

**MENTAL HEALTH: YOUNG PEOPLE'S KNOWLEDGE, BELIEFS,
ATTITUDES AND WISHES**

By

Aimée Webster

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ABSTRACT

Adolescents are especially vulnerable to mental health difficulties (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003). The Child and Adolescent Mental Health Service (CAMHS) Review (DCSF & DoH, 2008) highlighted barriers to support including capacity difficulties, stigma, young people's lacking knowledge and a lack of tailored services. Research, demonstrates weaknesses within young people's knowledge and beliefs regarding mental health and mental health support and historically accumulated stigmatising attitudes. A paucity of research also exists on young people's wishes for support (Dogra, 2005; Worall-Davies & Marino-Francis, 2008). The aim of this study is to use a mental health literacy framework (Jorm, 2000) to explore the knowledge, beliefs, attitudes and wishes of a community sample of young people regarding mental health and mental health support. This is to inform prevention and intervention within Hightown Local Authority and Highfields school¹. Adopting critical realism, focus groups and thematic analysis (Guest et al, 2012; Boyatzis, 1998) were used. Main findings illustrate the young people's broad knowledge-base, largely appropriate beliefs and attitudes. Opportunities were revealed for educationally-based, preventative support which enhances detail and security of knowledge, and addresses attitudes in gender sensitive ways. At the intervention-level, preferences were indicated for tiered support, with professional support delivered externally to school. In terms of delivery of support, feeling well-supported was important, along with confidentiality, accessibility, empathy and tailored support to their needs. In carrying forward these findings, the role of the EP, alongside the school and other stakeholders, is exemplified as integral.

¹ Pseudonyms

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CHAPTER 1

INTRODUCTORY CHAPTER

1.1 Background to the research

As part of my training on the Applied Educational and Child Psychology Doctorate at the University of Birmingham, I have completed a two year placement within an Educational Psychology Service (EPS) for Hightown (pseudonym) Local Authority (LA) which is a Metropolitan Borough Council in central England. An assessed requirement of my course is the submission of a thesis containing two volumes. This is the first volume of my thesis and consists of a study commissioned by the Principal Educational Psychologist (PEP) and Highfields school (pseudonym).

Highfields school had identified a significant sub-group of young people in Year Nine, who were presenting with mental health difficulties. Hightown LA also has one of the highest rates of mental health difficulties in people over the age of sixteen (DoH, 2011d). In light of this, the PEP and senior EP staff identified how they would like the EPS to further develop its capacity to meet the mental health needs of young people, by focussing upon the voice of the child. This is in-line with policy priorities within Every Child Matters (DfES, 2003), and the current *No Health Without Mental Health* proposals (DoH, 2011a), as both emphasise the central needs of the child or young person, person-centred planning and the responsibility of a range of organisations, in contributing to good mental health outcomes. It also relates to the United Nations Convention on the Rights of the Child (UN, 1990), which states how young people have a right to express their views on matters affecting them.

Further rationale for tailored mental health support for young people is provided in the literature. Primarily, there is significant, accumulated evidence that adolescence is a sensitive period for the onset of mental health difficulties (Bhardwa, 2013; Brandenberg et al, 1990; Collip et al, 2008; Costello et al, 2003; 2005; Harrop & Trower, 2001; Hill, 1989; Roberts et al, 1998). A number of risks have been considered within research to explain this phenomenon (Bond et al, 2001; Brooks-Gunn & Petersen, 1984; Gerard & Buehler, 1999; Harrop & Trower, 2001; Harvey, 2012; Meltzer, 2007; Spataro et al, 2004). This highlights the need for prevention and early intervention. Literature evaluating the effectiveness of mental health support for young people at different systemic levels, offers some support for a range of preventative and intervention-based support (Barrett & Turner, 2001; Carr, 2009; Chen et al, 2006; Essler et al, 2006; Esters et al, 1998; Green et al, 2007; Gumley et al, 2003; Kramer & Garralda, 2000; Paluska & Schwenk 2000; Pattison & Harris, 2006; Pistrang et al, 2008; Puskar et al, 2003; Squires, 2010; Wells & Stewart-Brown, 2003; Wilson & Zandberg, 2012; Wolpert et al, 2013; Young & Ensing, 1999). Despite these, findings from the CAMHS Review (DCSF & DoH, 2008) highlight capacity difficulties within current support systems, young people's lack of knowledge and awareness regarding support, stigmatising attitudes towards seeking support and a lack of support tailored to young people's needs. Indeed, research has acknowledged the limited knowledge base and restrictive beliefs of young people regarding mental health and appropriate mental health support (Armstrong et al, 1998; Bailey, 1999; Fox, 2005; Fox et al, 2007; 2010; Roose & John, 2003), as well as their negative and stigmatising attitudes (Bailey, 1999; O'Driscoll et al, 2012; Wahl, 2002;). This is particularly evident for males (Armstrong et al, 1998; Burns & Rapee, 2006; Chernets-Taha et al, 2009; Pinfold et al, 2005; Roose & John, 2003). However, to the author's knowledge and as cited within the literature only limited research exists regarding young people's knowledge, beliefs, attitudes and wishes surrounding mental health and mental health support (Boydell et al, 2010; Dogra, 2005; Roose & John, 2003).

Most encouraging, not only due to its success rate but also its exploration of young people's knowledge, beliefs and attitudes to inform preventative mental health support, are mental health literacy (MHL) initiatives (Jorm et al, 1997a). Contained within the objectives of MHL initiatives are intentions to support young people's awareness and knowledge of mental health and mental health support and improve their attitudes towards mental health difficulties and help-seeking (Jorm 2000, Rickwood et al, 2004; Pinfold et al, 2005). The broad frameworks of MHL initiatives to explore young people's perspectives is exemplified by Jorm (2000) and suggests flexibility to incorporate wider enquiries such as the exploration of young people's wishes regarding mental health support.

1.2 Aims

Thus in light of practice, research-based and policy-based rationales provided above, the research aims of this study were to inform preventative and intervention-based practice to meet the mental health needs of young people. Using an MHL framework, this included exploration of young people's knowledge, beliefs, attitudes and wishes regarding mental health, mental health difficulties and mental health support. The specific research questions of the study were the following:

- 1) What do young people know and believe about mental health and mental health difficulties?
- 2) What do young people know and believe about support for mental health difficulties?
- 3) What are young people's attitudes towards mental health difficulties and mental health support?
- 4) In terms of support, what would young people want if they were experiencing mental health difficulties?

1.3 Theoretical and conceptual position

The theoretical and conceptual position of this study is made explicit through references to Cicchetti and Lynch's (1993) ecological-transactional model of psychopathology. As well as acknowledging the complex interplay of factors and multiple systems within pathways to youth mental health difficulties, the structure of the model also relates to the tiered systems of mental health support available in the UK.

Critical realism informs the epistemology of this study as consideration and exploration of the knowledge, beliefs, attitudes and wishes of young people surrounding mental health and mental health support implies a „laminated“ reality (Bhaskar & Danermark, 2006, p. 278), inclusive of objective givens as suggested by current definitions of mental health and the existence of mental health support systems, and subjective understandings.

1.4 Methodology

Focus groups were utilised to collect young people's knowledge, beliefs, attitudes and wishes. Four focus groups consisting of between four and six young people aged thirteen years were included. In light of gender differences highlighted by previous research, two of these groups consisted of all females and the other two, all males. Data was analysed using Thematic Analysis (TA) as informed by Guest et al (2012) and Boyatzis (1998). Further detail and explication is provided regarding of the methodology and analysis in Chapter Five.

1.5 Structure of Volume 1

Chapters Two to Four contain a review of the literature relevant to the study aims. Chapter Two outlines the historical context of mental health including changes in conceptualisations over time and public attitudes. It then goes on to consider, using current conceptualisations, risks and protective factors relating to mental health outcomes in young people and framed within Cicchetti and Lynch's (1993) ecological-transactional model. The breadth of factors considered within this chapter, relate to the themes emerging from the focus groups, so as to appropriately frame their consideration within the literature. Chapter Three then uses this same model to outline and evaluate mental health provision for young people in the UK, which aims to capitalise on some of the protective factors, highlighted in the previous chapter. Following this, Chapter Four explores the knowledge, beliefs, attitudes and wishes of young people regarding mental health and mental health support according to literature findings. Chapter Five, as stated provides an account of the chosen methodology and analysis. Following Banister et al (1994) suggestion that a combination of analysis and discussion is appropriate within qualitative research, Chapter Six follows this structure. For instance, within Chapter Six, five code maps corresponding to the four research questions are provided. Following each of these code maps, emerging themes are analysed and contextualised within research highlighted in the literature review, as well as extant findings. Finally, implications for further research and practice are outlined.

CHAPTER 2

MENTAL HEALTH: CONCEPTUALISATIONS AND YOUNG PEOPLE

Key web-based search terms used: mental*, health, ill*, disorder*, adolesc*, child*, caus*, pred*, protect*.

Search engines used: Google Scholar via The University of Birmingham portal, PsycINFO and ProQuest for Social Sciences. These search engines were chosen for their comprehensibility and relevance to the study. Research making use of both qualitative and quantitative designs and which adequately considered young people's knowledge, beliefs and wishes, based upon sound methodological considerations were included.

2.1 Mental health difficulties: Current conceptualisations and attitudes.

Historical conceptualisations of mental health difficulties and their treatment have influenced public knowledge and attitudes. Indeed, genetic and medical conceptualisations, restraint and segregation have served to set individuals apart as different. Although compassion has been part of public attitude, such conceptualisations have inspired fear and the common belief that people with mental health difficulties are dangerous and unpredictable (Arnold, 2008; Hunter & Macalpine, 1974). Media and popular culture have fuelled this depicting people with mental health difficulties as dangerous (Hylar et al, 1991; Wilson et al, 1999) despite low rates of violent acts committed by people with mental health conditions (Mind & Rethink Mental Illness, 2008).

Other negative beliefs associated with mental health difficulties have included how individuals with mental health difficulties are unable to cope with the stresses and demands of daily life and are in effect, of lower social status (Rusch et al, 2005). These shaming beliefs have informed a long-standing stigma surrounding the experience of mental health

difficulties. Indeed, a review by Rabkin in 1974 highlighted how „the stigma of the label „mental illness“ has been widely documented since the early 1950’s“ and in 1996, Priest and others found that the general public in the UK did not feel comfortable talking to their GP about depressive symptoms for fear they may be judged as unstable. This also relates to self-stigma and motivations to hide mental illness due to one’s own stigmatising beliefs or awareness of society’s. Indeed, self-stigma is a significant barrier to help-seeking (Corrigan, 2004), particularly in males (Vogel et al, 2011).

It can be argued that modern definitions of mental health difficulties attempt to counter these attitudes by integrating biological factors with psychological and social factors. Indeed, the World Health Organisation’s (WHO) International Classification of Diseases (ICD), (WHO, 1993) the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) and current government policy (DoH, 2011a) recognise the interplay of these factors.

2.2 Definitions

Mental health can be personally (Jahoda, 1958), socially (Szasz, 1974) and medically defined; the latter of which focuses upon the absence of mental health difficulties. A number of definitions, descriptions and models therefore exist. Older literature (Jahoda, 1958) emphasises how more personal factors are important to mental health, including perceptions of the self and the world so as not to make „undue demands or impositions on others“ (p. 136)

In contrast, MacDonald and O’Hara’s Ten Element Map (1998) asserts how mental health is dependent upon both personal and social factors as well as emotional stability and security. For instance, within the Ten Element Map, environmental quality, self-esteem, emotional processing, self-management skills and social participation are included and argued to be relevant in promoting mental health.

A widely-used definition of mental health which incorporates all of the above factors relevant to mental health is that supplied by the World Health Organisation (WHO) (2013). It defines mental health as:

„A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to (their) community.“

Thus mental health is a vital component of daily life and functioning which has consequences on both an individual, collective and economic level (Tolan & Dodge, 2005). This agrees with literature which argues mental health is not just the absence of impairment but includes personal and social skills that promote „optimal functioning“ (Kazdin, 1993, p.128). Indeed, it is asserted by the WHO that mental health is additional to the absence of mental illness (WHO, 2015).

The WHO (2011) defines a mental disorder as:

„A clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference in personal functions“ (WHO, 2011, p87).

This is in line with the Diagnostic and Statistical Manual-V (DSM-V) criteria of mental disorders which makes reference to clinically significant distress and impairment of functioning (APA, 2012) leading to persistence and endurance of difficulties (APA, 2000).

Within this study „mental disorder“ is consumed under the umbrella term „mental health difficulty“. This is to convey not only the author’s position, but recognises continuum models of mental health in which mental health extends to mental difficulty along a continuum of severity, from sub-clinical and transient difficulties to clinically significant ones.

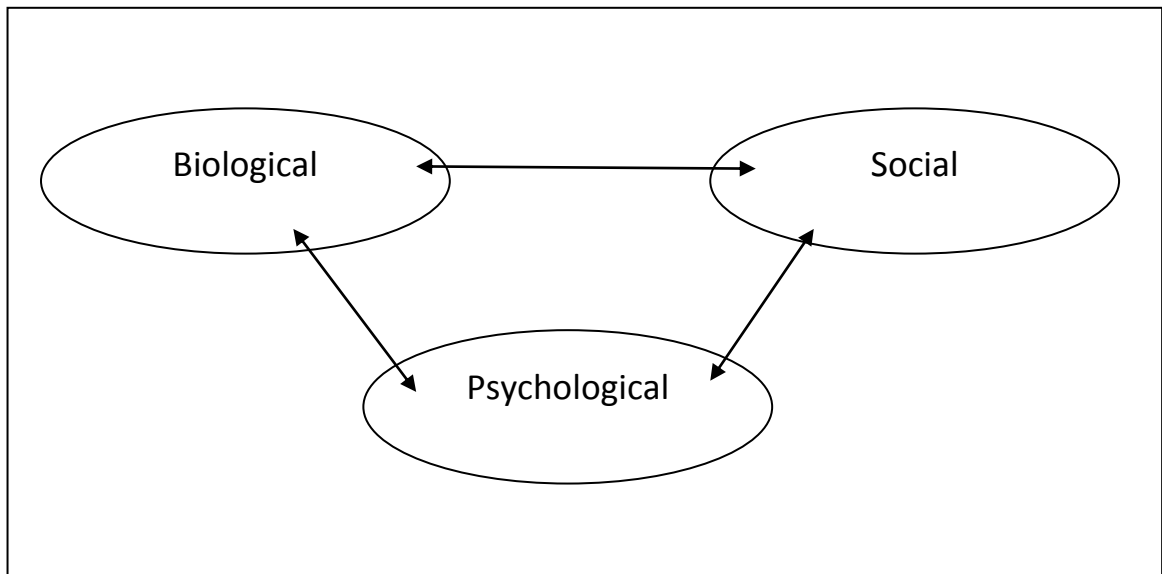
2.3 Modern conceptualisations: Theoretical models

Modern conceptualisations of mental health and mental disorder have also contributed towards negating damaging societal attitudes. For instance, biopsychosocial conceptualisations have been put forward (Engel, 1977), providing a more holistic rather than purely medical consideration. Salutogenic models, which focus upon factors constituting mental health, and continuum models, (Antonovsky, 1979; van Os et al, 1999) have also contributed to positively reframe mental health and create normalisation.

2.3.1 The biopsychosocial model

The evidence-base for biological causes of mental health difficulties has been found to be lacking such as the differing international rates of disorders like schizophrenia (Bhugra, 2005) and the confounding effects of medication on the brain which has undermined neurological theories of mental disorder (Moncrieff, 2002; 2007). Indeed, Read et al (2004) argues that the assumption that neurological insult or impairment is causal to mental illness is both unsubstantiated and ignores psychological and social causes which interact with biological factors to lead to mental health difficulties.

Figure One: The biopsychosocial model



Thus the biopsychosocial model was a reaction to the biomedical accounts of mental health difficulties, acknowledging multiple causation rather than specific pathogens, which also took account of social and psychological risks (Engel, 1977; 1980). With reference to Figure One, the biopsychosocial model put forward by Engel (1977) recognises that each factor is equally relevant within pathways to mental health difficulties (Ghaemi, 2009). Physiological as well as mental symptoms are acknowledged, with the interaction of factors, most significant and different according to individual differences (Gilbert, 2002). In this sense, the biopsychosocial model is pathogenic-focussed, and is a dominant model utilised within psychiatry (Kendler, 2010). Indeed, the biopsychosocial model is utilised in clinical research which makes use of diathesis-stress models. This is seen in van Os and colleague's (2009) proneness-persistence-impairment model, where social stressors interact with genetic vulnerabilities to result in clinical psychosis.

Criticisms of this model surround its eclectic nature and the freedom with which it provides practitioners to emphasise certain factors over others (Ghaemi, 2009). However, this may be compensated for by findings that social and psychological factors are powerful within the aetiology of mental health difficulties (Birchwood et al, 2000).

2.3.2 Salutogenic and pathogenic conceptualisations

More recently salutogenic models seek to identify resources which are protective against stressors and maintain mental health (Antonovsky, 1979; Becker et al, 2010).

Acknowledging some of the facets of the biopsychosocial model, and in-line with the position of this study with regard to mental health difficulties, salutogenic approaches explain how personal resources, together with protective and supportive environmental factors, interact with stressors, to result in varying life-time mental health outcomes, which exist along a disease-ease continuum (Antonovsky, 1979; 1985; 1996).

Such assets-based theories are recommended to inform mental health promotion (Lindstrom & Eriksson, 2005) such as those seen in schools (Wells & Stewart-Brown, 2003) as well as wider policy objectives put forward by the WHO, which address community-wide health inequalities (Harrison, et al, 2004) . Salutogenic and pathogenic approaches are not in opposition to one another rather, they are complimentary (Buch, 2006) and equally important (Becker et al, 2009). For instance, like that of pathogenic models, the ultimate goal of salutogenic approaches is to move individuals towards the healthy outcomes (Antonovsky, 1996). Thus as well as promotion-based approaches, prevention and intervention approaches which acknowledge risks are also part of the salutogenic package. This is represented in Figure Two which illustrates how different forms of mental health support direct or redirect individuals towards wellbeing according to their position on the disease-ease continuum.

Figure Two: Health in the River of Life (Eriksson & Lindstrom, 2008)

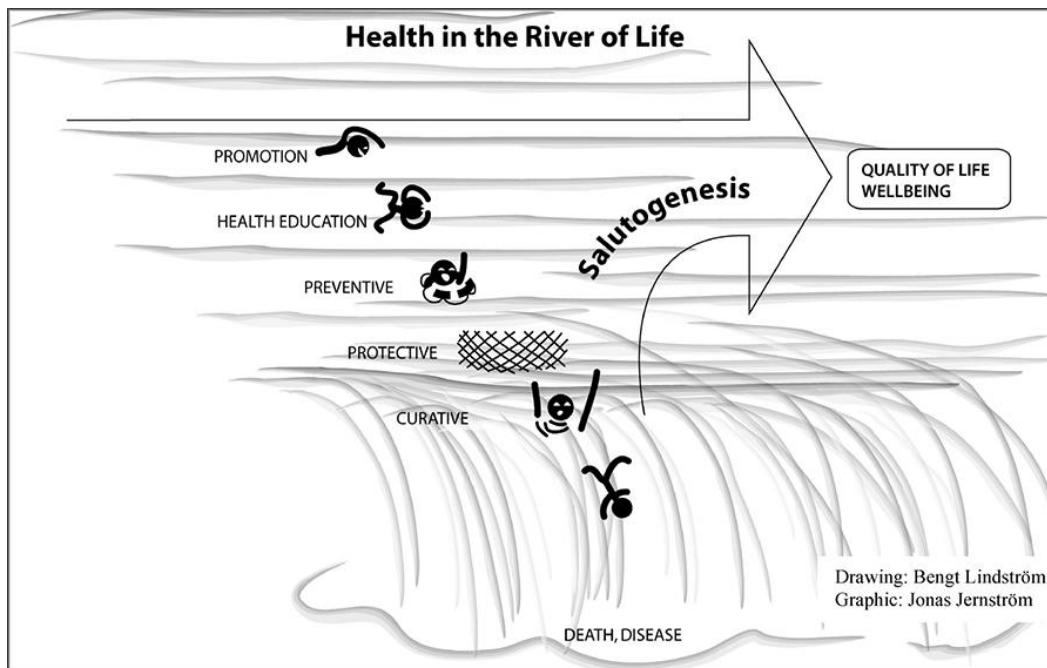
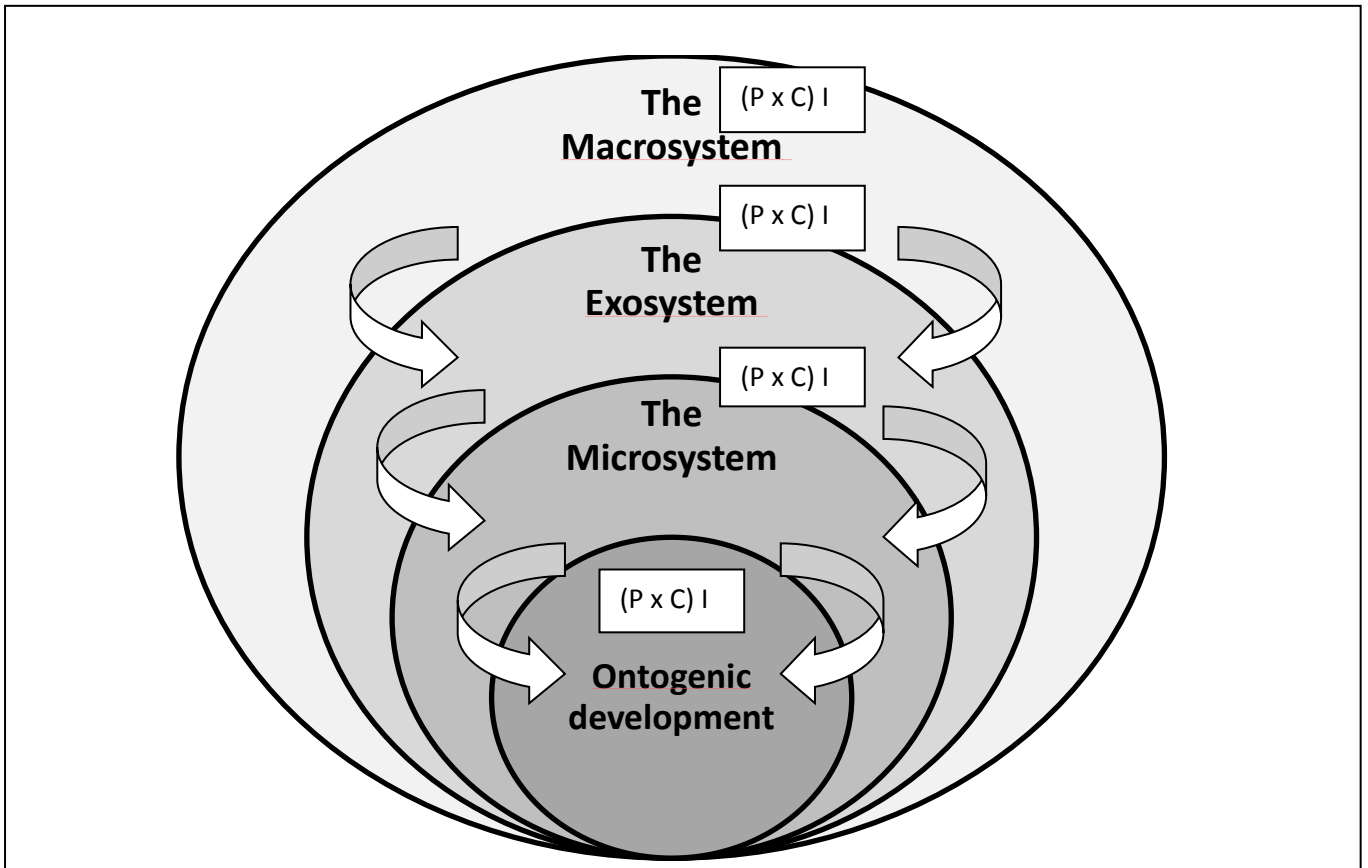


Image shown with the permission of Professor Lindstrom.

From large scale review studies, some support is given for the relationship between personal resources highlighted by this theory, and good health outcomes (Eriksson & Lindstrom, 2005). Indication is therefore given, that other factors are, to some extent contributory.

2.3.3 The ecological-transactional model.

Figure Three: Cicchetti and Lynch's (1993) ecological-transactional model.



NB: P- potentiating, C- compensatory, I- individual.

Cicchetti and Lynch's (1993) ecological-transactional model of psychopathology can encompass both the biopsychosocial and salutogenic/pathogenic models. It acknowledges biological, social and psychological potentiating factors, which are moderated by compensatory factors, which in-turn interact within increasing ecological systems around the individual. Ecological layers include individual processes at the Ontogenic level, familial processes in the Microsystem, the interaction of community and familial processes at the Exosystem and cultural values and beliefs within society at the Macrosystem level (Lynch & Cicchetti, 1998).

Similarly to the biopsychosocial model, the ecological-transactional model claims that it is the interaction and *transaction* of factors between ecological layers which is significant and impingent upon Ontogenic development (Cicchetti & Lynch, 1993; Cicchetti, 1989). How proximal or distal, transient or enduring, potentiating and compensatory factors are, has consequences, respectively for adaption-maladaption (Lynch & Cicchetti, 1998).

The continuum and complexity of mental health outcomes is explained with reference to individual differences and concepts of multi-finality and equi-finality. Dependent upon systemic differences, the former relates to how an isolated factor can lead to different outcomes and the latter how a number of factors can lead to the same outcome (Cicchetti & Rogosch, 1996; von Bertalanffy, 1968).

Much empirical support exists for this model in terms of risks and protective factors at different ecological levels (Osofsky, 1995; Cicchetti & Toth, 1993; Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1992). For instance Lynch and Cicchetti (1998) found relationships over a year-long period between community violence, child maltreatment and children's mental functioning.

As an all-encompassing model of mental health, its comprehensibility can be seen as both a strength and a weakness. On the one hand, it can provide a systematic framework for research but on the other it is merely a summary of the models of mental health which currently exist. In addition, its comprehensibility does not easily differentiate it from other theories and models. A further criticism of this model is that it does not necessarily show where to target support for mental health difficulties, as it can be argued that all systems, proximal or distal are relevant to the individual. Decisions of where to introduce support then rests with services which may be limited in resources and power, leaving them only influential to effect change within more proximal or local levels. This suggests the ecological-transactional model is more of a descriptive model rather than a directive one. Indeed, research exists to describe relevant

factors within the Macrosystem which may impact upon one's mental health (Cicchetti & Toth, 1997; Warner, 2004; Perlick et al, 2001) but unlike biopsychosocial and salutogenic models, little exists to conceptualise approaches to mental health support. Finally, the emphasis within this model upon individual differences which adds a caveat that mental health outcomes vary widely, can give a rather elusive impression. This is also seen in individual compensatory factors such as resilience which has been criticised for being instable and lacking in an agreed definition (Luther et al, 2000).

Considering some of the limitations of the ecological-transactional model and the purposes of the following chapters; to outline risks and available mental health support, it seems appropriate to make use of its encompassing, descriptive and systematic framework.

2.4 Young people

Consistent findings within research have noted that the age of onset for mental health difficulties is around childhood and adolescence (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Brandenburg et al, 1990; Hill, 1989; Roberts et al, 1998; Kessler et al, 2007). Worldwide prevalence rates during this time have been found to be as high as between 10 and 20 percent (Kieling et al., 2011) although wide variance is acknowledged within research (Costello et al, 2005). Within the UK an epidemiological and longitudinal study by (Meltzer, 2007) incorporating representative samples found a prevalence rate of 9.5 percent amongst young people aged five to fifteen years. This equated to one in ten young people having an ICD10 disorder including emotional, conduct, hyperkinetic (Attention Deficit and Hyperactivity Disorder, ADHD) and any other psychiatric disorder such as Autism, Pervasive Developmental Disorder, tics and eating disorder. Findings of the most common mental health difficulties encountered by young people include depression, anxiety, ADHD, eating disorders, conduct disorder and substance misuse (Doll, 1996; Costello et al, 2003; Ford et al, 2003; Fombonne, 2003). Indeed within the UK, upward trends in prevalence rates around this period have also been found (Collishaw et al, 2004; Busfield, 2012; Maughan et al, 2008).

Across England, there does not appear to be significant differences in the mental health status of young people and older adults, however, the area in which Hightown LA resides, appears to have one of the highest rates of mental health difficulties (DoH, 2011d).

Developmental psychology and neuroscience research has informed knowledge regarding youth vulnerability to mental health difficulties. From a developmental perspective, adolescence is a period of significant change (Elkind, 1967; 1978). Historically, much emphasis was placed upon physiological changes that occur in adolescence such as puberty to explain mental health difficulties (Brooks-Gunn & Petersen, 1984; Hall, 1905, Freud, 1969; Kestenberg, 1967). Indeed, pubertal changes trigger hormonal responses which are postulated

to play a part in behavioural and emotional changes (Bethea et al, 2002) and the higher rates of anxiety and depression found in females (Paus et al, 2008).

Social expectations and objectives change as an adult role supersedes the child's. Lapsley et al (1989) highlights these processes, describing how adolescents attempt to separate attachment ties with caregivers, individuate an identity and participate in increased socialisation to form stronger relationships with peers and establish romantic relationships. These challenging processes relate to descriptions of the „storm and stress“ (Elkind, 1967; 1978) of adolescence. The maturation of these processes has also been found to relate to sub-clinical psychotic-like experiences, with the achievement of these goals suggested to be protective against mental health difficulties (Harvey, 2012; Harrop & Trower, 2001; Fox, 2007).

Neuro-developmental research also acknowledges significant brain-based changes during adolescence and as a consequence, suggests the likelihood of mental health difficulties. Examples of these changes include structural changes in grey and white matter (Giedd et al, 1999; Pfefferbaum et al, 1994), changes in brain activity relating to delayed gratification (Steinberg et al, 2009) and theory of mind development (Blakemore et al, 2007) and changes in neural connectivity (Menon et al, 2005). Invoking a „moving parts get broken“ (p.954) explanation, Paus et al (2008) argue how mental health difficulties likely arise from anomalies or exaggerations of these neurological maturations which interact with other biological and psycho-social risks. Similar to the proneness-persistence hypothesis (van Os et al, 2009) which explains how developmental sensitivity to mental health difficulties in adolescence combines also with genetic risk-variability to result in persistent difficulties, Paus et al (2008) argue genetic factors may be influential upon neurological development. Indeed, compelling evidence exists regarding genetic factors from multivariate twin studies in which only a small number of shared genes were found to account for substantial variance across a number of neuroanatomic structures (Schmitt et al, 2007).

In line with the individual and environmental factors relevant to adolescent vulnerability, the following sections will now use the ecological-transactional model to discuss potential risks leading to mental health difficulties as well as protective factors.

2.5 Contributory risk and protective factors of mental health difficulties in young people.

2.5.1 Ontogenic development

Gender seems to be influential in mental health outcomes during adolescence. For instance, overall, incidence rates of any mental disorder are higher in males, particularly conduct disorder (Meltzer, 2007; Scott, 1998). For females, generally higher rates of depression have been found (Parker & Roy, 2001). Similarly to the above perspective, these findings suggest an interaction between the different social roles and expectations of males and females and the expression of biological factors within pathways to mental health difficulties.

Different rates of mental health difficulties have also been found across different ethnic groups, immigrant to the UK. Within South Asian and African-Caribbean populations for example, higher rates of depression have been found (Nazroo, 1997). A higher incidence and prevalence of psychosis has also been found in African-Caribbean populations (Sharpley et al, 2001). However, it appears that the social environment is influential in leading to such outcomes as higher rates of mental health difficulties have been found where non-white ethnic minority groups were proportionately smaller than the rest of the population (Veling et al, 2008; Boydell et al, 2001). This suggests that a marginalised community presence offers less protection to individuals. This may then, as suggested by research, leave individuals vulnerable to racial discrimination (Boydell et al, 2001) which has been linked to mental health difficulties, although little longitudinal research exists (Chakraborty & McKenzie, 2002).

Other, indirectly contributory, individual factors to poor mental health outcomes, are drug and alcohol abuse (Weaver et al, 2003) poor diet (Prince et al, 2007), insufficient exercise (Paluska & Schwenk, 2000) and relaxation (Rubia, 2009) and learning difficulties (Meltzer, 2007; Emerson & Hatton, 2007). However, as pointed out by Emerson and Hatton (2007) some of these factors are a proxy indicator of social disadvantage.

Certain personality variables have been considered protective against mental health difficulties. Steinhausen and Metzke (2001) found that for young people aged ten to seventeen, self-esteem compensated against mental health difficulties and an active coping style, protected against internalising disorders. The use of a community sample, self-report measures and a cross-sectional design, may however have invited bias, and cannot provide information regarding causation.

2.5.2 The Microsystem

Research has considered the role of the family environment in explaining mental health difficulties in adolescence (Gerard & Buehler, 1999). Adopting an epidemiological perspective, Meltzer, (2007) found maternal distress was predictive of childhood mental health difficulties. However, Connell and Goodman (2002) conducted a meta-analysis into the relative contribution of maternal versus paternal psychopathology on children. They found that although relationships between maternal psychopathology were stronger, they were only marginally so, were attributable to the age of the children included, the type of psychopathology investigated and methodological differences between studies.

Parental divorce has been related to enduring mental health difficulties however, the involvement of other factors highlights its complexity. For example, Ferguson et al, (2000) found that although marital disruption was related to suicidal behaviours in young people, it was amongst a profile of other related factors, such as previous sexual abuse, attachment

difficulties, personality variables and low familial social-economic status (SES) . The importance of parental SES to childhood mental health outcomes has been highlighted by a number of studies (Strohschein, 2005b; Zubrick et al, 1995; Meltzer et al, 1995). However, these studies have also emphasised how the quality of the child-parent relationship rather than diversion from the traditional family unit, threatened by divorce, is contributory to poor mental health outcomes in childhood (Meltzer, 2007).

The quality of child-parent relationships has been researched. For instance, Ackard et al., (2006) demonstrated that adolescents who valued their peer's opinions over their parents, perceived difficulties in talking to their parents and that their mothers cared little for them, related to poor mental health outcomes in both genders. However, the cross-sectional design of this study precludes much consideration of causation between family functioning variables and mental health outcomes.

A consistent finding within the literature is the link between early trauma and adversity such as abuse and domestic violence and poor mental health outcomes. Consistent with Cicchetti's hypotheses (Cicchetti & Lynch, 1993; Cicchetti, 1989) that unsupportive environments transact with and impact individual developmental stages, Harvey (2012) found early emotional trauma and attachment insecurity were moderated by developmental difficulties in adolescence which contributed to pathways to psychosis. Elsewhere, sexual, physical and verbal abuse in childhood has been more directly linked to the onset of psychosis (Read et al, 2005; Bak et al, 2005) personality, affective and anxiety disorders in both males and females (Spataro et al, 2004). An environment, gender interaction has been acknowledged within the research on adversity. For instance, in the Spataro et al (2004) study, males who had suffered sexual abuse were found to be more likely than females to have had treatment. This may have been due to the differential presentation of mental health difficulties according to gender, with males more likely to present with externalising difficulties (Meltzer, 2007; Scott, 1998).

In terms of protective factors, supportive family environments have been found to be particularly important in facilitating mental health (Chappel, 2012). For example, Flouri and Buchanan (2003) found that father involvement during childhood, in separated households, was protective against psychological maladjustment in adolescence. Steinhausen and Metzke (2001) found that for young people aged ten to seventeen years, acceptance from parents was compensatory against current risks associated with mental health difficulties. Ungar (2004) extended this protective influence to a range of adults who could offer support to a young person such as youth workers and foster parents.

2.5.3 The Exosystem

Social support is critical around the adolescent period as this is when a peer group is established to advance social skills and consolidate an identity (Elkind, 1967; Elkind & Bowen, 1979; Lapsley et al, 1989). Links between the failure to meet these objectives and poor mental health outcomes have been found (Harrop & Trower, 2001; Harvey 2012). This is supported by a longitudinal study conducted by Bond et al., (2007) in which low connectedness to one's social network and school setting was associated with mental health difficulties across the secondary school age-range. However, poor academic performance and substance misuse were also related to low social connectedness which could have also driven mental health difficulties. Greater detail of the effects of relational difficulties on mental health outcomes is provided by a recent thesis by Chappel (2012). Here, longitudinal analysis revealed relationships over time between chronic stressors within social relationships and internalising difficulties. However, initial levels of mental health were found to be the largest predictor of later mental health outcomes. Indeed, untangling the direction of causality between social difficulties and mental health outcomes is recognised as challenging, as social difficulties can be both a trigger and consequence of poor mental health Kawachi and Berkman (2001).

Relevant to peer group factors, research has looked at instances of bullying, finding convincing evidence of the detrimental effects of such adversity upon emotional wellbeing. For example, in a large, prospective, cohort study (Bond., et al, 2001), a history of victimisation from peers, predicted the onset of anxious and depressive symptoms in young teenagers, after adjusting for social network size and sociodemographic variation. Most importantly, evidence was found to suggest this relationship was unidirectional as prior anxious and depressive symptoms were not found to be significantly influential upon subsequent reports of victimisation.

The experience of stressful life events has been related to poor mental health outcomes in young people. This includes more isolated stressors such as school examinations (Denscomb, 2000) to more chronic adversities such as the effects of community violence and crime (Fowler et al, 2009). For instance, school examinations appear to have more transient effects upon mental health, contributing to more elevated periods of anxiety which are not persistent and enduring (McDonald, 2001). In contrast, witnessing community or parental violence were found to be related to post-traumatic stress disorder and major depressive episode in US adolescents (Zinzow et al, 2012). This relationship remained after controlling for gender, age, ethnicity, income and trauma history.

Protective factors at this level are found within relationships and social capital (De Silva et al, 2005). For instance, Chappel, (2012) found that peer support was important to sustaining mental health and that teachers could also act as buffers against certain forms of stress. These findings built upon Steinhausen and Metzke (2001) who pointed to the compensatory effects of peer acceptance against externalising disorders and its insulating effects against internalising disorders.

2.5.4 The Macrosystem

Fluctuations in the economy have been linked to poor mental health outcomes (Goldman-Mellor et al, 2010; Warner, 2004). Disproportionately to other groups, young people appear to have been particularly affected by the economic recession in 2008 with persistently high rates of youth unemployment (Bell & Blanchflower, 2011). As highlighted in the literature surrounding young people Not in Education, Employment or Training (NEET) such circumstances relate to poor mental health outcomes (Michaud & Fombonne, 2005). The negative effects of economic down-turn across Europe has also created financial difficulties for families, which in precipitating higher stress levels, has a detrimental effect upon parental wellbeing, parenting abilities and mental wellbeing in children and young people (Gili et al, 2013; Wahlbeck & Mcdaid, 2012). Additionally, Wahlbeck and Mcdaid (2012) went on to explain how government cuts to children and family support, leave individuals with mental health difficulties vulnerable, as they are dependent upon social, economic and environmental support mechanisms. This is supported by Wilkinson and Pickett (2009) who point out how income and social inequalities relate to poorer mental health outcomes within society (Wilkinson & Pickett, 2009).

Cicchetti and Toth (1997) highlighted how the political system in which one lives can also potentiate mental health difficulties. For instance, in countries in which there has been political violence, the mental health of children has been detrimentally effected (Hjern et al, 1988; Garbarino & Kostelny, 1996). However, a simple relationship is not observed. In the Hjern et al (1988) study family stress during exile and as refugees was also related to mental health difficulties in their children. In the Gabarino an Kostelny (1996) study which investigated Palestinian children's experiences in the West Bank, a negative family outlook plus political violence, correlated with more behavioural difficulties in their children,

particularly younger children and males. However, community variables, such as the level of political violence, were only a significant factor for females.

A final Macrosystem risk factor, related to political systems, are national atrocities such as 11th September 2001 terrorist attacks on the World Trade centres in the US. A study by Schuster et al in (2001) found that thirty-five percent of children aged five to eighteen years, had one or more stress symptom, in response to the terrorist attacks. Follow-up six weeks after the attacks, enduring effects were upon children's distress levels (Schlenger et al, 2002). In both studies, children themselves were not interviewed rather it was their parents reporting upon their child's perceived level of stress, which weakens some of these claims. However, assessing children more directly, Hoven et al (2005) did find that after six months, within New York City, 28.6% had probable anxiety or depressive disorders.

It is suggested by Wilkinson and Pickett (2009) that protective of mental health at this level is the creation of greater social equality, as countries which aspire to this, have greater mental and physical health outcomes. Political interventions such as welfare systems, equal opportunities within education and greater chances for social mobility, would underpin social equality.

2.6 Conclusion

Historical legacy has shaped current attitudes and conceptualisations towards mental health and mental health difficulties. Indeed, attempts to positively reframe mental health within salutogenic models exist alongside dominant pathogenic models, which are moderated with a more interactionist leaning.

Epidemiological evidence allows for the confident suggestion that young people are a particularly vulnerable group to mental health difficulties. Using current conceptualisations of mental health difficulties which are contained within Cicchetti and Lynch's (1993) ecological-transactional model, layers of biological, social and psychological factors, relevant to mental health pathways, have been explored for young people. Of note is the complexity of pathways to mental health difficulties at each layer. This is further highlighted by the transactional relationships between risks and protective factors across the ecological levels.

The following chapter will consider how systems of support respectively address and promote some of the risks and protective factors of mental health outlined within this chapter and contained within the multiple systems of Cicchetti and Lynch's (1993) ecological-transactional model.

CHAPTER 3

MEETING THE MENTAL HEALTH NEEDS OF YOUNG PEOPLE

Key web-based search terms used: mental health, service*, prov*, school, adolesc*, child*, policy, legislation, UK, NICE guidelines,

Meeting the mental health needs of young people entails a multi-systemic approach with increasing levels of support according to severity of need. Macrosystem (see Figure Four, p 27) policy and legislation guides Exosystem and Microsystem (see Figure Five, p 33) levels which implement approaches within increasing tiers of support. At the Ontogenic level (see Figure Six, p 46) individually-directed support is available. Consistent with Cicchetti and Lynch's (1993) argument that systems interact and transact with each other, systems of support address risk and promote protective factors of mental health across other systems. With reference to the risks and protective factors outlined in the previous chapter, this will be reflected upon after support has been outlined for each system. In light of the rise in mental health difficulties around adolescence (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001) and the potential for Tier 1 systems to support a larger number of young people, the following sections will focus upon prevention and intervention programs.

Figure Four: Macrosystem mental health provision for young people in the UK.

Macrosystem

Legislation:-

-Mental Health Act (Great Britain, 2007) -Children and Families Act (Great Britain, 2014) -Draft & final SEN Code of Practice (DoH & DfE, 2013; 2014)

Policy:-

-National Health Service (NHS) Health Advisory Service (HAS) (NHS & HAS,1995): *Together we stand*

-Department for Education and Skills (DfES) (2003): *Every child matters*

-DfE (2005): *Social and emotional aspects of learning for primary schools (SEAL): Guidance booklet.*

-DfE (2007): *Social and emotional aspects of learning for secondary schools (SEAL): Guidance booklet.*

-National Institute of Clinical Excellence (NICE) (2008): *Social and emotional wellbeing in primary education.*

-DCSF (2008) *Targeted mental health in schools (TaMHS) project: Using the evidence to inform your approach: a practical guide for head teachers and commissioners.*

-National Institute of Clinical Excellence (NICE) (2009): *Social and emotional wellbeing in secondary education.*

-DoH (2011a): *No health without mental health: A cross-government outcomes strategy for people of all ages.*

-DoH (2011b): *Talking therapies: A four-year plan of action. A supporting document to, No health without mental health: A Cross-Government Outcomes Strategy for People of All Ages.*

-DoH (2013): *Improving children and young people's health outcomes: A system wide response.*

3.1 The Macrosystem

Current legislation and policy has aimed to improve mental health care by providing support at varying levels, through multi-disciplinary, needs-focussed and person-centred approaches and ensuring greater access.

3.1.1 Multi-level support

In agreement with systemic theories (Cicchetti & Lynch, 1993), within the UK, policy suggests that mental health support be delivered at a number of levels. Largely, support is delivered at the community-level (Patel et al, 2007) and following the NHS and HAS Report (1995), a framework was provided for addressing mental health needs on a graduated basis, in accordance with severity and within four-tiers (Dogra, 2005). This is seen within the Child and Adolescent Mental Health Service (CAMHS).

More recent policy has reinforced this multi-layered approach including the DoH (2011a) proposals within their *No health without mental health* guidance. Similarly to NICE guidance (2008; 2009), these proposals advocate promotion, prevention and intervention-based approaches within a graduated response, particularly within community settings such as schools. Indeed, through the Early Intervention Fund government proposals have enabled the continuation of funding for the TaMHS project (DoH, 2011a) which makes use of graduated responses to mental health support in school.

The DoH (2011a) also more explicitly references the need multi-level support. At the individual-level, agendas to improve young people's resiliency, self-efficacy and self-help skills are apparent. Family-level support such as the provision of information regarding care and listening to the family's views is recommended. At the Exosystem-level, intentions to

continue to fund the Pupil Premium and the Healthy Schools program are evident as well as intentions to provide guidance to education providers on public health policy and additional training to school nurses. At the Macrosystem-level the government has committed to investing in mental health research and improving public knowledge of how to stay mentally healthy and combat against the barriers of stigma.

3.1.2 Multi-disciplinary

Consistent with biopsychosocial models, joint and coordinated support from a variety of mental health and non-mental health professionals is advocated (DoH, 2011a; Great Britain, 2014; DfE & DoH, 2013; DfES, 2003).

For instance, according to the Children and Families Act (Great Britain, 2014) and The Code of Practice (DfE & DoH, 2014) health, social care and education have a statutory duty to commission services together, to meet the special educational needs of young people, which may include mental health needs. Within the Every Child Matters recommendations (DfES, 2003), targets were set to establish a comprehensive CAMHS including social care and the NHS. Finally, government policy recognises even wider support such as the role that could be played by the voluntary sector, charities and social enterprises in supporting young people's mental health needs within their „Big Society“ agenda (DoH, 2011a).

The Mental Health Act (Great Britain, 2007) is also enabling of a multi-disciplinary approach as it has broadened the range of professionals who can support mental health needs, extending beyond medically trained staff to psychologists, occupational therapists and social workers. This not only recognises biopsychosocial approaches to care, it also acknowledges the interpersonal and psychological context in which mental health difficulties occur and require support (Read et al, 2004).

3.1.3 Person-centred

Person-centred approaches are prominent within the government's proposals (DoH, 2011a; 2011b). Emphasis is given to enabling young people themselves to make informed choices over their treatment and care plans. This may include deciding upon the setting within which they would prefer to receive therapy and relating care plans to their future aspirations. The DoH's (2013) document provides a further example of person-centred support. For instance, in responding to the recommendations of the Children and Young People's Health Outcomes Forum, commitments were outlined to listen to the voices of young people to provide feedback to services. Promises were also made to explore health outcomes that are most important to young people such as tackling bullying, effective health education in schools and how to access age appropriate information about services.

Person-centred approaches also extend to the needs of the family as outlined within the proposals for person-centred planning in the new Education Health and Care Plans (DfE & DoH, 2013; 2014). As well as producing plans for support in child-friendly language, support is tailored according to the individual and their families' needs taking into account what young people both want and need.

By placing the individual at the centre of their support, such strategies acknowledge individual differences within pathways to mental health difficulties and differences in outcome. This parallels principles of multi-finality and equi-finality as well as continuum models, which present a range of individual mental health outcomes, extending from healthy development to disease (Cicchetti & Lynch, 1993; Antonovsky, 1996).

3.1.4 Accessibility

The final theme of current legislation and policy are intentions to increase accessibility to mental health support, to capitalise on protective factors. Primarily, by simplifying the terminology surrounding mental health difficulties and reducing categories of mental disorder down to a single definition of mental disorder, the Mental Health Act (Great Britain, 2007) has widened the potential for support, by making more people eligible.

In addition, one of the intentions behind the DoH's (2011a; 2011b) documents, is to increase the number of people who make improvements, within their mental health. Indeed, within their proposals and four year plan (DoH 2011a; 2011b), commitment was made to extend talking therapies, through significant investment in Improving Access to Psychological Therapies (IAPT) program, to young people. This is also to be accompanied by government funding into the Time to Change anti-stigma campaign within the DoH (2011a; 2011b) documents, which attempts to change attitudes towards mental illness to facilitate help-seeking.

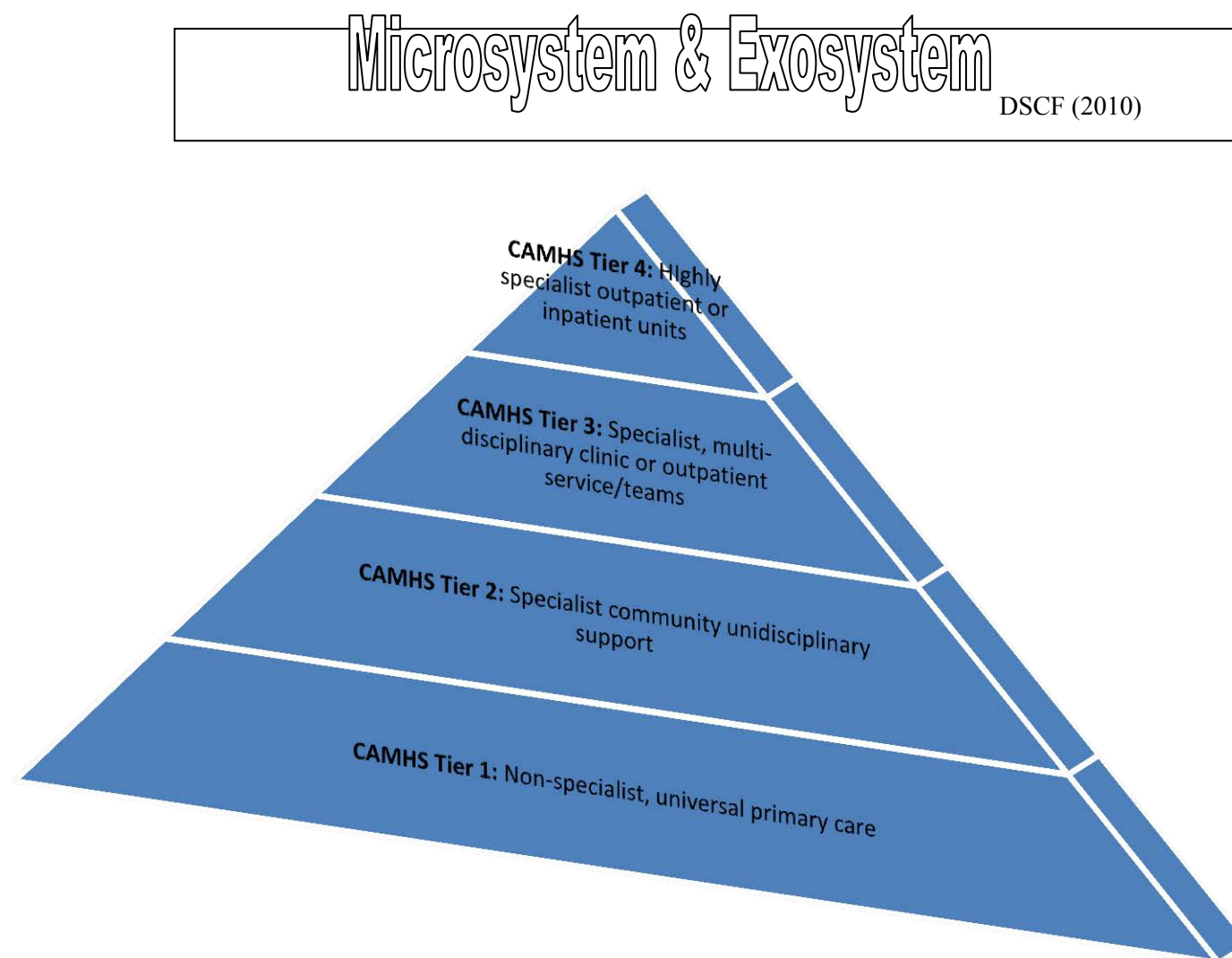
3.1.5 Reflections

By directing accessible, multi-level, multi-disciplinary and person-centred support, known individual, social and environmental risks can be addressed and protective factors can be promoted. For instance, by raising awareness and tackling stigma, protective factors at the Ontogenic-level are strengthened as more positive attitudes towards mental health are compensatory and enable help-seeking (Wrigley et al, 2005). At the Microsystem-level, person-centred planning and multi-disciplinary teams can address risks within the family system, promote and support cohesive family relationships. Exosystem risks such as bullying (Bond et al, 2001) can be addressed through school-based initiatives and person-centred approaches to enhance peer group relationships which are protective against mental health difficulties (Chappel, 2012). Finally, at the Macrosystem-level, ensuring economic support like the Pupil Premium, can negate financial risks associated with poor mental health outcomes promoting greater income and social equality.

However, in considering the above themes, several criticisms can be found. For instance, the potential diversity of training needs which may present as a result of multi-disciplinary approaches, may compromise quality support. Such diversity is also currently at odds with strategies in place to support more standardised practice within CAMHS (Garraalda & Yates, 2000). Secondly, by broadening the remit for mental health support are we not creating a larger support deficit for young people?

The following sections will evaluate the mental health support provided at Exosystem and Microsystem levels.

Figure Five: Microsystem and Exosystem: Mental health provision for young people in the UK.



3.2 The Exosystem and Microsystem

At the Exosystem and Microsystem, young people's mental health needs are met through the increasingly specialised CAMHS Tiers. Promotion, prevention and intervention are present within all of the Tiers, with the latter approaches more evident at the higher Tiers. The following sections will now discuss each Tier in-turn to describe how and with what degree of effectiveness, young people's mental health needs are met.

3.2.1 Tier 1

Meeting the lowest level of mental health needs, Tier 1 CAMHS involves universal, non-specialist care from professionals usually located within more generalised community settings. This commonly includes schools and General Practitioners (GPs) but also extends to the voluntary sector, health visitors and youth justice workers (DCSF, 2010). This section will therefore largely focus upon how schools and GPs meet the mental health needs of young people and offer a critique of their effectiveness.

3.2.1a Schools

Promotion-based approaches within schools educate individuals to encourage behaviours which are conducive to positive mental health and focus upon achieving an accepting school culture which motivates such actions (Weare, 2000). In a systematic review of fifteen studies, Wells and Stewart-Brown (2003) found that universal promotion of mental health was most effective in comparison to preventative approaches. However, the concluding suggestions were of combined approaches which also made use of targeted support.

Another example of mental health promotion within schools was the SEAL curriculum. This worked to promote mental health through changes to the culture of the school and through

teaching social skills, the management of feelings, encouraging empathy and self-awareness (DfES, 2005). However, an evaluation of SEAL within secondary schools revealed that at both the pupil and school-level no difference was made to mental health difficulties, social and emotional skills and behaviour (DfE, 2010). A lack of thorough monitoring, human and financial resources within schools, was thought to have contributed to these findings.

Further school-based support includes preventative and intervention-based approaches.

School nurses and psycho-educational initiatives, including more intensive one-one support are examples of this.

School nurses are a familiar body within schools making them accessible to young people (Croghan, 1999). The effectiveness of school nurse preventative work is noted by Puskar et al (2003) in which school-based programs, designed to improve emotional coping skills and administered by school nurses, lowered depressive scores and increased coping strategies in adolescents.

However, research surrounding the role and effectiveness of the school nurses is sparse (Wainwright et al, 2000). Confusion has also been found to surround their role, limiting its effective delivery as both nurses and young people are unclear as to their function.

The rationale of psycho-educational initiatives is to equip young people to recognise mental health difficulties and prevent their progression by strengthening cognitive and behavioural skills. For instance, within the FRIENDS program, principles of cognitive behavioural therapy (CBT) based on Kendall's (1994) Coping Cat are used to promote knowledge of and address key cognitions and behaviours of anxiety. Randomised controlled trials (RCTs) of this intervention has found post intervention (Barrett & Turner, 2001) and long-term reductions in anxiety (Barrett et al, 2006) suggesting its effectiveness. However, evaluative

studies of this program were mainly conducted within independent schools in Australia, with only a few in UK secondary schools (Stallard et al, 2005; Stallard et al, 2007).

Other examples of psychoeducational initiatives have emphasised more awareness raising approaches. The effectiveness of these approaches is demonstrated by Naylor et al (2009) who found that in comparison to a school receiving no intervention, after six lessons, attitudes towards mental health improved along with better identification of mental health difficulties and their causes. Reductions were also observed in scores on the strengths and difficulties questionnaire. However, it is important to note that samples were not randomly selected in this study meaning that such interventions may only be suitable for certain groups of pupils.

3.2.1b Mental health literacy

Some preventative programs have focussed more extensively upon improving the knowledge-base of young people surrounding mental health, mental health support and tackling stigmatising views (Esters et al; 1998; Essler et al, 2006). Such approaches are allied to more primary preventative strategies as they aim to educate the wider community, but also seek to encourage help-seeking when mental health difficulties occur. Examples of these approaches are captured by mental health literacy (MHL) initiatives. MHL was originally defined by Jorm (1997a) as „knowledge and beliefs about mental disorders which aid their recognition, management or prevention“ (p. 396). Its comprehensive approach involves:

- Improving the recognition of disorders and psychological distress.
- Developing knowledge and appropriate beliefs surrounding risk factors and causes.
- Developing knowledge and beliefs about self-help interventions.
- Developing knowledge and beliefs about professional help.
- Improving attitudes which enable recognition of mental health difficulties and appropriate help-seeking.

- Improving knowledge of how to seek mental health information.

This is achieved by first exploring individual knowledge, beliefs and attitudes to inform tailored, preventative programs. Such programs then address weaknesses surrounding knowledge of risks, knowledge of protective factors associated with mental health support; including self-help, and the identification of attitudinal barriers.

Criticism can be made of MHL initiatives. For instance, its focus upon educating the general public also suggests that the onus for recovery is on the individual, rather than the services which provide care. Rusch et al (2005) argued that by labelling mental health difficulties, perceptual differences between mental health and mental ill-health will be reinforced, thus perpetuating stigma. A study by Wright et al (2011) actually found that the use of accurate psychiatric labels was rarely associated with stigma in twelve to twenty-five year olds.

However, this did not extend to psychosis and schizophrenia. These labels continued to be associated with perceptions that a person is dangerous or unpredictable. This finding suggests stronger correlations between certain labels and stigma and that MHL and other educational initiatives alone, may not suffice in leading to improved help-seeking for these mental health difficulties.

Kelly et al (2007) claims that little research has been conducted upon MHL interventions.

However a number do exist and have been well-evaluated showing improvements post-intervention in most if not all areas of MHL (Rickwood et al, 2004; Pinfold et al, 2005). The effectiveness of MHL preventative interventions has been found in a large study by Wright et al (2006) with young people aged twelve to twenty-five. Data were gathered from service-user young people, parents and mental health professionals which informed a fourteen month, multi-level campaign to improve early recognition and help-seeking for mental health difficulties. Significant improvements were observed in young people's; awareness of campaigns, suicide risk, ability to self-identify depression and ability to estimate accurate

prevalence rate of mental health difficulties. Participants also perceived fewer barriers to help-seeking and improved their help-seeking behaviours for depression. However, other areas of MHL received more modest effects including; no significant changes in the recognition of discriminatory attitudes, no significant differences in the recognition of depression and psychosis in vignettes, no significant differences in the knowledge of sources of help and when analysis was only conducted on young people identifying themselves as having a mental health difficulty, improvements in help-seeking became non-significant. As main aspects of MHL, these results seem disappointing however a number of explanations could be given. Firstly, these results could be relating to the independent-sample design of the study and the fact that only depression and psychosis awareness was targeted within the campaign. Secondly, the demographic of the sample used may have also contributed these results. For example, although attempts were made to accommodate males" lower rates of help-seeking (Juszczak et al, 2003), randomised sampling could have led to disproportionately more males within the post-intervention group, who overall have been found to have lower MHL than females (Burns & Rapee, 2006; Chandra & Minkovitz, 2006; Cotton et al, 2006). Unfortunately, the ratio of males to females within the sample is not given. Thirdly, by using a wide age-range, developmental trends within the knowledge-base and attitudes of young people (Fox et al, 2007; 2010) may have played a part as the campaign may not have been sensitive to the diverse understanding and needs of the young people. Finally, by focussing on those who had a mental health difficulty this may have discounted those who effectively sought preventative help during the period of the study.

Another criticism of MHL initiatives involves its clinical approach to the concept of mental health difficulties and pathways to recovery. For example, MHL focuses upon remedying mental illness, drawing criticism for its emphasis upon bio-genetic causes of mental health difficulties, drug and other medical treatment (Read et al, 2004). It also incorporates a

Western approach to mental health and would not easily accommodate for instance, Eastern cultures, who may conceptualise mental health difficulties as spiritual possession thus necessitating spiritual or religious guidance and intervention (Mullick et al, 2013). It can be argued that cultural factors do not preclude MHL initiatives for certain groups, but along, perhaps with the acknowledgement of wider factors that bio-genetic, MHL approaches should employ a sensitive approach when attempting to address the lower rates of help-seeking found in minority cultures (Jorm, 2012).

Within schools mental health interventions have largely been implemented in the US with some success (Weare & Nind, 2011). For instance, the use of mentors or learning mentors, as they are referred to in UK schools (DfES, 2001), has led to improvements in wellbeing and resilience for young people, particularly when mentor programs are informed by theory, best practice and rapport is established (DuBois et al, 2002). In 1999, Armbruster and Lichtman found that an outreach service in schools made significant improvements in the mental wellbeing of children as rated on the C-GAS and the global assessment of functioning scale. This was comparable to a clinic sample of children, despite the reduced timeframe of delivery within the school setting. More recently Mendelson et al (2010) evaluated a mindfulness program within four schools finding that it alleviated difficulties associated with stress responses in young people such as rumination and intrusive thoughts. However, unlike the Armbruster and Lichtman (1999) study, the Mendelson et al (2010) study included a community sample of young people who did not have any known mental health difficulties. Elsewhere, Prout and Prout (1998) found that the most effective school-based, therapeutic interventions were group interventions and CBT with younger children.

An example of school-based mental health interventions in the UK is seen in the TaMHS project. TaMHS further developed SEAL universal approach, taking particular responsibility for the higher, preventative and intervention levels, which were delivered by TaMHS project

professionals, allied to CAMHS. In a study by Wolpert et al, (2013) which summarised the results of the national TaMHS evaluation, it was found to be generally effective, particularly in reducing behavioural difficulties in primary-aged pupils and pointing to how, for secondary-aged pupils, professional collaboration and information-giving best supported positive behavioural outcomes. The combination of promotion, prevention and intervention strategies agrees with literature which suggests such approaches are more effective in meeting the mental health needs of young people (Weare & Nind, 2011).

3.2.1c General Practitioners

Working within a secondary preventative model, General Practitioners (GPs) provide universal support, coming into contact with a significant percentage of young people with mental health difficulties (Kramer & Garralda, 2000). Pharmacological treatments administered by GPs such as anti-depressants have been found to be effective in reducing symptoms for young people (Emslie et al, 1997; Olfson et al, 2003). However evidence is contradictory, with findings of anti-depressants producing comparable effects to placebo conditions and indications research has overstated their efficacy (Pigott et al, 2010; Jureidini et al, 2004). In addition, some research has noted inadequate training of GPs in youth mental health, a lack of resources and deficiencies in the ability of GPs to identify young people in need of support (Jacobson et al., 2002).

3.2.1d Voluntary Sector

Evidence has been found for the effectiveness of mutual voluntary support groups in which individuals with mental health difficulties support and advise each other (Pistrang et al, 2008). Out of twelve studies, seven reported positive changes for people suffering with chronic, common mental health difficulties such as depression and anxiety. However the other five

revealed no differences between attenders and non-attenders and with limited evidence available, more evaluation is needed.

3.2.2 Tier 2

3.2.2a Educational Psychologists

At Tier 2, more persistent mental health needs may appear which may raise concerns but are not enduring and complex or yet perceived as severe. An example of Tier 2 CAMHS is the support offered by Educational psychologists (EPs). They are involved in the delivery of a range of therapeutic interventions to groups, individuals and their families. Their neutral status (Atkinson et al, 2011), skill-set, knowledge of adolescent development and school context (Squires, 2010), means they are well-placed to address such needs. Due to their largely statutory role (Mackay, 2007), balanced against their expertise in child development and wellbeing, EPs are more general therapeutic practitioners, commonly located at Tier 1 via the support and advice they provide to schools or at Tier 2, delivering more individual therapeutic work and assessment. Although, it has been highlighted (Squires, 2010) that with the support of further training and ensured clinical supervision, EPs have the skill-set to work at higher CAMHS Tiers.

Research detailing therapeutic work carried out by EPs such as motivational interviewing and solution-focussed brief therapy has been found to be effective (Young & Holdorf, 2003; Atkinson & Woods, 2003). However, little research exists on therapeutic EP work (Young & Holdorf, 2003) and some of these studies are based on case study designs, restricting the generalisation of findings. In addition, EPs themselves have critiqued their own effectiveness to meet mental health needs due to restricted opportunities for further therapeutic training and access to quality in-service, clinical supervision (Atkinson et al, 2013; Anderson, 2012).

3.2.3 Tier 3

3.2.3a Specialist and intensive therapeutic support and multi-disciplinary services

To meet persistent, enduring and complex mental health needs, Tier 3 includes more specialist multi-disciplinary teams, and allied professionals. Such professionals can include psychiatrists, clinical psychologists, community psychiatric nurses (CPNs), psychotherapists, occupational therapists, art therapists and social workers. Professionals may work as a team or separately.

An example of a specialist, multi-disciplinary team which includes psychiatrists, CPNs, support workers, clinical and research psychologists is the Early Intervention Service (EIS). Based upon community outreach principles this works to support young people experiencing early symptoms of psychosis (Spencer et al, 2001). Within this support is holistic individual and family-based therapy based upon cognitive-behavioural principles and to facilitate an awareness of signs of relapse (Birchwood et al, 2000). Moderation of levels of expressed emotion between family members, to enable a calmer, more supportive, family environment (Patterson et al, 2002) is also part of the support. Raising awareness to tackle stigma are further EIS objectives (Iris & NMHDU, 2010).

The effectiveness of EIS is seen in the reduction of the duration of untreated psychosis and relapse rates (Gumley et al, 2003; Bird et al, 2010). However, relapse rates for young people with psychosis are still high and although reduction in positive symptoms are noted, success in terms of functional recovery, is lagging (Killackey & Yung, 2007).

In terms of therapeutic support within this Tier, NICE guidelines recommend a range of staged cognitive behavioural approaches according to need (Clark, 2011). Much accumulated literature is available regarding the effectiveness of CBT in reducing depressive and anxiety-related mental health difficulties in young people (Cartwright-Hatton et al., 2004; Compton et

al., 2004; James et al, 2005; Albano & Kendall, 2002). In a review by Pattison and Harris (2006), other therapies have also been found to be effective for a wide-range of mental health difficulties including psychoanalytic, humanistic and more creative therapies. However, the effectiveness of these other therapies varied according to the type of mental health difficulty experienced.

Family therapy has also been found to be effective in reducing symptoms experienced as a result of anxiety-related disorders. Indeed its effectiveness has been found to be either comparable to other individuals therapies such as CBT (Carr, 2009) or significantly more successful in achieving recovery (Elliott, 1999; Heyne & King, 2004). However, management of all perspectives within the family can be challenging for practitioners. For instance Eisler et al (2007) found that conjoint meetings with the family and individual were less effective in supporting individuals with anorexia nervosa, if mothers expressed criticism towards their child.

3.2.4 Tier 4

3.2.4a Highly specialist care teams

Tier 4 involves tailored mental health support for individuals with the most severe, persistent enduring and complex difficulties (NHS & HAS, 1995). It also includes highly specialist out and inpatient care including specialist units and specialist psychiatric teams (DCSF, 2010).

Inpatient therapeutic interventions have been evaluated in a study by Green et al (2007).

Across a number of inpatient units and a range of mental health needs, significant improvements were observed according to the childhood global assessment scale (C-GAS), researcher, teacher and parent ratings in comparison to pre-admission periods. Therapeutic alliance independently predicted these outcomes which were also determined by premorbid family functioning.

Analysis provided by Green and Worall-Davies (2008) also found that assertive outreach approaches, often found within Tier 3, are effective at Tier 4 and are accumulating an evidence-base. However, much of this evidence has included samples of older adolescents and young adults. In addition, not enough evidence exists to sensitively discriminate which approaches; inpatient or assertive outreach, are best for which kinds of mental health needs.

3.2.5 Reflections

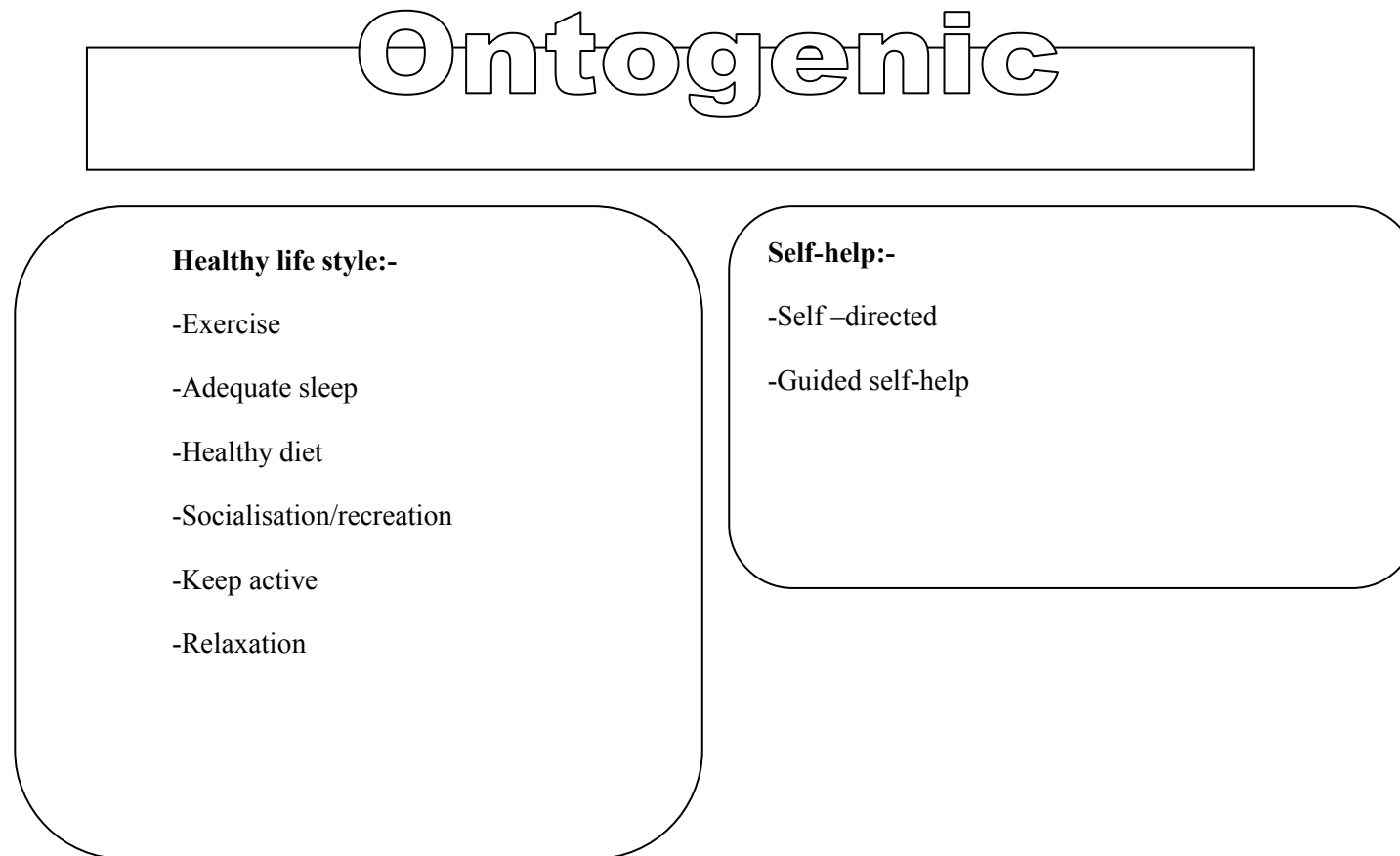
Tiered support within the Micro and Exosystems incorporates promotion, prevention and intervention-based approaches to meet the mental health needs of young people. Evidence suggests this is achieved with some success. Lower Tiers appear to accommodate this variety of support, particularly schools, whereas higher Tiers focus more predominantly upon either preventative or intervention-based approaches. As young people spend the majority of their time in schools and evidence suggests school-based support has enjoyed success, delivery of support in this context appears fruitful.

Exosystem and Microsystem risks are addressed and the promotion of protective factors is enabled by the above support. For example, Tier 1, educational initiatives and Tiers 2, 3 and 4 therapeutic interventions would consider and support biopsychosocial risk factors (Read et al, 2004) and work to enhance self-esteem and an active coping style (Kendall, 1994), which are protective of mental health (Steinhausen & Metzke, 2001). Family therapy, through outreach support, addresses family-level risks, including parental distress, promoting instead more supportive and thus protective, familial relations (Patterson et al, 2002). Multi-disciplinary outreach support also minimises Exosystem-level risks, providing occupational support to reduce the likelihood of young people becoming NEET.

Apart from MHL programs however, the needs of young people do not seem to be considered or explored prior to designing support.

The following section will now consider the effectiveness of mental health support at the Ontogenic level.

Figure Six: Ontogenic level: Mental health provision for young people in the UK.



3.3 Ontogenic level

Self-help support and practising a healthy life style is the focus of support at this level.

Although there is some cross-over between the two approaches (Williams, 2001), for the sake of clarity, the effectiveness of examples of such support will be considered separately and distinctly below.

3.3.1 Healthy lifestyle

Practising a healthy lifestyle promotes mental wellbeing. For instance, much research has been conducted on the effects of physical exercise on positive mental health outcomes (Paluska & Schwenk, 2000). A study by Biddle and Asare (2011) which synthesised findings of review articles, found that physical activity has the potential to reduce symptoms associated with depression and anxiety, however, as the evidence base of well-designed studies is limited for young people, firm conclusions cannot be drawn.

Associations between healthy patterns of sleep and positive mental wellbeing were observed in a study by Chen et al (2006). Adolescents who slept between six and eight hours per night, reported superior stress management capabilities compared to those who did not. The aims of this study were however to examine the effects of sleeping patterns on physical health outcomes such as obesity. Therefore, investigations into the effects on mental health would have been secondary in this study and not as detailed to provide a comprehensive understanding of such relationships.

Links between healthy eating and mental health outcomes are highlighted by studies which have found links between unhealthy eating and behavioural difficulties, obesity and depression and a lack of nutrients in the diet of individuals with poor mental health (Bamber

et al, 2007). However, the causal direction of these factors is unclear as for instance, feeling depressed can encourage poor food choices (Martyn-Nemeth et al, 2009) and little longitudinal data is available (Bamber et al, 2007).

Finally, engaging in recreation was found to be important to the recovery of individuals with mental health difficulties (Young & Ensing, 1999). Taking time for relaxation has also been found to have positive effects on mental health. For instance, the regular practice of meditation has been found to reduce the physiological effects of stress on the brain and is effective in ameliorating symptoms of mood disorders and anxiety (Rubia, 2009). However, the exact neurological mechanisms involved are yet to be identified.

3.3.2 Self help

A popularised preventative approach to meeting mental health needs is self-help. According to Baguley et al (2010), self-help, based upon the principles of CBT, have the most extensive evidence-base and thus included within many self-help programmes are step-by-step guides to increase knowledge and teach skills to cope with mental health difficulties (Wilson & Zandberg, 2012). Wilson and Zandberg (2012) also argue for two types of self-help the first being pure, self-directed self-help and the second guided self-help, in which professionals have a degree of input.

A number of controlled studies of eating disorders have shown improvements post guided self-help against traditional forms of therapy (Schmidt et al, 2007) and at follow-up (Mitchell et al, 2011). Lloyd and others (2012) have also found that telephone guided self-help is effective in reducing fatigue and increasing school attendance, post-intervention and at six months follow-up in young people with chronic fatigue syndrome. However, there have been conflicting findings in the eating disorders literature as Walsh et al (2004) found guided self-help not to be any more beneficial than a placebo, and in a number of other studies the

percentage of individuals benefitting from guided self-help post intervention has been found to be below 50% (Mitchel et al, 2011; Steele & Wade, 2008; Ghaderi, 2006).

3.3.3 Reflections

The effectiveness of Ontogenic-level support in meeting young people's mental health needs is supported to an extent, by evidence. This support addresses some of the known individual risk factors such as drug and alcohol abuse (Weaver et al, 2003), poor diet (Prince et al, 2007), insufficient exercise (Paluska & Schwenk, 2000) and relaxation (Rubia, 2009). By practising a healthy lifestyle and receiving guided self-help, active coping is reinforced. However, onus is very much on the individual to take advantage of this support. This may be particularly challenging for individuals with mental health difficulties and young people due to motivational issues and limited financial resources to engage in such support. In addition, other individual risk factors such as those associated with the onset of puberty, gender and ethnicity outlined in the previous chapter, are not addressed by this support.

It can also be argued that by enhancing active coping skills, self-help can also counter Microsystem, Exosystem and Macrosystem risks, as the individual is better equipped to manage such factors.

Considering such interventions are largely the responsibility of the individual, little research appears to have been conducted to examine whether such interventions are acceptable to young people or whether their particular mental health needs have been completely met.

3.4 Conclusion: Strengths and weaknesses of UK mental health provision – considering the CAMHS Review.

From the evidence, it appears that proposals within legislation and policy are evident to an extent within mental health provision in the UK and that support is generally effective in meeting the mental health needs of young people. As outlined, this is predominantly done by addressing known risks and promoting protective factors of mental health.

The effectiveness of this support is limited by; null or contrary findings (Pistrang et al, 2008; DfE, 2010; Young & Holdorf, 2003; Killackey & Yung, 2007; Mitchell et al, 2011; Walsh et al, 2004), a limited evidence-base and ability to generalise (Young & Holdorf, 2003; Stallard et al, 2005; 2007) and methodological weaknesses (Wright et al, 2006; Naylor et al, 2009).

It is also undermined by findings of the CAMHS review (DCSF & DoH, 2008) which, along with other research (Killackey & Yung, 2007; Prymachuk et al, 2012; Slowik & Noronha, 2004), has noted capacity difficulties and barriers to support due to stigma and young people's lack of knowledge of available support. Indeed, stigmatising attitudes not only significantly impact upon young people's ability to seek help and live normal lives (Mind & Rethink Mental Illness, 2013), they are apparent in young people (HSCIC, 2011) and research has found limitations in their knowledge of available support (Burns & Rapee, 2006). Due to these barriers and capacity issues, the gap between unmet need and mental health support for young people is significant (McGorry et al, 2007) and the largest worldwide (Herman et al, 2012). Within the UK, from data available, one in ten young people have a clinical diagnosable disorder (ONS, 2005; Meltzer, 2007). A review of the IAPT strategy revealed only twenty thousand fifteen to nineteen year olds accessed therapeutic support in 2012-2013 (HSCIC, 2014).

A further weakness identified by the CAMHS review (DCSF & DoH, 2008) is the lack of responsiveness to individual needs. This resonates with the lack of consideration for young people's wishes, knowledge, beliefs and attitudes within the above research and the development of support, despite calls for such practice within legislation and policy (DoH, 2011a; 2011b; 2013). A few examples do exist within research such as Harding's (2012) thesis on young people's experiences of TAMHs and evaluations of youth services in Australia (SPRC, 2009). However they did not consult young people to design services and tended to include ex-service-users, whose responses were not always acted upon to inform future practice (Worrall-Davies & Marino-Francis, 2008). In light of research which indicates young people's vulnerability to mental health difficulties, it would be valuable to consult community samples to inform service design.

Key strengths of school-based interventions are their ability to bridge the underserved gap in support (Armbruster & Lichtman, 1999; Amaral et al, 2011) and deliver support in a less stigmatising environment (Atkinson et al, 2013). Evidence from prevention and intervention approaches also offer promise of effective support particularly in light of the increasing onset of mental health difficulties during adolescence (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Brandenberg et al, 1990).

In particular, via objectives to first investigate knowledge, beliefs and attitudes to inform preventative interventions surrounding awareness-raising and attitude change to mental health and mental health support, the MHL framework combines these positive aspects and addresses areas for development within the CAMHS review (DCSF & DoH, 2008). In addition, due to its exploratory parameters, it can readily incorporate young people's wishes regarding support.

The purpose of the next chapter will therefore be to utilise the MHL framework to explore young people's knowledge, beliefs, attitudes and wishes surrounding mental health, mental health difficulties and mental health support to examine strengths and areas which may require further support.

CHAPTER 4

MENTAL HEALTH: YOUNG PEOPLE’S KNOWLEDGE, BELIEFS AND WISHES

Key web-based search terms used: child’s voice*, mental*, health, ill*, disorder*, adolesc*, child*, view*, opinion*, knowledge, understand*, attitude*, stigma*.

4.1 Young people’s voices

Due to the vulnerability of young people to mental health difficulties (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Brandenburg et al, 1990), ensuring that support is effective is crucial. One such way of doing this is for support to consider young people’s voices. This is central to inclusive practice, equality and fairness (Rudduck & Fielding, 2006; Boylan & Ing, 2005). There is also a moral and legal obligation to take account of young people’s voices as potential service-users. For instance, it states within the United Nations Convention on the Rights of the Child (UN, 1990) that young people have a right to express their perspectives on matters affecting them and within government policy are proposals for young people to be placed at the centre of support ((DoH, 2011a; 2011b; 2013). Although over the past two decades, research has turned its focus towards gathering the wishes of young service-users to inform service provision (Worrall-Davies & Marino-Francis, 2008; Plaistow, 2014) this crucial way of more efficiently and effectively directing scarce resources is still in its infancy (Roose & John, 2003).

In addition to collecting young people’s views research has also explored their knowledge, beliefs and attitudes of mental health and mental health support (Roose & John, 2003; Burns & Rapee, 2006). As seen and argued for consistently within research, enabling a better understanding of mental health which includes knowledge of risk and protective factors as

indicated within mental health support, leads to effective help-seeking (Jorm et al, 1997a; Jorm, 2000; Burns & Rapee, 2006; Balls, 2010; Wright et al, 2007).

Using the MHL framework (Jorm, 2000), the following sections will firstly explore the knowledge, beliefs and attitudes of young people surrounding mental health and mental health support. Secondly, young people's wishes regarding the kind of mental health support they would want, at the intervention level, will be explored.

4.2 Young people's knowledge and beliefs

4.2.1 Risks, vulnerabilities and identifying difficulties

Little research exists surrounding children and young people's knowledge and beliefs of mental health (Roose & John, 2003). From the available research however, it appears that from a fairly young age, children are able to understand some of the complexities surrounding mental health. Twelve to fourteen year olds in the Armstrong et al (2000) study reported a range of risks which may precipitate mental health difficulties such as parental difficulties, bereavement, peer rejection and bullying. A study by Roose and John (2003) found that ten and eleven year olds were also able to identify a number of social risks including friendship difficulties and bullying. Wider risks were identified in a sample of one hundred and six young people aged eleven to seventeen such as relational difficulties, environmental adversity, trauma, genetic disposition, congenital and psychological difficulties (Bailey, 1999).

Developmental trends appear to be apparent in children's understanding of mental health. For instance, children aged five and six who are likely to have little familiarity or experience of mental illness (Fox, 2005), cite medical risks such as contagion and contamination (Fox et al, 2010). This finding is preceded by Spitzer and Cameron (1995) and Bailey (1999) who found that younger children conceptualise mental illness as serious physical illness, suggesting how the physical and mental domains may not initially be viewed as distinctive by children and that young children do not have a clear understanding of what mental illness is (Wahl, 2002). With increasing age, children begin to develop a more sophisticated understanding. Fox et al (2007; 2010) demonstrated different conceptualisations of mental health between children aged five and six and those over eleven years of age. In comparison to the younger children, those, aged over eleven, referred less to medical explanations, acknowledging more internal

factors such as the psychological effects of impacting risks. Older children have also been found to attribute mental illness to „disturbances of thoughts and emotions rather than just behaviour“ (Wahl, 2002, p. 146) and are able to discriminate mental health difficulties from learning difficulties (Spitzer & Cameron, 1995). Such patterns of thinking are consistent with Piagetian theory as it would appear that younger children rely on more concrete explanations to explain mental illness whereas older children, more abstract notions (Inhelder & Piaget, 1958; Elkind, 1967). However, Fox et al, (2007) argues that is less to do with Piagetian developmental stages and more to do with children’s experiences of illness.

Young people have been found to believe that mental health difficulties are both universal, and specific to certain groups (Bailey, 1999). Genetic and environmental explanations are given to explain this specificity. These beliefs agree with trauma literature which suggests that mental health difficulties can onset at any point across the lifespan (Mueser et al, 2002; Turner & Lloyd, 1995). It also agrees with research which highlights particular groups as more susceptible such as first generation immigrants who may face higher levels of environmental, social and economic risks (Nazroo, 1997; Sharpley et al, 2001 & Veling et al, 2008). However, in terms of theories which have noted potential genetic vulnerabilities, they are by no means grouped according to such vulnerabilities due to the complexity of genetics and the manner in which they interact with environmental factors (van Os et al, 2009). Such theories also take account of developmentally sensitive time-points such as adolescence, which young people themselves do not seem to be aware of. However, this omission may be due to the limited literature available on young people’s beliefs surrounding vulnerability.

There also appear to be gender differences in the ability of children to identify mental health difficulties. Research has found girls to have significantly superior mental health literacy

(Cotton et al, 2006). For instance, studies have found that girls are comparatively more able to correctly identify signs of mental illness and more accurately predicting recovery time (Burns & Rapee, 2006; Chernets-Taha et al, 2009). Explanations for this have centred on gender role expectations which permit females to talk more freely about emotions and emotional difficulties (Chernets-Taha et al, 2009).

The sophistication of children's knowledge regarding mental health should not however, be overstated. For six and eleven year olds in the Fox et al study (2010), little consensus was reached regarding the conceptions of mental illness indicating greater variability in their understanding of mental health. In terms of identifying symptoms of mental health difficulties, conflicting results have also been found. For instance, in the Roose and John (2003) study children demonstrated sophisticated knowledge, identifying persistent emotional and cognitive difficulties which were in excess of what could be considered transient and reasonable. However, in an Australian study, sixteen year olds were only able to recognise overt signs of depression, such as suicidal intent, and then failed to discriminate this with reasonable reactions of sadness when recommending whether professional help should be sought (Burns & Rapee, 2006). A number of other studies have also found that young people do not have a secure understanding of the term „mental health“ as a description of emotional wellbeing (Lock et al, 2002). Instead they attribute pathogenic conceptualisations, confusing mental health with mental illness (Dogra et al, 2005) or attribute negative (Johansson et al, 2007) and stigmatising meanings (O'Reilly et al, 2009). This may also be relating to the stigma which surrounds mental health issues and the effects of media and popular culture which have created negative connotations around the word „mental“ (Hyler et al, 1991; Wilson et al, 1999) and no less for young people (Wahl, 2002). Finally, although a range of risk factors are referred to, the young people make no reference to the interaction of such

risks within pathways to mental health difficulties. This contrasts with current theoretical and empirical models (Cicchetti & Lynch, 1993; Engel, 1977). However, this may be a result of the limited research surrounding young people's knowledge-base of mental health.

4.2.2 Protective factors: Mental health support

From the limited research available it appears that young people have broad knowledge of support that is available for mental health difficulties and how to obtain this support (Bailey, 1999). Commonly cited sources of support by young people are counsellors, family and friends (Burns & Rapee, 2006). However, young people are also knowledgeable of a wider range of professional mental health support including GPs, professional, specialist mental health support such as therapists and counsellors, as well as non-mental health support such as school-based support and charitable organisations (Roose & John, 2003). Within this study the young people also indicated their knowledge of how systems of support worked, such as the sign-posting role of GPs to further, mental health specialist support.

Young people have been found to have particular beliefs regarding the best kind of support for individuals with mental health difficulties. For instance, they have cited medical staff such as doctors, psychiatrists and nurses as well as segregated settings in caring and secure medical or residential homes (Bailey, 1999). Similar responses are evident elsewhere where young people have been found to believe GPs, psychologists and psychiatrists are an appropriate form of help for individuals with mental health difficulties (Armstrong et al 1998; Kelly et al, 2007). However, their belief in the appropriateness of medical intervention is limited by their disapproval of medication (Wright et al, 2006; Kelly et al 2007). The HSCIC (2011) also found young people were more likely to say at the first sign of mental illness, that individuals should be hospitalised. Such responses may reflect beliefs individuals with mental

health difficulties are different and that inclusive provisions are somehow inappropriate to accommodate this.

However, despite the encouraging findings it does seem that young people's knowledge of mental health support is at a basic level as it appears to be determined by how popularised the support is, rather than its effectiveness. For instance, in Australian schools counselling services are common-place and may not always employ evidence-based practice (Burns & Rapee, 2006). The National Society for the Prevention of Cruelty to Children (NSPCC), a charity identified within the Roose and John study (2003), is also not a dedicated mental health service, but was mentioned because it was frequently advertised on television and in magazines.

Young people's knowledge surrounding the specialisms of different mental health professionals is also lacking (Burns & Rapee, 2006), and their knowledge of self-help has been described as unsophisticated. For instance in a study by Armstrong et al, (2000) young people reported how their self-help skills consisted of internalising feelings until they went away, and dealing with anger through acts of aggression.

From general findings that males' knowledge of mental health is lower than females, implications are made that males' knowledge of mental health support is restricted (Burns & Rapee, 2006; Chandra & Minkovitz, 2006). However, this is complicated by attitudinal factors such as the higher rates of stigma males associate with mental health service-use (Chandra & Minkovitz, 2006) and their reduced willingness to seek support (Juszczak et al, 2003).

4.3 Young people's attitudes towards mental health and mental health support

Much research has found stigmatising and negative attitudes towards mental health difficulties in young people. Indeed not only have negative attitudes been found in young children, they have also been found to increase with age and with increased knowledge of mental health (Wahl, 2002). This finding has been replicated over time. In an earlier study by Royal and Roberts (1987), primary-aged children were found to be more willing to make friends with an individual with mental health difficulties than college-aged young people. Studies have also found that young people believe people with mental illness are different, unable to cope, suicidal and dangerous (Watson et al, 2005) and elsewhere Bailey (1999) has found adolescents were able to cite a number of derogatory phrases and terms including „One slice short of a loaf“, „nutter“ and „demented“. However, such labels may not have been a representation of their own beliefs as they were asked to list names they had heard being used to describe people with mental illness. The belief that individuals with mental health difficulties are dangerous seems to be fairly specific. For instance, a study by O'Driscoll et al (2012) found that peers with ADHD were generally perceived more negatively than those with depression, apart from perceived dangerousness and fear stigma dimension. However, on an implicit level, peers with depression fared less well than those with ADHD as more negative views were expressed this way.

Gender appears to be an influential factor effecting stigmatising attitudes. A number of studies have found that males in general hold more stigmatising attitudes surrounding individuals with mental illness (Pinfold et al, 2005; Watson et al, 2004) and towards help-seeking (Chandra & Minkovitz, 2006). In contrast, females have typically been found to exhibit more benevolence (Ng & Chan, 2000; Olmsted & Smith, 1980). More specifically, adolescent males have been found to hold the strongest, negative, implicit attitudes towards

individuals with depression (O'Driscoll et al, 2012). Such negative attitudes have been found to negatively impact upon effective help-seeking (Gulliver et al, 2010). Indeed, levels of help-seeking in young people are notoriously low across Europe (Essau, 2005; Zachrisson et al, 2006) and world-wide (Sawyer, et al, 2001).

In an attempt to understand the driving factors behind the formation of stigmatising attitudes Jorm and Wright (2008) investigated responses in twelve to twenty-five year olds to vignettes of differing mental health difficulties. Analysis revealed associations between stigma and personal experience of mental ill-health, parental attitudes and media campaigns. This is somewhat surprising given how adolescents increasingly differentiate from their parents with age (Lapsley et al, 1989) and communicates how there may not be alternative challenges to such beliefs for young people. In determining higher rates of stigma in males, again this appears to relate to parental belief but may also be influenced by reduced mental health knowledge found in males, relative to females (Chandra & Minkovitz, 2006). However, within the Chandra and Minkovitz study (2006), the school curriculum addressed areas of mental health which were explored within questionnaire items, leading the authors to suggest gender differences may be more to do with the interaction between the presentation of information, male gender role and socialisation factors. Thus, it seems that if material is not tailored with a male orientation in mind, male gender roles influence the assimilation of mental health knowledge, which then impacts upon their associated beliefs.

4.4 Summary

From the limited evidence above, the sophistication and breadth of young people's knowledge of mental health including risk factors, vulnerabilities and identifying associated symptoms increases with age. However their overall understanding of mental illness and mental health is not secure. This may be due to the saliency of negative portrayals of individuals with mental health difficulties in the media. The complexity of mental health difficulties, captured by continuum arguments may also be contributing to young people's perceptions that mental health and mental illness are indistinct.

In terms of mental health support, young people are familiar with a range of professional and informal support. However, their choices for support are also determined by how commonly available support is. This suggests perhaps a lacking awareness of the range of mental health support beyond that which is obvious to them. This seems particularly true of self-help approaches, which appear to be at a basic level.

Evidence suggests that young people's attitudes towards mental health do not improve as they get older, particularly for males. That this finding has been replicated over time, suggests such attitudes are stable and resistant.

Gender differences also indicate that females feel more comfortable to discuss such issues and demonstrate more positive attitudes which also extend towards seeking help.

However, drawing conclusions upon the knowledge, beliefs and attitudes of young people, based on the above research should be made with caution. Not only is little research available, but as Wahl (20002) points out, research has used a variety of methods and has made little attempt to secure reliability of qualitative data. This limits direct comparisons and suggestions of main effects.

4.5 Young people's wishes

There is not yet a significant, accumulated literature on young people's wishes about the kind of support they would like (Boydell et al, 2010; Dogra, 2005). A review by Warral-Davies and Marino-Francis (2007) highlighted the paucity of research into the views of young people regarding CAMH services. Only thirteen suitable studies were found by this review and of those, methodological flaws were present, including a lack of information regarding the validity of measures, and insufficient details of the features of the sample. In addition, this study pointed out that none of the studies detailed any changes to services as a result of the collection of young people's views.

This agrees with other findings that young people are not actively involved in service development (Dogra, 2005; Roose & John, 2003) despite their wishes to be consulted and included (MHF, 2004; Street, 2004; DoH, 2011c).

The rationale for including young people in service development is not only to more closely meet their needs, but also to encourage their engagement with services (Dogra, 2005) which is a priority area in light of the CAMHs review (DCSF & DoH, 2008) and levels of need in young people (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001; Brandenburg et al, 1990; Hill, 1989; Roberts et al, 1998).

From the limited research that exists, themes have emerged amongst young people's wishes for mental health support for themselves or their age-group. For instance, when asked about support for their age group, young people have consistently made references to family and friends as the first port of call (Offer et al, 1991; Roose & John, 2003; Leavey et al, 2011; Armstrong et al, 1998). In comparison to their recommendations for individuals with mental health difficulties, young people have criticised medical support for themselves. As well as their disapproval of medication (Wright et al, 2006, Kelly et al, 2007), the inadequacy of GPs

in meeting emotional needs has also been highlighted, as they feel a trusting relationship is required (Burns & Rapee, 2006; Plaistow, 2014). Such reasoning also extends to their beliefs that faceless support such as help-lines are inappropriate for their age-group, with counsellors the preferred option (Roose & John, 2003). Young people's preferences for more informal support may be due to their awareness of stigmatising views surrounding seeking more official forms of support. However, young people do seem to be aware of the limits of informal support acknowledging how more complex issues should be dealt with via more formal means such as a GP who is able to signpost to secondary psychological services (Roose & John, 2003).

Despite the great potential for schools to meet the mental health needs of young people (Armbruster & Lichtman, 1999; Amaral et al, 2011; Atkinson et al, 2013), conflicting responses have been found for such support. In some studies young people have highlighted the inappropriateness of school-based support. Reasons for this have been; teacher's lack of confidentiality and the inability of school nurses to meet mental health needs owing to their restricted time in school (Roose & John, 2003) as well as young people's own lack of knowledge of how to access school nurses (DoH, 2011c). However, young people's responses in the Armstrong et al (1998) study indicated that teachers were appropriate to talk to regarding mental health issues.

More general themes within the wishes of young people have been found in a review by Plaistow (2014). Thirty-one UK studies, since 2000 were identified in this review, asking opinions of young people aged twelve to twenty-five years. One of the themes gathered from ex-service users and community samples was the need for greater accessibility which included alternative means of communicating with services, via telephone and email. Secondly, they wanted services to be more responsive, person-centred and tailored to their

needs. In particular, they wanted help to become more independent, to discuss a range of issues and have the choice to bring a family member or friend with them. They also wanted services to incorporate a more flexible approach which could be delivered through outreach services or other settings of their choice, nearer to their home. This agrees with findings elsewhere, in which young people have expressed preferences to choose where they would like to receive support (DoH, 2011c). It also echoes preferences for child-friendly settings which young people may feel more comfortable (Roose & John, 2003).

Access to humanistic, skilled and knowledgeable staff was also important to young people in the Plaistow (2014) study. Staff expertise was also valued by younger children in the Roose and John (2003) study. This may indicate restricted beliefs regarding the appropriateness of non-mental health specialist and community-based support.

The need for confidentiality and trust in the individual providing support also seems to be important to young people. This may relate to their anticipation that what could be discussed will be personal and could be discussed with parents. For instance, in the Plaistow (2014) review, young people feared to disclose to their GP in case they told their parents and in the Roose and John (2003) study, children communicated how a mental health service for children their age should be located outside of school.

A final theme in the Plaistow (2014) study was the need for more information, this included information regarding available mental health support and what to expect from it. This is seen elsewhere in which young people have suggested receiving inductions regarding for instance, the role of the school nurse and services they offer (DoH, 2011c). This theme also included young people's wishes to raise mental health awareness more generally through media campaigns and educational initiatives to address stigma. These points indicate the insight young people have regarding public knowledge and beliefs as well as their own knowledge of

mental health and mental health support which can produce barriers to gaining effective support.

Consistent with the above findings, gender differences appear to influence young people's preferences for support. For instance in the Roose and John (2003) study the children revealed how boys were less likely to seek out support at all. This corroborates Armstrong et al (2000) findings that males make more use of internalising self-help strategies or engage in acts of aggression to deal with anger. Again, these differences could be explained by gender role expectations. However they could also relate to the higher rates of stigmatising attitudes found within young males (Pinfold et al, 2005) effecting their ability to appropriately identify mental health difficulties and seek effective support.

4.6 Summary

From the above findings there appears to be a limited, but accumulating literature detailing young people's wishes regarding the kind of mental health support they would want. In contrast to their recommendations for individuals with mental health difficulties, informal support is favoured and may relate to associated stigma as well as the historical context of mental health treatment which has typically segregated individuals (Arnold, 2008). Their ambivalence toward school-based support is disheartening in light of research detailing its effectiveness and the potential of such support to reach young people (Naylor et al, 2009; Barrett & Turner, 2001; 2006; Stallard et al, 2005; 2007; Puskar et al., 2003; Armbruster & Lichtman, 1999).

The more general wishes of young people identified in the Plaistow (2014) review, echo previous policy pledges (DoH, 2011a) and earlier findings within the CAMHS review (DCSF & DoH, 2008) regarding the short-comings of mental health support for young people. This suggests continuing unmet needs and wishes.

4.7 General conclusion

This literature review has theoretically and empirically demonstrated the vulnerabilities of young people to mental health difficulties. Using Cicchetti and Lynch's (1993) ecological-transactional model, the risks of developing mental health difficulties at each ecological layer have been outlined for young people, along with available mental health support which compensates via the promotion of protective factors.

A review of available mental health support reveals how the effectiveness and evidence-base of existing support is generally encouraging but has limitations. The evidence-base of MHL programs (Rickwood et al, 2004; Pinfold et al, 2005) as well as their objectives to explore young people's knowledge, beliefs and attitudes in order to tailor educational initiatives, has great potential to address weaknesses highlighted in the CAMHS review (DCSF & DoH, 2008). Indeed, a critical examination of the limited research available revealed young people have negative attitudes, knowledge and beliefs which were not entirely consistent with research and the range of support available.

In terms of young people's wishes for mental health support, a limited evidence-base, particularly around their contributions to service development is observed (Dogra, 2005).

This is despite policy agendas such as person-centred planning (DoH, 2011a) and international recommendations to acknowledge the voice of the child (UN, 1990). However, young people are able and willing to contribute their feedback and wishes for support (Roose & John, 2003; MHF, 2004; Street, 2004; DoH, 2011c).

Thus, based on the vulnerability of adolescents to mental health difficulties (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001; Brandenberg et al, 1990; Hill, 1989; Roberts et al, 1998), areas for development within the CAMHS review (DCSF & DoH, 2008), and the need to address areas within the knowledge-base, beliefs and attitudes of young people, the first aim of this thesis is to explore young people's knowledge, beliefs and attitudes using an MHL framework. Based on the limited evidence-base of young people's wishes for support, policy and legal agendas, the second aim will be in addition to what MHL frameworks investigate, and will gather young people's wishes regarding the kind of mental health support they would want at the point of need. Although it is recognised within this study that mental health difficulties exists along a continuum of severity, focus will be given to clinically recognised difficulties.

It is hoped that this will make steps towards enabling more effective preventative and intervention-based mental health support for young people and add to limited evidence-base by providing data on a narrower age-range than previously focussed upon via MHL programs (Wright et al, 2006).

4.8 Research questions

In light of the two aims of this study which were:-

- 1) To explore young people's knowledge, beliefs and attitudes of mental health difficulties and mental health support.

AND

- 2) To explore young people's wishes for mental health support at the point of need.

Four research questions which operationalised as follows:-

- 1) What do young people know and believe about mental health and mental health difficulties?
- 2) What do young people know and believe about support for mental health difficulties and how to seek it?
- 3) What are young people's attitudes towards mental health difficulties and mental health support?
- 4) In terms of support, what would young people want if they were experiencing mental health difficulties?

CHAPTER 5

METHODOLOGY

5.1 Research aims

The aims of this study are four-fold and largely follow an MHL framework (Jorm, 2000). The first is to find out what young people know and believe about mental health and mental health difficulties. The second is to find out what young people know and believe about mental health support. The third is to find out what young people's attitudes are towards mental health difficulties and mental health support and the fourth is to gather the wishes of young people regarding the kind of mental health support they would want, if they were experiencing difficulty. As these questions relate to a specific context – Highfields School – and involve subjectivity, a qualitative design and analysis was employed which is described below.

5.2 Epistemological perspective

In light of the research aims which signal the endeavour to explore concepts and views which stem from an observable, objective reality, this study is situated within the critical realist paradigm. Bhaskar (2008) highlights how, similarly to positivism, critical realism acknowledges an objective and intransitive reality which occurs independently of our knowledge. Forming part of this reality are the people, structures, norms, events and mechanisms within society which have independent, generative and causal powers (Danermark et al, 2002). However, critical realism not only provides a scientific alternative to naive positivism, it also tempers more radical constructivism, which denies an objective reality at all (Maxwell, 2012). This is because critical realism acknowledges both an intransitive and transitive reality (Bhaskar, 2008). Unlike the intransitive reality, which exists

objectively and independently of our comprehension of it, the transitive reality incorporates people's ever-changing conceptions and knowledge of reality. Thus, it is proposed that the objects of social science such as mental health and mental health support are both real and constructed; socially produced and socially defined (Sayer, 1992).

Concepts are thought to mediate the relationship between real and constructed worlds. Thus, Danermark et al (2002) argue for the importance of considering everyday conceptualisation in social science research. This brings Danermark et al (2002) to highlight the central importance of language. Indeed, Habermas (1984) describes language as an interface between reality, intentions and collective norms. However, Danermark et al (2002) point out how, although language exists independently of intentions, it is not representative of reality and does not ensure meaning. Meaning within language is, in any case, not constant but changes over time, within different contexts and is subject to different meanings people attribute. In this sense, meaning is continually co-constructed subject to inter-subjective judgments and approval. Thus, the role of the social scientist is therefore to interpret people's interpretations, through a double hermeneutic process. Data gathered from these differing subjective parameters can then, according to Danermark et al (2002) be used to make inferences to universal conditions and previous research to generalise findings.

Compatible with critical realism and qualitative research design, this study chose focus groups as a method of data collection. The objective of focus groups is to obtain data on a number of participants' feelings, attitudes and perceptions surrounding a certain topic (Vaughn et al, 1996) or objective reality. As a group, participants are encouraged to interact with each other and co-construct their answers and relative meanings as social interaction is a core feature of the focus group method (Morgan, 1998; Puchta & Potter, 2004). Also, in agreement with Danermark et al (2002) suggestions, focus group researchers are the primary

instrument of data collection. In refereeing group dynamics, moderators become part of the interaction through careful questioning, summarising, framing and re-framing responses, to facilitate development of useful and appropriate responses (Puchta & Potter, 2004). Indeed, moderators must strike a careful balance between guiding conversation, and leading it (Vaughn et al, 1996).

5.3 Research design

Qualitative research is concerned with capturing perspectives, making use of more flexible methods and approaches to data collection and producing rich and deep data (Howitt, 2013). Indeed, a key strength of qualitative research design lies in its ability to generate rich data which is more appropriate to topics of interest within the social sciences. Qualitative research has the capacity to acknowledge subtleties which can be powerful. This opposes more reductionist, quantitative designs which may fail to surface such valuable insights (Robson, 2011).

Ritchie and Lewis (2003) suggest that it is also important to note the boundaries of qualitative research. For instance, as qualitative research positions itself away from positivist approaches, it acknowledges approximate or multiple realities and is not as concerned about generalisation of findings and knowledge (Howitt, 2013). Indeed, qualitative data is usually taken from small sample sizes (Robson, 2011), is often language-rich, bound by the time and social context within which it was produced. Greater specificity therefore, frames qualitative data and should be kept in mind when both interpreting and applying the findings of qualitative data. For example, findings cannot be generalised to the general population but can be transferred to a similar setting (Anderson, 2010; Vicsek, 2010) or contextualised amongst previous research, allowing for analytical generalisation (Danermark et al, 2002).

The interpretations of the qualitative researcher are based not only upon inductive and deductive reasoning but also their own views and experiences of the world (Robson, 2011). Together with the less transparent or accepted approaches of qualitative analyses, in comparison to quantitative analyses (Braun & Clarke, 2006), this can affect the rigour, reliability and trustworthiness of the data. Thus, additional checks and balances are incorporated to address this potential limitation including; iterative readings of the data over an extended period of time, making explicit the stages within chosen analytical approach, providing an audit trail of the analysed data, reflexivity and testimonial validity. All of these are addressed in the following sections.

5.3.1 Ethical considerations

Ethical standards were upheld prior to, during and following the study. Such standards were taken from the British Psychological Society Code of Ethics and Conduct (BPS, 2009), the Educational Research Guidelines recommended by the British Educational Research Association (BERA, 2011) and University of Birmingham's Code of Practice for Research (UoB, 2012). Full ethical approval was granted through The University of Birmingham's ethical review process on 3rd May 2013. Table One below contains the main ethical considerations which informed the design and conduct of the study.

Table One: Main ethical considerations which influenced the design of the study

<p>Informed consent</p>	<p>A meeting was held with the SENCO and persons responsible for inclusion within the school to discuss the parameters, expected outcomes and plans of the study. This included a full explanation of the study was given and discussion was given surrounding informed consent and arrangements for the focus groups. After school staff were happy to proceed and ethical approval was given by the University of Birmingham, plans were made for the focus groups to take place in July, 2013 (see below for full details of arrangements within the school).</p> <p>All of the students were invited to pre-focus group sessions where the purpose of the research was explained, necessary information was given and opportunities to ask questions were provided. They were also provided with information sheets (Appendix One) and written consent was obtained (Appendix Two).</p>
<p>Practical arrangements</p>	<p>After dates and times were agreed between the researcher and school staff for the focus groups to take place, the SENCO emailed pertinent teachers within the school to remind them where the pupils who had agreed to participate needed to go.</p> <p>The school arranged for suitable rooms in which to conduct the focus groups. Important in assisting qualitative research with</p>

	<p>young people (Danemark et al, 2002; Vaughn et al, 1996) each of the rooms was familiar to the young people, appropriate in dimensions to the requirements of the group discussion and free from extraneous distractions. Also important were efforts to ensure participants felt comfortable and able to contribute (Vaughn et al, 1996). This included making refreshments available to the young people.</p>
Confidentiality	<p>It was explained to the students that their responses would be kept confidential and that no reference would be made to their names on the transcripts or within future publications. After participating in the focus groups, they were informed of the need to respect the privacy of others' responses. The limits of confidentiality were also explained to the participants which involved liaison with the school educational psychologist if I believed from their disclosures that risks to themselves or others was likely.</p>
Young age of participants	<p>As the participating students were below the age of eighteen, which has ethical implications for their capacity to consent, parental consent, in line with BERA (2011) was sought. Parental invitation letters were sent out with opt-out slips at the bottom (Appendix Three). Parents were given two weeks to return the slip if they did not wish for their son or daughter to participate. Opt-out consent was the preferred choice of the</p>

	participating school as they were most familiar with this way of obtaining parental consent.
Voluntary status	At the start of each focus group and during the mid-point break, participants were reminded of their voluntary status and that they were free to withdraw at any point. However, it was explained that any data they had contributed would remain, as it would not be possible to identify them from transcripts.
Further support	At the end of each focus group, participants were debriefed and given further opportunities to ask questions. Websites to mental health support were provided on the debriefing sheets (Appendix Four).
Access to results	Highfields school will be able to access a summary of the research findings on completion of this study (see Appendix Five). A short presentation will also be delivered to Hightown EPS (Appendix Six) and an executive summary will be available to parents (Appendix Twelve). In addition, a short summary will be available for the young people who took part (Appendix Seven).

5.3.2 Method

Focus groups

There are many advantages to using focus groups. Amongst the most salient are; data is gathered from a group, providing rich, multi-source information (Robson, 2011). This more efficient way of collecting qualitative data allows for the inclusion of larger sample sizes than would be possible with single interviews. Secondly, as a result of the quality control provided by group dynamics, extreme or anomalous responses are moderated and shared views surface (Robinson, 1999). Finally, Robinson (1999) also highlights the co-construction of responses as a key feature of focus groups which supports individuals to contribute. This would be particularly advantageous when including young people who may require help to construct their opinions and boost their confidence to donate their opinions.

A disadvantage of focus groups relates to the considerable moderator expertise needed to manage and direct group processes, whilst at the same time facilitate participant responses (Robinson, 1999). As a consequence of such moderator involvement, moderator bias may influence responses.

To overcome these disadvantages, interviews were considered. However, it was decided that the relative advantages of focus groups, particularly their co-constructive element, could best accommodate the needs of young people when discussing a potentially abstract and according to research, largely unfamiliar concept (Wahl, 2002; Fox, 2010). In addition, the relative disadvantages of focus groups can be managed. For instance, to build focus group expertise, it is planned for each of the focus groups to inform practice on the next. Presentation of myself as non-expert, maintaining self-awareness of how my own beliefs and experiences may enter the group, and absence of any affiliations with school staff, will assist in neutralising potential, moderator bias (Vaughn et al, 1996).

Participants

Literature suggests that participants within focus groups share things in common (Krueger & Casey, 2000). To this end, all participants were recruited from the same year (Year Nine), with an average age of 14 and were of one gender in each of the groups. A further rationale for having separate male and female groups are the findings within the literature surrounding gender differences favouring females in MHL (Burns & Rapee, 2006; Chernets-Taha et al, 2009; Cotton et al, 2006), attitudes towards mental health (Ng & Chan, 2000; Olmsted & Smith, 1980) and help-seeking (Juszczak et al, 2003; Roose & John, 2003).

According to the literature, focus groups can legitimately comprise a wide-ranging number of participants. Recommendations range between six and twelve participants (Folch-Lyon & Trost, 1981), eight and ten (Wells, 1974) or between three and fourteen (Krueger & Casey, 2000; Bloor et al, 2001). However, Kitzinger and Barbour (1999) argue that such recommendations can be didactic and that the number of participants should be determined by the researcher's requirements. Thus, in this study it was decided that five participants in each focus group would provide a suitable forum to generate a range of viewpoints as well as enable all to contribute. This number is also consistent with recommendations for including children within focus groups (Vaughn et al, 1996).

Vaughn et al (1996) argue that the number of focus groups included should be dictated by the purpose of the research, the success of the first focus group and the number of groups required until participants' responses can be predicted. Thus four focus groups were included to enable sufficient opportunity for success and adequate saturation of responses.

In light of these sampling decisions and to ensure an equal distribution of participants from across the Year Nine year group, systematic sampling was used. This was done by alphabetising all the Year Nine students into separate male and female lists and dividing the

lists by fifteen to obtain a surplus of thirty young people. Due to absences, two groups of four, a group of five and a group of six participants were included. This meant that nine males and ten females took part. Table Two summarises the main features of each of the four focus groups including the order and duration of each.

Table Two: Summary of the main features of each of the focus groups.

Focus Group	Features
Focus Group 1	-Females -n=4 -Duration: 50 minutes, 40 seconds
Focus Group 2	-Males -n=5 -Duration: 38 minutes, 32 seconds
Focus Group 3	-Females -n=6 -Duration: 77 minutes, 29 seconds
Focus Group 4	-Males -n=4 -Duration: 58 minutes, 26 seconds

Design: structure and content

Prior to commencing the focus groups an opening statement outlined the purpose of the focus groups and together with „ground rules“, established what was and what was not to be expected within the focus groups. Puchta and Potter (2004) emphasise the importance of such preambles in order to facilitate successful focus group responses.

The structure and content of the focus groups is outlined by the semi-structured interview schedule (Appendix Eight). Questions included in this schedule covered all areas of MHL as informed by Jorm (2000). Table Three exemplifies this.

Table Three: MHL objectives and corresponding interview schedule questions used in the focus groups

MHL objective 1) Ability to recognise mental health difficulties.
Corresponding interview schedule questions:- -Questions eliciting the young people’s recognition of mental health difficulties from videos.
MHL objective 2) Address knowledge and beliefs about the causes of mental health difficulties.
Corresponding interview schedule questions:- -What causes mental health difficulties? Can anyone develop mental health difficulties?
MHL objective 3) Address knowledge and beliefs about self-help and professional help

Corresponding interview schedule questions:-

-What help is there for people with mental health difficulties?

-What help is best/worst?

-Do you think young people would know what support is out there and how to access this support?

MHL objective 4) Encourage attitudes that enable the recognition of difficulties and help-seeking.

Corresponding interview schedule questions:-

-What do other people think about someone with mental health difficulties?

-What would you think about someone with mental health difficulties living next door to you?

-What do you/people think about someone who was receiving help for mental health difficulties?

MHL objective 5) Address knowledge of how to seek mental health information.

-(after exploring their knowledge of available help) How can people get this help?

Due to the comprehensive nature of MHL frameworks and their broad aims to educate the public and encourage help-seeking (Jorm, 2000; Wright et al, 2006), additional questions were included. For instance, in line with salutogenic models of mental health (Antonovsky, 1979; 1985; 1996), a question surrounding the concept of mental health rather than mental

disorder was included. In terms of their beliefs concerning the best kind of help, questions asked what the best kind of help was for both individuals with mental health difficulties and themselves, at the point of need. This will enable a more rounded exploration of their beliefs and knowledge regarding support which has previously been researched separately (Bailey, 1999; Offer et al, 1991). It will also provide a more meaningful and informative comparison against their own wishes for support and indicate their attitudes towards individuals with mental health support. Regarding their wishes for support, areas included:

- What young people would like if they were experiencing mental health difficulties.
- Whether they would like this support in school.

Although Piagetian theory asserts that formal operational thought and thus the ability to think abstractly, is achieved by adolescence (Inhelder & Piaget, 1958; Elkind, 1967), empirical findings suggest this may not be universal (Kuhn et al, 1977). Therefore, the design of the semi-structured interview schedule and implementation of the focus groups took account of the cognitive variation that may be present in the young people as well as their potential unfamiliarity with the subject matter. For instance, concrete questions, videos, visual aids and prompts were included within a schedule designed for children and young people (Vaughn et al, 1996). Secondly, inspiration was taken from previous focus group research which had been successful in generating discussion amongst young people on the topic of mental health (Merriman, 2009). This included the use of group activities. Further details of the key design features are included in Table Four.

Table Four: Focus group design features which accommodate the young age of the participants and the complex topic to be discussed

Design feature 1
<p>- Semi-structured interview schedule (Vaughn et al, 1996) (Appendix Eight), including:</p> <ol style="list-style-type: none"> 1) Ice-breaker and warm-up sections. 2) Clarification of terms. 3) Movement from easier and broader questions to more difficult and specific questions. 4) Wrapping up and member check sections. 5) A closing statement.
Design feature 2
<p>-Visual aids and prompts (Appendix Eight & Nine), including:</p> <ol style="list-style-type: none"> 1) „Agree“ and „Disagree“ cards, „Group discussion“ and „Talking Partners“ cards to both stimulate and control discussion. 2) Laminated images relating to and providing context for the questions. 3) Further verbal prompts following questions included in the semi-structured interview schedule to elicit more detailed responses.
Design feature 3
<p>-Concrete tasks and questions:-</p>

Three short videos taken from the YouthSpace website (Appendix Four), depicting individuals with differing mental health difficulties, including psychosis, depression and obsessive compulsive disorder (OCD). These particular videos were chosen as they illustrated some mental health difficulties which young people were likely to be familiar with (depression, OCD) and one, which according to research (Jorm et al, 1997b), they are less likely to be familiar with; psychosis.

Design feature 4

-Group ranking activity:

This activity involved three ranking exercises. The first was to rank in order risks identified in terms of most and least likely to lead to mental health difficulty. The second was to rank in order the most to least recommended mental health support for individuals with mental health difficulties. The third was to rank in order the best to the worst routes to support. Such information was then used to discuss the most and least suitable forms of support, if they were to develop mental health difficulties.

5.4 Analysis

Within a qualitative paradigm and consistent with critical realism, analysis involves hierarchical description of social phenomena, ordered from surface observations to deeper analysis (Howitt, 2013; Robson, 2011). This entails analysis which is true to the data collected but also acknowledges the personal perspectives of the researcher, which are utilised to understand and interpret the data. Theoretical and empirical positions also guide a higher order analysis (Boyatzis, 1998).

A number of qualitative approaches of analysis suitable for focus group data exist. The main approaches and their features are contained in Table Five below.

Table Five: Features of main approaches to qualitative analysis (taken from Howitt, 2013).

Qualitative analysis	Description
Grounded theory (GT)	<ul style="list-style-type: none">-Typically employed methods are interviews and focus groups.-Process of systematic theory-building from the „social reality“ (Howitt, 2013, p.205) contained within the data.-Makes use of inductive rather than deductive processes.-Stages include: data familiarisation/iterative reading, coding data into categories to reveal relationships and theoretical ideas. Further sampling to test categories, relationships and

	develop theory.
Interpretative phenomenological analysis (IPA)	<ul style="list-style-type: none"> -Typically employed methods are semi-structured interviews and case studies. -Concerned with individuals' experiences, leading to psychological interpretations. -One account is initially analysed prior to researcher comparing with further accounts. Similarities and differences then form an important part of the analysis. - Makes use of inductive rather than deductive processes. -Stages include: data familiarisation/iterative reading, initial ideas, theme generation indicated by descriptive title, super-ordinate and sub-themes.
Discourse analysis (DA)	<ul style="list-style-type: none"> -Typically employed methods are group discussions and focus groups. -Concerned about the nature of talk or „language in action“ (Howitt, 2013, p229) in which beliefs and attitudes are constructed in language.

	<ul style="list-style-type: none"> -Theoretical themes underpin analysis. -Stages include: iterative reading of text, coding and categorisation.
Thematic analysis (TA)	<ul style="list-style-type: none"> -Typically employed methods are group discussions, focus groups and interviews. -Concerned with identifying major themes to provide description of the data. -Stages included: familiarisation with the data/iterative reading, conceptually theme and code the data, re-check codes to ensure they fit with the data. -Flexible approach to theme and code-finding and incorporating quantitative methods.

In considering the different approaches to qualitative analysis, TA was the most appropriate as the aims of this study were to provide a broad, descriptive account of young people's knowledge, beliefs, attitudes and wishes to inform future provision. The flexibility of TA to incorporate a number of approaches included in the above methods was also advantageous. For instance, within TA both deductive and inductive processes can be accommodated (Guest et al, 2012; Boyatzis, 1998). Thus, data and theory-driven codes can be generated. It is therefore a particularly appropriate approach given the critical realist stance of this study and

the use of the MHL framework which will both border and contextualise the young people's responses. More than just restricting findings to theoretical models like GT and DA or subjective experiences like IPA, TA relates findings to research questions and applies them to real world contexts (Guest et al, 2012). This is particularly relevant to the objectives of this study which seek to inform preventative and intervention-based mental health practice for young people.

Typically, qualitative methodology does not accommodate quantitative approaches. However, within the descriptive parameters of TA, and consistent with critical realism (Bhaskar, 2008; Danermark et al, 2002) quantitative analysis can be accommodated in which the frequency of codes can be counted to provide descriptive comparisons. Such analysis informed the discussion of themes and outcomes of the ranking activity to reveal the type of risks and support most and least highly ranked by the young people. In addition, code frequencies formed part of the analysis, of gender differences.

5.4.1 The TA process

A consequence of TA's flexibility, is a lack of commonly accepted protocol, meaning that attempts should be made, when using TA to detail how analysis is to be carried out (Braun & Clarke, 2006; Howitt, 2013). The following stages, which are also explicitly demonstrated within Appendix Ten, highlight how TA was conducted in this study which incorporated approaches by Guest et al, (2012), Boyatzis (1998) and Braun and Clarke (2006):

- 1) Iterative reading of the transcript data with research questions in mind.
- 2) Structuring of qualitative data according to questions asked to provide context to themes.
- 3) Initial idea-generation annotated in the margins of the transcripts.
- 4) Identifying emerging themes.
- 5) Identifying subordinate codes as higher order themes (Guest et al, 2012).
- 6) Identifying super-ordinate codes. All codes are represented within the codebook (Appendix Eleven).
- 7) Representing codes within a series of code maps which correspond to each research question.

Braun and Clarke (2006) state it is important to make explicit what counts as a theme. They suggest a theme describes an important aspect of the data which corresponds to the research question and represents a „patterned response“ (p. 10). Within this study, codes indeed captured data relating to research questions however, they did not necessarily represent a patterned response as it was felt this may restrict the variation of responses. Thus inductive and deductive processes were used to identify themes which did not depend upon

concurrence between groups. To further ensure that the young people's voices are represented whilst still clearly presenting and acknowledging the main themes, responses which were an exception to the main themes are highlighted and discussed within the analysis. They are also included alongside the main findings within sections detailing the implications of the findings and the presentation to Hightown EPS (Appendix Six).

The disadvantages and limitations of TA, like other qualitative forms of analysis lies in the fact that the researchers are very much „involved“ in the data and thus can bring their own interpretations.

5.4.1a Trustworthiness and reliability

As well as making the stages of TA explicit and presenting an audit trail from the raw data to themes and codes, other approaches used to strengthen the trustworthiness and reliability of the analysis, are summarised in Table Six.

Table Six: Further approaches to achieve greater trustworthiness and reliability

Testimonial validity	As highlighted within Table Four, member checking was a feature of the focus group design. This occurred throughout the interview and at the end of each group to summarise their thoughts and discussion. By including a member check, consensus within the groups was achieved and meaning could be clarified. This enabled a more accurate interpretation of data contributed by the participants.
Iterative readings	Transcripts were re-read and re-visited over a 12 month period. This assisted in refreshing on-going analysis and ensured themes and codes were continually checked against the raw data.
Audit trail of the analysis of data	Appendix Ten illustrates the relationship between the raw data and the development, presentation and analysis of codes. It utilises the TA process highlighted above by using

	<p>worked examples of analysed sections of focus group transcripts, relating to each research question. It also makes transparent codes relating to each of the focus groups which have then contributed to the common codes represented within the code-maps in Chapter Six.</p>
Reflexivity	<p>To reduce potential bias, a reflexive approach, guided by Mauthner and Doucet (2003) was employed. This took account of the social and emotional position of myself in comparison to the participants and how this may affect my interpretation of the data. For instance, as an older person, already familiar with mental health and mental health support from previous completing a Ph.D in psychosis, this may have framed some of my questioning and analysis of themes. By ensuring regular reflection upon and review of my interpretations of the data I was able to observe how my own experiences and assumptions may influence my analytical decisions. This process therefore assisted me in separating myself from the data, enabling me to get closer to what the young people</p>

	were trying to say.
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As already discussed, moderator expertise are important in managing focus groups and may, if inadequate, impact upon the trustworthiness of the data. It may therefore have been beneficial to include a pilot study to trial the focus group process, obtain and reflect upon the responses given. However, in light of my considerable experience managing young people and groups from my previous research and teaching career as well as plans which developed focus group expertise across the four groups, allowing one to inform the other, it was decided a pilot study would not be included.

5.4.1b Code frequencies

As recommended by Carey (1995), code frequencies will be counted at the group rather than the individual level as individual responses are interdependent within focus groups. Although by counting code frequencies at the group level, the responses of more dominant participants which others merely agree with or do not challenge may be substantially adding to the code frequency, it can be argued that this is broadly representative of social interaction processes which create knowledge and are recognised by a critical realist perspective.

Although where necessary, the number of groups in which a code emerges will be made explicit, to assist the discussion of the frequency with which codes emerge, other linguistic indicators will be used. This will include whether „all“ groups mentioned a code, whether „most“ groups mentioned a code and whether „some“ groups mentioned a code. „Most“ indicates the code is present in three groups, „some“, in two or one of the groups. This approach will also apply to responses given within the ranking activities.

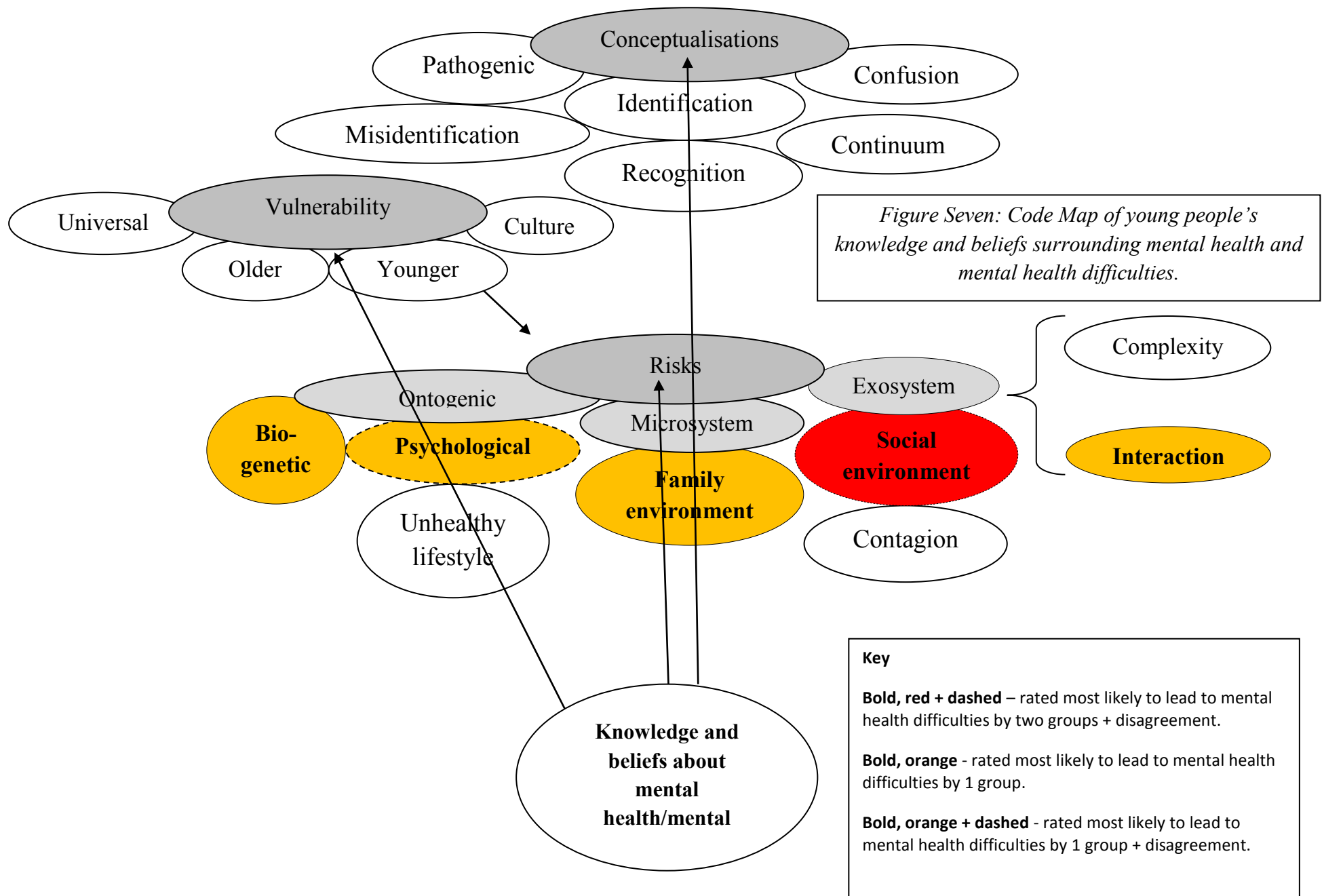
CHAPTER 6

DISCUSSION OF FINDINGS

As referred to in the Methodology chapter, a code map of each of the research questions will now be discussed in turn to provide analysis of the findings. Within the discussion of the findings, strengths and areas for development will be considered surrounding the young people's knowledge, beliefs and attitudes towards mental health, mental health difficulties and support. A summary of the findings of each code map will follow each of the discussions. The exception to this is research question three, where a summary follows the two code maps which accompany it. The final code map will detail the young people's wishes for support. In-line with both deductive and inductive processes, throughout the discussion of all of the code maps, findings will be considered within the context of literature already outlined as well as any new, relevant literature.

After the code maps, key gender differences found will be presented and discussed. The strengths and weaknesses of the study will then be outlined prior to providing an overview of the salient findings and their implications. Implications for practice will be discussed in terms of opportunities for preventative and intervention-based mental health support for young people.

1) What do young people know and believe about mental health and mental health difficulties?



6.1 Knowledge and beliefs about mental health and mental health difficulties

From the findings there are strengths and areas for development within the knowledge-base and beliefs of young people aged fourteen surrounding mental health and mental health difficulties.

6.1.1 Strengths: Conceptualisations, vulnerability and risks.

6.1.1a Conceptualisations

All of the groups were able to correctly identify and label certain mental health difficulties. This was consistently the case for certain mental health difficulties such as OCD and depression which were presented within the videos and may be due to their familiarity with such difficulties. In particular, their identification of depressive symptoms from the melancholy behaviour of the individual in the video, suggested sensitivity to such difficulties. However, in light of the lack of discrimination young people have previously demonstrated, between overt signs of depression such as suicidal intent and reasonable reactions of sadness (Burns & Rapee, 2006), This finding may have been driven by a lack of sensitivity to such difficulties.

All of the groups were able to recognise the presence of a mental health difficulty by describing symptoms and the potential impact such difficulties may have on an individual life. Earlier research with younger children corroborates this finding (Roose & John, 2003), suggesting that such tasks may not be challenging for young people. Indeed, all the groups were able to recognise mental health difficulties in this way.

'Seemed depressed' (Focus Group (FG 3))

'The OCD is like ruling over him' (FG3)

'Is it like psychological problems like paranoia and things like that...It sort of takes over their lifestyle really doesn't it?' (FG3)

'Hallucinating, hearing voices' (FG3)

'...he's like shutting everyone out...' (FG3)

'He could be going through a bad time' (FG1)

'Cus it's like affecting your health like mentally cus it's making you do things over and over again.' (FG2)

Finally, some of the groups appeared to understand how mental health difficulties exist along a continuum.

'...it could be maybe some worries or problems, it doesn't necessarily mean that it's going to be a mental health problem.' (FG4)

This hints that they are aware that transient and subclinical mental health difficulties may share a qualitative similarity with clinical-level mental health difficulties which agrees with continuum arguments (van Os et al., 1999).

6.1. 1b Vulnerability

In-line with previous findings (Bailey, 1999), all of the young people in this study believed that mental health difficulties were universal, in that all individuals are susceptible.

'You don't choose it, it just happens, to anybody.' (FG4)

'Nobody's perfect, so there's always a chance' (FG3)

However, all of the young people also believed that both older people and younger people were most vulnerable. Their reasons for selecting older adults surrounded the likelihood of developing neurologically degenerative diseases such as Alzheimer's disease and dementia. This may indicate some confusion around the distinction between neurological and mental health difficulties.

'...Alzheimers...like some...older people hear voices...But I think most young people have depression.' (FG1)

Similarly, to previous findings, (Bailey, 1999), environmental factors were prominent within the thinking of young people and were invoked to explain vulnerability in both older and younger individuals.

'And more pressure when you're younger, like exams and getting your future right and everything just like piles down on you.' (FG3)

'Older, cus someone in your family could die...they might be sad like a brother or somebody like a husband or wife could die.' (FG2)

Environmental factors were also considered when some of the groups highlighted the vulnerability of certain cultures. Indeed, as previously referenced, varying rates of mental health difficulties have been noted across different cultural groups within the UK (Nazroo,

1997; Sharpley et al, 2001). However, young people in this study employed a different reasoning, to the likelihood of social and economic deprivation, highlighted by research (Morgan et al, 2006). Some of the groups stated how certain cultures place higher expectations on their children, creating a stressful atmosphere in the home which induces mental health difficulties. Thus young people believe that Microsystem rather than Macrosystem and Exosystem risks, as implied by previous research, are a more influential mediator of cultural vulnerability.

6.1.1c Risks

Young people were able to identify a range of risks at varying ecological levels, apart from at the Macrosystem level.

At the Exosystem and consistent with previous findings of young people's responses, social risks were identified (Roose & John, 2003; Bailey, 1999). Indeed, all of the groups cited social difficulties including friendship difficulties, adversity/trauma and stressors.

'...pressure within the groups of friends that you have.' (FG4)

'Bad things happening to you....' (FG4)

'Did she get bullied at school?' (FG1)

'Stress...pressure.' (FG2)

At the Ontogenic-level, most of the groups identified psychological and biogenetic risks. This agrees with previous responses given by young people (Bailey, 1999; Fox et al, 2007; 2010; Wahl, 2002). In terms of psychological risks, this included emotional difficulties, differences in personality, previous experiences and the mind.

'You can be born with it as well I think...' (FG3)

'Cus like if your parents had it.' (FG4)

'You might feel suicidal' (FG3)

'Confidence' (FG4)

'Like, you could...from the past, then you see it again, it could scare you.' (FG4)

'Your mind...if you're mental you can basically get it from anything like spiders...Is it like something in your mind thinks it's not clean..?' (FG2)

Reference to psychological risks, is expected due to the age of the participants and developmental trends in thinking around mental health in which older children are able to discuss more abstract concepts (Fox et al, 2007; 2010). Indeed, the young people were aware of the distinction between mental and physical health.

Some groups also commented upon the interaction of individual and environmental risk factors stating how all of the risks they have identified could have a part to play in pathways to mental health difficulties. Research with adults found for the acknowledgement of environmental risk factors (Matschinger & Angermeyer, 1996; Priest et al, 1996; Jorm et al, 1997b). Thus in contrast, the young people's comments regarding an interaction of factors, suggests they have a sophisticated understanding of the aetiology of mental health difficulties. Indeed, their understanding is consistent with influential models of mental health (Engel, 1977; 1980; Antonovsky, 1979) and developmental psychopathology (Cicchetti & Lynch, 1993).

Most of the groups identified familial risks including parental and childhood factors, which have been found within pathways to mental health difficulties (Meltzer, 2007; Strohschein, 2005a; 2005b; Harvey, 2012; Read et al, 2005; Spataro et al, 2004; Bond et al, 2001).

‘...if like your mom and dad split up and it would make your like, your head feel weird, like different feelings.’ (FG4)

Some also highlighted an unhealthy lifestyle, such as having sleep difficulties which also has an evidence-base (Chen et al, 2006).

Consistent with the Roose and John (2003) findings, some of the groups understood the complexity of mental health difficulties, particularly surrounding risks. This included individual differences and how knowledge of causes is inexact due to its complexity. This echoes Cicchetti’s & Rogosch’s (1996) principles of multi- and equi-finality.

‘...everyone’s different and everyone reacts to things different, someone could react to some trauma but someone could not...’ (FG3)

‘I think it’s hard to know what can cause it because there’s so many, different things.’ (FG3)

In terms of their beliefs regarding the likelihood these risks could lead to mental health difficulties, rated most likely by two of the groups were social risks. This included adversity, trauma and stressors, all of which have a substantial evidence-base within pathways to mental health difficulties (Bond et al, 2001; Denscomb, 2000; Fowler et al, 2009; Read et al, 2005). However, included within social risks, one of the groups felt that friendship difficulties were least likely to lead to mental health difficulties. These responses suggest young people understand social risks hierarchically, in that adversity/trauma and stressors are more serious than friendship difficulties, which are a more common occurrence. This agrees with research which has investigated social connectedness but found other factors to be more contributory to poor mental health outcomes (Chappel, 2012).

Following this, rated most likely by one of the groups each were biogenetic, familial and psychological risks. An interaction of individual and environmental risks was also seen as most likely to lead to mental health difficulties by one of the groups. Biogenetic risks have been found within the aetiology of mental health difficulties (van Os et al, 2009). Also, beliefs in the significance of familial risks, communicates young people's understanding of their impact and agrees with the ecological-transactional model which locates Microsystem risks most proximally to the individual (Cicchetti & Lynch, 1993). For psychological risk factors however, disagreement occurred. Some groups felt personality factors such as confidence were most likely, but problems with the mind and emotional wellbeing difficulties were judged least likely. Such decisions suggest beliefs surrounding personal responsibility for the onset of mental health difficulties and possible confusion.

6.1.2 Areas for development: Conceptualisations, vulnerability and risks

6.1.2a Conceptualisations

Further weaknesses surrounded how the young people conceptualised mental health difficulties. For instance, most groups exhibited confusion over the direction between cause and outcome, between learning and mental health difficulties. Their confusion between mental health and learning difficulties is not entirely consistent with previous research which has found that with age, young people are better able to discriminate such difficulties (Spitzer & Cameron, 1995).

'Interviewer: What triggers it?' (FG2)

P1: 'Stress, depression' (FG2)

'...well my friend...her nan and granddad know this ...man he's er 70 and has got a mind of an eight year old...' (FG3)

Within the videos, some groups also misidentified some mental health difficulties, attributing the wrong label. Examples of this included the misattribution of psychosis for OCD and depression. This echoes previous research findings of the misidentification of mental health difficulties within adult samples (Jorm et al, 1997a) and may be because OCD and depression are more familiar to young people than psychosis.

Finally, when asked what they understood by the term „mental health“, all groups attributed pathogenic conceptualisations.

'People being crazy' (FG1)
'Mad person' (FG3)
'...not as medically developed as other people' (FG4)
'ill' (FG4)

This is a consistent finding within previous research (Dogra et al, 2005; Johansson et al, 2007; O'Reilly et al, 2009) and suggests that the negative connotations associated with the word „mental“, as propagated by popular culture and the media (Hyler et al, 1991; Wilson et al, 1991; Wahl, 2002), drives this. It also suggests young people do not have a sound understanding of mental health and mental health promotion, as championed by salutogenic models, are not salient within the thinking of young people.

6.1.2b Vulnerability

The absence of any reference to individual vulnerabilities allied to genetic or biological factors contrasts these findings with previous responses of young people (Bailey, 1999).

Indeed, „the young people“s emphasis on environmental factors indicates a lack of knowledge of the role of other genetic and neuro-developmental factors which interact with psycho-social risks to leave young people particularly vulnerable to mental health difficulties (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001; van Os et al, 2009; Paus et al, 2008). This suggests that although young people are aware they may be particularly vulnerable to mental health difficulties, they do not have a complete understanding of how or why they may be vulnerable to mental health difficulties.

6.1.2c Risks

Risk of contagion was cited by some of the young people. For instance, they communicated how being around people with mental health difficulties can cause one to develop such difficulties.

‘If you see people...it can send you that way like, if you look at someone, like crazy, you could turn out like that cus you feel that sorry for them...’ (FG1)

‘ He might even give you mental problems, cus he’ll make you scared to go home.’ (FG4)

This finding contradicts earlier studies which have found much younger children to cite these explanations due to their lacking experience of mental health difficulties (Fox et al, 2007; Fox, 2005). Likewise this finding may be an indication of their lacking experience, and thus limited knowledge.

Secondly, a lack of concurrence between the groups regarding the likelihood of risks leading to mental health difficulties, and only some groups highlighting certain risks as most likely, suggests the need to further develop their knowledge and understanding surrounding the contributions such risk factors make within pathways to mental health difficulties.

Finally, despite their understanding that mental health difficulties are part of the mental domain, their disagreements surrounding the likelihood of psychological risk factors leading to mental health difficulties, suggests confusion. For instance, personality factors such as confidence were seen as a most likely cause, but the mind was seen as least likely. This also suggests young people perceive mental health difficulties fatalistically, as part of an individual make-up.

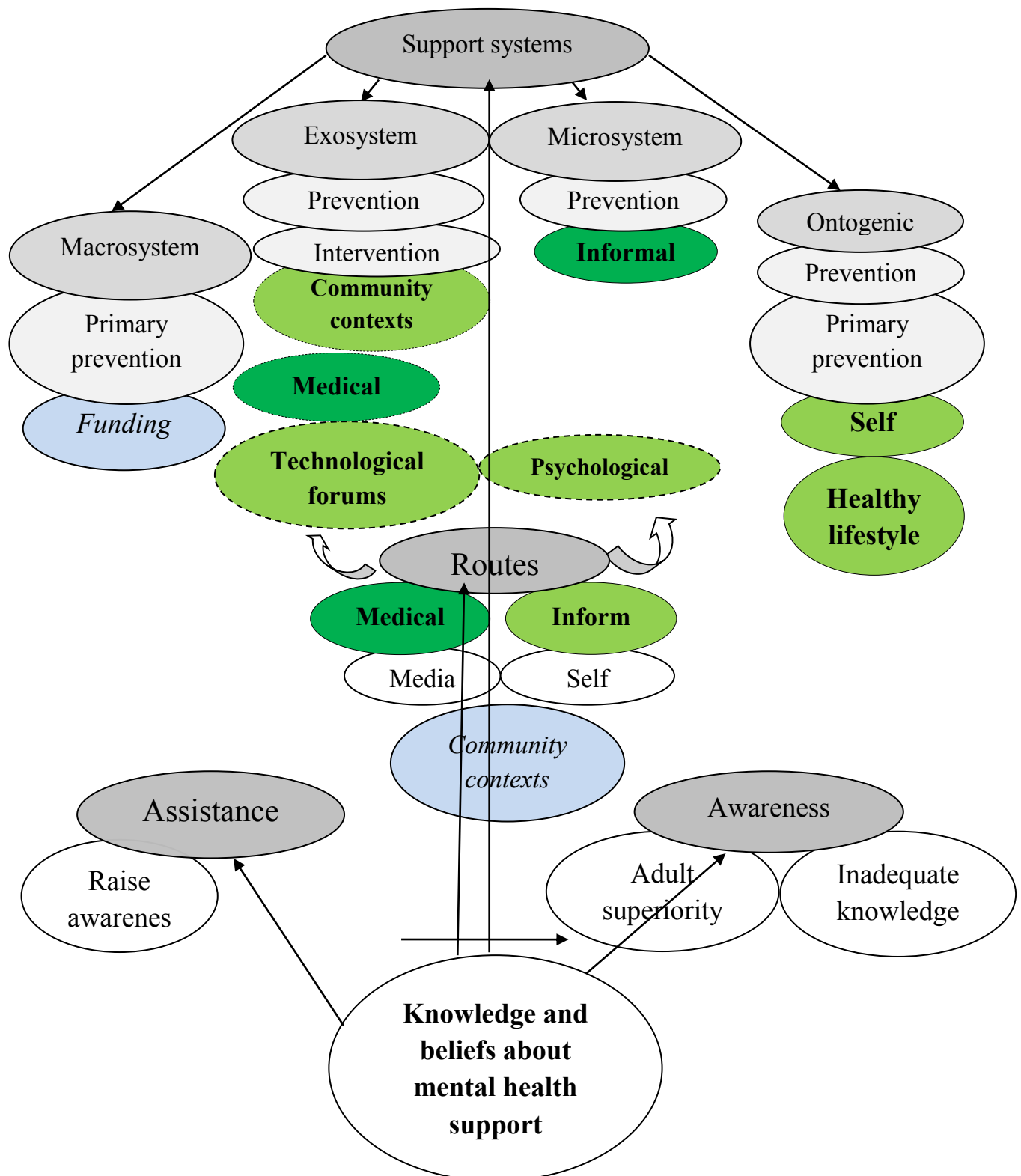
6.1.3 Summary

In summary, young people have a broad and developing understanding of mental health difficulties. Key strengths were their ability to identify more common mental health difficulties, their associated symptoms and impact upon functioning. They were able to identify groups of individuals who are potentially vulnerable and consider mental disorders as a universal phenomenon which exist along a continuum of difficulty. In terms of risks, they had a broad knowledge-base which was generally contextualised by research, demonstrating they had appropriate knowledge and beliefs of factors likely to lead to mental health difficulties.

Areas for development included; some of the groups' lack of knowledge concerning a wider range of mental health difficulties; confusion amongst all groups around cause and effect, mental health, learning and neurological difficulties. With all of the groups there was also a lacking awareness of what „mental health“ meant, references to contagion within all groups and no reference to the interaction of individual and environmental risk factors when explaining vulnerability. Finally, the lack of agreement amongst the groups, surrounding risk factors, lack of any reference to Macrosystem risks, confusion and fatalistic perceptions surrounding psychological risks, potentially signals their lacking knowledge regarding risks.

1) What do young people know and believe about support for mental health difficulties?

Figure Eight: Code Map of young people's knowledge and beliefs surrounding mental health support.



Key

Bold, dark green – most recommended by most groups.

Bold, dark green + dashed– most recommended by most groups + disagreement.

Bold, light green – most recommended by some groups.

Bold, light green + dashed– most recommended by some groups + disagreement.

Italics, light blue – least recommended by some groups.

6.2 Knowledge and beliefs about mental health support

6.2.1 Strengths: Support systems, assistance and routes.

6.2.1a Support systems

Young people noted a broad range of support for people with mental health difficulties, illustrating their broad knowledge-base. Examples of support largely centred on what currently exists within the Exosystem, including prevention and intervention-based support. For instance, all of the groups mentioned psychological support including psychologists, psychiatrists, therapists, psycho-education programs and mentors. All were also knowledgeable of medical support including GPs and hospitals with some mentioning more segregated settings such as inpatient care. Unlike previous findings (Burns & Rapee, 2006), the young people were aware of different professional specialisms, particularly the difference between medical doctors and psychologists.

‘...the doctors they don’t specialise in like mental wellbeing ...the other people who do that like psychologists and that kind of stuff...they take care of that...doctors...they can give you medication.’ (FG4)

Further Exosystem support highlighted by most of the groups included technological forums, including help-lines, on-line forums, NHS websites and „Talk to Frank“. Different community contexts in which mental health support can be delivered were also described by most of the groups including schools, community-based recreational activities, mutual and social support groups, residential homes and outreach support to home. These numerous examples agree with the range of support cited by young people in previous studies (Roose & John, 2003; Burns & Rapee, 2006; Bailey, 1999).

At the Microsystem-level, all groups referred to informal support such as friends and family. This highlights their awareness of this kind of support, echoing research which has identified positive familial relationships (Chappel, 2012) and socialisation (Young & Ensing, 1999) as protective.

Their knowledge of preventative and primary preventative support also extended to the Ontogenic and Macrosystem-levels. This respectively included self-help, living a healthy lifestyle and government funding. Most of the groups identified a range of self-help strategies. These included guided self-help was referred to as well as a range of pure self-help strategies such as; developing resiliency, staying positive, distracting one's self, being proactive, maintaining self-control and developing self-confidence. The first five of these approaches are recognised within the self-help literature (Wilson & Zandberg, 2012; Baguley et al, 2010), with the latter two relating to more generic, personality factors. Reference to personality variables by young people, such as self-control has previously been found (Roberts et al, 1984) however in this study, they were also critical of self-help for individuals with severe mental health difficulties, which echoes research recommendations (Williams, 2001).

'Battle through it' (FG3)

'...don't be negative...you can probably stay positive.' (FG4)

'Like do something to take your mind off things, get a job...' (FG3)

'...they could like ask someone for help, not just keep it to yourself.' (FG1)

'They could try and control it say if it was like anger issues or OCD, they could try and keep like control it.' (FG1)

'Have more confidence in themselves' (FG4)

'Obviously if you've got a major disorder, a big one then you wouldn't be able to do it by yourself.' (FG4)

In terms of living a healthy lifestyle some of the groups made references to eating a healthy diet, engaging in regular exercise and relaxation. Such comments indicate young people can, despite what is suggested by their pathogenic conceptualisations of mental health, identify ways to promote mental health.

Although a few groups commented how many forms of support were important, support most recommended by most of the groups was at the Microsystem-level, namely family and friends. Indeed, family and friends are an important source of support in protecting against mental health difficulties (De Silva et al, 2005; Chappel, 2012; Steinhausen & Metzke, 2001; Elkind, & Bowen, 1979). Most groups also recommended medical support as GPs would know more about mental health difficulties than friends and parents, although the groups disagreed over its appropriateness. For instance, GPs and medication were thought to be most appropriate, whereas inpatient care was judged least appropriate by some of groups.

At the Ontogenic-level some groups felt that self-help and practising a healthy lifestyle were most helpful. Specifically, forms of self-help most recommended were being proactive,

distraction and building resilience. In terms of a healthy lifestyle, relaxation, exercise and maintaining a good diet were most recommended.

More widely at the Exosystem-level, community-based, psychological support and support via technological forums received mixed recommendations by some of the groups. For community-based support, most recommended by some groups was outreach support to the family home, some other groups however, least recommended social support groups, as it was thought that they may not be suitable for everyone. For psychological support, most recommended by some groups were psychologists. For some other groups least recommended were psychological interventions and mentors. Some of their own negative experiences of psychological interventions, such as anger management, appeared to motivate their responses for such support.

<p>'It don't work...You just talk about anger and what makes you angry and you do like this stuff that didn't work.' (FG1)</p>
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Such findings provide a valuable phenomenological dimension to research which points to the success of psychological interventions in school (Barrett & Turner, 2001; 2006; Naylor et al, 2009), and literature which argues for benefits of school-based support (Armbruster & Lichtman, 1999; Amaral et al, 2011; Atkinson et al, 2013).

For technological forums, NHS websites were most recommended by some groups, whereas less mental health-specific websites such as „Talk to Frank“ and Child-line, were least recommended by some groups. This corroborates previous findings, as face-less support was also not appreciated by young people in the Roose and John, (2003) study.

Least recommended forms of support by some groups involved funding streams. Young people's lack of clarity regarding how funding translated into mental health support may have

accounted for this. For instance, rather than discourse surrounding the use of government funding to strengthen systemic support by maintaining services and research, responses surrounded how they could obtain it for themselves.

In light of their recommendations, it would seem that the young people generally favour a range of support for individuals with mental health difficulties. As multi-layer, multi-agency support is recommended by research and policy, this suggests they have generally appropriate beliefs and knowledge that a range of support is effective.

These recommendations agree to a certain extent with previous research which has generally found young people have particular beliefs regarding the best support for individuals with mental health difficulties, citing medical, other professional support and segregated settings (Armstrong et al, 1998; Kelly et al, 2007). However, their wider recommendations which involve a more inclusive focus including informal, promotion-based and needs-specific support offer some contrast this (Bailey, 1999; HSCIC, 2011).

6.2.1b Routes

In terms of accessing support, young people demonstrated knowledge of a range of routes.

Most of the groups identified how the GP, hospital, friends and family and media could assist them in obtaining support. Some of the groups also identified self-help routes and community contexts such as schools and charities.

'... doctors...put you through to a psychologist' (FG3)

'There's leaflets and everything...like internet' (FG3)

'Because... the hospital got like psychologists haven't they and stuff?' (FG4)

'Some people don't help you though so doctors, they don't...really bother, they don't put you through to psychologists, they just send you out, say you're fine so...' (FG3)

'Ask your parents maybe or friends or something' (FG4)

'Tell your Head of Year' (FG4)

'They need to get...the help by their...confidence obviously they need to actually tell someone first.' (FG4)

'Someone might have told ya, or you've overheard...' (FG1)

The Roose and John study (2003) supports these findings as young people highlighted their awareness of how GPs and the media could signpost to further support. However, some of the groups in this study were sceptical of GPs, recalling their own experiences of how GPs have been unhelpful in referring them to mental health support. Also, in addition to the Roose and John (2003) study, within this study, routes to support through hospital settings were also perceived to be helpful, highlighting pathways to care which commonly occur between accident and emergency departments and mental health care (Amaddeo et al, 2001). They also cited additional routes, including support through family and friends, from teachers within school and through self-help means such as being proactive. These various examples suggest that young people are aware of a range of ways of accessing help.

In terms of which routes were best for individuals with mental health difficulties, some of the young people again referred to their own experiences. For instance, following a debate in which some comments of personal dissatisfaction were expressed, most groups most preferred the GP route to support. Another preferred route by some groups was family and friends due to pre-existing relationships.

Possible reasons why these routes were chosen could have been because they were familiar to the young people and uncompromising of them. For instance community-based routes such as schools, were not favoured by some, as they believed this might affect relationships with teachers; a finding which echoed an earlier study (Roose & John, 2003).

‘...because you might have to face teachers like every day...’ (FG1)
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6.2.1c Assistance: Raise awareness

All of the young people were able to identify ways to raise awareness by increasing their knowledge of available support and mental health in general. This included the use of bulletins and educational initiatives within school, media campaigns and experience of individuals with mental health difficulties through befriending systems. Indeed, the young people felt that they had limited experience of available support in which to make informed decisions about it.

‘Distribute it at school and stuff.’ (FG3)

‘Schools teaching it more... Maybe you should be teaching it in Year 8...or even at primary school maybe.’ (FG4)

‘...more like in TV shows...none of them like really have bad mental health, like tourettes or something.’ (FG4)

‘Be nice to the people who have mental health and get to know them and actually talk to them and not be afraid of them and then they could find out more information off there.’ (FG1)

‘...I think I need to actually experience it to actually tell what...I want.’ (FG3)

The donation of such ideas suggests young people would be receptive to educational initiatives. In addition, the suggestions of the young people also highlighted opportunities to gather detailed information regarding the range of support from the perspectives and experiences of individuals with mental health difficulties.

Exception responses

However, some of the groups voiced how it may be unnecessary to raise awareness of support in these ways as they were able to do this for themselves.

‘Interviewer: This is something you would like to be told about? Is it important to know? Or could you find it out anyway?’

Probably find it out anyway.’ (FG2)

This response may be a reflection of how young people are accustomed to finding out information they require independently, on the internet. Rather than a potential barrier to the success of educational initiatives, it could provide valuable insight which could inform the design of future initiatives.

6.2.2 Areas for development: Support systems, routes and awareness

6.2.2a Support systems

It appeared that the young people lacked knowledge of some forms of support. Primarily, this is indicated by their lacking knowledge and confusion regarding funding, and self-help. For self-help this included references to personality constructs including self-confidence and self-control. Indeed, earlier studies have found young people to give similar references to personal skills, such as ignoring feelings or acting aggressively (Armstrong et al, 2000). It also suggests young people believe recovery is within the personal capability of the individual.

The pattern of responses within the ranking exercise also indicated a lack of awareness of the limitations of support, and restricted awareness of what constitutes effective support. For instance, although, certain group members did discuss some of the limits of self-help, aspects of it including practising distraction and resiliency-building, were amongst the most recommended forms of support within this study. Although developing skills to become more proactive would come under the remit of self-help approaches (Baguley et al, 2010), and would assist with lower-lever difficulties, self-stigma (Watson et al, 2007) and low motivation (Nestler et al, 2002), which often accompanies mental health difficulties, would likely obstruct such approaches without significant professional input.

6.2.2b Routes

Their references to self-help as a route to support, further indicates their unsophisticated understanding and confusion regarding this form of support. Echoing the above findings, it seems that self-help is viewed synonymously with more generic skills and a means of seeking help.

In addition, despite the range of options discussed for seeking help, the young people had rather restrictive beliefs regarding the most appropriate ways of seeking help. This may potentially limit their access to support.

6.2.2c Awareness

Despite their awareness of a wide-range of support, all of the young people believed that individuals of similar age to themselves would have inadequate knowledge of support. Adults instead, were thought to be better placed to know about this.

This contrary perception may relate to their more subordinate position as pupils within a school. However, it also communicates that young people believe their knowledge-base could be further developed and in echoing findings within the CAMHS Review (DCSF & DoH, 2008) regarding barriers to support, may signal potential difficulties in seeking help.

‘...we don’t get taught about it in school or anything...school don’t see it as a big enough thing, the teachers don’t’ (FG2)

‘Yeah, like older like if you were like in primary school or something they probably wouldn’t know that much about it.’ (FG1)

6.2.3 Summary

Young people have a broad knowledge-base of available mental health support and how to access it, which is referred to within academic research and policy. All of the groups were knowledgeable of medical, psychological and informal support, with most identifying community, technologically- based and self-help support. Some also identified promotion-based approaches such as living a healthy lifestyle and funding streams. In terms of accessing support all were knowledgeable of informal routes, with most groups highlighting routes to help through medical support and the media. Some groups also highlighted self-help and community-based routes.

Appropriate in light of research and policy were their wide-ranging preferences for support for individuals with mental health difficulties. These preferences suggested they knew and believed a wide range of support to be effective. They also demonstrated to a degree, that they understood the limitations of the effectiveness of support as seen in their similar recommendations for both informal and medical support. In terms of their preferences for routes to support, generally, appropriate beliefs were again demonstrated. Their preferences can be summarised as:

- 1) Informal with elements of promotion-based support
- 2) Inclusive
- 3) Medical and psychological in nature

4) Needs-specific

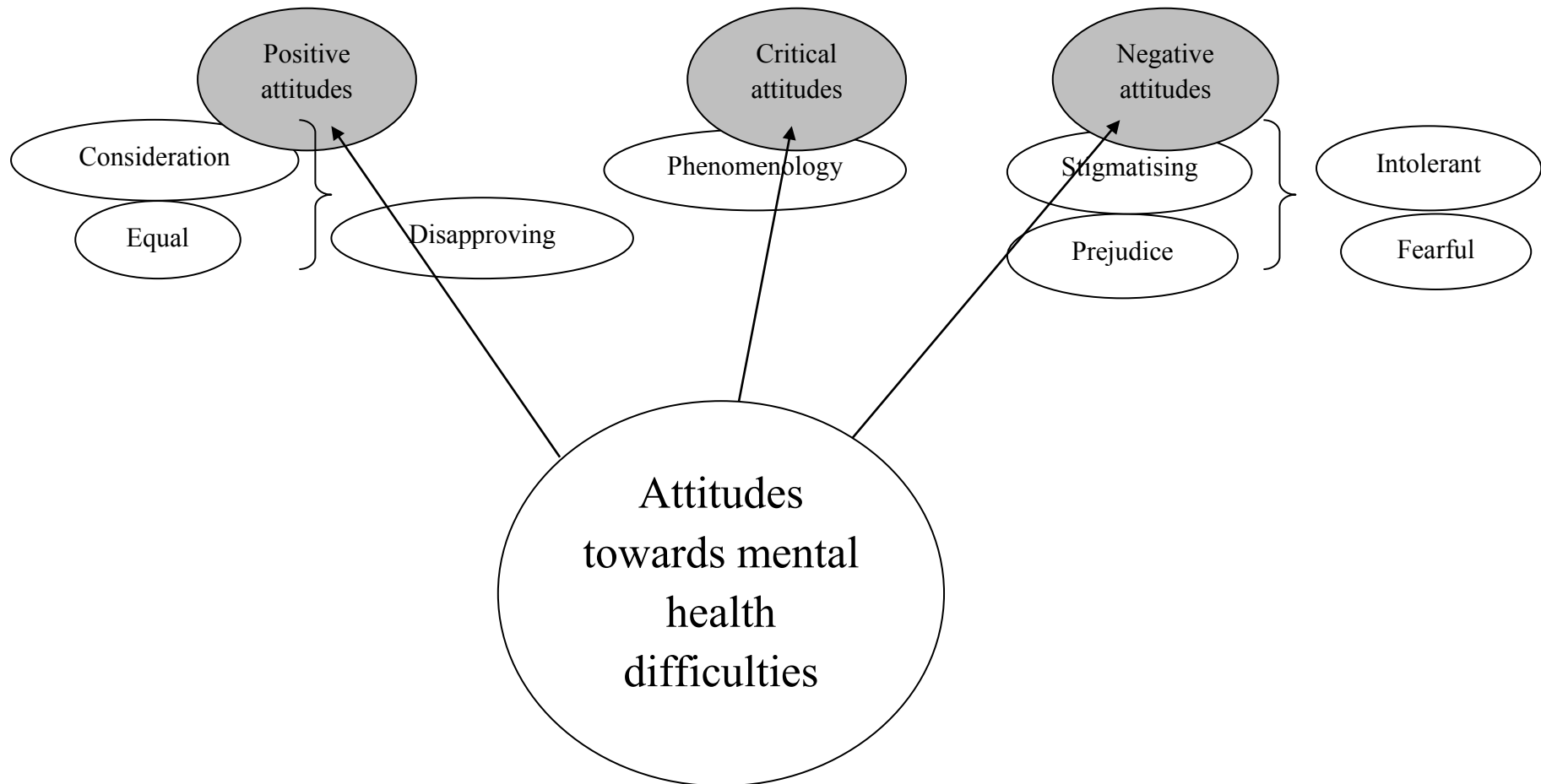
5) Delivered in a comfortable environment

Areas for development within their knowledge of available support were however, highlighted. These included:

- Limited knowledge of support as evidenced by;
 - Self-proclaimed limited knowledge of available support by all of the groups.
 - Limited knowledge and confusion surrounding self help and funding streams.
- Lack of knowledge and understanding regarding the limits of support and what constitutes effective support from;
 - Their beliefs that elements of self-help alluding to personal skills were the best kind of support for individuals with mental health difficulties.
- Lack of knowledge of a range of ways to access help from;
 - Their restricted beliefs regarding appropriate routes to support.
- Poor attitudes potentially indicated, towards receiving information regarding available support

1) What are young people's attitudes towards mental health difficulties and mental health support?

Figure Nine: Code Map of young people's attitudes towards mental health difficulties.



6.3 Attitudes towards mental health difficulties

6.3.1 Strengths: Positive and critical attitudes

6.3.1a Positive attitudes

The young people demonstrated real consideration of the circumstances and feelings of individuals with mental health difficulties. For instance, all of the groups highlighted the inequality and isolation faced by such individuals, suggested they were a victim of their difficulties and empathised how they lived in fear. This evoked feelings of sympathy in the young people.

‘They haven’t...got...opportunities like us...’ (FG3)

‘Less privileged people.’ (FG4)

‘...they’ve probably...had nobody to look after them.’ (FG3)

‘Because mental ill people are really scared people... and they think we’ll harm them...’ (FG3)

‘...he can’t help it.’ (FG4)

‘I just think it’s really sad and I feel really sorry for the people.’ (FG3)

All of the groups also communicated how individuals with mental health difficulties were the same as themselves and that they would treat them equally and kindly.

‘...they’re just a normal person that’s got a mental health issue, it doesn’t make them a different person...I wouldn’t think of anything different about them.’ (FG2)

‘You’d just be friendly to them and act like they’re a normal neighbour...’ (FG1)

This was also seen in their recommendations for support for individuals with mental health difficulties which focussed more upon less official, promotion-based forms as well as professional support delivered according to needs in a familiar and comfortable environment. This indicates a possible change in young people's belief systems and may relate to the expansion of community-based approaches (Eghigian, 2010), web-based support (Mind, 2013) and anti-stigma campaigns which have encouraged greater tolerance and inclusion (DoH, 2011a).

After accurately identifying society's stigmatising, prejudiced and intolerant attitudes, most of the groups expressed disapproval.

'...just think...they was weird...' (FG4)

'...think that they're crazy' (FG3)

'...people with Down Syndrome make the sandwiches...and like, loads...of people have been saying, oh I ain't gonna eat their sandwiches now...' (FG3)

'They just stay away from them cus they think oh what are they capable of...' (FG1)

'...they could bully em just cus they're different...' (FG1)

'...just take the mick out of them.' (FG3)

'...like it's mental not physical ...they could just think that they're attention-seeking...' (FG4)

'They shouldn't judge em just because they got mental health cus if they had it they wouldn't want people judging them...' (FG2)

'They should treat everyone the same, treat everyone as you want to be treated.' (FG1)

Indicating insight and understanding, the young people explained why such attitudes existed.

This included a lacking awareness and lack of education within society which agrees with opinions within the literature (Rusch et al, 2005). Social and cultural reasons were also invoked, including society's inability to accept difference, the negative messages parents pass

on to their children, media portrayals of individuals with mental health difficulties and the shame of mental illness propagated by certain cultures.

‘I don’t think they understand how serious (it is)...’ (FG3)

‘I think it’s...in the media, it’s like...portrayed...mental health people are really violent...’ (FG3)

‘...a lot of people have abandoned their...children with problems...because of their religion...’ (FG3)

‘I think people are scared of...being different though, sometimes because...we was put on this Earth and we all look different but when someone’s...quite extremely different, I don’t think people can handle it...’ (FG3)

‘(parents)...make the children, as they get older...start saying stuff.’ (FG3)

Their identification of negative societal attitudes and their awareness of what may contribute to them, suggests young people have a thorough understanding of such phenomena. Together with their positive attitudes and disapproval of negative societal attitudes, the suggestion is that the young people may be more accepting of individuals with mental health difficulties. This runs counter to some of the findings of previous research which has found that with increasing age from childhood, stigmatising attitudes become more apparent (Wahl, 2002). It also suggests they may be protected, to some degree against the stigma associated with having a mental health difficulty, allowing them to seek timely help preventing persistence difficulties (Rusch et al, 2005; Corrigan, 2004).

6.3.1b Critical attitudes

Calling upon phenomenology, some of the groups criticised the concept of mental disorder and its distinction with mental health. They argued that such a distinction was flawed, given the variety of human experiences, which may be the norm for a given individual, but is arbitrarily classified as a mental illness. This sophisticated thinking hints at a philosophical critique of the way in which mental health difficulties are diagnosed, resonating with the arguments of Szasz (1974) and acknowledging a critical realist stance.

‘Cus how do we know what’s going through each of our heads? ... I could be like seeing different things to what you lot are now, or hearing different things...we could all have it.’
(FG3)

‘People think that...you’ve gotta be the same....we actually might be different to them...’
(FG3)

Most importantly, together with their positive attitudes, this signals young people’s normalising approach to mental health and suggests they may be more accepting of developing a mental health difficulty.

6.3.2 Areas for development: Negative and critical attitudes.

6.3.2a Negative attitudes

Despite their ability to highlight negative societal attitudes and express their disapproval, similar negative attitudes were implicit within all of the young people's responses regarding individuals with mental health difficulties. For instance, within their discussions, the young people communicated stigmatising and prejudiced attitudes, referring to stereotypes.

'Strange' (FG3)

'Mad' (FG3)

'(They would)...cause a scene in front of everyone...' (FG2)

'...you never know what could happen could you really?...Yeah, they could do anything...they could do something stupid' (FG3)

'...they still have as much fun as a normal person would even though they are different, like they've got an illness.' (FG1)

'If the guy...living next to you doesn't (have any support), he could just be going randomly mental...like smashing his head up against the wall...' (FG4)

Related to their stigmatising and prejudiced attitudes, some of the groups also communicated an intolerance of individuals with mental health difficulties. However, in contrast to their discussion of society's intolerant attitudes, which mainly consisted of persecution and ridicule, the young people's intolerant attitudes consisted of references to how individuals with mental health difficulties were burdensome or troublesome to others.

'If you were in by yourself it could kind of affect you...you won't be looking forward to going home...you'd want to move out to be perfectly honest.' (FG4)

'Interviewer: What is that help?

...it gives the family like a break and he takes them out...' (FG1)

Fear of individuals with mental health difficulties was also communicated by most of the groups. This again related to their stigmatising and prejudiced attitudes as suggested by the analogies they use.

'I would be frightened because you don't know what they'd do...' (FG3)

'Interviewer: Would you be frightened at all?

Kind of if it's like night terrors . Like hearing him scream' (FG4)

But I'd, I'd try and like be yeah...it's just like a spider... You might be afraid of a spider...They're just as afraid of you...or like a bee they'll sting you because they're frightened of you.' (FG3)

Perhaps relating more to their consideration and insight into the circumstances of individuals with mental health difficulties, some of the groups also indicated that they were fearful of becoming mentally ill themselves.

'If you started having any symptoms for any...mental...illness I know I'd be scared.' (FG3)

Taking their negative attitudes altogether, they corroborate the long-standing public stigma (Rabkin, 1974; Priest et al, 1996; DoH, 2011a), prejudiced attitudes; particularly around violent stereotypes (Hunter & Macalpine, 1974; Wilson et al, 1999; Mind & Rethink Mental Illness, 2008), fear and intolerance (Arnold, 2008) which has surrounded individuals with mental health difficulties. These findings also agree with previous research detailing the stigmatising attitudes found in young people (Wahl, 2002).

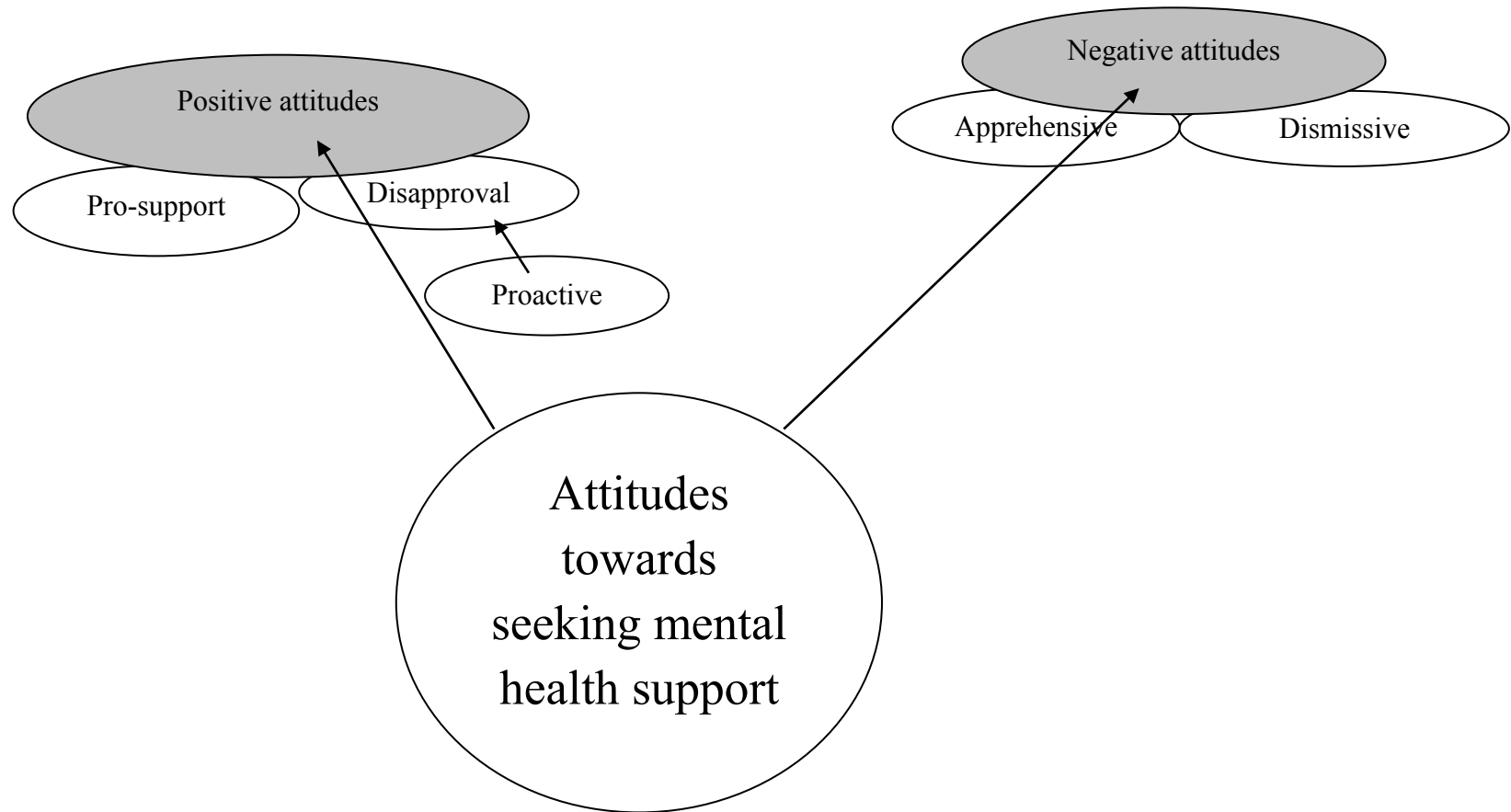
The double-standard of their own negative attitudes on the one hand, and on the other, their disapproval of society's similar, negative attitudes, undermines their apparent consideration for and acceptance of individuals with mental health difficulties, their acceptance of having a mental health difficulty themselves and ability to guard against the effects of stigma. Instead, this implies their more positive attitudes and disapproval of negative ones may have been motivated by social desirability.

However, it may also be that their implied negative attitudes were a result of them not having the correct language to use to convey what they mean. For instance, they often described how individuals with a mental health difficulty, had something „wrong“ with them, and in the case of the above quote, were described as „different“, when what they meant to say was that they had an „illness“.

6.3.2b Critical attitudes

Although they presented a rather sophisticated critique of the distinction between mental health and mental health difficulties, this alone does not imply a thorough understanding of this distinction. For instance, absence of any reference to recognised diagnostic processes, including the identification of disorder based upon impairment of functioning, persistence and endurance of difficulty (APA, 2000; 2012), suggests the young people may not have a clear understanding of this distinction.

Figure Ten: Code map of young people's attitudes towards seeking mental health support.



6.4 Attitudes towards mental health support

6.4.1 Strengths: Positive attitudes

The young people demonstrated some positive attitudes towards help-seeking. Most of the groups exhibited pro-support attitudes, highlighting how seeking support was the right thing to do to prevent or correct further difficulties.

'...they'm doing the right thing.' (FG3)

'...it's looking after them.' (FG4)

'...if they carry on living with it without any help, then the symptoms am just going to get worser and worser...' (FG3)

'They'll...soon be normal' (FG4)

Similarly to their identification of societal attitudes towards mental health difficulties, they were perceptive of society's negative attitudes towards seeking support, some of which have been identified within policy as barriers to support (DSCF & DoH, 2008; DoH, 2011a). This involved how individuals are perceived as weak or attention-seeking and how society holds stigmatising and prejudiced attitudes, viewing those who seek support as different or abnormal. For these reasons, the young people explained how individuals are embarrassed to seek help, indicating their awareness of self-stigma.

'That they'm cowards for having help.' (FG3)

'Some people might think that...they're making a big deal out of themselves, over-exaggerating...' (FG3)

'Some people might think that you're weird or...stupid...' (FG4)

'Yeah, cus they'd be embarrassed to tell anyone what's going on.' (FG3)

Some of the groups again, disapproved of these negative attitudes.

'Some people would...think oh, I'm superior...they're just pretty mean.' (FG4)

Most of the groups suggested being proactive to circumvent these attitudes. On a general level this included strategies such as ignoring negative attitudes, seeking adequate moral and mental health support, teacher interventions and „tit-for-tat“ behaviour. More specifically however, it involved raising awareness through education. Some individuals spoke about raising awareness to effect global changes, demonstrating compassion for the cause. This was not only to increase awareness of available support but also to address awareness of mental health difficulties, affecting change in associated negative attitudes here too. This, the young people thought could be addressed through education and experience of what it might be like to have a mental health difficulty.

'Just ignore them, just take no notice...' (FG4)

'...you can find like groups of people who have the same like disabilities and disorder as you and then you can actually socialise with those kind of people. They'll understand.' (FG4)

'(friends that) help them...to find out (about support, or) don't say anything...if they don't want anyone to find out' (FG1)

'...at the end of the day they've got all the support...they need' (FG3)

'...remove them from that class...or talk to the person.' (FG4)

'Become more like the person that thinking them things about them.' (FG4)

'Like awareness...in the world.' (FG3)

'...you need to focus on...the school because once they know when they're a child...at least they know when they're older...' (FG3)

The above attitudes could help to facilitate them in seeking support. Such positive attitudes contrast with current findings that attitudinal barriers to support still exist for young people

(DCSF & DoH, 2008; Mind & Rethink Mental Illness, 2013; HSCIC, 2011). Finally, their proactive attitudes to raise awareness, which appears to be a common theme in their thinking around mental health support, reinforces the suggestion that young people would be receptive to educational initiatives.

Exception responses

However some groups recognised this may be a challenge.

'They'll always...do it, because people just get a thrill out of like teasing...' (FG4)

From this comment, it seemed that some, to an extent, viewed attempts to improve people's attitudes as futile as some people would always target individuals with mental health difficulties. This may have been motivated by their awareness of bullying in schools.

6.4.2 Areas for development: Negative attitudes

All of the groups also expressed implicit, negative attitudes towards seeking mental health support. Unlike their attitudes towards individuals with mental health difficulties, some of their negative attitudes towards seeking support contrasted with negative societal attitudes they identified. For instance, rather than the more intolerant attitudes within society, they expressed more apprehensive ones. This was signalled in their discussions around how seeking support may feel daunting and isolating, requiring bravery on the part of the individual to seek support. This provoked feelings of admiration and compassion to provide assistance as noted above in their proactive attitudes.

'Interviewer: So do you think there are groups of people that know about (support)?

Or they could be scared.' (FG2)

'I'd say fair play to them for...standing up for themselves and getting help' (FG3)

'(Some people might think) that they'm cowards for having help...but it's not, I think it's brave.' (FG3)

'I'd comfort 'em, be supportive.' (FG1)

'...proud of them that they've actually gone and talked to someone to get help.' (FG1)

'I'd help them and stuff...I'd let them know...I'm there for them.' (FG1)

Like the dismissive attitudes identified within society, the young people also held dismissive attitudes. Included within these attitudes were explanations that support could potentially aggravate difficulties, can be unwarranted, unnecessary and unwelcome.

'But it could make it worse...if you're always talking about it...' (FG1)

'...when I was in primary school I got put on an individual behaviour program...I didn't really need it...some people who get it, don't enjoy it. They want to become normal but they have to face it so...' (FG4)

Some of the differences between society's and their own negative attitudes towards support, suggests their disapproval of society's negative attitudes, and the assertion of their own more positive ones, were genuine. However, their apprehensive and dismissive attitudes towards help-seeking, potentially related to their limited, detailed knowledge of support and awareness of negative societal attitudes, limits this, suggesting attitudinal barriers to support may still exist for young people, as indicated by policy (DCSF & DoH, 2008).

6.4.3 Summary

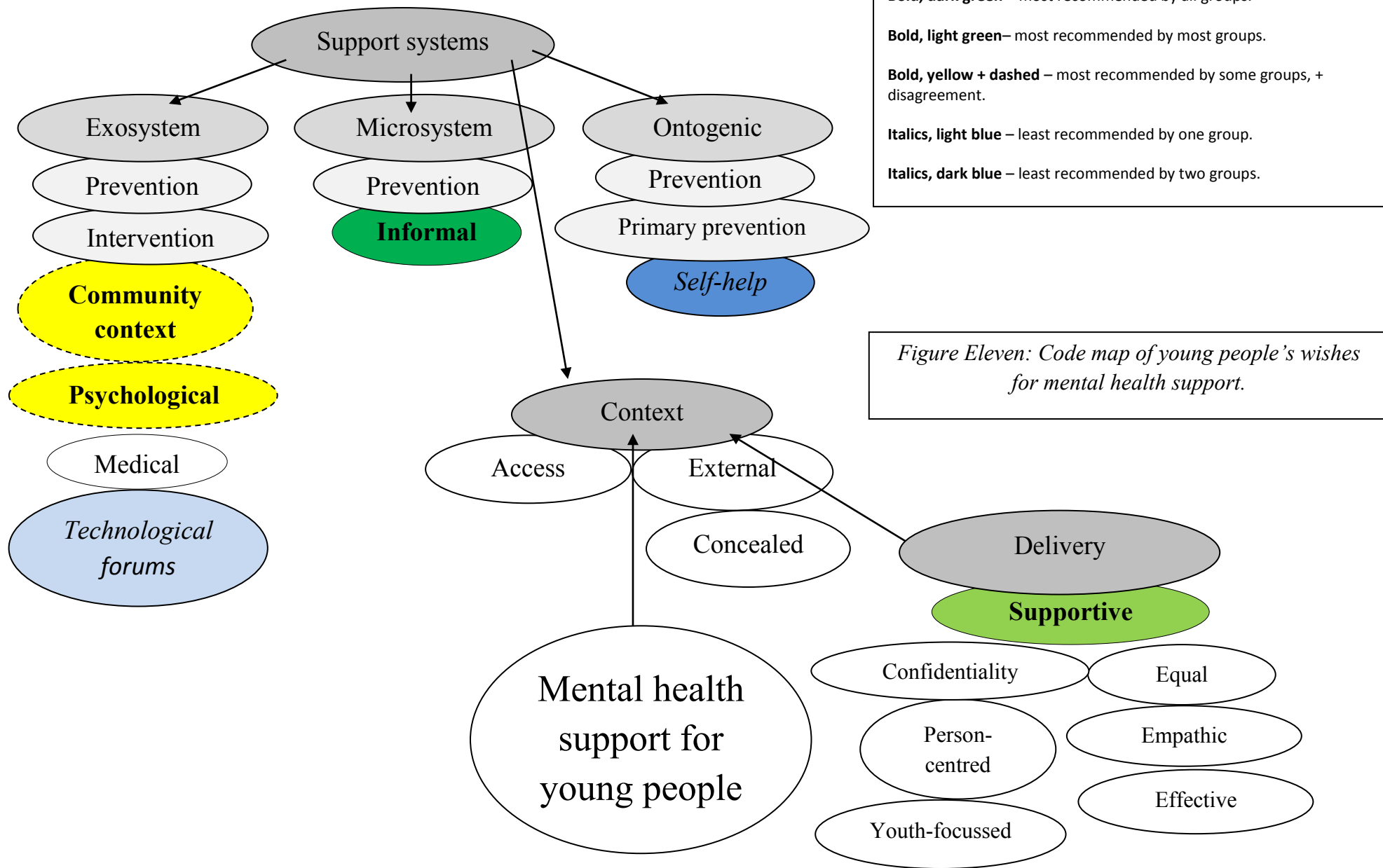
A number of strengths are noted within the young people's attitudes towards mental health difficulties and mental health support. All of the groups demonstrated positive attitudes towards individuals with mental health difficulties, including viewing them as equals. All of the groups also demonstrated consideration for their situation and all of the groups disapproved of negative societal attitudes. Some of the groups also demonstrated critical attitudes towards mental health difficulties, invoking phenomenological arguments to support their position that the classification of mental health difficulties is arbitrary.

In terms of mental health support, most of the groups indicated pro-support attitudes. Some of the groups expressed disapproval for society's negative attitudes towards help-seeking, with most highlighting proactive attitudes to guard against them.

The implications of these strengths are that to a certain extent, young people would be accepting of developing mental health difficulties, tolerant of others with mental health difficulties, and would seek timely support and would be receptive to educational initiatives surrounding mental health and help-seeking.

Areas for development include the prejudiced attitudes towards individuals with mental health difficulties held by all the groups. Most groups were also fearful of such individuals and some held stigmatising and intolerant attitudes. Finally, all of the groups held apprehensive and some dismissive attitudes towards seeking mental health support.

1) In terms of support, what would young people want if they were experiencing mental health difficulties?



6.5 Young people's wishes for mental health support

6.5.1 Support systems

Amongst the young people's wishes for support was preventative and intervention-based support at the Exosystem, Microsystem and Ontogenic levels. All of the groups felt that informal, psychological, medical and community-based support, were or contained suitable options.

Although the young people acknowledged how they would like as much support as possible, all of the groups agreed that informal support, including talking to friends and family was the most suitable, as they knew them best.

'Interviewer: ...What would be the best support for young people?

Friends and parents, socially, people close to you.' (FG4)

'I'd want my family more than anything.' (FG3)

'As much help as possible.' (FG2)

Community-based support received mixed responses. Some groups saw mutual support groups as least suitable whereas others saw social support groups which organise social activities as most appropriate. Within this, other forms of community support were thought to be suitable, including; charities, volunteers, school-based support such as mentors and teachers they have relationships with, and outreach support to their home.

'I'd go through mentors kind of thing...' (FG4)

'Like people come into your house...' (FG3)

'...clubs...you go...regularly (to)...they should make you do activities' (FG3)

'...go and have fun somewhere.' (FG1)

'Our Head of Year...I reckon she's...always there for you...' (FG3)

Mixed responses were also found for psychological support. Some groups felt that psychiatrists were most suitable, owing to the need for „experts“ or specialist professionals who understand the field of mental health. Also viewed as suitable by most of groups were psychologists, who could deliver therapy. In contrast, and echoing their earlier responses, psycho-educational initiatives, including anger management were seen as least suitable by some of the other groups.

'Interviewer:...Why is a professional important?

Cus they know what they are talking about and they can be sure that they can help you...Cus like family and friends they can just know about it but like professionals they're like specialised in it.' (FG2)

'Interviewer: What kind of support wouldn't...you want?...this? (anger management)

Nah' (FG1)

Medical support was also referred to by all of the groups such as GPs.

'I'd like a doctor as well to be honest, because a doctor knows more than your mom or dad' (FG3)

However, no preferences or feelings that this support was inappropriate were indicated. This may relate to the fact that GPs are integral to a number of general health difficulties and thus the young people do not feel they have to indicate their preferences for such support.

Thought to be least suitable by one of the groups were aspects of support delivered via technological forums such as „Talk to Frank“. This again, surrounded its lack of specificity to mental health.

Least suitable of all due to the fact two groups gave this rating, were self-help strategies, surrounding being resilient and proactive in seeking out support. On the contrary, they felt they would require more guidance and support.

‘Interviewer: ...What kind of help wouldn’t support young people?

Probably erm, Talk to Frank.’ (FG2)

‘...time to do it on your own, trying to pull through it on your own...it doesn’t work.’ (FG3)

‘I probably wouldn’t want to reach for help myself.’ (FG1)

These different types of support were also viewed hierarchically. For instance, most of the groups felt professional support was only required if difficulties were significant. Prior to this, support would be approached in a gradual fashion after other informal or community-based avenues had been explored such as talking to family and friends or seeing the school mentor. This agrees with previous research (Offer et al, 1991; Roose & John, 2003; Leavey et al, 2011; Armstrong et al, 1998), which has found young people view parents as a first port of call. Alongside higher level, professional support, it was felt by most of the young people that informal support and wider community-based support identified should continue.

'If it got really bad, I'd go to the doctors...' (FG1)

'I wouldn't want to take it too majorly, I wouldn't wanna...go straight into medication, psychologist, I'd take it slowly, I'd go through mentors kind of thing...' (FG4)

'...because your family don't know everything,...they're no doctors, they haven't got the qualifications or anything. So if you go to the doctors, they tell you there's something wrong, your..family can just support you...' (FG3)

' Because then if...you've got a problem which you won't share, but your parents know of it (they) could connect with the psychologist.' (FG4)

'Interviewer: Volunteers and professionals? Both?

Both, yeah' (FG2)

The similarities between some of the support recommended for others and for themselves, such as informal and professional support, suggests they were making certain recommendations based upon what support they would like for themselves. This implies empathy and perceptions of themselves along the same continuum as those with mental health needs, a theory suggested by research (van Os et al, 1999) and within pathogenic-salutogenic models (Antonovsky, 1979). Although in agreement with research which has found deference to informal support in young people (Offer et al, 1991; Leavey et al, 2011), preferences for professional support, contradict literature which has found young people to be critical of this support for themselves (Wright et al, 2006; Kelly et al, 2007; Burns & Rapee, 2006; Plaistow, 2014). Encouragingly, this implies young people may feel able to seek professional support.

However, also telling were the differences between the support they would most recommend for others and want for themselves. For instance, in opposition to how young people have previously only recommended professional and segregated support for others (Bailey, 1999; Armstrong et al, 1998; Kelly et al, 2007), a wider range of support was cited, indicating their general beliefs and knowledge of the effectiveness of wider support, and also hinting that they themselves may seek broader avenues of support. However, this was not so and for

themselves, a narrower range was preferred. These more specific preferences may work to exacerbate current accessibility difficulties (DCSF & DoH, 2008), but could also be capitalised upon to enable tailored mental health support for young people.

A final observation of these differences is that in giving the young people a directly relevant context in which to think about support by asking them what they would like, this appears to facilitate their understanding of what constitutes effective support. For instance, self-help, including building resilience and being proactive in seeking support, was thought to be least suitable for themselves with some groups doubting its effectiveness.

6.5.2 Context

Based on their concerns regarding social stigma, a strong theme, expressed by all groups was to have mental health support at an external location to their school. This seemed to be considered for more serious mental health difficulties and when receiving professional support. It was also to guarantee confidentiality and privacy. Some of the young people also felt that the focus within school should be on learning not mental health. Locations suggested included receiving support at home, at the doctor's surgery or at a general medical centre or clinic, funded by the school.

'Maybe we don't need to have the doctors in the school but ...they could be...connected to the school

Interviewer: ...a centre away from school?

Communal: Yeah.' (FG3)

'...if the school bought a small clinic for people to go to.' (FG2)

'...students could ...tease you just for being taken out of your lessons.' (FG4)

'...You never know who could be outside the door' (FG1)

' ...I wouldn't want to talk to the teachers about it...they'd tell other teachers...(at school)
I'd...concentrate on getting good grades...' (FG1)

Raised by some of the groups an important feature of this external support was that it was accessible; an area for development included within the CAMHS Review (DCSF & DoH, 2008).

'...if you wanna go in there ...you can just walk in...' (FG3)

'You should just get a noted and then signed off your Head teacher...' (FG3)

Of concern however, were comments made by some of the groups that this support should be concealed in some way. This communicates young people are conscious of being identified as receiving mental health support, undermining indications that they can protect themselves from negative societal attitudes.

'...at the front, it could just be an any illness, but at the back it could be like... just a mental health thing...' (FG3)

'...look like a normal block.' (FG3)

Wishes for an external setting for support is found in an earlier study with younger children (Roose & John, 2003) suggesting that confidentiality continues to be important to young people across a range of ages. Such preferences do threaten the role schools can play in closing the gap between current mental health provision and high levels of unmet need in young people (Armbruster & Lichtman, 1999; Amaral et al, 2011). However, from their earlier responses surrounding receiving support from teachers and mentors, young people perceive school staff as individuals who can assist with lower level mental health concerns, particularly if they have built a trusting relationship with them.

6.5.3 Delivery

Most important to the young people was to feel supported. Specifically, for some of the groups, they wanted to know someone would support and reassure them. This extended to friends and family and professionals.

‘I’d just want them to be there for me...’ (FG1)

‘...even though I’d be bad like I’d just be, I’d just wanna be told that I’m OK.’ (FG3)

Such wishes may relate to their apprehensive attitudes towards seeking mental health support and fear of developing a mental health difficulty.

All of the groups felt support should be delivered confidentially. This would be ensured by receiving support from individuals they can trust and who do not already have a relationship with them.

'...it should be confidential as well, they shouldn't ring your mom and dad and tell them you've been there...some children are embarrassed to tell their parents...' (FG3)

'Interviewer: And who would work in this centre?

Volunteers.

Professionals' (FG2)

Indeed, trust-building and concerns regarding the affects seeking support may have on relationships with adults is found in the literature (Roose & John, 2003; Burns & Rapee, 2006; Plaistow, 2014). It is also highlighted in their similar recommendations for individuals with mental health difficulties.

Most of the groups also felt support should be person-centred. For instance, they wanted to be listened to through regular feedback loops, for their opinions to be taken seriously and respected and to be given honest prognoses.

'Yeah I think what like we mainly need is someone like you who comes in and asks us what we actually want.' (FG3)

'Yeah, respect your opinions as well, like if you don't wanna do something..' (FG3)

'... I don't want them to be like...say if it's getting worse, I want them to tell me that it is...' (FG3)

'...like you see people, ah you need this help and like no, I don't want it...' (FG4)

'...you've told them (teachers) everything, and...you need them to come...Or like your family can come in with you if you feel comfortable.' (FG3)

'...if...you'm in the centre they say do you want us to ring your mom and dad and they say no, that should be ok...' (FG3)

They also wanted to be in control of their care including making decisions over their care, who could accompany them and who, information about their care could be disclosed to. This extended to bringing teachers along with them whom they feel they can trust and who they have confided in. This relates to their wishes for wider community-based support to continue alongside professional support.

In addition, some groups also wanted support to be youth-focussed.

‘I think we should specialise it cus...it’s different for young people...we need people to understand us differently ...and know that we don’t know as much as the adults’ (FG3)

These responses echo policy agendas (DoH, 2011a; 2011b) and the need for tailored support highlighted within the CAMHS Review (DCSF & DoH, 2008).

Perhaps in light of their awareness of negative societal attitudes and their compassion towards individuals with mental health difficulties, some of the groups stated they wished to be treated equally and with empathy.

‘...even though I’ve got mental health, that they (friends) don’t think of me differently...’ (FG1)
‘You just want people to be understanding...’ (FG3)

This also extended to their friends and family which again relates to the way in which young people view informal and professional support; as streams of help that run parallel to each other.

Finally, some of the groups also wanted support to be effective.

‘ We just want it to be simple and like helpful...’ (FG3)

This relates to many calls within research to develop what is known surrounding effective support, as well as aims within IAPT (DoH 2011a; 2011b; HSCIC, 2014) to improve access for young people to more effective therapies.

6.5.4 Summary

To summarise their wishes, in terms of support they feel is most suitable for them, it would appear informal support from parents and friends was the clear favourite. Following this, from their mixed responses, some of the groups thought aspects of community-based and professional, psychological support were most suitable. Generally, feeling supported and reassured by the support they received was important to them.

Overall, professional support was only appropriate if mental health difficulties persisted and other less formal routes at school and with friends and family had been explored. Whilst in receipt of professional support, the young people expressed they would like more informal and community-based support to continue. This included parents, wider community-based support identified and in some cases, for teachers to accompany them.

All of the young people would like professional support delivered outside of school, owing to the need for confidentiality which was very important to them.

Some of the groups' wishes surrounding the features of external support included:

- Accessibility
- Being concealed from view

Also most of the groups wished for support to be person-centred and most importantly, that they felt well supported. Some of the groups also wanted:

- To be treated with empathy
- To be treated equally
- Effective support

- Youth-focussed support

Their wishes highlight the on-going areas for development outlined within the CAMHS review (DCSF & DoH, 2008) and what continues to be important to young people (Plaistow, 2014).

6.6 Gender differences

In-line with research findings of gender differences within the knowledge-base, beliefs and attitudes of young people regarding mental health and mental health support (Cotton et al, 2006; Chandra & Minkovitz, 2006; Ng & Chan, 2000), a number of gender differences were observed. As gender differences are not included within the primary aims of this study, analysis will comprise a summary under areas investigated, focussing upon the most salient themes. Included in Table Seven, these will include themes with the highest ratings or recommendations and themes which echo earlier research findings. To provide a complete synthesis of the findings, these gender differences will also be contextualised within other findings, highlighted above.

Table Seven: Code frequencies according to gender differences

Themes	Females	Males
KNOWLEDGE & BELIEFS: MENTAL HEALTH DIFFICULTIES		
Bio-genetic	2*	1
Family environment	2*	1
Interaction	1*	2
Psychological	1	2*
Confusion	1	2
Culture	1	0
Misidentification	0	2
Complex	1	0
Continuum	0	1
KNOWLEDGE & BELIEFS: SUPPORT		
Informal	2*	2**
Community contexts	2*	1
Healthy lifestyle	1*	0
Medical	2**	2*
Psychological	2	2*
Technological forums	1*	2
Self-help	2*	1
ROUTES		
Medical	2**	1*
Informal	1	2*
ATTITUDES: MENTAL HEALTH DIFFICULTIES		
Fearful	2	1
Consideration	2	2
ATTITUDES: SUPPORT		
Pro-support	2	1
Proactive	2	1
Apprehensive	2	1
WISHES: MENTAL HEALTH SUPPORT		
Psychological	2	2*
Community context	2*	2
Access	1	0
Youth focussed	1	0
Concealed	1	0
Supportive	2*	1*
Empathic	1	0
Person-centred	1	2
Effective	1	0

NB: * 1 group rated theme most likely/most recommended

** 2 groups rated theme most likely/most recommended

6.6.1 Knowledge & beliefs: Mental health difficulties

Table Seven illustrates how males and females have an equivalent breadth of knowledge of risks. However, females believed a wider range of risks made important contributions to poor mental health outcomes. These differences suggest females have less restrictive and potentially more appropriate beliefs surrounding risks to mental health, in light of interactive factors models (Engel, 1980).

Both also spoke about the interaction of risk factors within pathways to mental health difficulties with one female group rating it most important and more male groups highlighting the process. This highlights they are both knowledgeable of interactionist perspectives which agrees with biopsychosocial (Engel, 1977), psycho-developmental (Cicchetti & Lynch, 1993) and pathogenic-salutogenic models (Antonovsky, 1979). However, some of the female groups appeared to appreciate the complexity of this interaction, referring to individual differences.

Their understanding of the concept of mental health difficulties, particularly exemplifies females' superior MHL as all the male groups misidentified psychosis for OCD and depression, and were more often confused between mental health and learning difficulties, cause and outcome than females.

However, the superiority of females' MHL, should not be overstated. For instance, apart from references to cultural vulnerability, in which one female group demonstrated understanding, males were comparable with females surrounding vulnerability, with all groups referring to the universality of mental health difficulties and the vulnerability of younger and older individuals. One male and one female group also made references to contagion explanations and all gave pathogenic interpretations. In addition, one male group also indicated their

understanding of the continuum of mental health difficulties and the contribution of unhealthy lifestyle choices, which were not evident within females' responses.

6.6.2 Knowledge & beliefs: Support

Males and females were generally knowledgeable of a range of support available for individuals with mental health difficulties. However, the male groups appeared to recommend a narrower range of support which mainly focussed upon informal support, with one male group also recommending medical and psychological support. In comparison, the female groups recommended a larger range of support, focussing more upon medical support, followed by one group recommending community-based support, living a healthy lifestyle, support via technological forums and self-help.

These differences suggest females believe wider support is effective and have more appropriate beliefs regarding support for mental health difficulties. However, their lack of any recommendations surrounding psychological support which has a known evidence-base (Barrett & Turner, 2001; Barrett et al, 2006; Holdorf, 2003; Compton et al, 2004; James et al, 2005) mitigates this as well as their recommendations surrounding aspects of self-help, which may be inappropriate in certain cases (Watson et al, 2007; Nestler et al, 2002). Their recommendations therefore suggest a lacking knowledge and understanding of the limits of support or what constitutes effective support.

In terms of accessing support, two female groups as opposed to one male group most recommended going through the GP. One male group also most recommended accessing support via informal routes. This suggests females have beliefs which limit ways to access support.

6.6.3 Attitudes: Mental health difficulties and support

Males and females demonstrated equally positive attitudes towards individuals with mental health difficulties. This counters earlier research which has found more benevolent attitudes to exist amongst females towards individuals with mental health difficulties (Olmsted & Smith, 1980; Ng & Chan, 2000). In terms of positive attitudes towards seeking support, in comparison to the single male group, both female groups demonstrated them, agreeing with gender differences captured by previous research (Armstrong et al, 2000). Indeed, their greater willingness to seek support, in comparison to male counterparts was spontaneously discussed by one of the female groups.

However, unlike the one male group, both female groups seemed to be more fearful of individuals with mental health difficulties, and becoming mentally ill themselves. Indeed, this difference around fear of becoming mentally ill was also brought up in discussion by one of the female groups. This may also be relating to the generally, higher levels of fear and anxiety observed within females, as well as gender role expectations, which permit them to express fear more openly (McLean & Anderson, 2009). In addition, countering their positive attitudes towards help-seeking both the female groups did indicate apprehension.

It is also important that these findings are contextualised by the generally prejudiced, stigmatising and intolerant attitudes exhibited by both male and female groups towards individuals with mental health difficulties. Comparable dismissive attitudes towards help-seeking were also apparent in both a male and female group.

These responses suggest how both males and females, may demonstrate negative attitudes towards both individuals with mental health difficulties and help-seeking. Gender role expectations for females may mask some of these attitudes or in some cases, surrounding their more fearful attitudes, amplify them.

6.6.4 Wishes: Mental health support

Both the two male and two female groups thought that as well as informal and community-based support, professional support in the form of medical and psychological help was also suitable, suggesting how generally both valued hierarchical support. However, differences lay in their ratings of what they thought was most and least suitable. For instance, for psychological support, one male group appeared to view this as most suitable, whereas one of the female groups criticised psycho-educational initiatives. Females on the other hand, thought support delivered within the community context was most suitable for their needs whereas males criticised the effectiveness of mutual support groups. These differences suggest males may prefer higher tier support in comparison to females, whose apprehensive attitudes to help-seeking may be driving this.

Feeling well-supported and reassured was most important to both males and females with one group from each rating this most highly. However, in comparison to males, both female groups spoke about this, and apart from requests for support to be person-centred, made by two male groups as opposed to one female group, females appeared to be more concerned with the context and way in which support should be delivered. For instance, one of the female groups spoke about accessible and youth-focussed support that is effective. This suggests females' greater knowledge and insight into the mechanics of mental health support. However, they also wanted support to be empathic of their situation and concealed from the public. These responses again, may relate to females' apprehensive attitudes towards support and their awareness of the stigma surrounding mental health difficulties all of which may create barriers to help-seeking, leaving them vulnerable.

6.7 Strengths and weaknesses

This study incorporated a number of strengths. Firstly, by using the MHL framework a thorough exploration of the knowledge, beliefs and attitudes of young people could be obtained. Secondly, unlike previous MHL research which includes samples with wide-age ranges (Wright et al, 2006), this study only included fourteen year olds providing specific MHL information. Thirdly, in addition to previous MHL research, this study also investigated the wishes of young people regarding the kind of mental health support they would want and gender differences across all areas. This has provided highly relevant data in which preventative and intervention-based, mental health support can be tailored. Such outcomes are supportive of policy, legal and moral agendas which point to the importance of person-centred approaches and representing young people's voices as potential service-users (DoH, 2011a; 2011b; 2013; UN, 1990).

Qualifying these overarching strengths there were however, some methodological weaknesses. The first weakness concerned the limited experiences of the young people regarding mental health, mental health support or being consulted, particularly on such topics. This may have disadvantaged them when contributing their knowledge and beliefs, and may have accounted for some of their limited responses. The inclusion of ex-or current service-users may have addressed this. However, in light of the general rise in mental health difficulties during the adolescent period (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001) and the research which has noted limited knowledge, understanding and negative attitudes surrounding mental health and available support, generally within young people (Fox et al, 2010; Armstrong et al, 2000; Burns & Rapee, 2006; Lock et al, 2002; O'Reilly et al, 2009), the aim of this study was to focus upon a community sample of young people, to inform tailored support.

The second weakness related to the use of ranking activities within the focus groups. Due to methodological decisions to only report most and least ranked themes this meant that only most, least and mixed rank themes were represented within the code maps, reducing the variance of responses.

A final weakness concerned the use of focus group methodology with young people. For instance, the young people's experiences of adult-led learning meant that the objective of focus groups; to discuss and co-construct amongst each other, was not always achieved. Indeed, for one of the groups in particular, a question and answer structure was employed to obtain responses. My own limited experience of focus groups was also a factor. For instance, although my role was to facilitate, on reflection, my involvement was more active; and although one was conscious not to lead any of their responses, this may have invited bias. However, such techniques appeared warranted according to the needs of the groups and literature which suggests the facilitator guides and directs discussion to obtain responses to research questions (Puchta & Potter, 2004). Also through a reflexive process, reflection upon and mindfulness of myself within the data was achieved. This was achieved through iterative reading of transcripts, rendering transparent responses that were genuine co-constructions of the group.

6.8 Overview of findings

An overview of the findings regarding the strengths and areas for development within the young people's knowledge, beliefs and attitudes at Highfield school is presented in Table Eight. Gender differences will be briefly discussed in a short section following Table Eight as well as implications for practice regarding preventative support.

Table Nine will summarise the main findings regarding the young people's wishes for support. Again, following this will be a section considering the implications for practice. In both cases, the central role of the EP will be considered.

Table Eight: Key strengths and areas for development identified within the young people's responses at Highfield school

<i>Strengths</i>	<i>Areas for development</i>
<ul style="list-style-type: none"> • Broad knowledge of and generally appropriate beliefs about the interaction and presence of risks within pathways to poor mental health at different ecological levels. • Broad knowledge and generally appropriate beliefs regarding vulnerable groups. • Knowledge of more common mental health difficulties and their impact upon functioning. • An understanding of how mental health difficulties exist along a continuum of difficulties. • Broad knowledge of the existence of mental health support at different ecological levels and how to seek it. 	<ul style="list-style-type: none"> • Insecure knowledge of risks: <p>-Limited awareness and confusion.</p> <p>-References to contagion.</p> <ul style="list-style-type: none"> • Lacking understanding of youth vulnerability to mental health difficulties due to absent discussion of individual neuro-developmental and genetic factors which interact with psychosocial risks. • Misidentification of less common mental health difficulties. • Confusion surrounding the differences between cause and outcome, learning difficulties, neurological and mental health difficulties. • Misunderstanding and lack of knowledge of „mental health“. • Limited knowledge of support:

<ul style="list-style-type: none"> • Generally appropriate beliefs and knowledge regarding the effectiveness of support as evidenced by their wide-ranging recommendations for individuals with mental health difficulties. • Some positive attitudes towards mental health difficulties and seeking support. • Identification and disapproval of society's negative attitudes towards mental health difficulties and help-seeking. • Proactive attitudes to increase knowledge of mental health difficulties, available support and protect against negative societal attitudes towards help-seeking. 	<ul style="list-style-type: none"> -Limited understanding, knowledge and awareness of certain support, the limitations of support and what constitutes effective support. -Beliefs which limit ways to access support. <ul style="list-style-type: none"> • Some negative attitudes towards individuals with mental health difficulties and seeking support.
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Thus, overall the young people in this study have a broad and developing knowledge-base and appropriate beliefs surrounding mental health difficulties and support which are broadly consistent with a range of research and policy recommendations detailed within the first two chapters of the literature review. Both their strengths and areas for development are generally consistent with previous literature. This is evidenced in research exploring young people's understanding, which describes how although such knowledge becomes more sophisticated with age, the security and detail of this knowledge is lacking (Fox et al, 2007; 2010; Burns & Rapee, 2006; Lock et al, 2002). Gender differences found which generally suggested females had superior knowledge and beliefs of mental health and mental health support, is also supported by literature (Chandra & Minkovitz, 2006; Cotton et al, 2006).

In terms of their attitudes towards mental health and mental health support, the young people exhibited a level of appropriateness, albeit with some negative attitudes. This again is generally consistent with previous literature which notes increasing, stable and resistant negative attitudes in young people (Royal & Roberts, 1987; Watson et al, 2005; Wahl, 2002). However, although females generally demonstrated more positive attitudes towards help-seeking, unlike previous research, they exhibited negative attitudes, surrounding those with mental health difficulties which were comparable to males" and indicated greater fear and apprehension. This is perhaps as a result of gender role expectations towards individuals with mental health difficulties, becoming mentally ill themselves and seeking support.

6.9 Implications for practice: Preventative approaches

In-keeping with the theoretical framework of this study, the implications for practice will be discussed with reference to the systems included in the ecological-transactional model.

6.9.1 Exosystem: Implications for practice within the school

Due to transferable nature of the findings of this study, valuable information can be provided to Highfields school regarding the knowledge, beliefs and attitudes of their Year Nine pupils surrounding mental health and mental health support.

As the findings suggest, the broad understanding and relatively appropriate beliefs and attitudes of the young people require some further development to enhance detail, security of knowledge and address attitudes within gender sensitive ways. In light of the young people's generally receptive attitudes to enhancing their knowledge and awareness of mental health and support, areas for development highlighted within Table Eight could be addressed via tailored educational initiatives which are aimed at the Year 9 cohort of Highfields school. These areas for development are collapsed and summarised within the bullet-points below and elaborated upon in the following sections:

- Educational initiatives to address knowledge and beliefs:
 - 1) Build upon and expand their knowledge of risks and pathways to mental health difficulties.
 - 2) Build upon and expand their knowledge of mental health, mental health difficulties as well as reduce confusion with other difficulties.
 - 3) Develop their understanding of youth vulnerability to mental health difficulties.

- 4) Address knowledge of wider mental health support, the limitations of support and its effectiveness. Also develop knowledge of a wider range of ways to access help.
- Educational initiatives to address attitudes:
 - 1) Address their negative attitudes to mental health difficulties and help-seeking.

6.9.1a Educational Psychologists: Tier 1

The delivery of mental health educational initiatives has typically been the responsibility of teaching staff supported by mental health professionals. However, training and competency issues for teaching staff (Walter et al, 2006) have presented barriers in the past. These constraints present opportunities for EPs who are often in schools, are aware of school systems and experienced in delivering mental health support at Tier 1 (Squires, 2010).

In light of their doctoral training (Gelso, 2006), EPs have the theoretical and psychological knowledge to inform educational initiatives surrounding mental health, mental health support and attitude change. Their thorough understanding of child development, research, awareness of the importance of acknowledging young people's contributions and of being sensitive to gender differences also make them invaluable in contributing to educational initiatives, particularly the training and supervision of school staff to deliver such initiatives.

For instance, using the findings of this study, EPs could compile training which could be delivered to staff at Highfields school who would then be responsible for delivering educational initiatives based upon this training. The following bullet-points exemplify key objectives of this training:

- To address the young people's lacking knowledge of risks and pathways to mental health difficulties.

EPs could clarify the nature of these risks with reference to research, outline key theoretical models of risks, risks at each ecological level and highlight the importance of the interaction of individual and environmental risks. To clarify the nature of risks, EPs could explain and provide examples of how an individual may be exposed to risks and how this may lead to a mental health difficulty. This could address, for instance confusion surrounding psychological risks; misunderstandings around contagion and may also help to more clearly demonstrate cause and outcome to the young people.

- To address the young people's lack of discrimination between mental health and mental health difficulties.

EPs could highlight the importance of modelling appropriate language associated with being mentally healthy and mentally unhealthy and regularly exposing pupils to that language. Pathogenic-salutogenic models could also be explained to school staff to support this distinction. This could also provide a framework in which the continuum of mental health could be more explicitly addressed, such as what it looks like to be mentally healthy, what promotes this, as well as broadening their knowledge of a wider range of mental health difficulties, in-line with MHL objectives (Jorm, 1997a). This may also provide a useful context in which to delineate mental health from learning and neurological difficulties.

- To develop the young people's understanding of youth vulnerability to mental health difficulties

Using evidence, EPs can illustrate to teaching staff the rise in mental health difficulties during the adolescent period. They could then use research and theory to demonstrate how

neuro-developmental changes and genetic factors interact with psychosocial risks to make young people especially vulnerable to mental health difficulties.

- To increase the young people's knowledge of mental health support.

EPs could provide reviews of research to teaching staff which will enable them to demonstrate the effectiveness of different forms of support for young people, including the limitations of this support. Information surrounding self-help, psychological interventions and how funding streams relate to the network of mental health support within the UK at varying ecological levels is also necessary. Illustrations of the various ways young people can access support could also be included.

- To improve young people's attitudes towards individuals with mental health difficulties, seeking available mental health support.

As suggested by the young people, experience of mental health support and ex-service users could assist in building their knowledge, but it could also address some of their negative attitudes. Using their experiences gained from multi-agency working, EPs could peak the young people's interest in mental health support by sign-posting to teaching staff, mental health professionals who are available for presentations as well as local support which could accommodate school visits.

Another way of addressing attitudinal barriers is for the school EP to illustrate how school staff can harness the young people's positive, critical and proactive attitudes. This could be achieved by exploring and deconstructing stigma around mental health and help-seeking. This could be done with reference to its historical context which could be easily accommodated within the secondary school curriculum. A further approach is to make use of the young people's suggestions to raise awareness and involve them within campaigns. By involving them in a more active approach to raising awareness, the young people may

feel and perceive that they are making a real difference, reducing some of their beliefs that improving attitudes to help-seeking is futile.

In terms of gender differences, from the findings, key areas for development are highlighted for both males and females.

For males within Year Nine at Highfield school key areas for development include:

- Broadening their beliefs surrounding the type of risks which can contribute to mental health difficulties.
- Increasing their understanding of the importance of the interaction of risks within pathways to mental health difficulties.
- Increasing their knowledge of less common mental health difficulties.
- Reducing confusion between learning, neurological and mental health difficulties, cause and outcome.
- Extending their knowledge and beliefs regarding effective support.
- Improving attitudes towards seeking mental health support.

For females within Year Nine at Highfield key areas for development include:

- Building their knowledge and understanding of the limits of support or what constitutes effective support.
- Broadening their knowledge and consideration of wider routes to support.
- Ameliorating their fearful and apprehensive attitudes towards individuals with mental health difficulties and seeking mental health support.
- Developing their understanding of the continuum of mental health.

Bearing in mind the gender differences found, EPs could provide assistance, again via training. In light of research which found how the presentation of educational material is important when increasing the MHL of males (Chandra & Minkovitz, 2006) and how gender role expectations may be at their strongest surrounding attitudes (Chernets-Taha et al, 2009), EPs could suggest ways teaching staff could sensitively address the above gender differences. For example, and as suggested within their exception responses, web-based searches in which they can browse available support more independently may be more appealing to males. Their awareness of the challenges of affecting attitudinal change may result in resistance to initiatives which directly address attitudinal change. Therefore it may be better to address such issues via lessons which target knowledge-building, indirectly influencing attitudinal change.

For females, their apprehensive attitudes could be addressed through opportunities to build experience. As seen from their narrower preferences for mental health support when they were asked what they would like, EPs could interpret this finding to suggest that females should be supported to decide upon the effectiveness of mental health support by making it relevant to themselves and their own needs.

Table Nine: Young people's wishes for support.

Type of support:-
<ul style="list-style-type: none"> • Informal and community-based support as first port-of-call, for lower-level mental health needs (.i.e. parents, friends and school mentors). • Preferences for professional support for higher-level mental health needs (.i.e. psychological and medical professionals). • Community-based and informal support to run alongside professional support (.i.e. wider community-based support identified, teachers and parents supplying moral support). • Higher level, professional support located externally to school.
Delivery:-
<ul style="list-style-type: none"> • Confidential • Accessible • Concealed • Well-supported • Person-centred • Youth-focussed • Effective • Treated equally • Empathy

6.10 Implications for practice: Intervention-based approaches

6.10.1 Exosystem: Implications for practice within and outside of the school

The findings summarised within Table Nine provide useful information to Highfield school surrounding what support young people, within Year Nine would like if they had a mental health difficulty. Their views regarding tiered mental health support, which mainly identified school-based support for lower-level difficulties and external support for higher-level difficulties highlights the role of schools to potentially bridge the gap of unmet mental health needs (McGorry et al, 2007; Armbruster & Lichtman, 1999).

As an advocate for young people's voices, EPs could communicate these wishes to school staff and discuss some of their implications. In addition, EPs could highlight their role within the increasing tiers of support requested by the young people.

6.10.1a Educational Psychologists: Tier 1 with elements of Tier 2 (enhanced Tier 1)

The young people's preferences for informal support, as their first port of call, has implications for ensuring support to parents and young people as potential peer supporters. From their experiences of working in schools and with families, EPs could be instrumental in both guiding and delivering this support to add more specialist input.

For instance, EPs could hold regular, informal workshops at school to support parents by providing strategies for supporting their child's mental health. This would also provide parents with a comfortable forum in which they can ask questions and receive regular, on-going support for themselves. Separate workshops could also be held for the young people so they can also be made aware of best ways to support their friends if they required mental health support. According to their preferences for social support groups which run activities, the structure and set-up of groups of peers who could participate in after school support and recreation sessions could be guided and monitored by the school EP, via school staff feedback.

From their preferences for mentors, The EP could also provide regular supervision to school mentors, providing them with appropriate strategies and training to identify when presenting difficulties require intervention at a higher tier.

6.10.1b Educational Psychologists: Tier 2 and Tier 3

In terms of meeting higher-level mental health needs, the role of the EP is three-fold.

Firstly, EPs could assist with the practical implications of such support. One suggestion from the young people was that external support was funded by the school. EPs could therefore conduct a needs analysis to inform school's funding decisions regarding the creation of accessible external support for Highfield pupils.

Another practical implication involves communicating and negotiating the young people's wishes for the delivery of support to local professionals and wider community-based support. From their role within multi-agency work (Leadbetter, 2006) EPs are well-equipped to do this.

Implications surrounding information-sharing and confidentiality could also be highlighted by EPs, especially in light of the young people's wishes for their parents, and in some cases teachers to accompany them when receiving professional support. EPs' experiences of maintaining ethical standards of research and practice would inform them of such issues, communicating for instance, the need for written and informed consent when information-sharing and the importance of setting out the limits of a confidential service. Potentially, support would also have to be offered to parents and teaching staff who may find their supportive role challenging or upsetting.

Secondly, EPs could showcase their own therapeutic skills and experiences to both the school and the other professionals/individuals. For instance, EPs could demonstrate their knowledge of therapeutic approaches and using case-study evidence, their ability to deliver effective Tier 2 support. By identifying themselves within multi-disciplinary teams as

seems to be indicated within the young people's wishes, EPs could also highlight their ability to work alongside clinicians to deliver Tier 3 mental health support.

Thirdly, in ensuring their wishes for person and youth-centred support, as indicated by the young people's desires for regular feedback loops, EPs could utilise their skills and familiarity with evaluation and review cycles. To do this, EPs could gain regular feedback from all stakeholders and the young people in receipt of support to ensure continual improvement and tailored support.

6.11 General conclusion

Overall, encouragement is given that young people have a broad knowledge-base and largely appropriate beliefs regarding mental health difficulties and the effectiveness of available mental health support. However, opportunities for educationally-based preventative support which is sensitive to the gender differences found are presented to address the security and detail of their knowledge, challenge negative attitudes and build upon their positive attitudes towards mental health and mental health support.

In terms of their wishes for support, they would like a tiered approach with professional support external to school. Aspects of the delivery of such support are that the young people feel supported and treated equally. They also wanted confidential support, tailored to their needs, that is accessible, empathic and effective. Aspects of the type and delivery of support vary according to gender. Encouragingly, the role of the school in meeting their potential mental health needs is indicated at the prevention and intervention-level.

Weight is given to these findings due to their relationship with theory, research and policy. In carrying forward these findings by implementing preventative and intervention-based support, the role of the EP alongside the school and other stakeholders, is integral.

As mental health difficulties also extend into early adulthood (Collip et al, 2008, Harrop & Trower, 2001) and EP support is set to extend up to young people aged twenty-five (Great Britain, 2014), future research could utilise MHL to explore the needs and wishes of older young people.

6.12 Personal learning

Reflecting upon my journey through this piece of research, my knowledge, skill-set and practice as an educational psychologist have been enhanced in two, main ways. Firstly, having had extensive experience of research positioned within traditional, positivist scientific paradigms, this study has allowed me to gain greater knowledge and skills surrounding qualitative research design and appreciate its value and contribution within social science. Secondly, in working with young people, I have realised the value of listening to their views not only because what they say is useful when designing and providing support directed at them but also because they, like adults have something to say and want to be heard.

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Appendices

Do I have to take part?

You do not have to take part and can decide to leave at any point. The researcher will not be able to remove answers that you have given in the group after you have given them.

What are the benefits of taking part?

It is important that you have your say about things that affect young people. You will be helping us to understand what young people want from emotional wellbeing support services. You will also give use useful information about what young people your age-group think and understand about emotional wellbeing.

Thank you for reading.

Researcher contact details:

Aimee Harvey

Literature review

A lot of evidence suggests that adolescence is a sensitive period for the onset of mental health difficulties (Collip et al, 2008; Bhardwa, 2013; Costello et al, 2003; 2005; Harrop & Trower, 2001; Brandenberg et al, 1990; Hill, 1989; Roberts et al, 1998). A number of individual (brain, hormonal, developmental changes), familial, social and wider risks have been considered within research to explain this phenomenon (Paus et al, 2008; Blakemore et al, 2007; Brooks-Gunn & Petersen, 1984; Meltzer, 2007; Harvey, 2012; Gerard & Buehler, 1999; Spataro et al, 2004; Harrop & Trower, 2001; Bond et al, 2001). This highlights the need for prevention and early intervention. Literature evaluating the effectiveness of a wide range of mental health support for young people, offers some support for a range of preventative and intervention-based support (Wells & Stewart-Brown, 2003; Gumley et al, 2003; Squires, 2010; Kramer & Garralda, 2000; Pistrang et al, 2008; Puskar et al, 2003; Barrett & Turner, 2001; Esters et al, 1998; Essler et al, 2006; Pattison & Harris, 2006; Green et al, 2007; Carr, 2009; Wolpert et al, 2013; Paluska & Schwenk 2000; Chen et al, 2006; Young & Ensing, 1999; Wilson & Zandberg, 2012). Despite these findings, the CAMHS Review (2008) highlights capacity difficulties within current support systems, young people's lack of knowledge and awareness regarding support, stigmatising attitudes towards seeking support and a lack of support tailored to young people's needs. Research elsewhere also agrees with the Review's findings, including young people's limited knowledge of mental health and mental health difficulties, in general (Fox, 2005; Fox et al, 2007; 2010; Bailey, 1999; Armstrong et al, 1998; Roose & John, 2003; Wahl, 2002; Bailey, 1999; O'Driscoll et al, 2012; Armstrong et al, 1998; Burns & Rapee, 2006; Chernets-Taha et al, 2009; Pinfold et al, 2005). This research is however, still quite limited, particularly so for what young people would want if they were to suffer a mental health difficulty (Plaistow et al, 2014).

Design of the study

Jorm's (1997a) mental health literacy framework which looks at young people's knowledge, beliefs and attitudes towards mental health and help-seeking was used in this study. It can be used to inform educational initiatives which could build young people's knowledge, address their potential stigmatising and negative attitudes and increase the likelihood that they would seek help for themselves. Young people's wishes for mental health support, should they need it, were also explored.

The research questions were therefore:

- 5) What do young people know and believe about mental health and mental health difficulties?
- 6) What do young people know and believe about support for mental health difficulties?
- 7) What are young people's attitudes towards mental health difficulties and mental health support?
- 8) In terms of support, what would young people want if they were experiencing mental health difficulties?

Four focus groups were held with between four and six young people aged fourteen. This included two female and two male groups. All answers were analysed thematically and are presented in the Tables below. Gender differences were also compared and summarised in Tables Two and Four.

Findings

Table One: Strengths and areas for development regarding the young people's knowledge, beliefs and attitudes surrounding mental health difficulties and mental health support.

Strengths:-

- Broad knowledge of and generally appropriate beliefs about the interaction and presence of risks within pathways to poor mental health.
- Broad knowledge and generally appropriate beliefs regarding vulnerable groups.
- Knowledge of more common mental health difficulties and their impact upon functioning.
- An understanding of how mental health difficulties exist along a continuum of difficulties
- Broad knowledge of the existence of mental health support at different ecological levels and how to seek it.
- Generally appropriate beliefs and knowledge regarding the effectiveness of support as evidenced by their wide-ranging recommendations for individuals with mental health difficulties.
- Some positive attitudes towards mental health difficulties and seeking support.
- Identification and disapproval of society's negative attitudes towards mental health difficulties and help-seeking.
- Proactive attitudes to increase knowledge of mental health difficulties, available support and protect against negative societal attitudes towards help-seeking.

Areas for development:-

- Insecure knowledge of risks:
 - Limited awareness and confusion.
 - References to being able to „catch“ mental health difficulties.
- Lacking understanding of why and how adolescents are vulnerable to mental health difficulties.
- Misidentification of less common mental health difficulties.
- Confusion surrounding the differences between cause and outcome, learning difficulties, neurological and mental health difficulties.
- Misunderstanding and lack of knowledge of „mental health“.
- Limited knowledge of support:
 - Limited understanding, knowledge and awareness of certain support, the limitations of support and what constitutes effective support.
 - Beliefs which limit ways to access support.
- Some negative attitudes towards individuals with mental health difficulties and seeking support.

Table Two: Gender differences surrounding knowledge, beliefs and attitudes towards mental health and mental health support.

Females	Males
Strengths:	Strengths:
<ul style="list-style-type: none"> • Identification of less common mental health difficulties. • Greater ability to distinguish between mental health, neurological and learning difficulties, cause and outcome. • Beliefs that a wider range of risks make important contributions to poor mental health outcomes • Recognition of the importance and complexity of the interaction of risks • Beliefs that a wider range of mental health support may be effective • More positive attitudes towards help-seeking 	<ul style="list-style-type: none"> • Continuum of mental health difficulties • Beliefs that a wider range of routes to mental health support may be effective • Less fear towards individuals with mental health difficulties and becoming mentally ill themselves. • Less apprehensive about seeking help.

Areas for development:	Areas for development:
<ul style="list-style-type: none"> • Lacking knowledge & understanding of the limits of support or what constitutes effective support. • More restrictive beliefs surrounding ways to access support. • Fear towards individuals with mental health difficulties and becoming mentally ill themselves. • More apprehensive attitudes to help-seeking. • Lack of any reference to the continuum of mental health 	<ul style="list-style-type: none"> • Misidentification of less common mental health difficulties. • Confusion between mental health, learning difficulties and neurological difficulties, cause and outcome. • More restrictive beliefs regarding the type of risk which can contribute to mental health difficulties. • Lacking recognition of the importance of the interaction of risks within pathways to mental health difficulties. • More restrictive beliefs about effective mental health support. • Less positive attitudes towards seeking mental health support.

Table Three: The young people's wishes regarding mental health support

Type of support:-
<ul style="list-style-type: none"> • Informal and community-based support as first port-of-call, for lower-level mental health needs (i.e. parents, friends and school mentors). • Preferences for professional support for higher-level mental health needs (i.e. psychological and medical professionals). • Community-based and informal support to run alongside professional support (i.e. wider community-based support (volunteers, charities), teachers and parents supplying moral support). • Higher level, professional support located externally to school.
Delivery:-
<ul style="list-style-type: none"> • Confidential • Accessible • Concealed • Well-supported • Person-centred • Youth-focussed • Effective • Treated equally • Empathy

Table Four: Gender differences within the young people's wishes for support.

Females	Males
<ul style="list-style-type: none"> -More preferences for community-based -Feeling well-supported and reassured -Accessible -Youth-focussed -Empathic -Effective -Concealed 	<ul style="list-style-type: none"> -More preferences for psychological support -Person-centred support

How to support young people?

Overall, the findings suggest that your Year Nine pupils have a broad understanding and relatively appropriate beliefs and attitudes surrounding mental health difficulties and mental health support. Females in general were more knowledgeable and demonstrated more appropriate beliefs and attitudes. However, further development is needed to enhance the detail, security of their knowledge and address attitudes in gender sensitive ways. Your school educational psychologist (EP) could support you to address these areas for development. Below are a few ideas:

Preventative support

It may be possible after discussion with your school EP for them to deliver training which addresses the areas for development identified. Your school EP may also provide suggestions as to how to sensitively address some of the gender differences found, within this training. This could then feed into educational initiatives you may design for your Year Nine pupils.

Suggested training objectives to equip school staff to:

1. Build upon and expand knowledge of risks and pathways to mental health difficulties.
2. Build upon and expand knowledge of mental health, mental health difficulties and reduce confusion with other difficulties.
3. Enhance understanding of youth vulnerability to mental health difficulties.

4. Build knowledge of wider mental health support surrounding its limitations and effectiveness.
5. Build knowledge of a wider range of ways to access help.
6. Address negative attitudes to mental health difficulties and help-seeking.

Intervention-based support

From the findings, the young people appear to see the school as mainly helpful for lower-level mental health difficulties. They also wanted to turn to family and friends as a first port of call. For more serious difficulties, external, professional support is preferred. At this level, the young people wanted wider community-based support (charities, volunteers) and their family to continue to offer moral support. In some cases they also wanted a teacher, who knows them well, to come with them.

A range of options for external support were discussed. These included, outreach support to their home, a GP surgery and a mental health centre. One option as for this mental health centre to be funded by the school.

From these findings, there are a number of ways your school EP may be able to help:

- 1) Provide support and strategies to families and peers through workshops, social support and activity-based groups.
- 2) Provide support, strategies and supervision to school mentors.
- 3) Guide and support the school with regard to the practical implications of funding and delivering external support:
 - a) Helping staff to consider implications for information-sharing, confidentiality and support which may arise if young people would like their family, friends and teachers to continue to support them when they are in receipt of professional support. EPs could also provide pastoral and therapeutic support for parents, teachers or peers who may have found it difficult to support a young person whilst they were receiving support.
 - b) Helping staff to conduct a mental health needs analysis to understand the demand for external support.
 - c) Support and facilitate multi-disciplinary communication to ensure the young people's remaining wishes for the delivery of support are heard.
- 4) Illustrate their therapeutic skill-set and experience to demonstrate their potential role within externally delivered mental health support.

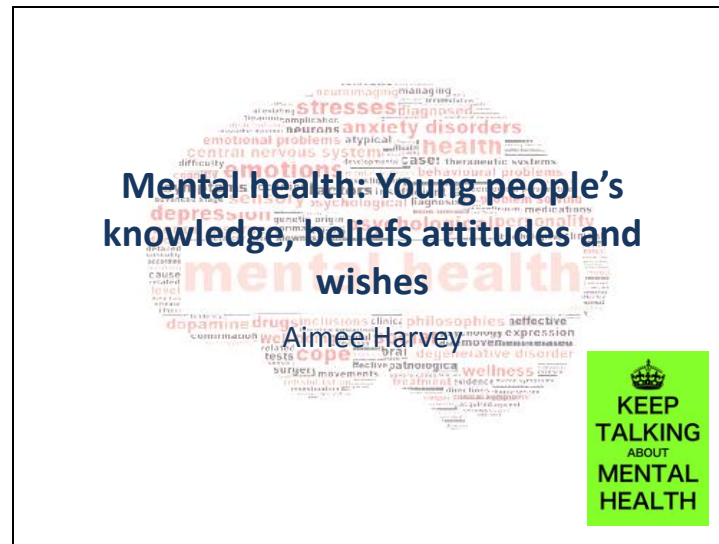
5) Evaluate mental health support from all stakeholders and collect feedback from the young people in receipt of support. The young people expressed real desire to be heard so that support is tailored and relevant to them.

If you would like to ask any questions regarding this study or the implications for support please contact ... and ask to be put in contact with Aimée Harvey, who would be happy to assist you further.

May I take this opportunity also to extend my thanks for this opportunity to conduct research at your school.

Yours sincerely.

Aimée Harvey.



Commissioning/purpose of the research

- A local secondary school (Highfields, pseudonym) requested direction from the EPS to support the mental health needs of a subgroup of young people.
- LA EPS wanted to develop ways in which their service could meet the mental health needs of young people.

Definitions

- **WHO (2013): Mental health**

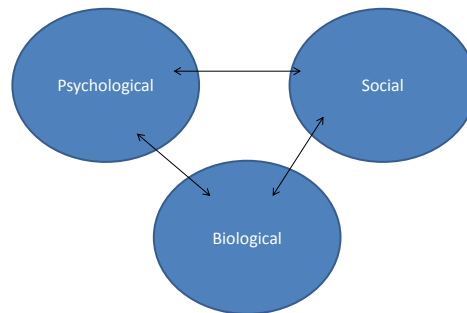
'A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to (their) community'

- **WHO ICD-10: Mental disorder**

'A clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference in personal functions'

Current conceptualisations

- Biopsychosocial model



Engel

-Each factor is equally relevant in pathways to MH difficulties. In particular it is the interaction of the factors that is the most significant.

-Has been criticised for being too eclectic but social and psychological factors are powerful i.e. Birchwood et al, 2000 and provides a more humanistic approach.

Current conceptualisations

- Pathogenic/Salutogenic
 - Pathogenic: Focus on disease and causes.
 - Salutogenic: Focus on health and protective factors.

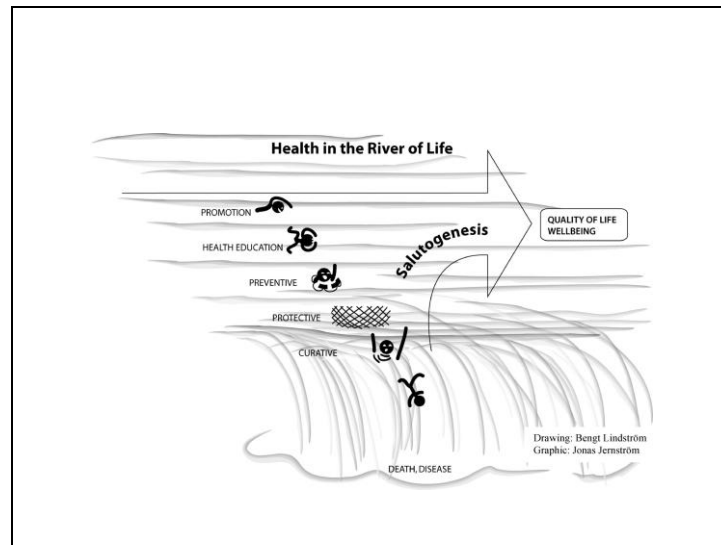
Stressor X Coping resources X Environment =
Continuum of mental health outcomes

SOC

- A personal orientation and perception that stressors are predictable, comprehensible, meaningful and manageable.

GRR (Generalised Resistance Resources)

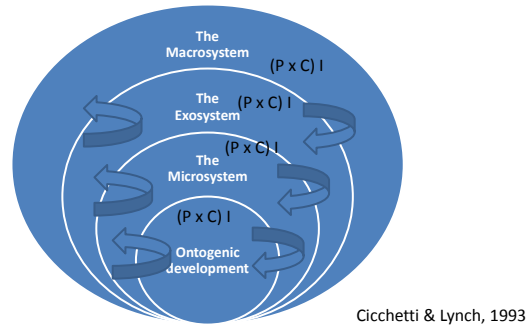
- Physical, emotional, cognitive and interpersonal resources one has to hand which guides the SOC.



Current conceptualisations

Summarises previous models:

- Ecological transactional model:



-Developmental psychopathology represents a movement toward understanding the causes, determinants, course and sequelae, prevention and treatment of mental disorders by integrating knowledge from multiple disciplines within an ontogenic framework (Cicchetti, 1984;1993).

-Developmental psychopathology: requires more than just cause-and-effect. It involves an understanding of mechanisms and processes that eventuate in adaptive versus maladaptive outcome as well as continuum arguments to inform prevention and intervention.

-NB: Risk and vulnerability factors do not cause maladaptation they are indicators of a complex matrix of processes and mechanisms that impact on individual development.

Protective, compensatory:

Can best be conceptualised as opposites of vulnerability factors. Protective factors appear to be the positive pole of risk factors (Stouthamer-Loeber et al, 1993). '...most contextual variables in the parents, the family, the neighbourhood and the culture at large seem to be dimensional, aiding in general child development at one end and inhibiting it at the other.'

Young people

- Rise in the onset of mental health difficulties around adolescence and young adulthood (Collip et al, 2008; Harvey, 2012, Harrop & Trower, 2001).
- Increased need for **prevention** (i.e. education) *and* **early intervention**



Ontogenic level:
Risk x Protective factors

POTENTIATING (RISKS):-

- Pubertal, physiological changes (Brooks-Gunn & Petersen, 1984).
- Gender x increasing age (Meltzer, 2007; Gove & Herb, 1974).
- Ethnicity (Nazroo, 1997).
- Unhealthy lifestyle choices (Prince et al, 2007).

COMPENSATORY (PROTECTIVE):-

- Self-esteem & active coping strategies (Steinhausen & Metzke, 2001).

Microsystem:
Risk factors x Protective factors

POTENTIATING (RISKS):-

- Unstable family life, maternal distress (Meltzer, 2007).
- Early sexual abuse (Spataro et al, 2004)

COMPENSATORY (PROTECTIVE):-

- Parental and peer support and acceptance (Chappel, 2012; Steinhausen & Metzke, 2001).

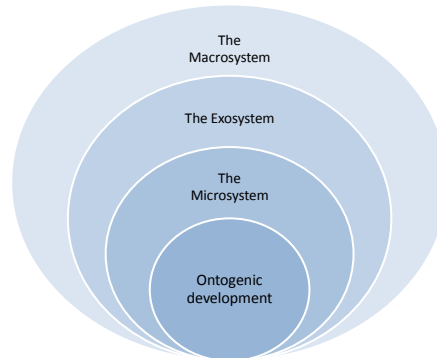
Exosystem: Risk factors x Protective factors

- POTENTIATING (RISKS):-
 - Community violence (Lynch & Cicchetti, 1998).
 - Substance abuse (Kazdin, 1996).
 - Bullying (Bond et al, 2001).
 - Low connectedness to social networks (Bond et al, 2007)
 - Major life events (Chappel, 2012).
- COMPENSATORY (PROTECTIVE):-
 - Social capital (De Silva et al, 2005)
 - Peer support and acceptance (Chappel, 2012; Steinhausen & Metzke, 2001)

Macrosystem: Risk x Protective factors

- POTENTIATING (RISKS):-
- Political violence (Cicchetti & Toth, 1997).
- Income inequality (Wilkinson & Pickett, 2009).
- COMPENSATORY (PROTECTIVE):-
- Greater social equality (Wilkinson et al, 2009)

Prevention and intervention in UK: Meeting the mental health needs of YP



Macrosystem

Legislation: The Mental Health Act (2007).

NICE guidelines.

Government policy: *No health without mental health.*

Health Advisory Service Report (1995): Tiered approach.

Exosystem

1-4 Tiers: schools, GPs, hospitals, community-based.

Microsystem

2-3 Tiers: outreach support, family support teams, social care.

Ontogenic

Individual differences (resilience), self-help, healthy lifestyle.

CAMHS Review, 2008

- Barriers to support:
 - 1) Capacity difficulties
 - 2) Stigma
 - 3) Young people's lack of knowledge of available support
 - 4) Lack of responsiveness to individual needs

Agrees with:

- Research on capacity issues (Killackey et al, 2007; Prymachuk et al, 2012; Albee, 1982; Slowik & Noronha, 2004; Jones, 2006)
- Research noting young people's limited knowledge and particular beliefs surrounding mental health (Fox et al, 2007; 2010; Burns & Rapee, 2006) and mental health support (Burns et al, 2006; Roose et al, 2003; Bailey, 1999; Armstrong et al, 1999) and stigmatising attitudes (Wahl, 2002).
- Paucity of research on young people's wishes regarding mental health support (Warral-Davies & Marins-Francis, 2007).

Rationale for research

- Adolescence as a vulnerable time-period for mental health difficulties
- Address CAMHS Review findings
- Explore weaknesses within the knowledge-base, beliefs, attitudes of YP towards mental health and mental health support
- Add to limited research available
- United Nations Convention on the Rights of the Child (UN, 1990): YP are potential service-users
- Person-centred approaches (EHCP & Government proposals for mental health '*No health without mental health*')

Exploring YPs' knowledge-base, beliefs, attitudes and wishes

- Framework: Mental health literacy (MHL) (Jorm, 2000)
- Focus upon improving YP's understanding of mental health difficulties, mental health support and facilitating help-seeking
- Enjoyed success and utilises YPs' data to inform subsequent support
- Flexible framework to incorporate YPs' wishes

- Recognise specific disorders/different types of psychological distress
- Knowledge and beliefs about risk factors and causes
- Knowledge and beliefs about self-help interventions
- Knowledge and beliefs about professional help available
- Attitudes which facilitate recognition and appropriate help-seeking
- Knowledge of how to seek mental health information

-Fits conceptually with the biopsychosocial model, ecological transactional models and salutogenic/pathogenic.

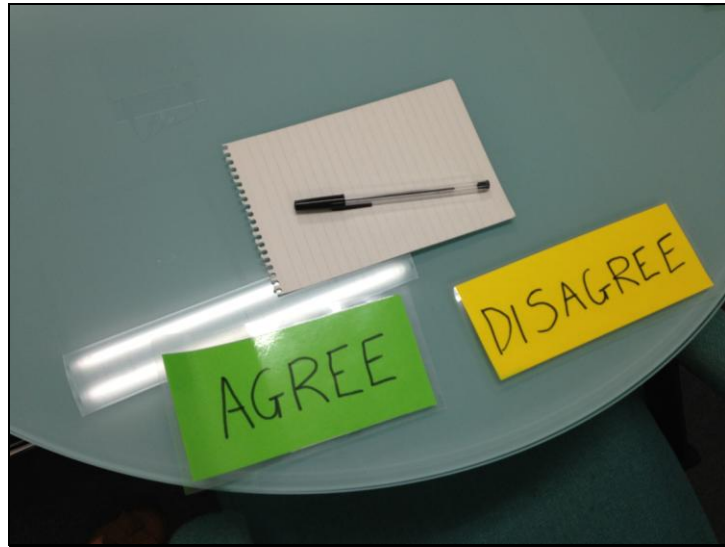
Research questions

- 1) What do young people know and believe about mental health and mental health difficulties?
- 2) What do young people know and believe about support for mental health difficulties?
- 3) What are young people's attitudes towards mental health difficulties and mental health support?
- 4) In terms of support, what would young people want if they were experiencing mental health difficulties?

Methodology

- Critical realist
- Four focus groups (2 male, 2 female)
- Applied thematic analysis (qualitative and quantitative)







Findings: Strengths and areas for development within the young people's knowledge, beliefs and attitudes.

- ***Strengths***

- Broad knowledge of and generally appropriate beliefs about the interaction and presence of risks within pathways to poor mental health at different ecological levels.
- Broad knowledge and generally appropriate beliefs regarding vulnerable groups.
- Knowledge of more common mental health difficulties and their impact upon functioning.
- An understanding of how mental health difficulties exist along a continuum of difficulties
- Broad knowledge of the existence of mental health support at different ecological levels and how to seek it.
- Generally appropriate beliefs and knowledge regarding the effectiveness of support as evidenced by their wide-ranging recommendations for individuals with mental health difficulties.
- Some positive attitudes towards mental health difficulties and seeking support.
- Identification and disapproval of society's negative attitudes towards mental health difficulties and help-seeking.
- Proactive attitudes to increase knowledge of mental health difficulties, available support and protect against negative societal attitudes towards help-seeking.

- ***Areas for development***

- Insecure knowledge of risks:
- Limited awareness and confusion.
- References to contagion.
- Lacking understanding of youth vulnerability to mental health difficulties due to absent discussion of individual neuro-developmental and genetic factors which interact with psychosocial risks..
- Misidentification of less common mental health difficulties.
- Confusion surrounding the differences between cause and outcome, learning difficulties, neurological and mental health difficulties.
- Misunderstanding and lack of knowledge of 'mental health'.
- Limited knowledge of support:
 - Limited understanding, knowledge and awareness of certain support, the limitations of support and what constitutes effective support.
 - Beliefs which limit ways to access support.
- Some negative attitudes towards individuals with mental health difficulties and seeking support.

Findings: wishes for support

Type of support:-

Informal and community-based support as first port-of-call, for lower-level mental health needs (.i.e. parents, friends and school mentors).

Preferences for professional support for higher-level mental health needs (.i.e. psychological and medical professionals).

Community-based and informal support to run alongside professional support (.i.e. wider community-based support identified, teachers and parents supplying moral support).

Higher level, professional support located externally to school.

Delivery:-

- Confidential
- Accessible
- Concealed
- Well-supported
- Person-centred
- Youth-focussed
- Support should be effective
- Treated equally
- Treated with empathy

Gender differences

Females	Males
Strengths:	Strengths:
<ul style="list-style-type: none"> • Identification of less common mental health difficulties. • Greater ability to distinguish between mental health, neurological and learning difficulties, cause and outcome. • Beliefs that a wider range of risks make important contributions to poor mental health outcomes. • Recognition of the importance and complexity of the interaction of risks. • Beliefs that a wider range of mental health support may be effective. • More positive attitudes towards help-seeking. 	<ul style="list-style-type: none"> • Continuum of mental health difficulties. • Beliefs that a wider range of routes to mental health support may be effective. • Less fear towards individuals with mental health difficulties and becoming mentally ill themselves. • Less apprehensive about seeking help.

Females	Males
Areas for development:	Areas for development:
<ul style="list-style-type: none"> •Lacking knowledge & understanding of the limits of support or what constitutes effective support. •More restrictive beliefs surrounding ways to access support. •Fear towards individuals with mental health difficulties, becoming mentally ill. • More fearful and apprehensive attitudes to help-seeking. •Lack of any reference to the continuum of mental health. 	<ul style="list-style-type: none"> •Misidentification of less common mental health difficulties. •Confusion between mental health, learning difficulty and neurological difficulties, cause and outcome •More restrictive beliefs regarding the type of risk which can contribute to mental health difficulties •Lacking recognition of the importance of the interaction of risks within pathways to mental health difficulties. •More restrictive beliefs about effective mental health support. •Less positive attitudes towards seeking mental health support.

Females

Strengths

-Appropriate beliefs at the individual and environmental level i.e. Biogenetic, familial and social risks most likely to lead to mental health difficulties.

-Recommended wider support (but also omitted psychological and recommended self-help)

Weaknesses

-Lack of any reference to psychological support and recommendations for self-help.

Males

-Narrower recommendations for support (informal, medical & psychological).

Wishes for support by gender...

Females	Males
-Preferences for community-based support	-Preferences for psychological support
-To feel supported	-Person-centred support
-Accessible	
-Youth-focussed	
-Empathic support	
-Effective	
-Concealed	

-Hierarchical support = males and females.

Way support was delivered seemed to be more important to females

Exosystem: Implications for practice within the school

Preventative support (Tier 1)

-EPs could compile training which could be delivered to teaching staff at Highfields school who would then be responsible for delivering educational initiatives.

Main ideas:-

1) To address the young people's lacking knowledge of risks and pathways to mental health difficulties:-

EPs could-

-Clarify the nature of these risks with reference to research.

-Outline key theoretical models of risks.

-Highlight the importance of the interaction of individual and environmental risks.

-Explain and provide examples of how an individual may be exposed to risks and how this may lead to a mental health difficulty.

2) To address the young people's lack of discrimination between mental health and mental health difficulties:-

EPs could-

-Highlight the importance of modelling appropriate language associated with being mentally healthy and mentally unhealthy.

-Refer to pathogenic-salutogenic models and continuum arguments

-Contribute to broadening knowledge of a wider range of mental health difficulties.

Point 1 – *‘Explain and provide examples of how an individual may be exposed to risks and how this may lead to a mental health difficulty.’* - This could address, for instance confusion surrounding psychological risks; misunderstandings around contagion and may also help to more clearly demonstrate cause and outcome to the young people.

Point 2 – *‘Contribute to broadening knowledge of a wider range of mental health difficulties.’* – this could also work to address their confusion with other difficulties.

Exosystem: Implications for practice within the school

Preventative support (Tier 1)

3) To develop the young people's understanding of youth vulnerability to mental health difficulties

EPs could -

-Use research to show the rise in mental health difficulties during the adolescent period.

-Demonstrate how neuro-developmental changes and genetic factors interact with psychosocial risks to make young people especially vulnerable to mental health difficulties.

4) To increase the young people's knowledge of mental health support:-

EPs could-

-Provide reviews of research to demonstrate the effectiveness of different forms of support for young people, including the limitations of this support.

5) To improve young people's attitudes towards individuals with mental health difficulties, and seeking mental health support.

EPs could-

-Sign-post staff as to how young people could gain experience of mental health support and ex service-users.

-Show staff how to harness the young people's positive, critical and proactive attitudes.

Point 4 – *'To increase the young people's knowledge of mental health support.'* - Information surrounding self-help, psychological interventions and how funding streams relate to the network of mental health support within the UK at varying ecological levels is also necessary. Illustrations of the various ways young people can access support could also be included.

Point 5 – *'To improve young people's attitudes towards individuals with mental health difficulties, and seeking mental health support.'* - This could be achieved by exploring and deconstructing stigma around mental health and help-seeking. This could be done with reference to its historical context which could be easily accommodated within the secondary school curriculum. A further approach is to make use of the young people's suggestions to raise awareness and involve them within campaigns. By involving them in a more active approach to raising awareness, the young people may feel and perceive that they are making a real difference, reducing some of their beliefs that improving attitudes to help-seeking is futile.

Time to Change – children and young people's programme. Young champions can become involved in campaigns (www.time-to-change.org.uk/news/young-people-tackling-stigma-and-discrimination). Could also register to be a member of the Young Virtual Panel.

Exosystem: Implications for practice within the school – gender differences

- EPs could provide assistance via training.
- Presentation of educational material is important when increasing the MHL of males (Chandra & Minkovitz, 2006).
- Gender role expectations may be at their strongest surrounding attitudes (Chernets-Taha et al, 2009).

Consider –

-Web-based searches in which they can browse available support more independently may be more appealing to males.

-Their awareness of the challenges of affecting attitudinal change may result in resistance to initiatives which directly address attitudinal change. Therefore target knowledge-building to indirectly influence attitudinal change.

-Address females apprehensive attitudes through opportunities to build experience.

-Make support relevant to them to support females to think about the effectiveness of different support.

Considerations informed by their exception responses i.e. they believe it to be unnecessary to be taught about mental health support. They also thought it would be a challenge to affect attitudinal change.

Exosystem: Implications for practice within and outside of the school

Intervention-based support (Tier 1 with elements of Tier 2)

- 1) Support and strategies to family and peers through workshops, social support groups.
- 2) Support and strategies to mentors.

-Enhanced Tier 1 support.

2) Preferences for informal support, as their first port of call, has implications for ensuring support to parents and young people as potential peer supporters.

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Exosystem: Implications for practice within and outside of the school

Intervention-based support (Tie 2 and Tier 3)

3 roles for EP:

- Practicalities:
 - 1) Needs analysis to inform funding decisions as one option for external support.
 - 2) EP as advocate for YPs voices to multi-disciplinary teams (community-based, medical and psychological professionals)
 - 3) Parallel formal and informal support has implications for information-sharing, confidentiality and support.
- Therapeutic input:
 - 1) EPs could showcase their own therapeutic skills at Tie 2 and alongside clinicians at Tier 3
- Evaluation:
 - 1) EP to be involved in the evaluation of support from all stakeholders and young people in receipt of support.

5) The combination of these roles means the school could meet a range of mental health needs, meeting calls for schools to bridge the gap of unmet mental health needs (McGorry et al, 2007; Armbruster et al, 1999), reducing capacity difficulties



Appendix Eight

Interview schedule

Resources:

- Flipchart
- Marker pens (2 different colours)
- Computer with internet access
- Whiteboard screen to show videos
- Water
- Note paper and pens for YP

Opening Statement

-Hello (ladies, gentlemen), welcome and thank you for attending the group today. My name is Aimee and I am from Birmingham University. I also work at ...which is a service that supports young people at school. I am here today as I am interested in what you know and think (views/opinions/beliefs) about mental health, mental health difficulties and the help/care that is available. The answers you give will help us and your school to understand what young people think about mental health difficulties and what they would like to support them. This is not like a school-based activity. I will be asking you to talk with and listen to each other and use your agree and disagree cards in response to other people's comments, rather than just answer me. There are no right or wrong answers, I am interested in what you think and everyone thinks differently, so speak as honestly as you can. You may use the note paper to jot down some of your ideas while others are talking as a reminder for you when you want to speak.

Your answers will be tape recorded, written up and grouped together with some people's answers used as examples. No one's name will be used at any time, so no one will know what you said. Your answers will then be put into presentations to your school, my service and a written piece of work for my University.

If you would like to speak to me privately after the session about what has been discussed or if you would like to add anything further that you did not get chance to discuss then please stay behind at the end.

If you need someone to talk to following the focus group then please speak with Ms. Xxxx who can provide you some support and can contact me.

-Ground Rules (write on flipchart paper and pin to wall):-

- Take your time and discuss what you think with others
- You may add to/agree/disagree with others at any time but try not to talk over others, use the 'agree' and 'disagree' cards and facilitator will invite you to speak
- Everyone gets a chance to speak
- Everyone must be respectful of each other's views, no teasing or making fun.

- All contributions are valuable
- Right to pass
- Due to limited time, I may need to stop you and redirect our discussion
- We must respect privacy and not discuss other people's answers outside the focus group.

(any others YP may like to add?)

Are there any questions about this? Is everyone OK to start?

ICE BREAKER ACTIVITY:-

(Tape recorder off:- go around the group introducing yourself and saying your favourite TV program)

Warm up:-

-(Group discussion):- Can you tell me what is important to young people like yourselves?

Clarification of terms:-

-(*Talking partners*) Discuss with a partner the first thing that comes to your head when you think of 'mental health'?

Probe: What is 'mental health' not?

Probe: What are 'mental health problems'?

Probe: Can you give me some examples?

Probe: Can you tell me more?

5 mins

Easy and nonthreatening Questions:-

Recognise specific disorders/different types of psychological distress:-

VIDEOS - Psychosis (end at 6.50) -Depression (start at 0.18, end at 1.40) -OCD (start at 0.10, end at 2.35)

-Play each video followed by these questions:-

- (*Group discussion*):- What is happening in this video?

Probe: Are they having difficulties?

Probe: What kind of difficulties?

Probe: Could this be a mental health difficulty?

1) (*Group discussion*):- Can you identify other types of mental health difficulties?

Probe: Can you tell me about what that would look like?

Probe: What symptoms?

15 mins

More difficult questions:-

Knowledge and beliefs about risk factors and causes:-

2) (Talking partners then Group discussion) What causes mental health difficulties? (note down on flipchart and then rank order them)

Probe: What do you think may have caused some of the mental health difficulties we saw in the videos?

Probe: How do you think this happens?

3) (Group discussion) Can anyone develop mental health difficulties?

Probe: Are some people more vulnerable than others?

Probe: If so why do you think this is?

Probe: If not, why not?

10 mins

-----BREAK :- REFRESHMENTS (5 mins)-----

(check that everyone is still assenting to participate in the focus group).

Attitudes towards mental health difficulties:-

4) (Talking partners):- What do other people think about someone with mental health difficulties?

Probe: How do they behave towards them?

Probe: What do they say about them?

Probe: What are their beliefs?

Probe: Are they correct?

5) (Group discussion):- What would you think about someone with mental health difficulties living next door to you?

Probe: How would you feel/think about someone from one of the videos living next door to you?

Probe: Why do you think you would feel/think this?

10 mins

Knowledge and beliefs about help available and how to access help:-

6) (Talking partners then Group discussion):- What help is there for people with mental health difficulties? (Note down on flipchart)

Probe: Refer to YP in videos to help

Probe: Is there anything they could do or other people could help them with?

7) (Group discussion):- What help is best/worst? (Rank order on flipchart)

8) (Group discussion):- How can people get this help?

9) (Group discussion):- Which routes are best/worst?

10) (*Group discussion*):- Do you think YP would know what support is out there and how to access this support?

Probe: Are there any groups of people that may have better knowledge of this?

Probe: What could help YP to know what support is out there and how to access it?

11) (*Talking partners then Group discussion*):- What do you/people think about someone who was receiving help for mental health difficulties?

Probe: (If negative) What could help this person? 15 mins

Mental health support service for young people:-

12) (*Group discussion*):- If you or a friend were having mental health difficulties, what kind of support/help would you want?

Probe: Is this the best support for YP in your opinion?

Probe: What kind of support wouldn't help YP?

13) (*Talking partners then Group discussion*):- Would you like this kind of help in school?

Probe: What would it look like?

Probe: Who would work there?

Probe: What range of services/support would they offer?

Probe: How could you access it?

Probe: Where could it be in school?

Probe: If not, where else would you prefer it to be, if at all? 15 mins

Wrap up:-

-Indicate that we have run out of time/coming to a close.

-Summary of main points.

-Recognise any conversational points that were not completed.

-Last comments from the group.

Member check:-

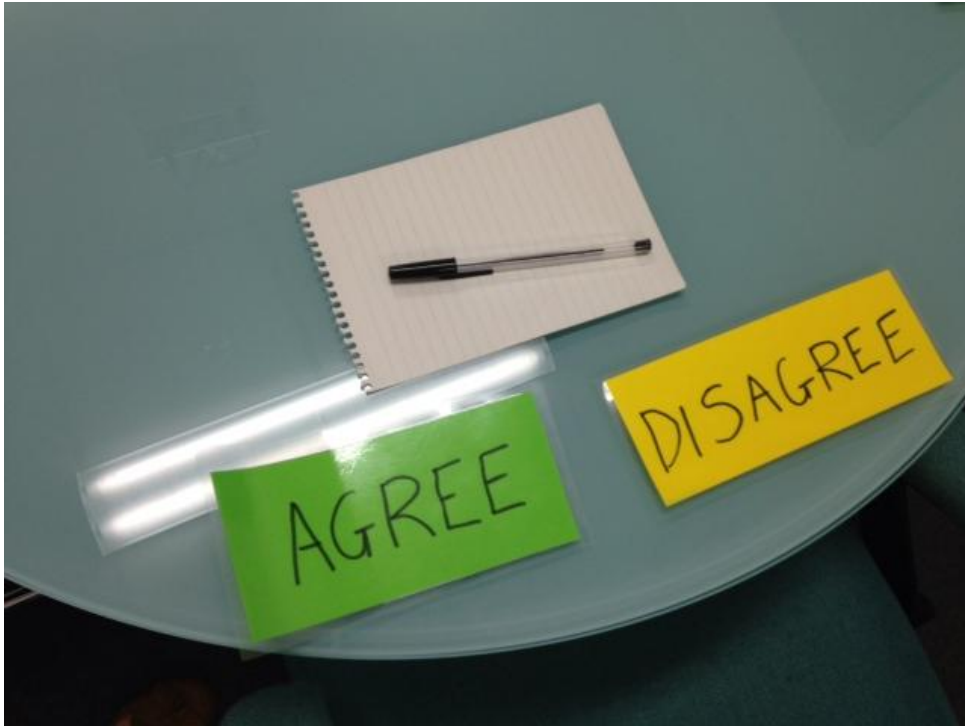
-Check consensus of mental health support i.e. how many YP wanted a mental health service in school/not? (tally).

Closing statements:-

-As we come to a close, I need to remind each of you that none of your names will be used when I write up what has been recorded on the tape-recorder. After analysis the recordings will be destroyed. Please refrain from discussing the comments of the group members with others and that you respect the right of each of you to remain anonymous. Are there any questions I can answer? May I thank you all for your participation in this research. This has been a successful focus group thanks to your excellent contributions.

Appendix Nine





Guidelines for the analysis of codes

- All codes are a summary of the raw data from any number of the focus groups which provide answers to research questions.
- All codes are 1-2 word summaries.
- Codes consist of subordinate and superordinate categories.

All codes from individual focus groups across research questions:

Code map 1: Knowledge and beliefs about mental health/mental health difficulties	
Focus group 1	<u>Conceptualisations:</u> -Pathogenic -Identification -Recognition <u>Vulnerability:</u> -Universal -Older -Younger <u>Risks:</u> -Family environment -Social environment -Bio-genetic -Contagion
Focus group 2	<u>Conceptualisations:</u> -Pathogenic -Identification -Misidentification -Recognition -Confusion <u>Vulnerability:</u> -Universal -Older -Younger <u>Risks:</u> -Social environment -Psychological -Interaction
Focus group 3	<u>Conceptualisations:</u> -Pathogenic -Identification

	<ul style="list-style-type: none"> -Recognition -Confusion <p><u>Vulnerability:</u></p> <ul style="list-style-type: none"> -Universal -Older -Younger -Culture <p><u>Risks:</u></p> <ul style="list-style-type: none"> -Family environment -Social environment -Bio-genetic -Psychological -Interaction -Complexity
Focus group 4	<p><u>Conceptualisations:</u></p> <ul style="list-style-type: none"> -Pathogenic -Identification -Recognition -Continuum -Misidentification -Confusion <p><u>Vulnerability:</u></p> <ul style="list-style-type: none"> -Universal -Older -Younger <p><u>Risks:</u></p> <ul style="list-style-type: none"> -Family environment -Social environment -Bio-genetic -Unhealthy lifestyle -Psychological -Interaction -Contagion
Code map 2: Knowledge and beliefs about mental health support	
Focus group 1	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Community contexts -Informal -Psychological -Self-help <p><u>Routes:</u></p>

	<ul style="list-style-type: none"> -Medical -Media -Community contexts -Informal <p><u>Assistance:</u></p> <ul style="list-style-type: none"> -Raise awareness <p><u>Awareness:</u></p> <ul style="list-style-type: none"> -Inadequate knowledge -Adult superiority
Focus group 2	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Technological forums -Informal -Psychological <p><u>Routes:</u></p> <ul style="list-style-type: none"> -Informal -Media <p><u>Assistance:</u></p> <ul style="list-style-type: none"> -Raise awareness <p><u>Awareness:</u></p> <ul style="list-style-type: none"> -Inadequate knowledge -Adult superiority
Focus group 3	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Technological forums -Informal -Psychological -Self-help -Community contexts -Healthy lifestyle <p><u>Routes:</u></p> <ul style="list-style-type: none"> -Medical -Media <p><u>Assistance:</u></p> <ul style="list-style-type: none"> -Raise awareness <p><u>Awareness:</u></p> <ul style="list-style-type: none"> -Inadequate knowledge -Adult superiority
Focus group 4	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Technological forums -Informal

	<ul style="list-style-type: none"> -Psychological -Community context -Funding -Self-help <p><u>Routes:</u></p> <ul style="list-style-type: none"> -Informal -Media -Medical -Self-help -Community contexts <p><u>Assistance:</u></p> <ul style="list-style-type: none"> -Raise awareness <p><u>Awareness:</u></p> <ul style="list-style-type: none"> -Inadequate knowledge -Adult superiority
Code map 3: Attitudes towards mental health difficulties	
Focus group 1	<p><u>Positive attitudes:</u></p> <ul style="list-style-type: none"> -Consideration -Equal -Disapproving <p><u>Negative attitudes:</u></p> <ul style="list-style-type: none"> -Prejudice -Stigmatising -Fearful -Intolerant
Focus group 2	<p><u>Positive attitudes:</u></p> <ul style="list-style-type: none"> -Consideration -Equal -Disapproving <p><u>Negative attitudes:</u></p> <ul style="list-style-type: none"> -Prejudice -Stigmatising
Focus group 3	<p><u>Positive attitudes:</u></p> <ul style="list-style-type: none"> -Consideration -Equal -Disapproving <p><u>Critical attitudes:</u></p> <ul style="list-style-type: none"> -Phenomenology <p><u>Negative attitudes:</u></p> <ul style="list-style-type: none"> -Stigmatising -Fearful

	-Prejudice
Focus group 4	<u>Positive attitudes:</u> -Consideration -Equal <u>Negative attitudes:</u> -Fearful -Prejudice -Stigmatising -Intolerant
Code map 3: Attitudes towards seeking mental health support	
Focus group 1	<u>Positive attitudes:</u> -Pro-support -Proactive <u>Negative attitudes:</u> -Dismissive -Apprehensive
Focus group 2	<u>Negative attitudes:</u> -Apprehensive
Focus group 3	<u>Positive attitudes:</u> -Pro-support -Proactive -Disapproval <u>Negative attitudes:</u> -Apprehensive
Focus group 4	<u>Positive attitudes:</u> -Pro-support -Proactive -Disapproval <u>Negative attitudes:</u> -Dismissive
Code map 4: Mental health support for young people	
Focus group 1	<u>Support systems:</u> -Medical -Community context -Informal -Psychological -Self-help <u>Context:</u>

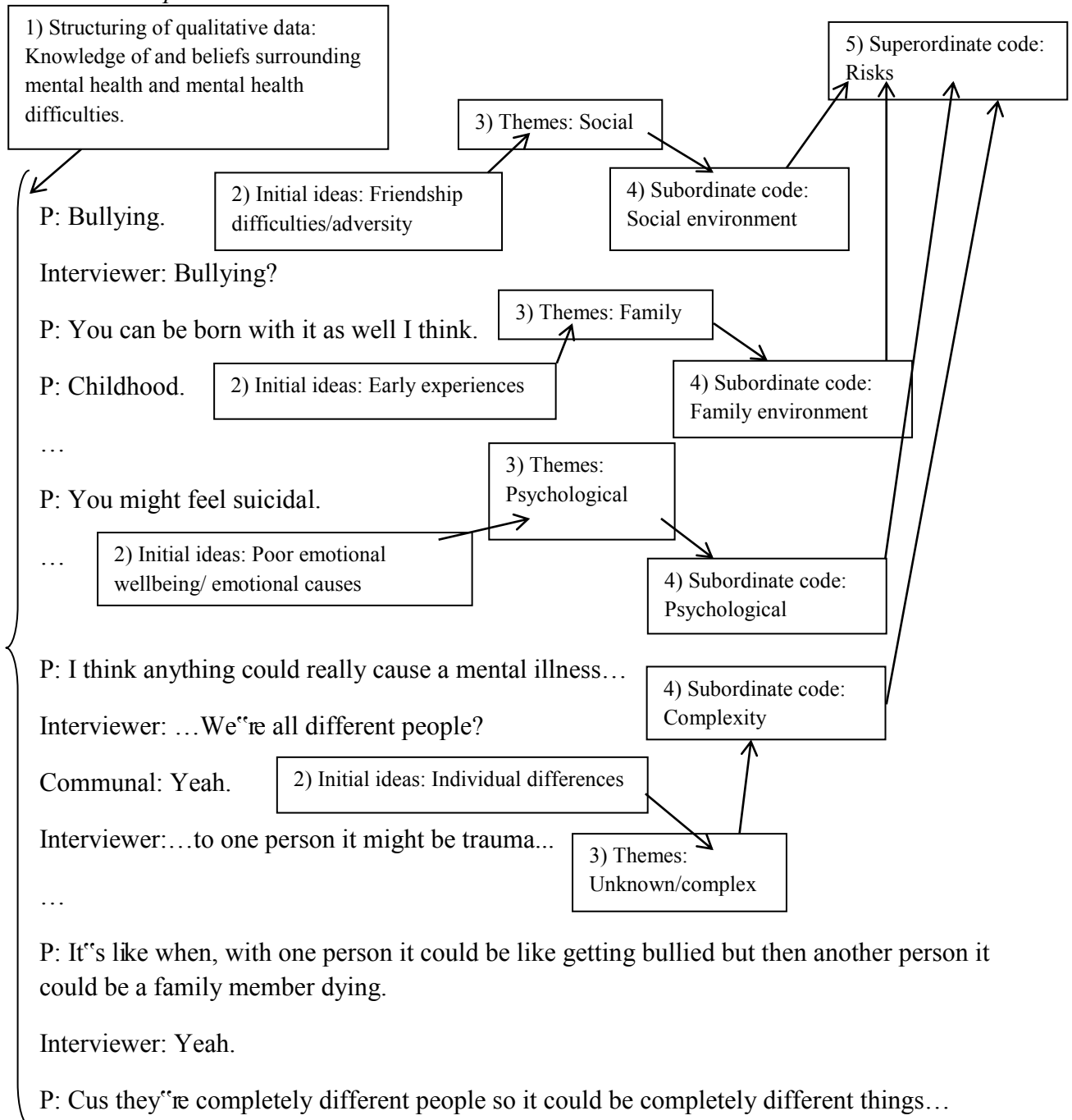
	<p>-External</p> <p><u>Delivery:</u></p> <ul style="list-style-type: none"> -Confidentiality -Supportive -Equal
Focus group 2	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Community context -Informal -Psychological -Technological forums <p><u>Context:</u></p> <ul style="list-style-type: none"> -External <p><u>Delivery:</u></p> <ul style="list-style-type: none"> -Confidentiality -Person-centred
Focus group 3	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Community context -Informal -Psychological -Self-help <p><u>Context:</u></p> <ul style="list-style-type: none"> -External -Concealed -Access <p><u>Delivery:</u></p> <ul style="list-style-type: none"> -Confidentiality -Supportive -Empathic -Person-centred -Youth-focussed -Effective
Focus group 4	<p><u>Support systems:</u></p> <ul style="list-style-type: none"> -Medical -Community context -Informal -Psychological

	<u>Context:</u> -External <u>Delivery:</u> -Confidentiality -Supportive -Equal -Person-centred -Confidentiality
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Worked examples of analysis of codes across all research questions:

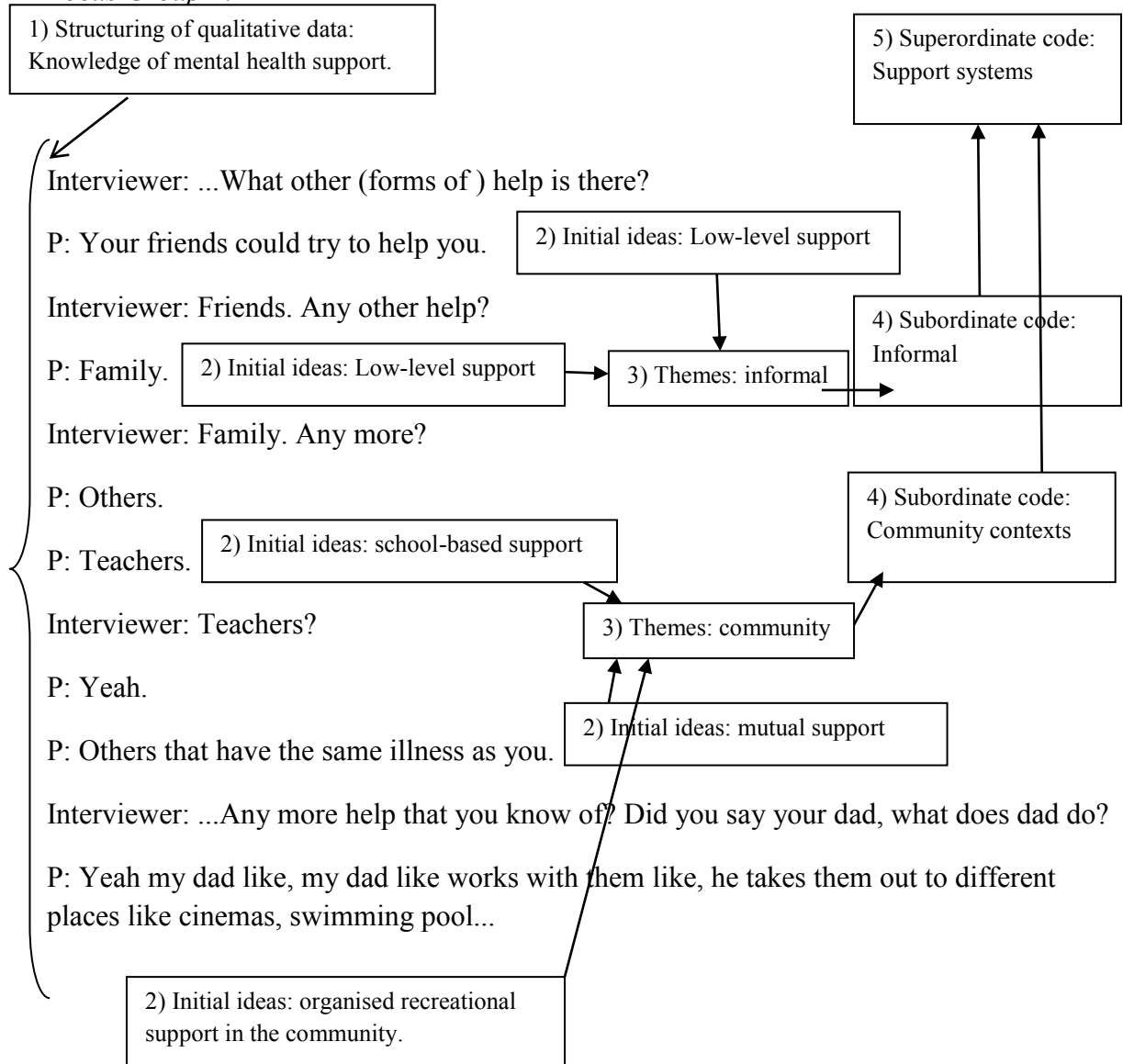
- 1) What do young people know and believe about mental health and mental health difficulties?

Focus Group 3:-



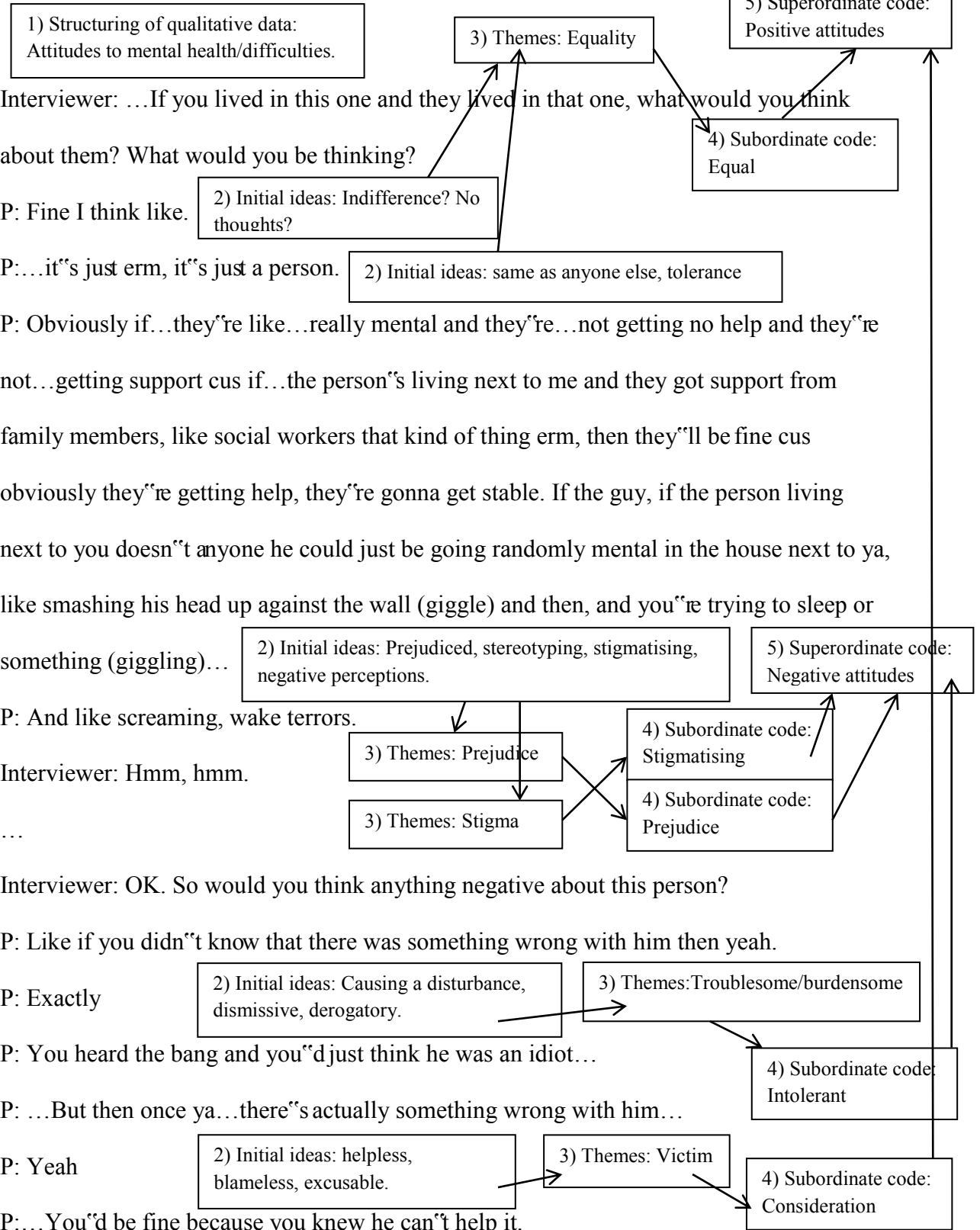
2) What do young people know and believe about support for mental health difficulties?

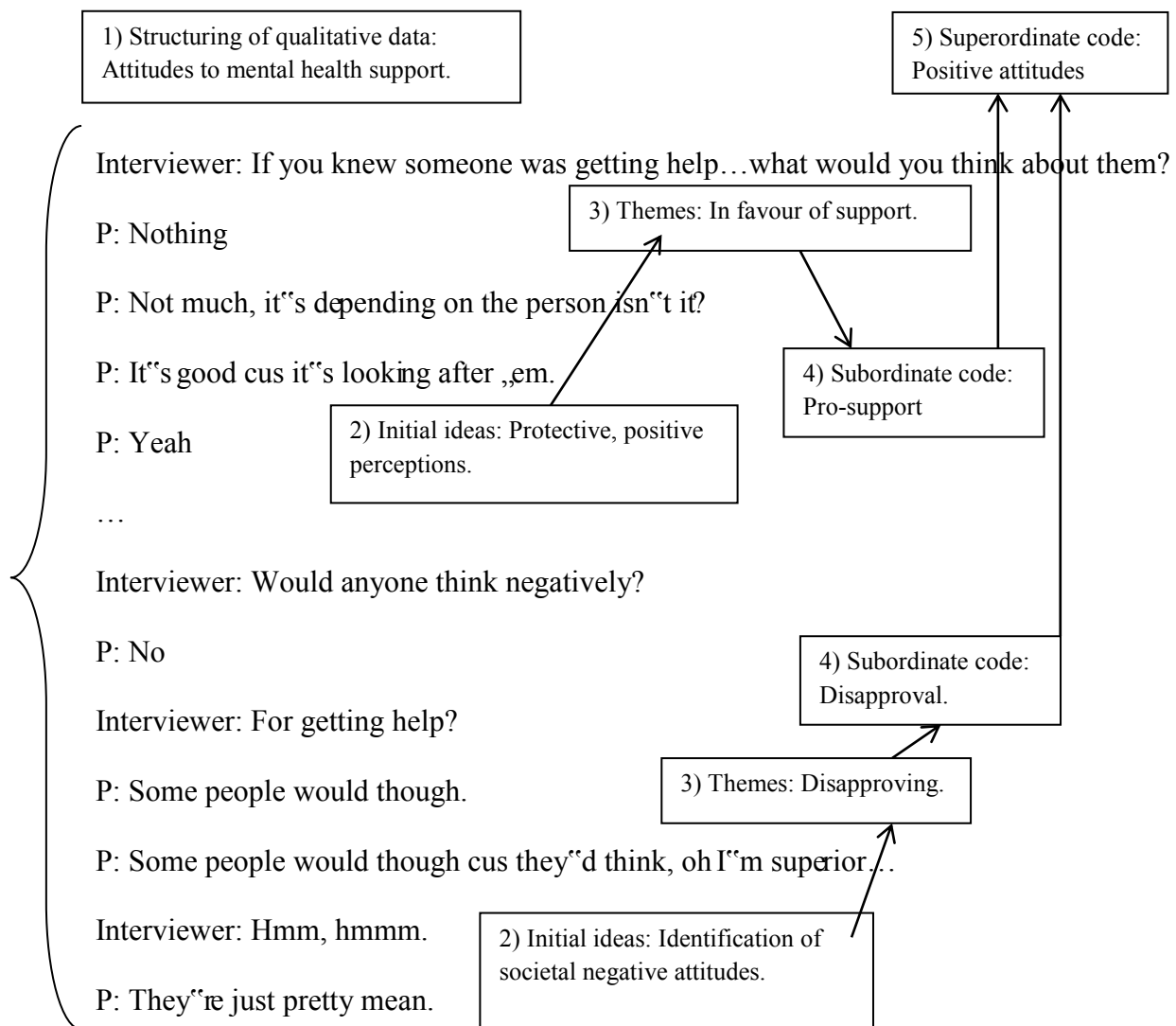
Focus Group 1:-



3) What are young people's attitudes towards mental health difficulties and mental health support?

Focus Group 4:-





4) In terms of support, what would young people want if they were experiencing mental health difficulties?

Focus Group 2:-

1) Structuring of qualitative data:
Wishes for mental health support.

Interviewer: ...so if you or a friend were having mental health difficulties, what kind of support would you want? We talked about the support up there, what would you want to help you?

P: As much help as possible.

3) Theme: Informalised

5) Superordinate code:
Support systems

4) Subordinate code:
Informal

Interviewer: As much as help as possible? Which one on there would you like?

P: Family and friends.

Interviewer: Family and friends?

2) Initial ideas: Non-professionals

4) Subordinate code:
Psychological

P: Psychiatrist.

Interviewer: You want a psychiatrist?

2) Initial ideas: Professional, psychological,
more formalised, therapy

P: And like professionals and they could help with...

3) Theme: Formalised psychological support

P: Can like talk to you and go deep into a conversation with you...

4) Subordinate code:
External

...

Interviewer: Yeah? Would you like this kind of help in school?

P: No.

3) Theme: Outside location

5) Superordinate code:
Context

Interviewer: Professional help? No? Why wouldn't you like it in school?

P: Cus like everyone could like know.

Interviewer: Everyone would know?

2) Initial ideas: School inappropriate, location
away from school. Need for privacy,
awareness of ridicule from others.

5) Superordinate code:
Delivery

P: Hmmm, people would probably take the mick.

Interviewer: They'd take the mick?

3) Theme: Privacy

4) Subordinate code:
Confidentiality

P: Like, if you had it out of school then no one would like, you wouldn't have to tell anyone anything and they wouldn't find out..

Code book

Appendix Eleven

Code Map 1: Knowledge and beliefs about mental health/mental health difficulties.	
Conceptualisations	Use this overarching code to capture subordinate codes of young people's conceptualisations/understanding of mental health and mental health difficulties.
Pathogenic	Use this subordinate code where the young people indicate a pathogenic understanding of the term 'mental health'.
Identification	Use this subordinate code where young people correctly identify mental health difficulties by name.
Confusion	Use this subordinate code where young people confuse the distinction between mental health, learning and any other kind of mental difficulty and between risk and outcome.
Misidentification	Use this subordinate code where young people attribute the wrong mental health difficulty either by name or description.
Recognition	Use this subordinate code where young people are able to recognise a mental health difficulty by referring to associated symptoms and impact upon functioning.
Continuum	Use this subordinate code where young people refer to the continuum of mental health needs, i.e. low level difficulties to disorder.

Vulnerability	Use this overarching code to capture subordinate codes of young people's knowledge of vulnerability.
Universal	Use this subordinate code where young people indicate beliefs that anyone can develop mental health difficulties.
Older	Use this subordinate code where young people indicate beliefs that older people are more vulnerable to developing mental health difficulties.
Younger	Use this subordinate code where young people indicate beliefs that younger people are more vulnerable to developing mental health difficulties.
Culture	Use this subordinate code where young people indicate beliefs that certain cultural groups are more vulnerable to developing mental health difficulties.
Risks	Use this overarching code to capture subordinate codes of young people's knowledge of risks surrounding mental health difficulties.
Contagion	Use this subordinate code when young people refer to being able to 'catch' mental illness from being around others with mental health difficulties.
Complexity	Use this subordinate code when young people refer to how pathways to mental health difficulties are complex, unknowable and vary according to individual differences.
Interaction	Use this subordinate code when young people refer to how internal and external risks likely interact with each other within pathways to mental health.
Ontogenic	Use this anchor code for subordinate codes at the ontogenic level.

Bio-genetic	Use this subordinate code when young people refer to inherent, individual risks that have a biological or genetic basis.
Psychological	Use this subordinate code when young people refer to any kind of psychological risk. This can include emotional difficulties, differences in personality, previous experiences and the mind.
Unhealthy lifestyle	Use this subordinate code when young people refer to risks associated with living an unhealthy lifestyle such as poor sleep, lack of exercise and poor diet.
Microsystem	Use this anchor code for subordinate codes at the microsystem level.
Family environment	Use this subordinate code when young people refer to risks associated with the family environment, i.e. parental and childhood factors and references to upbringing.
Exosystem	Use this anchor code for subordinate codes at the exosystem level.
Social environment	Use this subordinate code when young people refer to risks associated with the social environment, including friendship difficulties, adversity/trauma and stressors.
Code Map 2: Knowledge and beliefs about mental health support.	
Support systems	Use this overarching code to capture subordinate codes of young people's knowledge of systems of support.
Macrosystem	Use this anchor code to capture subordinate codes detailing the young people's knowledge of available support at the macrosystem level.

Primary prevention	Use this summary code to summarise the young people's knowledge of primary preventative support.
Funding	Use this subordinate code when the young people refer to funding streams to support individuals with mental health difficulties.
Exosystem	Use this anchor code to capture subordinate codes detailing the young people's knowledge of available support at the exosystem level.
Prevention	Use this summary code to summarise the young people's knowledge of preventative support.
Intervention	Use this summary code to summarise the young people's knowledge of intervention-based support.
Community contexts	Use this subordinate code when young people refer to community-based support for individuals with mental health difficulties. This includes: schools, residential settings, mutual support groups and outreach support to the home.
Medical	Use this subordinate code when the young people refer to medical support for individuals with mental health difficulties.
Technological forums	Use this subordinate code when young people refer to technologically-based support for individuals with mental health difficulties. This includes: help-lines, on-line forums/chat, NHS websites and other websites/forums i.e. 'Talk to Frank'
Psychological	Use this subordinate code when young people refer to psychological support for individuals with mental health difficulties. This includes: psychologists, psychiatrists, therapists, psycho-education programs and mentors.

Microsystem	Use this anchor code to capture subordinate codes detailing the young people's knowledge of available support at the microsystem level.
Informal	Use this subordinate code when young people refer to support from family and friends for individuals with mental health difficulties.
Ontogenic	Use this anchor code to capture subordinate codes detailing the young people's knowledge of available support at the ontogenic level.
Self help	Use this subordinate code when young people refer to self help support for individuals with mental health difficulties. This includes: developing resiliency, staying positive, distraction, being proactive, maintaining self-control, developing self-confidence and guided self-help.
Healthy lifestyle	Use this subordinate code when young people refer to practising a healthy life-style to support or protect against mental health difficulties in others. This includes: relaxation, eating a healthy diet, engaging in regular exercise and recreational activities.
Routes	Use this overarching code to capture subordinate codes of the young people's knowledge of routes to support.
Medical	Use this subordinate code when young people refer to medical routes to support for individuals with mental health difficulties.
Informal	Use this subordinate code when young people refer to informal routes to support for individuals with mental health difficulties.
Media	Use this subordinate code when young people refer to media-based routes to support for individuals with mental health difficulties.

Self help	Use this subordinate code when young people refer to self-help as a route to support for individuals with mental health difficulties.
Community contexts	Use this subordinate code when young people refer to community contexts routes to support for individuals with mental health difficulties.
Assistance	Use this overarching code to capture subordinate codes of the young people's ideas to increase their knowledge of support.
Raise awareness	<p>Use this subordinate code when young people refer to raising awareness to improve their knowledge of available mental health support.</p> <p>This includes; befriending individuals with mental health difficulties/gaining experience of individuals with mental health difficulties, bulletin updates within school and media campaigns.</p>
Unnecessary	Use this subordinate code when young people refer to it being unnecessary to be taught explicitly about available mental health support.
Awareness	Use this overarching code to capture subordinate codes of the young people's general awareness of available mental health support.
Adult superiority	Use this subordinate code when young people refer to how adults have a better knowledge of available mental health support than they do.
Inadequate knowledge	Use this subordinate code when young people refer to their own inadequate knowledge of available mental health support.

Code Map 3: Attitudes towards mental health difficulties	
Positive attitudes	Use this overarching code to capture subordinate codes of the young people's positive attitudes towards individuals with mental health difficulties.
Consideration	Use this subordinate code when the young people show consideration towards individuals with mental health difficulties. This can include insightful consideration of their position within society, empathy and sympathy.
Equal	Use this subordinate code when the young people indicate how individuals with mental health difficulties are the same as everyone else and should be treated equally.
Disapproving	Use this subordinate code when the young people express any disapproval towards negative societal attitudes towards individuals with mental health difficulties.
Critical attitudes	Use this overarching code to capture subordinate codes of the young people's critical attitudes towards the concept of mental health difficulties.
Phenomenology	Use this subordinate code to capture young people's references to people's varied experiences of mental health and how the diagnosis of mental health difficulties is arbitrary.
Negative attitudes	Use this overarching code to capture subordinate codes of the young people's negative attitudes towards individuals with mental health difficulties.
Stigmatising	Use this subordinate code when young people indicate their stigmatising attitudes towards individuals with mental health difficulties.

Prejudice	Use this subordinate code when young people indicate their prejudiced attitudes towards individuals with mental health difficulties. This can also include stereotypes of individuals with mental health difficulties.
Intolerant	Use this subordinate code when young people indicate their intolerant attitudes towards individuals with mental health difficulties. This includes; how young people perceive individuals with mental health difficulties as burdensome or troublesome to others.
Fearful	Use this subordinate code when young people indicate how becoming mentally ill is frightening. Also use this code if the young people indicate how individuals with mental health difficulties are frightening to them.
Code Map 4: Attitudes towards seeking mental health support	
Positive attitudes	Use this overarching code to capture subordinate codes of the young people's positive attitudes towards help-seeking.
Pro-support	Use this subordinate code when the young people indicate pro-support attitudes towards mental health support. This includes; references to mental health support as the right thing to do, that it is corrective or preventative.
Disapproval	Use this subordinate code when the young people express any disapproval towards negative societal attitudes towards help-seeking.
Proactive	Use this subordinate code when the young people express proactive attitudes to protect against negative societal attitudes towards help-seeking. This includes less formal approaches such as; ignoring, protecting oneself by getting back at oppressors and

	seeking moral support and support from class teachers. It also involved seeking adequate mental health support and raising awareness of support and mental health in general through education.
Negative attitudes	Use this overarching code to capture subordinate codes of the young people's negative attitudes towards seeking support.
Apprehensive	Use this subordinate code when the young people reveal any apprehensive or fearful attitudes towards seeking support. This can include references to; feeling daunted by support, how receiving support is isolating and requires bravery.
Dismissive	Use this subordinate code when the young people refer to how mental health support can aggravate difficulties, can be unnecessary, unwanted or forced on an individual.
Code Map 5: Mental health support for young people	
Support systems	Use this overarching code to capture subordinate codes of the young people's wishes for support.
Exosystem	Use this anchor code to capture subordinate codes detailing the young people's wishes for support at the exosystem level.
Prevention	Use this summary code to summarise the young people's knowledge of preventative support.
Intervention	Use this summary code to summarise the young people's knowledge of intervention-based support.
Psychological	Use this subordinate code when the young people refer to psychological support. This includes psychiatrists, psychologists and psycho-educational initiatives.

Medical	Use this subordinate code when the young people refer to medical support. This includes GPs.
Community context	Use this subordinate code when the young people refer to community-based support. This includes mutual support groups, social support groups, charities, volunteers, school-based support (i.e. mentors and teachers) and outreach support to the home.
Technological forums	Use this subordinate code when the young people refer to technological support. This includes websites/forums i.e. 'Talk to Frank'.
Microsystem	Use this anchor code to capture subordinate codes detailing the young people's wishes support at the microsystem level.
Informal	Use this subordinate code when the young people refer to support from friends and family.
Ontogenic	Use this anchor code to capture subordinate codes detailing the young people's wishes for support at the ontogenic level.
Primary prevention	Use this summary code to summarise the young people's knowledge of primary preventative support.
Self-help	Use this subordinate code when the young people refer to self-help support. This includes developing resilience and being proactive in seeking out support.
Context	Use this overarching code to capture subordinate codes of the young people's wishes for context in support should be delivered.
Access	Use this subordinate code when the young people refer to wanting accessible mental health support. This can include references to 'walk-in' centres.

External	Use this subordinate code when the young people refer to wanting mental health support outside of school. This can include, home visits and external mental health or general health centres.
Concealed	Use this subordinate code when the young people refer to wanting support to be hidden in some way. This can include references to the building in which support is delivered looking 'ordinary' and located behind other buildings.
Delivery	Use this overarching code to capture subordinate codes of the young people's wishes for the delivery of support.
Supportive	Use this subordinate code when the young people refer to wanting to feel supported and reassured by mental health support.
Confidentiality	Use this subordinate code when the young people refer to the need for confidential or private support.
Equal	Use this subordinate code when the young people refer to wanting to be treated the same as they were before they required support or treated the same as everyone else.
Person-centred	Use this subordinate code when the young people refer to wanting support to be person-centred. This can include; the need for respect and honesty, to be in control of their care (decision-making, who can accompany them and who details regarding their care can be disclosed to), providing regular feedback to inform support and for their opinions to be taken seriously.
Empathic	Use this subordinate code when the young people refer to wanting support to be empathic of their situation.

Youth-focussed	Use this subordinate code when the young people refer to wanting support to be tailored to youths only.
Effective	Use this subordinate code when the young people refer to wanting support that is effective.

In terms of their wishes for support, the young people said they would like a tiered approach with professional support outside of school if they were to have more severe mental health difficulties. When receiving higher support for mental health difficulties, the young people thought it was important to feel supported and be treated equally to everyone else. They also wanted help to be accessible, empathic and effective, confidential and tailored to their needs. The young people felt that their school could play a part in helping them with lower and higher-level mental health difficulties.

Differences between girls and boys in terms of their knowledge, beliefs, attitudes and wishes were also found. Girls had greater knowledge and generally more appropriate beliefs about mental health and mental health support. Girls had more positive attitudes towards seeking help for themselves. However, both boys and girls had some negative attitudes regarding mental health difficulties and seeking mental health support.

If you would like to ask any questions regarding this study or what may happen next with these findings, please contact ... and ask to be put in contact with Aimée Harvey, who would be happy to assist you further.

Yours sincerely.

Aimée Harvey.