thesis.

2.3.2.1 Risks Associated with Biological Changes

Some research suggests that vulnerability to mental health difficulties is hereditary. A familial link has been observed between family members and their offspring in mental health disorders such as schizophrenia, bipolar disorder, schizoaffective disorder and major depression (Hamilton, 2011; The Centre for Genetics Education, 2012). The likelihood of someone in the general population developing a condition during their lifetime increases if the parents or siblings, particularly identical twins, are affected. Also, children with developmental disorders are at greater risk of developing mental health problems in comparison to typically developing children (Eapen, 2013). Development disorders encompass difficulties in the cognitive, physical, emotional and behavioural spheres, including, for example, autism, learning difficulties, and cerebral palsy. These children and young people are particularly vulnerable due to the complexity of difficulties, compounded by the psychological and financial demands posed on their families and carers.

Another risk factor linked with biological changes in the brain is stress. Stress can increase or prolong the pruning of neuronal connections in individuals who might have a genetic predisposition or experiential vulnerability to stress from childhood. Adolescents that are facing normal stresses of life, often caused by development itself, and, are also predisposed or exposed to environmental stress when undergoing synaptic pruning, can reinforce the process of pruning (Siegel, 2014). An emerging line of research has indicated that stress makes young people more susceptible to mental health or psychiatric difficulties such as depression and anxiety (Eiland & Romeo, 2013) and has a long-term effect on well-being. Furthermore, early life stress such as neglect or abuse in childhood has been linked to the altered synaptic plasticity of the brain that hinders the normal pruning process and manifests in complex behaviours later in life, for example in risk-taking behaviours, addiction and depression (Selemon, 2013).

2.3.2.2 Risks Associated with Psychological Changes

Biological changes have a considerable impact on psychological functioning in adolescence. Young people start to identify with values that are different from their nuclear family and they increasingly re-evaluate what motivates them, whom to connect with, and appraise what is worth paying attention to (Christie & Viner, 2005). Young people are present-orientated, lack awareness of future consequences and have underdeveloped decision-making skills due to the slow maturation of the cognitive-control system (Steinberg, 2007). This could have an impact on their adherence to behaviours that

promote health and well-being. As identified earlier, young people experience increased emotionality and impulsivity as the development of the PFC lags behind the limbic system development.

Young people do not always welcome biological changes as many experience skin problems or weight gain. They often struggle to identify with their new look when the body changes, as they grow facial or body hair and their voices start breaking (Eccles, Wigfield, Harold & Blumenfeld, 1993). Fear of weight gain is one of the leading causes of eating disorders with its highest onset in adolescence (Gander, Sevecke & Buchheim, 2015). It has been estimated that 1.25 million people in the UK suffer from an eating disorder, of which the most affected is the population of 14 to 25 years old (Beat Eating Disorders, 2018). Adolescents, especially boys, are also affected by the late onset of puberty. Early maturation in boys has been associated with positive body image, confidence and better-developed self-concept (Reiter & Lee, 2002). However, boys that mature late often experience emotional distress and poor self-esteem and are more likely to be teased or bullied at school.

Further, young people are at risk in relation to their sexual identity. For example, adolescents identified as a sexual minority, namely, gay, lesbian or bisexual, are more likely to be bullied, teased and experience violence from others than their heterosexual peers and have suicidal ideation (Berlan, Corliss, Field, Goodman, Austin, 2010).

Individuals' age, gender, social positioning and socio-economic status could also have an impact on their sense of worth (Bachman, O'Malley, Freedman-Doan, Trzesniewski & Donnellan, 2011). For instance, being a subject of prejudice for belonging to minority ethnic or religious groups can pose a threat to one's self-worth. Research also showed that having physical or mental health difficulties, being stigmatised, bullied, persecuted or discriminated against was associated with low self-esteem (Paterson, McKenzie & Lindsay, 2012). Further, socioeconomic status or belonging to a particular class system has an impact on one's self-worth (James & Amato, 2013). Low self-esteem [LSE] is often related to, and maintained by, maladaptive behaviours such as avoidance, procrastination, confrontation or aggression (Lim, Saulsman & Nathan, 2005). These can serve as coping strategies and help individuals to protect their sense of self (ego) or identity from painful emotions, such as fear, emotional pain, shame, despair, guilt, embarrassment, anxiety, or rejection. Lastly, LSE could lie dormant in individuals and only become active when they face threatening situations or experience traumatic events (Martinez, 2017).

2.3.2.3 Risks Associated with Social Changes

Societal or peer pressure was identified as risk as it can influence young people to engage in exploratory behaviours such as smoking, drinking, experimenting with drugs or sexual activity. This can expose young people to health-related problems caused by smoking and drug use, addiction, teenage pregnancy and sexually transmitted infections [STI]. It is estimated 207,000 children in the UK start smoking each year and that 40% of adult smokers started smoking before the age of 16 (Hopkinson, Lester-George, Ormiston-Smith, Cox & Arnott, 2013). It has been reported that the earlier children and young people start to smoke, the higher the risk of developing health problems such as respiratory difficulties, lung cancer or heart disease.

Sexual maturation is also associated with experimental behaviours that could result in unwanted pregnancy in adolescence or contracting STI. Despite national efforts to prevent teenage pregnancy in the UK, the rates are still relatively high in comparison to other developed countries (Public Health England, 2018; Sedgh, Finer, Bankole, Eilers, & Singh, 2015). Teenage pregnancy is associated with health inequalities and poor outcomes for young parents and their children (Dennison, 2004). STIs are infections passed on from person-to-person through sexual contact. The incidence of STI is the highest amongst 15 to 24 years old, accounting for 62% of new Chlamydia diagnosis, 52% with gonorrhoea, 51% with genital warts and 41% with genital herpes (Public Health England, 2018*a*). If untreated, Chlamydia can cause serious health problems, including fertility problems in women. Chlamydia and genital warts (caused by a human papillomavirus [HPV]) became the most diagnosed STI amongst sexually active 15 to 24 years old (Mohammed, Blomquist, Ogaz, Duffell, Furegato, Checchi, Irvine, Wallace, Thomas, Nardone, Dunbar & Hughes, 2018). To protect young people, the government initiated interventions with preventative measures such as the National Chlamydia Screening Programme (Public Health England, 2014) and the National Human Papillomavirus Vaccination Programme (Department of Health, 2015*a*). Due to this, there were 2,361 fewer Chlamydia diagnoses and a 90% decrease in genital warts amongst 15 to 24-year-olds in 2017 (Public Health England, 2018*a*).

Young people are also facing risks associated with social media consumption and online safety (The Children's Society & Young Minds, 2018). The virtual world is difficult to regulate and creates a potential platform for bullying, also referred to as cyber bullying. Cyber bullying could result in psychological trauma and negatively impact on their physical and psychological health. Children and young people commonly use social media for interaction and consider it a necessary part of their life. A recent inquiry on online

safety and cyber bullying reported that an estimated 44% of children and young people spend an extensive amount of time (>3h/day) on social media while 1 in 10 would use social media consistently between 12 pm to 6 am (The Children's Society & Young Minds, 2018). A growing amount of evidence links social media usage to poor mental health. The negative impact is associated with decreased self-esteem (46% of girls reported a negative impact on their self-esteem), feelings of being excluded or inadequate (56% of young people reported being excluded from conversation or groups on social media).

Mental health problems affect young people from all social classes (Patel, Flisher, Hetrick & McGorry, 2007). However, it has been indicated that socio-economic inequality, such as deprivation and poverty, has been associated with higher prevalence of mental health problems (Mental Health Foundation, 2015; Pickett, James & Wilkinson, 2006). Associated risk behaviours in adolescence are binge drinking, drug use and delinquency. These contribute to health inequalities and have devastating consequences on adolescents' future, many of whom are facing reduced educational and work opportunities, and a decline in overall well-being (Elgar, Pfortner, Moor, De Clercq, Stevens & Currie, 2015).

2.3.3 Protective Factors in Adolescence

Protective factors considered here are qualities or attributes adolescents possess or have access to on a personal level or through their families, communities or the larger society. These factors help young people to deal more effectively with challenges and life stressors, mitigate harmful impact or eliminate risks. These could be young people's own skills and strengths or resources, supports and coping strategies available to them. Basic components that support adolescents' mental health are a nutritionally balanced diet, active lifestyle, sufficient sleep and good personal hygiene (e.g. Brand, Kalak, Gerber, Clough, Lemola, Bahmani, Puhse & Holsboer-Trachsler, 2017). These health-enhancing behaviours were associated with positive physical well-being, psychological well-being, healthy self-esteem, positive family relationships and a positive perception of learning (Knox & Muros, 2017). Furthermore academic attainment has been identified as a predictive factor of positive emotional, behavioural and social well-being (Gutman, Brown, Akerman & Obolenskaya, 2010) Gutman et al. (2010) also observed that young people' well-being improved when they were satisfied with their performance at school.

Confidence and positive self-esteem have been correlated with a healthy mental state and positive changes in well-being. These were body satisfaction, enhanced communication skills, enhanced coping abilities and resilience in relation to mental health difficulties and life stressors (Ingram, 2013). In psychology, self-esteem refers to

individuals' self-assessment and subjective representation of their worth, attributes, abilities and their social adequacy (Leary, Tambor, Terdal & Downs, 1995). It has been observed that self-confidence drops during early adolescence at age 9 to 13, as well as towards the end of young adulthood age 8 to 23 (Pickhardt, 2013) due to the dramatic developmental changes and risks discussed previously. Young people seek autonomy and independence. They experiment with adult behaviours and face mistakes and consequences. Certain experiences are more impactful than others and have the potential to diminish adolescent's self-esteem.

This section looked at important physiological and psychological domains that are characteristic of adolescence. These are transitional in nature and were considered in the discussion of this study's findings. The following section will examine the current services that are available to young people in the United Kingdom.

2.4 The Landscape of Young People's Mental Health Support in the UK

This section provides an overview of young people's mental health services together with recent changes instigated by the new governmental initiative known as 'the transformation agenda'. Accordingly, we look at the way in which schools are increasingly involved in young people's mental health and well-being.

2.4.1 Young People's Mental Health Services

CAMHS professionals are based across various settings that were traditionally organised within a four-tier structure (HC, 2014). The conceptualisation of the 4-Tier model is displayed below (*see* Figure 2.4). Tier 1 services comprised of general support from non-mental health specialists such as school nurses, general practitioners [GPs], social workers and voluntary agencies. They generally offered advice and treatment for mental health difficulties that presented as less severe. CAMHS specialists that worked in tier 2 services were mental health workers based in the community and primary care, including counsellors working in clinics, schools and youth services. Similarly, tier 3 services were based in the community; however, they provided specialised support for more severe presentations. They operated within a multi-disciplinary team and coordinated care with psychiatrists, psychologists, psychotherapists and social workers. Tier 4 services were the most specialist and included day units and specialised outpatient and inpatient hospital units. They treated young people with severe mental health difficulties such as depression, eating difficulties and psychoses.

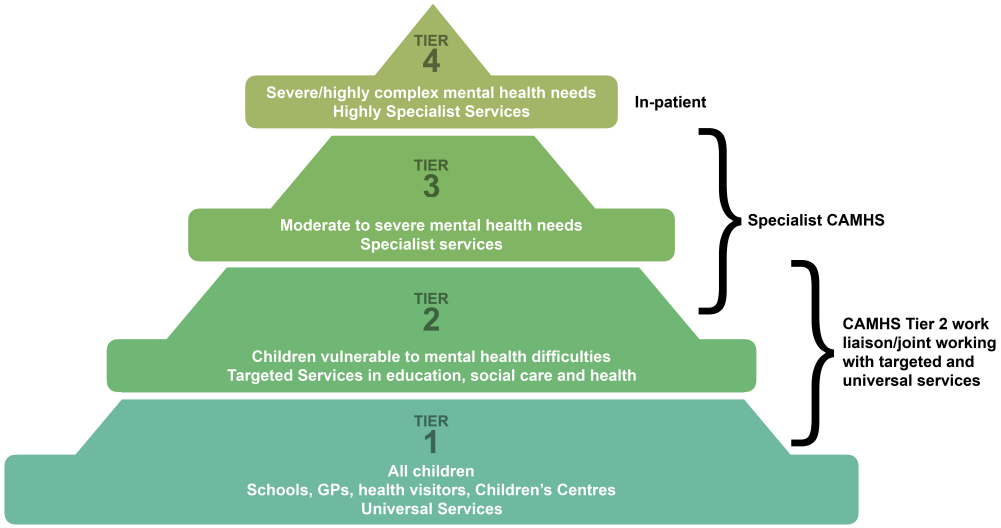

Figure 2.4 4-Tier model of CAMHS services (adapted from HC, 2014).

In some cases, CAMHS professionals work with young people in their homes or in the context of youth centres and youth offending services. A referral pathway to CAMHS is typically arranged through the individual's GPs, health visitor, paediatrician, school doctor or nurse, psychologist, special educational needs coordinator [SENCO] based at the school, or social worker (NHS, 2016). CAMHS professionals are skilled in determining young people's difficulties and providing adequate intervention through various talking therapies or psycho-education. Some professionals, such as psychiatrists both diagnose and prescribe medication. Specially trained nurses also prescribe medication. CAMHS professionals also act as young people's advocates and provide expert opinion to the courts in relation to their welfare issues.

On average, CAMHS process approximately 460,00 referrals per year of which 200,000 receive treatment (DH & DfE, 2017). Many others are signposted to other services that are based in the private or charitable sectors. Nonetheless, as indicated earlier, CAMHS are struggling to meet the increasing demands for mental health support. CAMHS resources have been systematically reduced since 2010 (Young Minds, 2014), impacting on their efficacy and availability (HC, 2014). Whilst demands for mental health services are soaring, the Clinical Commissioning Groups [CCGs] were forced to freeze or cut budgets to mental health services, such as CAMHS, especially between the years 2013-2015 (RCPsych, 2016). CCGs are clinically led, statutory NHS bodies that determine how the government funding is prioritised, distributed and spent (NHS Clinical Commissioners, 2018). There are 195 CCGs in England responsible for managing health care services in local authorities [LA]. It was reported that on average funding for CAMHS has fallen by £50 million per year from 2009 to 2014 (RCPsych, 2016). Yet, between the years 2009 to 2015, there has been a 50% increase in hospital admissions of 0 to17 year-olds. However,

only 6% of the total NHS spend, allocated to mental health provisions, went to CAMHS (Thorley, 2016). Within the most affected were early intervention services, experiencing a 55% reduction in funding in 2015/16 (£1.4 billion) in comparison to 2010/11 (£3.2 billion). Reduced funding resulted in an increased demand for support. To the present day, many young people with mental health issues still struggle to access CAMHS (DH & DfE, 2017; HC, 2014; NHS England 2014). They are often subjected to long distance travel, long waiting times and increased referral thresholds, meaning that only the most severely affected receive get appointments. The increased pressure of budget cuts on CAMHS provision perpetuating insufficient services is illustrated in Figure 2.5.

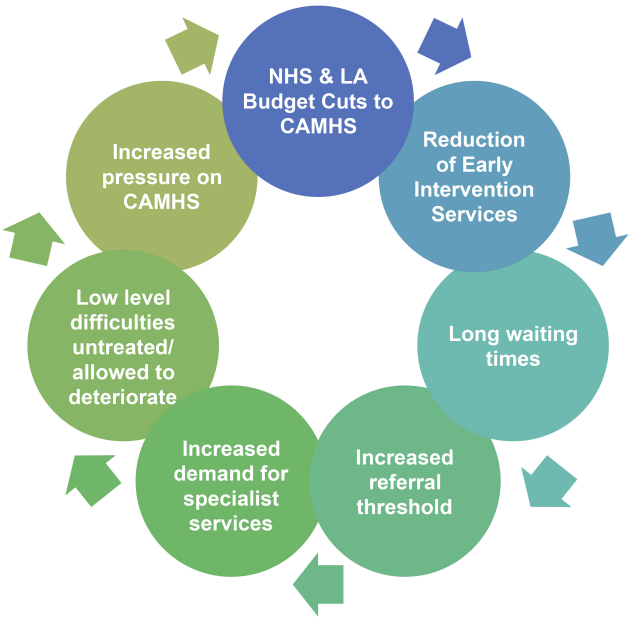

Figure 2.5 The vicious cycle of budget cuts on CAMHS (adapted from Thorley, 2016).

As discussed in the introduction, young people's mental health issues pose a national concern. In the last 20 years, the UK Government made numerous changes in public policy to improve CAMHS services (DH & DfE, 2017). Several initiatives, developed in a partnership with the Public Health England [PHE] and the Department of Health, were discussed earlier such as the National Chlamydia Screening Programme that aimed to protect young people and manage risks in sexual behaviours. PHE is an executive agency that is sponsored by the Department of Health. Their primary responsibilities are to ensure the efficiency of the public health policies, advising government and supporting action by local government, the NHS and the public. PHE is also active in social affairs and pledged to reduce health inequalities in disadvantaged groups by promoting healthier lifestyles. The UK government also recognised that poor mental health in young people undermines their academic attainment (DfE 2016) and, accordingly, determined that schools should be

increasingly more responsible for accommodating schemes and services, which promote and address psychological well-being (DH & DfE, 2017; DH, 2015; DfE, 2015).

The House of Commons Health Committee evaluated the shortcomings of CAMHS in 2014 and reported that: “The lack of reliable and up to date information about children’s and adolescents’ mental health and CAMHS means that those planning and running CAMHS services have been operating in a fog” (HC, 2014, p.3). They commissioned an audit of the investment strategies and spending on CAMHS and planned to develop a monitoring system for the service specification standards across local authorities. The main focus was on the importance of early intervention, timely support, funding strategies for early interventions, management of referrals, vulnerable groups (such as children/young people with health conditions), access and quality of inpatient provisions (particularly in relation to education) and the transition from CAMHS to adult services. A DH and NHS England joint taskforce urged a ‘transformation agenda’ for children and adolescents’ services that would provide a national policy with clear funding and directive trajectory for CAMHS. The aims and objectives were outlined in the Future in Mind report (DH, 2015). The government commitment to this transformation was reflected in an additional £1.25 billion funding allocated to health, education and children's services up to 2019/20. The limit of national funding has also increased, with £143 million in 2015/16 and £250 million in 2016/17 (Thorley, 2016). LA's were expected to engage in a multi-agency approach, which would increase collaboration across services involved in young people’s mental health services.

Following the impactful Future in Mind document (DH, 2015), more resources have been allocated to the transformation of children and young people services. This included a paradigm shift in the structure of CAMHS. For example, the THRIVE model was developed as a radical replacement of the traditional 4-Tiered system (*see* Figure 2.4) (Wolpert, Harris, Hodges, Fuggle, James, Wiener, McKenna, Law, York, Jones & Fonagy, 2015), proposing changes to the conceptualisation and delivery of CAMHS. The key areas of interest related to payment systems, quality improvements and performance management.

The THRIVE model is based on the whole school system that encompasses services beyond the NHS, including education, social care and a range of other facilitating agencies. The model is aimed at improving provisions by offering transparent and transferable planning and delivery pathways. This collaborative element is also conducive to policy changing. Within the whole system approach, the THRIVE framework attempts to align the needs of various groups of children and young people with adequate support. A

clear distinction between individuals' need for treatment and their need for support was emphasised to ensure the best possible outcomes. This approach empowers service user involvement, builds on their strengths and is applicable to homogeneous groups. It is organised into five needs-based groupings for young people with mental health problems and their families (*see* Figure 2.6). These needs-based groupings are distinct and perceived in terms of individual's needs and choices within each group, a skill base required to meet these needs, a conceptualisation used to describe needs and resources that are required to meet individuals needs.

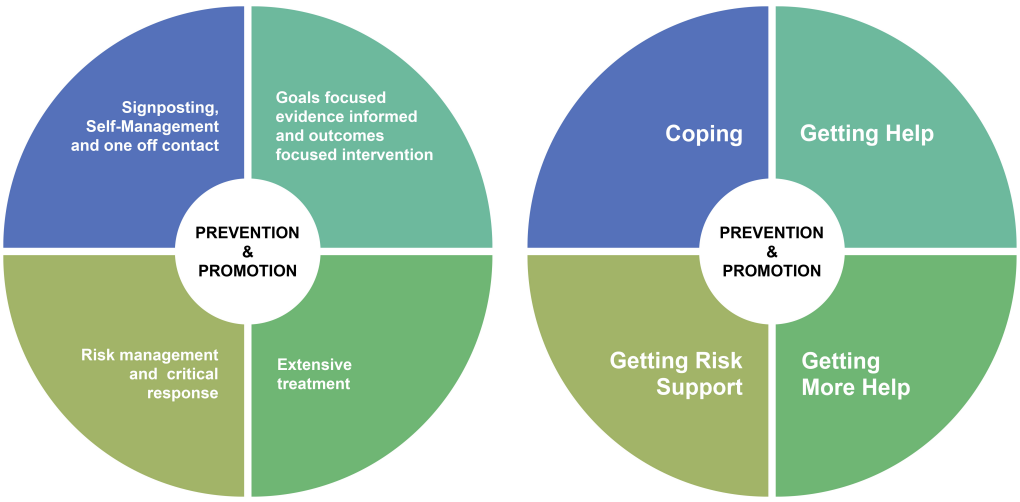

Figure 2.6 The THRIVE framework (adapted from Wolpert et al., 2015).

The THRIVE model has been implemented in practice in line with the Choice and Partnership Approach [CAPA] (Kingsbury & York, 2013). The CAPA is a collaborative model of engagement and clinical assessment in a service users delivery that focuses on the enhancement of the effectiveness of services and user satisfaction with services. Therefore, it emphasises a person-centred approach in service delivery as opposed to a method primarily informed by the severity and complexity of difficulties. Furthermore, it focuses on the importance of individuals' resilience and increased involvement of schools and community in the promotion and management of mental health problems (Wolpert et al., 2015).

The national Future in Mind programme (DH, 2015), showed continuous commitment to transform services and develop a model of care that detects early signs of deterioration in children's and young people's mental health and well-being. Commissioners, healthcare providers, local authorities, community and voluntary sector and social care services were required to develop a transformation plan for their area. These plans are now publically accessible via NHS, LA or CCGs websites to provide transparency. Typically, they include an overview of planned services, the progress of the transformation date, differences made

so far and ambitions for the future (e.g. NHS Cheshire & Wirral Partnership, 2018; NHS Warrington, 2018). Information on collaboration and engagement across involved agencies is also accessible, including their engagement with the THRIVE model and work with schools.

Implemented changes and efforts to transform children and young people's services have been a subject of evaluation. The Care Quality Commission [CQC] systematically reviewed the quality of CAMHS services. The outcomes of these evaluations were recently published in the Green Paper *Transforming children and young people's mental health provision* (DH & DfE, 2017) and showed that mental health services are still fragmented, disjointed and offer poor care to young people. The secretary of State for Education, Justine Greening and the Secretary of State for Health, Jeremy Hunt said on the matter:

> We are now investing more than ever before in mental health services, and a huge programme of work is underway to transform children and young people's mental health services. Across the country, there are many committed health staff working hard to improve care for children and young people with a mental health problem. However, in some cases, support from the NHS is only available when problems get really serious, is not consistently available across the country, and young people can sometimes wait too long to receive that support. (DH & DfE, 2017, p.2)

Evidently, young people's mental health is currently a pressing issue that urged the current Conservative Government to review and reform the Mental Health Act 1983. The Green paper set out an ambition to improve CAMHS services specifically in relation to prevention and improved access to treatment. Attention was also paid to determinants of poor mental health, such as social causes, and the promotion of schools and other professionals in mental health support for young people. The section below discusses the role of schools in addressing mental health difficulties.

2.4.2 School-based Well-being & Mental Health Interventions

According to the Institute for Public Policy Research [IPPR] (Thorley, 2016), the education, education, mental health report stated that "three children in every classroom [are] experiencing a clinically diagnosable condition" (2016, p.3). Secondary schools play a crucial role in preventing and signposting mental health problems in young people, alongside the wider community and NHS provision (DH & DfE, 2017). Currently, a range of interventions is targeted at pupils' well-being and their mental health needs at schools. These are delivered either at the individual level or group level. School-based services and

schemes were designed to safeguard pupils, be easily accessible, and aimed at wide presentation of psychological distress. The availability and quality of these interventions, however, vary across secondary schools (Thorley, 2016). The main contributing factors are the school's lack of funding and resources, as well as their insufficient influence on commissioning decisions made by CCG (Thorley, 2016).

It is within the schools' remit to decide how to allocate their budget and prioritise their resources. As schools are primarily educational establishments, priority goes to academic attainment. Additional funding is also available to schools. To tackle inequalities in young people from disadvantaged backgrounds, the government introduced the Pupil Premium [PP] funding in 2011 (£2.5 billion in 2014-15). This support was aimed at pupils from low-income families, children in care, those eligible for free school meals in the last six years or pupils whose parents were in the armed forces (Ofsted, 2012). The Department for Education typically allocates pupil premium grants [PPG] to schools and local authorities (Education Funding Agency, 2017) identified as eligible. The eligibility is derived from the school census and alternative provision census. These schools and local authorities then decide how to use the money: on free school meals, teaching assistants, support workers, counsellors, educational trips or school visits, subsidising uniforms or equipment. The schools are obliged to produce specific information that highlights the PP contribution to the academic improvement of specific children. However, there is a lack of transparency on how the PPG is spent or managed at schools (Ofsted, 2012) as often schools do not separate the PPG from the main budget or use the PPG to maintain existing provisions, not directly benefiting the children from disadvantaged backgrounds. The benefits and appropriate use of PPG are a topic of ongoing evaluation, with some recent evidence of its efficacy (Lepkowska, 2014).

Schools offer varied well-being or mental health support packages and services to young people (Thorley, 2016). These are based on the principles of the THRIVE model (*see* Figure 2.6) and are broadly categorised into school-based provision of prevention and promotion services; school as a point of early identification services, triage and referral; schools that are either a provider of early intervention services or a focal point from which support is delivered (Thorley, 2016). The specification of each category is discussed next.

2.4.2.1 Preventative School-based Services

This category of services facilitates the delivery of preventative services that promote positive mental health and well-being. These would have previously been classed within the Tier 1 category (*see* Figure 2.4) (Thorley, 2016). Mental health support in this category

is largely skill-based and aimed to increase behaviours, knowledge and resilience that would result in the facilitation of good mental health. These services could be either whole school interventions or target pupils who are vulnerable or are at risk. A list of determinates for high-quality provision is summarised in Table 2.1.

PREVENTION & PROMOTION: High Quality Provision Characteristics

• Learning on mental health is embedded in the curriculum
  ○ *E.g. education on risk factors and the symptoms of specific conditions*
• Awareness-raising activities
  ○ *Through assemblies, posters and campaigns.*
• Anti-stigma work
  ○ *E.g. through initiatives such as the Time to Change campaign*
• An emphasis on a school ethos that places high value on mental health and wellbeing
• The absence of teaching or other practices that might contribute to the development or exacerbation of mental health problems.
• Clear referral pathway
  ○ *Signposting towards CAMHS or support in the community*
• The provision of opportunities for peer support

Table 2.1: Characteristics of high-quality prevention & promotion provision in secondary schools (adapted from Thorley, 2016).

Schools are well equipped to provide preventative support through the whole-school interventions, as their application is widespread within the UK, evidenced-based and ensure coherent and universal collaboration (Thorley, 2016). Further, it has the potential to timely identify difficulties and enable young people to build necessary skills that promote well-being and good mental health.

The whole-school interventions vary in aims and objectives. For example, the whole schools initiative *Achievement for all* aims to improve behaviours in young people, help to build positive relationships and reduce or prevent bullying (Humphrey & Squires, 2011). The personal, social, health and economic (PSHE) education is a non-statutory programme designed to improve children and adolescents mental health and personal growth (HC, 2014). Schools can flexibly adopt it in their curriculum to help pupils with learning, build confidence, resilience and explore sensitive topics such as self-harm behaviours, anxiety or bereavement. The Social and Emotional Aspects of Learning (SEAL) programme (Humphrey, Lendrum, Wigelsworth, 2010) supports pupils to develop emotional intelligence. Other interventions focus on the prevention of certain risk behaviours such as the school-based smoking prevention programmes (Swann, Carmona, Ryan, Raynor, Barış, Dunsdon, Huntley & Kelly, 2010).

Group interventions are an attractive choice for schools as they are universal, easily applied and cost and time effective. However, upon evaluation some of the initiatives yielded very little or no effect (Thomas, McLellan & Perera, 2013), were vague and unrealistic with very little quality control (Weare, 2015). Moreover, lots of these interventions require manpower. Often, these initiatives are allocated as an additional role or responsibility to staff employed at schools, such as teachers or teaching assistants (Kidger, Gunnell, Biddle, Campbell & Donovan, 2009). Such increased demands can put negative pressure on professionals due to a lack of time (Kinman, Wray & Strange, 2011), training, or perceived competency (Rossi, Pavey, Macdonald & McCuaig, 2015).

2.4.2.2 Early Identification, Triage and Referrals

School-based services that are based in the second category are responsible for the timely recognition of mental health difficulties in young people in addition to offering preventive and well-being interventions (Thorley, 2016). Services should facilitate initial triage assessments of an individual's mental health needs and signposted them to external services for specialised support if necessary (e.g. CAMHS). A request for triage assessment can come from parents, school staff or pupils themselves when any signs of distress, or behavioural and emotional concerns are identified. These services are effective only if parents, staff and pupils are aware of this pathway. Therefore, communication and strong relationships between pupils, parents and schools are essential.

Furthermore, tools are available in schools for the identification of emerging emotional and behavioural problems. For instance, the Strength and Difficulties Questionnaire [SDQ] (Muris, Meesters & Berg, 2003) is an effective monitoring and screening measure that can determine negative changes in pupils' development (Taggart, Lee & McDonald, 2014). School staff that receive appropriate training and feel confident could administer the SDQ. However, the efficacy of triage assessments remains inconsistent across schools (Thorley, 2016). Due to the variation of CAMHS services in local areas and lack of clearly defined or established referral pathways, the outcomes of initial assessments often end up unresolved.

2.4.2.3 Early Intervention

This category involves services that offer evidence-based early interventions suitable for young people. Such services are most commonly carried out by trained mental health professionals, including school-based counsellors, psychologists, mental health nurses and

mental health workers. According to the THRIVE model (*see* Section 2.4.1) early interventions are suitable for young people in the getting help category (Thorley, 2016). These were previously organised under the Tier 2 category. Early interventions are typically offered at schools that also have preventative and assessment services as triage and an appropriate referral pathway is necessary to access treatment (Thorley, 2016). Despite the important role the early intervention services play in the management of emerging mental health problems, they are not widely available across secondary schools (Thorley, 2016).

School-based counselling [SBC] is the most prevalent one-to-one therapeutic intervention available to young people in the UK's schools (Cooper, 2013). SBC provides a platform for individuals to examine their difficulties with a qualified professional in a confidential, supportive and non-judgmental environment and could be instrumental in the detection of emerging mental health problems (DfE, 2016). The evidence of the usefulness and effectiveness of mainly humanistic, non-directive counselling offered in UK secondary schools is slowly increasing (Cooper, 2009; Cooper, 2013; Cooper, Fugard, Pybis, McArthur & Pearce, 2015) and shows that counselling is associated with significant reductions in levels of psychological distress in adolescents and young adults. SBC was recognised as a valuable early intervention for a range of emerging problems in young people without specified criteria for entry (Cooper, 2009; 2013). Therefore, young people can seek counselling for a range of issues such as depression, anxiety, family issues, anger, bereavement, eating problems, substance misuse as well as for more severe difficulties such as self-harm, abuse, or suicidal thoughts. (Cooper, 2013). In Cooper's critical evaluation of SBC (2013) 80% of 1,426 clients - with abnormal (32.7%), borderline (26.4%) and normal (40.9%) range of psychological difficulties - perceived SBC as helpful and regarded counselling as a positive and rewarding experience that brought positive change and contributed to their overall well-being. Only a small majority reported no change but none of the clients reported a negative change. Similarly, counselling services were perceived as useful by school staff with a particular appreciation earned in relation to the guidance and management of emotional and behavioural difficulties at school (DfE, 2016).

Several problems have been identified with SBC, including its availability, managing the increased demand of young people for mental health support and adequate qualifications of counsellors that are providing support (Thorley, 2016). Although the availability of counselling services is increasing in the UK (Harland, Dawson, Rabiasz & Sims, 2015) there are still a large proportion of schools (approximately 30%) that do not

offer access to SBC. In contrast, schools in Wales provide statutory SBC in all secondary schools since 2008 and this was met with widespread satisfaction (Welsh Government, 2011). Furthermore, schools that have SBC are often not meeting the demand and instead young people are put on a waiting list or can slip through the system, allowing for their difficulties to worsen or mental health problems to arise. Lastly, there is a high variation in training and competency between counsellors that currently lack regulation. The DfE and DH (DH & DfE, 2017), however, planned to change this and ensure that counselling services are facilitated, accessible to all young people in need and offer quality support.

In line with the above-discussed efforts to involve young people in service delivery (Kendal et al., 2017; NHS England, 2017) Cooper (2013) identified specific areas of improvement in SBC. These are; the emphasis on young people's increased participation in the planning and developing of SBC; a focus on finding out what is appealing to young people and how to meet their needs, priorities and concerns; efforts to increase the rate of young people's self-referrals for SBC with the aim of enhancing their involvement and autonomy; measures to increase the equity of access - offering and encouraging support to young people from under-represented ethnic backgrounds, disabilities and regions and offering a choice of interventions to young people that are delivered by suitably qualified staff.

The increased demand on schools to meet young people's mental health needs as well as the budget cuts altered the roles and responsibilities of the school staff in recent years (Hanley, Winter & Burrell, 2017; Thorley, 2016). Professionals that are typically involved in emotional and behavioural support in school settings include teachers, counsellors, SEN-COs, pastoral care, the safeguarding teams, etc. The key responsibilities of school staff and health professionals across the three categories discussed above are summarised in Table 2.2. However the nature of the mental health support offered at schools varies significantly across secondary schools and is often unclear to staff, young people, and parents (Thorley, 2016). Currently, the whole-school approach is lacking a reliable body that would assure quality and consistency of provision (Thorley, 2016; Young Minds, 2014).

	Category 1		Category 2		Category 3	
Function	**Promotion**	**Prevention**	**Early Identification**	**Triage**	**Referral**	**Early Intervention**
Teachers	x	x	x			
Pastoral Staff	x	x	x	x	x	x
Counsellors		x	x	x	x	x
School Nurses	x	x	x	x	x	
Psychologists				x	x	x
CAMHS professionals	x		x	x	x	x

Key	
Primary responsibility	x
Secondary Responsibility	x
Co-ordination responsibility	x

Table 2.2 Key responsibilities of school staff involved in mental health provisions (adapted from Thorley, 2016).

2.5 Chapter Summary

This literature review examined the existing research on views and experiences of young people towards mental health services in the UK. Further, it highlighted that adolescence is associated with the emergence of many common mental health problems. Furthermore, it has been established that both schools and child and adolescent mental health services currently face numerous challenges to provide adequate support in relation to the mental health provision (HC, 2014; Thorley, 2016). Schools are increasingly required to accommodate the growing demand for the mental health provision that young people urgently require. According to recent governmental efforts to transform mental health provisions, school and community services are expected to facilitate preventative care and early intervention. The present study aimed to contribute to this debate and explore young people's views on the support and services available to them at school and in their communities. Young people's views and experiences of the availability, accessibility and usefulness of well-being and mental health services were of particular interest. The aim of this study is to examine young people's understanding of these services while providing them with an opportunity to contribute to the debate on the transformation agenda.

CHAPTER 3.

METHODOLOGY

3.1 Introduction

This chapter outlines the methodology of the present study and details the research design with consideration of its ontological and epistemological stance. Notably, it describes the research question, methodological procedures for sample selection, data collection, and protocol used for data analysis. Further, this study looks at the ethical issues that were pertinent to this study and how these were managed. This chapter ends with detailing trustworthiness criteria for this research, along with the measures used to determine rigour.

Research Question

To revisit the research question, this research set out to explore young people's views and experiences of wellbeing and mental health support that was available to them at their school and community. This study was interested in young people aged 11 to 16 years. Participation was random and selected from a school based in the North West of the United Kingdom. The research question explored:

What are young people's (11-16 years) views and experiences of wellbeing and mental health support at their school and community in the UK?

Specifically, it focused on areas related to:

- The availability of wellbeing and mental health support to young people at their school and community.
- The accessibility of wellbeing and mental health support to young people at their school and community.
- The usefulness of wellbeing and mental health support to young people at their school and community.

3.2 Philosophical Underpinnings

Epistemological assumptions form the bases for both quantitative and qualitative research and are related to the origins and production of knowledge in relation to reality and how it is conveyed within research (Guba & Lincoln, 1994). Epistemology helps the

reader to understand "how we can know and what we can know" (Coyle, 2016, p.11) and is usually discussed in relation to ontology. Ontology reflects researchers' understanding and assumptions they hold about the nature of reality and existence, in relation to their research. It determines the research design and impacts on the choice of epistemology, data collection and analysis. Epistemology in quantitative research is rarely acknowledged as its position is usually assumed as, for example, positivism or empiricism (Coyle, 2016). Positivism and empiricism are derived from a logical understanding of phenomena that are confirmed by statistical evidence. The qualitative approach, however, adopts a range of epistemologies that are suitable for different research methods. Within the qualitative enquiry, researchers pay particular attention to conceptual paradigms that organise their research. This organisation is underpinned by philosophical and theoretical frameworks and informs how the research is conceived, what it pays attention to and how the outcomes are generated and interpreted. Therefore the methodology used in qualitative research is considered from a place of understanding of a specific epistemology, which the researcher identifies with.

The range of qualitative research methods with possible philosophical underpinnings is illustrated in Saunders, Lewis and Thornhill's (2012) structure named the 'research onion' (*see* Figure 3.1). This structure outlines the stages that are instrumental in qualitative research design. Working from the outer layers towards the centre, the researcher must progressively develop a coherent design strategy that reflects their epistemological and ontological stance.

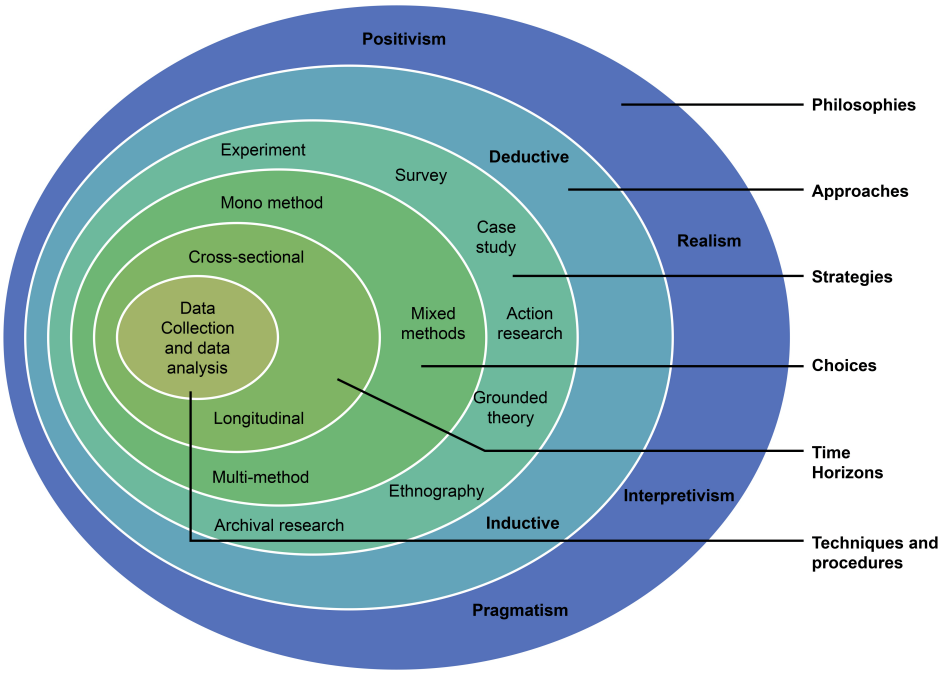

Figure 3.1 The research onion (adapted from Saunders, Lewis & Thornhill, 2007).

The following section outlines the conceptual framework that underpins the epistemological position of this study. Specifically, it addresses two domains. The first domain is concerned with this study's ontology and details assumptions the researcher makes about the world. The second domain focuses on epistemology and outlines what kind of knowledge this research produces. Further, it details how the current methodology conceptualises the role of the researcher in the research process.

3.2.1 Ontology

The study's ontology refers to the researcher's understanding of the nature of being. A researcher's beliefs and values represent their truth and are reflected in the choice of methodology and interpretations of findings (De Gialdino, 2009). The transparency and acknowledgement of the researcher's understanding of knowledge and fact formation help the reader to interpret this information about what constitutes a fact. The present study focuses on social phenomena and therefore the wider research context of ontology is not discussed here. In social science, ontology distinguishes between two positions, objectivism and subjectivism in reference to culture and organisation (Bryman, 2001). Bryman (2001) defined the organisation as reflecting a social need for order, rules, shared cultural values and regulation. Objectivism suggests that 'social phenomena have an existence that is independent or separate from actors within it' (Vanson, 2014). Thus social reality is constructed externally from an individual. The ontological assumption here is referred to as realism. The world and knowledge are categorised by a collection of perceptions and observations that explain the world. Individuals are socialised to these perceptions and this understanding reflects their reality (Coyle, 2016) unless their perceptions are damaged by other factors. Objectivism, also referred to as positivism or empiricism, is commonly aligned with quantitative methods that strive to obtain accurate knowledge of things or beliefs by collecting and analysing data in a generalisable and reliable fashion.

In contrast, qualitative research is aligned with subjectivism, also referred to as constructivism or interpretativism, and opposes some of the positivistic assumptions (Coyle, 2016). It considers a reality where meaning is a subject of constant change and evolution that is mediated by social interaction and experience (Burr, 2015). It implies that human beings construct their reality over time, depending on their personal experience and interaction with their surrounding. In line with the present study, qualitative design does not strive to understand one's truth from an objective lens that could be applicable to others but rather to obtain a personal account of an individual's perception to better

understand their version of the truth. Qualitative research could adopt inductive or deductive reasoning. Inductive reasoning embodies an experiential approach (Braun & Clarke, 2006) where theoretical constructs stem from the data. Deductive reasoning is rooted in theory and guides the analysis. Historically there has been a long-standing debate about the generalisability of qualitative findings and whether the researcher could accurately capture participants' reality from their accounts (Allport, 1962; Henwood & Pidgeon, 1994; Pidgeon & Henwood, 1997). This resulted in the emergence of several epistemological positions (Denzin & Lincoln, 2005). This ranged from a positivist understanding of classic ethnographic methods, popular between 1900 to 1945, that were characterised by field notes and observations, to a range of approaches available today such as constructivism, contextualism, phenomenology, structuralism or feminism.

3.2.2 Epistemology

This study identifies with an epistemological position of social constructivism (Burr, 2015; Charmaz, 2006;). Social constructivism acknowledges the importance of human development in relation to social interactions with others (Andrews, 2012). Namely, it suggests that individuals learn about the construction of concepts and meaning through interactions with others in their surroundings. Furthermore, individuals' cognition and attitudes towards the world are influenced by their culture, including language, history, religion, socio-economic status or traditions. Social constructivism, also referred to as interpretivism, emerged over thirty years ago (Andrews, 2012) in the field of social science. In qualitative research, social constructivism provides a useful framework for phenomenological research as it focuses on the interpretation of individuals' understanding of their world, their meaning and experience (Creswell, 2013). Collecting data through the use of open-ended questions enables participants to fully explore and describe the experiences that capture their reality and understanding. The data obtained through this methodology offer unique insight and new knowledge into understanding the phenomenon in question.

3.3 Research Design

To answer the research question that examined the views and experiences of young people, a qualitative methodology was applied to data collection and analysis. Traditionally, qualitative methodology is primarily exploratory and provides useful tools for information gathering that might be missed using more quantitative measures (Denzin

& Lincoln, 2005). It is concerned with meaning and embraces the phenomenological inter-subjective experiences of individuals by studying their insight, structures of consciousness and experiences (Willig, 2008; Corbin & Strauss, 1990). Currently, the views and experiences of young people of mental health services are not represented in the literature and there is limited evidence detailing their opinions on this topic. Thus a qualitative design enables a greater understanding of this area by providing insight into the depth, richness and complexity of participants' experiences. Such insights are rare in quantitative research as methods of data collection are commonly obtained from fixed-response questionnaires.

Qualitative research evolved over the past century into a useful framework for social science researchers and has undergone significant scrutiny for its validity and reliability (Willis, 2007). It was criticised for rejecting traditional elements appraised in quantitative research (Geertz, 1983) and proposed that positivistic research yields broad-brush results that fail to embrace multiple perspectives and situational context. On the contrary, it provides knowledge that is subjective and potentially bracketed. Therefore the choice of qualitative methodology should be well suited to its enquiry and highlight what it is and what it is not trying to measure or achieve. The goal of qualitative research is not aiming to demonstrate inferences or correlations that are commonly drawn from statistical studies or to deduce findings from larger samples or standardised testing. Rather it is an approach that acknowledges multiple perspectives and realities. It has an interpretative value and a scope for in-depth, informative and contextualised knowledge (Morrow, 2005). The goal of this study was to explore the phenomenological views and experiences of a small group of participants with the intention to deepen our current understanding of the question at hand.

This study considered a phenomenological form of analysis, such as Interpretative Phenomenological Analysis (IPA). IPA is a fitting method for exploration of participants' views, experiences, attitudes and perceptions, and pays particular attention to historical, cultural and linguistic contexts (Willig, 2008). However, the primary focus of this study was concerned with the details of participants' views and exposure to mental health services rather than their cultural, political or contextual positioning. Arguably excluding participants' contextual information could be perceived as depriving the current study of potential richness, considering that contextualism adds more layers to the knowledge (Madill, Jordan, Shirley, 2000). This study interviewed 21 participants and adding demographic information would go beyond the scope of the current thesis project. Therefore participants' demographic information in relation to their gender, age or socio-

political status was considered in data collection but not included in data analysis. Studies with larger sample sizes are better suited for thematic analysis, allowing for more comprehensive navigation through a significant amount of qualitative data. The thematic analysis (Braun & Clarke, 2009) examines data through a coding method and aims to produce a systematic representation of the participants' experience and understanding of the phenomenon under investigation through the identification of categories of meaning and experience. The categorisation is derived from common themes that are observed in the data (Willig, 2008). The characteristics of thematic analysis are discussed in more detail in section *Data Analysis.*

3.4 Sampling Method

This section outlines information about the sampling method. In particular, it describes the eligibility criteria, sampling size, school selection and method that was utilised within this research. A purposeful sampling method was utilised to recruit participants to ensure information-rich data (Patton, 2011). Purposeful sampling is the most common method of sampling in qualitative research and ideal in situations where specific participants are sought out based on the research question. This is applicable in the present study as the research question targeted a specific demographic of people. Purposive sampling is highly prone to researcher bias as it is predominantly based on the researcher's judgement. The current study attempted to minimise this bias, as the researcher was not directly involved in the recruitment of participants. The school representative carried out the sampling method by following clear criteria defined by a theoretical framework. Arguably, the school representative could selectively pick a sample of students that were known for certain attitudes or behaviours other than characterised in the eligibility criteria. However, the collected data were analysed from the perspective of the research and therefore minimised some of the associated biases by the appropriate use of thematic analysis. This section ends with a detailed outline of the recruitment procedure.

3.4.1 Eligibility Criteria

The eligibility criteria for participants were carefully considered with the aim to adequately answer the research question and determine the reliability of this research. The aim was to recruit participants from a state-funded school that was non-selective, in order to include participants from a variety of backgrounds and abilities. Therefore grammar, single-sex, independent, special or voluntary aided religious schools were excluded. A suitable secondary school for recruitment was identified in a district of a large city in the

North of the United Kingdom. The contextual information about the recruited secondary school is summarised in Appendix (AA*a* & AA*b*), including details about the student population in relation to the Pupil Premium, as well as well-being and mental health provisions that are available to them at the school.

The selection process was mindful of characteristics specific to the targeted population. Eligibility was in line with the issues identified in the literature review. To encourage diversity and variation, participants from various backgrounds, races, ethnicities, religions, gender or sexual orientations were considered. Furthermore, this study welcomed young people with or without experiences of mental health or wellbeing services that were available either within or outside of their schools. Participation was also open to young people with or without mental health problems, physical disabilities, learning difficulties or challenging behaviours. This research also paid particular attention to ethical standards and requirements that were applicable when working with young people in the UK. These criteria are summarised in Table 3.1 *Research Inclusion and Exclusion Criteria* below.

	Inclusion Criteria	Exclusion Criteria
Age	• Young people [YP] aged 11 to 16 years old	• CHILDREN under the age of 11 and young ADULTS over the age of 16 years
Gender	• Both males and females, including all gender identities	
Education Status	• YP currently in the state education system	• YP not in the education system • YP in selective secondary schools • CHILDREN or ADULTS in the education system
Physical & Mental Health [MH]	• YP in good health • YP with long-term conditions • YP with learning difficulties or physical disabilities • YP with visual or hearing impairments • YP with not known MH issues or diagnoses • YP with known MH issues or diagnoses	• YP at crisis or with acute MH conditions • CHILDREN or ADULTS in good health • CHILDREN or ADULTS with long-term conditions • CHILDREN or ADULTS with learning difficulties or physical disabilities • CHILDREN or ADULTS with visual or hearing impairments • CHILDREN or ADULTS with not known MH issues or diagnoses • CHILDREN or ADULTS with known MH issues or diagnoses
Experience of MH and Wellbeing Services	• YP who accessed support, MH or wellbeing services at their school in the past • YP who accessed support, MH or wellbeing services in their community in the past • YP who has not accessed support, MH or wellbeing services at their school in the past • YP who has not accessed support, MH or wellbeing services in their community in the past	• YP who were accessing support, MH or wellbeing services at their school at present and were at a potential risk of emotional distress • YP who were accessing support, MH or wellbeing services in their community at present and were at a potential risk of emotional distress • YP who were not accessing support, MH or wellbeing services at their school at present and were at a potential risk of emotional distress • YP who were not accessing support, MH or wellbeing services in their community at present and were at a potential risk of emotional distress
Background	• YP from various ethnic, cultural and religious backgrounds	• CHILDREN and ADULTS from various ethnic, cultural and religious backgrounds
Cooperation	• YP known to be able to represent their own, or their peer's opinions and attitudes comfortably, for instance, a class representative	• YP known to be unable to represent their own, or their peer's opinions and attitudes comfortably
Consent	• YP who were open, willing and approachable to taking part in the research and talking about their experiences with services. • YP whose parents agree for them to participate in the research	• YP unwilling or reluctant to talk about services or take part in the research. • YP whose parents did not consent to take part in the research

Table 3.1 Research inclusion and exclusion criteria.

3.4.2 Recruitment Procedure

The recruitment process was carried out over four school days and took place between May 2017 and July 2017. A selected form teacher acted as a representative who was appointed to recruit participants in order to protect participants' personal information and data. It was agreed that the representative would draw on her own knowledge and judgment to select the sample and therefore no medical or other records had to be accessed to identify the sample and breach confidentiality. The rationale for the recruitment procedure was agreed with the school representative. The school representative obtained the recruitment procedure together with an interview schedule and assent/consent procedure a month prior to the interview. During this time the researcher maintained regular contact with the school representative and addressed any arising questions or concerns. The recruitment procedure included the following steps:

Prior to recruitment the appointed school representative sent a letter (Appendix AB) to the parents/guardians of the 21 identified children and asked them for their permission to approach their son/daughter about taking part. The letter briefly outlined the purpose of the study and included the Participant Information Sheet [PIS] (Appendix AC) to those who wanted to learn more about it. This letter was written by the researcher and emailed to the representative as a template for distribution with the intention to reduce their workload. Parental consent forms (Appendix AF) were also attached, seeking their consent.

In the case when parents wanted to give their consent for their child to be approached about participation, they were asked to sign the attached consent form and send it back to the school representative. Parental consent was required from parents of all prospective participants; therefore, the ‘Gillick’ competency assessment (Gillick, 1985), that decides whether a child under 16 years of age is able to consent without parental permission, was not required. All participants who were offered and accepted the invitation were included in the study.

Once consent was obtained, the school representative approached the identified young person and explained the research aims and objectives. The young person was then given some time, approximately five days, to think about it and took the PIS and assent form (Appendix AG) home to consider their participation. No pressure was put on young people to make their decision. In cases where the selected young people decided to participate, they were asked to sign and return the assent form to the school representative. Afterwards, the interview was arranged with the young person through the school representative.

The school representative recruited the participants on a “first-come-first-served basis” (Robinson, 2014, p 32.). All approached participants and their parents gave consent to take

part. Therefore there was no need to identify additional students who fitted the criteria. In case a satisfactory and representative sample was not achieved a *Four staged plan of recruitment* was devised to aid the researcher and the school representative to recruit participants. This plan was also emailed to the school representative (Appendix AH) and detailed the following steps for participants' recruitment:

Stage 1. The recruitment sample - It was agreed that an appointed school representative would select the sample. Once this representative was appointed, all details of the study were communicated to and agreed with this person. This school representative ensured a representative distribution of conditions, gender and age in line with the eligibility criteria.

Stage 2. The first set of interviews - In collaboration with the school it was agreed to schedule one to six interviews per day, amounting up to a maximum of 21 days of interviewing.

Stage 3. Review – Once a satisfactory number of interviews were achieved (8 to 20) the researcher would assess whether the collected data was sufficient, audible and adequate. In the case that the data was inadequate, or resulted in fewer than 8 interviews, the second wave of interview invitations would have been undertaken through the school representative. At that stage, the data would not be analysed to prevent potential bias that might occur during the 2nd wave of interviewing (e.g. confirmation bias; question-order bias; leading questions and wording bias). This process would repeat until a satisfactory sample - a minimum of 8 participants and a maximum of 20 participants were obtained.

Stag*e 4. The second set of interviews* – The second wave of the interviews would be carried out in the same fashion as detailed in the first wave specified above. Once again, the school representative ensured that the participants' characteristics were in line with the eligibility criteria. These were not provided to the researcher. Stages 3 and 4 of the recruitment process would be repeated until a satisfactory sample is achieved. However, all students that were approached agreed to participate and their recordings were audible, eligible and adequate; therefore the 2nd wave of interviewing was not necessary.

3.4.3 Sampling Size

Twenty-one pupils aged 11 to 16 years old were interviewed for this study. Fourteen females and seven males took part in a secondary school from Key Stage 3 and 4. Key Stage 3 includes students aged 11 to 14 years old and Key Stage 4 includes students at 14 to 16 years old. A figure of 21 participants was in keeping with qualitative projects of this kind and in line with the resources available to complete the thesis project (Guest, Bunce & Johnson, 2006; Emmel, 2013). For successful qualitative research, Braun, Clarke and

Weate (2016) recommended 10-20 interviews for a medium thematic analysis project, such as a UK Professional Doctorate. Further Guest et al. (2006) proposed that a figure of six to twelve interviews is a sufficient number to deliver more representative findings if the sample is heterogeneous; the quality of data is high and the analysis procedure robust. To ensure a significant pattern across the data and reach satisfactory saturation a calculation based on the sample homogeneity (detailed below) yielded a minimum of eight participants. Reaching saturation depends on the complexity of data, researchers' experience, stamina, resources available and the time frame for the studies' completion (Ryan & Bernand, 2004). A maximum of twenty interviews appeared realistic given the timeframe and complexity of the present study. However one of the participants had a twin sister who learned about the study at home and was keen to take part. She was therefore included in the study, amounting to a total of 21 participants.

As discussed earlier, the type of purposive sampling method used in this study was maximum variation sampling. This research aimed to capture a wide range of perspectives related to the same topic by approaching young people with diverse experiences and backgrounds. Therefore this research targeted representation of participants with the following characteristics and experiences:

- **Group A:** Students with Experiences of *Past Mental Health Issues*
- **Group B**: Students with Experiences of *Long-Term Physical Conditions*
- **Group C:** Students with Experiences of *No Known Mental Health Issues or Other Conditions*

To fulfil the minimum sample criteria of 8 participants, it was decided to recruit slightly larger sample from Groups A and B, than from Group C. The rationale behind this was based on the fact that participants from Group A and B would be more likely to be exposed to mental health and wellbeing services and therefore provide to some extent more in-depth accounts of their experiences and views. Thus the minimum required sample of participants for both groups A and B were three participants each and two participants from Group C. The distribution of these conditions is summarised in Table 3.2 *Preferred Representation of Sample Characteristics* together with an ideal spectrum of gender and age variation. These requirements were discussed and agreed with the school representative prior to recruitment. However, the distribution of the sought out characteristics was negotiable. It was intended as guidance to point the school representative in the preferred direction. The aim was to achieve maximum variation sampling and to simplify the recruitment process. After the recruitment, the school

representative reported that the selected sample met the sought characteristics detailed in Table 3.2.

	Sample characteristics sought in the identified school			Achieved
Sample	**KNOWN:** • Past MH issues • Past service use	**KNOWN:** • Long-term medical conditions	**NO KNOWN:** • MH issues • Other conditions • Service use	 ✓ ✓ ✓
Number	• A minimum of 3 ≥	• A minimum of 3 ≥	• A minimum of 2 ≥	✓
Gender ratio	• Males: ≥ 1 • Female: ≥ 1	• Males: ≥ 1 • Female: ≥ 1	• Males: 1 • Female: 1	✓ ✓
Age	• 11 to 12 yrs: ≥ 1 • 13 to 16 yrs: ≥ 1	• 11 to 12 yrs: ≥ 1 • 13 to 16 yrs: ≥ 1	• 11 to 12 yrs: 1 • 13 to 16 yrs: 1	✓ ✓
Achievd	✓	✓	✓	

Table 3.2 Preferred representation of sample characteristics.

3.5 Data Collection

This section describes the process of how the data were obtained and analysed. Specifically, it details the research questions and the nature of the questions asked in the interviews as well as it explains how this study aimed to answer the research questions. This section ends with a description of the interview procedure, detailing the delivery and specifications of the interviews.

3.5.1 Interview Questions

To examine the research question this qualitative research chose to collect the data using semi-structured interviews with open-ended questions. Semi-structured interviews offer a non-directive exploration of the topic within the realms of the research question (Willig, 2008), as opposed to structured interviews that rigorously keep the participants to a set of questions and do not allow them to divert and explore new ideas and concepts. The interview was delivered in two parts. The first part focused on the introduction of the study and the second part on the semi-structured interviews. Only the second part of the interview was audio recorded and further transcribed for the analysis. Both parts of the interview are detailed in Appendix AI, and the outline of the interview schedule was closely followed during the interview.

The first part of the interview was designed to introduce the researcher and their study to participants. This allowed participants to settle in, familiarise themselves with their surroundings and potentially reduce anxiety. The researcher firstly thanked them for their

participation and explained their rights to withdraw from the study. Safeguarding and confidentiality limitations were outlined and discussed with participants. Participants were reassured that there were no right or wrong answers and all views or interpretations related to the questions were welcomed. The researcher then described to participants what the study was aiming to achieve and explained terms such as *well-being* and *mental health* to establish a common language based on the definition of mental health provided by Galderisi, Heinz, Kastrup, Beezhold and Sartorius (2015). To describe mental health the following was read out to all participants:

> Mental health refers to a person's psychological and emotional state. Our wellbeing reflects how we feel about ourselves, others and things that are going on for you and how well you can cope with your day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year.

Several examples of good mental wellbeing were offered, such as being able to *feel relatively confident in yourself and have positive self-esteem; feel and express a range of emotions; cope with the stresses of daily life.* Participants were offered space to ask clarifying questions and it was ensured that these questions were answered.

The second part of the interview focused on the semi-structured interview. The researcher in collaboration with their supervisor devised eight open-ended questions of interest and offered numerous prompts throughout the interview. Interview questions are detailed in Appendix AI. Specifically, these questions aimed to encourage participation, expression and discussion (McLaughlin, Holliday, Clarke & Ilie, 2013) around participants' thoughts and experiences. Participants were encouraged to verbalise and articulate their ideas, opinions and feelings. The researcher purposefully tried to avoid questions that could be perceived as leading or suggestive. Particular attention was given to language used in the formulation and delivery of any verbal or written materials, ensuring that communication was clear, coherent, user-friendly and appropriate for young people of various ages. Jargon and correcting of participants when they spoke was omitted. All information disclosed during interviews or the process became a part of the data and was analysed qualitatively. Use of age-appropriate tools was also available to encourage communication, such as rapport building, and the use of metaphors (Zakaira & Musta'amal, 2014).

3.5.2 Interview Procedure

Interview times were arranged in collaboration with the school representative to ensure that they were scheduled for a convenient time that was not disruptive to either the

student's learning or the school timetable. Each participant took part in a single interview, lasting between 30 to 45 minutes. Prior to the interview, the researcher explained the aims and objectives of the research again to the participants. The researcher asked the participants if they still wanted to participate in the study and gave them an opportunity to consider their decision once again. This was done in the presence of the school representative for additional support. When the young person agreed the assent forms were signed by all present parties and therefore contained three signatures in total, one belonging to the participant, one to the school representative and the last one to the researcher. These signatures are evidenced for each participant in their *Assent Forms.* Participants were informed that they could take a break or cease the interview at any point without providing a reason. If this were the case, necessary arrangements would be made for participants to return another time to finish the study. All participants finished the interviews without breaks or other interruptions. The interview process was flexible in accommodating participants' pace and their needs. The interviews were audio recorded on a digital recorder. Afterwards, these were uploaded onto a computer and stored in a password protected files that were encrypted. This password was available to the researcher only.

3.6 Ethical Considerations

This study was subject to ethical approval obtained from the University of Manchester (Appendix AJ). It is in line with the ethical research requirements outlined by the School of Environment, Education and Development (Manchester Institute of Education, 2014). Further, it adhered to the ethical standards specified in the Health and Care Professions Council (HCPC, 2015), and the British Psychological Society guidelines (BPS, 2014). This research paid particular attention to participants' confidentiality, consent and support. An approval to use transcription services was sought from the University of Manchester Ethics Committee and the researcher proceeded once this was granted. (Appendix AK). The selected transcription service adhered to strict confidential policies and ensured security on a number of levels. For instance, the audio files were handled and stored on a password protected secure-server that was only accessible to them and the researcher. Their Confidentiality agreement together with Terms and Conditions were reviewed and approved by the Ethics Committee.

3.6.1 Confidentiality

Due to the nature of the study and sample procedure, a particular consideration was given to confidentiality and anonymity. Participants had their rights explained to them regarding confidentiality, with exceptions of public interest limitations such as safeguarding (Data Protection Act, 1998). Safeguarding requirements could result in limitations to confidentiality and can affect or even lead to terminating the interview. The limits to confidentiality were thoroughly discussed with participants in consideration of organisational policies. By definition participants that are 16 years old or over have rights to confidentiality as adults, but in the present study, they were also subject to third-party influences. For instance, these were their parents, carers or teachers who possessed authority over them and therefore, any sensitive data or safeguarding issues were handled adequately and reported if necessary. No safeguarding issues arose during the process of this research. Interviews were carried out in a quiet and comfortable room where confidentiality and privacy were ensured. The room was located in a building next to the main school and this offered further privacy to the participants. Data from all interviews were audio recorded using a Dictaphone and the material was subsequently transcribed into text. Transcribed data were stored in encrypted files to ensure safe data protection. All names and personal details were anonymised so no inferences could be made about the participants.

3.6.2 Informed Consent

Participants' assent was obtained prior to data collection. Parental/caregiver and school consent were also obtained prior to the study. All participants received an information sheet that summarised the study details and offered the opportunity to ask more questions. It listed their rights to withdraw their participation at any point before, during or after the interview. To accommodate parents and students from different school years and abilities, three Participant Information Sheets [PIS] were devised. The information provided in all PISs was identical. However, the researcher adapted their language according to the audience. The use of complicated language and jargon was limited or minimised in the PISs that were aimed at younger students. Specifically, one PIS was aimed at parents, caregivers and teachers (Appendix AC). Another PIS was devised for participants between the age of 11 and 12 and for students with literacy difficulties (Appendix AD). The last PIS was distributed to students between the age of 13 and 16 years (Appendix AE).

Furthermore, the researcher provided a verbal description of the study to all participants prior to the interview. This was also suitable for participants with literacy difficulties.

3.6.3 Further Support and Relationships with Research Participants

The researcher was conscious of the vulnerabilities associated with the targeted group of participants. She holds a clear Disclosure and Barring Service check and was deemed as suitable to work with vulnerable groups and children. Throughout the data collection, the researcher minimised the opportunities that might carry potential openings to distressing feelings or emotions and ensured that a distress policy was in place (Appendix AL) that stated a clear pathway of dealing with any safeguarding issues. Further, the researcher was aware of potential power dynamics as participants might view an adult as an authority figure. To address this imbalance, the researcher promoted equality and empowerment in the relationship by being transparent about confidentiality and safeguarding limitations, and by encouraging collaboration and helping the participants to exercise choice and control. The researcher communicated to participants that the research was carried out through a third party (University of Manchester), with the aim to remain impartial and confidential. It was reiterated to participants on numerous occasions that this study was solely interested in their views and perspectives.

Participants were offered support throughout the recruitment and data collection process. The timing of the interviews was in line with the needs and preferences of the participants and agreed with the school representative. Interviews took place in a familiar environment, which was quiet, free from distractions, and private. Emphasis was placed on creating a safe and confidential space. The school representative was also aware of the participants' whereabouts at all times as they were ‘in loco parentis' and, therefore, bore responsibility for them. The researcher understood the school system and the importance of the school curriculum and worked flexibly to ensure that participants were not missing lessons or important school events. The school representative attempted to minimise the impact of this and arranged with the participant to miss a lower priority class. The participants were offered an opportunity to be accompanied by an assistant of their choice during the interview (i.e. teaching assistant, support worker, or teacher). All participants felt comfortable to complete their interviews unaccompanied. The researcher also accommodated participants' preferences and worked flexibly with their abilities, by being mindful of their concentration levels and offering opportunities to take breaks when necessary.

3.7 Data Analysis

This section firstly provides an overview of how the data were transcribed, and secondly, it focuses on a method that was used to interpret the data. The transcribed data were analysed qualitatively using thematic analysis (Braun & Clarke, 2006). Thematic analysis is introduced, followed by an outline of the steps that were undertaken in the analysis. This section ends with a critical appraisal of thematic analysis, including its trustworthiness, reflexivity and limitations.

3.7.1. Interview Transcription

The interviews were transcribed to a written format to present the data for the analysis. While the interviews themselves varied in length, overall, more hours of interview were recorded than what was initially expected. The time required to type up these interviews proved burdensome, impacting on timely submission of this thesis. Therefore a decision was made to use audio transcription services to aid this process.

A total of 16 interviews were transcribed by the transcription service and the remaining five by the researcher. A verbatim method was utilised to transcribe the data. It provided an adequate level of detail for analysis, documenting all verbal and non-verbal utterances. This included pauses, punctuations, repetitions or hesitations to produce a thorough and close to the original account of the interview. Verbatim transcription is in line with Braun and Clarke's recommendations for adequate transcription, stating that "constructionist thematic analysis does not require the same level of detail in the transcript as conversation, discourse or even narrative analysis" (2006, p.17). An example of one of the transcribed interviews is attached in Appendix AM.

3.7.2 Thematic Analysis

The present study used thematic analysis (Braun & Clarke, 2006) to analyse collected data due to its suitability for phenomenological enquiry (Guest, MacQueen, Namey, 2012; Willig, 2008), allowing for in-depth evaluation of participants' views, reflections, preferences and emotional responses towards the phenomenon in question. This phenomenological component of qualitative enquiry is in line with humanistic psychology (Braun & Clarke, 2006) as it allows participants to be heard and use their own language of expression. Such expression is rare in quantitative research as methods of data collection are commonly obtained from fixed-response questionnaires. The thematic analysis offers a rigorous qualitative methodology for identifying patterns, organising and interpreting

meaning across the whole the data set. Braun and Clarke (2006) developed thematic analysis into a clear, structured and flexible method of data analysis that allows for cross-referencing between the entire data set (Braun & Clarke, 2006; Hayes, 1997). The findings also have the potential to be applicable beyond the theoretical assumptions outlined by a study (Guest, MacQueen & Namey, 2012).

Furthermore, thematic analysis (Braun & Clarke, 2006) is compatible with social constructivism. Braun and Clarke (2006) argued that findings do not simply emerge from the data and they "do not subscribe to a naïve realist's view of qualitative research where the researcher can simply 'give voice' to their participants" (p. 7). In contrast, they state that the researcher makes a decision of how themes are identified, findings interpreted, what is acknowledged and what is either intentionally or unintentionally carved out to support or dispute their arguments. Similarly, social constructivism argues that categories and theories do not emerge from the data, but are constructed by researchers through their interaction with the data (Ponterotto, 2005). Thus researchers create an explication, organisation and presentation of themes and categories from the data rather than the themes being discovered within the data. To accurately capture this process the researcher should acknowledge their reasoning and decision-making that led and shaped their finding as well as their philosophical and theoretical perspectives and experiences. As a result, the produced knowledge or theoretical construct will constitute one particular reading of the data rather than the only truth about the data. How the role of the researcher was conceptualised in this study is further discussed below in the section entitled *Trustworthiness.*

Thematic analysis could be either deductive or inductive (Braun & Clarke, 2006). A deductive method is theory-driven (Crabtree & Miller, 1999; Hayes, 1997) and is based on 'top-down' analytical processing where the researcher identifies with a particular theoretical or epistemological position. Qualitative methodologies that broadly adopt this framework are for example conversation analysis (Hutchby & Wooffitt, 1998) or Interpersonal Phenomenological Analysis (IPA) (Smith & Osborn, 2003). In contrast, the inductive approach is data-driven (Boyatzis, 1998) and uses 'bottom-up' interaction with the data. It is independent of a particular theory and can be applied to a range of epistemological and theoretical approaches. Here the researcher systematically examines the whole data set and reports occurring patterns and themes. Consequently, new theories are constructed or links to existing theories are made (Guest, MacQueen & Namey, 2012). The process of theme identification should be therefore free from pre-existing theoretical assumptions.

Further, theme identification could focus on either a semantic or latent level of data interpretation. A semantic theme embodies the explicit meaning of the data that reflects an accurate description of participants' responses. The latent level interprets the data explicitly and implicitly and includes researchers' interpretation of underlying ideas, patterns and assumptions. Latent interpretation adds depth, complexity and richness (Boyatzis, 1998). Importantly, as detailed in the epistemology section, a complete separation from the researcher's theoretical epistemological responsibilities is not possible. Therefore this study's findings do not emerge from the data but rather are constructed by the researcher. A similar framework could be found in other qualitative approaches such as grounded theory (Corbin & Strauss, 2015; Charmaz, 2006), narrative analysis (Murray, 2003) or discourse analysis (Burman & Parker, 1993).

The present study used the inductive approach on the latent level to analyse the data to embrace the inquisitive nature of student response from a social constructivist epistemological position. The following section details the process of thematic analysis and describes the procedures for data examination, coding and theme organisation and the production of findings.

3.7.3 Thematic Analysis Procedure

NVivo 11.4.3 software (2014) was used to analyse the data and categorised themes into meaningful patterns. The data were interpreted through a six-phase coding process (Braun & Clarke, 2006) that guided the researcher to develop themes inductively within the raw data, prior to interpretation. Figure 3.2 *Data Analysis Flow Chart* details the succession of the coding process applied in this study. Coding refers to the initial process of themes' development through recognition of important moments, occurrences or ideas within the dataset (Boyatzis, 1998). The focus extends beyond words and expressions beyond implicit and explicit meaning within the data (Guest, MacQueen & Namey, 2012). A code can generate several labels that contribute to a theme (Saldana, 2016). A theme is a patterned response or meaning that is constructed from the data (Braun & Clarke, 2006). Identification of a theme is commonly determined by a frequency of a particular response and their relevance to the research question. Higher frequency of a theme does not automatically indicate their importance as infrequent themes could add equal significance to our understanding of the data. Ultimately the researcher decides which themes are constructed or not. Their judgement is therefore instrumental in the analysis (Starks & Trinidad, 2007). To capture the essence of a theme in the final stage of analysis, each theme should have a central organising concept. This concept summarises and

meaningfully defines the core assumptions of the theme in a coherent fashion. Without this, the theme lacks credibility.

Several factors could impact on the coding process and should be considered and regularly reviewed during the analysis. These are for instance the researcher's familiarity with data, their understanding of the analytical process, and occurrences of potential personal biases. To monitor the researcher's involvement with the data, a reflexivity journal was used throughout the analysis. Particular attention was given to assumptions the researcher was making during the analysis, their understanding of the strategies used and the learning that occurred. Potential pitfalls and how these were examined are discussed later in the section entitled *Trustworthiness.*

Figure 3.2 Data analysis flow chart (adapted from Braun & Clarke, 2006, p.35).

As detailed above the analysis was carried out in accordance with the six-phase coding process. The researcher's adherence to it is detailed below.

Phase 1: Familiarisation with data: In this phase, I uploaded all transcribed interviews into NVivo software and read and re-read data several times in order to become familiar with its content. To fully immerse myself with the subtleties and richness of the accounts I also listened to the recordings several times and made notes or highlighted sections that

were considered significant for this study. Particular attention was paid to recognising important moments in relation to the research questions. An example of this entry in my reflexivity journal is provided in Appendix AN.

Phase 2. Generating initial codes: After I became familiar with the data, I started to generate initial codes and patterns by systematically collating information into codes. To aid efficient analysis, data were reduced into categories and these were preliminarily labelled by a description that reflected some significant finding. NVivo software makes this process easy to manage, as all codes collate entries from participants who contributed to that particular code into a single document. This accessibility makes the information more transparent and the process of analysis faster. These codes were examined again and their content was read through. Consequently, some amendments were made that resulted either in generating new codes or removing some insignificant data extracts. This phase yielded a comprehensive list of codes. The links between these categories and research questions were thoroughly examined in my reflexivity journal. Identification and development of these codes are illustrated in Appendix AO.

Phase 3: Searching for themes amongst codes. In this phase, the generated codes were organised and combined into themes that reflected a meaningful pattern. Initially, 9 themes were created and thoroughly explored. Further analysis recognised that some of the themes shared similarities, thus reducing the total amount of themes to seven. Each theme was labelled in a way that described their characteristics. Further, the relationship between each of the themes was examined, combining the data into overreaching themes. The list of candidate themes is available in Appendix AP.

Phase 4: Focused on reviewing themes that were identified in phase 3. A similar procedure was applied, focussing on the relationship between the themes in relation to the research question. Theme patterns were illustrated and carefully analysed. Similarities and differences within each theme were collated into subthemes and repeatedly examined, compared and contrasted. The characteristics of the subthemes were also considered with sub-themes from other themes. Any overreaching relationship was recorded and illustrated in the analysis. Appendix AR demonstrates this complex relationship and how the researcher understood this process.

Phase 5: Defining and naming themes. Here the final theme names and sub-themes were produced together with detailed description of their properties and characteristics. Furthermore, their contribution to the understanding of the data was highlighted. This is documented in Appendix AS.

Phase 6: Producing the final report. In this last phase, the researcher evaluated the particular contribution of each theme to the overall understanding of the data. The researcher also performed further checks of the themes and returned to the original sources of data and evaluated them for accuracy. A sample of stage 6 is demonstrated in Appendix AR.

3.7.4 Trustworthiness

Trustworthiness, also known as validity, credibility, or rigour, refers to a measure of quality in qualitative research (Morrow, 2005). The assessment of quality is based on the epistemological underpinning and therefore the criteria could vary considerably from study to study. To assess the data for hypothetically related themes and still providing statistically sound results depends on good qualitative analysis (Joffe, 2012). This requires a shift from focusing on causation to meaning and from statistical analysis to interpretation. To ensure quality when conducting thematic analysis, this study adhered to the six-phase coding process detailed in the data analysis section. Further in line with Braun and Clarke's (2006) recommendations, this study considered the following pitfalls.

Firstly, researchers should ensure adequate and extensive data analysis. An analysis that is characterised by a collection of extracts that are defined by a poor analytic narrative or contain merely paraphrased responses of participants' accounts is weak. Rather analysis should be used to illustrate an analytical point in support of the finding that was identified by the researcher.

Secondly, researchers should avoid using interview questions to determine a theme. Such practice demonstrates poor analytical work and limits patterned responses across the whole data set (Braun & Clarke, 2006). Furthermore, this applies to a mismatch between theory and analytic claims or between the research question and the form of thematic analysis used. Consistency between interpretations and theoretical framework should be ensured.

Thirdly, unconvincing analysis features themes that contain too much overlap between them, or themes that are not internally coherent and consistent. All aspects of the theme should correspond with a central idea or concept. To avoid this Braun and Clarke (2006) suggested ensuring that the majority of the data are adequately captured, interpreted, presented in rich detail and that multiple aspects of possible outcomes are conveyed. To convince the reader of the plausibility of the findings, Braun and Clarke (2006) recommended including more than two data extracts per theme. Data vignettes should represent the essence of the theme as accurately as possible. This would prevent reporting

of few unsubstantiated instances of a phenomenon into a concrete finding that is actually lacking in evidence.

Fourthly, researchers should ensure consistency between the data and their analytical claims. A weak analysis would occur if such claims cannot be supported by the data; the presented data extracts suggest another analysis or even contradict the claims. Further, the weak analysis does not appear to consider other alternative readings of the data and fails to consider variation or contradiction in the account that is produced. Lastly, the theoretical assumptions of the analysis should be provided in detail, clarifying how it was undertaken and for what purpose.

For qualitative research to be accepted as trustworthy, Fereday and Muir-Cochrane (2006) advocated that researchers should demonstrate a trail of evidence throughout the research process that explains in detail the process of data collection, analysis and interpretation. Further Nowell, Norris, White and Moules (2017, p.1) concluded: "Researchers must demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible" (p. 1). They also stated that this could be achieved through clear communication of the findings, acknowledging subjectivity and reflexivity by stating their epistemological position. These beliefs correspond with criteria that were originally introduced by Lincoln and Guba (1985) to parallel the quality appraisal in quantitative assessment. These criteria were credibility, transferability, dependability and confirmability. Table 3.4 illustrates how these are represented in relation to quantitative research, together with what sort of questions qualitative rigour targets and by which methodology.

Nowell et al. (2017) identified Lincoln and Guba's criteria as suitable for quality appraisal for thematic analysis. The following section describes the steps undertaken to demonstrate quality and rigour in the present study. These were carried out according to Lincoln and Guba's criteria and were utilised to the researcher's best ability and resources available.

Qualitative Research	Quantitative Research	Questions that underpin the principles of qualitative research (Pretty, 1994, p.42)	Application in Research
Credibility	Internal validity	How can we be confident about the 'truth' of the findings?	• Prolonged engagement • Persistent observation • Triangulation • Peer debriefs • Negative case analysis • Member checking • Researcher reflexivity • Referential adequacy
Transferability	External validity	Can we apply these findings to other context or with other groups of people?	• Evidence of detailed descriptions of the research process
Dependability	Reliability	Would the findings be repeated if the inquiry were replicated with the same or similar subjects in the same or similar context?	• Evidence of a detailed audit trail • Logical, traceable, and clearly documented research process
Confirmability	Objectivity	How can we be certain that the findings have been determined by the subjects and contexts of the inquiry, rather than biases, motivations and perspectives of the investigator?	• Triangulation • Audit trails • Confirmability audits • Reflexivity

Table 3.3 Criteria for qualitative rigour (adapted from Nowell et al., 2017).

Credibility

Credibility is concerned with the accuracy of the researcher's interpretation and representation of the data and whether these accurately reflect participants' experiences or views. Credibility represents the quality of the data rather than the quantity. Credibility could be determined by a number of techniques such as prolonged engagement, persistent observation, data collection triangulation, researcher triangulation, member checking or researcher's reflexivity. However it could be argued that results that are the most credible, accurate and believable are the ones that were checked with participants, also referred to as 'member checking'.

Member checks were not carried out in the present study, as the researcher did not have direct access to the sample prior and after the research took place. Participants were recruited via a selection process carried out by a school gatekeeper who kept their personal information anonymous to ensure confidentiality. Furthermore, the researcher purposefully omitted the use of participants' names, age or any other identifying features in the analysis that could connect them to their responses.

Triangulation refers to the consistency of findings across the data in relation to the chosen research design in order to capture different dimensions of the same phenomenon. Data triangulation refers to using evidence from multiple sources of information to support

the findings. Patton (1999) noted, “Triangulation is ideal but it can also be very expensive. A researcher's limited budget, short time frame, and narrow training will affect the amount of triangulation that is practical” (p.1192). The current study is a case in point as the researcher had limited time and resources to provide cross-data validity checks. The present study used only one source of information, young people. However, it made efforts to achieve triangulation by combining purposeful sampling and the inclusion of multiple perspectives (Patton, 1999). This study used a sample that was varied and represented groups of young people from different ages (11 to 16years), cultural backgrounds, and with a range of experiences with mental health services.

Similarly, the researcher's triangulation involves using multiple investigators to engage in the analytical process of the data. This was partially achieved in the present study when the findings were checked and discussed with the research supervisor.

The researcher’s credibility is also crucial, as she was the instrument of this qualitative enquiry. The researcher’s affiliation with the study, personal experiences, academic background and connection with the topic of discussion could have an effect on the interpretation of the findings. Personal information, such as how the researcher’s age, gender, ethnicity or experiences related to the research question are relevant and should be disclosed (Patton, 1999). Therefore the next section provides this information to demonstrate the researcher’s reflexivity.

Reflexive Statement

Researcher’s Positioning - In my undergraduate and postgraduate studies, I have gravitated towards quantitative design. Its organised, objective and well-defined approach provided a welcome structure to conduct research and make sense of it. During my doctoral training, I have conducted a couple of small-scale qualitative studies and initially missed the safety of statistical certainties specific to quantitative studies. Qualitative research is characterised by the detailed description of a certain phenomenon, and words and interpretation of events are an important part of an analysis. English, not being my first language, perhaps contributed to a lack of confidence and reluctance to use language as a method of analysis. In contrast, interpreting numbers and probabilities seemed much more straightforward. Moreover, the concept of mathematical probability provided objectivity, reassurance and certainty that something is or is not likely to happen. This certainty mirrored my relationship with truth, my ontology. My recent exposure to qualitative research challenged my natural inclination towards quantitative research design and I have recognised the benefits of the phenomenological enquiry. Furthermore, to accommodate

the demands of the current project, qualitative research is the best suited. I aimed to tap into the perceptions and understandings of the interviewed young people and to fully explore their reality and how their truth is constructed within their school and community settings.

Researcher's background - At the time of the data collection and analysis the researcher was a 36-year old, white European female born outside of the UK. Compared to some of the participants the researcher's experiences differ in the following aspects. The researcher completed her secondary education between the years 1996 to 2000 in Slovakia. At the time the Slovakian educational system was heavily marked by the country's difficult political climate. The country underwent many structural changes that stemmed from the fall of the Soviet Union and Communism in 1989. At the time psychological support was accessible mainly to students with learning disabilities, students with behavioural problems or children that lived in care. Student counselling and wellbeing services were not prevalent and mental health or wellbeing was rarely discussed. Therefore, the researcher had limited experiences or knowledge of mental health services as a young person. This potentially aided the objectivity of the researchers approach to this study as her research was less likely to be influenced by her own childhood experiences of the UK schooling and mental health system. The researcher moved to the UK age 18 and since worked with children and young people within the UK educational setting. This included working as a teaching assistant in primary and secondary schools, and as a trainee-counselling psychologist in psychological services for young people. Here the researcher learned about the schooling system and young people's experiences of mental health support at school. These experiences sparked her curiosity and interest in exploring their experiences and views towards mental health and wellbeing services that are available to them. The researcher was not affiliated with the school where the study took place and had no conflict of interest.

Researcher's Interaction with Data - The researcher chose thematic analysis for its accessibility and theoretical flexibility when analysing qualitative data (Braun & Clarke, 2006). It is also suitable for novice qualitative researchers like myself. In their paper, Braun and Clarke (2006) stated, "It is the first qualitative method of analysis that researchers should learn, as it provides core skills that will be useful for conducting many other forms of qualitative analysis" (p.4). The thematic analysis appealed to me for its clearly defined structure and theoretical flexibility. Over the last couple of years, I have learned to appreciate its robustness and agree with Braun and Clarke (2006) who in their

paper concluded to advocate thematic analysis as a useful and flexible method for qualitative research in the realms of psychology and beyond.

With the aim to limit personal judgements, projections or biases that could impact on the data collection or analysis I have followed the coding procedure of thematic analysis (Braun & Clarke, 2006). At times it was difficult to clearly distinguish between the particular stages of the coding analysis. Allowing time for analysis, and having a good understanding of the coding process was crucial in organising my findings and gaining perspective. I have frequently discussed my progress in research supervision and carefully scrutinised the findings. To aid this process, I kept a reflexive diary and recorded my observations or any contact with the literature that was relevant to young people, mental health or mental health services. I have noted the time, date and description of the information, analytical deduction or observation that formed or shaped my understanding.

Transferability

Transferability refers to the generalisability of inquiry (Nowel et al., 2017) and in qualitative research could be applied only to a direct transfer from one case to another. To demonstrate transferability, a study should provide thorough and detailed description of the methodological process. This study produced a highly detailed and accurate account of the research process, including details of the data collection, data analysis and interpretation as evident in this method. Thematic analysis is widely recognised for its transparency and systematic approach and therefore it is easily transferable (Vaismoradi, Jones, Turunen, & Snelgrove, 2016). The appendices include further information that was pertinent to this study, including the specification of the school, the sample and information that was disseminated to the school, participants and their carers. The transparency of this process should enable an external researcher to repeat the inquiry and theoretically achieve similar results.

Dependability

To demonstrate dependability, this research ensured clear and traceable documentation of the research analysis. The researcher aimed to present this study in a logical and coherent manner to aid transparency and audit. The researcher consistently adhered to the 6-stage coding process of thematic analysis to ensure prolonged engagement and persistent observation of the data. The researcher checked for alternative explanations within the sample by detailing the number of participants that contributed to each theme or subtheme

and substantiated these observations by participants' vignettes of their views and experiences.

Confirmability

Confirmability corresponds with researchers' adherence to their established epistemological and theoretical position. It is commonly achieved once the above-mentioned criteria have been met. In line with Koch's recommendations (in Gearing, 2004), I have kept a self-critical reflexive journal to monitor my involvement with this study. This journal served as an audit trail where I reflected on my analytical choices throughout the entire study to demonstrate my decision-making process and the evolution of theoretical and methodological concepts. *Reflexivity* has been considered as a central component to the audit trail (Nowell et al., 2017) as it provides a critical account of the researcher's reflections, values and insights that ultimately shaped this research. These were detailed earlier in the reflexivity statement and also detailed the researcher's background and personal experiences in this field.

3.8 Chapter Summary

The methodology chapter described the steps that were undertaken to complete this study in a linear manner. It was explained that the philosophical underpinnings of this study are defined by social constructivism, as the researcher positions herself as an active part of the analytical process. To fully enable young people's views and experiences to be explored it was established that this study was suitable for a phenomenological enquiry. The chosen method of data collection was semi-structured interviews that were further examined via the 6-stage process of the thematic analysis (Braun & Clarke, 2006). The rigour of this study was appraised through the recently revised criteria (Nowell et al., 2017) suitable for thematic analysis.

CHAPTER 4.

DATA ANALYSIS

4.1 Introduction

The aim of this chapter is to present the findings of this study using thematic analysis. The data was generated from semi-structured interviews with young people on their views and experiences on mental health services and well-being provisions that were available to them at school or in their community. The data was analysed across the whole dataset and coded into coherent themes. These were further interpreted by comparing theme frequencies and theme co-occurrence. Through thematic analysis, one central theme was constructed that was interlinked with three master themes and eleven related sub-themes. The central theme was labelled *Patterns of Help-seeking Behaviours in Young People*. The three identified master themes were *Available Support and Services, Young People's Views and Preferences for Mental Health Care and Services* and *Barriers to Accessing Support.* Most of the subthemes were further clustered into sub-categories, amounting to a total of a further nineteen successive subthemes. The succession of the central theme, three master themes and their eleven subthemes are depicted in Figure 4.1.

This findings chapter is organised into six subsections, including the introduction and conclusion paragraphs. The remaining four sections centre around findings captured in the central theme and the three identified master themes. Each theme varies in size and contains input from all participants. The sub-categories, however, do not always reflect input from all participants. This is represented by a given ratio of participants' input contributing to each theme. The extent of participants' contributions to each theme is not a representation of its significance or impact, as this was not the study's focus. However, provided ratios aimed to position themes and sub-themes into a wider context of the whole sample. Throughout the chapter, headings of the central theme, master themes and sub-themes are presented in italics to enhance clarity. In the following sections, a brief summary is provided for each theme and subtheme.

Participants' verbatim quotes are included in each category and sub-category in order to demonstrate the findings and to reflect the central aspect of each theme. Superfluous information was removed from some participants' extracts in order to improve the consistency and readability of the text. These are identifiable as a sequence of three full stops in the text, such as '…' The names used are pseudonyms, randomly selected to

protect participants' identity. Participants' gender is assigned correctly; however, their age has been omitted to further protect their anonymity.

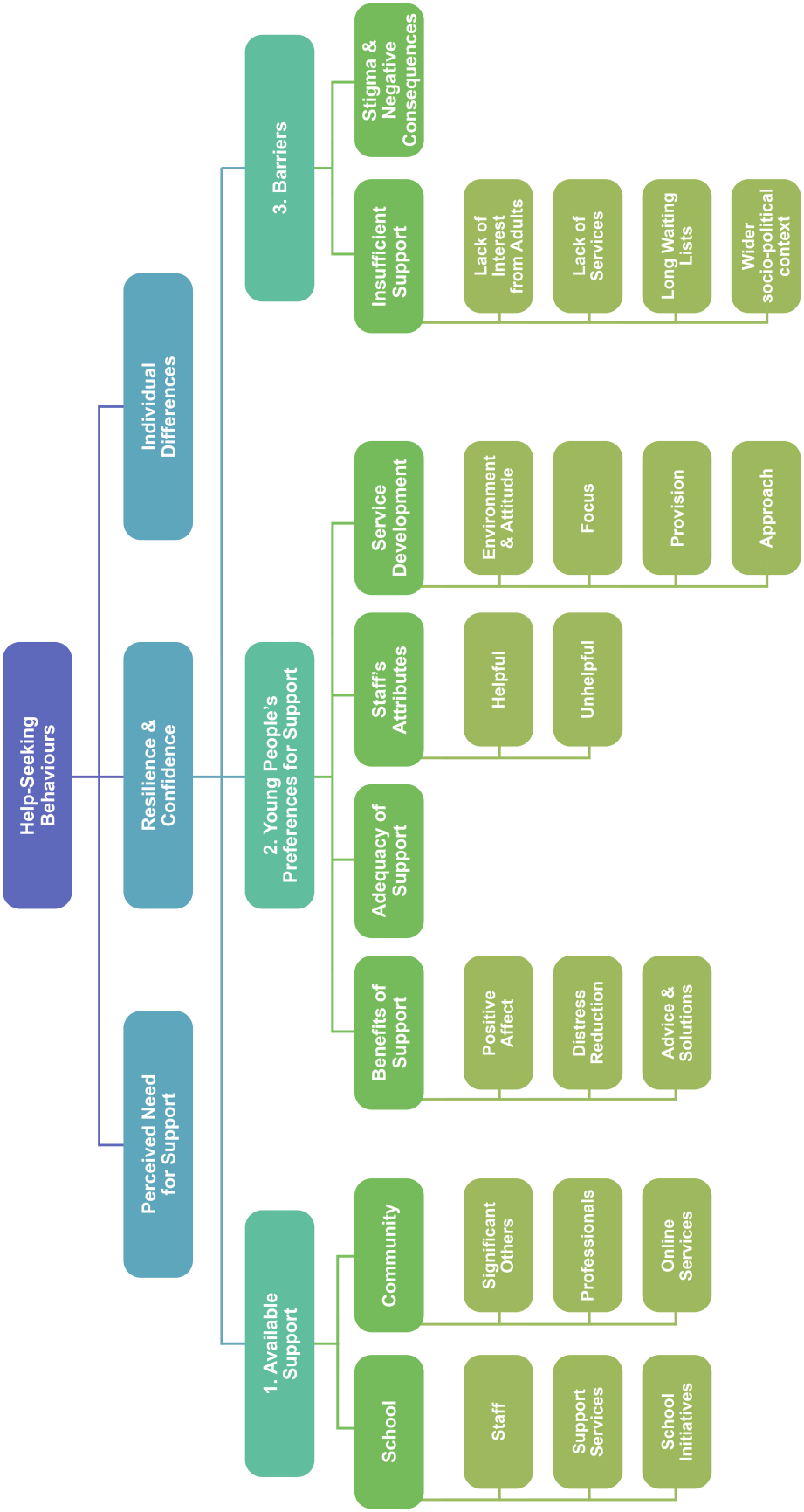

Figure 4.1 A successive representation of identified themes and subthemes.

4.2 CENTRAL THEME: Patterns of Help-Seeking Behaviours in Young People

The central theme encapsulated patterns of help-seeking behaviours in young people that were frequently and consistently observed across the whole dataset. The help-seeking patterns were also observed in the three master themes. Further, the central theme appeared to conceptually span across the features of availability and accessibility of the support services that formed bases for the research question. A graphical illustration suggesting a relationship between different themes and the concept of availability and accessibility of services is depicted below in Figure 4.2.

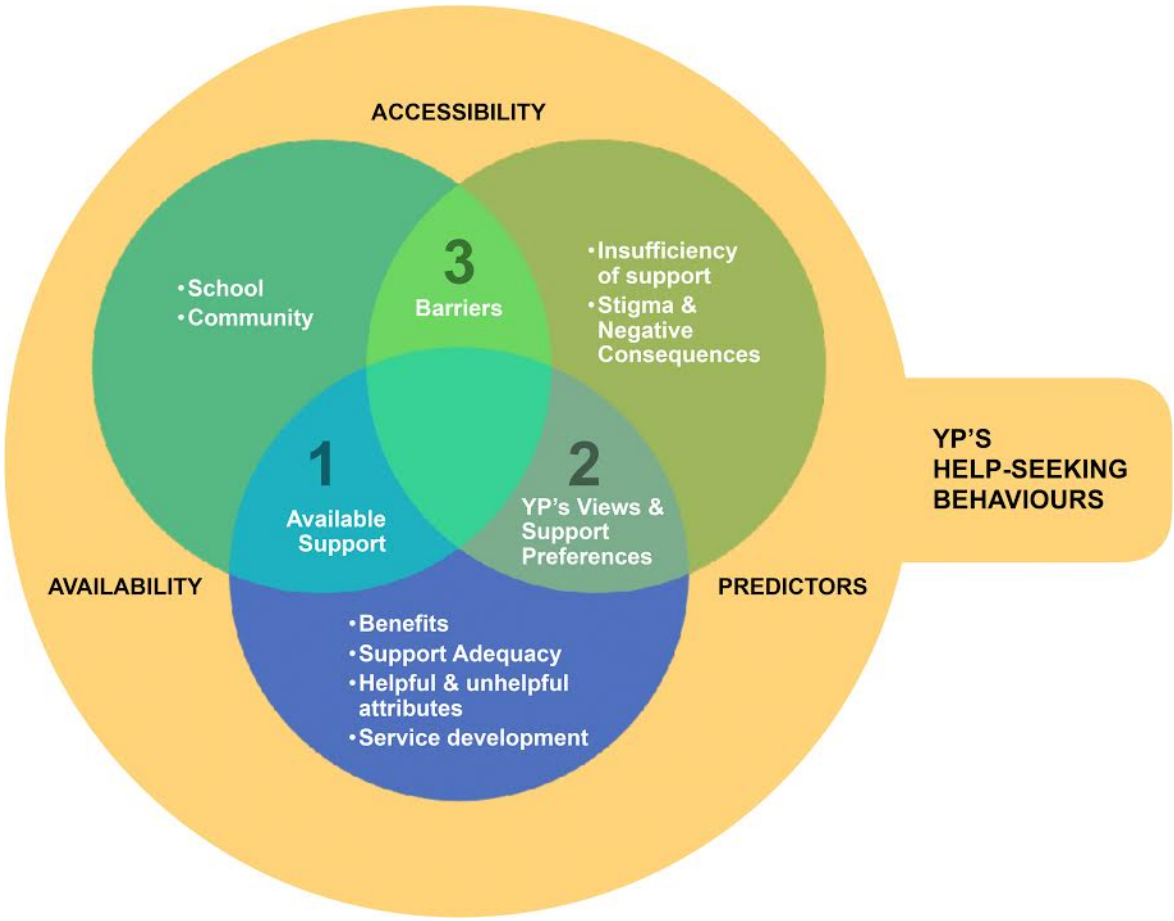

Figure 4.2 Integration of the research questions and findings.

In all likelihood, these findings resulted from the nature of the interview questions. For instance, questions such as *Who can you talk to about problems or worries at school?* or *Have you ever talked to someone about your worries?* Prompted young people to convey their tendencies to seek help. It was observed that help-seeking behaviours inform young people's views, experiences and engagement with mental health services and well-being support.

The central theme categorised three mediators that featured in young people's views and experiences towards mental health services. These mediators were participants' *perceived need for support, resilience and self-confidence,* and *individual differences*. For instance, young people's perceived confidence impacted on their decisions to seek support or engage with support services. In some accounts, participants' help-seeking behaviours were informed by their person-specific variables such as their age, gender or race. The central theme captured some consistencies in young people's help-seeking that were observed across a particular group. These trajectories were common for the particular group but inconsistent with other young people. Such categorisation together with the interconnectedness between the central and master themes is illustrated in the following example. Some participants reported that boys prefer to deal with their problems alone [central theme: individual differences] because they believed that sharing is a sign of weakness [master theme 3. barriers: stigma]. Although this encapsulates a distinction of help-seeking behaviours between boys and girls [gender variables], it was also identified as a stigma that prevents boys from seeking help. The interconnectedness between central themes and master themes is highlighted further in the text where relevant. The following section summarises findings from the three subcategories relating to the central theme.

4.2.1 Perceived Need for Support

This sub-theme reflected on participants' need for support. Present findings suggest that this sub-theme is intrinsically connected with other themes and highlights the fact that young people have established trajectories of help-seeking regardless of their experiences or exposure to worries, difficulties or mental health services.

Questions that stimulated discussion on this topic were, for example, *Have you ever talked to someone about your worries when you were at/outside of school?* or *What a boy/girl in your class would do if they had problems or worries at school?* In this study, ten out of twenty-one participants reported a low need or preference for support, reporting limited worries, difficulties or experiences with help-seeking. The remaining eleven participants reported experiences of worries and engagement in help-seeking. The level of perceived difficulty contributed to participants' decisions to seek help. For instance, if participants perceived having no worries, their need to seek help was also low. However, if participants experienced worries, their need for support increased and then they made a decision whether to deal with their worries by themselves or approached someone else for help. It was observed that participants were likely to seek help if the intensity of their

worries/difficulties was high. None of the participants who experienced worries reported leaving their difficulties unresolved.

Importantly, the group who reported low-need for support showed similar levels of awareness of support that was available to them as the help-seeking participants. Similar findings were observed in their views and preferences for helpful and unhelpful features of care as well as reported barriers. Thus, their contributions to the other findings are equal. This suggested that young people are an informed consumer group as to what support is available to them irrespective of their past experiences of help-seeking.

Participants' responses that reflected a low need for support are further explored in this section. The help-seeking patterns of behaviour of all participants are further addressed in the following sub-themes and mater themes.

A significant proportion of the sample reflected a low need for support in the following accounts:

"I've never really experienced any troubles that I would feel I would need to talk to someone about…" (Aimee)

"I don't really experience like problems coz usually I'm like quite happy, I don't really experience that" (Jonny).

However, most of these participants showed awareness of support that was available to them if needed, suggesting that young people are informed about their options. For example, Aimee added the following to the above statement: *"I haven't really had any worries in school. Um, and if I do, I would just tell my friends."*

Similarly, Georgia noted: *"I haven't had any worries… but if I did, I would talk to them [school]."*

Further, Eva reported: *"I never really like experienced any full worries but, erm, there's been times where I've like fallen out with other people and making me feel bad and stuff like that…and I have told, like the head of the school who have more authority and power over like the general school. So they're probably the best to talk to if anything like that is happening."*

Eva also highlighted that young people choose the particular support channel according to the nature of their problem: *"Well, most people in the school would…if they had a problem that remains at home…they would probably tell safeguarding. But if it was just a problem with like friends or anything you could just go to your like head of year and they would help like resolve it a bit if you can't do it yourself."*

The perceived seriousness of young people's difficulties also impacted on whether they sought help or not. For example, Aimee reported: *"It depends what the situation is. If it's something, like, big and important then you…I think you have to tell a teacher, but I've not been in anything that's, like, that big, so I wouldn't tell the teacher."*

Farid confirmed this by saying: *"If it's too big for me and I can't do it by myself, I'll just go to the friend."*

As mentioned earlier, it is evident that young people show a reliance on support that was available to them either at school, at home or in their community. These accounts suggest that young people are actively making decisions to seek help or not when experiencing worries, highlighting patterns of help-seeking behaviours in young people.

4.2.2 Resilience & Self-confidence

Present findings suggest that resilience and self-confidence appeared to mediate participants' perceived need for support. It was observed that some participants felt confident in dealing with their difficulties and this resilience influenced their decision to seek help. Participants reported that being older increased their confidence to deal with their problems more effectively, highlighting a link between confidence and another sub-theme: *individual differences* (participants age). This sub-theme summarised reflections of 13 out of 21 participants that either directly or indirectly demonstrated participants' confidence and resilience when experiencing worries.

Young people showed a consistent pattern of resilience and confidence when dealing with difficulties. For instance, Farid reported: *"If I'm, like, having a bad day, I like to keep it to myself most of the time, just so, like, I can get through it by myself. So I'd like to sort out sometimes the stuff by myself."*

Similarly, to Jonny who said: *"Well I do have people to talk to but then it's not like, it's not like a big thing to talk about I just get over it the next day."*

Further, Zaid reflected on the topic and discussed contributing factors that, in his opinion, increase confidence:

Zaid: "I have like confidence in my own personality, I have confidence like that. I know that if someone's going to attack me I don't really… coz my dad taught me a lot of moves like how to defend [myself] … I don't really have worries but my confidence is like really high coz I believe in myself, …"
R: "What else do you think helps to build one's confidence?"

Zaid: "Like, probably like just trusting yourself really, … also having … a sibling helps your confidence as well, …coz my sister is older than me … she is like teaching me loads of stuff … what's going to happen in year ten to build my confidence, so I'm ready for it. … My parents help me a lot, …like my dad."

Julia's statement suggests that resilience improves with age and young people gain different perspectives as they mature. She said:

"Like, when you're younger, if, you just really want to cry when anything happens, or, erm, it does really make you upset. Well obviously, erm, when you're older, you know to, you know more how to deal with the situations that you've come across."

4.2.3 Individual Differences

Individual differences, such as gender, age, race and socio-economic status were identified as the third mediator of help-seeking behaviours in young people. This sub-theme encapsulated the interconnected nature of social categorisations in relation to participants' perceptions of mental health support. It has been observed that it has a high potential to be associated with certain degrees of disadvantage and discrimination.

Perceived gender differences were identified when seeking support or dealing with difficulties. For instance, Abigail stated:

"Boys don't really tell anyone, coz they keep it to themselves unless is like their close mates but they still don't tell. I think they feel like they're being weak if they say anything…"

A similar response was given by Rhian to the researcher's question *'What do you think a boy or a girl in your class would do if they had problems or worries at your school?':*

"I think the girls would probably… Um, me personally like, how I've seen it like with my friends, like the girls would probably cry and tell their friends or the parents. Where the boys would just hold it all in and just keep it to themselves, if you get me? For example I'd probably cry and then I'd go and tell one of my like…my best friends or something and they'd tell me what I should do. Whereas when, when something's wrong with my brother, he gets angry and he'll be moody but he won't tell anyone what's wrong. And you'd be like, what's wrong, and he won't say nothing." (Chloe)

Julie, once again highlighted the importance of age when experiencing worries: *"When you're younger, you are a bit more, you know, a bit more open to being hurt, and stuff. When you're older, you know more how to deal with the situations that you've come across… I think year sevens need a bit more help. Because obviously, my little brother*

here, he's in year seven. And he's, he's quite a sensitive little boy, and obviously, erm, he's, I feel like he doesn't know that the help is there."

Zaid reflected how his worries decreased with getting older: *"Everyone is kind of like, coz now we're in year nine, like, year seven was that kind of the start, people, they weren't even that scared but now year nine is gone everyone is just chilled with each other no one gets into fights, everyone is calm with each other."*

Abigail reflected on differences of race and socio-economic status in help-seeking behaviours:

"People who are from working class backgrounds or different ethnic backgrounds or stuff like that, I think they experience mental health very differently to the way I do. Mental health is not about being like, oh, well this is what's going to happen, you're all going to get the same treatment. It's about this is an individual. So, I…like my friend who is a white male from a progressive family might have a different experience to a traditionally Muslim boy."

To conclude, this central theme suggests that young people's help-seeking behaviours are determined by their perceived need for support. Further, individual differences frequently featured in young people's responses, such as age, gender, socio-political status, confidence and resilience. Furthermore, help-seeking behaviours appear to change over time and vary from participant to participant. These patterns were closely linked with other themes identified in this study, such as availability and barriers to support, and young people's preferences for support.

4.3 MASTER THEME 1. Perceived Availability of Support Services by Young People

This master theme captured a variety of well-being support, mental health services and resources that were seen as available to young people at their school and community. Participants' responded to questions such as *To whom they could talk about their problems or worries at school/outside of school?* It was observed that participants sought help for an array of difficulties ranging from family and relationship issues, anxiety, bullying, depression, grief, stress and eating difficulties. All participants reported one or more resources of support from school and community, such as staff members, family members, school well-being initiatives and mental health services. To aid transparency, the findings are organised within two categories, support available at *school* and support available in young people's *community*. A further three subgroups were identified for each category. This representation is illustrated below in Figure. 4.3. Amongst others, young people

identified teachers, family members, friends and safeguarding staff as sources of preferred support. The range of these findings suggests that young people are informed consumers of support services and they know whom to approach for help.

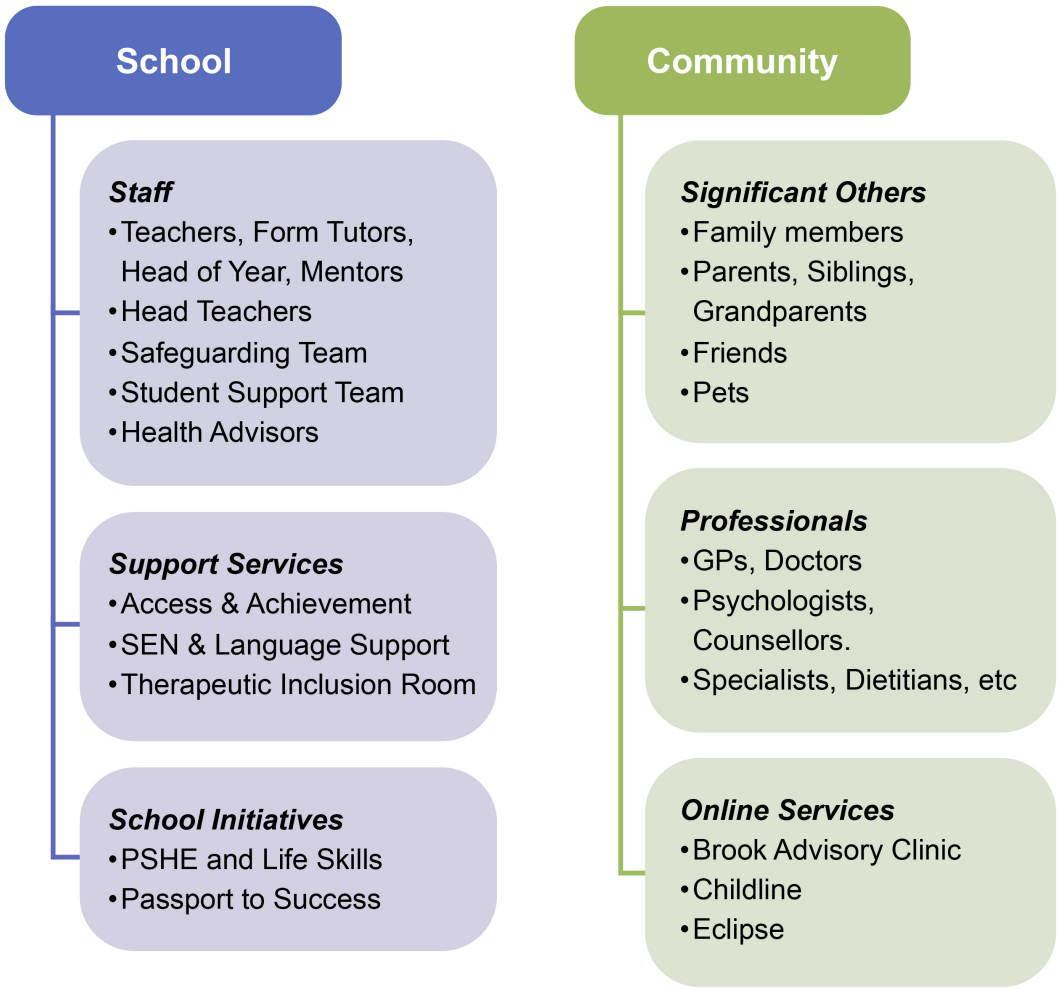

Figure 4.3 Support and services available to young people at school and community.

4.3.1 Support at School

This sub-theme categorised support that was reported as available to young people at school. Most participants (18/21) reported using school staff as a primary source of support or as a gatekeeper to support. Young people showed awareness of many services as outlined in the next two sections.

4.3.1.1 Staff

Young people reported consistent reliance on staff at school in relation to addressing their difficulties. This included teachers, form tutors, mentors, safeguarding team, head of year, head teachers, safeguarding team, student support team, health advisors and nurses.

Young people reported feeling comfortable to address a range of issues with school staff. Having a mentor or staff that displayed a caring attitude was reported as particularly useful. For instance, Abigail reported:

"Here in the school we have teachers that genuinely do care and they genuinely are lovely and really nice…"

Similarly, Alvita stated: *"When it's something going on in school but not really that bad, I'll go to like my head of year and like a mentor and this and that, to, em, like try and get me over it or help me with it."*

Having a mentor appeared to be particularly beneficial as reflected in Jess's statement: *"It really helps to have someone there that it's gonna be there for you so if you really need a mentor at school you can just go and talk to them as well."*

Anna highlighted the diversity in issues she felt comfortable discussing with her mentor:

"Erm, say, in a girl's case, like relationship problems. Like, say, a boy and stuff. Like, Miss X she's like our mentor, she's one of our, like, key stage leaders, like, most girls would go to her if they were having, like, problems, or like, my boyfriend, da, da, da. Like, just 'cause you can tell her most things, and she'll, like, dead, she'd be, like, proper try and sort things out, and help, and stuff. But yeah, or like, say they were, like, feeling depressed... or being bullied, go to Miss X... and she would help."

Further, Zaid highlighted the multi-agency approach adopted by the school:

"[I would] go to one of our teachers, your form teacher because she is like, she is like a person that you see every morning, every day so you'd just go to your form teacher. It's around fifty minutes so you could just wait around with form teacher and ask her questions like that or like I'm worried about this and then she would like ask, she won't like put your name forward but she would just make sure that you're safe and all that. Or maybe go to another teacher, like head or deputy head or something like that, she might put your name and then you might go see deputy and have a little chat with him like what can we do to resolve that."

4.3.1.2 Support Services and School Initiatives

Twelve out of twenty-one participants identified school support and services. These were the Special Educational Needs [SEN] and Language Support, the Access and Achievement [A&A] team, and Student Support. Student support included pastoral care, learning mentors, therapeutic inclusion room, safeguarding, and health issues. This

school's student support also facilitates access to external agencies, and from these participants mentioned Childline, Brook Advisory Clinic and Eclipse. An overview of the support services available to the students at the selected school is attached in Appendix AA. School initiatives reported were PSHE and life skills and RESPECT therapy. The most discussed strands of the PSHE were diversity and discrimination rights and bullying. These findings are demonstrated in the following section.

Participant's views towards support services were in line with the following statement:

"Student services is basically a place where, there are a key people which can, you can even be whatever, you can ask them whatever you want like I have use their phone to tell my parents I'm coming, pick me up at this time, you can use their phone for free they won't charge you for anything. And student services is like a place where you can ask the teacher for help like with anything like and then she like help and there's also she'll put you in with more teachers these services are open to everyone. So you can just decide and talk to everyone at student services." (Zaid)

Julie described how support services distribute their useful information and links to support around the school:

"There's, obviously, posters and stuff around school saying you can talk about it [worries]. Or maybe if you don't want to talk about it to a member of staff, they do, the school does offer, erm, like, websites and stuff, where you can go and talk to people on them. Erm, anonymously, so they don't know who you are. They offer that help, and they give you them websites, and different ways, and how to do it on there, and what to do, a step by step for the website."

Zoe described the therapeutic room as a place *"where you talk to someone who's gonna always be there at school but I guess it's just like… informally like, It's very casual."*

Chloe further reported that it is a place: "*Where you talk about your feelings, and then you play games and all that to show how you feel and stuff."*

A&A was described as a place *"Where you can go to just clear your head for a few minutes"* by Joy and *"There's like colouring, Lego and all that so you can just sort of like fiddle whilst…just sort of like thinking and like when you feel safe enough or comfortable enough to go back out…and go back to your lesson."*

Farid discussed the benefits of support the A&A provides, such as *"If you break your arm or you can't write, then they have stuff to help you through, so they can give you, an iPad or, like…like a mini, like, computer that can…you can write in, so you make*

sure that you don't miss any learning… So when it comes to tests, you're keeping up with everything."

Abigail also identified school initiatives such as: *"We have someone from sexual health counselling. Like we have PHSE lessons from them. They really good."*

The RESPECT teaching programme has been described in the following example:

Zaid: "RESPECT… is teaching you how to... help yourself in the future, like it also teaches you how to your sexual health and make sure like you don't accidentally do something bad… Something like that, and how discrimination is bad for others and how it can affect your health so yeah."
Researcher*: "Is it more like building your resilience?"*
Zaid*: "Yeah, so then you don't go in the future and like go and do that. Also teaches you… things like how… explains like stuff like, drugs are bad for you like, how to use… stuff that is good for you and, like drugs are bad for you and how to not to use things like that, yeah…"*

The above vignettes showed that young people are aware of the mental health support that was available to them at their school and community, although their knowledge of the availability of support varied from participant to participant.

4.3.2 Support in Community

This sub-theme categorised support that was reportedly available to young people outside of school and in their community. Most participants relied on their family members and friends for their support. Participants showed awareness of external sources of support, such as their GPs, mental health professionals and online resources. This subtheme was organised into further three categories, *significant others, professionals* and *online support*. These together with the evidence for these findings are presented next.

4.3.2.1 Significant Others

This subtheme refers to people in the participants' lives who were classed as their sources of psychological support but were not affiliated with their school or any other services. These included family members such as parents, siblings, cousins, grandparents, friends and, in several cases, pets. Young people's reliance for support on significant others appeared strong and consistent across the sample. 19 out of 21 participants reported approaching parents when having worries. 17 participants confided in their friends with

their problems. Examples of help-seeking behaviours and support received are illustrated in Jess's extract who stated:

"It's just nice to know there's someone there for you, especially your family, it's really nice. So like my brother is turning 30 this year, I can talk to him and he won't … so if I was saying anything that he found offensive he would never get angry at me he'd just try to ask me why I did that so it's nice to have a big brother like that."

Similarly, Chloe reported: *"…my brother just has a habit, and he just like cheers me up, and like… Like say for example I'm sad about something, he'll be like, he'll talk me through it, he'll let me go into the like details, description and everything. And then he'll just cheer me up and he'll be like, em, how did you get yourself into it, da-da-da? He'll help me get out of it. And then when I've got like…got out the situation or when I feel better, like we'll go out and we'll play football or we'll go out and we'll run or we watch a film in my room…"*

Findings also show a pattern of preference for people participants deemed as supportive, appropriate and useful. This was demonstrated in Farid's statement: *"Most of the time, I think they [YP] go to a friend first. To, like, to get everything out, because they're, like, someone who they trust first, get everything out…and then, because their friends will know, like, what to do…because they're really close… If I was sad, I would go to my friend, and I don't want my parents to know so I'd just tell the school… But if I don't want the school to know then I'll just tell my parents, and then sort it out… like that. Depends on, like, what the issue is, and if you want a teacher to know about it. Or is…do you want to keep it personal with your family? And, like, just let them know and get over it without the school, so it doesn't go, like, everyone…knows about it. Keep it secret."*

Jonny also highlighted his awareness of friendship limitations when he stated: *"You can tell them [friends] like pretty much everything, 'cause I've got a lot of friends that I trust, it's just that you wouldn't really want to rant at them or like just things like that. Downside of the rant is… them getting bored, not being your friend, things like that. Or if they find it offensive, things like that, then they would like tell everyone and then you'd get under pressure and things like that."*

4.3.2.2 Professionals

Eight participants showed some awareness of professional help that was available to them outside of their school such as general practitioners, psychologists, counsellors,

specialists, dieticians, etc. Only a small number of participants reported personal experiences with these services or extended knowledge on the support that was available to them. For instance, Rhian stated:

Rhian*: "Like, obviously there's your GP and stuff. I do know one, but I can't think from the top of my head but I do know about them, yeah."*

Researcher*: "So you do know that there's help available to you if you want to?"* Rhian*: "Yeah, yeah."*

Abigail also said: *"I've talked to a therapist and I talked to someone when I was in hospital for a bit and I had to talk to a mental health professional when I was there. So, I talked to one of them…she was part of the NHS. I have [also] spoken to a private one…because I'm lucky enough for my parents to be able to afford one…but I only think I went for that one session, I can't quite remember."*

Joy described her experience with a mental health professional:

Joy*: "I told her [doctor] I'd been having problems at school and she said, tell me everything about it, not, well, tell me who did it, tell me what's the problem? Well, it's gonna be alright, have a biscuit, type thing [laugh]… She just sort…er, sat me down and said, tell me all about it, don't leave any detail out…, which was really good and… I really liked that… Erm, I told the doctor some things my parents didn't know. They just sort of…afterwards they just interrogated me… Erm, but it was really, really helpful."*

Researcher*: "So did it feel okay to have them [parents] in the room as well?"*

Joy*: "Erm, at some points, yeah. When I was talking about something a bit private I'd say, can you go out the room, please [laugh]?...Erm, and I trusted this doctor a lot more than my parents, apparently. That's what my parents said afterwards…but it was really, really helpful and I really…enjoyed, er, going to see this doctor and hopefully…I'll be able to see her again soon."*

4.3.2.3 Online Services

Seven participants showed an awareness and usage of online services such as Childline, Brook or school online resources. However, the perceived efficacy of these services differed amongst participants. For instance, Jane reported positive experiences with online services:

Jane: "I once spoke to Childline online…'cause of, like…I used to get left out loads and like, no one really spoke to me."

Researcher*: "Yeah. And was that helpful?"*

Jane*: "Yeah, it was. Like, they, sort of, gave loads of, like, different options, to choose. Like, if you want…like, er, if you get left out, like, to ignore it. Or to maybe try and get back…"*

Some benefits of online services were evident in Georgia's statement: *"They [school] have a website… …where you can, like, say, your problem anon…anonymously. So, you can do it privately and, like, they don't need to know who you are. But if you still, like, say your problems and then they'll also help with that as well…"*

However, some criticisms of online services were also raised. For instance, Alex stated: *"Ehm, there's like other things available, like online things like Brook, Childline, and things like that. But sometimes they don't do like the best of work from what I've heard. It's like they don't really do like the best job you can get better services. Like is, I think is better if you're talking to someone face to face. I think it could be better if they explain things better, like if you're talking to someone face to face they can explain it to you more but they'll just give you like one answer if you're on Brook."*

Jane shared similar experiences: *"I sometimes find that, like, own experiences on Childline aren't, like, that helpful 'cause, like, you don't really know who they are or…anything."*

Researcher*: "Uhm-hmm. So what support might be a bit more, kind of, useful?*

Jane*: "Um, I think school…support…"*

In summary, master theme 1. portrayed an array of support services that participants reported as available inside and outside of their school environment. These findings suggest that young people are aware of individuals and services that provide support.

4.4 MASTER THEME 2. Young People's Preferences For Support

This master theme encapsulated three important findings. Firstly, participants' help-seeking was informed by their perceived benefits of support. These findings are categorised in sub-category 4.4.1. Secondly, 16 participants reported satisfaction with the mental health provision available to them at school; however, the majority believed that these could be improved. Sub-category 4.4.2 discusses these findings in more detail. Participants preferences and suggestions for youth-friendly support is categorised in sub-categories 4.4.3 & 4.4.4 Young people defined helpful and unhelpful attributes they were looking for in staff or professionals. These factors determined whether young people were

comfortable and motivated to seek support or, conversely, compelled them to avoid support or services. Each subcategory is discussed individually in the next four sections.

4.4.1 Perceived Benefits of Support

Eleven participants reported numerous benefits of help-seeking, such as feeling valued, improvements in mood, increased self-esteem, better focus and productivity, psychological relief and reduction of distress, anxiety and stress. Young people responded well to receiving help and appreciated answers to their problems, as well as receiving practical solutions, and coping strategies. Further, young people reported that practical support and non-academic activities were perceived to increase resilience and confidence. These findings were encapsulated in three sub-categories, *Increase in Positive Affect and Behaviours, Psychological Relief and Distress Reduction,* and *Advice and Useful Techniques.* The following sections will contain the participant's vignettes to illustrate the findings.

4.4.1.1 Increase in Positive Affect and Behaviours

Participants reported beneficial aspects of received support such as increased happiness, self-esteem and productivity. For instance, Asif received help from his teacher for being bullied at school and the benefits are captured in the following extract.

Asif*: "It made me feel happy 'cause, um…'cause at least that person didn't do it again. And they won't do anything else to me."*

Researcher*: "And was it helpful?"*

Asif*: "Yeah, it was…helpful."*

Researcher*: "In what way?"*

Asif*: "Um, by telling them that they were bullying me, so I could…I wouldn't get hurt".*

Researcher: *"Was it unhelpful in any way?"*

Asif: *"Er, no."*

Researcher*: "Uhm-hmm. Do you think anything else could have been done?"*

Asif*: "No…"*

Further, Joy reflected on well-being support that was available to her at school and linked it with increased motivation and increased confidence.

Researcher: *"Do you think your school helps students to feel good about themselves and their lives?"*

Joy: *"Erm, yeah, er, 'cause…well, there's a lot of positive slogans everywhere like, you can do this. You're…you're gonna do this and the teachers, if you're feeling stuck teachers can come round and…say…like say, I've seen you do this before, you can do it again…and be really helpful and it really makes you feel good about yourself when you finally finish…doing the thing that you've been wanting to achieve. Erm, like, er, we have a health and well-being week… once a year… and, erm, it's really good 'cause… it's like, it's a week about feeling good about yourself and…with the like achieving stuff…and I really like…that sort of…thing."*

Lastly, Farid reflected on how being supported helps him to stay focussed and keep up with his work at school:

"So they're [school staff] always watching for the signs so every student do their best and have, like, the best, time possible in here. Because, like, they have to be happy. So you can be, like, more focused in lessons, like have, err, better results at the end as well because it will help you when it comes to tests, if you had a bad day you wouldn't have enough work in your book. You would be, like, stuck with what to do, but then if you're having a good day, you're doing a lot of work, you're focusing in lessons, being happy then that will help you at the end when you're doing your tests."

4.4.1.2 Psychological Relief and Distress Reduction

Participants reported that receiving psychological support lead to relief and reduced stress. Similarly to Asif, Farid was also bullied at school and his help-seeking resulted in reduced distress and a change in his perspective as is evident in the following example:

Farid: *"I went to my form tutor because… of bullying… they were always… making fun of [me]… And it was, like, getting out of hand a bit, and I was getting sad. I tried… to fix it by myself first but it wasn't working 'cause, like, even if I told them to stop, they would still do it again… And… there's no way to stop it, so I went to my form tutor, I spoke to her about it, then she, like, spoke to the boys… …and then… everything was sorted and… since then even if people still say it now, I find it quite funny myself… get over it in a better…in a good way."*

Zoe expressed how seeing support could prevent their difficulties from escalating: *"If you're having troubles at home or like you don't talk to your parents or I don't know it's really nice to talk to people. To get it out and if you don't, some people take it out on other people and then they get put in exclusion or they get a detention or whatever and I think if, if someone asked about why they're doing it or why they bullied people or*

whatever they'll probably come up with a quite a reasonable explanation that people could sort out."

Further, Anna echoed a similar sentiment: *"Like, 'cause some people might not want, might not want to say it, but they might feel down. Like, most people are just like, smile all the time, but then you don't know what's really going on behind closed doors. So, it's like, I don't know, like, if people got offered a place out of school to go, and speak to someone, like, that they knew they could trust, I bet most, I bet most people would, and there'd probably be less people, there'd probably be less people depressed..."*

4.4.1.3 Advice and Useful Techniques

This subtheme encapsulates the beliefs of a large group of participants (15) who reflected on the usefulness of solution-focused advice and techniques that were offered to them when they sought help. This sub-theme relates to another sub-theme *Helpful Attributes of Support,* which is discussed in the next section.

Julie reported feeling relieved after she received advice and support from her teacher, who allowed her to explore her difficulties:

Julie: *"Because, obviously, it is good to just get it off your chest, and speak to someone. And she [teacher] actually does really help, and she gives good, good advice. And, yeah."*

Researcher: *"So in what way was it helpful?"*

Julie: *"Yeah, I think it was just good that you had someone to speak to. Because quite a lot of people just keep it in, and then bottle it all up, and then it comes out in one big thing. Whereas, if you talk to someone about it, before it's, like, gets worse and worse ...then it actually is, it does really help."*

Farid reported that practical support like breathing techniques helped to reduce his preoccupation with worries:

"Because when, like, if I was in a class and my teacher knows I do good normally, but I wasn't doing good that day, and I was just, like, sitting there doing nothing, then the teacher will know, she'll be, like, do you want to have a breather, stand outside, like, calm down, do you want some help, and, like, that helps the student to, like, get the thing out, especially when, like, some people like to keep…like to keep stuff for themselves when they can't really, like, go over it, so they have a big problem and they can't get over it, sometimes people don't like to speak to anyone about it, and keep it to

themselves, and that sometimes…that's sometimes, like, the teacher will know that they're not telling anyone…"

The above-discussed subtheme summarised young people's positive experiences of support and listed numerous positive outcomes of support.

4.4.2 Perceived Adequacy of Services

This sub-theme reports participants' perceptions towards the adequacy of support services available to them at school. Sixteen participants were satisfied with the support; however, twelve of these participants reported that their school could do much more to improve services. Five students felt that the support was insufficient. One participant expressed the view that adults are not 'really' interested in young people's problems and focus on academic attainment instead. This was consistent with the previously reviewed literature, highlighting that schools' main purpose is to educate rather than to ensure good well-being in young people. Further, they reported a lack of services and stigma around mental health. These factors impacted on young people's help-seeking or reduced opportunities for timely support. The insufficiency of support services is further categorised in the master theme 3. Barriers to Support. Figure 4.4 is an approximate representation of young people's views and experiences on the adequacy of support.

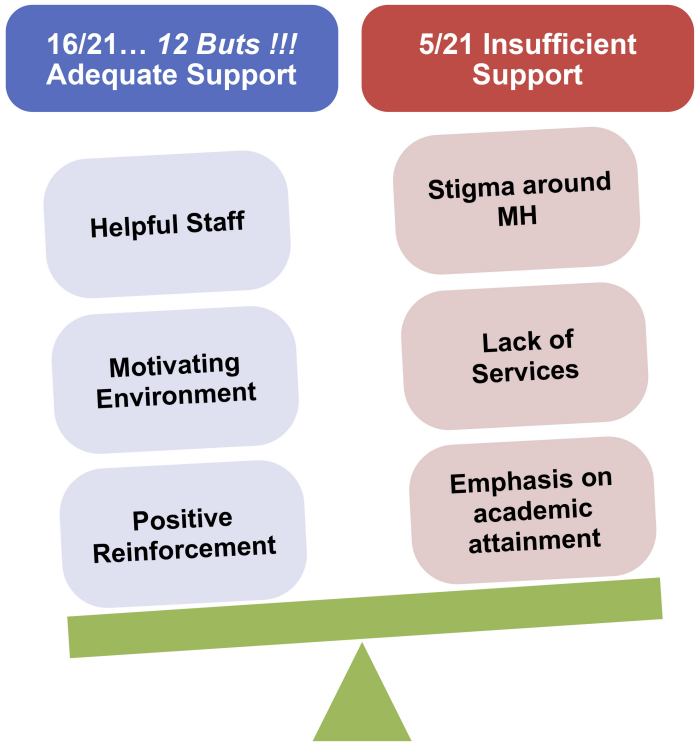

Figure 4.4 Young people's views on the adequacy of support services.

Some examples of participants' satisfaction with services are illustrated in the following accounts:

"I think people at this school are doing quite a good job in this sort of things that could change to make people feel better." (Zoe)

"Yeah, I think it [school] does…because, like… you could almost, like, go to see anybody if you need anything, the teachers always, like, tell you, like, you can, like, speak to them and they're, like, friendly." (Georgia)

"Yeah, erm, obviously, it does, it does, like, kind of promote that everyone's equal, and all of that stuff." (Julie)

Researcher: 'Do you think your school offers enough support for you and the other students?'

Jane: "Yeah, they do. Like, they're always there…to, kind of, talk to, like, the beginning of school, in school and after school."

To the question *Do you think anything else could be done?* Asif replied: *"Not really."*

Alvita however offered examples of encouragement she received at the school:

"Yeah, 'cause they say, you're a brilliant student, your work is amazing, just keep trying and then you'll get there. That's what makes people just try harder and harder just to like get to that top, to see the top…"

Note that the encouragement focussed on the enhancement of academic performance rather than well-being.

A majority of students (16) believed that schools could do more to support their well-being. For instance, Zoe's statement below was in line with the beliefs of many other participants:

"I think they need to offer a bit more support like making the therapeutic room bigger and get in more people to do that job but then also pay them slightly more as they don't get paid that much for listening to worries of our students…"

Further, Rhian stated: *"Once again, some people need more help than others, I don't think they really give that."*

This subtheme reflected participants' general contentment with support services. Although a majority of participants felt supported by their school and community, many identified areas for improvement. These improvements are discussed in detail in the following two sub-themes, *Helpful and Unhelpful Attributes,* and *Areas for Service Development.*

4.4.3 Helpful and Unhelpful Attributes

Collectively, participants reported a comprehensive list of characteristics or attributes they would like to see in someone who is offering support to them. They also communicated attributes they found unhelpful. These findings form the basis for this subtheme that is further categorised into two subsequent subthemes - *Helpful* and *Unhelpful Characteristics and Approach*. Their defining features are summarised below in Figure 4.5.

Participants communicated their preferences with certainty and listed factors that would determine their help-seeking. For instance, participants stated that they would seek support from someone whom they felt comfortable with, who was approachable, non-judgemental and who showed interest in them. The principles of confidentiality and trust were paramount to a large number of participants. It has been observed that these factors determined the likelihood of participants accessing support. The most frequent themes of these findings are illustrated in the two following subsections.

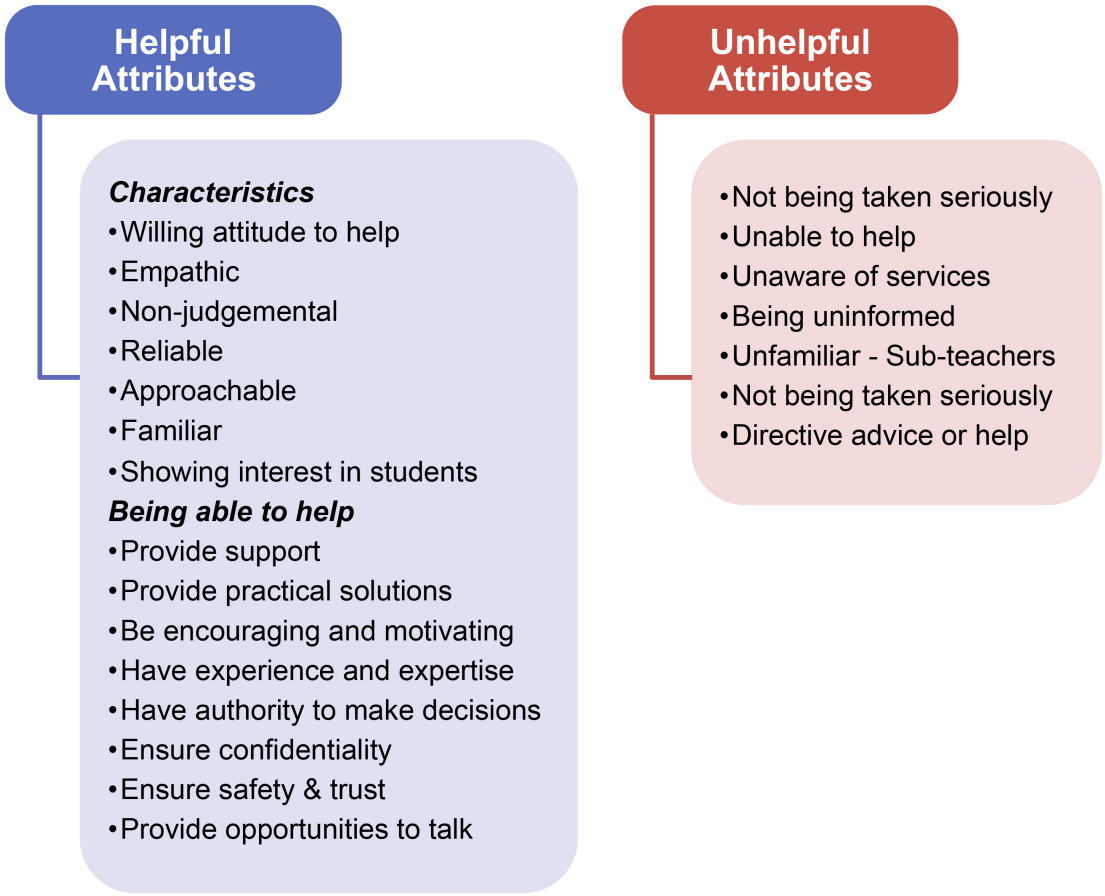

Figure 4.5 Helpful and unhelpful attributes of support services.

4.4.3.1 Helpful Characteristics and Approach

Young people valued personalised one-to-one approach. For instance, Zoe stated:

"The way that they understood and were listening it was just really nice to know there is someone there to talk to."

Julie spoke about the importance of confidentiality, safety and talking to someone who is familiar:

"I don't really want to go to someone that I don't really know. Erm, it makes you obviously feel safe, that you know that person...the mentor. And that, erm, well obviously, she's nice...and it's good to have that nice person that you know. That you can speak, it's a safe environment. Especially that it's, like, a closed room."

Further, Anna stated that being listened to and being prioritised was important to her. To the researcher question *"Have you ever talked to someone about your worries, at school?"* she replied:

"Definitely. Miss X, obviously, usually. Because they listen, like... Because, like, you go home and your parents might be busy, 'cause, like my mum, she has, like, a baby, as well, and she's quite busy. So I usually tell somebody in school. Or, my friends."

Chloe discussed helpful elements, such as empathy and advice coupled with understanding stemming from personal experiences or struggles, when receiving support from staff at school in contrast to her friends:

"Yeah, it made me feel a lot better when I spoke to my mentor. Because my friends, I told them and I felt better, but then they weren't like really good at advice because they've not really been through it. Where when I told my mentor, like she gave me advice that sounded like she'd been through it herself…like she spoke to me about it. She asked me how it made me feel, like how did I feel before it happened, and then she asked me what do I like best. And then I was like running, and then she was like, so why don't you focus on running to take your mind off your problems? And then that's when I started running and then I ended up running on sports day for an athletics team."

Rich also voiced his preference for an empathic and non-judgemental approach:

Researcher: *"What would be important to you if you ever felt like you did want to talk to anyone about your worries at school?"*

Rich: *"Um, they're understanding and empathetic, and they don't judge you. Like they treat you like other people and they treat you the same as everyone else. They don't, like…they don't give you special treatment but they are helpful to you."*

Researcher: *"Yeah. In what way could it be helpful?"*

Rich: *"Like…like, just make you feel better about the situation instead of giving you, like, techniques on how to calm down, if say, if you had an anger problem or something like that."*

Researcher: *"So the techniques wouldn't be helpful?"*

Rich: *"Er, not to me… Just giving you like a different opinion… on the situation would be helpful".*

Although Chloe's and Rich's preference for care overlapped in many aspects, their attitude to advice differed. Thus, differences in preferences emphasise the need for individualised approach and tailored interventions.

4.4.3.2 Unhelpful Characteristics and Approach

The reported list of unhelpful attributes was as long as the helpful one. However, as most of these were direct opposites of the helpful attributes, such as being judgemental, unreliable, or not listening, only unique concepts related to unhelpfulness are presented here. These were: being misinformed, unskilled or not being taken seriously. For example, Joy's reflections on unhelpful elements of support were:

"Sometimes he's [teacher] quite unhelpful…because he doesn't really know what to do sometimes."

Georgia criticised advice she received as too directive:

"I think it'd be important if they, like, listened, they didn't try to, like, say stuff like, oh, you should have, like, asked someone else, or like you should have done this and you should have done that. You should, like, listen and, like, be kind or, like, help you through it."

Additionally, Rhian stated that not all staff at school are available or willing to provide support or direct students to get help:

"Like the sub-teachers don't do you anything, like they say that they do something but then they don't do anything. It's only like a minority of the teachers that do stuff."

Eva reflected on her friend's experiences of not being taken seriously in other schools:

"In our school they're quite good but in other schools I…I know that students that have told teachers stuff and they've not took it as seriously as they probably should have. So it…it…everyone should be on a mutual understanding of when someone trusts you with something, you try and make the best of it and try and help them."

This suggests that other school might differ in their approach to mental health and support. To conclude this section highlighted participants clear preference for empathic, non-judgemental support.

4.4.4 Areas for Service Development

Together with helpful and unhelpful elements of support, participants identified numerous ideas and suggestions for service improvement that were categorised in this subtheme. The areas of development reflect young people's views on the current state of support services together with proposed changes that could be implemented to meet their needs and preferences. Their ideas centred around four domains: *Environment and Attitude, Focus, Provision* and *Approach.* Each domain contains two or more subcategories and these are summarised below in Figure 4.6.

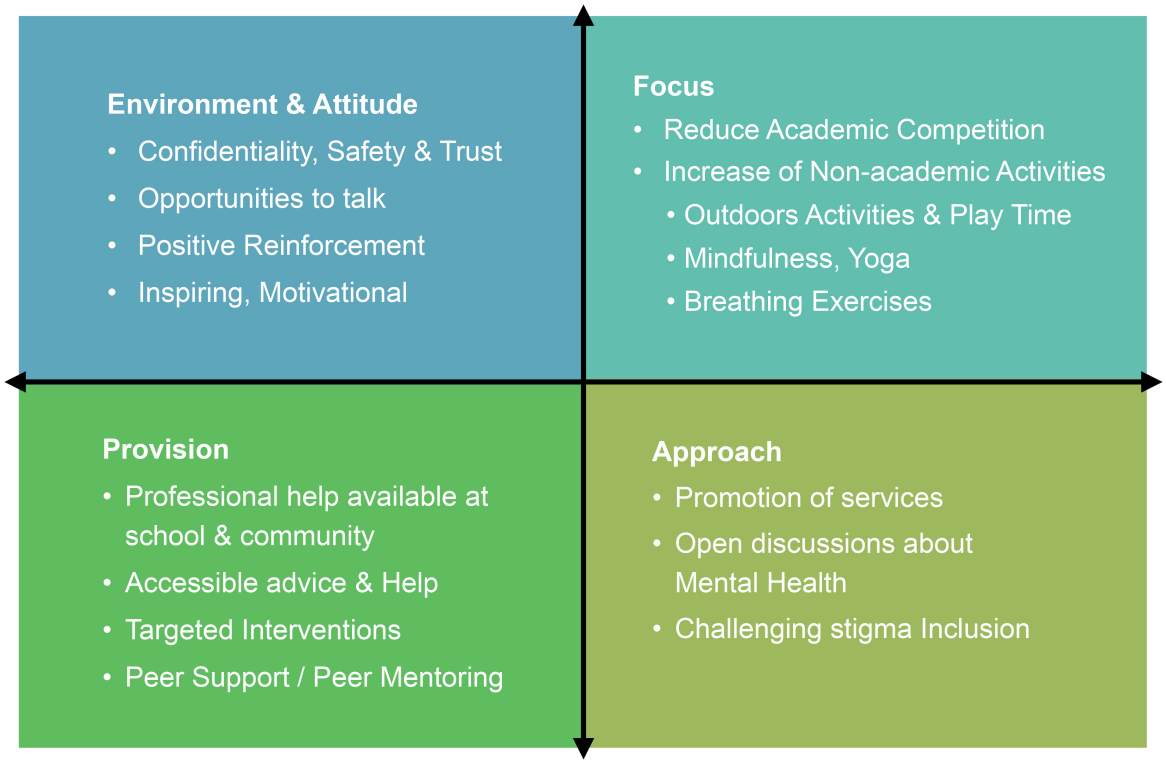

Figure 4.6 Categorisation of service development ideas.

The involvement of young people in service development seems crucial as they are on the receiving end of those services. This was captured in Julia's statement:

"I think, maybe ask the student what they would rather do in that situation. And obviously, erm, go on what they say. Because sometimes, obviously, adults can act on, straightaway, just what they think is the best idea for the situation....but not on the

child. Because it could, the situation could get a lot worse if something did…was done... erm, in the wrong way."

The following sections provide details of participants' ideas representing each of the four sub-categories.

4.4.4.1 Environment and Attitude

This sub-category reflected elements that participants deemed important when sharing their worries and difficulties with others. These were ensuring confidentiality, safety and trust, creating opportunities to talk and an environment that is inspiring, motivating and reinforces positive behaviours. Participants reported that providing a safe and trusting environment with a certain level of ensured confidentiality, where they can disclose their worries, was imperative. For instance, Nelly voiced fears about sharing her worries with others due to a possible breach of confidentiality in the following extract:

Researcher: *"How did you feel about talking to others about your problems?"*

Nelly: *"Scared."*

Researcher: *"U-huh. Do you want to tell me a bit more about it?"*

Nelly: *[pause] "Again, like, I don't know how they would react to it. [pause] And that's it."*

Researcher: *"Yeah. Was it helpful?"*

Nelly: *"It was helpful trying…getting it out, but, like, [pause] people…the…the teacher will probably tell someone else, saying, like, you shouldn't do this, shouldn't do that because. [pause] And it was privacy, like, I wouldn't be able to trust that teacher again…if they told someone."*

Alvita also reflected on the importance of confidentiality:

"I have this type of trust that I'll say to like...we won't tell anyone, we won't even like speak to it or we might have these problems about this and that. Em, like they'll just keep it to themselves, like those would be the only ones like hearing it, they won't spread it around like some people would."

Participants reported that there are limited opportunities to talk and express their worries when necessary. They suggested that creating areas where young people could disclose their worries safely would prevent their difficulties from escalating. For instance, Anna stated:

"So, it's like, I don't know, like, if people got offered a place out of school to go, and speak to someone, like, that they knew they could trust, I bet most… people would, and there'd probably be less people, there'd probably be less people depressed..."

Another helpful strategy that helped Alvita to reduce distress was:

"I write it down on a piece of paper, er, I write down all my worries and then just after like letting it out on the piece of paper I rip it up and put it in the bin so like no-one knows that, but you will feel much better that you've got it out, sort of."

Therefore, offering young people opportunities to express themselves can enable them to resolve their issues in a more timely and effective way and move on. Interestingly, Abigail suggested art therapy as a useful avenue:

"I think art therapy for young people's useful as well 'cause then it doesn't feel like therapy. It doesn't feel like, oh, you're going to do therapy. It's…you're going to do art, and then talk about your problems…"

Further, young people suggested that it would be helpful if adults would pay equal attention to positive as well as negative behaviour. For example, Anna voiced her frustration that often students who have misbehaved have been punished but the root of their problem has not been addressed:

Anna: *"They could… support children… that are just really smart. But not well behaved. …to be fair, they do have the green room, so they bring them here, so it's like a quiet space, so they can work themselves. But it would be nicer if they could do that most lessons. And like, have, like, most people just think, oh he's naughty, like, leave him, he's naughty, he's misbehaving, he doesn't want to do anything. But then, he'd be the most smartest child in that classroom, and it's like, they don't support him enough, for him to show how smart he is. They just say, oh, he misbehaves, he's naughty, leave him out. On call him, send him to the exclusion room. They don't, they don't want to, like, notice you're being quiet…, they don't try and look through his behaviour...and… how smart he actually is."*

Researcher: *"So what do you think would be helpful in this situation?"*

Anna: *"Erm.. They could… try sitting down and do that one to one with him more, like, that person could have more one to one."*

A more balanced approach and useful strategies were suggested in Chloe's example:

Chloe: *"Or like when they go 'oh you're so dumb'. Like even though they don't actually mean it, it sticks in your head and makes you feel like…I don't know. It kind of just brings you down, if you know what I mean?"*

Researcher: *"Okay. So it's, um, you tend to focus on the negative?"*

Chloe: *"Yeah. So school should like do something to help you all understand that you should listen to the positive and not the negative, or listen to both, not just one. Or like do something to change the negative into a positive."*

Anna reflected that being motivated by her teacher helped her to overcome her difficulties and exceed her expectations:

"She [mentor] was like, do you have any idea what you want to do, and we spoke about it, and then she was like, she was speaking about which colleges are best. And I was like, I want to do this, but I'm not too good at science, and it's like what I need mainly. And she was like, well that's fine, we can work on it. They kind of motivate you, they kind of help you believe that you can do something that you don't believe that you can. Like, I'll say, I can't do it, I can't do it, and they'll be like, you can do it, you've just got to put your mind do it. So they kind of really motivate you."

In light of the above, participants preferred an environment that was safe, respectful and motivating. Also, they asked for more opportunities and designated areas where they could share their worries openly and in confidence.

4.4.4.2 Focus

Participants reported that they would appreciate less focus on academic attainment and more involvement in non-academic activities. It was reported that academic attainment was associated with competition amongst students that leads to stress or feelings of being inadequate. Instead, more emphasis should be placed on non-academic activities such as outdoor sports and play. Participants suggested more opportunities for activities that reduce stress and anxiety and increase focus such as mindfulness techniques, Yoga, and breathing exercises. These findings are reflected in the following extracts.

For example, to the question *"Do you think your school helps students to feel good about themselves and their lives?"* Laura communicated her beliefs on too much focus on academic attainment:

"Mm, no to be honest, because it's all about just grades. They don't see the outcome and, like, what actually happens to kids if they don't get good grades. That's all they care about, to be honest. And, like, they just don't speak to kids about other things what could be bothering them. Like, instead of always just talking about grades, say, this…someone's here to talk to you if you're feeling low or someone's…here, blah,

blah, blah. Like, give you motivation really. Yeah. But there's not that much… motivation."

Participants spoke of the benefits of increased participation in non-academic activities and how these could translate into improved confidence and friendships. For example, several participants suggested outdoor activities such as:

"I think it would be very nice if like we could do more things which would make us have more friends so like doing things in the park so like instead of doing PE and get some fresh air and make some more friends… I think when you're stressed it's really nice just to go out and, I don't know, try to calm yourself down and in PE we used to, well we sometimes still do this but we do meditation and yoga and things like that and I think if we did that slightly more especially during exams it might help and we might become less stressed. Because I swear lots of people when we were doing it just fell asleep [laugh] because it was so calming. It just makes you feel so nice afterwards." (Zoe)

"I don't know if this is right, but, like, letting us, like, play around the school, this is also helpful, especially that we're, like, getting into, like, the end of school, like, Year Ten, Eleven, and letting us play around, have, like, play football, table-tennis and stuff like this, like just having fun around the school can make people, like, have a more better day. 'Cause, like, you go with a friend, you play, you're forgetting about it… So, like, you're thinking of the good things now… And forgetting about, like, what happened or, like, the bad thing. And just, like, helps letting it, like, just go over it quickly, and that also, like, helps." (Farid)

4.4.4.3 Provision

Participants highlighted a need for specialised support such as professional help that should be available and accessible at school or in their community. Chloe believed that having a school counsellor would be useful:

Chloe: *"I think they [school] should get a counsellor, to be honest."*
Researcher: *"Why do you think that might be helpful?"*
Chloe: *"Because… Just because my mentor is nice, not all of them like are easy to talk to. And like some people don't find it easy to talk to like the mentor they have to see every day. Whereas if there's a counsellor, you don't particularly have to see the counsellor every day, so it's like… Like some people prefer to talk to someone you know very well, some people prefer to talk to people you don't 'cause then you don't have to*

see them and go through all the aw-awkwardness. So they should get a counsellor for people… that like feel like that."

Researcher: *"So someone a bit more independent?"*

Chloe: *"Yeah."*

Similar beliefs were expressed in the following examples:

"Probably, to get like someone, like a professional at this to like talk to people and they should like work at school maybe. So you should just go to them. And it should be anonymous." (Jonny)

"I think they need to offer a bit more support like making the therapeutic room bigger and get in more people to do that job but then also pay them slightly more as they don't get paid that much for listening to worries of our students…" (Zoe)

Rhian: *"Like one of my friends is going through a hard time but they're not helping her, like they say they're helping but they just put her on a list! But the list is like never ending, and they just don't do anything."*

Researcher: *"Can you think of what would be helpful?"*

Rhian: *"Like… I don't know, coz the list is just for the therapeutic room so they could like expand the therapeutic room to more areas and like more people to talk to, like to refer them to professional people but they don't really do that. Like to get a professional help in who are willing like to work with kids our age."*

Lastly, Chloe highlighted the need for an individualised approach as not all participants liked to talk about their feelings as is evident in the following statement:

Chloe: *"She [teacher] asked me if I wanted to go in the therapeutic room… that's where you sit… and you talk about your feelings, and… play games and all that to show how you feel and stuff. But I didn't want to go in there. I don't really like speaking about my feelings or my emotions so I didn't want to."*

Researcher: "Okay. So some people don't find it that useful…talking about their emotions?"

Chloe: *"No. Some of them do, some of them don't. A lot of my friends prefer to speak about their feelings, and a lot of them have been like, em, put into the therapeutic room a lot of times…to speak about all their feelings."*

Researcher: *"So what is it about emotions you, you don't particularly like talking about?"*

Chloe: *"I don't know. Like I just… I love talking but I don't like talking about my feelings or my emotions. I don't know why. I just prefer to like hold it into myself…"*

Thus, services should ensure that interventions are targeted to the needs of an individual.

4.4.4.4 Approach

Participants also reported that services should be better promoted and visible to improve the dissemination of information. This would lead to better mental health literacy amongst young people and awareness of existing services. The need for improved promotion of services was captured in the following:

Laura: "*Like, they put up posters but they don't put…they don't say anything about anything, like. They don't say it in assemblies or form or anything. It's just posters and you don't really see them."*

Researcher: *"Uhm-hmm. So you, kind of, forget they're there then after a while?*
Laura: "Yeah."

Participants offered suggestions that would help to improve communication:

Alex: *"I think this school offers very good help, and they're always open to talk to but some people in our school they like hold it in a lot and I don't think is that good to hold it so I think the school needs to like do more and like promote it [support] more and open it more because you only get a message once a term and some people will often go there but then it leads to bigger things if they hold it in so they need that support, yeah. Saying like if there's like a problem with mental well-being or something then you can come and talk to us. But I think we should receive that message more often so people feel more comfortable to, like to go to them."*

Researcher: *"How come, do you think this would make you more aware? What you think would be helpful at the time?*

Alex: *"Probably, to get like someone, like a professional at this to like talk to people and they should like work at school maybe. So you should just go to them. And it should be anonymous."*

Alex also highlighted a preference for allocated mental health professional at the school as it was discussed in the section above.

Additionally, Jonny offered a suggestion: *"Maybe like every so often, like every term, they could go into like just a random selection of a lesson and see if anyone needs help, if anyone does need a mentor, anything like that."*

Researcher: *"Yeah, so just be proactive throughout the year rather than just at the beginning?"*

Jonny: *"Yeah."*

The importance of having an open discussion about mental health and challenging the associated stigma was reflected in Abigail's statement:

"I think, people respond to more role models very well. And I think people like Prince Harry coming to talk about his mental health is even a step in the right direction…and quite a lot of football stars and stuff like that talking about mental health is definitely a good idea…because it almost takes away this idea of, you know, guys don't have mental health problems."

Chloe pointed out that staff and professionals should always challenge preconceptions that might have been created by reputation:

"I think they just need to listen, like regardless if you're, you're good or you're bad or whatever. They need to listen as well because, just because I'm in a bad group, it doesn't mean that I'm going to get everything wrong, if you know what I mean? Like you just get labelled that, oh she's probably going to lie her way out of it. But to be honest, I'll tell the truth. When I've done something, I'll tell you I've done it."

To conclude, master theme 2 detailed views of young people in relation to mental health support and services. Participants voiced a strong preference for a non-judgemental and empathic approach that would enable them to express their worries freely. Further, participants suggested numerous improvements to mental health services that would increase young people's engagement with and access to these services. The suggestions were for schools and communities to:

- Provide opportunities to talk in a safe and accommodating environment;
- Ensure mental health support that is professional and understands the needs of young people;
- Increase focus on non-academic activities to enhance well-being and reduce stress, and
- Recognise and implement the merits of the person-centred approach.

4.5 MASTER THEME 3. Barriers to Accessing Support

The master theme *barriers to accessing support* were constructed from participants' feedback in relation to the perceived sufficiency of mental health and well-being services that were available in their schools and communities. This theme categorised responses

that predominantly addressed help-seeking barriers in terms of accessibility, availability and usefulness of mental health provision. The interview questions that stimulated discussion on this topic were, for example, *Who can you talk to about your worries at school/outside of school?* and *Do you think your school helps students to feel good about themselves, and their lives?* These questions aimed to explore whether young people have access to support when needed or what might be stopping them from accessing services. The following sub-themes of barriers were categorized, *Insufficient Support* and *Stigma & Negative Consequences.* These sub-themes are discussed next.

4.5.1 Insufficient Support

As discussed in the sub-theme *Adequacy of Support*, five participants reported dissatisfaction with the support that was offered to them either at school or in the community. However, a further 12 participants expressed beliefs that support is insufficient. For instance, to the question *Do you think the school offers enough support for you and other students?* several participants gave negative feedback in line with the following:

> *"I don't think it does. I don't think any school does…unless it's extremely, extremely specialised or private…"* (Abigail)

> *"Mm, no to be honest, because it's all about just grades. They don't see the outcome and, like, what actually happens to kids if they don't get good grades. That's all they care about, to be honest. And, like, they just don't speak to kids about other things what could be bothering them. They just… You know, straight grade…" (Laura)*

> *"Like for me yeah, but I think other students are… going through bad times I don't think they, I think they could do more."* (Rhian)

Also, Chloe highlighted the insufficient input and lack of communication between the school's well-being services and young people:

> *"No, they [school] told us once in an assembly and it was like, em, I don't know what it's called. But they gave us like this little card and it's like, em, your emotions, your, your mental something. And then, em, and your hormones and everything on a card, and then like this number at the bottom, and it's like you text or whatever and you'll get a reply. But then that was just a card, and I think everyone's lost the card now."*

This theme is closely linked with young people's preferences towards support discussed in master theme 2., as these sub-themes also detailed the unhelpful attributes of support and need for improvement in many areas. This subtheme, however, focuses solely

on the identified barriers that are further categorised into four subcategories: *Lack of Interest from Adults, Lack of Services, Long Waiting Lists* and *Wider Socio-political Context.*

4.5.1.1 Lack of Interest from Adults

One of the reported barriers that prevented young people from help-seeking was the perceived lack of interest from school staff or other adults, in reference to their attitudes when approached for help. For instance, young people felt that adults/staff simply utter platitudes rather than offer real support and that they are not proactive about enquiring about the well-being of all students. Furthermore, participants perceived that school staff did not offer the sort of support that young people required. The evidence for this sub-category is captured in the following statements:

> *"I think it's generally unhelpful when there's no one there to be like, you know, it's going to be alright, it's going to be okay, you are going to be alright, these are the things that are happening to you and it's normal."* (Abigail)

> *"But I think they [school] could maybe offer more… because you kind of have to go to them, if there's a problem. Like, it would be nice if, like, some children, during school, they just walk around and… if they were like, are you okay, do you need a chat, da, da, da. Most teachers would [offer support] if they seen someone upset, but like, it would be nice if everyone could be asked, and like, treated, treated more equally, in a way. Because some people will go to Miss A. more than others. Some people are more scared about going to Miss A., because they don't know what she's gonna say. So it would just be nice if, like, everyone was reassured that they can go to a, a teacher, if there's something wrong."* (Anna)

In the next account, Rich reflected on his negative experience with help-seeking at school:

> *"When you go and talk to someone about it, but the teachers, for me, don't make me feel much better. Some teachers are, like…I'm having a bad day, and then they come and be really grumpy with me or whatever. Come and be grumpy, and it makes me feel worse and angry then… sometimes."*

Laura reported that young people at her school do not always come forward with their problems and instead would keep it to themselves, for the following reasons:

> *"There's no one, like, really there…they don't really ask that type of things and it would be weird to bring it up. There isn't that much support…"*

The above-discussed findings suggest that participants formed their understanding either on their perceptions towards those who offer support/services or from lived experiences of help-seeking. This distinction gives us important information on the formation of young people's perceptions. If their beliefs and attitudes are based on hearsay or poor understanding of available mental health provision, the school or commissioners' focus should be on addressing stigma and improvement of mental health literacy. If participants perceptions are informed by their past struggles to access support, the focus should be on improved access to services. These findings are examined further in the discussion chapter.

4.5.1.2 Lack of Services

Young people expressed a consistent need for more services and opportunities to address their worries at school and community. Similar findings were previously discussed in the master theme 2., where participants highlighted the need for a more accommodating environment that creates opportunities to talk. In this sub-theme participants reported that current services are not meeting increasing demands for mental health support and they are often forced to address their problems without support or professional help. The following examples capture participants' difficulties when accessing support at school and in the community.

Rhian reflected on difficulties accessing support at school:

"The list is just for the therapeutic room so they could like expand the therapeutic room to more areas and like more people to talk to, like to refer them to professional people but they don't really do that."

Further, Abigail explained that although it seems that there is support available to them, it is very difficult to actually receive it. She stated:

"A lot of the time when people say, oh, I'm depressed, the Government says, there's enough money for you to get help, there's this pathway to get help, there's that pathway to get help, but it's obstacle after obstacle and it's just unfair. It's basically putting people through something that they shouldn't be put through… especially if they're in a fragile state of mind. "

Further, she added: *"We have someone from Brook come in [to school] who is…every now and then but I think…but I think places are also incredibly limited for the mental health…"*

In the following statement, Anna expressed her frustration with the lack of services in her community and reflected on many of the services being closed down in recent years:

"I think, like, they could put more services out of school. Because it's good at school, but… on the weekend, you don't know about. And like… youth centres, and stuff, they've all been closed down. So even on the weekend, you want to go out with your friends, there's nowhere to go. So, and you don't want to hang around on the street because it's cold... Yeah, and, erm, but yeah, there's no medical centres, like, on a weekend, that you can go and speak to people. Even most libraries, now, like aren't even open on weekends. And it's just like, on the weekend, there's nowhere to go. It's not like you can come into school on a weekend and speak to a member of staff in school."

Abigail described the struggles she experienced when accessing support services in the community. She stated a preference for support based at school, as it was convenient, often timely and easily accessible.

"Unfortunately, because the school have a lack of money what they've done is they've had to promote peer to peer talking…about mental health, which I think is incredibly important, but I also think it's a real struggle and I don't think a lot of kids, say, in my year are comfortable either going to another mental health service apart from the one that's in school where it feels like it's not a big deal…but if a kid has to go to their GP and say, I want a counsellor, then they have to go through the whole process, it's a lot of work. Whereas if you come here you get a referral and that's it…and you don't have to talk about it with millions of other people and just people asking you, what are your problems this, that and the other. ***So, it almost feels like jumping through hoops.*** *Whereas here it's simple. Because there's so little availability it's not effectual at all and it's not sustainable because there's not the money for it and there's not places for it. So, while it is good it's there it's helping a very, very small percentage of the people who definitely have problems but I think it's more systematic than that."*

Moreover, Abigail pointed out that there are other options available; however, they also come with financial costs:

"But it's the fact that I am a middle class kid, so if I wanted therapy I could get my parents to pay for it. It's expensive, it's really, really expensive [laughs], but I could get them to pay for it… …but if you're working class and, you know, you struggle, you…say you live in an apartment, you've got to pay rent, you've to do this, that and the other, then how the hell are you going to pay for some expensive therapist week in week out…"

In one interview the conversation centred on young people's awareness of mental health services. The researcher asked: *"So how come some people know about the services and some people don't?*" Abigail responded:

"Some of us are very vigilant… and get annoyed very frequently at the school. [Laughter] That and I have friends who have used it because they've gone to their head of year and explicitly had to explain…what their needs were… and then they were referred to it and been placed on a very long waiting list. The same with the…I think we have the therapeutic room, which is with a very nice…but you get a very short period of…availability for that. You wait…I think it's six months, I think, I'm not quite sure…and then you get it for about six months."

The present findings show that young people are willing to engage in help-seeking; however, their efforts are affected by the limited availability of services. Their awareness suggests that they are actively seeking support for their mental health needs.

4.5.1.3 Long Waiting Lists

This sub-theme is closely related to the subject discussed above. As evident from the current findings and reviewed literature, the lack of services and increased demand for mental health resulted in long waiting lists. Young people reported frustration with long waiting lists and delayed access to support. One participant was also confused about the decision process for support referrals. She reflected on her friend's need for support that is yet to be met. These findings are evident below.

Frustration with long waiting lists was voiced in Rhain's statement:

"Like one of my friends is going through a hard time but they're not helping her, like they say they're helping but they just put her on a list! But the list is like never ending, and they just don't do anything."

Zoe also reflected her frustration when waiting to receive support:

Zoe: *"I think [we need] more opportunities to get into the think room because I was on the list for a very long time but I never got in but my friend basically was just really, really upset and they got her in straight away and it just felt a bit like 'but I've been on the list for 3 years!' which is like that's a bit confusing."*

Researcher: *"Three years is a long time…"*

Zoe: *"Hmm yeah [laughs]… basically ever since I've been in the school so it's just a little bit like, but yeah that's why."*

Young people found the selection process as to who receives support confusing. Notably, it appears that some young people receive support more readily. Joy reflected on this in her statement:

Joy: *"It would be good that… more teachers, more therapeutic rooms…'cause my friend's been waiting on the list for about a year now. Yeah, and I've been in twice…and she doesn't think that's really fair so…I'm trying to get her [laugh] a place."*

Researcher: *"Is there any difference between who gets in?"*

Joy: *"Erm, I don't know 'cause I'm… quite a target…in my school… so, erm, I think…but I'm not sure why I got seen more than her 'cause her… mum died when she was little and she's…she cries quite a lot and she's not a very happy person. So I think she needs to be seen more than me."*

It is apparent that young people often have to wait a long time to receive support. Moreover, this support comes more readily to some than to others. Young people are informed about services available and communicate discrepancies in access between themselves. These discrepancies can be perceived as inequality and further prevent young people from seeking help.

4.5.1.4 Wider Socio-Political Context

This subcategory reflects the views and experiences of one participant, Abigail, and captures her discontentment with the inadequacy of services on a structural level. Abigail argued that her school is doing what they can in terms of mental health support; however, she felt that schools are constrained by the restrictions of government policies and allocated budget. Although Abigail was the only participant who expressed particular views and experiences on this subject, the sentiment translates into many themes identified by other participants. Naming a few: lack of services, long waiting times, and ideas summarised in the areas of service development. The most poignant messages are highlighted in bold for emphasis.

"*I think that I am in a lucky position with this school, I still think it's insufficient… because there is a complete disregard in current society. I think it's not schools' fault and I don't think it's the people's fault, I think it's the Government's fault and they just don't listen and it's ridiculous…at the end of the day.* ***Yeah, it's like numbers on a sheet; it's turning people into statistics****. I think it's just completely ruined people's perception of… and I think while on one hand I understand it there's a lot of*

money…there's not a lot of money in the budget. ***I think there should be more money put in the budget… because at the moment it truthfully feels like they don't give a shit."***

*"**They** [government] **need to** just get their act together…and **realise that mental health is serious, it's happening and it's delaying more people than any other disease, which is r…absolute ridiculous. Our young men are killing themselves and no one's doing anything. They're all just sitting around talking about how they want to kill foxes and it's…pisses me off, but young people have been marginalised and ignored and I think it's just a completely unfair** that we've just ignored the needs for so long that it's almost reached a boiling point in which people are just like, this is what is going on."*

*"**I think that especially teenage kids have had so much pressure put on them, especially by the media and pornography, and it's like that they have such a distorted view of how they should be that when they're not there it almost is upsetting…unfair, and because of this we're all unhappy."***

Abigail communicated strongly and passionately how she felt about the current state of political affairs. These findings indicate that young people are informed and interested in issues of social justice and care about their future in relation to mental health.

4.5.2 Stigma & Negative Consequences

This theme captured stigma in relation to how young people view mental health difficulties or how negative consequences prevented some participants from seeking help or support. Reported negative consequences were participants' fears that others, such as their family or peers, would get upset or that it would make their situation worse. Stigma was also related to fears of being labelled or targeted by others. The following examples demonstrate these findings.

Several students reported fear of negative consequences:

"Well with friends, they could turn it against you. And with, like, your mum or something, could, like, obviously, like, hurt them…if you told them something." (Laura)

"Erm, sometimes, if maybe you wanted to, erm, talk about something that's going on within your family, that maybe a teacher would think is, like, you'd need to report, but you couldn't in that situation, and they reported it. Obviously, I understand that it would help your safety, and everything like, like that. But it would, erm, potentially make the situation worse at home, if there was anything, an issue like that." (Julia)

Researcher: *"Why do you think most of people wouldn't seek help?"*

Aimee: *"Cause they'd feel like it'd make things worse…and if you tell someone, then it's just going to all come back to you… and it'll just get worse."*

Researcher: *"So it's actually better not to say anything?"*

Aimee: *"I don't think its better not to…but that's what a lot of people think, I would say."*

Researcher: *"So it can have… bad consequences if you say anything?*

Aimee: *Yeah. And the teachers don't always do something about it… They'll just… say they put that person in say exclusion room or a detention or something, it won't normally stop it and then it will just get it worse because, like…'cause they'll know, like, you said something…"*

Some participants reported that they would not seek help as they felt that they were being labelled or would not be believed. Chloe stated:

"If like me and a friend had an argument and the friend went and told first, my opinion wouldn't really get listened to. They'd just straight away make an assumption of what happened. But like sometimes they'll listen but… Because… my group's like really loud, like forever getting in trouble. They don't really listen to my group as much. But if it was like someone good who always listens, they get listened to, if you know what I mean? So they don't really offer enough support for the people that have like led into the bad tracks. 'Cause… Because of my group, we're always loud, playing music, running around. We are a naughty group to…like together. Individually we're not, but when we're together we are. They're always causing trouble. So because we've already been put into…we've already been put into that category of that group that's naughty, they don't really listen to us that much."

Also, Rich explained the perceived impact of other people knowing that he had mental health issues:

Rich: *"Then when… I get to take time out of lessons, um, it was good, but I still felt a bit awkward trying to leave lessons when everyone…everyone else is in lesson…"*

Researcher: *"In what way did it make you nervous?"*

Rich: *"Just going and asking…for a pass…and say I've got a problem, yeah…"*

The last master theme *Barriers to Accessing Support* captured young people's views on the adequacy of available services and highlighted obstacles they have to face when accessing these services, such as shortage of services, long waiting lists and stigma associated with mental health.

4.6 Chapter Conclusion

This study was interested in young people's views and experiences of mental health support that was available to them inside and outside of their school. The findings categorised help-seeking behaviours amongst participants that appeared to correlate with their perceived need for support, resilience, self-confidence and individual differences. Most participants showed awareness of the benefits of help-seeking and identified barriers to accessing support such as lack of services, long waiting lists and perceived stigma. Further, participants provided a substantial list of helpful and unhelpful features of support, detailing preferred qualities in mental health professionals and services. It appeared that an individualised approach to care was favoured by young people as they showed a preference for wanting to: feel valued, be respected, be listened to, be encouraged to make shared decisions, be involved in collaborative planning and be supported in self-management. The next chapter conceptualises these findings in relation to existing literature.

CHAPTER 5.

DISCUSSION OF FINDINGS

5.1 Introduction

The research explored the views and experiences of young people towards mental health support in their school and community settings with a focus on its availability, accessibility and usefulness. The findings were categorised in a central theme labelled *Patterns of help-seeking behaviours in young people.* Young people's help-seeking behaviours were characterised by factors including *Perceived need for support*, *Resilience and self-confidence,* and *Individual differences.* Further, the central theme was associated with three main themes: *Available support; Young people's preferences for support;* and *Barriers to accessing support.* This chapter discusses these findings in relation to the research introduced earlier in the literature review, as well as to other relevant existing research.

In a similar way to the literature review, this section adopts an inductive process of research enquiry. It is organised into five sections. The first section introduces help-seeking in young people, characterised by their need for support, resilience, self-confidence and individual differences. This is followed by a discussion of mediators of help-seeking, including young people's attitudes towards help-seeking, and facilitators and barriers of help-seeking.

Section 3 provides a brief overview of theoretical understandings of help-seeking. Psychological coping is also introduced and discussed in relation to theory. The significance of merging these two research fields is explained and highlights the need for a collaborative approach.

Section 4 introduces implications and recommendations that have arisen from the present study. Particular attention was paid to implications for clinical practice and mental health provision at schools and community. This chapter ends with a brief summary of the key points discussed in this chapter.

5.2 Help-seeking Patterns in Young People

Findings presented in the central and the three adjacent master themes mapped out patterns of help-seeking behaviours in young people. It has been identified in the literature that help-seeking is an effective way of coping with psychological distress that leads to

prevention, reduction and early intervention for mental health difficulties (Rickwood, Deane, Wilson & Ciarrochi, 2005). The current findings showed that participants' help-seeking was characterised by participants' *Perceived need for support, Confidence and self-reliance* and *Individual differences.* Help-seeking patterns in young people appeared to depend on numerous person-related factors and to have the potential to change over time, reflecting the dynamic period of adolescence (Christie & Viner, 2005) as discussed in the literature review.

The Perceived Need for Support

It was observed that participants' help-seeking was influenced by their perceived need for support. Participants reported frequent reliance on numerous sources of support. However, a substantial number of participants (10 / 21) reported low engagement with help-seeking and preferred to address their problems on their own. Current findings are consistent with the research observed in the literature. Help-seeking has been delineated as adaptive help-seeking and help-negating (Deane, Wilson & Ciarrochi, 2001; Ciarrochi, Wilson, Deane, & Rickwood, 2002; Rickwood et al., 2005; Wilson, Deane, Ciarrochi & Rickwood, 2005). Rickwood et al. (2005) defined adaptive help-seeking as:

> An act of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience. Help-seeking is a form of coping that relies on other people and is therefore often based on social relationships and interpersonal skills. (p. 4)

In contrast, help-negating occurs when young people intentionally decide not to or are reluctant to seek help (Rickwood et al., 2005). Help-negating was reported as a relatively common behaviour amongst young people with serious mental health issues, including depression, suicidal ideation, eating disorders and substance misuse (Gould, Velting, Kleiman, Lucas, Thomas, & Chung, 2004). Young people's attitude reflected a belief they should deal with their problems alone. It has been observed that young men are particularly at risk as they are often reluctant to seek support for their mental health difficulties (Lynch, Long & Moorhead, 2016). Furthermore, two studies reported that the intention to seek help decreased when young people's level of suicidal ideation increased (Deane, Wilson, & Ciarrochi, 2001; Wilson, Ciarrochi & Rickwood, 2005). Participants that preferred to solve their own problems are further discussed in the sub-theme *Confidence and self-reliance.*

One of the main themes, *Available support,* reported participants' frequent reliance on numerous resources of support, including family members, school staff and mental health

professionals, at times of distress or when experiencing worries. These resources were categorised as sources of support at school and in the community and included a variety of people whom young people could talk to. Similarly, Rickwood et al. (2005) distinguished the nature of support that was available to young people and termed support as *informal* and *formal help-seeking*. Informal help-seeking refers to support that is acquired from friends and family and is offered by individuals not formally trained in mental health matters. Formal help-seeking is sought from professionals that have appropriate training in mental health, including psychiatrists, psychologists, nurses, teachers, youth workers, pastoral units, and leaders in religious communities. Rickwood et al. (2005) reported that young people are often reluctant to approach formal sources of help regarding their mental health issues and instead turn to informal sources, preferring to disclose to their friends first. This is consistent with the social changes in adolescence reviewed earlier (Viner & Barker, 2007), which is characterised by a decreased reliance on parents or carers and increased reliance on their friends.

Both informal and formal sources of help could act as gatekeepers of support which promote and facilitate access to mental health services. Informal gatekeepers such as family and friends could use various methods to navigate young people towards help-seeking, such as encouragement, signposting them to appropriate services, or providing more information about the support that is available. Nevertheless, informal sources might not be sufficiently skilled or aware of support services, or their own attitudes towards mental health might be influenced by stigma, meaning instead their support or advice could act as a barrier. In recent years, professionals at school, such as teachers, became increasingly responsible for signposting young people to mental health support. However, as highlighted in the reviewed literature (Hanley, Winter & Burrell, 2017; Thorley, 2016), teachers are juggling these responsibilities on top of their teaching duties. Moreover, teachers are not always adequately trained to recognise signs and manage risks associated with mental health problems or to signpost young people towards appropriate help.

Self-reliance and Confidence

Self-reliance was observed in participants who believed they had sufficient skills to deal with their difficulties on their own. Amongst these were participants that could not recall having worries or difficulties. However, they were aware of where to seek help if necessary. This preparedness suggested a self-belief in their own capacity to handle problems as they arise, otherwise known as self-efficacy. High self-efficacy has been associated with good mental health and positively linked to the management of stress,

depression, generalised anxiety disorder and performance anxiety (Bandura, Pastorelli, Barbaraenelli, & Caprara, 1999; Gross, Conrad, Fogg, & Wothke, 1994; Martin & Gill, 1991; Zajacova, Lynch, & Espenshade, 2005). The concept of self-efficacy was developed by Albert Bandura (1997) who defined this cognitive ability as "individuals' perceived capabilities for learning or performing actions at designated levels" (in Schunk & Meece, 2005, p.72). Self-efficacy is influential in the areas of social, emotional and behavioural development and is mediated by numerous variables. According to Bandura (1997), these could be categorised in reference to social, personal and contextual factors. Personal factors include motivation and affective states; contextual factors include, for example, changing environments, and social factors refer to individuals' expectations of others (Schunk & Meece, 2005).

Consistent with the research discussed in the literature review, young people undergo numerous changes in their cognitive functioning and develop beliefs about their own competence and efficacy (Christie & Viner, 2005). Self-efficacy is related to self-regulation (Ryan & Deci, 2004) and motivation (Schunk & Zimmerman, 2007), and these are strengthened through positive modelling observed in others (Schunk & Zimmerman, 2007). Further, self-efficacy and self-esteem are often discussed simultaneously. However, in the literature, they are regarded as two separate concepts. Bandura (1997) made a distinction as follows: "Confidence is a nondescript term that refers to the strength of belief but does not necessarily specify what the certainty is about. Perceived self-efficacy refers to belief in one's agentive capabilities, that one can produce given levels of attainment" (p. 382). A most functional efficacy is achieved when individuals' estimation of their own competence is slightly exaggerated, leading to increased motivation and achievement (Bandura, 1997). Thus encouragement should be facilitated in support services and educational establishments to promote optimism among young people and ensure access to resources and development of skills to be successful.

Individual Differences

Gender differences were also observed in the present study and this is consistent with the literature (Rickwood et al., 2005). Rickwood et al. (2005) showed a higher reliance on help-seeking in girls than in boys. The present study reported similar findings and suggests that boys are less likely to seek formal or informal help. However, the role of gender difference was highlighted predominantly by female participants, when in fact the findings showed that both girls and boys 'kept worries to themselves' depending on their coping style. It could be argued that the views of this particular group of participants were

informed by gender stereotypes and therefore further exploration of the relationship between gender and help-seeking is recommended.

Furthermore, it was also observed that girls were more likely to act on behalf of their friends and bring attention to or disclose personal information about their friends' emotional needs to teachers or counsellors. This phenomenon was also reported in the present study when several female participants reported that they spoke to teachers about their friends' mental health needs.

Previous research also suggests that young people considered the nature of their difficulties when seeking help (Rickwood et al., 2005). For instance, in Rickwood et al.'s (2005) study, young people were found to be more comfortable to disclose relationship problems to their friends, personal problems with their parents, and problems at school to their educators. Similarities were observed in the present study, showing patterns of help-seeking in relation to participants' self-reliance, individual differences and the nature of the difficulty. These individual differences reflect participants' idiosyncrasies in behaviours, thoughts and feelings, which were captured in their responses. This diversity highlights a unique trajectory of participants' needs, preferences, awareness and perceived barriers when seeking help. Preference for support shows that some interventions are more effective for certain demographics (Taylor & Stanton, 2007). Interventions that have the flexibility to be adjusted to individuals needs could accommodate wider groups and hard-to-reach populations and yield better outcomes. Consistent with the aims of personalised care (Ahmad, Ellins, Krelle & Lawrie, 2014) services should strive to combine their knowledge of individuals' coping styles with their help-seeking preferences and tailor an intervention around their needs.

5.2.1 Help-seeking Facilitators: Attitudes, Emotional Competence and Mental Health Literacy

Present findings suggest that young people cope with distress either actively and engage in adaptive help-seeking, or passively, by negating help. Individuals' attitudes towards help-seeking are a contributing factor whether they seek help or rely on themselves (Rickwood, 2006). Young people's attitudes are often informed by their beliefs and past experiences of support as well as reflecting the attitudes of significant others. Attitudes to help-seeking could be supporting and encouraging or preventative and diminishing individuals' access to treatment. Positive attitudes towards self-care are often evident in effective coping as they translate into individuals' perceived self-efficacy to work out their own problems, or having the confidence to ask others for help. Young

people's decision to seek help could be based on consultation with a number of sources, both formal and informal. Rickwood et al. (2005) observed that young people are vulnerable to external influence and decisions are often influenced by people they trust. This highlights the importance of relationships in the help-seeking process, as they potentially determine whether young people seek help or not.

Young people's attitudes towards help-seeking were an instrumental part of the main theme 2, *Young people's preferences for support.* Participants' attitudes were reflected in all four subthemes; *Benefits of support; Adequacy of support; Staff's attributes and Service development.* For example, Julie stated *"I don't really want to go to someone that I don't really know'.* Their attitudes were also reflected in their preferences for helpful and unhelpful features of support, both on the interpersonal and service-user level. Findings suggest that young people want to be valued, be respected, be listened to, be encouraged to make shared decisions, be involved in collaborative planning and be supported in self-management of their difficulties. These values are in line with the features of person-centred care (Ahmad, Ellins, Krelle & Lawrie, 2014). In healthcare, the person-centred approach refers to a collaborative process between the healthcare professional and the service user that is characterised by shared decision-making and intervention planning.

Gulliver, Griffiths and Christensen (2012) reported that positive attitudes and past experiences of service involvement facilitate help-seeking, together with encouragement from others, established relationships with service providers and having access to resources on the internet. Facilitators act as an intervention that encourages and enables the help-seeking process. McCann Mugavin, Renzaho and Lubman, (2016) further identified factors that facilitate help-seeking. These were trustworthiness and confidentiality of services, strong community support systems, the perceived expertise of available support, emotional competence, increased mental health literacy and openness with friends and family. Strong social support has been identified as a valuable coping resource (Taylor & Stanton, 2007) that gives individuals a sense of security, being valued, loved and cared for. It has been associated with good wellbeing, reduced psychological distress, including depression, chronic stress or anxiety.

The findings of the present study are in line with these findings. Notably, the participants echoed the importance of trust, confidentiality and an encouraging environment. These values are in line with the features of person-centred care (Ahmad et al., 2014). In healthcare, this refers to a collaborative process between the healthcare professional and the service user that is characterised by shared decision-making and

intervention planning. The following section introduces the concept of emotional competence and mental health literacy and their role in the facilitation of help-seeking.

Emotional competence was described as having a skill and language to express one's difficulties (Garner, 2010). These skills are essential for recognition and interpretation of emotions and enable individuals to respond to them constructively. Competency is determined by emotional capital (Gendron, 2004), which was defined as a set of inherent resources that could be used for personal and professional development within an individuals' environment. An emotionally competent person is able to understand that all emotions are normal and necessary, including less pleasant ones such as anger, embarrassment or fear. Appropriate expression of emotion can be facilitated through communication or understanding of the emotional source. Emotional suppression, aggression or avoidance could lead to distorted memories or impaired relationships with others. Emotional competence has been linked with increased well-being (Ciarrochi & Scott, 2006). Emotional competence facilitates both formal and informal processes of help-seeking. It has been observed that girls are better at expressing their worries and more open to sharing than boys (Rickwood et al., 2005).

Mental health literacy (MHL) is a concept derived from health literacy and refers to individuals' ability to comprehend and make appropriate use of medical information (Kutcher, Wei & Coniglio, 2016). MHL has been redefined several times to embrace its complexity. Kutcher, Bagnell & Wei's (2015) definition reflect this and states:

> Understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities. (p. 235)

According to some studies, people with high MHL use support more appropriately and are able to navigate through available information more effectively than someone with low mental health literacy (Ellis, Del Giudice, Dishion, Figueredo, Gray, Griskevicius, Hawley, Jacobs, James, Volk & Wilson 2012; Gabe Harley & Calnan, 2015). Ellis et al. (2012) reported that patients with lower levels of literacy were more likely to use sources from social groups, television and newspapers to aid their understanding on health matters in contrast with patients with high levels of literacy, who preferred information from specialist internet sources and were more likely to engage in collaborative healthcare consultation.

Increased access to information through the use of the Internet was the aim of healthcare and political advocacy initiatives to redefine public help-seeking behaviour (Hunt, Koteyko & Gunter, 2015) and reduce dependence on clinicians. However, these efforts are not necessarily all positive (Price, 2016). The readily available and infinite information, especially on the Internet, can increase young people's anxiety as information varies in quality and often provides conflicting messages (Gutierrez, Kindratt, Pagels, Foster & Gimpel, 2014). The usefulness of the available information could aid or confirm individuals' gathered knowledge on the problem, but at the same time could contrast with advice from a trusted professional source and create uncertainty, leading to increased involvement from the health staff (in Price, 2016). Nevertheless, patients preferred to consult with healthcare professionals about their circumstances as they questioned the objectivity, completeness and trustworthiness of their information sources, especially in relation to the Internet (Ellis et al., 2012).

5.2.2. Help-negating and Person-Related Barriers

Young People identified several barriers to help-seeking and accessing support in the present study. These were related to insufficiency and inadequacy of mental health support and perceived stigma about mental health. In particular, young people complained about long waiting times, had difficulties accessing services and receiving timely interventions. These barriers are consistent with several themes discussed in the literature review in the Future in Mind Report (DH, 2015), and in the Green Paper on the *transformation agenda* (DH & DfE, 2017).

In the literature, barriers to help-seeking were categorised by Saunders, Zygowicz and D'Angelo (2006) as person-related or treatment-related. In their study, examining barriers to alcohol treatment, they identified person-related barriers as participants' preference to handle the problem on their own, self-stigma, embarrassment and lack of motivation. Treatment-related barriers were associated with the knowledge of treatment availability, accessibility and effectiveness of treatment. Saunders et al. (2006) concluded that person-related and treatment-related barriers are equally important as they actively influenced individuals' engagement throughout the help-seeking process. However, the person-related barriers were a reliable predictor of treatment outcomes.

A number of person-related and treatment-related barriers are associated with help-negating. Fischer (2015) pointed out a number of differences in individuals' abilities to make enquires about their health issues, affecting their effectiveness in help-seeking. These were influenced by many factors, such as resources, their attitudes, confidence, mental

health literacy, individuals' beliefs and past experiences, lack of emotional competence, and relationship with mental health providers. Current literature on help-seeking behaviours of young people centres on person-related barriers to accessing support. For instance, Salaheddin and Mason (2016) identified in a cross-sectional survey that young people are reluctant to access support due to stigma and negative perceptions surrounding mental health. Similar evidence was observed in a systematic review (Gulliver, Griffiths, and Chritensen, 2010) that reported perceived stigma and embarrassment as a common barrier to help-seeking amongst young people. In another study, Gulliver et al. (2012) observed similar findings in young elite athletes and additionally highlighted the importance of relationships and past experiences. Young athletes were more likely to seek help if they had positive relationships with providers or when they received encouragement from a trusting source (e.g. a coach). Having negative past experiences of help-seeking reduced their likeliness to try again. Help-seeking behaviours were also systematically examined in young people with eating disorders (Ali, Farrer, Fassnacht, Gulliver, Bauer & Griffiths, 2016). Adding to the barriers already detailed were young people's feelings of shame, denial, lack of insight into the severity of the illness and ambivalence to change.

Further reported barriers include the problems of recognising the symptoms of mental health difficulties, also referred to as poor mental health literacy, and preference for self-reliance (Gulliver, Griffiths & Chritensen, 2010). Help-seeking behaviours are particularly delayed within migrant communities (McCann et al., 2016), prolonging access to treatment and negatively affecting outcomes for mental health difficulties such as anxiety, depression or substance use. Amongst the stigma of mental illness, other barriers were identified. These were poor mental health literacy in young people and their families, lack of cultural competency, knowledge of support structure and financial costs.

5.3. Theoretical Understanding of Help-seeking

In line with the above, the following section introduces the most influential theories of help-seeking in social science. The aim is to position the present findings within the existing literature. The concept of help-seeking in young people and adults has been an area of long-standing research interest and has been effectively investigated over the last 20 years (Price, 2016; Rickwood & Thomas, 2012). Help-seeking has been identified as an adaptive way of coping with difficulties by obtaining support from external sources (Rickwood et al., 2005; Rickwood & Thomas, 2012). The understanding of individuals' help-seeking behaviours is important for healthcare providers as improved knowledge

could manifest in more efficient service delivery and increased service user engagement (Price, 2016).

Over the years social scientists conceptualised models of help-seeking and underpinned its psychological and social process. Baker (2007) extended the understanding of help-seeking not only as a formal process of behaviour that occurs when individuals access healthcare and services at the time of need. He also included informal enquires about the help that precedes individuals' actual engagement with help as an important stage that informs help-seeking (Baker, 2007). As described earlier, informal help-seeking comes from lay-supporters, such as family members or friends whom the individuals trust and can express their worries. Baker described processes of help-seeking as instrumental, informational, affiliative and emotional. Instrumental processes refer to sourcing a treatment and solving an individuals' problem. When individuals only want to understand their problems better, they engage in the informational process. Affiliation happens when individuals have an opportunity to discuss their problems with others. Lastly, emotional processes refer to guidance or strategies individuals obtain in order to address their problems.

The following section provides a quick overview of the existing theories and models of help-seeking and their relevance to the proposed model of this study. These are the *Continuity theory* (Atchley, 1999); *Social Behaviour Model* (Anderson & Newman, 1973); *Reactance theory* (Brehm, 1966); *Attribution theory* (Kelly, 1967); and Walster, Berscheid & Walster's *Equity theory* (in Wacker & Roberto, 2008).

Continuity Theory

Continuity theory (Atchley, 1999) organises individuals' mental health capacity in relation to the understanding of their own beliefs and beliefs of those in their environment. Individuals' help-seeking reflects their coping abilities, strengths and weaknesses, that in turn inform their choices and decisions (Wacker & Roberto, 2008). It is based on the theory of adult development which allows individuals' perception of their own competency to change over time or when it gets challenged at a time of need. Atchley (1997) positioned individuals on a continuum, with independence at one end and dependence on the other and suggested that:

> People will be attracted to past views of self . . . the coping strategies that have been successful, ways of thinking that have been effective, people that have been supportive and helpful, and environments that have met the need for security and predictability. (p. 272)

Individuals' dependence on others corresponds with their feelings of worth and help-seeking identity, as it could influence their personal reputation as a problem solver (Wacker & Roberto, 2008). Thus individuals that cope with their difficulties independently and self-sufficiently, and display a low dependence on others might delay professional consultation or be reluctant to accept support as they are not willing to break down their established perception of themselves (Price, 2016).

Social Behaviour Model

Social behaviour model (Anderson & Newman, 1973) was developed to better understand individuals' engagement with services. This model is still influential today and informs our understanding of factors that predispose, facilitate and prevent service users from the use of services. Predisposing factors identified were individuals' personal and demographic characteristics such as age, race, gender or attitudes towards help-seeking and services that are available. These also include individuals' social structure such as their education and marital status, occupation, social and community positioning (Wacker & Roberto, 2008). Similarly to the present study, identified facilitators were family, friends and community resources, together with financial assurance, transportation availability, and awareness of available services. One of the noted predictors of individual service use was also their perception and evaluation of their need. The Social Behaviour Model was further utilised by Phillips, Morrison & Anderson (1998) and enriched with environmental variables, including individuals' understanding of a problem through notions of self-care and responsibilities as well as stigma towards mental health. The influential relationship between enabling factors and individuals' perception of need is illustrated in Figure 5.1 and proposes that individuals base their decisions and perceptions towards help-seeking on consultation and advice from others or knowledge that is available to them.

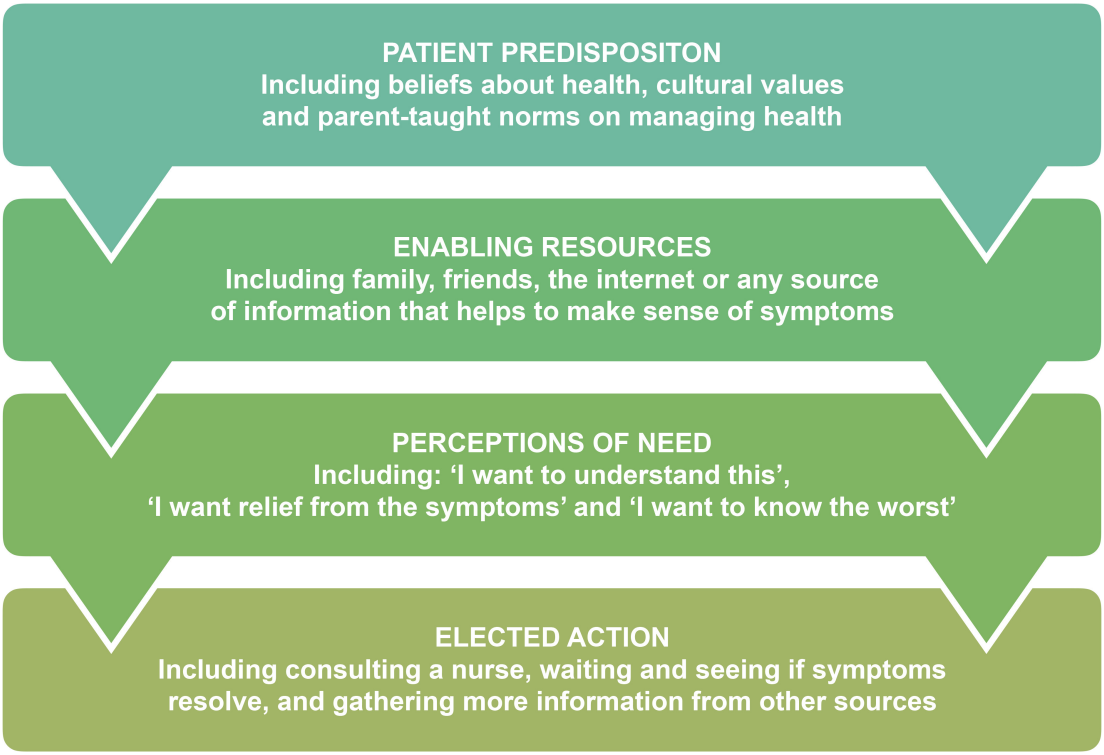

Figure 5.1 Social behaviour model of help-seeking (adapted from Price, 2016).

Reactance Theory

The reactance theory (Brehm, 1966) pays attention to the importance of values such as freedom of choice and autonomy. Individuals respond with reactance when these values are threatened (Wacker & Roberto, 2008). The reactance is greater when individuals' perceived importance and loss of autonomy is greater. In relation to help-seeking, individuals consider the costs associated with their difficulties, including personal and financial losses such as the inability to work, pressures of paying or going for treatment or losing earning potential (Dillard & Shen, 2005). Whether real or perceived, these disadvantages might contribute to individuals' decision not to seek help, consult professional help, or commit to long-term treatment. For instance, young people might refuse to go to therapy because it clashes with other social arrangements and poses a threat to their identity. Despite the encouragement from family and their therapist's attempt to accommodate young people's timetables, they would still prefer to spend time with their friends, not miss out on socialising and risk the opportunity of being ostracised.

Attribution Theory

Kelly (1967) proposed that a rational response to problems is to understand why things are happening and to predict outcomes in a controlled way. Individuals would then make efforts to solve problems alone if possible or, if unable, to consult with others and resolve

them with support. Attribution theory suggests that a health concern is not only a threat that could be ignored, but it is also a challenge individuals strive to resolve (Price 2016). The need to act on symptoms or worries is conditioned by individual differences, past positive and negative experiences, socio-cultural environment, and tendencies to help-seek and follow advice.

Attributions are understood by individuals as perceived causes for events or occurrences in their lives. Attributions contribute to whether individuals perceive these causes as success or failures, and inform their future behaviours or learning. Therefore if help-seeking was successful in the past, individuals are more likely to seek help in the future.

Equity Theory

Equity theory defines a social concept of reciprocal interaction between the giver and the receiver. In 2073 Walster, Berscheid and Walster proposed that individuals desire to maintain equity in relationships and feel indebted if they receive more than they deserve (in Wacker & Roberto, 2008). This imbalance can result in distress or negativity towards the giver and challenge individuals' perception of the situation. In the context of healthcare, patients may be reluctant to receive help if they cannot offer anything in return. Offering assistance or paying for treatment could equalise their sense of inequality. Arguably, a sense of equity is restored in countries that provide social securities, as individuals feel that they have contributed to healthcare by paying towards the system (Wacker & Roberto, 2008). If for any reason the equity balance cannot be restored and individuals are unable to reciprocate the assistance, changing their perspective on the situation might lead to improved engagement and increased help-seeking. Involving individuals in a more collaborative approach with professionals could restore this balance and facilitate mutual assistance in problem-solving and the intervention process (Lu, 1997). Consequently, individuals would feel justified and empowered.

In line with the literature, the present study showed a variation of characteristics, facilitators and barriers that determine help-seeking in young people. Moreover, it showed that young people often avoid help and choose to deal with their worries alone. Different coping styles in young people when dealing with difficulties suggest that *help-seeking* is a method of *coping* with psychological distress. Coping with psychological distress reflects individuals' efforts and the ability to handle or deal with adversity in life (Pearlin & Schooler, 1978). The literature on coping is as comprehensive as the literature on help-seeking. However, it has been observed that this literature has evolved separately (Rickwood et al., 2005).

Moreover, there is a lack of discussion and systematic evaluation of mediators that are involved in coping and individuals' access to mental health support providers (Mitchell, McMillan & Hagan, 2017). The following section provides a brief overview of the current literature on coping in an effort to contextualise this study's findings within a wider research context. Furthermore, it highlights the connection between two areas of research interest, namely coping and help-seeking.

Lazarus and Folkman (1984) proposed that the coping process involves an *appraisal* of the potential threat and *action,* referring to a cognitive or instrumental strategy that is applied to manage or master threat. Coping resources necessary for managing the challenges of daily living are often diminished or absent in people with mental health disorders, such as depression, psychosis or anxiety (Taylor & Stanton, 2007). Individuals' coping style can explain how they deal with adversity but also assist in intervention planning (Folkman & Moskowitz, 2004).

Taylor and Stanton (2007) contextualised coping origins and consequences and provided a description of resources and processes that are involved. This model offers a lifespan perspective that moves from the development of individuals' coping resources in early life to mental health outcomes when coping processes manifest at times of stress later in life. Taylor and Stanton (2007) reviewed risk factors and resources of coping. They reported that low self-esteem, low sense of control, adverse effects of relationships, poor ability to establish positive relationships, and developmental risks were associated with poor coping ability. Coping resources refer to a psychosocial construct that Taylor and Broffman (2011) defined as "individual differences and social relationships that have beneficial effects on mental and physical health outcomes" (p.1). These were psychological control or mastery (Taylor & Stanton, 2007), hope (Snyder, Harris, Anderson, Holleran, Irving & Sigmon, 1991), high self-esteem (Hu & Ai, 2014) and social support (Brand, Laier & Young, 2014).

Further outcome-based expectancies such as optimism and pessimism were associated with psychological well-being and recovery (Carver, Scheier & Segerstorm, 2010). For instance, optimism was found to improve psychological well-being and speed recovery in contrast with pessimism which was associated with expected negative outcomes. As discussed earlier in the literature review, the genetic predisposition was linked to mental health disorders and it was identified as a contributor to coping (Taylor and Stanton, 2007). The effectiveness of coping is also determined by one's environment. Early life stressors increase the risk of mental health problems and poor coping. Certain cortical areas of the brain such as the amygdala are responsive to stress as they arm individuals' nervous

systems to act and protect them from a threat in their environment. Young adults with experiences of harsh family environments had an altered neural pathway for regulating stress, due to increased activity in the amygdala. A harmonious family environment was linked to a modest amygdala reaction to threatening stimuli (Taylor & Broffman, 2011).

In the literature, the organisation of coping processes has been appraised for their intended function and distinguished as either a problem-focused or emotion-focused approach, versus avoidance-orientated coping.

Problem-focused coping is characterised by individuals' attempts to resolve their stressful or distressing situation. Individuals might apply their problem-solving skills to understand their situation, manage their time and get organised. To manage threats or stressors, they would use assertive communication or ensure instrumental social support. Their goal is to reduce or eliminate the source of stress or threat.

Emotion-focused coping is directed towards individuals' own emotional reaction to perceived threat and aims to reduce or manage internal turmoil, stress or anxiety.

Emotion-focused coping involves distraction with pleasurable activities, like talking with friends, the use of relaxation and mindfulness techniques, or obtaining emotional support from others. These strategies can generate acceptance of one's situation (Zeinder & Hammer, 1992), decrease stress, hostility and depression; and increase gratitude and life satisfaction (Folkman & Moskowitz, 2004). Problem-focused coping has been associated with greater perceived control and positive psychological and physical wellbeing (Taylor & Stanton, 2007), in contrast with the emotion-focused coping. However, in recent years the research support for emotion-focused coping such as mindfulness, breathing techniques or acceptance is rapidly mounting (Forsyth & Hayes, 2014; Kohl, Rief & Glombiewski, 2013; Stoeber & Janssen, 2011).

Denial, distancing, avoidance, and positive reappraisal are associated with emotion-focused strategies (Taylor & Stanton, 2007). They reflect individuals' beliefs about harm and loss and can manifest as self-blame and social withdrawal. Defensive coping occurs when individuals unconsciously use strategies that distort their understanding of the situation or deny the reality of their situation. Individuals could also distance themselves from the problem and minimise its impact on their lives. Avoidance refers to a shift in attention when one intentionally does not pay attention to the threat. Positive reappraisal occurs when individuals ignore negative aspects of the stress and only focus on the positive ones.

Effective coping and associated positive states such as resilience, compassion, optimism self-esteem, self-confidence and hope have been studied widely in the field of positive

psychology. Positive psychology emerged in the 1960s through the works of Martin Seligman and actively contributed knowledge on human coping abilities to the public health and educational fields (Positive Psychology Program, 2018). Positive psychology has also largely contributed to the development of many psychological interventions for preventing and managing many common mental health problems (Bolier et al., 2013), such as depression, psychological trauma, stress and anxiety. Interventions include a range of cognitive behaviour therapies that teach individuals problem-solving techniques, effective coping strategies and interpersonal skills. The emphasis is on the overall enhancement of wellbeing, as it was recognised that mental health is more than just an absence of mental illness (WHO, 2001). The importance of coping is visible in the WHO's definition "Mental health is a state of well-being in which the individual realizes his or her own abilities, **can cope** with the normal stresses of life, can work productively, and is able to make a contribution to his or her community" (2001, p.1). The research on resilience and confidence have been already sufficiently reviewed in this study and its practical application is evident in many school initiatives such as the PSHE and SEAL programme (*see* Chapter 2 section 2.3.2). Importantly the inclusion of emotional skills into the curriculum could have a positive effect on young people's coping style.

In conclusion, this section discussed a number of facilitators and barriers that young people experience in help-seeking. It has been argued that help-seeking is an adaptive pattern of coping with psychological distress. Young people's engagement with help-seeking is mediated by a perceived need for support, individual differences, confidence and self-esteem, attitudes towards help-seeking, emotional competency and mental health literacy. These could either facilitate adaptive help-seeking or act as a barrier and result in help-negating. Adaptive help-seeking could be formal or informal and is determined by the support that is available, accessible and useful.

5.4 Implications and Recommendations from the Study

This study identified that young people are to some extent informed about support and services that are available to them in their school and less so in their community. They reported reliance on multiple sources of support that were either formal (support based at school) or informal (friends and family). Their patterns of coping with difficulties were also established, and these highlighted that young people have individual coping styles depending on their preferences, attitudes, physiology, socio-economic backgrounds, past experiences and social environment. The following section looks at the implications of these findings in relation to clinical practice and service development. Lastly, it also

discusses the implications for the field of counselling psychology, considering the researcher's background in this field.

5.4.1 Implications for Clinical Practice

This study discussed the recent national efforts to improve mental health in young people (DH & DfE, 2017) and how as a result a range of initiatives and interventions have been developed over the last thirty years. These efforts aimed to increase young people's general well-being, access to mental health services and appropriate interventions (Thorley, 2016). However, it appears, most initiatives and interventions are directed at young people that are actively seeking help and are motivated to ask adults for help. Understanding help-seeking as a feature of coping with psychological distress could help professionals to identify the behavioural patterns of young people that indicate whether they are likely to seek help or not.

There are a number of challenges that prevent young people from seeking help. Amongst the one discussed above were factors linked to help-seeking and coping, that suggest that these patterns and behaviours are formed by individuals' beliefs, attitudes, culture and social environments, but also informed and reinforced by facilitators and barriers to support. Additionally, young people strive for autonomy and independence and have a growing need for self-efficacy and autonomous decision-making. Therefore professionals should facilitate the provision of formal and informal sources of support where possible. In order to improve help-seeking Price (2016) identified four precepts for nurses to identify and respond to patients' concerns more imaginatively. The current findings from this study are in line with these principles and could be adapted to use by professionals that work with young people, including teachers, youth workers, school nurses, or young people who wish to promote awareness of mental health needs to their peers.

Firstly, Price (2016) suggested that service users should have better opportunities to make help-seeking enquiries. Health campaigns are to be carefully designed and contain clear and straightforward information and links for further resources. The present study identified that young people are aware of sources of support. However, they often do not know the extent of mental health provision that is on offer at their schools and in their community. Improved promotion of services could assist in disseminating this information.

Further, mental health campaigns could enhance mental health literacy. Educational pamphlets have proven to be an effective strategy for risk minimisation and portal for information sharing (Bester, Di Vito-Smith, McGarry, Riffkin, Kaehler, Pilot & Bwire,

2016; Gaskin, Griffin, Hauser, Katz & Klein, 2010; Price, 2016). Educational pamphlets on common mental health disorders can provide young people and gatekeepers with quick access to important information and links to resources. Information about signs and symptoms with clear links to avenues of further consultation can encourage the reader to seek help. These pamphlets or posters could be provided at school or GP surgeries in common areas or more discretely in corridors, toilets, or teachers'/counsellors' offices. Delivering information through presentations and formal or informal talks was also found to encourage help-seeking and consultation with professionals (Wilson, Bignell & Clancy, 2003).

Secondly, Price (2016) recommended to professionals to be vigilant and seize opportunities to identify problems. Timely interventions should be ensured, especially to young people at times of crisis and when levels of hopelessness are high. Frequently asking simple questions about mood and the current state of affairs could reduce suicide ideation. Routine screening measures at schools could detect changes in young people's psychological coping and signal risks associated with common mental health disorders

Thirdly, professionals should watch out for covert signs of help-seeking during formal or informal consultations. Discrete concerns, however small, should be acknowledged and questioned as this might reduce distress and open up access to useful resources. Improved knowledge of coping patterns can also assist gatekeepers to identify covert signs of help-seeking. Participants in this study disclosed that young people lack opportunities to discuss their issues and feel that their problems are often overlooked. Therefore paying closer attention to young people could prompt a dialogue that might reveal signs of distress. Encouraging the expression of concerns could be especially useful for groups that were identified as likely to help-negate, individuals who are not forthcoming, withdrawn or seemingly independent, and have difficulties in recognising signs of mental health problems. Outreach and taking mental health provision *to* young people might have to be necessary as those who need help are often the least likely to seek it (Rickwood et al., 2005).

Lastly, Price (2016) suggested for professionals to conceive themselves as facilitators of help, enquiry and someone who can assist young people with problem-solving. Young people might be more likely to approach gate-keepers for help or information if gatekeepers are widely recognised for their resources. Respecting their decision to follow their advice or recommendations should be granted. However, implications should also be discussed. The present findings showed that young people value confidentiality, safety and trusting relationships. Professionals should bear this in mind and deliver an environment

that enhances trust and safety. Alternatives for reaching out to young people with lower social engagement and preference for more anonymous forms of help-seeking should also be promoted and provided. Internet access to online services, phone help-lines or counselling services that are located in the private areas of the school could decrease help-negating (Rickwood et al., 2005).

5.4.2 Implications for Service Development

The present study yielded help-seeking patterns in young people. These findings encapsulated young people's views on the availability, accessibility and preferences for support services. It showed that young people respond differently to psychological distress. Explicating this understanding on to a service pathway that categorises help-seeking as a part of coping could provide professionals with transparent ways of working and help them to identify the individualised needs of young people better. It could also enhance staff's understanding of their responsibilities as gatekeepers to mental health services, and assist in the identification of young people that are at risk but help-negate. This pathway could be shared with young people and increase their mastery of coping and adaptive help-seeking. Enabling young people to be better informed about their patterns of coping could increase their self-efficacy, reduce stigma and increase their engagement with services and their development. A conceptualisation of pathways could help healthcare providers and mental health gatekeepers to adopt a more unified approach. It could assist in creating interventions that allow for individual differences, signal and monitor risk, signpost young people and gate-keepers towards support or advice and identify maladaptive coping. Consequently, this would improve safeguarding practices and multi-agency communication.

The present findings observed age differences in help-seeking that are consistent with the psychological and social changes in adolescence. Importantly it showed that young peoples' coping styles are subjected to their development, new experiences, and changing beliefs, therefore could change from day-to-day. Healthcare professionals or gate-keepers should not presume that young people would cope with psychological distress in the same manner as it was observed in the past. Thus professionals should be vigilant of changes in young people's coping and provide support that is flexible. Illustrating the dynamic components of help-seeking could inform professionals about the changing needs of young people and prevent stereotyping.

Teachers or youth workers often go beyond the remit of their responsibilities and competencies and assist young people with mental health issues (Hanley, Winter &

Burrell, 2017; IPPR, 2016). Increased mental health literacy amongst teachers as well as informal gatekeepers, including parents, could lead to positive outcomes. For instance, if gatekeepers had increased awareness of signs and symptoms of distress, it could make it easier to identify existing or emerging mental health issues in young people. It could also reduce gatekeepers' own stigma towards mental health issues and improve their negative attitudes towards help-seeking.

According to the precepts of the 'transformation agenda' for children and adolescent services as initiated by the Future in mind report (DH, 2015), schools and mental health professional should be actively involved in the design and decision-making process of the mental health services with local authorities. However, the *Education, education mental health* report (Thorley, 2016) highlighted that only one-quarter of schools were aware of the transformation plan in their area, yet less than 40% of those aware were involved in planning and service delivery. The report stated:

> This is symptomatic of a wider disconnect between health commissioners and the education system. This evidence suggests that the transformation agenda has yet to translate into a significant improvement in schools' involvement in the planning and delivery of mental health services to children and young people in collaboration with other commissioners, providers and partners. (Thorley, 2016, p. 27)

Improving communication between schools, mental health professionals, local authorities, social services and other agencies is therefore paramount to improved service delivery. Clear guidelines and shared resources that are easily accessible by all agencies could improve this communication and help all to work towards a common goal. Defining our understanding of coping and help-seeking is an attempt to improve communication between young people, mental health professionals and schools, to identify common trajectories.

Improvement of communication between agencies is pertinent especially at current times due to the rapid expansion of English schools classified as academies. Since the passing of the Academy Act in May 2010, the number of secondary schools classed as academies grew dramatically (Thorley, 2016), estimating just over 2000 out of 3,381 schools to be classed as academies in 2016. According to changes to the governmental policy, it is expected that by 2022 all schools will become academies and local authorities would not be involved in their management (Department for Education, 2018). Academies are independent schools that receive their funding directly from the government, rather than their local authority and have "greater freedom to commission a range of services according to their particular preferences and the nature of their pupils" (Thorley, 2016,

p.27). Charitable bodies, known as academy trusts, oversee the organisation of academies and provide them with strategic planning, advice and support. However, the UK government has very little influence on the provision of mental health services in academies. Lacking a governmental commissioning body that regulates the quality of school-based mental health provisions could further increase fragmentation and poor communication between services.

The extent of the promotion of mental health and well-being varies across schools. The UK Office for Standards in Education (OFSTED) is an inspection body that regularly monitors standards in schools and has a strong influence on school policies. Recent changes to the OFSTED framework mirrored the precepts of the 'transformation agenda' and revised standards with a view to improving to the quality of mental health provision at schools (Ofsted, 2015). However, a recent analysis of OFSTED reports showed a predominant focus on academic attainment (Thorley, 2016), with only 32 per cent of reports making an explicit reference to pupils' mental health and emotional wellbeing. Thus schools direct most of their already limited budget and resources towards educational outcomes, leaving schools insufficiently incentivised to promote mental health provisions. This could be to the detriment of young people's mental health as they are under pressure to perform well. A similar sentiment was captured in the present findings when participants reported that the school is more interested in their grades than in young people's wellbeing.

5.4.3 The Role of Counselling Psychology Within the 'Transformation Agenda'

Psychologists and particularly counselling psychologists are well equipped to understand the range of issues involved in coping and help-seeking, as a typical undergraduate psychology training involves studying the field of positive psychology and concepts such as self-esteem, self-efficacy and relationships with others in help-seeking. Moreover, counselling psychologists undergo intensive applied training in varied therapies, typically including humanistic and cognitive behavioural therapies. These therapies were identified as effective ways to facilitate coping. Counselling psychologists, therefore, have the understanding and skills to facilitate positive coping in young people and to identify signs and symptoms in individuals who are negating help.

Most UK counselling psychology doctoral training courses acknowledge the benefits of an integrative approach to therapy and encompass it into their training. The integrative approach merits humanistic values that are present in person-centred therapy and suggests that it is not the case that one-size-fits-all (James & Amato 2013; Cooper & McLeod,

2011; Cooper, 2009). Moreover, it acknowledges the benefits, variability and appropriateness of multiple therapeutic approaches that are available in clinical practice. Pluralistic interventions include a range of third-wave interventions that combine cognitive-behavioural and humanistic approaches. These are, for example, Dialectical Behaviour Therapy [DBT], Acceptance Commitment Therapy [ACT], and Compassion Focused Therapy [CFT]. These therapies facilitate positive change and increase self-confidence in a gentle but proactive way when merged with principles of humanistic approaches and focused on the importance of self-acceptance, mindfulness, assertiveness and compassion in therapy. Counselling psychology embraces diversity and issues of social justice and pays attention to individual phenomenological experiences, needs, beliefs and wishes (Moller, 2011). This understanding is especially useful to assist with covert help-seeking, as psychologists are trained to facilitate exploration of underlying behaviours of patients and identify patterns of social interaction, including coping style, withdrawal, denial or avoidance. Contributing their expertise to the shared action plan would improve service delivery, interventions, prevention and multi-agency communication. Vigorous training on the mental health needs of young people should be ensured and consistent across all universities that provide doctoral training in counselling psychology.

Further, counselling psychologists are well equipped to disseminate information to formal and informal sources of support. They can facilitate training days at schools on mental health issues and focus on the most common mental health difficulties found among young people, including depression, anxiety, stress, eating disorders, suicide and self-harm. Talks could encourage discussions amongst students and gatekeepers and reduce stigma around mental health.

5.5 Chapter Summary

The discussion chapter summarised the main findings of this study and interpreted them according to a theoretical understanding of psychological coping in young people in relation to access to support services. An overview of the current literature on coping and help-seeking was discussed, and this highlighted the importance of mediators to psychological coping that influence young people's need for support. These were: personal attributes; the roles of formal and informal sources help-seeking; attitudes, facilitators and barriers to help-seeking. Lastly, the implications and recommendations of the present findings were discussed in relation to clinical practice, service development and the field of counselling psychology, reflecting the views and preferences of young people.

CHAPTER 6.

CONCLUSION

6.1 Introduction

This final chapter provides a brief summary of the key findings of the present study and the extent the stated research question has been addressed. Contribution to knowledge will follow highlighting original points that this study brings to the existing literature. Section three looks at the limitations of the present study. This chapter ends with listing a number of directions for future research.

6.2 Summary of the Thesis and Findings

The aim of this study was to give young people aged 11 to 16 years a platform to voice in their views and experiences towards wellbeing and mental health services based at their school and community, as established in the introduction these views are currently underrepresented in current literature. This study was hoping to deliver findings that provide a deeper understanding of young people's needs and wishes in relation to their mental health. The research question focussed on the aspects of *availability, accessibility and usefulness of* mental health support for young people.

The context for the present study was introduced in the *Introduction Chapter* explicating the rationale for the present study and detailing the nature of the research questions. An overview of key literature was aimed to establish a basis for this study's rationale. In particular, the background information encompassed a current understanding of wellbeing and mental health in adolescence, mental health services that are available to young people and their views and experiences of these services. Definitions of the key terms used in the research were also explained. The chapter concludes with an overview of the structure of the thesis to provide direction and to facilitate clarity.

The Literature Chapter adopts an inductive approach and provides a research review of the three main areas concerned in this study. Firstly it provided an overview of the current research on young people's views and experiences towards the UK's mental health. Secondly, it reviewed literature research on mental health difficulties in adolescence and described how young people are defined in this study. It also highlighted the importance of adolescence as a period of change due to its susceptibility to mental health difficulties and why it deserves our attention. Further protective and risk factors present in

adolescence were discussed. Lastly, this chapter reviewed the literature on the current landscape of mental health services available to young people in the UK.

The Methodology Chapter outlined the methodology of the present study and detailed the research design with consideration of its ontological and epistemological stance. This study is in line with the ethos and values of counselling psychology that holds humanistic and phenomenological values and adopts a pluralistic stance towards therapy and research (Cooper & McLeod, 2011; James & Amato, 2013;) and therefore embraces the worldview that there are multiple truths or ways of understanding of the same phenomenon in question. The epistemology of the present study aligns with the principles of social constructivism (Burr, 2015) and acknowledges the importance of development and learning in relation to social interactions with others. *The methodology chapter* provided a detailed description of methodological procedures for sample selection, data collection, and the protocol used for data analysis. The data was collected through semi-structured interviews and later analysed through thematic analysis (Braun & Clarke, 2006). Further, the ethical issues that were pertinent to this study and their management were reviewed together with the trustworthiness criteria for this research alongside the measures used to determine scientific rigour.

The Data Analysis Chapter provides findings of the present study that were constructed through thematic analysis. One Central Theme was constructed that was interlinked with a further three master themes and eleven related sub-themes. The central theme was labelled *Patterns of Help-seeking Behaviours in Young People* that was characterised by three sub-themes *Perceived Need for Support, Resilience and Self-confidence,* and *Individual Differences.* The Master Theme 1. *Available Support and Services* had two associated sub-themes *Support Available at School* and *Support Available in Community.* The Master Theme 2. *Young People's Views and Preferences for Mental Health Care* had four related subthemes *Benefits of Support, Adequacy of Support, Staff's Attributes* and *Service Development*. The Master Theme 3. *Services* and *Barriers to Accessing Support* was defined by two sub-themes *Insufficient Support* and *Stigma and Negative Consequences.* Most of the subthemes were further clustered into sub-categories, amounting to a total of a further nineteen subthemes.

The Discussion of Findings Chapter is concerned with a discussion of the main findings that are summarised and interpreted in relation to the current literature. The key themes suggested that young people were aware of the benefits of psychological support. They identified the need for more services and provided a comprehensive list of helpful and unhelpful features of support, both on the interpersonal and service-user level. This study

mapped out patterns of help-seeking behaviours in young people that were characterised by their perceived need for support, resilience, confidence and individual differences. Identified barriers to accessing support were lack of services, long waiting lists and perceived stigma. Young people appeared to favour precepts of person-centred care as they want to feel valued, respected, listened to, encouraged to make shared decisions, be involved in collaborative planning and be supported in self-management. It was suggested that young people know what is best for what they need in terms of mental health support. Their awareness of their help-seeking behaviours highlighted the importance of their input in areas of service development and delivery. These findings were reviewed with the current literature on help-seeking and coping as it became apparent that these two fields of research are complimentary despite evolving separately. Together with the reviewed literature, the present study argues that the concepts of coping and help-seeking are inherently connected and should be considered together in service development in order to improve young people's access to mental health services. A discussion of the theoretical understanding of psychological coping is also provided. Lastly, the study's implications and recommendations are included with a particular focus on clinical practice, service development and the role of counselling psychology. Importantly, these reflect the wishes and preferences of young people voiced in the present study. This study proposed that having defined pathways to support could highlight features of formal and informal help-seeking, as well as attitudes, barriers and facilitators of help-seeking in young people and lead to improved and timely access to mental health support.

The next section provides a brief overview of the unique contributions of this study, followed by the limitations and directions for future research.

6.3 Contribution to Knowledge

At the time of completion of this study, the importance of young people's views towards mental health services was nationally recognised (Young Minds, 2018). In recent years, mental health services for young people have been undergoing radical changes in their delivery, especially since the introduction of the transformation agenda (DH, 2015). One of the recognised aims of the agenda was to improve service user's involvement as it leads to improved quality of care and outcomes of services (NHS, England, 2017). Young people repeatedly requested to be an active part in planning and development of services and their views have attracted increased research interest in recent years (Kendal, Milnes, Welsby, & Pryjmachuk, 2017; Coates & Howe, 2016; Coates & Howe, 2014). This study aimed to further this discussion and contributed evidence on young people's views and

preferences towards mental health services that were available to them in school and community settings. Consistent with the reviewed literature, the present findings showed that young people expressed a need to have agency in their own care, treatment and recovery (Young Minds, 2018). Furthermore, this study detailed specifications for helpful and unhelpful aspects of mental health care. For instance, young people voiced a preference for trained professionals who respect their views and experiences and offer confidential support. A need for an individualised approach to care planning and service development was identified as well as opportunities to take part and make their own decisions.

The current findings reiterated the extensive body of literature on help-seeking behaviours in young people. For example, identified themes showed young people's reliance on their teachers, friends, family and other professionals for support and are aware of the benefits of psychological support. Their engagement with support services depends on numerous mediating factors and perceptions towards help-seeking. It was identified in this study and the existing literature that young people cope with psychological distress differently and do not always engage in formal or informal help-seeking (Rickwood, Deane, Wilson & Ciarrochi, 2005). Building on Rickwood et al. (2005) findings, this study mapped out patterns of help-seeking behaviours of young people that were mediated by a perceived need for support, resilience, confidence and individual differences. Identified barriers to accessing support were lack of services, long waiting lists and perceived stigma. The present findings were in line with an extensive body of literature on coping and help-seeking. The study of coping and help-seeking in young people and adults has been an area of long-standing research interest and has been effectively investigated over the last thirty years (e.g. Taylor & Broffman, 2011; Pride, 2016; Taylor & Stanton, 2007; Folkman & Moskowitz, 2004). Help-seeking has been identified as a way of coping with psychological distress. However, the literature on coping and help-seeking evolved separately (Rickwood et al., 2005).

The inductive conceptualisation of the present findings looked at these two study fields and highlighted the importance of understanding young people's help-seeking in the context of psychological coping. Young people’s likelihood to engage with help-seeking and consequent accessing of support was linked with a number of factors including personal characteristics, such as age and gender, attitudes to help-seeking, facilitators and barriers to help-seeking. The current findings suggest complex relationships between these factors and further investigations are required to determine them more clearly. An

understanding of this interaction could help health professionals to provide more tailored interventions to young people who seek help or tend to help-negate.

6.4 Limitations of the Study and Directions for Future Research

This section looks at the limitations of the present study and offers recommendations for future research.

A potential limitation of this study relates to the broad focus of the research question and the discussion of the findings. The analysis yielded a significant amount of codes that categorised young people's attitudes, views and experiences of mental health services into a master theme *Help-seeking Behaviours* that was interlinked with the three main themes *Available Support, Young People's Preferences for Support* and *Barriers to Support*. Although all the themes reflected the views and experiences of young people towards mental health services, the discussion of the findings focussed predominantly on the patterns of help-seeking behaviour among young people. This could be attributed to the design of the research question as it targeted a wide area of interest, including participants' views and experiences on availability, accessibility and usefulness of mental health services. Narrowing the scope of the research question and a focus on one area at the time would provide more comprehensive results. For example, semi-structured interviews asking questions solely around the availability of mental health support could have stimulated more in-depth discussion around formal and informal sources of support and young people's awareness of such services. Similarly, a focussed exploration of the accessibility of mental health services could yield a fuller picture of facilitators and barriers to support services. Lastly focussing solely on the usefulness of services could yield answers of what young people think and feel about them.

Furthermore, the interview questions were predominantly concerned with young people's use of school-based provisions. Specifically questions 1 to 7 asked participants about their views and experiences of support they receive at school. Only question 8 asked about provisions that were based outside of participants' school. Therefore the semi-structured interviews failed to encourage a balanced exploration of participants' views and experiences of services inside and outside of their school. Information provided to the participants also lacked a definition and a specification of what constitute mental health services at school and in the community. Originally this was a part of the study's design as this research was interested in what young people consider in relation to mental health services. However, clarity of the parameters of mental health services would define a common language between the study's aims and participants' understanding of the research

interest. Arguably, this has led to a collection of second-hand data reflecting views and experiences of young people that had limited access to community services. Approaching participants within community mental health services would have been more representative.

Participants' demographic information was purposefully not collected and accounted for in the analysis. Therefore the findings are tentative in relation to participants' age, gender, race cultural reference, or socioeconomic status and require further exploration. Participants' personal experiences of mental health and physical difficulties were also omitted from the analysis in order to protect their anonymity. In hindsight, this information would strengthen the connections between the identified themes or provide new explanations for current findings.

The sample recruitment process could also be scrutinised for a potential bias associated with the school representative's assumptions and attitudes towards this study. Although this study aimed to ensure a representative sample as specified in the eligibility criteria, the final selection process was conducted through a third party. Students' willingness to participate in the study might have reflected their relationship with this particular gatekeeper, whether to its advantage or detriment. Moreover, the school representative had their own responsibilities towards the school and preconceptions that were likely reflected in the decision-making process, impacting on which pupils were chosen for the study. However, an independent route to recruitment was constrained due to the confidentiality limitations relevant to this particular group of participants.

The sample size was in line with the recommendation for the qualitative enquiry. However, the amount of data resulted in broader categorisation of findings, missing the opportunities to explore the richness of young peoples accounts. Further exploration would allow for a closer examination of individual differences and their role in help-seeking and help-negating. A more systematic investigation is required to highlight individual differences in coping and help-negating in girls and boys as well as among different cultures. Young people's age also featured significantly in the present findings. However, it was not systematically evaluated. Thus an investigation of coping strategies at different stages of young people's development, across early, middle and late adolescence could be beneficial. This could be particularly beneficial to enhance our understanding of engagement of services in early versus late adolescence. Also focusing on a smaller amount of participants through the means of a more nuanced analysis, such as an interpretative phenomenological analysis, could provide additional information that was potentially missed in the present study.

In addition, it is important to bear in mind that the present study represents the views of a small number of participants that were based in a particular demographic location. In 2016-17 the school was allocated PP for 39% of pupils suggesting a large number of students in a need of additional support from the school. The school appeared to allocate a significant amount of resources towards their well-being and mental health provision. However, a significant number of participants reported a shortage of mental health resources. Further exploration of the extent of the mental health provision that was available and their demand would provide a more complete picture. Collecting data from multiple sources, also referred to as triangulation of data, would ensure more credible data. For example, interviewing school teachers, parents, carers or school providers would increase the validity of the study (Guion, Diehl & Mc Donald, 2013). This study would further benefit with other credibility checks, such as the researcher's triangulation or member checking.

Importantly research that focuses on young people's views in isolation should be carried out routinely and globally. It would reflect views of a more representative sample and also detect changes in young peoples preferences cross-culturally. Only ongoing research can keep up-to-date with new legislation, advances in technology and the forever changing needs of young people.

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APPENDICES

Appendix AA*a*: Brief Description of the School Involved in the Study

Total number of pupils	1496
Ofsted rating	Good
Number of pupils eligible for Pupil Premium [PP]	742 (Over 37% of the school community)
Total PP budget	£767,772
	SUPPORT AVAILABLE AT SCHOOL
The Access & Achievement Department Staff: **Curriculum Leader;** **The Special Needs Co-ordinator (SENCO);** **Specialist SPLD teacher;** **Teaching assistants**	▪ After school interventions ▪ Short-term intervention ▪ Learning programmes delivered in withdrawal sessions including some off-site provision, additional support in the classroom or other learning interventions developed on an individual needs basis. Aim to develop independent working, greater confidence and raised self-esteem.
THE PASTORAL EXPERIENCE	Each student is in a Tutor Group with a tutor who acts as the key point of contact for parents and staff for all matters relating to the students in that form. Form tutors work closely with their tutees and have an overview of academic progress and emotional well-being. Each Year group is led by a Head of Year who has overall responsibility for the progress, monitoring, safety and welfare of students in the Year group.
LEARNING MENTORS	A Learning Mentor is attached to each Year group. The mentors work closely with the Heads of Year to offer one to one support and group work sessions to students, as well as offering another point of contact for parents.
THERAPEUTIC ROOM	School's trained team delivers play and art sessions to individuals and groups of students who may be dealing with personal issues such as bereavement or having difficulty engaging in lessons.
TRANSITION TO COLLEGE	Full support available to pupils in the College Application process.
SAFEGUARDING TEAM	The safeguarding team works to ensure that students' emotional, physical and welfare needs are being adequately met. The team works alongside Children's Social Care and a wide range of other agencies to put quality interventions in place where students and their families require additional support out of school.
HEALTH ADVISER [HA]	HA offers a range of services for students including healthy eating, smoking cessation, sexual health, and contraception. Furthermore the HA provides the school with health information and support for students with medical conditions.
OTHER	The school has a number of web links and useful contact numbers.

Appendix AA*b*: An Example of PSHE & Life Skills Curriculum Programme for Year 11

YEAR 11	Autumn 1	Autumn 2	Spring 1	Spring 2	Summer 1
Strand	Living in the Wider World	Living in the Wider World	Living in the Wider World	Health & Well-Being	Health & Well-Being
Life Skills Lesson	Goal Setting Building Skills for the Future Careers Options and the World of Work Kudos and Careerscape	Careers and options The World of Work and how it is changing Job Satisfaction Where to get information and advice Building Skills as a Learner College Applications	Diversity Discrimination Rights Laws Liberties and Justice Financial Capability	Personal Attributes Health & Hygiene Goal Setting Building Skills for the Future	Revision and Exam Preparation - being enterprising about how you learn Healthy Body, healthy mind
Session 1	Developing employability skills - time management	Taking full advantage of work experience opportunities	The unacceptability of all forms of discrimination,	What is self-confidence and self-esteem?	How to manage stress - with reference to exam preparation
Session 2	Developing employability skills, self-organisation, presentation,	Volunteering opportunities in the local area	The need to challenge discrimination in the community	Evaluate how our self-esteem and self-confidence are affected by the judgements of others.	Stress management - tips for exams
Session 3	Developing an online presence	Rights and responsibilities at work	The need to challenge discrimination in school and in the workplace	How can we feel better about ourselves?	Stress management - tips for exams
CDI FRAMEWORK MAPPING	LO1 - recognise what you have to offer LO2 - be positive about your own story LO3 review and reflect on how you have benefitted as a learner from careers and work related learning LO10, LO11, LO12; LO15	LO4 - Explain key ideas about careers LO5 - explain how work is changing LO6 - explain different types of business LO7 - find relevant job and labour market information LO15	LO8 - Recognise and Challenge Stereotyping	LO12 - show that you can be enterprising in the way you learn	LO12 - show that you can be enterprising in the way you learn

Appendix AB: Letter to the Parents informing them about the Study

Letter to Parents

Dear Parent(s) Or Guardian(s):

I am writing to tell you about a study that is being carried out in our school by a researcher from the University of Manchester. The researcher wants to ask some of our students what they think about the help available in and outside school for young people who have worries, or are going through difficult times. We are therefore contacting parents of a few students who may, or may not have had worries or difficulties, to tell them about this study and consider giving us permission to ask their child if they would like to take part.

The study is titled: **Young People's Perceptions Towards Services that Support Wellbeing and Mental Health.** If you would like to learn more about this study, an information sheet is enclosed with this letter.

This project will be conducted at [School's Name] over [Date] to [Date] but the young people will take part in only one interview. This interview will last between 30 and 45 minutes. Students will be asked whether they know about the support available in school or elsewhere. They will also answer questions on how they feel about this sort of support at their school. The interview will give our students a chance to comment on how they feel about support for wellbeing and mental health that is available to them and their classmates. They will not be asked about any current or past worries or difficulties they have had. For more information about the study please read the attached 'Participation Information Sheet'.

If you decide that your child may be asked whether they would like to take part in the study you should sign the Consent Form (attached) by the [Date] and return it to me in the enclosed envelope.

If you are not interested in learning about the study, and/or do not want your child to be asked whether they would like to take part in an interview, you do not need to take any action.

Your child will not be approached about taking part in the study without your permission.

Sincerely,

Appendix AC: Participation Information Sheet for Parents, Caregivers & Teachers

MANCHESTER 1824

The University of Manchester

30.01.2017

Participant Information Sheet for Parents / Caregivers

Study Title:

Young People's Perceptions Towards Wellbeing and Mental Health Services

Your child is being invited to take part in a research study conducted by a student, trainee counselling psychologist Lucia Fernandez-Arias from the University of Manchester as a part of her doctoral thesis. The aim is to examine young people's perceptions towards wellbeing and mental health services available to them at their schools and in their community.

Please take time to read the following information carefully and ask questions about anything you do not understand before deciding whether your child can participate. Your child will also be asked his/her permission. Your child can decline to participate, even if you agree to allow participation. You and/or your child may also decide to discuss it with your family or friends. If you and/or your child decide to participate, you will both be asked to sign the consent and assent form. Please keep this copy for your information.

Thank you for taking the time to read this.

Who will conduct the research?

Researcher: Lucia Fernandez-Arias

Manchester Institute of Education
Ellen Wilkinson Building
The University of Manchester
Oxford Road, Manchester M13 9PL.

What is the purpose of the research?

This study examines young people's experiences and opinions on wellbeing and mental health services that are available to them at their schools and their communities. The risk of developing mental health problems increases as children grow into teenagers and so it is important they can get some support if they need it. Therefore if we can learn about what young people need, want and think about issues relating to well-being and mental health we could contribute to the improvement of current or future services and provide help that is better tailored to their needs.

Why have your child been chosen?

The researcher is interested in different views and experiences young people might have when they experience worries or are going through difficult times and about the help that is available to them in and outside of school. This study is interested in how young people perceive sources of support available to them relating to well-being and mental health difficulties.

Your child is one of a number of students who is being invited to take part, to represent a range of the following characteristics of young people that are attending secondary school: students that may or may not have mental health or physical difficulties; are of age between 11 to 16 years old;

are either males or females; and come from various ethnic and cultural backgrounds. The selec process will be negotiated by the school representative in line with their ethical and confidenti policies and the researcher will **NOT** have access to the any of your child's personal informa mentioned above.

What would your child be asked to do if he/she took part?

If your child and you decide to take a part, he/she will be invited to participate in an interview the above-mentioned researcher, which will last approximately 30 to 45 minutes. The interview take place at your child's school at a day and time that is convenient for them and will not a their learning. The researcher will ask questions regarding their experiences, thoughts and feel towards wellbeing and mental health services at their school and communities such as counse services. There are no foreseeable risks to take part in this research, and there is no obligatio answer any questions in the interview that your child does not want to answer.

What happens to the data collected?

The interview will be audio recorded (using a Dictaphone), and later will be transcribed by researcher into text. After the transcription this audio recording will be destroyed and no vo recorded evidence of the interview will be kept. The transcribed document would be passv protected and your child's personal details anonymised so your child's identity would be protec Those transcripts would be stored for five years at the University of Manchester archives destroyed afterwards. The transcription will be analysed using thematic analysis to summarise issues about wellbeing services that participants bring up in the interview. Participants will have option of reviewing these themes to ensure the summarised information represents the sort things they were saying.

How is confidentiality maintained?

All information your child will share will be private and protected. To ensure confidentiality anonymity all audio recordings will be transcribed into a word document. These files wil password protected (encrypted) and stored securely at the University of Manchester. Only researcher will have access to these files. Audio recordings will be then destroyed.

Any paper copies of data will be locked securely in a cupboard, which only the researcher will h access to. Collected data will not be shared with anyone else other than the researc Pseudonyms (false names) will be used if participant quotes are included in the report. identifiable information for participants will be used at any point in the research process.

All collected data will be destroyed five years after dissemination of the findings.

What happens if your child does not want to take part or change his/her mind through ou the study?

It is up to your child and you to decide whether or not to take part. If you both decide to take pa you will be given this information sheet to keep and be asked to sign a consent/assent form.

If you decide to take part you are still free to withdraw at any time without giving a reason.

Will your child be paid for participating in the research?

There is no financial reward for taking part in this study.

What is the duration of the research?

Your child will take part in a single interview with the researcher, which will last for approximate 30 to 45 minutes.

Where will the research be conducted?

The interview will take place in a quiet room at your school. Your child can choose to have teaching assistant or other member of school staff to attend the interview with his/her if preferred.

Will the outcomes of the research be published?

Findings from the study will be published in a Doctorate thesis at the University of Manchester ar some of the information will be published in scientific journals.

Who has reviewed the research project?

This project has been reviewed by the University of Manchester Research Ethics Committe 1/2/3/4/5/.

What if I/my child want to make a complaint?

Minor complaints

If there are any issues regarding this research your child/you should contact the researcher in the first instance:

Lucia Fernandez-Arias: lucia.hrmlova@postgrad.manchester.ac.uk.

Or please contact the research supervisor Dr Alison Alborz at alison.alborz@manchester.ac.uk

Formal Complaints

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact the Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 2046.

What Do I Do Now?

If you have any queries about the study or if you are consenting for your child to take part in this study then please contact the researcher, by emailing:
lucia.hrmlova@postgrad.manchester.ac.uk.

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC reference number].

Appendix AD: Participation Information Sheet for 11-12 Years Old

MANCHESTER 1824

The University of Manchester

Participant Information Sheet

Young People's Perceptions Towards Wellbeing and Mental Health Services

I am inviting you to take part in this study that is for my doctoral studies at the University. I want to find out what young people at your school think about wellbeing and mental health services. Before you decide whether to say 'yes' or 'no', it is important you should understand why the research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. Please ask if anything is not clear or if you want more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will do the research?

I, Lucia Fernandez-Arias will do the research. I am a student from the University of Manchester. I have been given DBS clearance. This means the government have said I'm OK to do work and research with children and young people.

Manchester Institute of Education
Ellen Wilkinson Building
The University of Manchester
Oxford Road, Manchester M13 9PL.

What is the research for?

I am interested in the views of young people at your school towards wellbeing and mental health services because I want to find out how we can help to improve these services for them in the future. Wellbeing services are any help that young people can get when they feel sad or unwell in a way that is hard to explain to other people.

Why have I been chosen?

You have been invited to participate because you might have an interesting views and opinions about this topic.

What would I have to do?

You will take part in an interview with me, which will last about 30 to 45 minutes. The interview will take place at your school on a day and at a time that doesn't affect the things you need to do at school. I will ask you questions about your experiences, thoughts and feelings towards support for wellbeing at your school and outside of school - such as counselling services.

What happens to the things I say at my interview?

The interview will be audio recorded and then transcribed (typed out) by the researcher. The recording will be then destroyed. The transcript will be analysed to summarise the points that you and other students have made about support at school.

How is my information kept private?

All information you will share with me will be private and not shown to others. I will give an ID number to the transcript of your interview. If I include what you say in anything I write, I will give you a pseudonym (false name) if necessary. Your interview will be stored securely in an encrypted file that is password protected and I will be the only person who has access to this file.

What happens if I say 'no' or change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you should keep this information sheet and sign the assent form. If you decide to take part you can still drop out of the interview or ask for your information to be deleted for up to two weeks after your interview. You don't have to give a reason for dropping out and this will not affect the things you do at school in any way.

Will I be paid?

There is no payment for taking part in the study.

How long will I have to take part?

You will take part in just one interview with me. The interview will last for about 30 to 45 minutes.

Where will the interview take place?

The interview will take place in a quiet room at your school. You can ask for a teaching assistant or other school staff member to stay with you during the interview if you wish.

What if I want to complain about the research?

For a small complaint, you (or your parent/carer) can email either:

Me, at lucia.hrmlova@postgrad.manchester.ac.uk.

Or my supervisor, Dr Alison Alborz at alison.alborz@manchester.ac.uk

For a big complaint, or if there are any problems you don't want to talk to me or my supervisor about, you can email or call the University manager:

Research Governance and Integrity Manager
email: research.complaints@manchester.ac.uk
Phone: 0161 275 2674 or 275 8093

What should I do now?

If you have any questions about the research please contact me, and I will give you some answers.

If you want to take part, please sign the 'Assent Form' that is with this information. You should give your Assent form to….XXXXXX by …date…, and they will help to arrange a time for me to talk to you.

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC reference number].

Appendix AE: Participation Information Sheet for 13-16 Years Old

MANCHESTER 1824

The University of Manchester

29.03.2016

Participant Information Sheet

Young People's Perceptions Towards Wellbeing and Mental Health Services

You are being invited to take part in a research study as a part of a Doctorate Thesis in Counselling Psychology. The aim is to explore the perceptions of young people towards wellbeing services available to them at their schools and in their communities.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

I, Lucia Fernandez-Arias will conduct the research. I am a student from the University of Manchester and I have had a clear DBS check. This means I'm OK to do research with young people.

Manchester Institute of Education
Ellen Wilkinson Building
The University of Manchester
Oxford Road, Manchester M13 9PL.

What is the purpose of the research?

This study examines young people's experiences and opinions on wellbeing services that are available to them at their schools and outside school. The overall aim is to enhance our understanding of young peoples needs and preferences that can lead to an improvement of current mental health services.

This study is interested in support for wellbeing in school and also what the youth mental health services in your area offer. I am interested in how young people perceive these sources of support.

Why have I been chosen?

This study is interested in views and experiences you and other young people might have when experiencing difficulties or seeking help for your problems. You have been invited to take part because your school teacher suggested that you may have interesting views about this topic.

What would I be asked to do if I took part?

If you decide to take a part, you will be interviewed by me. This will take approximately 30 to 45 minutes. The interview will take place at your school on a day and time that is convenient for you. The researcher will ask you questions regarding your experiences, thoughts and feelings towards wellbeing services at your school and outside school, such as counselling services.

What happens to the data collected?

The interview will be audio recorded and later on put into a written form by the researcher. The audio recording will then be destroyed. The transcription will be analysed to summarise the issues about wellbeing services that you and other participants bring up in interview. You will have the option of reviewing these themes to ensure the summarised information represents the sorts of things you were saying.

How is privacy maintained?

All information you will share with me will be private and will not be shared to others. The information you disclose will be completely anonymous throughout the research process.

To ensure confidentiality and anonymity all audio recordings will be transcribed into a word document. These files will be password protected (encrypted) and stored securely at the University of Manchester. I will be the only one to have access to these files. Audio recordings will be then destroyed.

Any paper copies of interviews will be locked securely in a cupboard, which only I will have access to. Collected data will not be shared with anyone else other than the researcher. Pseudonyms (false names) will be used if quotes from your or any other interview are included in the report.

All collected data will be kept at the University but destroyed after five years.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you should keep this information sheet and sign the consent form. If you decide to take part you can still withdraw up to two weeks after the interview, without giving a reason. Withdrawing from the study will not affect you in any way at school.

Will I be paid for participating in the research?

There is no payment for taking part in the study.

What is the duration of the research?

You will take part in a single interview with me, which will last for approximately 30 to 45 minutes.

Where will the research be conducted?

The interview will take place in a quiet room at your school. You can choose to have a teaching assistant or other member of school staff to attend the interview with you if you wish.

Will the outcomes of the research be published?

Findings from the study will be published in a Doctorate thesis at the University of Manchester and some of the information will be published in scientific journals.

Who has reviewed the research project?

This project has been reviewed by the University of Manchester Research Ethics Committee 1/2/3/4/5/.

What if I want to make a complaint?

Minor complaints

If there are any issues regarding this research you should contact the researcher in the first instance:

Lucia Fernandez-Arias: lucia.hrmlova@postgrad.manchester.ac.uk.

Or please contact the research supervisor Dr Alison Alborz at alison.alborz@manchester.ac.uk

Formal Complaints

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact the Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 2046.

What Do I Do Now?

If you have any queries about the study or if you are interested in taking part then please contact the researcher, by emailing: **lucia.hrmlova@postgrad.manchester.ac.uk**.

If you would like to take part in an interview, complete and sign the attached Consent form. Give this form to……. by….date…. They will arrange a time for me to come to do an interview with you.

Appendix AF: Parental Consent Form

ASSENT-PARENTAL PERMISSION

Young People's Perceptions Towards Wellbeing and Mental Health Services

If you are happy for your child to participate in this study please complete and sign the consent form below.

	Please Initial Box
1. I confirm that I have read the attached information sheet about the study and had the opportunity to think about the information and ask questions, and had these answered satisfactorily.	
2. I understand that my child's participation in the study is voluntary and that he/she is free to withdraw at any time without giving a reason. I understand that this will not affect their schoolwork in any way.	
3. I understand that the interview will be audio recorded and that the recording will be destroyed once the researcher transcribes the interview into text where my child's personal details will be anonymised.	
4. I agree that anonymous quotes from my child's interview may be included in any reports or articles written about the findings.	
5. I agree that any data collected may be shown to the research supervisor.	

I agree that my child can be invited to take part in this study.

Parent / caregiver's Name	Date	Parent / caregiver's Signature
School representative's Name	Date	School representative's Signature
Researcher's name	Date	Researcher's Signature

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [Ref: 2017-0231-2935].

Appendix AG: Participant Assent Form

ASSENT FORM

Young People's Perceptions Towards Wellbeing and Mental Health Services

If you are happy to participate please complete and sign the assent form below.

	Please Initial Box
1. I have read the information about the study. I had a chance to think about the information and ask questions and was happy with the answers.	
2. I know that I do not have to take part in the study if I don't want to. I know that I can drop out at any time up to two weeks after my interview, and do not have to give a reason. I know that this would not affect anything I do at school.	
3. I know that my interview will be audio recorded and that the recording will be destroyed once the researcher transcribes the interview into text, where my personal details will be anonymised.	
4. I agree that some of the things I say in my interview can be put into reports and articles, provided that no one will know that I said those things.	
5. I agree that my interview document (which won't show my name) may be shown to the research supervisor.	

Yes, I would like to take part in the above project

Write your name here	Date	Write your Signature here
School representative's Name	Date	School representative's Signature:
Researcher's name	Date	Researcher's Signature

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [Ref: 2017-0231-2935].

Appendix AH: Recruitment Process & Assent/Consent Procedure

The sample selection

The sample selection will be negotiated with the head teacher and the appointed school representative in line with the inclusion and exclusion criteria specified below. This process will be done anonymously and participants' experiences would be only disclosed in the interview if they choose to do so. It has been agreed with the school representative that she will draw on her own knowledge and judgment to select the sample and therefore no medical or other records would have to be accessed to identify the sample and breach confidentiality.

The appointed school representative would identify young people that they know:

- are currently in good health
- have accessed support, mental health or wellbeing services at their school or in the community in the past
- have long term conditions (regardless of whether they have accessed this type of support)
- may be open and approachable to talking about services.

The appointed school representative would also identify young people:

- that have no known mental health issues or other conditions
- known to be able to represent their own, or their peer's opinions and attitudes comfortably, for instance, a class representative.

A sample representing secondary school students with the following characteristics would be sought, but cannot be guaranteed:

- Experiences of:
  - ***Past mental health issues*** (≥ 3)
  - ***Long term conditions*** (≥ 3)
  - ***No known MH issues or other conditions*** (≥ 2).
- Equal gender distribution over the sample ensuring the following groups are represented:
  - 11 to 12 years old
  - 13 to 16 years old

- The overall sample to include students from various ethnic, cultural and religious backgrounds.

Assent and Consent procedure

- The appointed school representative will send a letter to the parents/guardians of the 20 identified children and ask them for their permission to approach their son/daughter about taking part.
- The letter will briefly outline the purpose of the study and offer the participant information sheet to those who want to learn more about it (Letter is uploaded in the documents below). The PIS and consent form would provide more information.
- If parents want to give their consent for their child to be approached about participation, they would be asked to sign an attached consent form and send it back to the school representative.
- Parental consent will be required from parents of all prospective participants, therefore, the 'Gillick' competency assessment would not be required.
- Once the consent is obtained the school representative will approach the identified young person and explain the research aims and objectives. The young person will then have some time (5 days) to think about it and take the PIS and assent form home to make their decision. If they decide to participate they will return the signed assent form to the school representative.
- Afterwards, the interview will be arranged with the young person through the school representative.
- At the interview, the researcher will ask the participants if they still want to participate in the study and sign the assent form in their presence, so the assent form will have three signatures – participant's, school representative's and researcher's. The researcher will explain the aims and objectives of the research again to the participant.
- Where invitations to approach a child about participation are not agreed by parents, or child assent is not given, the school representative will identify additional students who fit the criteria, and the same process of contacting parents for permission to approach their child about taking part, and child PIS and assent procedures will be followed.

Recruitment process and Interviews

- A maximum of 20 participants will be recruited from the school.
- All participants who are offered and accept the invitation would be included in the study.

- Interviews will be arranged in collaboration with the school representative to ensure that they are scheduled for a convenient time that is not disruptive to either the student's learning or the school timetable.
- One to four interviews will be scheduled per day, amounting up to a maximum of 20 days of interviewing.
- After the first set of interviews (arising from the 20 invitations to take part) the researcher will assess whether the collected data is sufficient, audible and adequate. If the data is inadequate, or resulted in fewer than 8 interviews, a second wave of interview invitations will be undertaken through the school representative. However, the data will not be analysed at this stage to prevent potential bias that might occur during the 2nd wave of interviewing (e.g. confirmation bias; question-order bias; leading questions and wording bias).
- This process will repeat until a satisfactory sample - a minimum of 8 participants and a maximum of 20 participants is obtained.

Sample characteristics sought in the identified school			
Sample	Known past wellbeing/mental service use	Long term conditions	No known MH issues or other conditions or known service use
Number of Participants	≥ 3	≥ 3	2
Gender ratio	• Males: ≥ 1 • Female: ≥ 1	• Males: ≥ 1 • Female: ≥ 1	• Males: 1 • Female: 1
Age of participants	▪ 11 to 12 yrs: ≥ 1 ▪ 13 to 16 yrs: ≥ 1	▪ 11 to 12 yrs: ≥ 1 ▪ 13 to 16 yrs: ≥ 1	▪ 11 to 12 yrs: 1 ▪ 13 to 16 yrs: 1

Appendix AI: Interview Questions

Thank you, for agreeing to take part in this research. The interview will take about **30** to **45** minutes but if you want to stop you can do this at any time. Just let me know. There is no problem with this.

About the questions

I want to hear what are your thoughts and experiences of well-being and mental health services that are available to everyone at your school and also those that are available near where you live.

What I mean by well-being and mental health services is any sort of support for young people who are worried about problems that affect them.

I would like to hear what you know about these services and your thoughts and feeling about using them.

There are no right or wrong answers to these questions; I just want to know what students like you think about these things.

What is mental health and well-being?

Mental health refers to person's psychological and emotional state. Our well-being reflects how we feel about ourselves, others and things that are going on for you and how well you can cope with your day-to-day life. Our mental wellbeing is **dynamic.** It can change from moment to moment, day to day, month to month or year to year.

If you have good mental wellbeing you are able to:

- Feel relatively confident in yourself and have positive self-esteem
- Feel and express a range of emotions
- Build and maintain good relationships with others
- Feel safe and engaged with the world around you
- Live and study productively
- Cope with the stresses of daily life
- Adapt and manage in times of change and uncertainty

<table>
<tr><th colspan="3">INTERVIEW QUESTIONS</th></tr>
<tr><td>1.</td><td colspan="2">What does well-being mean to you?</td></tr>
<tr><td>2.</td><td colspan="2">What do you think a boy/girl in your class would do if they had problems or worries at school?
▪ [Prompt] Can you tell me more about that?</td></tr>
<tr><td>3.</td><td colspan="2">Who can you talk to about problems or worries at school?</td></tr>
<tr><td rowspan="3">4.</td><td colspan="2">Have you ever talked to someone about your worries when you were at school?</td></tr>
<tr><td>Answer - YES</td><td>Answer - NO</td></tr>
<tr><td>How did you feel about talking to others about your problems?
[Prompts]:
▪ Was it helpful?
- In what way?
- What did they do that was helpful?
▪ Was it unhelpful in any way?
- Did anything make you feel more worried or unsure?
- What sorts of things made you feel this way?
▪ Why did you think that about it all?</td><td>Have you ever had worries that you would have liked to talk to someone about in school?
▪ Answer – YES [Prompts]:
- Why didn't you talk to someone?
- What would have been helpful?
- Was anything helpful?
- What did you do instead?
▪ Answer – NO [Prompts]
- What do you do if you have any worries?
- How does that help?</td></tr>
<tr><td>5.</td><td colspan="2">What would be important to you if you ever felt like you did want to talk about your worries at school?
[Prompt] Can you tell me more about that?</td></tr>
<tr><td>6.</td><td colspan="2">Do you think your school offers enough support for you and the other students?
▪ What do you think, feel about that?</td></tr>
<tr><td>7.</td><td colspan="2">Do you think your school helps students to feel good about themselves and their lives?
▪ [Prompt] What more do you think can be done?</td></tr>
<tr><td rowspan="3">8.</td><td colspan="2">Have you ever talked to someone about your worries outside of school?
▪ [Prompt] For example, through the doctor or from a youth service?</td></tr>
<tr><td>Answer - YES</td><td>Answer - NO</td></tr>
<tr><td>▪ Was this helpful?
- In what way?
- What did they offer that was helpful?
▪ Was it unhelpful in any way?
- Did anything make you feel more worried or unsure?
- What sorts of things made you feel this way?
▪ Why did you think that about it all</td><td>Have you ever had worries that you would have liked to talk to someone about outside of school?
▪ Answer – YES [Prompts]:
- Why didn't you talk to someone?
- What would have been helpful?
- Was anything helpful?
- What did you do instead?
▪ Answer – NO
Do you know if there is anyone to talk to about worries outside of school?
[Prompt] For example, through the doctor or a youth service?
- What do you do if you have any worries?
- How does that help?</td></tr>
</table>

AJ: Ethics Approval

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Ref: 2017-0231-2935

24/05/2017

Dear Miss Lucia Fernandez-Arias, , Dr Terry Hanley, Dr Alison Alborz

Study Title: Views and experiences of young people towards mental health services

University Research Ethics Committee 5

I write to thank you for submitting the final version of your documents for your project to the Committee on 16/05/2017 17:45 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Additional docs	Interview Schedule	20/10/2016	IS1
Additional docs	Distress Policy	20/10/2016	DP1
Additional docs	Participation Information Sheet	20/10/2016	PIS1
Additional docs	Participant Information Sheet (11-13 years old)	20/10/2016	PIS 11&13yrs
Additional docs	Recruitment Plan	20/10/2016	RP1
Additional docs	Consent Form	01/11/2016	CS1
Topic Guide	Interview Schedule	01/11/2016	IS2
Topic Guide	Recruitment Plan	06/11/2016	RP1
Participant Information Sheet	Participation Information Sheet	13/11/2016	PIS2
Participant Information Sheet	Participant Information Sheet (11-13 years old)	13/11/2016	PISYA
Consent Form	Consent Form	13/11/2016	CF1
Distress Protocol/Debrief Sheet	Distress Policy	13/11/2016	DP
Lone Worker Policy/Procedure	Fieldwork%20Risk%20Assessmen%20Form	21/11/2016	FRA
Additional docs	Fieldwork%20Risk%20Assessmen%20Form	21/11/2016	FRA1
Topic Guide	Recruitment Plan (Updated)	27/11/2016	RPU
Consent Form	Assent Form (Participants)	28/11/2016	AF
Topic Guide	Interview Schedule	10/05/2017	I.S. Corrected
Participant Information Sheet	PIS Participants 13-16 yrs Corrected	10/05/2017	Corrected
Consent Form	ASSENT-PARENTAL PERMISSION Corrected	11/05/2017	Corrected
Consent Form	Participants Assent Form Corrected	11/05/2017	Corrected
Additional docs	A Sample Letter to Parents	11/05/2017	1.
Participant Information Sheet	PIS Participants 11-12 yrs Corrected	12/05/2017	Corrected
Participant Information Sheet	PIS Parents Corrected	12/05/2017	Corrected
Consent Form	Confirmation from Chorlton High	12/05/2017	2
Participant Information Sheet	Recruitment Process & AssentConsent Procedure	12/05/2017	Corrected
Additional docs	Revised EDUCM1140 Research Proposal	12/05/2017	Corrected

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

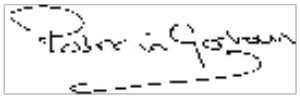
1. Amendments
2. Breaches and adverse events
3. Notification of progress/end of the study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a **UREC Feedback Form**. Instructions for completing this can be found in your approval email.

We wish you every success with the research.

Yours sincerely,



Ms Patricia Gorham

Secretary to University Research Ethics Committee 5

Appendix AK: Ethics Approval – Use of Transcription Services

****Please ensure you read the contents of this message. This email has been sent via the Ethical Review Manager (ERM) system on behalf of the University of Manchester.****

Dear Miss Lucia Fernandez-Arias,
Thank you for submitting your amendment request on 27/11/2017 09:37 for project: 2017-0231-4372 ;
entitled: Views and experiences of young people towards mental health services which has now been approved. Your documentation has been suitably updated to reflect the proposed changes, please ensure you use this documentation.
Please note that if you have submitted revised supporting documents to accompany your amendment request, the approved versions of these are listed in a table below.

Document Type	File Name	Date	Version
Additional docs	1st_Class_Tarriff_010917	23/11/2017	1st Class Tariff
Additional docs	ClientCharterSeptember2017	23/11/2017	1st Class T&C

We wish you every success with the research.
Best wishes,
Mrs Patricia Gorham
Secretary to University Research Ethics Committee 5

Appendix AL: Distress Policy

Distress Policy: Interview

Prior to the interview

- I will have a list of numbers of suitable organisations to refer the participant to should distress occur
- Ongoing informal consent will be prioritised throughout the process.

Low level distress

Indicators of low level distress:

- The participant states that they are experiencing some stress or distress
- Fidgeting
- Poor eye contact
- Crossed body language

Action that will be taken:

- If requested by the interviewee, stop the interview immediately and only resume with agreement.
- Check with the participant periodically if they are feeling OK to carry on.
- If the participant feels able to continue, resume the interview.

Medium level distress

Indicators of medium level distress:

- The participant states that they are experiencing stress or distress
- Looking tearful
- Visible agitation
- Flushing

Action that will be taken:

- If requested by the interviewee, stop the interview immediately and only resume with agreement.
- Ask the interviewee if they would like to take a break or stop the interview entirely.
- Remain calm and express concern.
- Guide interview away from any apparently more distressing aspects of the discussion.
- Focus on more positive experiences and achievements.
- If the participant feels able to continue, resume the interview.
- Offer a debrief sheet to the interviewee containing contact details for relevant organisations.
- Encourage the participant to make contact if she experiences more distress after the interview.
- Keep supervisor informed of any difficulties.

High level distress

Indicators of high level distress:

- The participant states that they are experiencing high levels of stress or distress
- Uncontrollable crying
- Shaking
- Shouting
- Becoming hostile

Action that will be taken:

- If the interviewee is crying, ask them if they wish to pause or stop the interview.
- If the interviewee is shouting or hostile, pause or stop the interview immediately.
- If the distress subsides, ask whether they would like to arrange another meeting to complete the interview.
- If the distress does not subside, ask no further questions relating to the research project.
- Evaluate whether the interviewee is a danger to herself or others and if deemed to be at risk, contact the emergency services.
- Ask if the interviewee would like to contact a friend, relative or colleague to support them, or offer to contact the supporter on their behalf.
- Offer a debrief sheet to the interviewee containing contact details for relevant organisations.
- Encourage the interviewee to contact a health provider.
- Stay calmly with the interviewee until they feel able to leave the room safely.
- With permission, follow up the interview with a courtesy call.
- Encourage the participant to make contact if further distress is experienced after the interview.
- Keep supervisor informed of any difficulties.

Appendix AM: Transcription Example from the Interviews with Young People

R: So, I'll just put it on the top. Er, so the first question is what does wellbeing mean to you?

P: I think wellbeing is more about sort of a holistic person. So…so being active but also eating right and…

R: Aha.

P: …sort of being able to have useful social relations but not relying too heavily on those social relations, basically being sort of a balanced person.

R: Mmm.

P: So, having good things that make you happy but also doing things that make you a better person. So, sort of having good choices but still enjoying yourself. So…

R: Aha.

P: …sort of perfect mix of doing what is right basically.

R: Aha.

P: …but also thinking about, you know, how people are... No, that's not right [laughs], sorry. No…

R: No, no, it could be, yeah.

P: …I'm thinking about sort of what makes you happy but also what needs to be done.

R: Aha, aha.

P: So, it's sort of making sure the two are balanced…

R: Aha.

P: …because if you get too much of a good thing then it can make you, say, fat or unhappy…

R: Yeah.

P: …because you're doing stuff like that, or in jobs, or whatever…

R: Aha.

P: …too much, but if you're doing a mix of the two then if you're doing too much of the sort of stuff you have to do then you get stressed…

Appendix AN: Data Analysis Step 1: Familiarisation with the Data

Preliminary findings.

1. **What does well-being mean to you?**
    a. Health
    b. Happiness
    c. Feeling fine
    d.
2. **What do you think a boy/girl in your class would do if they had problems or worries at school?**
    a. Think room
    b. Talk to teachers/head teachers
    c. Keep it to them self (boys)
3. **Who can you talk to about problems or worries at school?**
    a. People who are identified as supportive
        i. Teachers
        ii. Close Friends
        iii. Mentors
        iv. Parents

    b. Helpful
        i. Relief to share a burden
        ii. Felt understood, validated, listened to
        iii. Someone is there for them
        iv. A space / Opportunity to talk
    c. Unhelpful
        i. A long waiting list
        ii. Mistrust
4. **Have you ever talked to someone about your worries when you were at school?**
    a. Calculate a percentage
    b. Helpful
    c. Unhelpful

5. **What would be important to you if you ever felt like you did want to talk about your worries at school?**
    a. Confidentiality/anonymity
    b. Trust
    c. Transparency
    d. Being approachable
    e. Non-judgemental
    f. Having solutions to their problems
    g. Professional opinions in relation to their difficulties

6. **Do you think your school offers enough support for you and the other students?**
    a. Yes – percentage
        i. Good at talking to pupils
        ii. Always there, watching
        iii. RESPECT
        iv. Measures – positive reinforcement.
    b. Yes but made following suggestions:
        i. More support
        ii. Bigger think rooms/space out
        iii. Opportunities to make more friends
        iv. Doing things outside – fresh air

Appendix AO: Data Analysis Step 2: Generating Initial Codes

Name	Memo Link	Sources	References
(Is there) Enough support at schools according to YP		0	0
No it does not		5	6
YES BUT Areas for improvement		10	13
Yes it does		17	35
Accessing support		2	2
Advisor		1	1
Attributes (service or person offering the services)		3	13
Helpful attributes		4	11
Approachablefamiliar		6	8
Attitudes Willing to Help		12	21
Authority & Power		1	2
Confidentiality		13	20
Empathy		8	10
Experience		13	16
Feeling confortable		16	24
Learning Skills		3	3
Listen & Provide opportunities to talk		17	34
Motivating &positive reinforcement		6	8
Non-judgemental		8	11
Professionalism		10	13
Safety and Trust		10	18
Showing interest in pupils		5	8
Solution focused intervention different perspective		15	29
Unhelpful attributes		1	1
detached, uncomprihensive support		1	1
Giving advice, help		2	2
Not being taken seriously		4	9
Subteachers		2	2
Teachers		1	2
Being unhelpful, not being taken seriously		1	1
Unable to help		2	2
unaware of services or help		2	2
unfamiliar		1	1
Barriers to accessingseeking support		8	20
Age related		1	3
Current system society		2	14
Long waiting lists		4	7
persoanal reservations		3	5
Benefits of addressing problems		10	18
Competition amongst students		2	4
being perfect		1	4
Geneder differences		3	7
Boys		4	6
GD- Solution focussed intervention		0	0
Weakness		1	1
Girls		2	4
GD- Solution focussed intervention		1	1

Appendix AP: Data Analysis Step 3: Searching for themes amongst codes

Name	Sources	References	Created On	Created B
1. Availability of MH and Wellbeing Support	4	9	5 Mar 2018 at 15:53	LFA
Staff at school	1	1	19 Jun 2018 at 12:43	LFA
Mentors	8	16	5 Mar 2018 at 16:23	LFA
Safeguarding	6	8	5 Mar 2018 at 13:44	LFA
Teachers, Head teachers	18	47	5 Mar 2018 at 13:49	LFA
Student services	5	7	19 Mar 2018 at 15:59	LFA
Counselling serivces Brooks	1	4	22 Mar 2018 at 19:...	LFA
Respect- initiative	2	6	19 Mar 2018 at 16:03	LFA
Think room Access & Acheievement Time out Gr...	9	18	19 Mar 2018 at 15:07	LFA
Support available outside of school	1	1	5 Mar 2018 at 15:54	LFA
Family	18	45	5 Mar 2018 at 15:55	LFA
Friends	17	36	16 Mar 2018 at 17:25	LFA
GP, other professionals	5	9	26 Mar 2018 at 17:...	LFA
ONLINE SERVICES	8	11	16 Mar 2018 at 16:55	LFA
2. Accessibility	0	0	19 Mar 2018 at 19:12	LFA
Barriers to accessing or seeking support	0	0	10 Apr 2018 at 17:30	LFA
6. Individual Differences	2	2	9 Apr 2018 at 20:08	LFA
Insufficient support	3	3	10 Apr 2018 at 16:34	LFA
Stigma & Negative consequence	7	11	10 Apr 2018 at 16:23	LFA
No support required or sought	5	5	26 Mar 2018 at 17:...	LFA
3. Usefulness of Current Support to YP	0	0	26 Mar 2018 at 16:...	LFA
8. Benefits of addressing problems	0	0	19 Mar 2018 at 15:40	LFA
Feeling Valued	2	4	22 Jun 2018 at 15:41	LFA
Help to reduce distress prevent MH difficulties	3	3	22 Jun 2018 at 16:10	LFA
Increases Hapiness & Self-esteem	4	5	22 Jun 2018 at 16:21	LFA
Practical Help	1	2	22 Jun 2018 at 16:26	LFA
Relief	8	11	22 Jun 2018 at 15:39	LFA
Addequate Support at School	16	32	26 Mar 2018 at 16:...	LFA
Adequate Support BUT	12	16	3 Apr 2018 at 12:18	LFA
Non-sufficient	5	6	26 Mar 2018 at 16:...	LFA
7. The meaning of 'Wellbeing'	20	50	20 Feb 2018 at 14:...	LFA
Factors	8	17	20 Feb 2018 at 19:...	LFA
Higher purporse	1	2	20 Feb 2018 at 19:...	LFA
positive effects on wellbeing	1	1	20 Feb 2018 at 20:...	LFA

Appendix AR: Data Analysis Step 4: Reviewing Themes

Name	Sources	References	Created On	Created By
1. Availability of MH and Wellbeing Support	4	9	5 Mar 2018 at 15:53	LFA
Staff at school	1	1	19 Jun 2018 at 12:43	LFA
Student services	5	7	19 Mar 2018 at 15:59	LFA
Support available outside of school	1	1	5 Mar 2018 at 15:54	LFA
2. Accessibility	0	0	19 Mar 2018 at 19:12	LFA
Barriers to accessing or seeking support	0	0	10 Apr 2018 at 17:30	LFA
No support required or sought	5	5	26 Mar 2018 at 17:...	LFA
3. Usefulness of Current Support to YP	0	0	26 Mar 2018 at 16:...	LFA
8. Benefits of addressing problems	0	0	19 Mar 2018 at 15:40	LFA
Addequate Support at School	16	32	26 Mar 2018 at 16:...	LFA
Non-sufficient	5	6	26 Mar 2018 at 16:...	LFA
7. The meaning of 'Wellbeing'	20	50	20 Feb 2018 at 14:...	LFA
Balance	3	11	20 Feb 2018 at 19:...	LFA
Factors	8	17	20 Feb 2018 at 19:...	LFA
Unsure	3	6	20 Feb 2018 at 19:...	LFA

Appendix AS: Data Analysis Step 5: Defining Themes

Name	Sources	References	Created On	Created B
7. The meaning of 'Wellbeing'	20	50	20 Feb 2018 at 14:...	LFA
Balance	10	21	20 Feb 2018 at 19:...	LFA
Physical state	12	23	20 Feb 2018 at 14:...	LFA
Psychological state	18	36	20 Feb 2018 at 14:31	LFA
Barriers	0	0	Today, 11:49	LFA
Insufficient support	3	3	10 Apr 2018 at 16:34	LFA
Current system society	1	13	22 Mar 2018 at 19:...	LFA
Lack of interest	6	7	5 Mar 2018 at 16:14	LFA
Lack of services	5	8	22 Mar 2018 at 19:41	LFA
Non-sufficient	5	6	26 Mar 2018 at 16:...	LFA
Stigma & Negative consequence	7	11	10 Apr 2018 at 16:23	LFA
Focus on academic attainment	1	1	Today, 12:09	LFA
Individual Differences	0	0	Today, 11:37	LFA
1. Perceived Need for Support	5	6	5 Mar 2018 at 13:56	LFA
No preceived worries	9	10	5 Mar 2018 at 13:59	LFA
No support required or sought	6	6	26 Mar 2018 at 17:...	LFA
Perceived resilience and confidence	5	10	19 Mar 2018 at 15:30	LFA
Keep it to them self	10	18	16 Mar 2018 at 16:24	LFA
6. Individual Differences	2	2	9 Apr 2018 at 20:08	LFA
Competition amongst students	2	4	5 Mar 2018 at 16:45	LFA
being perfect	1	4	22 Mar 2018 at 19:17	LFA
Geneder differences	3	7	5 Mar 2018 at 13:46	LFA
Boys	5	7	5 Mar 2018 at 13:46	LFA
GD- Solution focussed intervention	0	0	5 Mar 2018 at 14:08	LFA
Weakness	1	1	5 Mar 2018 at 13:53	LFA
Girls	2	4	5 Mar 2018 at 13:47	LFA
GD- Solution focussed intervention	1	1	5 Mar 2018 at 14:07	LFA
Resilience and Confidence	1	1	Today, 11:16	LFA
Mediators of Help-seking Behaviours	0	0	Today, 11:47	LFA
4. Sought out Attributes	4	16	5 Mar 2018 at 13:50	LFA
Helpful attributes	4	11	5 Mar 2018 at 15:38	LFA
Approachablefamiliar	6	8	19 Mar 2018 at 19:35	LFA
Authority & Power	1	2	5 Mar 2018 at 16:27	LFA
Confidentiality	13	23	5 Mar 2018 at 13:52	LFA
Empathy	8	10	19 Mar 2018 at 16:26	LFA
Experience	13	16	19 Mar 2018 at 15:57	LFA
Feeling confortable	16	27	5 Mar 2018 at 13:51	LFA
Learning Skills	3	3	19 Mar 2018 at 16:08	LFA
Listen & Provide opportunities to talk	17	35	5 Mar 2018 at 16:28	LFA
Motivating &positive reinforcement	6	8	3 Apr 2018 at 12:38	LFA
Non-judgemental	8	11	5 Mar 2018 at 15:44	LFA
Professionalism	10	13	5 Mar 2018 at 14:04	LFA
Reliable Attitudes Willing to Help	12	23	5 Mar 2018 at 15:45	LFA

Appendix AT: Data Analysis Step 6: Report Writing

Name	Sources	References	Created On	Created B
CT A. Help-seeking behaviours of YP	0	0	10 Jul 2018 at 11:37	LFA
Individual Diferences	0	0	10 Jul 2018 at 15:07	LFA
AGE	2	2	10 Jul 2018 at 14:13	LFA
Geneder	3	5	5 Mar 2018 at 13:46	LFA
Boys	6	8	5 Mar 2018 at 13:46	LFA
GD- Solution focussed intervention	1	1	5 Mar 2018 at 14:08	LFA
Weakness	1	1	5 Mar 2018 at 13:53	LFA
Girls	2	4	5 Mar 2018 at 13:47	LFA
GD- Solution focussed intervention	1	1	5 Mar 2018 at 14:07	LFA
Race Social Class	1	1	10 Jul 2018 at 14:52	LFA
Perceived need for support	10	16	5 Mar 2018 at 13:59	LFA
Perceived resillience and confidence	15	33	19 Mar 2018 at 15:30	LFA
MT 1. Available Support	0	0	10 Jul 2018 at 11:42	LFA
Community	1	1	5 Mar 2018 at 15:54	LFA
Family	19	48	5 Mar 2018 at 15:55	LFA
Pets	2	3	3 Apr 2018 at 14:09	LFA
Siblings	4	6	19 Mar 2018 at 15:13	LFA
Friends	17	39	16 Mar 2018 at 17:25	LFA
GP, other professionals	5	9	26 Mar 2018 at 17:...	LFA
Therapist psychologist	3	4	19 Mar 2018 at 15:37	LFA
ONLINE SERVICES	8	11	16 Mar 2018 at 16:55	LFA
Brooks	1	1	3 Apr 2018 at 11:57	LFA
Childline	2	2	3 Apr 2018 at 11:57	LFA
School	0	0	25 Jun 2018 at 15:57	LFA
School Initiatives	1	1	25 Jun 2018 at 15:59	LFA
Counselling serivces Brooks	1	4	22 Mar 2018 at 19:...	LFA
Respect- initiative	2	6	19 Mar 2018 at 16:03	LFA
Staff at school	1	1	19 Jun 2018 at 12:43	LFA
Mentors	8	16	5 Mar 2018 at 16:23	LFA
Safeguarding	6	8	5 Mar 2018 at 13:44	LFA
Teachers, Head teachers	18	49	5 Mar 2018 at 13:49	LFA
Student Support services	5	7	19 Mar 2018 at 15:59	LFA
Think room Access & Acheievement Time out Gree...	9	18	19 Mar 2018 at 15:07	LFA
MT 2. Aspects of Mental Health	0	0	Today, 09:11	LFA
8. Benefits of addressing problems	0	0	19 Mar 2018 at 15:40	LFA
7. The meaning of 'Wellbeing'	20	50	20 Feb 2018 at 14:...	LFA
Balance	10	21	20 Feb 2018 at 19:...	LFA
Physical state	12	23	20 Feb 2018 at 14:...	LFA