Exploration of Young People and Educators' Views of Mental Health Literacy and Ways to Increase Mental Health Literacy Within Schools

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Abstract

The prevalence of common mental health (MH) problems is on the rise among the populations of western nations (Ohrnberger, Fichera & Sutton, 2017). Mental health problems (MHPs) can have serious consequences, including sleeplessness, drug and alcohol addiction, family conflict and suicide (Gaddis, Ramirez & Hernandez, 2017; Lo, Gupta & Keating., 2017). Furthermore, support for young people (YP) with MHPs within the United Kingdom (UK) is lacking (Frith, 2016).

One way to facilitate YP accessing support for a MHP, is by increasing YPs knowledge of MH, reducing stigmatising views and increasing awareness of available support (Jung, Sternberg & Davis, 2016; Gaddis et al., 2017; Lo et al., 2017). These elements can be conceptualised as ones' mental health literacy (MHL) (Jung et al., 2016).

This research thesis was designed to investigate the extent of YPs MHL. A role for MHL programmes was explored, as were relationships between MH knowledge, stigmatising views and attitudes towards help seeking. Both pupil and educators' views as to how best to raise MHL in schools were also explored.

A mixed-method, 2 phased design was employed. Phase 1 consisted of the administration of a questionnaire which was composed of 3 measures: Mental Health Knowledge Schedule (MAKS), Evans-Lacko, Little, Meltzer, Rose, Rhydderch, Henderson and Thornicroft, 2010; Peer Mental Health Stigmatization Scale (PMHSS), McKeague, Hennessy, O'Driscoll & Heary, 2015; Mental Health Seeking Attitudes Scales (MHSAS), Hammer, Parent and Spiker, 2018. 398 participants aged 12-13 years took part in phase 1 and results were analysed using SPSS. Phase 2 consisted of 3 focus groups with 13 year old pupils (n=22). Phase 2 also included semi-structured interviews with 3 special educational needs coordinators (SENCos) which were thematically analysed.

The results of this study identified an opportunity to enhance YPs MH knowledge (mean score = 20.4, where a score of 0 = completely incorrect MH knowledge, a score of 30 = totally correct MH knowledge and a score of 18 = neutral MH knowledge). Results also showed that perceptions of societal stigma (m = 10.4) were significantly higher than personal stigma levels (m = 6.2) where $p<0.01$. Phase 2 of this study identified barriers to receiving MH support, including limited MHL. Phase 2 identified prospective ways to increase the MHL of YP, including: staff training; parental involvement; integration of MH into curriculum; resources within school; links with external services. Implications of these findings were discussed, including the role of the educational psychologist.

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Contents

List of Tables and Figures

Abbreviations

Term	Definition
ARE	Age related expectations
CAMHS	Child and Adolescent Mental Health Service
CYP	Child or young person
EH4MH	Early Help for Mental Health
EP	Educational psychologist
FG	Focus Group
INT	Intention
MAKS	Mental health knowledge schedule
MHSAS	Mental health seeking attitudes scale
MH	Mental health
MHL	Mental health literacy
MHP	Mental health problem
PBC	Perceived behaviour control
PSHE	Physical, social, health and emotional
PMHSS	Peer mental health stigmatization scale
SD	Standard deviation
SENCo	Special educational needs coordinator

SEN	Special educational needs
SEND	Special educational needs and disabilities
SSI	Semi structured interview
TPB	Theory of planned behaviour
UK	United Kingdom
YP	Young people

1.0 Introduction

1.1 Authors Background and Introduction to the Topic

I am a trainee educational psychologist working in the South West of England and studying for a Doctorate in Educational, Child and Community Psychology, through Exeter University. I have a keen interest in the mental health (MH) of children and young people (CYP) which partly originates from my time working as a swimming teacher and teaching assistant, as well as personal experiences with my own children and their social networks. These avenues offered me an insight into the difficulties that some young people (YP) face and the impact upon their MH. How they are subsequently supported differs dramatically between individuals and it is this imbalance of opportunities that I find hard to accept. As such, I explored a career in educational psychology whereby I have opted to research the extent of MH support within schools.

1.2 Establishing the Issue and Prevalence of Youth Mental Health Problems

The World Health Organization (WHO) characterises mental health (MH) as the ability to realise one's full potential, cope effectively with stress, work productively, and contribute to community (World Health Organisation, 2014). WHO (2014) define a mental health disorder as comprising a broad range of problems, with different symptoms, generally characterised by a combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, anxiety and disorders due to drug abuse (WHO, 2014). Mental health disorder and other terms, such as MH problem (MHP) and mental illness, are used interchangeably with definitions overlapping (Mind, 2017). For the purpose of this thesis, I will refer to the term 'MHP', which is described as ranging from common problems such as depression and anxiety to rarer problems such as schizophrenia and bi polar disorder (Mind, 2017).

Prior to exploring the prevalence of MHPs, it should be noted that the universality of MH encompasses stress and that it is common for individuals with positive MH to experience stress (Mental Health Foundation, 2019a). Stress can be defined

as the degree to which one feels overwhelmed or unable to cope as a result of pressures that are unmanageable (Mental Health Foundation, 2019a). Experiencing stress can be an appropriate response with beneficial effects e.g. motivation, removal of self from a dangerous environment. However, sometimes stress can become excessive which can impact negatively upon ones MH. Schools can present as considerable sources of stress to some YP and as such it is important that the promotion of positive MH and wellbeing is encouraged as a means of preventing the development of MHPs (O'Reilly, Svirydzenka, Adams & Dogra, 2018).

The prevalence of common MHPs is on the rise among the populations of western nations (Ohrnberger et al., 2017). Research shows that half of all MHPs manifest by the age of 14 years, with 75% manifest by age 24 years (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005). Furthermore, almost a quarter of CYP in the United Kingdom (UK) show some evidence of a MHP, including anxiety and depression (Frith, 2016) and 90% of school leaders have reported an increase in the number of students experiencing anxiety or stress over the last five years (Association of School & College Leaders, & National Children's Bureau, 2016). With child and adolescent mental health service (CAMHS) turning away nearly a quarter of children referred to them (Frith, 2016) a significant number of YP are experiencing MHPs and are in need of adequate support. Recent evidence suggests that the average maximum waiting time for a first appointment with CAMHS is 26 weeks, and 42 weeks until the start of treatment (Frith, 2016).

Researchers place an emphasis on a burdened MH service, stressing an excess of referrals and a requirement to reduce waiting times for CAMHS (Frith, 2016). However, little evidence exists regarding the effectiveness of CAHMS. Measuring outcomes are challenging due to the diversity of the population and the variety of measures (Wolpert, Jacob, Napoleone, Whale and Edbrooke-Childs, 2016). Nonetheless, on behalf of the Child Outcomes Research Consortium (CORC) Wolpert et al., (2016) conducted an analysis of data related to outcomes for children seen across a selection of services between April 2011 and June 2015. Findings indicate that 4 in 5 children endorsed receiving 'good help' with 9 in 10 parents agreeing. One in three children stated that they had 'recovered' with 3 in 10 parents agreeing. One in two children selected that they had 'reliably

improved' and 1 in 10 children selected that they had experienced a 'reliable deterioration.'

When we consider that 38% of responses indicated 'no reliable change' and a response rate of 73%, arguably results do not suggest a strong evidence base for CAHMS. Furthermore, with the lack of a comparator group, it could be suggested that a proportion of recovery rates may not be due input from CAHMS but rather spontaneous remission (Wolpert et al., 2016). In addition, analysis included 21 different child report measures and 15 different parent measures; different scales use different approaches to calculate thresholds, presenting challenging when comparing across scales and populations (Wolpert et al., 2016). Therefore, all data should be treated tentatively (Wolpert et al., 2016).

More evident within the literature, is the view that MHPs can have serious consequences, including sleeplessness, drug and alcohol addiction, family conflict and suicide (Gaddis et al. 2017; Lo et al., 2017). Research suggests that the impact of serious MHPs on life expectancy is higher than that of recognised adverse exposures, such a smoking and obesity (Chang et al., 2011). Youth MHPs are associated with poor academic performance, disrupted psychosocial development, lower rates of high school completion, and increased health risks (Moon, Williford & Mendenhall, 2017). A recent analysis of the British Cohort Study demonstrated that emotional health in childhood is by far the most important indicator of life satisfaction and personal outcomes as an adult (Layard, Clark, Cornaglia, Powdthavee & Vernoit, 2014).

Recognising the negative impact of MHPs and its growing prevalence in the UK, in January 2017, UK Prime Minister Theresa May, unveiled a commitment to tackle the high levels of MHPs, by putting forward a comprehensive package of reforms to improve MH support at every stage of a person's life (DoH, 2017). It is widely recognised that early intervention is fundamental to MH recovery (Pinfold, Stuart, Thornicroft & Arboleda-Florez, 2005) and as such May pledged to raise awareness of MH in both primary and secondary schools (DoH, 2017). Schools have been identified as an ideal point of entry to MH care for children given the significant amount of time children spend in school due to mandatory attendance policies (Moon et al., 2017). Schools are a universal service, accessed five days

a week by most children. This means that over the course of their education, children spend over 7,800 hours at school (Organisation for Economic Co-operation and Development, 2014).

As such, in December 2017, the Department for Education together with the Department of Health unveiled a Green Paper outlining forthcoming aims (DoH & DfE, 2017). One goal is for every school and college to have a designated MH lead by 2025. The MH lead will oversee the help that the school gives to pupils with MHPs and help staff to identify signs of MHPs. In preparation for the new role of MH lead, the Government has stated within the Green Paper that they aim to seek people's views on how CYP should learn about MH within schools. However, training just one member of staff within a school arguably gives the impression that pupil MH is a specialist issue, rather than something that all staff should take ownership of. To effectively promote the MH of students, MH awareness needs to be embedded throughout schools and this requires the training or up skilling of all staff and pupils (YoungMinds, 2017).

One way to raise awareness is to increase the MH literacy (MHL) of YP (Wong, Cheng, Zhuang, Ng, Pan, He & Poon, 2017). MHL is defined by Jorm (2000) as "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p.396). Research indicates that people who do not have MHL may have difficulties recognising the symptoms of MH issues and disorders within themselves and in others, and cannot adequately communicate information regarding symptoms to others (Wong et al., 2017). Furthermore, an individual with limited MHL experiences difficulty in obtaining health information using medical services, which can lead to greater depression, unhealthy lifestyle and a higher risk of mortality (Jung et al., 2016). Therefore, higher levels of MHL are associated with reduced duration and severity of MHPs (Drake, Haley, Akhtar & Lewis, 2000).

In summary, MHPs amongst YP within the UK is increasing in prevalence (Ohrnberger et al.,2017) with detrimental consequences including poorer educational outcomes and health implications (Gaddis et al. 2017; Lo et al., 2017). Current government agenda seeks to raise the level of MH support YP receive within educational settings. One way to increase MH support within schools is by developing YP MHL (Wong et al., 2017). In line with the societal aims described, an exploration of how to raise the MHL of YP was attempted as

part of this thesis. The next section will cover individual themes found within the literature concerning MHL and interventions designed to raise MHL.

2.0 Literature Review

2.1 Introduction to Literature Review

Within this literature review, I shall provide a critical overview of existing literature surrounding the concept of MHL including the benefits of having MHL and ways in which MHL can be raised.

I will offer an appraisal of relevant sources providing information within this area and critically discuss differing arguments. I will conclude by showing how my project fits with the existing literature.

2.2 Literature Search Procedure

The literature was gathered using PsycInfo, ScienceDirect, GoogleScholar, and ResearchGate databases. I also used the Google search engine to research the prevalence of the topic in the modern media. The following terms were used, in various combinations: Mental health literacy; measuring mental health literacy; young people; children; adolescents; mental health, mental health support in schools; mental health stigma; mental health literacy educational programmes; social cognition models. Each separate term achieved between 180,000 and in access of 2.5 million results. I refined the results by combining the terms and as such provided more specific themes e.g. 'measuring mental health literacy young people' and 'adolescent mental health literacy educational programmes stigma'.

MH awareness amongst YP within the UK is of growing concern and a topical subject (DoH & DfE, 2017). As such, there was an array of literature exploring aspects of YP MHPs with a significant amount of research originating in Australia. I propose that, in order to support YP MH within the UK, there is a role for increasing YP MHL within educational settings. I will support my argument by discussing information within the following sections.

2.3 The Importance of Mental Health Literacy for Seeking Support

According to Jorm's (2000) widely accepted definition, MHL can be defined as "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p.396). MHL is an important factor in MH care, including help seeking, helping others and also reducing stigma (Jung et al., 2016).

Research shows that individuals with higher levels of MHL are better equipped to identify their own symptoms and are more aware of possible treatments (Jung et al., 2016; Gaddis et al., 2017; Lo et al., 2017). Moreover, these people are more aware of the importance and benefit of seeking professional help (Hom, Stanley, & Joiner, 2015). In addition, higher MHL is associated with recognising signs of MHPs in other people and helping them to access support. Furthermore, research suggests that YP experiencing MHPs are likelier to approach their peers for support than a professional (Gaddis et al., 2017; Lo et al., 2017; Jung et al., 2016).

Conversely, research indicates that low levels of MHL are associated with a delay in seeking help and early termination of treatment (Jung et al., 2016). Individuals with lower rates of MHL are less likely to identify their symptoms as signs of a MHP (e.g. sleeplessness, loss of weight) due to the limited knowledge they have surrounding MH (Drake et al., 2000). Furthermore, people with lower rates of MHL are less likely to seek help for an identified MHP due to feelings associated with shame, as they are aware of the negative beliefs and myths surrounding MHP e.g. that people with MHPs are intellectually challenged (Tatlow-Golden & McElvaney, 2015).

With the prevalence of MHPs amongst YP at an all-time high in the UK, together with limited access to professional support (Frith, 2016), it is arguably more important than ever that members of the public take ownership of their MH (Jorm, 2012). YP of today are the next generation of doctors, teachers, parents and community workers, thus it is of paramount importance that MHL of the young is explored in order to help create an understanding and supportive society for the future (Grove, Riebschleger, Bosch, Cavanaugh & Van Der Ende, 2017; Jorm,

2012).

2.4 Methods to Measure Mental Health Literacy

Studies exploring MHL tend to look at measuring MHL across diverse populations, evaluating the effectiveness of training programmes and examining factors related to MHL (Jung et al., 2016).

There is no consistent way to measure to MHL (Greig, MacKay & Ginter, 2019) and a lack of a standardised measure limits the comparison of MHL levels across populations and cultures (Jung et al., 2016). Questionnaires have been used to measure MHL (Dogra, Omigbodum, Adedokun, Bella, Ronzoni & Adesokan, 2012; Evans-Lacko et al., 2010; Hirai & Clum, 2000) but could be subject to desirability bias as participants select an answer they feel they should (Pinfold et al., 2005). Conversely, vignettes have been used as a measure of MHL, allowing participants to generate their own thoughts and beliefs rather than select one from a pool of answers (Burns & Rapee, 2006). However, it is argued that vignettes rarely cover the breadth of aspects of MHL e.g. knowledge of causes and effects (Jorm, 2000; Jung et al., 2016).

Recognising the many different components of MHL, Jung et al., (2016) developed a multi-component measure which looked at three factors: knowledge of MH; beliefs of MH; knowledge of resources for MH. In an attempt to bridge the gap between questionnaires and vignettes this questionnaire included a "don't know" option as part of a Likert scale. The rationale for this was to reduce bias as it would help prevent participants selecting an answer which they did not agree with (Jung et al., 2016). This measure was found to have good reliability (coefficient alpha in the special case for dichotomous choices of Kuder Richardson 20 0.83) and provides a tool to promote early intervention by measuring MHL among adult community members i.e. not professionals (Jung et al., 2016).

Nonetheless, there is still no consistent way to measure MHL, with researchers selecting tools that measure different aspects of MHL (Greig et al., 2019). Wei, McGrath, Hayden & Kutcher (2015) conducted a systematic review of all measures of MHL in the UK and found 401 separate tools. When considering the

measures that were validated, 14 seek to explore knowledge of MH, 65 measures explore stigma and 10 explore help seeking behaviours. Researchers should consider the constraints within any measure, for example, the extent to which they cover the broad concept of MHL (Jung et al., 2016). Furthermore, many studies using CYP have used participants under the care of health-related services e.g. social work, nursing. Therefore, methodological concerns exist regarding the extent to which findings can be generalised to the wider population of CYP (Wei et al., 2015).

2.5 Stigma

Public perception of stigma relating to MHPs refers to a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with MHPs (Corrigan & Penn, 1999). Clement et al., (2015) outline several different types of stigma that someone experiencing a MHP can encounter. They are as follows: anticipated stigma (the anticipation of personally being treated unfairly); experienced stigma (having previous experience of being treated unfairly); internalized stigma (holding negative views about oneself); perceived stigma (ones perception of the general public's level of stigmatizing views towards people with MHPs); stigma endorsement (the views of people experiencing a MHP towards other people experiencing a MHP); treatment stigma (the stigma associated with receiving treatment for a MHP)
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Research suggests that stigma related to MHP is widespread worldwide (Natan, Drori & Hochman, 2017) and that stigma impacts negatively on those with a MHP (Wei et al., 2015). Stigma leads to low levels of hope, self-esteem, self-efficacy, and quality of life in people with a MHP (Mittal, Sullivan, Chekuri, Allee & Corrigan, 2012).

In addition, MH stigma can also act as a barrier to prevention and treatment (Wei et al., 2015); research shows that many people experiencing a MHP are reluctant to seek help as they are aware of the negative beliefs and myths surrounding MH (Tatlow-Golden & McElvaney, 2015; Jung et al., 2016). 'Help seeking' covers both the initiation of seeking help and also the engagement with care (Clement et al., 2015) and evidence suggests that there is a relationship between stigma and help

seeking (Clement et al., 2015; Schomerus & Angermeyer, 2008). Corrigan (2004) suggested that stigma may deter help seeking through two routes: by people attempting to avoid both public stigma and internalized stigma. Further adding to this argument, Schomerus and Angermeyer (2008) proposed that help seeking may be impeded by treatment stigma and internalized stigma. Clement et al., (2015) conducted a systematic review covering five electronic databases from 1980-2011. The researchers aimed to explore the relationship between stigma and help seeking by reviewing both quantitative and qualitative studies. Clement et al., (2015) concluded that there was a small to moderate detrimental impact of stigma on help seeking and that the key stigma types involved in this relationship were treatment stigma and internalized stigma, adding to the existing evidence base. The findings of this review also highlighted other barriers to help seeking; issues of confidentiality within disclosure, a want to deal with the problem alone and not recognising a need for care (Clement et al., 2015).

Therefore, widespread stigma can mean that people experiencing MHPs may feel ashamed and as such are less likely to seek help than if they were experiencing a physical problem (Tatlow-Golden & McElvaney, 2015). Stigma may decrease help-seeking behaviour from a MH professional (Blais & Renshaw, 2013; Mittal et al., 2012; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014) and as a consequence, lead to worsening health outcomes (Shim & Rust, 2013). Dell' Osso, Glick, Baldwin & Altamura (2013) proposed that the outcomes for untreated MHPs include longer duration of illness and higher severity of symptoms. Dell' Osso et al., (2013) suggested that this relationship was especially strong when considering individuals experiencing psychosis, bipolar disorder, depression and anxiety disorders

Stigma can also decrease the social interaction that people experiencing a MHP can encounter, due to feelings of shame and low confidence when interacting with others (Lo et al., 2017). Moreover, general members of the public can hold negative beliefs, making them less likely to want to interact with someone that has a MHP, for example, to believe that people experiencing a MHP are dangerous (Jung et al., 2016). In addition, when referring to people with MHPs, YP with lower levels of MHL tend to use terms such as "psycho" and "wacko", leading to further social exclusion (Rose, Thornicroft, Pinfold & Kassam, 2007).

The ignorance, prejudice and discriminatory views that people can hold surrounding MH, is linked to MHL (Evans-Lacko et al., 2010). Research indicates that those with higher MHL have lower stigma (Jorm, 2012) and that improving public knowledge about MH can impact positively on stigma (Jung et al., 2016; Evans-Lacko et al., 2010).

2.6 Educational Programmes Aimed at Raising Mental Health Literacy

Attempts to raise the MHL of pupils via educational programmes have been attempted, with examples in Australia, Korea, the UK and America (Choi, 2017; Weist & Albus, 2004). Chisholm, Patterson, Torgerson, Turner, Jenkinson & Birchwood (2016) explored the impact of contact with an individual with experience of a MHP. Participants were Year 8 children from a secondary school in Birmingham, UK. Participants participated in a one day educational programme, either with contact and education or education alone. In terms of raising MHL and reducing stigma, results indicated significant improvements in the education alone group, compared to the contact and education group. However, with less than 700 participants from only one school setting, the scale of the study was small. Furthermore, measures of MHL and stigma were taken only two weeks after the intervention; it could be argued that a large sample and longer-term study is needed.

Choi (2017) reported that in Korea, a MHL programme was developed for immigrant women and that it successfully decreased stress levels and raised knowledge and awareness of MH. Participants completed an eight-week course delivered by practitioners specifically trained for the purposes of the study. However, given that participants were Korean women, findings cannot be generalised to UK adolescents.

Schools have been identified as an ideal environment for MHL programmes due to the volume of YP attending and the amount of time spent there (Coles, Ravid, Gibb, George-Denn, Bronstein & McLeod, 2016; Kutcher, Bagnell & Wei, 2015; Pinfold et al., 2005). Furthermore, research shows that people experiencing MHPs are more likely to approach their peers for support, thus stressing the importance of students having good MHL (Jung et al., 2016). Moreover, research in America suggests that MH programmes operated in schools are effective for

serving hard-to-reach populations such as children in rural areas or racial and ethnic minority children (Weist & Albus, 2004).

The MHL of teachers and educators is also recognised as an important factor in supporting the MH of pupils, as teachers can act as important role models for YP (Wei et al., 2015). However, few studies have focused on the MHL of educators (Wei et al., 2015). Aside from acting as role models, school support staff are regarded as important MH support resources that have been traditionally underutilized (Atkins, Hoagwood, Kutash & Seidman, 2010). However, many teachers feel under-skilled to offer guidance on MH (Walter, Gouze & Lim., 2006; Moon et al., 2017). In June 2015, the Teacher Voice Omnibus Survey reported that two thirds of teachers felt they lacked the appropriate training to help identify MHPs in pupils (DoE, 2015). Furthermore, recent research (Frauenholtz, Mendenhall, & Moon, 2017) has noted that limited MHL among educators might impede the effective collaboration among interdisciplinary teams.

Supporting the above view that MHL of educators is a fundamental aspect to raising the MHL of pupils, research exists stressing the importance of developing a system to enhance adults' awareness and knowledge of YP MHP (Atkins et al., 2010; Coles et al., 2016; Jensen et al., 2011; Walter et al., 2006). In the USA, school administrators and educators have been found to have a desire to boost their MHL by increasing their knowledge and understanding of MHPs, behaviour management techniques and specialised skills (Moon et al., 2017)

Furthermore, in the UK, as part of an enquiry into MH and education, in March 2017, YoungMinds carried out a survey of 452 YP aged 11-18 on behalf of the Health and Education Select Committees. Eighty one percent of YP said that they would like their school or college to teach them more about how to look after their MH and 90% of the YP surveyed said that they would like MH to be more important to their school or college (YoungMinds, 2017).

Given the existing evidence which supports a need for MHL programmes (YoungMinds, 2017; Moon et al., 2017; Atkins et al., 2010; Coles et al., 2016) what naturally follows are the questions surrounding a suitable structure and content. When designing a MHL intervention it is useful to consider previously successful frameworks. Weare (2015) took evidence from a systematic review

looking at educational programmes which aimed to raise the emotional wellbeing of pupils and respond to the MH needs of pupils. Weare (2015) highlighted that many of these programmes had positive outcomes including: academic learning (motivation, readiness to learn); staff wellbeing (improved teaching ability); pupil happiness; development of social and emotional skills; prevention and reduction of MHPs. However, it has been proposed that such positive outcomes are dependent upon how well designed and implemented the programmes are and that a whole school approach should be adopted (Banjeree, McLaughlin, Cotney, Roberts & Peereboom, 2016). This means that all parts of the school organisation work coherently together and that there is genuine involvement from all staff, pupils, governors, parents, community members and outside agencies (Weare, 2015; Banjeree et al., 2016). Therefore, implying that assigning a single MH support worker within a school does not account alone for a sufficient MH intervention.

Another key aspect to a whole school approach is the ethos of the classroom; evidence suggests that the programme should concentrate on the core values, attitudes, beliefs and culture of the classroom which will build on the feelings of acceptance, respect and sense of belonging that people experiencing a MHP will have (Weare, 2015; Banjeree et al., 2016; Short, 2016). Therefore, when attempting to implement a whole school approach a goal should be to create an environment in which all people within the environment feel listened to, understood and empowered

Part of the process of people feeling empowered and listened to within a whole school approach, arguably begins within the design of the programme as there is an opportunity for the target audience to have their views heard. Dunsmuir and Cobbald (2016) suggested strategies for EPs when working with schools to promote child MH. One strategy was to gain multiple perspectives from all involved, including pupils and teachers. Kelly, Jorm and Wright (2007) suggested there were seven key components to a successful MH education programme, the first one being to carry out preliminary research with the target audience. The remaining six suggested components are as follows: 1. To base the intervention on a theoretical model e.g. the suicide intervention project applied the theory of planned behaviour (Ajzen, 1991) 2. To divide the intended audience into relatively

homogenous groups. 3. Messages should be designed and tailored to the separate groups 4. Messages should be placed using the appropriate types of media, according to the group i.e. a newspaper for a parent. 5. Evaluations should be carried out throughout the intervention to ensure the messages are reaching the target audience. 6. A final evaluation should take place to explore whether the intervention successfully changed attitudes and or knowledge.

Concepts within a whole school approach are advocated by Kelly et al., (2007) and Weare (2015) and supported further by Jones and Bouffard (2012) who stated that there is a "need to shift our attention from a sole focus on 'programmes' to a 'continuum' approach that can provide an integrated, everyday foundation" (p.12). However, other research suggests that whole school multi- component approaches are no more successful than the single-component of a classroom based only intervention (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011). That being said, the researchers did point out that the difficulties that are encountered with the implementation of a whole school approach may be a barrier to their success; with a multi-component model comes extra organisational and logistical difficulties (Durlak et al., 2011). Thus, this research arguably does not undermine the positive outcomes of a whole school approach but rather it highlights the practical difficulties.

In addition to the practical and logistical difficulties of the implementation a whole school multi-component approach to raising MHL, is the argument that whole school approaches are sometimes too vague and diluted to be effective (Lendrum, Humphrey & Wigelsworth, 2013). Lendrum et al., (2013) suggested that for a whole school approach to be effective it needs to be undertaken over realistic, incremental steps.

Another key aspect to consider when designing a MHL programme or intervention, is the highly technical world that YP now live in, with a high prevalence of social media use (Coles et al., 2016). Kaplan and Haenlein (2010) define social media as "a group of internet-based applications that build on the ideological and technological foundations of Web 2.0, and that allow the creation and exchange of user generated content" (p.61). Online social networking is a two-way and direct communication that includes sharing of information between

several parties amongst social media platforms (Moorhead, Hazlett, Harrison, Carroll, Irwin & Hoving, 2013) and represents a prominent form of communication in many people's lives (Naslund, Aschbrenner, Marsch & Bartels, 2016; Shepherd, Sanders, Doyle & Shaw, 2015).

People experiencing MHPs are increasingly using social media platforms to share their experiences or seek advice (Naslund et al., 2016). An online survey of 207 young adults conducted by Gowen, Deschaine, Guttadara and Markey (2012) found that those experiencing MHPs were more likely to express their personal views and build connections with others on social media, than YP who did not have a MHP. In fact, 94% of the participants who were experiencing a MHP used social media to connect with others. Social media can provide a safe platform for people with differing MHPs to connect and support one another (Highton-Williamson, Priebe & Giacco, 2015) and such online communities can be referred to as 'peer to peer support' (Naslund et al., 2016). Peer to peer support may present new opportunities to promote recovery as certain barriers are removed, e.g. treatment stigma (Hert et al., 2011). As discussed previously within this thesis, there are many barriers to seeking help, including fear of stigma and not wanting to disclose identity (Clement et al., 2015). Thus, online peer to peer support enables one to avoid these barriers and feel empowered by the amount of control they have over what they disclose and when (Naslund et al., 2016; Highton-Williamson et al., 2015). Moreover, connecting with others experiencing similar MHPs can be a catalyst for seeking formal care (Naslund et al., 2016). However, it is important to consider the risks of peer to peer support; due to the limited regulation of online communities one could be subjected to uncredible and/or unrealistic advice as well as hostile communications (Lawlor & Kirakowski, 2014; Kaplan, Salzer, Solomon, Brusilovskiy & Cousounis, 2011). Furthermore, without professional moderation, participants may be exposed to dangerous advice or to people that may seek to take advantage of their vulnerability (Kaplan et al., 2011).

Given the research suggesting that social media can provide support to people experiencing MHPs, it has been suggested that social media is uterlised as part of a MHL programme (Alvarez-Jimenez et al., 2013). However, an online intervention has been attempted and results were inconclusive (Naslund et al.,

2016); Alvarez-Jimenez et al., (2013) delivered an evidence based psycho-education intervention enhanced by moderated peer to peer support, called 'Horyzons'. The project took place over a one month pilot study and included 20 participants who had experienced a first-time episode of psychosis. Some participants reported that they found the intervention empowering and increased their social connections (Alvarez-Jimenez et al., 2013) however other participants did not report this. Having said that, the researchers report that there was a significant decrease in depressive symptoms one month post intervention (Alverez-Jimenez et al., 2013) and so it has been argued that results are mixed and as such, inconclusive (Naslund et al., 2016). However, this study used a manufactured social media site, indicating that results cannot be generalised to established social media sites as the network in the study lacked the dynamics, norms and atmosphere of a genuine social media site (Lawlor & Kirakowski, 2014).

Other studies have explored social media as a resource of MH support (Shepherd et al., 2015; Kaplan et al., 2011). Shepherd et al., (2015) focused on a specific discussion on the social media network 'Twitter' and conducted a thematic analysis of the comments made. Twitter allows users to communicate in statements (tweets) of up to 140 characters in length. Communication between users can be facilitated through the use of 'hashtags' whereby users can contribute to existing conversations by including the said hashtag to their statement. Shepherd et al., (2015) identified the hashtag conversation #dearmentalhealthprofessionals and conducted a thematic analysis on 515 tweets containing this hashtag. The role of Twitter as a social space for communication regarding the experience of MHPs was explored, as was the means of Twitter in allowing users to communicate their feedback on their experiences of MH care. Results suggested that the Twitter platform did not give way to in-depth discussion as each statement is limited in length. However, Shepherd et al., (2015) suggested that it did allow the opportunity for users to provide links to external support, illustrating the strength of social media platforms as a 'central hub of discussion facilitating the coordination of groups of individuals with shared experience or interests' (p.6). In other words, this study suggests that social networks can facilitate larger support networks or direct communication

between service users and MH professionals. However, the extent to which these results can be generalised is questionable as the individuals who participated in this particular conversation were said to be mostly from the United Kingdom (UK) and America; some discussions were specific to one particular country, e.g. insurance costs of professional care.

Given the existing research concerning the opportunity to utilize social media (Alvarez-Jimenez et al., 2013) as well as the guidance regarding the framework of a successful intervention (Weare 2015; Kelly et al., 2007) together with the aims within the Government's Green Paper to seek the views of YP (DfE & DoE., 2017) it is important to explore the views of YP with regard to an intervention and in particular barriers to accessing support and the potential of online support.

When designing a MHL programme, as well as exploring YP views, professionals should also consider the research surrounding how best to facilitate behaviour change. With that in mind, the next section will explore social cognition models that seek to explain health related behavior.

2.7 Social Cognition Models Linking Mental Health Literacy to Actions

The ability to predict and explain health related behavior is important to a range of researchers and professionals concerned with developing interventions to change behaviours (McEachan, Conner, Tylor & Lawton, 2011). Different social cognition models exist which address the process by which people behave (Von Wagner, Steptoe, Wolf & Wardle, 2009) and I shall now discuss how the theory of planned behaviour (TPB) (Ajzen, 1991) can be applied to interventions concerned with raising MHL.

The TPB (Ajzen, 1991) is a frequently cited and influential model for predicting Garcia, 2016) and is concerned with the predictions of intentions. The theory states that behavior is determined by intention (INT) and perceived behavioural control (PBC). INT is the motivational component and is determined by an individual's attitude towards the behavior (e.g. "Is the action of seeking MH support positive or negative?") and subjective norms (e.g. "What will people think if I seek MH support?"). PBC is the extent to which people perceive they have control over engaging in the behaviour and, as such, is weighed up between how

powerful inhibiting factors are versus how powerful facilitating factors are. For example, having lots of spare time to access MH support (medium factor) versus the financial cost (big factor).

McEachan et al., (2011) conducted a meta-analysis of research which had applied the TPB to the analysis of behaviours across both adolescents and adults. The studies were concerned with many different types of behaviours (e.g. healthy eating, visiting the doctor) and results indicated that overall the TPB provided strong predictions of intention and behavior. The age of the sample of participants moderated the relationship between the components of the model and when considering adolescents, social norms within INT appeared to have the largest role in predicting behaviours.

Therefore, when considering educational programmes aimed at raising the MHL of YP, the application of the TPB further supports the notion that the MHL of YP is fundamentally important in indirectly assisting an individual to seek MH support; social norms (e.g. "What will people think if I go and visit the counselor?") will arguably become more positive as levels of MHL rise. Thus, exploring MHL of YP and ways to increase it is very important in terms of attempting to influence the MH behaviours of YP.

2.8 Future Research Suggestions

It is widely accepted that people with higher levels of MHL are better placed to support other people with MHPs and also to help themselves in terms of prevention and treatment (Jung et al., 2016; Jorm, 2015; Wong et al., 2017; Tatlow-Golden & McElvaney, 2015). Research also highlights a need and desire, from both staff and pupils, for education programmes aimed at raising the MHL of YP and educators (Natan et al., 2017; YoungMinds, 2017). There is a need for training to enhance educators' MHL to increase their ability to support YP with MHPs (Anderson, Werner-Seidler, King, Gayed, Harvey & O'Dea, 2019). A notable gap in prior research is a lack of studies that focus on the skills that educators would need in order to support their pupils MHL (Moon et al., 2017; Wei et al., 2015) Therefore, there is a lack of research looking into exactly what an education programme aimed at raising MHL for students would entail; research needs to focus on ways to raise MHL of pupils as well as ways to upskill

teachers (Andeson et al., 2018; Moon et al., 2017; Wei et al., 2015).

There is a gap in research exploring educators' readiness to commit to MHL programmes (Anderson et al., 2019). Moreover, most studies concerning this concentrate on urban areas and it could be argued that findings cannot be generalised to rural areas, given that urban areas may have greater access to MH services (Moon et al., 2017).

Research also identifies a need to explore the views of the YP regarding MHL, existing MHL programmes and potential education programmes (Burns & Rapee, 2006; Coles et al., 2016; Lo et al., 2017). In order to design an education programme accessible and relevant to the YP of today, it is important to explore how adolescents use the internet and social media to seek help (Coles et al., 2016). As discussed in the previous section, there appears to be potential in utilizing social media as a means of MH support for YP (Naslund et al., 2016; Highton-Williamson et al., 2015) however more research in this area is needed to add to the evidence base.

When considering the gap within research exploring YP views regarding MHL, it is also important to explore the relationship between stigma and help seeking (Clement et al., 2015). Clement et al., (2015) identified that stigma has a detrimental effect on help seeking within adults but suggested that research was needed to explore this relationship within the younger community. Furthermore, Clement et al., (2015) identified that a barrier to seeking help is an unrecognition of there being a need to seek help. Thus, there is an opportunity to investigate the extent to which YP recognise the importance and benefit of seeking help.

2.9 Current Research

My review has highlighted some gaps in research, namely the exploration of the following: pupil and educators' views with regards to ways in which MHL could be increased; necessary teacher skills to implement MHL programmes; YPs attitudes towards seeking help for MHPs; online MH support. When considering the gaps, together with the growing prevalence of MHPs, I have identified a research area which is both current and relevant to both theory and practice; an

exploration of YP and educators' views with regards to MHL programmes. The proposed research is relevant as it responds to current Government policies aimed at raising awareness of MH in schools. The proposed research is unique as it taps into many gaps in the existing literature by exploring YP and educators' views of prospective MHL programmes, including the prospect of online support. Preliminary research with the target audience group has been argued as the most important factor when designing an intervention programme (Kelly et al., 2007). Thus, this research could impact upon practice by adding to the limited literature concerning pupil views of MHL programmes and thereby informing future MHL interventions.

I aim to investigate the extent of MHL of YP. For clarity, the operational definition of MHL that I will be using in this research is 'knowledge of MH (signs and symptoms); beliefs of MH (stigma); knowledge of resources of MH (help seeking) (Jung et al., 2016). By measuring these three components of MHL I hope to explore whether there is an opportunity for MHL programmes and also to investigate relationships between MH knowledge, stigmatizing views and attitudes towards help seeking. I also aim to explore both pupil and educators' views as to how best to raise MHL in schools, with a focus on social media as a means of support and a whole school versus single component approach to MH awareness.

The reasoning behind this research is; to improve the MHL of YP, empowering them to recognise the signs of symptoms of MHPs within themselves and others and to become better placed to access support. Research suggests that raising the MHL of YP can reduce the stigmatising views they hold regarding MH, thereby helping to create a more accepting and inclusive environment for the next generation.

3.0 Methodology

3.1 Restating Aims of the Research

The aims of this research are:

Phase 1

- o To gather YP views of MH

- o To gain a broad sense of whether low MHL is associated with stigma towards MH

- o To identify what needs there are for MHL programmes in schools

Phase 2

- o To explore the views of YP regarding prospective MHL interventions

- o To gain the perspective of SENCos regarding existing MHL of YP in schools

- o To explore the views of SENCos regarding prospective MHL interventions

- o To identify a role for the EP in raising the MHL of YP within schools

Having established the aims of the current research, I then shaped these aims into specific research questions (Thomas, 2017). Given the exploratory nature of the research, the questions needed to investigate a complex issue yet needed to be precise enough to ensure it was possible to find an answer (Thomas, 2017). Furthermore, I anticipated that the questions within phase 2 would emerge from the answers derived from phase 1 (Creswell & Clark, 2017).

3.2 Research Questions

Phase 1

RQ1: To what extent do Year 8 (12 and 13 year old) children have MHL?

A thorough literature review has identified to me that a significant amount of YP in the UK are experiencing MHPs. Research also suggests that MHPs are less prevalent within those YP who have a higher level of MHL. The MHL of the YP in this research needs to be explored in order to inform the next phase of the research; what areas of MHL are lacking and how can these be improved.

RQ2: To what extent does MH knowledge correlate with stigma?

Research suggests that holding stigmatising views towards MH is a barrier towards seeking help for MHPs. There is a lack of research exploring the stigmatising views of YP in the UK towards MH and how this links to their MH knowledge.

Phase 2

RQ3: What are the views of Year 8 pupils (12 and 13 year olds) regarding prospective MHL programmes in schools?

As part of the green paper (DoH & DfE, 2017) the Government seeks to explore YPs views in order to guide intervention. Currently, research within this area is lacking.

RQ4: What are the views of SENCos regarding prospective MHL programmes in schools?

SENCos will be responsible for implementing MHL programmes in schools yet their views are seldom sought. If the Government is to successfully raise the MHL of YP, it is important that those responsible for implementing MHL programmes are consulted prior to their design.

RQ5: How might EPs facilitate MHL programmes in schools?

There is a lack of research exploring the views of YP and educators with regard to MHL programmes in schools. Such a qualitative method may provide the opportunity to identify a key role for the EP in facilitating such programmes.

3.3 The Concept of Methodology

Methodology is the study of method (Thomas, 2017) and this chapter will present and discuss the methods used in this research project. Methodology can be seen as a strategy of enquiry that guides a set of procedures (Denzin and Lincoln, 2000; Creswell, 2009). The beliefs of researchers about different methodologies and the component research methods is associated with a particular approach to knowledge.

Before I explain the methods used in this study, I must first explain the paradigm, or approach to knowledge, that I have taken. A paradigm is a fixed set of assumptions about the way inquiry should be conducted (Thomas, 2017; Ghiara, 2019) and one's paradigm is therefore inextricably linked with the research one does (Ghiara, 2019). The paradigm that I used was pragmatism.

Pragmatism suggests that what is true is subjective for individuals (Feilzer, 2010) and that reality is subject to change (Braun, Clarke & Terry, 2014). Given that the pragmatic approach supports the view that there are multiple realties, pragmatism supports a 'what works' attitude towards selecting research methods (Tashakkori & Teddlie, 1998) by emphasising the importance of common sense and practical thinking (Mertens, 2007). Therefore, a pragmatic approach embraces methods that are most appropriate for the purpose of the research question (Creswell, 2009) and such approaches demonstrate that both quantitative and qualitative methods of data collection are beneficial in research (Briggs, 2019). A pragmatic approach is therefore congruent with mixed-methods as both methods can help researchers to understand different aspects of human experiences (Tashakkori & Teddie, 1998).

By adopting a pragmatic approach to this research, I am focusing on the research problem and the potential consequences of the research, thereby attempting to solve the problem of raising MHL amongst YP in the 'real world' (Briggs, 2019; Creswell & Clark, 2017).

3.4 Research Design

In line with the pragmatic approach, this research collected data in a sequential manner using methods from quantitative and qualitative traditions (Creswell &

Clark, 2017) and as such adopts the research design, mixed-methods. This has the advantage of compensating the weaknesses from both methods whilst benefitting from the strengths of both methods (Creswell & Clark, 2017). That is to say, the strength of objective data gathered in phase 1, will add support to the subjective data gathered in phase 2. Also, the strength of the production of rich descriptions from the qualitative data in phase 2, will support the quantitative data gathered in phase 1 (Denscombe, 2014). Adopting a mixed-method approach provides stronger inferences through both the breadth of quantitative data and the depth of qualitative data (Tashakkori & Teddie,1988). Furthermore, using mixed-methods provided me with an opportunity to explore divergent findings from different viewpoints (Tashakkori &Teddie, 1998). Investigating differing viewpoints, enables triangulation of data; the ability to fill in any gaps (Denscombe, 2014).

This research followed two phases; phase 1 used a quantitative method and phase 2 used qualitative methods of data collection. The sequence of these methods was important as the data obtained from phase 1 informed phase 2 (Tashakkori & Teddie, 1998). In other words, the data obtained from phase 1 helped me to narrow down the questions posed to participants in phase 2 and conclusions drawn from this this research will be based on both phases 1 and 2.

3.5 Ethical Issues

This research thesis received ethical approval from The University of Exeter, Graduate School of Education Ethics Committee (see Appendix 2 for certificate and Appendix 1 for ethics application). All four schools informed parents/carers of the research taking place by emailing them a letter from myself (see Appendix 3). Consent was passive for phase 1 and active for phase 2, with selected parents and carers receiving a separate email for phase 2 (see Appendix 3 and 4 respectively).

Information on the participants' rights to not take part were included at the beginning of the questionnaire, as well as a verbal reminder by myself. Given the nature of the topic, there was a possibility of evoking an emotional response from the YP involved in both phases of the research. As such, measures were taken

to prevent harm coming to participants and are discussed in detail within the ethical application (Appendix 1).

The SENCos in phase 2 received a written information and consent letter, of which they signed and returned prior to the interview (see Appendix 5).

I was present at all schools during the data collection phases of this study should any issues or questions arise.

4.0 Phase 1: Methodology

It was important to choose the methods which I thought would best answer my research questions (Briggs, 2019). Phase 1 sought to answer RQ 1 'To what extent do Year 8 (12 and 13 year old) children have MHL?' and RQ 2 'To what extent does MH knowledge correlate with stigma?' The selected design frame of the study was cross-sectional; groups of individuals were studied at the same time (Thomas, 2017).

4.1 Phase 1: The Construction of the Questionnaire

The questionnaire comprised of a selection of measures identified by Wei, McGrath, Hayden and Kutcher (2015) as validated tools to explore MH knowledge, behaviour and attitudes. For clarity, the operational definition of MHL that I will be using in this research is 'knowledge of MH (signs and symptoms); beliefs of MH (stigma); knowledge of resources of MH (help seeking)' (Jung et al., 2016). The following scales were selected:

> Mental Health Knowledge Schedule (MAKS); Evans-Lacko et al., 2010 (12 questions- exploring knowledge)

> Peer Mental Health Stigmatization Scale (PMHSS); McKeague et al., 2015 (24 questions- exploring stigma)

> Mental Health Seeking Attitudes Scale (MHSAS); Hammer et al., 2018 (9 item scale-exploring help seeking)

Please see Appendix 6 for a copy of the full questionnaire

4.1.1 Rationale for selecting the Mental Health Knowledge Schedule

I decided upon the MAKS to measure participants MH knowledge for several reasons, the first one being that it is brief and feasible instrument for assessing

stigma related MHK (Evans-Lacko et al., 2010). The MAKS seeks to explore six domains of stigma related knowledge: help seeking; recognition; support; employment; treatment; recovery (Chisholm et al., 2016) and as such, could provide useful information to help me to understand the relationship between knowledge and behaviour across several aspects of MH knowledge. Although developed originally for the 25-45 age group by Evans-Lacko et al., (2010), other authors have used the MAKS with much younger children with little loss of reliability (Chisholm et al. 2016). However, as the tool covers sub scales that may not be related, the MAKS is not intended to be used as a scale alone; it has low levels of internal consistency (Cronbach's alpha= 0.65) (Chisholm et al., 2016). Importantly, the MAKS is designed to be used in conjunction with other tools to elicit information to help understand relationships between knowledge and behaviour (Evans et al., 2010). Wei et al., (2015) conducted a systematic review of tools that measure MH knowledge and concluded that the MAKS has a good level of test –retest reliability (0.71 using Lin's concordance statistic). Wei et al., (2015) added that no one tool was superior to another and, when selecting the MAKS for their own research, Chisholm et al., (2016) stated that the MAKS has been extensively reviewed. I carried out internal reliability calculations for all of the measures I proposed to use and their scores are appended (Appendix 12). The scores for the measures were good to adequate. I will refer to these analyses again in the results section.

The MAKS has been used with the general public worldwide and with adolescents (16 years) (Chisholm et al., 2016; Wei et al., 2015). For example, the DfE commissioned a project called 'Time to Change' which aimed to monitor changes in attitudes towards MH in England, over time. The MAKS was used as a measure, alongside other tools, yielding significant data identifying trends; from 2009-2013, the MH knowledge of people aged 35- 54 years had developed more than those aged 16-34 years (Evans-Lacko. S, Corker. E, Williams. P, Henderson. C & Thornicroft, 2014).

Lastly, the MAKS adopts closed questions within a structured questionnaire; arguably a more effective way of measuring MH knowledge, than for example vignettes, as it accesses factual information (Evans et al., 2016).

4.1.2 Rationale for selecting The Peer Mental Health Stigmatization Scale

The PMHSS is a theory based stigma questionnaire suitable for children and adolescents (McKeague et al., 2015). In fact, the mean age of participants in the development of this questionnaire was 12.99 years; within the age bracket of the participants within the current research. Furthermore, Wei, McGrath, Hayden and Kutcher (2018) conducted a systematic review of tools designed to measure the stigma levels of mental illness, and identified 101 tools. Of these, only eight were designed with participants in secondary schools, none of which were developed in the UK. The PHMSS was developed in Ireland; geographically closer to the UK.

In addition, this measure was found to be a sound instrument with a good level of test-retest reliability (for positive items r= 0.753, for negative items, r= 0.645). Internal consistency was also found to be high (Cronbach's alpha = 0.806) (McKeague et al., 2015). Again, when considering the findings from Wei et al., (2018) the PHMSS was one of the 69/101 tools that was found to have reached the criteria in terms of its methodological quality in most of its measurement properties.

Also, the PHMSS is based on a conceptualisation of stigma that has been drawn from previous research (Corrigan & Shapiro, 2010); consisting of stereotypes, prejudice, discrimination and lower status. Finally, the PHMSS distinguishes between societal stigma (ones' perception of most people beliefs) and personal stigma (the individuals beliefs), potentially providing interesting information in terms of barriers to seeking help; do individual's own views or their perceptions of other people's beliefs require development.

4.1.3 Rationale for selecting The Mental Health Seeking Attitudes Scale

The development of The MHSAS was based upon the theory of planned behaviour (TPB) (Ajzen, 1991). Hammer et al., (2018) argue that the TPB is one of the most cited social scientific theories in help seeking research and as such any scale measuring help seeking attitudes should be grounded in this theory.

With that in mind, Hammer et al., (2018) ensured that the scale was constructed using Ajzen's guidelines (2006) and as such the measure is a 7-point scale whereby attitudes are treated as a single construct and is measured unidimensionally, producing an overall evaluation score (Hammer et al., 2018). Furthermore, based on evidence that respondents can be bias with their responses according to the page position, half of the positive valance pole items are on the right-hand side of the page, with the other half on the left-hand side (Hammer et al., 2018).

Finally, the MHSAS has good internal consistency (Cronbach's alpha= 0.94) and good test-retest reliability (0.76).

4.2 Analysis of Data from Phase 1

In order to answer RQ 1, data from all three scales were input into SPSS and anaylsed descriptively. In order to answer RQ 2, Pearson one tailed tests were conducted to explore correlations.

4.3 Rationale for Using Questionnaires

Questionnaires produce a large amount of objective and quantitative data from a large number of participants in a time efficient manner (Creswell & Clark, 2017). Moreover, questionnaires are an economical way of collecting data (Thomas, 2017) and allow for the generalisation of findings to populations and for statistical comparisons between individuals, groups and variables (Thomas, 2017; Alreck & Settle, 1995).

Given that research suggests online questionnaires have a significantly lower response rate than paper questionnaires (Madge, 2006) I provided paper questionnaires to each participant. Instructions were stated at the beginning of each scale and participants were asked to complete their details on the front of the questionnaire; gender, school. Participants were informed that they did not need to complete any or all of these background details if they did not want to as data would be anonymous.

The questionnaire consisted of three established scales, all utilizing closed questions. Closed questions were chosen, as opposed to open-ended questions,

as they elicit clear measurable data; open ended questions require coding schemes (Krosnick & Presser, 2010). Despite research suggesting that closed questions are less likely to measure factually correct knowledge due to participant selecting a 'best fit' response (Oppenheim, 1992) I selected closed questions as other research suggests that participants are more likely to select the answer 'don't know' if they are required to answer an open-ended question (Krosnick & Presser, 2010). This is said to be due to participants not being sure if their answer would be appropriate (embarrassment) and/or not immediately recalling an answer (Oppenheim, 1992; Tourangeau & Yan, 2007).

Likert scales (Likert, 1952) were used as they have been found to be reliable, valid and responsive (Hasson & Arnetz, 2005). Moreover, verbal Likert scales, as opposed to numerical, appear to be easier for YP to understand (Krosnick & Presser, 2010). However, participant interpretation of the language may differ (Krosnick & Presser, 2010). Two of the scales used (MAKS and PMHSS) used verbal Likert scales.

With regards to phase 1, I aimed to remain detached from the process as to not influence data collection with my thoughts, perceptions and feelings (Creswell & Clark, 2017). The quantitative, objective and unbiased data that was produced in phase 1 could be generalised to the wider population (Creswell & Clark, 2017). Findings from phase 1 offered an indication as to the extent of MHL amongst pupils from other schools in similar settings e.g. same age range, rural authorities.

This next section will describe the method of phase 1 including pilot stage, participation selection, data entry and ethics.

4.4 Phase 1 Pilot

To ensure that the questions were understood by YP aged 12 and 13 years and to establish a realistic time frame in which the questionnaires could be completed, I piloted the questionnaire. The pilot group consisted of 15 YP in Year 8 of a local independent school. Questionnaires were completed within a 10-30 minute timeframe. Two students queried the structure of the MHSAS (Hammer et al.,

2018) questionnaire; these individuals were unsure of the scaling. Outcomes of the pilot study were as follows:

> To allow a timeframe of 30 minutes for complete of the questionnaire.
>
> To ensure I was present at the start of each questionnaire so that I could explain the scaling system of the MHSAS should anyone be unsure.

4.5 Phase 1 Sample Population

A stratified sampling method was adopted; the selected population was that of secondary schools within a county in the south west of England. Invitations to take part in the research project were sent to seven government funded secondary schools. Emails were sent to both the head and SENCo of each school, whereby some were forwarded to another member of staff e.g. research coordinator. Information within the initial email explained the two-stage process and the fact that participating schools would receive outcomes of the research, including recommendations for improving the MHL of pupils, upon completion of the project.

These schools fell into two local authorities; Eastspring County Council and Westfay County Council. Of the seven schools, four agreed to participate; two from each local authority. Selective schools were not chosen to participate in the research as to limit selection bias; data representative of the wider population was required (Thomas, 2017). Pseudonyms have been provided to protect participants anonymity.

Participants within Year 8 (12 and 13 year olds) were selected to participate in the project as research suggests that half of all MHPs manifest by age 14 years of age (Kessler et al., 2005). Therefore, this age group is arguably an at-risk group and as such the views of this age group should be considered when forming a MHL programme in schools.

Emails were sent to parents and carers of all Year 8 students, containing information regarding the aims of the research and potential involvement from their child. Parents and carers were informed that consent was 'opt out' and so were only required to contact the school should they *not* wish for their childto particppate. One parent utilsed this option.

I asked schools to randomly select approximately 100 of their Year 8 students to participate with the questionnaire, allowing for a wide representation of the Year 8 population; this large sample size decreases the chances of getting a distorted representative of the Year 8 population (Thomas, 2017).

4.6 Phase 1 Procedure

Participants in each school were assembled into one room, either all 100 or three rooms consisting of approximately 30 each. I introduced myself as a researcher from Exeter University and explained my aim was to improve the way schools supported the MH of its pupils. I added that in order to do that, it was necessary to gain individuals' genuine beliefs, stressing the importance of not copying a peer. I informed pupils of their right not to answer the questions and to hold up their hand should they need assistance. I informed pupils that their teachers would not see their responses and they need not attach their names to their questionnaires.

With the help of a teacher(s), I handed out the questionnaires to each individual. Upon completion, I collected the questionnaires.

4.7 Phase 1 Data Entry

Quantitative data from phase 1 was coded and input into the statistical analysis software package, SPSS 24. Descriptive statistics were used to establish the following themes:

- Gender

- Levels of MH knowledge

- Levels of stigma related beliefs regarding MH

- Levels of help seeking attitudes

- Any correlation between MH knowledge and stigma related beliefs regarding MH.

5.0 Phase 1 Results

This chapter is intended to report the findings of phase 1 of this study. The analysis of the findings of phase 1 is presented in chapter 6.

5.1 Demographic Data

Table 1

Missing Data

Scale	Percentage of missing data
MAKS	2.8%
MAKS part 2	5.1%
PHMSS personal stigma	8.1%
PMHSS societal stigma	6.1%
MHSAS	19%

All data was anaylsed, including cases with missing data. There is no established cut off regarding acceptable percentages of missing data (Dong and Peng, 2013) with thresholds ranging from 5% too 40% (Madley-Dowd, Hughes, Tilling and Heron, 2019).

Table 2

Participant Numbers, Percentages and Gender

Gender	Number of participants	Percentage
Male	197	49.9 %
Female	178	45.1 %
Missing	20	5.1 %
TOTAL	**395**	

Table 2 details the gender split between participants. I would suggest that the above figures highlight that there is a gender balance in this study, therefore the results represent the views of both males and females accurately

Table 3

The Balance between Schools

School	Number of participants	Percentage
School 1	70	17.7 %
School 2	83	21 %
School 3	66	16.7 %
School 4	176	44.6 %
TOTAL	**395**	

Table 3 details the number of participants from each school. The comparatively large number of participants from school 4 is due to school staff preference of administering the questionnaire the entire year group, due to practical reasons.

5.2 Mental Health Knowledge Schedule

The Mental Health Knowledge Schedule was made up of two parts: part 1

(questions 1-6) and part 2 (questions 7-12). Part 2 is intended to measure participants MHL. Part 2 is intended to offer interesting informtion that may support analysis.

Table 4

Participants Responses to Questions 2, 3, 4 and 5

Question	Agree Strongly (5)	Agree Slightly (4)	Neither Agree or Disagree (3)	Disagree Slightly (2)	Disagree Strongly (1)	Missing	Mean	SD
2. If a friend had a mental health problem, I would know what advice to give them to get professional help	18 %	38.2 %	28.1 %	9.4 %	4.1 %	2.3 %	**3.58**	**1.03**
3. Medication can be an effective treatment for people with mental health problems	10.9 %	29.9 %	44.8 %	6.8 %	5.6 %	2 %	**3.34**	**0.97**
4. Psychotherapy (e.g. talking therapy or counselling) can be an effective treatment for people with mental health problems	33.9 %	34.2 %	26.1 %	2 %	1.5 %	2.3 %	**3.99**	**0.92**
5. People with severe mental health problems can fully recover	8.1 %	21.3 %	47.1 %	17.2 %	4.1 %	2.3 %	**3.12**	**0.94**

Table 4 details the results from questions 2, 3, 4 and 5 of the MAKS. The responses to these questions have been selected as they highlight the limited

knowledge that participants have with regards to MH, and in particular, treatment for MH.

Participants were required to give their response for each item on a scale from 0 to 5, indicating their level of MH knowledge, ranging from very low to very high respectively. A score of 3 indicates a neutral response.

As shown in the Table 4, it was found that only 29.4% of participants agreed that people with a severe MHP can fully recover. With regards to forms of treatment, encouragingly 68.1% of participants agreed that talking therapies can be an effective treatment for people with MHPs. However, 44.8% of participants indicated that they did not know whether medication was an effective form of treatment and 41.6% responded that they would not know what advice to give a friend, in order to access professional help.

For the complete table of results, detailing frequency of responses to each of the 12 questions within the MAKS, please refer to Appendix 7.

Figure 1 below illustrates the overall results from question 1-6 on the MAKS. Figure 1

Total Score MAKS, Questions 1–6
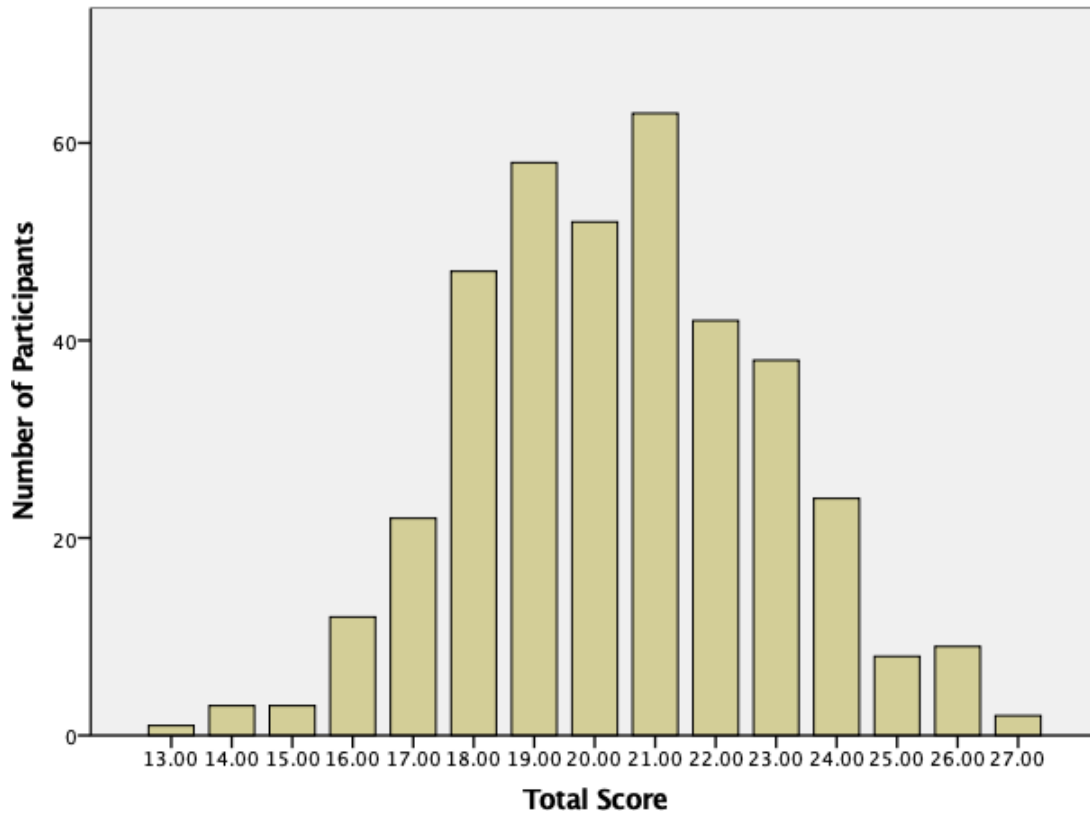
Figure 1 illustrates the total score that participants achieved on the MAKS, questions 1 to 6. Participants were able to achieve a mean score ranging between 0 (totally incorrect MH knowledge) to 30 (totally correct MH knowledge) where a neutral score was 18. Participants who completed the MAKS part 1 achieved: **mean = 20.41** and **standard deviation= 2.49.**

Figure 2 below illustrates the results from questions 7-12 on the MAKS

Figure 2
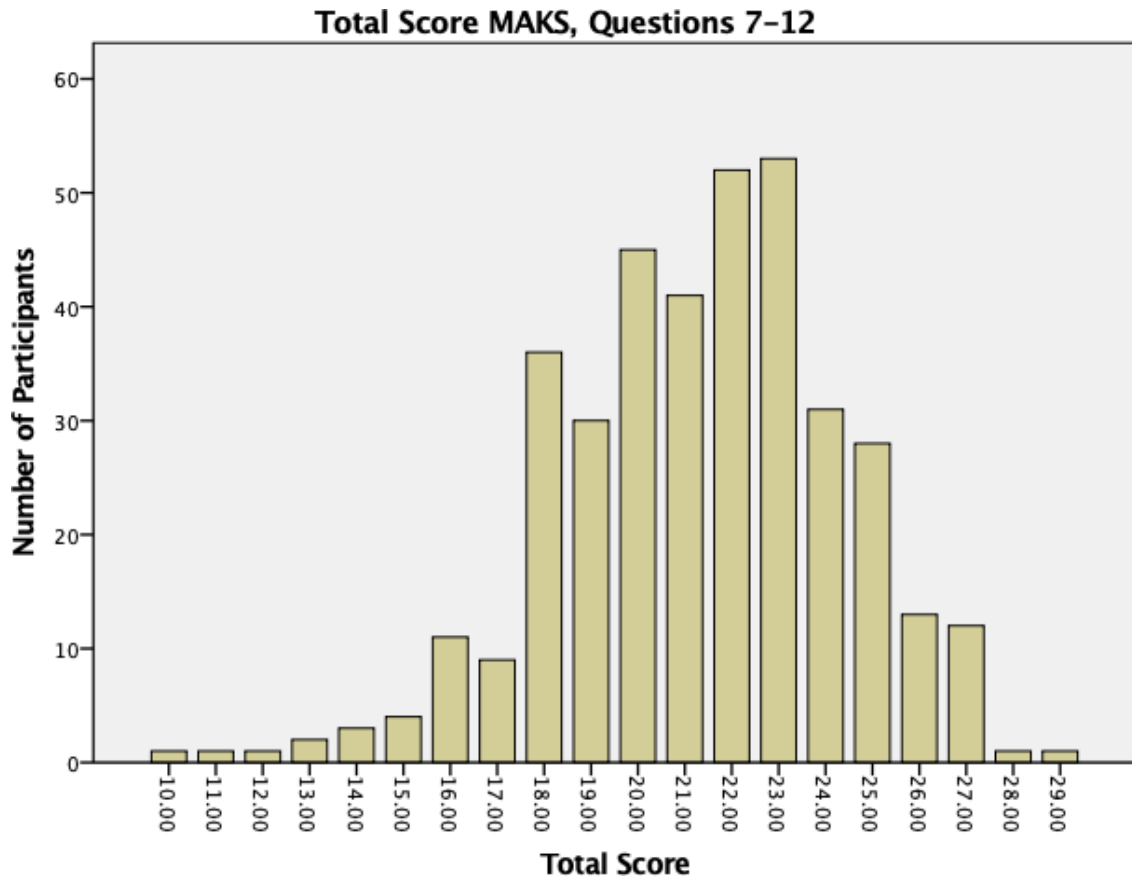
Figure 2 illustrates the total score that participants achieved on the MAKS, questions 7-12. Participants were able to achieve a mean score ranging between 0 (totally incorrect MH knowledge) to 30 (totally correct MH knowledge) where a neutral score was 18. Participants who completed the MAKS part 2 achieved: **mean** = 21.32 and **standard deviation**= 3.04.

Questions 7-12 were designed to offer any additional information that may support analysis. Comparison of the data between Figures 1 and 2, indicate that participants' level of MH knowledge is very similar across all aspects measured.

5.3 Peer Mental Health Stigmatization Scale

The Peer Mental Health Stigmatization Scale (PMHSS) was made up of two parts; part 1 measured participants <mark>perceptions</mark> of societal stigma (questions 1-12) and part 2 measured personal stigma (questions 13-24).

5.3.1 Societal stigma: items 1-12 on the Peer Mental Health Stigmatization Scale

Figure 3
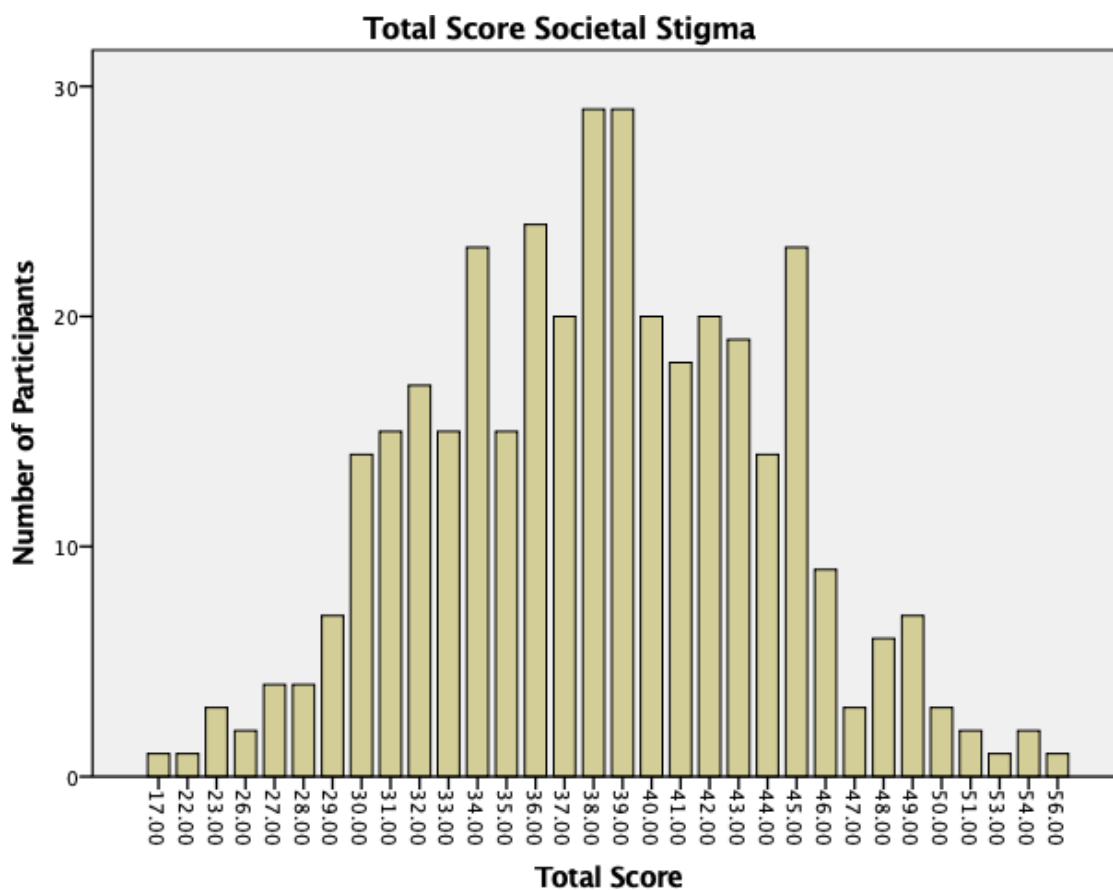
Figure 3 illustrates the total scores that participants achieved on items 1-12 on the PMHSS. Items 1-12 measure perceptions of societal stigma; the degree of stigma an individual believes their peers hold towards MHPs. Participants were able to achieve a mean score ranging between 0 (very high societal stigma) to 60 (very low societal stigma) where a neutral score was 36. Participants in the societal stigma sub scale achieved: **mean 38.15** and **standard deviation = 5.96**.

For the full table detailing responses to questions 1-12, please refer to Appendix 8.

5.3.2 Personal Stigma: items 13-24 on the Peer Mental Health Stigmatization Scale

Figure 4

Total Score Personal Stigma
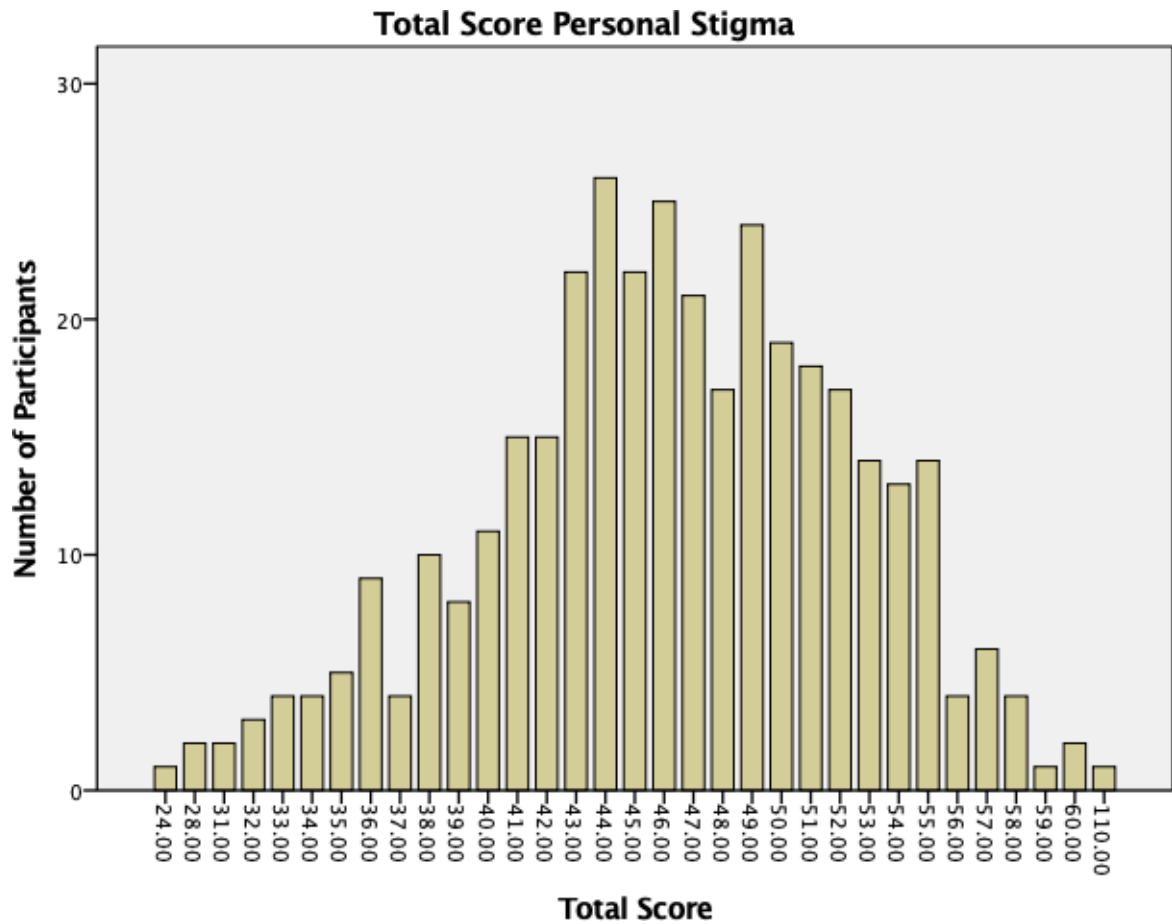
Figure 4 illustrates the total scores that participants achieved on items 13-24 on the PMHSS. Items 13-24 measured levels of personal stigma; the degree of stigma that one holds towards MHPs. Participants were able to achieve a mean score ranging between 0 (very high societal stigma) to 60 (very low societal stigma) where a neutral score was 36. Participants in the personal stigma sub scale achieved: **mean 46.26** and **standard deviation= 7.11**.

For the full table detailing responses to questions 13-24, please refer to appendix 9.

The above graphs demonstrate a normal distribution, indicating the suitability for parametric statistical tests (Field, 2009).

5.3.3 Differences between societal stigma and personal stigma

Table 5

Paired Sample t-test to show Difference between Participants Perceptions of Societal Stigma and Personal Stigma Levels

Pair	Mean	Standard Deviation	Standard Error men	95% Confidence Interval of difference Lower	95% Confidence Interval of Difference Upper	Sig. (2-tailed)
Societal Stigma- Personal Stigma	8.14	7.92	0.43	-8.98	-7.31	.000

Table 5 details the difference in participants perceptions of societal and personal stigma. The table shows that there is a significant difference (M= 8.14, SD= 7.92 *p*=<0.001).

I have provided three example items from the PHMSS which demonstrate the differences between personal and societal stigma. They are as follows:

Table 6

Frequencies of Responses to the Question Exploring 'Looking Down' on Someone who has a Mental Health Problem

Question	Agree Strongly	Agree	Neither Agree or Disagree	Disagree	Strongly disagree	Missing	M	SD
Societal Stigma	1.5%	30.6%	35.2%	26.6%	4.3%	1.8%	**3.02**	**0.91**
Personal stigma	0.8%	3.5%	15.7%	36.7%	42.3%	1%	**4.17**	**0.88**

Table 6 details the frequencies in responses for the following two statements: Societal stigma '*Most people look down on children who visit a counsellor because they have emotional or behavioural problems*'; Personal stigma '*I look down on children who visit a counsellor because they have emotional or behavioural problems*'. Both questions explore 'looking down' on those who have a MHP.

Table 6 shows that 32.1% of participants perceive that their peers look down on those with MHPs, whereas only 4.3% of participants actually do look down on people with a MHP.

Table 7

Frequencies of Responses to the Question Exploring Intelligence of people with a MHP

Question	Agree Strongly	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Missing	M	SD
Societal Stigma	6.3%	28.6%	39%	23.8%	1.5%	0.8%	**3.15**	**0.91**
Personal Stigma	21%	52.9%	19%	4.3%	1.8%	0.8%	**4.01**	**2.72**

Table 7 details the frequencies in responses to the following two statements: Societal stigma '*Most people believe that children with emotional or behavioural problems are just as intelligent as other children*'; Personal stigma '*I believe that children with emotional or behavioural problems are just as intelligent as other children*'. Both questions explore the intelligence of those who have a MHP.

Table 7 shows that 34.9% of participants perceive that their peers believe that people with MHPs are just as intelligent as other children, whereas 73.9 % of participants actually do believe that people with MHPs are just as intelligent as other children.

Table 8

Frequencies of Responses to the Question exploring Being Friends with Someone with a Mental Health Problem

Question	Agree Strongly	Agree	Neither Agree or Disagree	Disagree	Disagree Strongly	Missing	M	SD
Societal Stigma	13.9%	33.2%	40%	11.6%	0.5%	0.8%	**3.49**	**0.89**
Personal Stigma	24.8%	43.5%	27.1%	2.5%	0.3%	1.8%	**3.92**	**0.81**

Table 8 details the frequencies in responses for the following two statements: Societal stigma '*Most children would be happy to be friends with somebody who has emotional or behavioural problems'*; Personal stigma '*I would be happy to be friends with somebody who has emotional or behavioural problems'.* Both questions explore the potential of being friends with someone who has a MHP.

Table 8 shows that 47.1% of participants believe that their peers would be happy to be friends with someone who has a MHP, whereas 68.3% of participants actually would be happy to be friends with someone who has a MHP

5.3.4 Gender differences between personal and societal stigma

Table 9

Paired Samples t test to show Difference between Personal Stigma and perceptions of Societal Stigma between Makes and Females

Pair	Mean	Standard Deviation	Standard Error Mean	95% Confidence Interval of difference Lower	95% Confidence Interval of difference Upper	Sig. (2-tailed)
Boys Personal Stigma- Boys Societal Stigma	6.22	7.87	.61	5.02	7.42	.000
Girls Personal Stigma- Girls Societal Stigma	10.39	7.54	.59	9.22	11.56	.000

Table 9 details the differences between levels participants' perception of societal stigma and their levels of personal stigma. The analysis was done for males and females separately. Information within Table 8 shows that males have a significant difference in their levels of perception of societal and personal stigma (M= 6.22, SD= 7.87, p=<0.01) and that girls do too (M=10.39, SD=7.54, p=<0.01.) This means that both males and females had significantly higher levels of perceptions of societal stigma than personal stigma. This also shows that the difference between societal and personal stigma is greatest for females

5.4 Mental Health Seeking Attitudes Scale

Figure 5
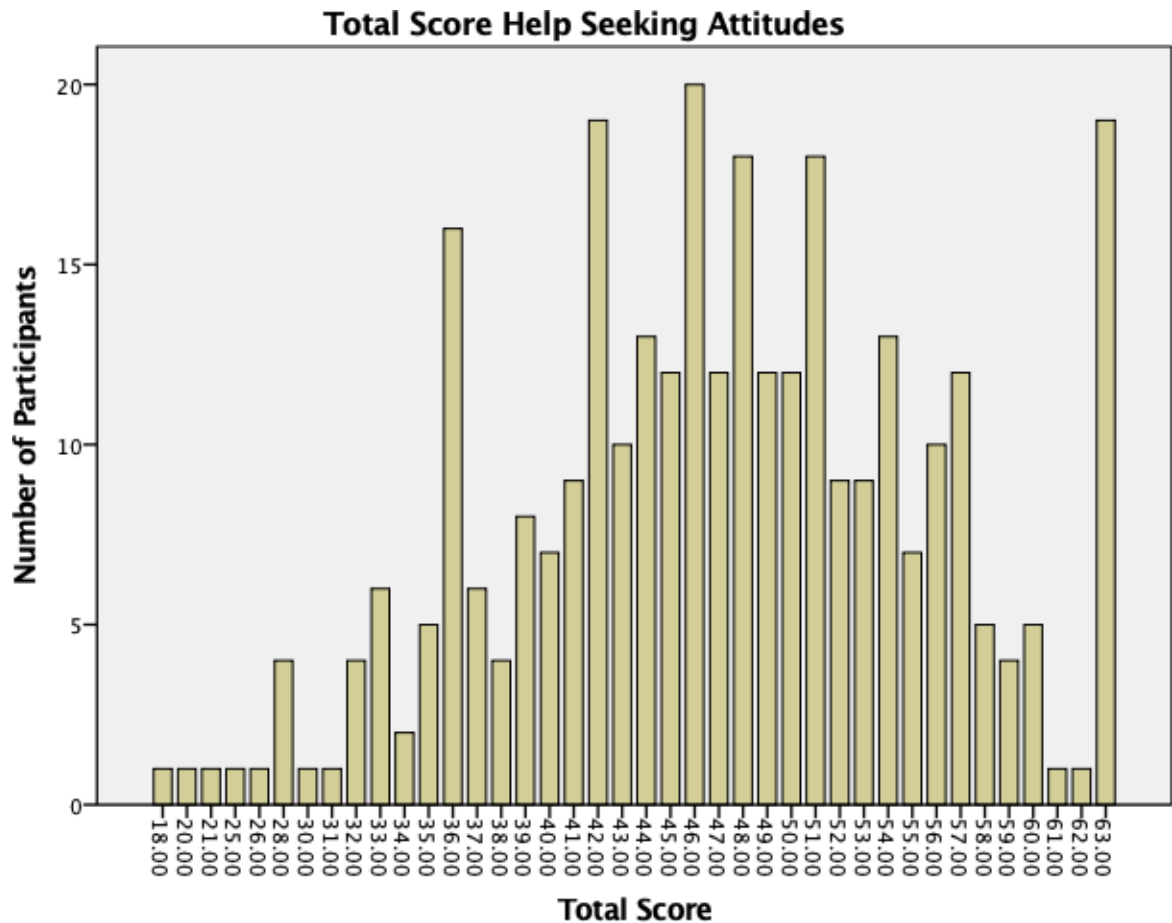
Figure 5 is a visual representation of participants total scores on the MHSAS, which measured how positive or negative participants attitudes towards seeking professional help for a MHP were. Participants were able to achieve a mean score ranging from 0 (very negative attitude) to 63 (very positive attitude) where a score of 36 was neutral. Participants in this study achieved: **Mean = 46.96**, **Standard Deviation = 8.79.**

For the table detailing full responses to the MHSAS, please refer to Appendix 10.

5.5 Gender Differences Between All Scales

Figure 6

Gender split between all scales
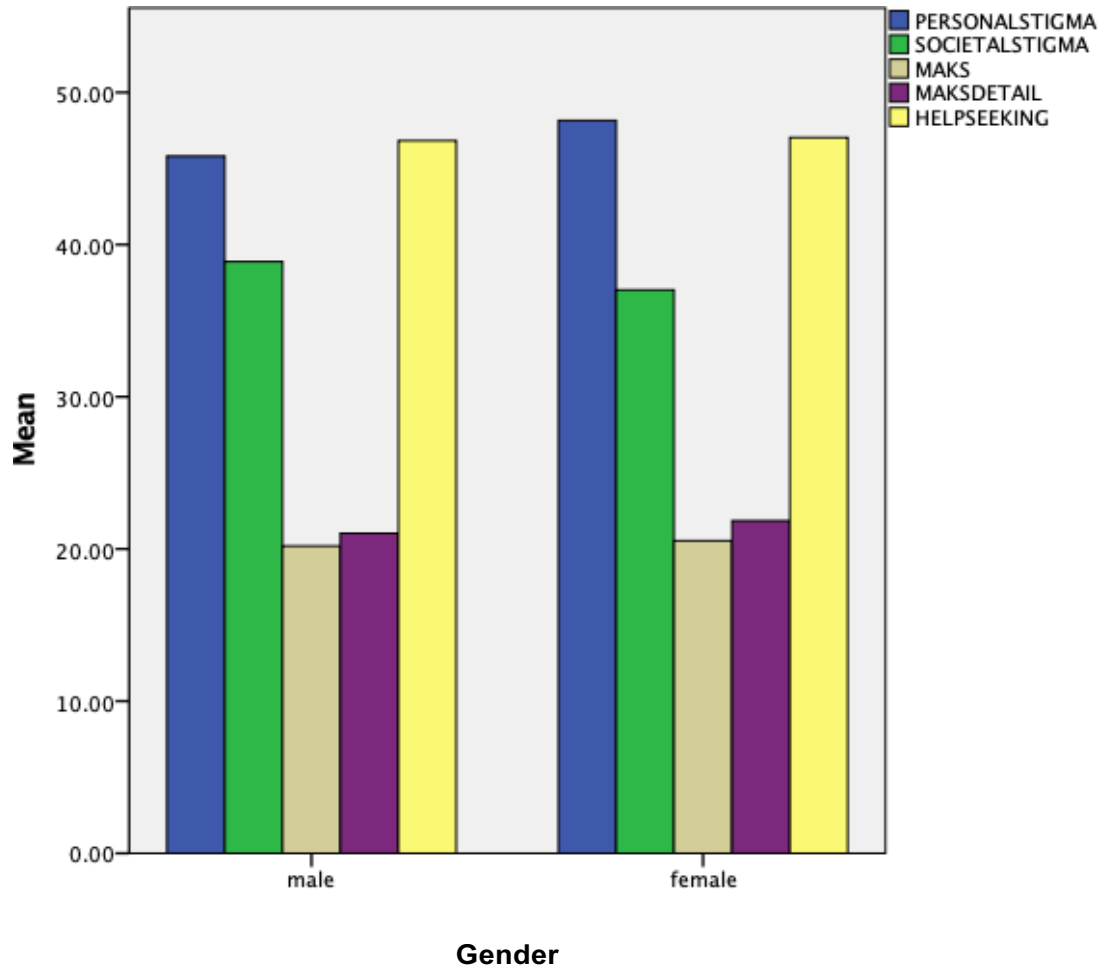
Figure 6 shows the gender differences in scores on each of the following scales: MAKS, MAKS details, personal stigma, societal stigma, attitudes towards seeking help. The graph illustrates that for each sub scale they were no significant differences between males and females. The only significant difference between gender is the gap between one's levels of perception of societal stigma and their personal stigma; it is significantly greater in females.

Table 10

Table of Multiple t test comparisons to show gender differences across all five scales

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Scale	Mean Difference	Standard Error Difference	t	df	Sig. (2-tailed)
Personal Stigma	2.33	0.752	-3.09	344	0.002
Societal Stigma	1.71	0.626	2.73	352	0.007
MAKS	-0.396	0.258	-1.54	362	0.126
MAKS Detail	-0.840	0.315	-2.67	354	0.008
Help Seeking	0.164	1.011	0.16	304	0.871

Table 10 shows the differences in means between males and females across all five sub scales. Multiple testing was conducted as five hypothesis were examined. The results show that there was a significant difference between the means of gender in three scales: Personal stigma, Societal stigma and MAKS detail. (Field, 2009).

Girls had a significantly higher levels of personal stigma (M= 47.49, SD, 5.65) than boys (M= 45.17, SD= 8.03) conditions, $t(344)$= 3.09, p= 0.002.

Boys had significantly higher levels of societal stigma perceptions (M=38.91, SD= 5.60) than girls (M= 37.20, SD= 6.18) conditions, $t(352)$= 2.73, p= 0.007.

Girls scored significantly higher on the MAKS detail subscale (M= 21.77, SD= 2.88) than boys (M= 46.99, SD= 8.71) conditions, $t(354)$= 2.67, p= 0.008.

As the number of tests increases, so does the possibility of finding at least one of them to be statistically significant by chance; the problem of multiplicity (Streiner & Norman, 2011). In order to ensure that the multiple tests were statistically significant, a Bonferroni correction was applied to the alpha level to control the type 1 error rate (Field, 2009). The alpha level (.05) was divided by the number of tests conducted (5) to produce an adjusted p value of .01. Thus, the multiple t tests were statistically significant (p= <0.05).

Please see Appendix 22 for the SPSS output of the multiple testing.

5.6 Correlations Between Scales

5.6.1 Correlation between mental health knowledge and societal stigma

In order to explore if there was a correlation between MH knowledge and perceptions of societal stigma, I conducted a 1 tailed Pearson correlation test. I hypothesised that greater levels of MH knowledge would be correlated to lower perceptions of societal stigma. A weak, positive significant correlation was found

(p=<0.01, rs= 0.281). The higher participants scored on the MAKS, the higher the participants scored on the PMHSS societal stigma scale.

5.6.2 Correlation between mental health knowledge and personal stigma

In order to explore if there was a correlation between MH knowledge and personal stigma, I conducted a 1 tailed Pearson correlation test. I hypothesised that greater levels of MH knowledge would be correlated to lower levels of personal stigma. A positive weak linear relationship was found (p=<0.01, rs= 0.133). The higher participants scored on the MAKS, the higher the participants scored on the PMHSS personal stigma scale.

5.6.3 Correlation between personal stigma and attitudes towards seeking help

In order to explore if there was a correlation between personal stigma and attitudes towards seeking help, I conducted a 1 tailed Pearson Correlation test, inputting data from the PHMSS personal stigma subscale and MHSAS into SPSS. I hypothesised that lower levels personal stigma would be correlated to lower levels of attitudes towards seeking help. A significant but weak relationship was found (rs= 0.136, p=<0.01). This means that the more positive one's levels of personal stigma, the more positive their attitudes towards seeking help.

5.6.4. Correlation between societal stigma and attitudes towards seeking help

In order to explore if there was a correlation between perceptions of societal stigma and attitudes towards seeking help, I conducted a Pearson 1 tailed Correlation test, inputting data from the PHMSS societal stigma subscale and MHSAS into SPSS. I hypothesised that lower perceptions of societal stigma would be correlated to lower levels of attitudes towards seeking help. No significant relationship was found between societal stigma and attitudes towards seeking help (rs= 0.88, p=0.65).

For tables detailing the results from the above four Pearson Correlation Tests, please see Appendix 11.

5.7 Reliability

Peer Mental health stigmatization scale, part 1- societal stigma

Reliable: Cronbach's alpha 0.769

Peer Mental health stigmatization scale, personal stigma

Reliable: Cronbach's alpha 0.729

Mental Health Knowledge Schedule –part 1, knowledge of mental health

Unreliable: Cronbach's 0.125

If delete item 6, Cronbach's alpha 0.292

Attitude Towards Seeking Help

Reliable: Cronbach's alpha 0.860

It should be noted that according to the reliability tests, the MAKS is deemed unreliable. However, the MAKS seeks to explore multi dimensions which may not be related. Therefore, the MAKS has low levels of internal consistency and is not intended to be used as a scale alone (Chisholm et al., 2016; Evans-Lacko et al., 2010).

Furthermore, differences exist between the level of internal consistency of the MAKS found within the current research (Cronbach's alpha 0.125) and that within existing literature (Cronbach's alpha 0.65). I would suggest that such differences are due to the age differential of participants as the scale was originally developed for the 25-45 age group.

For tables detailing the results from the above Cronbach's alpha reliability tests reliability tests, please see Appendix 12.

6.0 Phase 1 Discussion

The following section discusses the results of phase 1 in further detail. Phase 1 sought to answer:

RQ 1: To what extent do Year 8 (12 and 13-year-old) children have MHL?

RQ 2: To what extent does MH knowledge correlate with stigma?

Within this section, answers to RQ 1 and RQ 2 will be presented. The relevance of findings to existing literature will be discussed throughout, as will links to phase 2.

6.1 Research Question 1: To What Extent Do Year 8 (12 and 13-year-old) Children Have Mental Health Literacy?

The participants in this study completed a questionnaire comprising of three measures: MHK; MH stigma levels; attitudes towards seeking help. These three attributes make up a widely accepted definition of MHL (Jorm, 2000). I shall discuss the results from each scale in turn and then conclude what this indicates collectively.

6.1.1 Knowledge and links to phase 2:

Within the MH knowledge scale, participants achieved a mean score of 20.41 with a SD of 2.49. Participants could achieve a score ranging from 0 (incorrect MH knowledge) to 30 (completely correct MH knowledge) with a neutral score of 18. A mean score of 20.41 indicates an opportunity to enhance Year 8 pupils MHL.

When exploring the responses to individual questions within the MAKS, a lack of knowledge with regards to the effectiveness of medication as a form of treatment

was apparent; 44.8% of responses indicated that they did not know whether medication was an effective treatment for people experiencing MHPs. Only 29.4% of participants responded that they agreed that people with severe MHPs can fully recover; 8.1% strongly agreed and 21.3% agreed slightly. I suggest that these statistics reflect the uncertainty that YP have with regards to MH treatment and prognosis, impacting negatively upon perceived levels of control over their MH (Chisholm, Patterson, Greenfield, Turner & Birchwood, 2018).

These findings indicate an opportunity to increase YP knowledge of effective MH treatments, supporting existing research: Kelly et al., (2007) found that only 40% of a sample of 12-25 year olds considered that antipsychotics would be helpful for a person with psychosis. Furthermore, Wright, McGorry, Harris, Jorm and Pennell., (2006) found that only 40% of 18-25 year olds felt that antidepressants were helpful. In addition, Gulliver, Griffiths & Christensen, (2010) suggested that the belief that treatment would not help, is a main barrier to seeking help for a MHP. These statistics are worrying as limited knowledge of MH care may hinder public acceptance of medication as a form of support (Jorm, 2000). This resonates with other empirical research which suggests that, for those individuals experiencing MHPs, having knowledge of MH is an important factor in accessing MH support (Vanheusden, Mulder, Van der Ende, Van Lenthe, Mackenbach & Verhulst, 2008). Vanheusden et al., (2008) suggested that 65% of young adults (19-32 years of age) do not seek MH care when experiencing MH symptoms due to a number of reasons: inability to recognise symptoms; ignorance about availability of treatment and a belief that formal care would not have an impact upon symptoms.

However, on a positive note, a total of 68.1% of participants responded that they either agreed or strongly agreed that talking therapies can be an effective treatment for people with MHPs. This is promising as it indicates that the accepted consensus is that psychotherapy is effective. Talking therapies have been shown to alleviate symptoms of MHPs for a variety of individuals, with benefits including the facilitation of problem solving (Mind, 2019; Mental Health Foundation, 2019b). Explanations for the success of talking therapies have been attributed to their exploratory nature and thus the opportunity to identify causes of negative feelings, empowering individuals to facilitate change (Mental Health Foundation, 2019b). The National Institute for Health Care Excellence (NICE) recommend

certain types of talking therapies, e.g. cognitive behavioral therapy and counselling, for a range of MHPs such as anxiety, depression, obsessive compulsive disorder and post-traumatic stress disorder (NICE, 2019). Research within the literature supports this: Reavley & Jorm (2011) conducted a survey and found that counsellors were rated amongst the top three sources in terms of ability to help when experiencing a MHP; only close friends and general practitioners scoring higher. Furthermore, Yoshioka, Reavley, Hart and Jorm (2015) carried out a survey using 311 Japanese students, aged 15-19 years, in order to assess recognition and beliefs about treatments for MHPs. They found that for depression and schizophrenia, counsellors received the highest rating for levels of helpfulness.

This finding highlights an avenue to be explored in phase 2: the concept of YP learning about effective treatments as part of a MHL programme.

However, whilst YP do accept talking therapies are an effective treatment, they do not appear to know how to access them. Alarmingly, when presented with the statement *'If a friend had a mental health problem, I would know what advice to give them to get professional help'* a total of 41.6% of responses indicated that they either disagreed or did not know. It is widely accepted, and empirically supported that people will only seek MH support if they know how to access what is available (Kelly et al., 2007). Therefore, the current finding that YP are not aware of how to access professional help is worrying; research suggests that delaying or avoiding formal care for MHPs results in longer duration and worse outcomes (Clement et al., 2015). Dell'Osso et al., (2013) found that this effect was particularly damaging for those experiencing psychosis, bipolar depression, major depression and anxiety. Research suggests that peer to peer interactions are becoming increasingly important as part of recovery and support (Reavley & Jorm, 2011; Naslund et al., 2016). Moreover, one typically decides to reach out to a peer to discuss personal MH issues at a time when they are experiencing significant distress (Perry & Pescosolido, 2015). Therefore, the response that individuals receive from peers could prove detrimental to their recovery (Naslund et al., 2016).

Responses to '*If a friend had a mental health problem, I would know what advice to give them to get professional help'* further indicated to me that there is an opportunity for MHL programmes in schools; YP need to be equipped with the

knowledge, not only to support themselves but also their peers. In addition, it highlighted a concept to explore in phase 2; the extent to which YP knew what to do if they, or a peer, was experiencing a MHP.

At this stage, I would like to return to the theory of planned behaviour (TPB) (Ajzen, 1991); a frequently cited and influential model for predicting social behaviour (Ajzen, 2011; Bohon et al, 2016). The TPB suggests that behaviour is determined by INT (a motivational component, determined by an individual's attitude towards the behavior and subjective norms) and PBC (the extent to which people perceive they have control over engaging in the behaviour and is weighed up between the power of inhibiting factors versus facilitating factors.)

Thus, when applying the TPB to the current research, the more MH knowledge a YP has (INT) together with the extent to which they believe they have control over engaging in accessing support (PBC), both determine whether the YP will participate in the behavior of accessing support.

Therefore, when considering the answer to RQ1 and applying the TPB, it is important to remember the following: the more MHL YP have, the more likely they are to access MH support should they need to.

Results from the MAKS indicate a role for MHL programmes in schools. This supports existing research. For example, Bohon et al., (2016) conducted a study using 279 college students in California, in order to explore whether the TPB could be applied to YP accessing MH services. Participants were asked to complete three scales designed to measure attitudes, social norms and PBC. Bohon et al., (2016) concluded that the more positive the attitudes towards care and the higher the PBC, the greater the intention to seek MH support. Bohon et al., (2016) suggested that educating college students about MHPs and treatment and enhancing knowledge about available support might improve treatment rates for students suffering with depression. However, limitations to this study should be noted: the population sample consisted of American college students and so findings cannot be generalised to the Year 8 pupils in England. Furthermore, 35.9% of participants self-reported symptoms of depression ranging from minor to severe, approximately 10% higher than that of the population of YP (Frith, 2016). This limits the extent to which results can be generalised to the wider population within the current research.

To sum up, the results from the MAKS, which concentrated on the level of MH knowledge, indicate an opportunity to enhance YPs MH knowledge. The limited knowledge within my sample, supports research and suggests a role for MHL programmes in schools (YoungMinds, 2017; Moon et al., 2017; Atkins et al., 2010; Coles et al., 2016; Yoshioka et al., 2015). Concepts to be further explored in phase 2 include: YP learning about effective treatments as part of a MHL programme; the extent to which YP would know what to do if they, or a peer, was experiencing a MHP.

6.1.2 Stigma and links to phase 2:

Another aspect of MHL that was explored as part of this research, was YP levels of stigmatising views towards MH. The scale used to measure this was the PMHSS as it allowed me to explore participants perceptions of societal stigma separately to their personal stigma. Responses to this scale were particularly interesting and highlighted a concept to be further explored in phase 2; the possibility of perceptions of societal stigma acting as a barrier to accessing support for a MHP.

Responses revealed that participants levels of personal stigma (the amount of stigmatising views that one holds towards MH illnesses) were relatively positive: m= 46.26 (SD 7.11) where participants were able to achieve a mean score ranging between 0 (very high societal stigma) to 60 (very low societal stigma) where a neutral score was 36.

In contrast, participants scored lower on the societal stigma scale; measuring the amount of stigmatising views that one believes their peers hold towards MH (m= 38.15, SD= 5.96). This indicates that levels of YPs personal stigmatising views towards MH, is lower than their perceptions of public stigma.

For example, when presented with the statement '*I look down on children who visit a counsellor because they have emotional or behavioural problems*', participants achieved a mean score of 4.17 (SD, 0.88). A total of 79% of participants responded that they disagreed with this statement. In contrast, within the social stigma sub-scale, when participants were presented with the statement '*Most people look down on children who visit a counsellor because they have*

emotional or behavioural problems', participants achieved a mean score of 3.02 (SD, 0.91). In this case, a total of 30.9% responded that they disagreed with the statement. These statistics indicate that over three quarters of the sample population do not look down on those with a MHP yet they have a misconception that their peers do. Furthermore, within the personal stigma sub-scale, when participants were presented with the statement '*I would be happy to be friends with somebody who has emotional or behavioural problems'*, a mean score of 3.92 was achieved (SD 0.81). A total of 68.3 % agreed with this statement. However, within the societal stigma subscale, a total of 47.1% agreed with the statement '*Most children would be happy to be friends with somebody who has emotional or behavioural problems'* and a mean score of 3.49 was achieved (SD 0.89). Again, these statistics indicate a discrepancy between personal and perceptions of societal stigma.

Research into personal versus societal stigma appears to be lacking, especially that of adolescents. However, findings within the current study echo that of the limited research in that perceptions of societal stigma is generally higher than personal stigma (McKeague et al., 2015; Corrigan, Watson & Barr, 2006). Pedersen and Paves (2014) examined societal and personal stigma toward MH help seeking among a diverse range of young American adults (mean age 19 years). The authors found that participants endorsed higher levels of societal stigma than personal stigma.

This finding causes concern; perceiving one's peers and teachers to hold stigmatising views towards MH may act as a deterrent to approaching them, or others, for support. This idea is widely supported within literature (Tatlow-Golden & McElvaney, 2015; Jung et al., 2016; Clement et al., 2015). Corrigan (2004) stated that stigma may deter help seeking through two routes: desire to avoid shame and desire to escape public stigma. This view is supported by Clement et al., (2015) who, in order to explore the impact of stigma on help seeking, conducted a systematic review from 1980-2011 examining qualitative and quantitative studies from 5 data bases. Clement et al., (2015) suggested there were several types of stigma, including perceived stigma; one's views about the extent to which people in general hold stigmatising views towards MH (societal stigma). Clement et al., (2015) argued that perceived stigma (societal stigma) acts as a barrier to seeking help. However, it should be noted that participants in

this study were adults and so generalisability to adolescents is questionable. In fact, Clement et al., (2015) suggested that further research into adolescent stigma was needed.

6.1.3 Gender differences

In order to explore gender differences with regards to levels of stigmatising views, I conducted a paired samples t-test. Results showed that the gap between personal stigma and perceptions of societal stigma was significantly larger for females (males M= 6.22, SD 7.88; females M= 10.39, SD 7.54). The same gender differences are found within existing research: Pendersen and Paves (2014) found the discrepancy between the two types of stigma was largest amongst females. Wu, Bathje, Kalibatseva, Sung, Leong & Collins-Eaglin (2017) surveyed over 8000 American college students and identified three distinct stigma groups: high personal and low societal stigma; average personal and high societal stigma; low personal and low societal stigma. Wu et al., (2017) reported that 40% of participants fell into the average personal, high societal group and these participants were more likely to be female. Males were more likely to be in the high personal, high societal group. Wu et al., (2017) found that individuals within the high personal, high societal group reported higher levels of depressive symptoms. Implications include targeting tailored MHL programmes towards at risk groups (i.e. males) such as via media. The population sample in Wu et al., (2017) research had a mean age of 20 years and as such implications cannot be applied to current target population. However, the research offers support that males demonstrate higher levels of personal stigma.

6.1.4 Summary

In summary, the findings from the PMHSS indicate that the participants had a significantly higher level of perceptions of societal stigma than personal stigma. This highlighted a concept to be further explored in phase 2; the possibility of perceptions of societal stigma acting as a barrier to accessing support for a MHP. In addition, the discrepancy found between personal and societal stigma identified an opportunity to correct any misconceptions that peers hold stigmatising views towards MH (Pederson & Paves, 2014).

6.1.5 Attitudes towards seeking help and links to phase 2

In order to measure participants attitudes towards seeking help for MHPs, the MHSAS was used. The total mean score was 46.96, SD 8.79. A total score ranging from 9 (very negative views) to 63 (very positive views) was possible. Therefore, results from this study indicate that overall, participants have a relatively positive attitude towards seeking professional help for MHPs. However, there is an opportunity to enhance attitudes towards MH help seeking further.

Help seeking covers both the initiation of seeking help and also the engagement of care (Kovandzic et al., 2011) and is said to be a component of ones MHL (Jung et al., 2016). A minority of CYP with MHP access treatment, with rates as low as 25% of treatment being repeatedly reported across the UK, USA and Australia (Green, McGinnity, Meltzer, Ford & Goodman., 2005). This is a particularly concerning statistic as research indicates that failure to seek help prolongs illness and increases the frequency of relapse (Clement et al., 2015). This highlights the importance of exploring participants attitudes towards seeking help for MHPs.

There is limited research exploring YP's attitudes towards seeking professional help for MHPs in the UK. However, it is widely accepted in Australia that there is a reluctance for YP to seek help for a MHP (Rickwood, Deane & Wilson, 2007). Rickwood et al., (2007) stated that such a reluctance to seek help is a challenge for early intervention, which is vital during adolescence. Other research within Australia indicates a gender difference between attitudes towards seeking help; Donald, Dower, Lucke and Raphael., (2000) explored the help seeking attitudes of 3092 YP aged 15-24 and found that 30% of males, compared to 6% of females, said they would not seek help for a MHP. The current research does not corroborate such a finding as no gender differences were found. More recent research conducted in America by Lannin, Vogel, Brenner and Abraham & Heath., (2016) also found no gender differences. However, the population sample within the research conducted by Donlad et al., (2000) was older than that of the current study, offering a potential explanation for differing findings with regard to gender differences.

Existing research indicates the following possible reasons why YP may be reluctant to seek professional help: stigma; lack of perceived need; unaware of services available; scepticism about effectiveness of treatment (Eisenberg,

Downs, Golberstein & Zivin., 2009; Lannin et al., 2016; Lannin, Guyll, Vogel & Madon., 2013).

Other research suggests that as YP progress through adolescence they experience a growing need for autonomy and independence as well as an increasing belief that they should be self-reliant when faced with problematic situations (Wilson, Deane & Ciarrochi, 2005). The concept of self-reliance and resilience has been discussed within research (Brown & Carr, 2018; Gulliver et al., 2010). Brown and Carr (2018) considered the government policy guidance 'Mental health and behaviour in schools' (DfE, 2016) which distinguishes between 'a clinically diagnosed MH disorder' and 'less severe problems.' For 'severe needs' schools are advised to make the appropriate referrals to specialist agencies. However, for 'less severe problems' schools are advised to identify the problem as early as possible and build up the YPs resilience. Within the policy, the concept of resilience is defined as: a sense of self-esteem and confidence; a belief in one's own self efficacy and ability to deal with change and adaptation; a repertoire of social problem-solving approaches (DfE, 2016). Brown and Carr (2018) argue that, implicit within the policy is the view that by building psychological resilience infers a previous mental weakness or lack of ability to cope.

The point I would like to raise here is the potential danger of YP holding negative views towards seeking professional help for MHP due to a belief that they should be resilient, and as such, deal with the situation alone (Wilson et al., 2005; Brown & Carr., 2018; Gulliver et al., 2010). Gulliver et al., (2010) suggested exactly this, as they argued that a preference for self-reliance is a barrier to seeking help for MHPs.

In summary, the results from the current research indicates that participants have a relatively positive attitude towards seeking help. My findings do not corroborate with the limited research which states that YP have less positive attitudes towards seeking help. This therefore highlights an issue to be explored in phase 2; how YP feel about asking for help and potential barriers for doing so.

6.1.6 Summary to research question 1

In phase 1 of this research I sought to answer the question 'To what extent do Year 8 (12 and 13-year-old) children have MHL?'. I attempted to do this by measuring the three aspects of MHL; MH knowledge; stigma; attitudes towards seeking help.

Findings from the three scales indicate that there is an opportunity to enhance the MHL of Year 8 students. Specifically, results suggest that participants have limited MH knowledge and have a high level of perceived societal stigma. Together, this suggests limited MHL and highlights an opportunity to increase YP MH knowledge and reduce YP perceptions of societal stigma. One way to attempt this, is via MHL programmes in schools.

6.2 Research Question 2: To What Extent Does Mental Health Knowledge Correlate with Stigma

An aim of this research was to gain a broad sense of whether low MHL is associated with stigma towards MH within YP. In order to investigate whether MH knowledge correlates with stigma, I conducted a Spearman 1 tailed Correlation test, inputting data from the MAKS and PHMSS into SPSS. Two separate analysis were undertaken; one using data from the societal stigma sub-scale, the other using data from the personal stigma sub-scale.

A significant correlation was found at the 0.01 level between the MAKS and societal stigma, where $r_s = 0.281$. A positive, weak linear relationship was found; the higher participants scored on the MAKS, the higher the participants scored on the PMHSS societal stigma scale. This means that the more MH knowledge a YP has, the less they perceive their peers to hold stigmatising views towards MH.

A significant correlation was found at the 0.01 level between the MAKS and personal stigma, where $r_s = 0.133$. The higher participants scored on the MAKS, the higher the participants scored on the PMHSS personal stigma scale This means that the less MH knowledge a YP has, the less stigmatising views they hold towards MH.

In other words, findings from this study indicate that whilst MH knowledge is

correlated with stigma, the relationship is weak. When exploring societal and personal stigma separately, results suggest that levels of participant MH knowledge has a greater impact upon YP own stigmatising views as opposed to their perceptions of peers stigmatising views towards MH.

Findings from the current research concerning the relationship between stigma and MH knowledge, is supported within literature. The limited research within this area does suggest that MH knowledge is related to stigma (Thornicroft, Rose, Kassan & Sartorius, 2007; Rossetto, Robinson, Reavley & Henderson, 2019). For example, Chandra and Minkovitz (2007) conducted 57 in-depth interviews with 13-14 year olds in USA exploring how MH attitudes are shaped. Chandra and Minkovitz (2007) argued that MH knowledge contributes to MH attitudes among teens. Other studies within USA echo these findings: Bulanda, Bruhn, Byro-Johnson and Zentmyer (2014) evaluated a youth-led MH awareness campaign by measuring MH knowledge and stigma pre-and post-intervention. One hundred and twenty students took part in the intervention, aged 11-13 years, and results suggested that raising YP practical knowledge about MH can lead to less stigmatising attitudes. Bulandu et al., (2014) suggested that peers are a good resource for stigma change.

However, other research is less convincing: Pinto-Foltz, Logsdon and Myers (2011) evaluated the intervention 'In our own voice' which aimed to improve MH knowledge in order to reduce stigma. The intervention took pace in the USA, using 156 13-17-year-old females. Results indicated that the intervention significantly raised participants MH knowledge but did not significantly lower participants stigma levels. Moreover, in England from 1993- 2003 the Department of Health commissioned a campaign to increase public MH knowledge. Levels of MH knowledge and stigma were measured pre-and post-campaign and findings identified that there was not a significant decrease in levels of stigmatising views towards MH.

On the other hand, anti-stigma campaigns tend to measure changes in knowledge and attitudes, as opposed to behaviour (Rossetto et al., 2019) therefore the extent to which increased MH knowledge impacts upon stigmatizing behaviour is unknown; it may be that anti-stigma strategies which focus on increasingly MH knowledge, have greater positive effects than have been identified (Rossetto et al., 2019).

In summary, the extent to which MH knowledge correlates with stigma is slight. This finding, together with the lack of convincing evidence exploring YP within the UK, means that more research is needed before strong conclusions about the extent to which MH knowledge correlates with stigma can be drawn. I plan to investigate this concept further in phase 2.

6.3 Correlation Between Stigma and Attitudes Towards Seeking Help

When analysing the data set from the three scales, I decided to explore a potential relationship between stigma and attitudes towards seeking help. I conducted a Pearson 1 tailed Correlation test, inputting data from the PMHSS and MHSAS into SPSS. Two separate analysis were undertaken; one using data from the societal stigma sub scale, the other using data from the personal stigma sub scale. The results were interesting: A positive, weak linear relationship was found between personal stigma and attitudes towards seeking help ($r = 0.136$, $p=<0.01$) This means that the more positive one's levels of personal stigma, the more positive their attitudes towards seeking help. Interestingly, no significant relationship was found between societal stigma and attitudes towards seeking help ($r= 0.88$, $p=0.65$).

The above findings suggest that YP attitudes about seeking professional help for MHPs, are more affected by their personal stigma as opposed to their perceptions of their peers' levels of stigmatizing views. and their perceptions of their peers' levels of stigmatising views. This finding is supported by previous research; Eisenburg et al., (2009) conducted a study using a random sample of 5555 students from 13 universities across USA. Not only did the results show that societal stigma (M=2.43) is considerably higher than personal stigma (M=1.01) but also that personal stigma was significantly associated with a lower likihood of receiving support (OR = 0.80, $p=<0.01$) whereas societal stigma was not. However, other research suggests that both personal and societal stigma negatively predict help seeking attitudes (Barney, Griffiths, Jorm & Christensen, 2006).

Personal and societal stigma aside, the argument that stigma is a factor which affects YPs willingness to access professional MH support, is widely supported within literature. For example, Clement et al., (2015) conducted a systematic review of 144 studies to explore the impact of MH related stigma on help seeking for MHPs. Five electronic data bases were examined and the authors concluded that stigma has a 'small to moderate sized negative effect on help seeking' (p.1). However, as Clement et al. (2015) highlighted, this systematic review included adults as opposed to CYP and recommended that more research exploring the relationship between stigma and help seeking in adolescents should be undertaken. Prior to Clement at al., (2015) work, Chandra and Minkovitz (2006) did explore the relationship between help seeking and stigma with adolescents; 274 13-14-year-old girls in USA participated and findings suggested that both levels of MH knowledge and levels of stigma surrounding MH affected their willingness to access help. It should be noted that this study arguably lacked a diverse population of participants, consisting only of girls from medium/high socio-economic backgrounds. Thus, the extent to which these findings can be generalised to the wider population of YP in England, could be disputed.

Salaheddin and Mason (2016) attempted to identify barriers to seeking help for MHPs by conducting a cross sectional online survey using 144 participants aged 18-25 in the UK. Stigma was found to be a key barrier with the most highly rated stigma barrier being 'feeling embarrassed or ashamed' (81% of participants selected this response). Again, limitations of the study are apparent; the survey was online which limits respondents to those who have access to the internet. This method raises the possibility of selection bias; the potential of respondents consisting largely of people who have a view they wish to share, thus skewing the sample population resulting in a non-randomised sample (Tourangeau & Yan, 2007). Moreover, whilst this study did include UK participants, the age range was older than the cohort within the current research. Nonetheless, the view that stigma is a barrier to seeking help can be found easily within a literature search, with researchers stressing the need for evidence based MHL programmes designed to reduce stigma and improve access to care (Arango et al., 2018).

Numerous researchers have implemented MH awareness programmes in an attempt to lower levels of stigma. For example, Pinfold, Toulmin, Thornicroft, Huxley, Farmer and Graham (2003) conducted a school based MH intervention with 472 14-15-year-old UK secondary school students. Participants attended two MH awareness workshops and completed pre-and post-questionnaires measuring their stigma levels and behavioural attitudes. Participants were followed up six months post intervention. Positive changes in student views were recorded as from a possible mean score of -5 to +5, results were as follows: Attitude scores rose from a pre-intervention mean of 1.2 (SD, 1.8) to 2.8 (SD, 1.9) at the one week follow up. At the six months follow up, the mean score had dropped slightly to 2.3 (SD, 1.9). These findings suggest that educational sessions are a useful approach to improving the stigma levels of YP in the UK. However, no control group was used in this study, thereby weakening the findings. Moreover, arguably measuring attitudes at six months post intervention, is still relatively short term and offers no indication as to whether effects were long lasting. This is the case for much of the research exploring effects of anti-stigma campaigns, with Rosetto et al., (2019) suggesting a need for longitudinal research.

This thesis will now detail the specific design and procedure of phase 2 of the study. The results of phase 2 will then be presented in diagrams displaying themes with evidential text extracts, followed by an analysis and discussion of phase 2 results.

7.0 Phase 2 Methodology

7.1 Restating the Aims of Phase 2

Phase 2 sought to answer:

RQ3 : 'What are the views of Year 8 pupils (12 and 13 year olds) regarding prospective MHL programmes in schools?'

RQ4 : 'What are the views of SENCos regarding prospective MHL programmes in schools?'

RQ5 : 'How might EPs facilitate MHL programmes in schools?'

This phase of the study was split into two parts, both ustilising qualitative methods. Phase 2a comprised of focus groups (FGs) with YP and sought to answer RQ3 and RQ5. Phase 2b included semi-structured interviews (SSIs) with school SENCOs and sought to answer RQ4 and RQ5.

7.2 Construction of the Focus Groups

The two phases of this study were linked by the responses to the questionnaire. The information obtained from phase 1 provided topics of which to explore and seek clarity on. For example, perceived societal stigma acting as a barrier to seeking help. The qualitative design of the FG provided the opportunity to elaborate on and add depth to the responses from the questionnaire, as well as exploring YP views on prospective MHL programmes.

The construction of the FG was based heavily upon guidance by Kruger and Casey (2002). For example, the groups contained between 4-10 participants, participants sat in a circular position, a short introduction was given, pre-determined questions were posed, probes were used and a verbal summary was provided at the end, of which participants were invited to add to. See Appendix 13 for a full FG schedule.

7.3 Rationale for Using Focus Groups

A FG is defined by Powell and Single (1996) as "a group of individuals selected and assembled by researchers to discuss and comment on, from personal experiences, the topic that is the subject of research' (p. 499).

In order to answer RQ3 and RQ5, I decided that FGs would be the most suitable means of collecting qualitative data. This was for several reasons, one being Bagnoli and Clarks (2010) argument that the space that a FG provides, facilitates debate and the unmasking of opinions allowing people to explore their thoughts more deeply than they may in a 1:1 interview. This argument is supported by Kitzinger (1994) who argues that it is the interaction between participants that is useful in terms of eliciting rich data and by Madriz (2000) who states that a group situation encourages free expression of ideas during informal interaction.

I decided that FGs were a particularly suitable method to elicit YP views due to the limited structure (Skop, 2006) and non- judgmental setting (Powell & Single, 1996). Research suggests that YP feel more able to communicate their views within this informal setting amongst a group they feel similar to (Bagnoli & Clark, 2006) as they feel empowered (Madriz, 2000; Powell & Single, 1996). Moreover, FGs have been shown to facilitate the discussion of unanticipated issues and ideas (Skop, 2006), which is particularly pertinent for RQ3 and RQ5.

As with all methods of data collection, FGs are not without disadvantage. For example, the dynamics of a FG gives way to the issue of conformity; participants may follow the general argument of the group without deviating to offer a differing opinion or point of view (Skop, 2006). As per guidance within the literature (Skop 2006; Krueger & Casey, 2014) I aimed to limit conformity by paying attention to students' contributions (Hyden & Bulow, 2003) and vocalising approval when an alternative view was expressed.

Another potential limitation of the method of FGs is the degree to which, I as the moderator, was able to produce a standardised process and therefore comparability across groups (Skop, 2006). FGs lend themselves to a fluid, participant led process which may achieve spontaneous comments that may touch on issues that were not predetermined by the researcher (Skop, 2006). Consequently, the questions and structure may differ between FGs. However,

arguably this 'limitation' can result in an accumulation of information (Skop, 2006). Based on a recommendation by Morgan (2002) I decided upon a balance between standardised questions and open discussion; a set number of pre-determined questions would be asked within the first half of the FG, leaving the second half to open discussion.

7.4 Construction of the Semi-Structured Interview

The information obtained from phase 1 and the FGs (phase 2a) guided the construction of the preset questions within the SSIs. For example, learning that a significant number of YP were not aware of the MH resources available within their schools, led me to explore the issue of how school staff communicate these resources to all pupils.

The construction of the SSI was heavily guided by Doody and Noonan's (2013) evidenced based guidance on preparing and conducting interviews. Doody and Noonan (2013) suggest that questions be pre-arranged in a set order, starting with the simplest and working towards the more complex. Doody and Noonan (2013) also suggest that the interview should take place in a private environment in which the participant considers to be safe. Furthermore, questions should not be leading and the researcher should aim to stay impartial. At the beginning of the interview, I reintroduced myself, my role and aims of the research. I reminded each SENCo of their right to withdrawal and explained that I would be audio recording the interview. I added that all data would be kept anonymous and the audio tape would be destroyed once the data had been transcribed. This information was also produced in writing and SENCos were asked to sign the consent form (please see Appendix 5).

7.5 Rationale for Using Semi-Structured Interviews

SSIs are described by Fylan (2005) as "conversations in which you know what you want to find out and so you have a set of questions to ask and a good idea of what topics will be covered- but the conversation is free to vary and is likely to change substantially between participants" (p.65)

A search within the literature, suggests a range benefits to using SSIs as a method of collecting data (Fylan, 2005; Cohen & Crabtree, 2006; Doody & Noonan, 2013; Smith, Flowers & Larkin, 2009). Many of the said reasons for selecting SSIs fitted well with the pragmatic approach to this research. For example, SSIs are a time efficient way of collecting rich, qualitative and comparable data (Cohen & Crabtree, 2006; Fylan, 2005). Furthermore, pre-arranging a set of questions allowed me to be prepared and perform the interview with competence (Cohen & Crabtree, 2006) whilst still allowing the space for the interviewee to express their views in their own terms (Cohen & Crabtree, 2006). This space allows participants to produce a rich and deep accounts of their experiences and views as well as producing the opportunity to explore issues that arise spontaneously (Smith et al., 2009). Please see Appendix 14 for the full interview schedule.

8.0 Phase 2 Method

8.1 Focus Group Pilot

To ensure the method of FG was able to elicit information to answer RQ3 and RQ5, I conducted a pilot study in a local independent school. Parental consent was obtained (see Appendix 4). The FG contained four YP (two male, two female) and lasted for 30 minutes. The method of creating a collective mind map was also tested during the pilot study. Following the pilot of 2a, no changes were made to the method.

8.2 Focus Group Sample Population

The sample population for phase 2a were Year 8 pupils that may or may not have taken part in phase 1. SENCos were asked to send out information and consent forms to the parents/carers of 12 students in Year 8, with the aim of selecting 6-10 participants to take part (please see Appendix 4 for a copy of the parental information and consent form). To ensure results could be generalised to the wider population of Year 8 students (Thomas, 2017) SENCos were asked to select a group of participants that contained the following: equal amount males and females; a range of academic ability (two above age-related expectations (ARE), two at ARE and two below ARE; at least one pupil with SEND).

8.3 Focus Group Procedure

Participants in each school were assembled into one room with a circular table. After a brief introduction, each SENCo left the room. I then gave a brief description of my research and the current task. Participants were told that they could leave at any time and that I would be in the room for about 30 minutes after the session, should anyone wish to talk to me about any resulting issues raised.

8.4 Focus Group Qualitative Analysis

Qualitative research methodologies refer to methods that can describe and explain behaviour and interactions, without statistical procedures (Fossey,

Harvey, McDermott, & Davidson, 2002). Qualitative methods are therefore subject to bias interpretation of findings and as such it was important that I, as the researcher, was able to offer a transparent account of analysis of the findings (Fossey et al., 2002). To ensure I was to produce credible data that reflected the perspectives of the participants I planned to record the participants views transparently by creating a mind map, collaboratively with participants. (Fossey et al., 2002).

Within the literature, different ways of recording data obtained during a FG are described. Tong, Sainsbury and Craig (2007) conducted a thorough review of qualitative methods, including FG and SSIs, and devised a 32-item checklist concerning how to quality assure qualitative methods. Recording of data is within the list; Tong et al., (2007) suggest that whilst audio recording is the most accurate means, it is not always appropriate as it can be overly intrusive (Fossey et al., 2002) and that providing justification for chosen means of recording data is the most important aspect of data recording. Also included in the checklist, is the requirement of clear feedback to participants regarding interpretations of their responses.

With these guidelines in mind, as well as the pragmatic approach to this research, I decided that obtaining signed consent from parents/carers for audio recordings of their children's views on a potentially controversial and sensitive issue, could be problematic. I decided upon the alternative method of generating a collective mind map of participants responses to each question posed, and trajectories generated. (Please see Appendix 15 for an example). This had the benefit of enabling me to accurately summarise the groups responses and views at the end of each FG.

Responses were thematically analysed following the six phase guidelines produced by Braun et al., (2014). (Please see Appendix 21 for Braun et al., (2014) for the table displaying the phases of thematic analysis). Thematic analysis allows the researcher to identify, analyse and report themes within data using an inductive (bottom up) process. This means that themes can be generated from the data organically as part of an active process, as opposed to deductively (top down) whereby themes are identified first and data is them found to match said

themes (Braun & Clarke, 2006). This enabled me, the researcher, to identify connected patterns, highlighting overarching themes (Braun & Clarke, 2006).

8.5 Semi-Structured Interview Pilot

In order to ensure that the pre-arranged questions sought to answer RQ 5 and RQ 6, and that the questions posed made sense to the interviewee, the interview was piloted (Fylan, 2005). The pilot interview took place within a local independent school and lasted for 25 minutes. The interview was audio recorded to ensure the equipment captured the interview in full. The recording was deleted post interview. No changes were made to the structure following analysis of the pilot.

8.6 Semi-Structured Interview Sample Population

The sample population for phase 2b were the SENCos from each of the schools that had participated in phase 1. Invitations were sent via email to each of the SENCos, detailing their role in phase 2b. Three of the four SENCos accepted their invitation and a time was arranged for me to visit each SENCo at their setting on a 1:1 basis. The fourth SENCo did not take part in phase 2b as was absent from work due to long-term sick leave.

8.7 Semi-Structured Interview Procedure

I met with each SENCo at their school setting on a 1:1 basis in a private room. I reminded each SENCo of my role as a researcher and the aims of the research. I asked them if I could audio record the interview to ensure I captured all of the information. I informed each SENCo that once I had thematically analysed their responses, the audio recording would be deleted and that their responses were anonymous. All SENCos signed a consent form, confirming they had understood and agreed to this procedure. An example of this information and consent letter can be found in Appendix 5.

8.8 Semi-Structured Interview Qualitative Analysis

As described above in section 8.4 (FG qualitative analysis) it was important to produce data that was an accurate reflection of participants views (Fossey et al., 2002). Given that this phase used adult participants, I regarded the most pragmatic approach to be audio recording and transcribing of data. The

transcription software Wreally was used to produce a full transcription of the interviews (please see Appendix 17). I then thematically analysed the transcripts following the six phase guidelines produced by Braun et al., (2014) (Appendix 21).

9.0 Results Phase 2

This chapter will detail thematic analysis from both parts of phase 2; the FGs and SSIs. I will then discuss the findings from both parts together.

9.1 Thematic Analysis of Focus Groups with Young People

9.2.0 Coding the data and finding themes:

Following thematic analysis guidelines from Braun and Clarke (2006) the first phase to analysing the data from the FGs was to familiarise myself with the data. This process involved the reading and re-reading of the quotes that I had noted from each FG against the table plans to ensure that I had assigned the correct quotes to the correct participants. Furthermore, re-reading the quotes and the maps that I had drawn up collaboratively with participants, reinforced my understanding of the comments made; it was important that I had conveyed the correct meanings. Please see Appendix 15 for an example of a collaborative mind map from the FG and Appendix 16 for an example of a FG transcript.

Phase 2 also involved re-reading, this time with a focus upon repeating patterns of interest. I did this using multiple copies of the data and highlighter pens, assigning particular extracts (with shared meanings) to particular codes. This was an inductive method; the whole of the data was scrutinised and codes were not pre-determined by me, the researcher.

During the third phase I sorted the codes into themes; I examined the codes, looking for overarching themes into which the codes fitted. At this point, when codes required more definition, sub themes were also identified. I then created thematic maps to illustrate the relationship between themes, sub-themes and codes.

Phase four was the process of reviewing the themes for 'internal homogeneity' and 'external heterogeneity' (Braun & Clarke, 2006). Internal homogeneity is when the data within the themes form a unified whole and external heterogeneity

is when the data within each theme is sufficiently distinct from other identified themes. In order to ensure validity of the themes, it was at this point that I returned to the original data set to check that the meanings identified were reflected in the created themes.

Phase five was the process of refining and defining the themes by stating clearly the principle of each theme and how it relates to the research questions.

The last phase included a write up of each theme, providing examples of the data to illustrate the relevance to the research questions.

In order to display the findings succinctly, I assigned each participant with a code. Each quote will be attached to the relevant participant code, as exampled in Table 10. For a full table, refer to Appendix 20.

Table 11

Examples of Participant Codes

Title	Code
Focus Group 1, participant 1	FG1 A
Focus Group 2, participant 2	FG2 B
Focus Group 3, participant 3	FG3 C

In the following section, a thematic map is provided, followed by an analysis of each sub theme with example quotes. For a full thematic table, please see Appendix 18. Please note, the italicised sections are taken from notes made during the FGs and therefore may not be direct quotations from the YP.

9.2.1 Theme 1: attitudes towards seeking help

Figure 7 Theme 1: Thematic Map
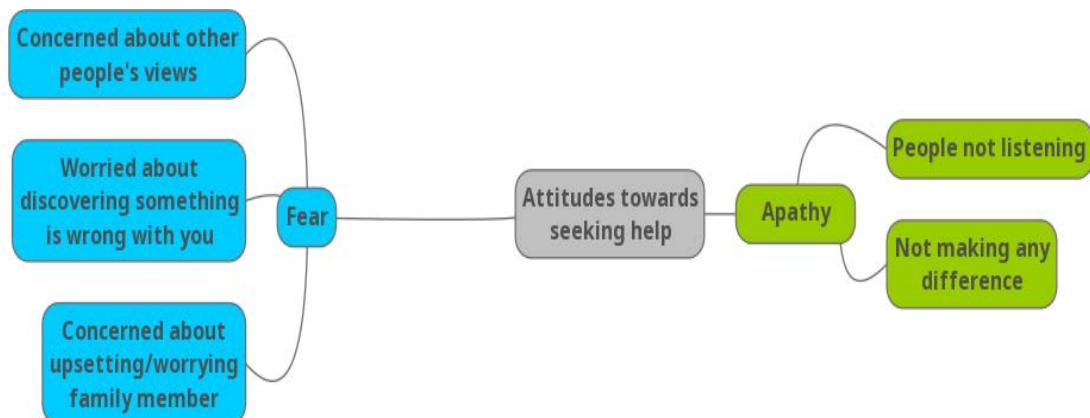
9.2.2 Sub-theme: fear

<u>Concerned about other <mark>peoples'</mark> views:</u> All of the participants across all FGs, identified concern over what other people may think of them as a deterrent to seeking help for a MHP. When I raised the issue of what a YP may feel about seeking help if they had a MHP, there was a strong message of 'fear' across all three FGs. Some participants vocalised the fear of what their peers would think of them:

"I'd worry what my mates would think..." FG1 D

Other participants expressed concern over what their family members would think of them:

"I dunno…I'd be too scared to get help, I think, 'cos I'd like be worried about what my mum and dad would think of me. You know, like disappointed…"

FG2 A

Two participants vocalised that they had experienced MHPs and had benefitted from help. Both participants spoke retrospectively and explained how scared they felt about potential judgements from others, including their teachers and peers:

"I was really scared about getting help as I thought 'oh my god…my friends are gonna find out!' I was worried they would think I was crazy and treat me differently. I know that's not true now, my mates were great, so great. But at the time I was feeling so down and I hadn't been through anything like that before so I didn't know. " FG1 A

Worried about discovering something is wrong with you: Over half of the participants vocalised that they would be worried about getting help for fear of discovering that they had something 'wrong' with them. In all three FGs, this prospect was discussed. In FG1, one person volunteered this fear and two others uttered agreement. In FG2, three participants vocalised this fear with two others agreeing and in FG3, two people vocalised this fear with four participants agreeing.

Examples of comments coded into this theme are as follows:

"I reckon some people would be scared to find out if they had something wrong with them so they just wouldn't go and get help…" FG1 B

"I wouldn't want to find out I was mad or had problem with my brain or something!' FG3 I

Concerned about upsetting /worrying family member: Eight out of 21 participants told me that a YPs attitude towards seeking help for a MHP might be affected by the concern for the welfare of their loved ones:

"Some kids, like, wanna protect their families and that. Y' know, so if they like went to get help then their parents would find out and be really worried about them." FG3 C

"I was really worried about upsetting my mum, like, worrying her. That definitely made it harder for me to tell her…" FG2 B

9.2.3 Sub-theme: apathy

People not listening: The idea that seeking help was not worthwhile was brought up in all three FGs. In each group, one participant expressed this view and it was echoed by other participants:

"I'd be like, what's the point…People won't actually listen. They might belittle it and say stuff like 'Oh, you'll get over it…'" FG3 G

"Oh my God, so true. The teachers would be like 'don't be so silly, there's nothing wrong with you…get on with it'…" FG3 I

Not making any difference: Participants referred to the idea that receiving help would not have a positive impact upon their MH. This point was raised by two participants in two of the FGs and both times the view was supported by two other participants:

"Kids might not wanna get help as it must be so hard to actually make that step and for what? They might think that it won't actually work anyway…so what's the point of putting yourself out there. No point." FG2 H

"Yeah…it's a big deal asking for help and would it even make a difference? I think it might, but I really don't know. So, I can totally see why some kids might not bother" FG2 C

9.3 Theme 2: Stigmatising Views Around Mental Health Problems

Figure 8 Theme 2: Thematic Map

9.3.1 Sub theme: perceived weakness

Boys are strong: The view that it would especially difficult for boys to admit they had a MHP, as opposed to girls, was expressed in all three FGs. This viewpoint was agreed with by the majority of participants, with participants adding that boys have a particular stereotype to uphold. Discussions around this notion unveiled participants views that MHPs are seen by the wider community as a weakness and that this stigmatising view is particularly difficult for boys experiencing a MHP as society expects boys to be the opposite of weak:

"Well, I'm not being funny or anything, but like, it's harder for boys I think, 'cos boys are supposed to be 'big men'. You know, strong." FG2 G

Disability: The notion of MHPs being viewed or treated as a disability and that this is a stigmatising view of MH, was raised in all three FGs. Seventeen of the 22 of the participants either vocalised this opinion or agreed to it:

"Having a mental health problem is treated like having a disability or something." FG1 E

"Pretty sure the kids with the mental health problems go to room x, you know, the one with all the SEN kids. Don't know how they end up there." FG3 H

9.3.2 Sub theme: embarrassment

<u>Uncool:</u> The sub theme 'uncool' has been created as, a number of comments from participants concerning the embarrassment of having a MHP, directly referred to the notion that to have a MHP would be incompatible to being 'cool' or 'popular'. Example comments are as follows:

"I think it's actually even harder for popular, sporty kids to get help for mental problems as it's like, further for them to fall." FG2 G

"It would be really hard for a popular kid to admit they had a MH problem."

FG3 B

<u>Being different from peers:</u> This sub theme has been created as, when discussing the embarrassment associated with having a MHP, some participants specifically referred to the notion that most CYP want to 'fit in' with their peer group, appear 'normal' and that falling outside of this norm would be embarrassing. For example:

"For a lot of kids at school, you just want to fit in and be like your mates. You might not want to get help as people will see you as different to them." FG3 D

"Well, it's embarrassing…we all, well most of us, just wanna be 'cool' and that. Having a mental health problem isn't exactly cool is it. D'ya know what I mean?"
FG2 F

9.4 Theme 3: Barriers to Seeking Support for a Mental Health Problem

Figure 9 Theme 3: Thematic Map
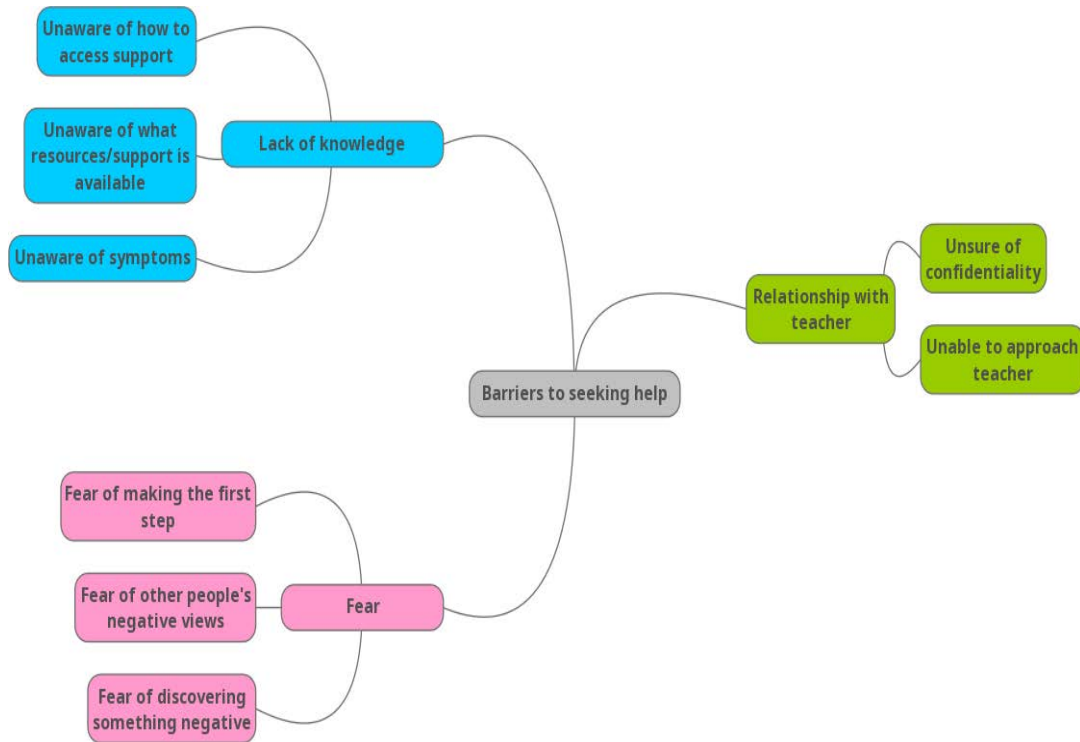
9.4.1 Sub-theme: lack of knowledge

Unaware of what resource/support is available: Apart from the two participants who had previously accessed MH support, alarmingly, none of the participants were aware of the MH resources within their schools that were available to them and their peers. Approximately half of the participants knew that there was a particular adult within the school whom dealt with pastoral care or that there was a specific room that YP could access, however none of the participants could confidently name an adult or a room. Some participants were aware that there were YP in their schools that did access MH support on some level, but again, they did not know what kind of support and who it was available to. Examples of comments reflecting these views are as follows:

"I don't know what help there is in school. I think I'd probably google it." FG3 A

"No idea (what support is available in this school). Is there?" FG1 E

<u>Unaware of how to access support:</u> This sub theme has been created as it reflects the views of the vast majority of participants. Apart from the two participants who had accessed MH support, none of the participants knew how to access the support that was available within their school. Even when the discussion developed and the participants were made aware that there was a school counsellor, for example, none of the participants could say how to access this support.

"I wouldn't have a clue who to ask for help or where to go. It isn't spoke about. Only the kids who are in really bad way know, but if something started to go wrong for me or a mate I wouldn't know where to go." FG3 E

"Pretty sure the kids with the mental health problems go to room x, you know, the one with all the SEN kids. Don't know how they end up there." FG3 H

<u>Unaware of symptoms</u>: When discussing with the participants reasons why YP may not seek help for a MHP, the idea that some YP may not realise they had a MHP, became apparent:

"They may not identify it in themselves" FG2 G

"Maybe they wouldn't realise they had a problem. They might just think they were having a bad day(s) and should get over it" FG3 I

9.4.2 Sub theme: relationship to teacher

<u>Unsure of confidentiality:</u> When discussing barriers to seeking help, many participants discussed their relationship to a particular teacher being a facilitator

or inhibitor. Within this, the concern that a teacher would not respect their confidentiality was expressed; these participants explained that for this reason they would be reluctant to confide in a teacher. Examples include:

"Um, not sure I could tell a teacher. There was one I got on really well with but she's left now. There isn't really anyone else I'd trust not to tell everyone."

FG1 D

"No, I wouldn't tell a teacher. I'd be too worried that they'd go and blab." FG2 G

<u>Unable to approach teacher:</u> Within the discussions about how the YPs relationship to the teachers could hinder them asking for help, a number of participants explained that they would not feel comfortable approaching a teacher. Some went on to say that this was because their teachers were particularly busy and lacked the time, some explained that they did not feel close enough to them.

"I can't think of a teacher I would want to tell. Some of them are pretty stressed. Just, no… I couldn't speak to any of them." FG3 E

"No, I wouldn't approach one of my teachers. There isn't anyone I know well enough, if that makes sense." FG1 D

9.4.3 Sub theme: fear

<u>Fear of making the first step:</u> When discussing the prospect of a YP asking for help for their MHP, a strong theme of fear emerged. I have split this theme into three, the first one being the 'fear of making the initial step'. This is because many participants expressed this specific concern. For example:

"I think it would be scary making the first step." FG1 D

"The scariest thing was the very first time I told my mum. I was sooo scared. I was so worried about what she would say and think. Embarrassed, everything. So yeah, I think actually telling someone for the first time is so scary that it stops people from getting help." FG1 A

Fear of other people's negative views: Another sub theme of the theme 'fear' was the fear of other peoples' negative views. This concern was expressed by the majority of participants:

"You'd be really worried about what people would think of you if they found out you were getting help for mental health problems. They might think you're mad or something." FG2 C

Fear of discovering something negative: This sub theme of fear reflects a concern of a number of participants. These YP explained that they might be reluctant to seek help for a MHP for fear of discovering that they had a serious illness:

"Some people could be scared of getting help in case they find out there's something really wrong and then they might worry that they wouldn't get better." FG3 D

"I reckon some people would be scared to find out if they had something wrong with them so they just wouldn't go and get help…" FG1 B

9.5 Theme 4: Ways to Support Young Peoples' Mental Health Literacy in Schools

Figure 10 Theme 4: Thematic Map
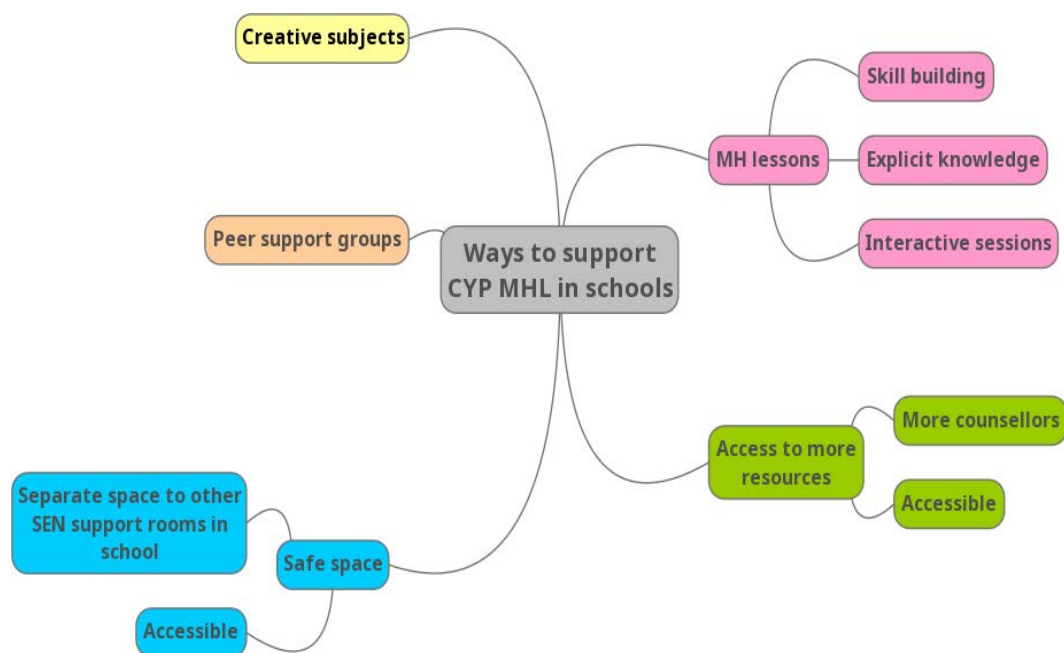
9.5.1 Sub theme: safe space

Separate space to other SEN support rooms in the school: I asked the participants in each FG to think of ways that their schools could help support their MH and develop their MHL. The idea of having somewhere to go was generated within each FG; more than half of the participants agreed that for someone who was experiencing a MHP, it would be helpful to have access to a quiet separate space within the school. The participants stressed that this room should be a different one to the room that already exists in their school(s) as the current room is used by children with SEN, including behavioural difficulties. The reasons given were that it was important that the room was calm and quiet and also that you could access it without others thinking you had a SEN or a behavioural issue.

"I think that we do have a somewhere where people can go, but the teacher has to give you permission. But it's where all the kids with special needs go and all the ones that don't behave in lessons…so it's really noisy. It would be good to

have somewhere, like, on its own so if people saw you going there they wouldn't think that you were one of those other kids." FG2 G

Accessible: When participants discussed having a safe space within their school, one individual from each FG suggested that the room be accessible. Many of the other participants within the FG then agreed. By accessible, I am referring to the suggestion that the safe space be open to all students, as oppose to referral only. Some participants discussed knowledge of a safe space with their school however, as far as they were aware, it was only available to particular students.

"There is a room you can go to here, but you not just anyone. You have to be given permission by a teacher." FG1D

9.5.2. Sub theme: peer support groups

This theme does not contain any sub theme categories as the comments relating to the prospect of having peer support groups did not contain enough variation to require the theme be split. The suggestion of peer support groups was put forward by at least one participant in each FG and supported by at least two others each time. A peer support group was described as a place that YP with similar experiences and concerns could talk confidentially within a small group. A total of three participants suggested the peer support group be similarly arranged to the FG they were currently in; informal, intimate and relaxed.

"…talking to other kids in a group. Where you can get together and talk about MH together. A group like this." FG3 B

"Yeah, so you can talk with other kids that are going through the same thing. I think that would be good." FG3 C

9.5.3. Sub theme: access to more resources

<u>More counsellors:</u> Participants in each FG spoke about the need to increase the number of counsellors in their school. Comments from participants echoed findings identified in phase 1; the value that YP place upon talking therapies.

"I think there should be more counsellors at school so that we can get help quickly. You could sign up to have an appointment, like the next week or something." FG1 D

"Having more counsellors, definitely. Talking to someone that wasn't in my family really helped me." FG1 A

<u>Accessible:</u> When the participants spoke about having more counsellors in the school, they added that it was important that the counsellors, and other resources within the school, be easily accessed. It became apparent, across all three FGs, that the YP were not aware of what resources and support was available to them in their school and furthermore they would not know how to access it. This category was created to reflect the ideas from participants that YP should all know *how* to self-refer and access the support within school.

"…but you'd need to know who to ask to get to see a counsellor. It's no good having more if you don't know where they are there or how to book an appointment." FG3 E

9.5.4 Sub theme: creative subjects

This theme does not contain any sub theme categories as the comments relating to the prospect of having creative subjects within the national curriculum did not contain enough variation to require the theme be split. This sub theme has been created to reflect the idea from a number of participants, across all three FGs, that increasing the amount of creative lessons would be beneficial to students MH.

"We used to get to do photography and I loved that, it really helped me relax. I could just be me. Now you can't even do what you want in art, the teachers says you've drawn it wrong." FG3 C

9.5.5   Sub theme: mental health lessons

When asked about ways in which their schools could better support pupils MHL, many participants expressed a desire for regular MH lessons. As the researcher, I provided each FG with a selection of ideas in which students could be taught about MH. Options included: visiting speakers; assemblies; a six week MH course; optional MH lessons; compulsory weekly MH lessons. The overwhelmingly opinion across all three FGs was for students to participate in weekly, compulsory MH lessons. Themes of prospective lessons are as follows:

Interactive sessions: More than half of the participants explained that prospective MH lessons should be interactive, giving pupils the opportunity to ask questions, elaborate on points made and be an active member of the lesson. Participants explained that interactive sessions would encourage the normalising of talking about MH to both teachers and peers.

"We should have lessons where you can actually talk, have discussions in class. Not just the teacher telling you stuff. Like what we're doing now, that would be good." FG1 A

"If we spoke about mental health stuff in class I think it would make it easier to talk to teachers if we had a problem…we'd be used to talking to them about it."
FG2 F

Explicit knowledge: When asked if participants had any lessons regarding MH, the majority of participants referred to their 'PSHE' lessons. It was explained to me, several times, that topics within PSHE involved 'wellbeing' and 'looking after yourself'. However, the majority of participants vocalised that they did not learn about MH in these lessons; the subject was considered by most participants, across the three FGs, to be a 'waste of time'. With this information in mind, when

participants were asked to describe the 'ideal' MH lesson, one of the features included the content of the lessons. Participants expressed a desire to have explicit conversations about MH with their teachers where they could be informed about signs and symptoms of MH, ways to support those experiencing MHPs and ways to help themselves. Participants also told me they would like statistical information regarding success rates and longevity.

"Learning about things that we don't already know, what are all the mental health problems and how to get better. In PSHE we just get told load of stuff we already know. You know, about bullying and things. It's quite patronising."

FG1 D

Skill building: Another feature of prospective MH lessons suggested by the participants, was that of learning skills to look after one's own MH. Ideas such as relaxation and mindfulness were suggested by some participants.

"It would be useful to learn about ways to sort of help yourself." FG1 A

In summary, thematic analysis of the FG data identified 4 key themes which are important to understanding how to raise the MHL of YP. Themes identified are: attitudes towards seeking help; stigmatising views around MH; barriers to seeking help; ways to support YP MHL. Within each theme, sub-themes were identified and have been discussed.

I will now detail the thematic analysis from phase 2b (interviews with SENCos).

9.6 Semi-Structured Interviews Thematic Analysis

In the following section, a thematic map is provided, followed by an analysis of each sub them with example quotes. For a full thematic table, please refer to Appendix 19.

9.7 Theme 1: Barriers to Young People Getting Help

Figure 11: Thematic Map
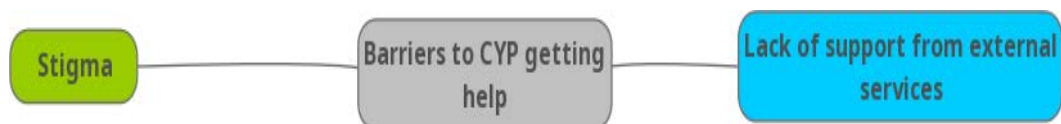
9.7.1 Sub-theme: stigma

Two of the three SENCos considered stigma around MH to be acting as a barrier to accessing help; SENCOs suggested that YP do not want to be associated with the negative connotations associated with MH.

"There are still words that kids use and you know, call people 'crazy' or 'she's mental' and not necessarily understand that it is related to MH…" SENCo 3

"…I'd probably think that maybe more boys find that (stigma) a barrier and that, you know, there are a lot of teenage suicides that are boys, aren't there? I think there are some that would matter what people said and it would hold them back from coming to ask for help." SENCo 3

"I think of the stigma of MH twenty odd years ago, people kept it quiet and some were ashamed. People associated it with, you know, mad houses…you'd have

your children taken off you. Today, attitude is very different but we have a long way to go." SENCo 1

9.7.2 Sub-theme: lack of support from external services

Two SENCos made a reference to the support for external services being fundamental to facilitating support for the YP in their school with MHPs.

"When we put out a cry for help when we say we've got a YP who, you know, has significant needs, they go on a waiting list and I'm not going to get anywhere near CAMHS…And then when we get YP who do go to CAMHS they get 12 weeks and then that's it, done and dusted, whether or not the work is done…" SENCo 1

"…we have another 15 kids who are seeing CAMHS regularly on top of that. We really need that external support for such complex needs." SENCo 3

9.8 Theme 2: Barriers to Improving Mental Health Literacy

Figure 12 Theme 2: Thematic Map
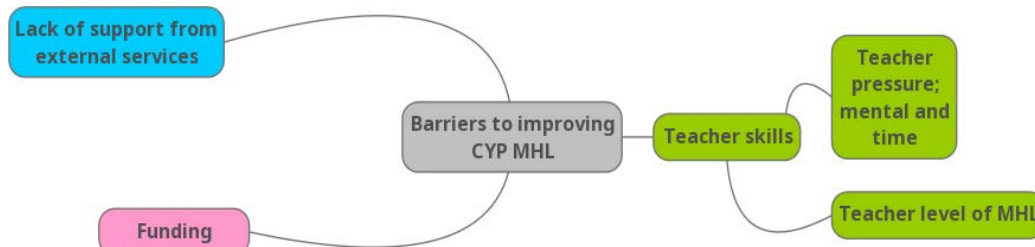
9.8.1 Sub-theme: teacher skills

Teacher level of MHL: All three teachers spoke about how their teachers' MH knowledge was fundamental to supporting YP MHL. One SENCo told me about how MH knowledge affects the teachers' confidence in dealing with sensitive MH issues.

"To increase YP MHL, it needs to be talked about more generally. But I think the difficulty that we have, and probably most schools will have, is that the teachers doing the talking on a day to day basis, not knowing how…you can't have kids asking questions getting the right advice if the teacher doesn't feel like they can answer them." SEN*" SENCo 3*

"…you couldn't really be successful in a school, supporting children's learning and MH, as a teacher or an educationalist or a member of support if you didn't have some understanding of MH." SENCo 1

"They (staff) have a good level of MHL…in order help support the childrens' MH and knowledge of MH, we've worked really hard over the last sort of two or three years to get training in for staff." SENCo 2

Teacher pressures (mental and time): Two SENCos spoke about how supporting YP MHL puts extra pressure of the teachers. This in turn impacts upon the teachers' ability to fulfil all aspects of their, now wider, role effectively.

"We actually did this a year ago; we gave every child a fun lesson in their timetable…it worked well but we just don't have the funding we got then and I can't afford the time. This is really sad. I think it's the situation for a lot of people and that's a definite barrier, isn't it...? It was jolly hard work to sort out but it was really positive because it just gave the YP an opportunity to just be." SENCo 2

"You can't be a jobsworth if you're a SENCo, but we're trying to deal with more complex needs that need to be dealt with by professionals. We're so busy holding them at the top that the bottom doesn't get seen to as we don't have the

time…it puts added pressure on teachers and we already have so much pressure to get children to pass their exams." SENCo1

9.8.2 Sub-theme: funding

All three SENCos communicated that a lack of funding is a barrier to supporting YP MH and raising YP MHL.

"Well the other thing is funding. The government needs to back up their agenda with money to schools. We need to be able to pay for staff to implement the strategies and support YP as early as possible." SENCo 1

"We actually did this a year ago; we gave every child a fun lesson in their timetable…it worked well but we just don't have the funding we got then and I can't afford the time. This is really sad. I think it's the situation for a lot of people and that's a definite barrier, isn't it? If the government are serious about this and they really want to put this big push towards MH they are gonna have to back it up with some money…." SENCo 2

"We're told MH is that you know, something that we all really need to support and everyone needs to have a MH lead in their school yet all the funding has been cut an it's the first thing that gets cut in your school budget. So we're kind of doing stuff with no money. We're so lucky that this community group has been funding X. And they've got funding now to go until the end of this academic year, but you know, we don't know beyond that, but now it's gone really well and I know the plan from the government is more funding for MH but its' the way each county sends out the money. I think that's certainly here where it falls down for SEN and MH." SENCo 3

9.8.3 Sub-theme: lack of support from external services

All three SENCos explained that the help they receive from external services is important in terms of supporting the MHL of YP. One SENCo explained that limited help from external services has the knock-on side effect of lessening the amount of time staff can work upon building up YPs MHL by working preventatively.

"And there's just not enough resource for the higher-end. So, we hold on to the higher end for longer rather than passing them on and enabling us to focus at the lower end doing some more preventative work, helping to raise pupils MHL"
SENCo 1

"…we have another 15 kids who are seeing CAMHS regularly on top of that. We really need that external support for such complex needs." SENCo 3

"We always have the drugs people that come in. They always do a really hard hitting dramatic performance…and we've done work with X; he has done lots of relaxation, lots of media meditation and online resources with the students. Ideally, we would benefit from more of this kind of input to help us to support our YP MH." SENCo 2

9.9 Theme 3: Ways to Improve Mental Health Literacy

Figure 13 Theme 3: Thematic Map
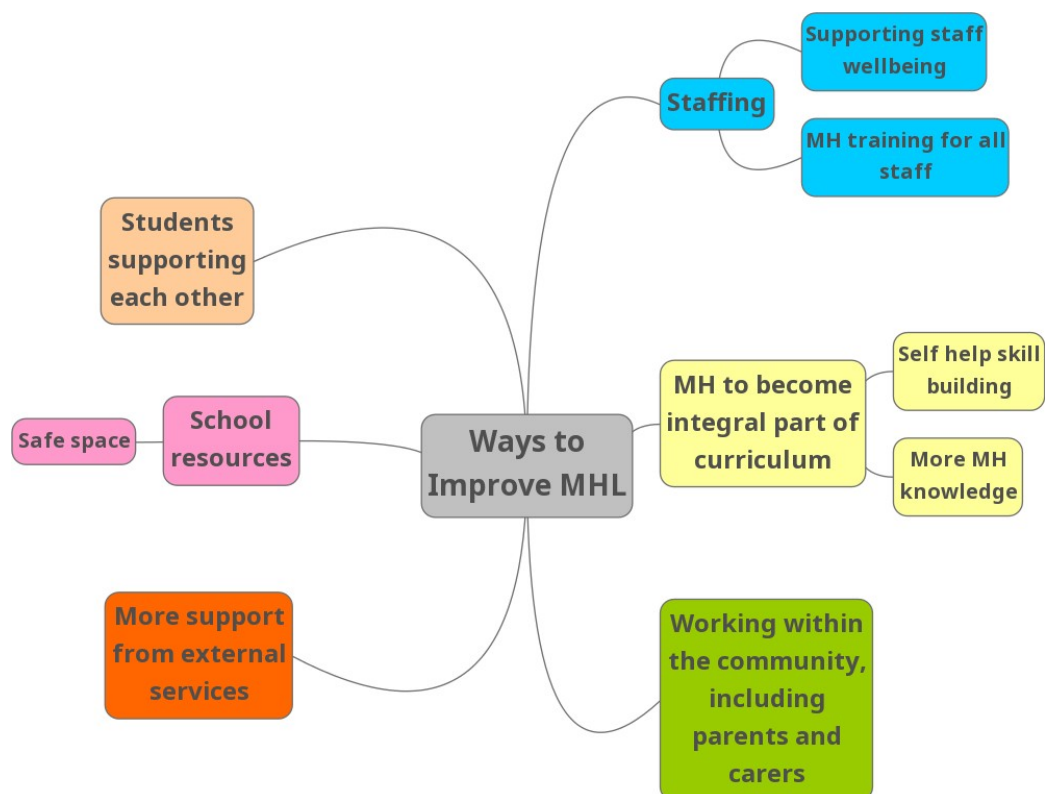
9.9.1 Sub-theme: students supporting each other

Supporting each other: Two of the three SENCos discussed ways in which they are hoping to develop their pupils' abilities to support each other. The SENCos explained that, given limited MH support resources, the facilitation of peer support could result in children benefitting from support at an earlier stage, thereby preventing worsening of MHPs.

" …then they'll train the kids up who get these cool little broaches and they'll be MH ambassadors." SENCo 3

"The one area that we want to look at is how we get YP involved in supporting them to support each other. I know there are schools that have got sort of MH champion students who are trained at a level to be able to support their peers and I think that's for me. It's about getting the whole PSHE programme right to offer the support and understanding to everybody and then to have some of our student mentors (like champions) to be able to be there for children that just need light touch support or just a bit of understanding." SENCO 2

9.9.2. Sub-theme: mental health to become an integral part of curriculum

Self- help skill building: Two of the SENCos expressed the view that, in order to support YP MH, it would be useful for the YP to develop self-help skills including relaxation skills and use of electronic applications. The SENCos expained that providing YP with basic tools, could empower them to maintain a good level of MH throughout life.

"Things like art, music, textiles, needlework, sport, you know, those things are being eroded. I'm well aware that in primary school that goes out of the system while they focus on English and Maths for SATS. So those creative areas that are therapeutic themselves are not being provided in school." SENCo 1

"We've done work with X…he has done lots of relaxation, meditation and online resources with the students…" SENCo 2

"The EH4MH has been really good for us…they've done training on 'normal magic'; to teach the kids to do the little things that will really boost our wellbeing. It's really quite common sense things that you don't necessarily think about being the things that make you feel good." SENCo 3

More MH knowledge: All three SENCos told me that, in order to increase the MHL of their pupils, MH should be incorporated into the curriculum. SENCos explained that if MH was a valued aspect of the curriculum, the subject would receive the time and resources that other more esteemed faculties do.

"I think that the topic of MH will need to be incorporated somewhere on the curriculum as part of the social, emotional and MH education PSHE programme…you need to build a programme on how to keep healthy mentally." SENCo 1

"We've introduced a new PSHE programme…everybody's got a one hour a week 'x' lesson, which is our PSHE programme…Whoever picks up responsibility for it will have responsibility for our whole MH strategy as a college…" SENCo 2

"It's just quite difficult to make sure there is that quality of teaching in the same way that there is for all the other subjects. It's like, you know, it's like with everything at the moment…we're told MH is something we all really need to support and every school needs to have a MH lead yet all the funding has been cut and it's the first thing that gets cut in your school budget. MH needs to be given funding and a priority within curriculum so schools don't skip it." SENCo 3

9.9.3 Sub-theme: school resources

Safe space: Two of the SENCos talked about the value of providing the pupils with a 'safe space'. SENCos acknowledged that some YP require a calm environment in which they feel secure and unthreatened. However, SENCos identified logistical challenges with the implementation of such an intervention, such as safeguarding and limited space.

"We have one (a safe space). They can't just turn up though, it's not self-referral. If they just need timeout, they can come to student reception. But that's the only place we allow them to go because we have to know where they are. Some children do have a designated safe space and that's a bit of a different scenario." SENCo 1

"It (MH programme) will be led by them (pupils)…they (EH4MH) have done a lot of work about this in schools and students were saying that they wanted somewhere that they could go at break and lunch time, that they could have a chat with somebody and just offload. They didn't necessarily want it to interrupt lesson or be particularly formal… but just have a room where they could go and feel that everyone was in tune with the fact that they were feeling a bit rubbish and to just, you know, have a hot chocolate…So that's probably what it would look like here because we don't have many spaces for lunch. I mean we have a SEN classroom, but then there's a stigma of it being for kids with teaching assistants…" SENCO 3

9.9.4. Sub-theme: more support form external services

In terms of ways to increase the MHL of pupils, all three SENCos discussed the importance of the support they receive from external services and how, ideally, this should increase. SENCos explained that staff can feel overloaded with YP MHPs of which they feel ill-equipped to deal with, adding that these YP require specialist support. Furthermore, staff require more time and energy to implement preventative strategies and implement intervention aimed at less severe MHPs.

"We have another 15 kids, or so, who are seeing CAMHS, regularly. We really need that support for such complex needs" SENCO 3

"When we put out a cry for help when we say we've got a YP who, you know, has significant needs, they go on a waiting list and I'm not going to get anywhere near CAMHS. It's just sort of trying to find a needle in a haystack. And then when we get YP who do go to CAMHS they get 12 weeks and that's it, done and dusted, whether or not the work is done. If they don't engage then they get bumped out but actually it might be where they were at that moment in time…This needs to change." SENCo 1

"*There's just not enough resource for the higher-end. So, we hold on to the higher end for longer rather than passing them on and enabling us to focus at the lower end and doing some more preventative work*" SENCo 1

9.9.5 Sub-theme: working within the community, including parents and carers

Two of the SENCos communicated positively about involving the community in an attempt to indirectly support YP MH. One SENCO spoke from experience, advocating for a model utilising the resources within their community. The other SENCo discussed the idea that some parents can feel intimidated within the school environment and how this barrier prevents parents from learning how best to support their child.

"*I think I would like to see some real ways of working with parents because quite often we don't actually see the parent until there's some sort of crisis…Some parents need additional scaffolding and they're the ones that are reluctant to come forward because they know they're going to be judged…it would be really good if we could run some information evenings…things like "What's a normal teenager's response?"* SENCo 2

"*We started this committee following the death of one of our students…members of the X Town Council; Police; Chaplains; me (SENCo); the Head); parents; a few local business owners…We discussed what we could do to support YP and bridge the gap between school and MH…"* SENCo 3

9.9.6 Sub-theme: staffing

Supporting staff wellbeing: Two of the three SENCos acknowledged the growing pressure that staff are under and how, when considering the MH of pupils, it was also important to consider the MH of staff.

" *X is at the moment coordinating a lot of staff mental wellbeing. So, we've had things going on; there's a lot of running groups now in school and they're doing nice little short sessions after school. We did a survey of all of the staffs MH and how much they work at home and their stress levels…they came up with a sort*

of list of things that staff wanted and well-being really topped the list. So, we'll be doing yoga on a Monday now (30 staff members do yoga on a Monday after school and someone comes in from the Yoga Centre) lots of runs, bike rides and actually it's really brought the staff together. We're just kind of then rolling out a similar thing to the kids…" SENCO 3

"Well of course, it (extra fun sessions) puts added pressure on teachers and we have so many pressures already to get the children to pass their exams."
SENCO 1

<u>MH training for all staff</u>: All three SENCos communicated the importance of MH training for all staff members, explaining that this will improve teachers' ability to help increase the MHL of their pupils.

"They (pupils) have a good MHL…We've worked really hard over the last sort of two or three years to get training in for all staff…" SENCo 2

"Because of this governments agenda to have everybody in school as a MH first aider, we've sent a teacher on to the training…I know she is liaising with our deputy head about how to take that forward." SENCo 1

"So, they're (Early help 4 Mental Help) going to work through a strategy with me and the staff. So, we'll come up with a whole school policy and an action plan of what that's going to look like over the next three years…" SENCo 3

In summary, thematic analysis of the SSI data identified 3 key themes which are important to understanding how to raise the MHL of YP. Themes identified are: barriers to improving MHL; barriers to YP getting help; ways to improve MHL. Within each theme, sub-themes were identified and have been discussed.

Emerging themes and sub-themes from both FG and SSI will be discussed further within the next chapter. In doing so, answers to RQ3 and RQ4 will be explored.

10.0 Phase 2 Discussion

The following section discusses in further detail, the results of phase 2 which sought to answer:

 RQ3: What are the views of Year 8 pupils (12 and 13 year olds) regarding prospective MHL programmes in schools?

 RQ4 : What are the views of SENCos regarding prospective MHL programmes in schools?

 RQ5: How might educational psychologists facilitate mental health literacy programmes in schools?

The relevance of findings to existing literature will be discussed throughout.

10.1 Research Question 3: What are the views of Year 8 pupils (12 and 13 year olds) regarding prospective MHL programmes in schools?

Before answering this question, I would like to return to its relevance. If the government is to design and implement MH education programmes within all UK schools (DfE & DoH, 2017) then, fundamental to its success, is argued to be the consideration of YP views (Woolfson, Woolfson, Mooney & Bryce, 2009; Bowers, Manion, Papadopoulos & Gauvreau, 2013). Seeking the views of the target audience was therefore an aim of this thesis.

When exploring YP views with regards to potential MHL programs within schools, three key themes were identified: sessions to be interactive; contain explicit knowledge regarding signs and symptoms, prevention and treatment; involve skill building, e.g. relaxation techniques. In addition, the participants discussed ways in which a wider school approach could benefit their MH. They included: having access to a separate safe space; the use of peer support groups; access to counsellors; participating in more creative subjects.

I shall begin by discussing participants views regarding the content of MHL programmes.

10.1.1 Mental health literacy programme content

10.1.1.1 Interactive sessions

More than half of the participants across the three FGs discussed how useful interactive MH sessions could be through having the opportunity to take part in discussions and reciprocal conversations with both peers and teachers. This suggestion echoes that of existing research. For example, Woolfson et al., (2009) conducted research in Scotland using questionnaires with 773 pupils aged between 11- 17 years of age which aimed to explore the ingredients of an effective MH programme. A key theme that emerged was that delivery should be interactive, including discussion, role play and videos (Woolfson et al., 2009). Moreover, Pinfold, Thornicroft, Huxley and Farmer (2005) evaluated the Mental Health Awareness in Action (MHAA) campaign in England which delivered interventions to 109 police officers, 78 adults working with people with MHPs, and 472 pupils aged 14-15 years. MHAA involved two 50 minute sessions. Knowledge, attitudes and behavioral intentions were measured at baseline and at follow up. Findings indicate that the greatest impact of all, was the interactive element of listening to people sharing their experiences and the discussion that followed. However, the aspects of interactive discussion that appear to be helpful in increasing MHL are unclear thus indicating a need for further research (Pinfold et al., 2005).

10.1.1.2 Explicit knowledge

When asked about the extent to which YP learn about MH in schools, participants referred to Personal, Social, Health and Economic (PSHE) lessons. The overarching view was that PSHE lessons were an inadequate way to teach YP about MH as they generally contain generic information regarding bullying and staying safe on the internet. Participants informed me that the PSHE lessons lack informative and/or useful knowledge regarding MH, for example facts about symptoms, implications, treatments and ways to access help.

Support for this view is found within literature. Willis, Clague and Coldwell (2013) explored the effectiveness of PSHE lessons across primary and secondary schools in England. Local authority representatives, teachers, support staff, parents and pupils made up 248 participants whose views were explored. When considering the emotional health and wellbeing element of PSHE, results indicated that views within primary and secondary schools differ. Participants viewed it as effective in only 28% of secondary schools, whereas the figure was 60% in primary schools. The authors suggested that this difference was due to primary and secondary schools having dissimilar purposes of PSHE, which then tailored the content and the extent to which it was valued as part of the curriculum. Wills et al., (2013) suggested that the primary school purpose of PSHE was to underpin learning and as such tends to have a higher status PSHE coordinator and more time within the curriculum. In contrast, within secondary schools, the purpose of PSHE is considered to be helping YP with life issues and so it is often linked to local issues, such as bullying and gang violence; a point reiterated by the secondary school pupils in this study, who said that PSHE lessons include content surrounding social issues. Furthermore, in March 2017, YoungMinds carried out a survey of 452 children and YP aged 11-18 as part of an enquiry into MH and education, on behalf of the Health and Education Select Committees. Eighty-one percent of YP said that they would like their school or college to teach them more about how to look after their MH and 90% of the YP surveyed said that they would like MH to be more important to their school or college (YoungMinds, 2017).

Desocio, Stember and Schrinsky (2006) designed and implemented a MH education programme including the explicit information suggested by participants in this study. Six sessions, 45 minutes in length, were delivered to 370 10-12 year old pupils in America. Classes involved open discussion and included: facts about the brains connection to MH; information regarding stress management; available resources; and descriptions of MHPs. Pre and post-test questionnaires were adopted and results suggested a significant improvement in participants MH knowledge (mean score increased by 1.5, p = .000).

The above evidence corroborates the feedback from participants in this study; both the value of explicit MH knowledge and the perception that YP do not currently receive clear knowledge regarding MH. Furthermore, when exploring

barriers to seeking help for MHPs, the theme 'lack of knowledge' emerged; being unaware of MH symptoms, available support and how to access available support, were reasons why YP may not seek help. Thus, the barrier 'lack of knowledge' further supports participants' suggestion that a MH programme should contain explicit MH knowledge.

10.1.1.3 Skill building

Participants suggested they should be taught coping strategies to enable them to deal with stressful, everyday life events. Specific ideas were proposed, including mindfulness. Mindfulness is an activity that encourages awareness to emerge through purposefully paying attention (Kabat-Zinn, 2003). Ongoing mindfulness practice allows one to gradually acquire the ability to be aware of inner states, such as emotions, thoughts and physical sensations, as well as to their environment (Weare, 2013). Mindfulness is argued to be an acceptable and well-tolerated intervention that CYP can benefit from (Burke, 2010). Benefits include reduced levels of stress and anxiety as well as the development of coping skills (Coholic, 2011).

Teaching mindfulness in schools is a relatively new idea, however mindfulness training is currently being introduced into school curriculums (Carsley, Khoury, Heath, 2018). Researchers have attempted to review the evidence for short, classroom centered mindfulness based interventions (Kuyken et al., 2013; Weare, 2013; Carsley et al., 2018). Findings indicate that mindfulness interventions yield small to medium positive effects on CYP social, psychological, physical and cognitive development. Furthermore, Weare (2013) reported that the approach was popular with both teachers and pupils. However, Weare (2013) stressed the need for more research involving larger scales and longer follow up periods and added that there is a need to reduce bias as those who design mindfulness interventions, tend to be those who evaluate it. Also, Carsley et al., (2018) showed that, although mindfulness interventions do demonstrate positive effects on CYP, the effect was strongest for older adolescents (15-18 year olds). It could be that the interventions were most successful for older adolescents as they are developmentally closer to adulthood, the age group that the interventions were originally designed for (Carsley et al., 2018). Further adaptations are

required to adolescent mindfulness programmes, to ensure they are effective (Carsley et al., 2018).

In summary, whilst evidence is lacking, it is at least suggestive that teaching YP mindfulness in schools is beneficial to their holistic development and ability to cope with stressful situations (Burke, 2010; Caholic, 2011; Weare, 2013). This is supportive of the views expressed by participants within this study.

When thinking about the execution of a MHL programme involving mindfulness, it is important to carefully consider the implementation of the programme (Dulak et al., 2011; Carsley et al., 2018). Wilde et al., (2018) did just that, as they explored the facilitators and barriers to the implementation of mindfulness based interventions in UK secondary schools. Four requirements for successful implementation were found: a commitment from people both running and supporting the intervention; adequate time and financial resources for training and delivery; an acknowledgement from the people involved that positive change takes time and often includes 'ups and downs'; a thorough understanding from those involved of the meaning and benefits. Therefore, if MH programs are to include a skill building component, such as mindfulness, it is important that the teachers delivering the programme have a full understanding of its purpose.

Furthermore, Carsley et al., (2018) identified that mindfulness interventions were more successful when facilitated by teachers as opposed to external agencies. The authors attributed teacher success to the likelihood that teachers continue to reinforce elements of the intervention throughout the week. This suggestion further emphasises the impact of teacher knowledge and commitment upon the success of an intervention.

So far, I have discussed the views of participants with regards to the content of a MHL programme. I shall now go on to discuss the comments made by the YP in this study regarding broader ways in which school staff could support their MH.

10.2 Broader Ways in Which Schools Can Support Young People's Mental Health

10.2.1 Accessible safe space, separate from other special educational needs support rooms

More than half of the participants expressed the view that for someone experiencing a MHP, it would be useful to have access to a 'safe space' within the school that was easily accessible i.e. not requiring referral. Across all three FGs participants acknowledged that such rooms already exist within their schools but are intended for the use of people experiencing a diverse range of SEN. As such, it was important to some participants to have access to a room solely for the use of those experiencing a MHP. Reasons for this were as follows: firstly, SENs can include YP demonstrating noisy and/or disruptive behaviours. It was explained that this may not be conducive to the relaxing and calming environment desired for someone with a MHP. Secondly, sharing a space with others having similar difficulties, creates the opportunity to share and discuss experiences with peers who may understand your perspective. Thirdly, some participants voiced the apprehension at sharing a room with people with SEN for fear of being labelled by association.

Participants' suggestion of schools having a 'safe space' for those with MHPs, is supported within the literature (King & Chantler, 2002; Spalding, 2001). King and Chandler (2002) designed the 'quiet room' project within a primary school in the UK. The room was staffed by a teaching assistant who had experience of talking with CYP with emotional and behavioral problems. Efforts were made to create a calm environment, with soft lighting, relaxing music and a range of activities available e.g. story books, paints. Eight children with emotional or behavioral problems were identified and referred to the quiet room where they spent one session a week, for two terms. The children and teachers involved gave qualitative feedback post intervention and results suggested that all children benefited from their time in the quiet room. Benefits included the developed ability to communicate thoughts and feelings, as well as provision of a private space to discuss matters with an adult. This potentially then led to early intervention and/or referral to an external agency.

Spalding (2001) created a similar project in which a 'quiet place' was created for children within UK primary schools. Findings suggest that the rooms were special places where visual, auditory and kinesthetic activities engendered feelings of calmness and relaxation. Furthermore, the intervention was said to have had a positive effect on the emotional development of the children who attended, plus a calming effect on the whole school as teachers reported that they were relieved

to have somewhere immediate that they could refer distressed children to (Spalding, 2001).

These two examples took place within primary schools, however the principle can be adapted for use in secondary schools (Spalding, 2001). In fact, work by Kidger, Donovan, Biddle, Campell and Gunnell (2009) suggested exactly that, following views sought from teachers and pupils regarding the ways in which schools support pupils' emotional health and wellbeing. Interviews and FGs were conducted in eight secondary schools in England and one suggestion made by both staff and pupils was the creation of safe spaces within schools to facilitate relaxation and understanding discussion.

10.2.2 Peer support groups

Participants within this study suggested that peer support groups could be a way to support YP experiencing MHPs. Peer support has been described as a process of the mutual offering of emotional and social support between people sharing a similar condition, with the aim of facilitating a desired social or personal change (Gartner & Riessman, 1982). Evidence suggests that peer support groups can have positive outcomes for those attending (Miller, Esposito-Symthers & Leichtweis, 2015; Solomon, 2004; Salzer, 2002; MacArthur, Harrison, Caldwell, Hickman & Campbell., 2016). For example, Gould and Clum (1993) conducted a meta-analysis of 40 studies exploring the outcomes of self-help groups, including peer support, and reported positive results such as an increase in problem-solving skills and a reduction in problems such as sleep disturbances and negative affect. The overall effect size (ES) at posttreatment was 0.76, with an ES= 0.53 at follow up. Studies that used control groups had a lower ES (0.74). However, when you consider Wolf's (1986) interpretation of ES (ES= 0.12, small effect; ES= 0.5, medium effect; ES 0.8, large effect) results suggest that self-help groups and peer support groups have a positive impact upon participants. Interestingly, Gould and Clum (1993) found that depression was one of the conditions to be most positively affected by the peer support groups (ES= 0.74). Also, when peer support and treatment were combined, results were even more promising (ES= 0.93). However, caution should be taken with this last finding as only three studies included the combined use of peer support and therapeutic treatment. Moreover, the studies investigated within this meta-analysis contain

adults and as such, generalisability of findings to secondary school settings is debateable.

Nonetheless, reasons for the success of peer support groups have been suggested within the literature as including social support and experiential knowledge (Rickwood, Deane, Wilson & Ciarrochi, 2005). Salzer (2002) explained that social support is the availability of people who let one know they can and will help. Moreover, connecting with others experiencing a similar MHP can be a catalyst for seeking formal care (Naslund et al., 2016). Also, experiential knowledge encourages understanding and empathy (MacArthur et al., 2016). Other explanations include the credibility of peers and their shared cultural background (MacArthur et al., 2016); knowing that comparable people are facing similar challenges can be highly reassuring, creating a sense of belonging (Onrust, Otten, Lammers & Smith, 2016). Furthermore, affiliation with peers is said to form an integral part of identity development (Cotterell, 1997).

When discussing peer support groups with participants within this study, I proposed the idea of online peer support. With online social media use continuing to rapidly increase (Kaplan et al., 2011; Naslund et al., 2016) it has been suggested that online peer support may present new opportunities to promote recovery and self-esteem (Naslund et al., 2016). Moreover, research suggests that a growing number of people are using the internet to seek help and information regarding their MH (Wetterlin, Mar, Neilson, Werker, Krausz, 2014). Studies exploring the outcomes of online peer support are mostly positive, with findings suggesting that the ease with which YP can access online forums and groups reduces barriers to seeking help, such as financial costs and perceived societal stigma (Naslund et al., 2016; Berry, Lobban, Belousov, Emsley, Nenadic & Bucci, 2017). However, research into online peer support is limited; few studies use control groups and some studies have used manufactured social media sites which arguably lacks the norms, dynamics and atmosphere of a naturally occurring online community (Kaplan et al., 2011; Naslund et al., 2016).

The lack of certainty within the literature regarding the effectiveness of online peer support was reflected in the views of participants in this study: the majority of YP did not demonstrate a desire to use the internet for support but only as a means of seeking information. The overwhelming opinion was that emotional

support would best be obtained by face to face interaction. However, if schools are to implement peer support groups, efforts should be made to ensure that there is clarity among participants as to what their roles are and that the group is moderated by a professional (Kemp & Henderson, 2012). For example, should one member disclose information regarding self-harm, members of the group need to be clear that it is beyond their role to support the YP and they should know who to share this information with.

10.2.3 Access to counsellors

When analysing the data from the FGs data in this study regarding ways in which their school could better support YP MH, the theme of 'access to counsellors' emerged. Participants voiced the recognition that had been identified in phase 1, that talking therapies are a successful way to treat MHPs. The majority of participants did not know if their school had a counsellor. A minority of participants expressed a view that they thought there was a school counsellor but did not know who it was or how to access him or her. Only two participants could name their school counsellor as they had received support from them, personally. The amount of available school counsellors differed between the three schools, ranging from 0-8. Despite this difference, the general consensus across all three FGs was one of there being a lack of pastoral support and a desire for easier access to a school counsellor.

Across the UK, provision of school based counselling is inconsistent (British Association for Counselling and Psychotherapy, 2015), a finding that is supported within this study. In a recent report from the Department of Education (2018) an expectation was set out that all UK schools should provide access to counselling services. Furthermore, O'Brien, Greatley and Meek (2015) reported on their task to set out a plan of how society needs to prevent MHP and promote good MH. The task was initiated by former Labour leader, Ed Miliband, and involved consultation with a wide range of individuals, including health practitioners, patients and policy experts. One of the recommendations set out within the report was that all CYP should have access to age appropriate counselling and therapy within their school. O'Brien et al., (2015) went on to say that having such a highly

accessible system of pastoral support would remove the lengthy and time-consuming referral system to outside agencies (Frith, 2016).

The suggestion that all CYP will benefit from access to a school based counsellor is supported empirically (Cooper, 2009; Pybis, Hill, Cooper & Cromarty, 2012; Rupani, Haughey & Cooper, 2012; McElearney, Adamson, Shevlin & Bunting, 2013). Rupani et al., (2012) adopted a mixed-method approach when exploring the views of 21 people (aged between 12-17 years) who had received school based counselling in the UK. Findings suggested that all participants' learning had indirectly benefitted from the counselling; participants reported improved levels of concentration and motivation to study. The authors suggested that counselling resulted in the students spending less time worrying about their problems, allowing them to focus more in lessons. However, despite there being a gender balance between participants, the sample population was small, meaning generalisability to the wider population is questionable. Moreover, the findings from this study were based upon pupil perceptions and as such may not be reliable (Thomas, 2017).

However, other research supports that of Rupani et al., (2012). For example, Cooper et al., (2009) assessed the experiences and outcomes of over 10,000 CYP in receipt of school based counselling across the UK. Cooper et al., (2009) found that over 82% of CYP considered counselling as 'helpful' and 90% of teachers reported a positive impact upon pupils' willingness to learn. In addition, both CYP and staff viewed school based counselling to be a highly accessible, non-stigmatising and effective way to reduce psychological distress (Cooper et al., 2009).

In summary, the views of the participants in this study are supported by government led reports and empirical evidence, suggesting that there is a need for all CYP to have access to a school counsellor.

10.2.4 Participating in more creative subjects

For clarity, throughout this thesis, the understanding of 'creative subjects' that will be used is that adopted by Universities and Colleges Admissions Service (UCAS) which includes the following subjects: fine art; design studies; music; drama;

dance; cinematics; photography; crafts; creative/imaginative writing (Universities and Colleges Admissions Service, 2019).

YP within each FG told me that they had noticed a reduction in the number of creative subjects within the curriculum (e.g. music and photography) adding that they would both enjoy, and benefit from, participating in more creative activities. Participants' perception of there being a limited amount of creative activities within the curriculum, is not a novel one; it is widely accepted that the UK has taken an increasingly prescriptive approach to education (Grainger, Barnes & Scoffham, 2004; Tucker, 2015). The education system within the UK is highly politicised and tightly controlled by external services (Grainger et al., 2004; Robinson, 2001; Priestley, Biesta, Philippou, & Robinson., 2015) which consequently reduces teachers' professional autonomy as their work is confined (Tucker, 2015; Robinson, 2001). Within the scrutiny of teacher performance comes the pressure of CYP attainment within the core subjects, specifically numeracy and literacy (Tucker, 2015; Robinson, 2001). As such, creative subjects demand less time within the curriculum (Maisuria, 2005). The current education system may not reflect the value that successful education is more than achieving qualifications (Robinson, 2001) and that creative subjects can lead to wider, holistic benefits (Grainger et al., 2004; Knifsend & Graham, 2012; Maisuria, 2005).

There is a wide range of evidence suggesting that creative activities can benefit adolescents. Such benefits range from higher school grades to reduced depression. (Grainger et al., 2004; Nompula, 2012; Knifsend & Graham, 2012; Daykin, Orme, Evans, Salmon, McEachran & Brian, 2008; Bungay & Vella-Burrows, 2013; Leckley, 2011; Dworkin, Larson & Hansen, 2003; Cortina & Fazel, 2015). For example, Bungay and Vella-Burrows (2013) conducted a review of 20 papers exploring the effects of creative activities on 11-18 year olds in the UK, Canada, Australia and America. The authors concluded that participating in creative activities can have a positive effect on behaviour changes, self-confidence, self-esteem, levels of knowledge and physical activity. Dworkin et al., (2003) argued extra-curricular activities (including creative subjects) are a way for adolescents to make friends and explore their interests and identity. Furthermore, Dworkin et al., (2003) suggested that such activities offer adolescents the opportunity to belong to different contexts, facilitating a sense of

belonging. Further support of this view comes from Leckey (2011) who conducted a literature review and concluded that creative activities can be a way of improving psychological wellbeing, by promoting relaxation and a means of self-expression.

However, whilst the evidence does suggest that creative subjects improve CYP MH, evidence can be criticised for limited control trials, small samples, lack of follow up measures and researcher bias (Marshall & Hutchinson, 2001). In addition, Marshall and Hutchinson (2001) found conflicting results as some partakers of creative activities demonstrated negative outcomes, such as agitation and aggression.

Nonetheless, participants expressed the view that they would like to increase the amount of time within school that they were able to participate in creative activities. Participants explained that this would increase the amount of time they could relax in school, in turn having a positive effect on their MH. This argument is supported by evidence (Grainger et al., 2004; Nompula, 2012; Knifsend et al., 2009; Bungay & Vella-Burrows, 2013; Leckley, 2011; Dworkin et al., 2003).

10.3 Summary of Research Question 3

In summary, phase 2 sought to answer RQ3 'What are the views of Year 8 pupils (12 and 13 year olds) regarding prospective MHL programmes in schools?'. According to the YP in this study, an effective MHL programme would contain the following three elements: interactive sessions; explicit knowledge regarding signs and symptoms, prevention and treatment; involve skill building, e.g. relaxation techniques. The YP also explained that a successful MHL programme should be supported by a wider, whole school approach consisting of the following elements: having access to a separate safe space; the use of peer support groups; access to counsellors; participating in more creative subjects. I have related YP views and ideas in relation to existing research which, by and large, supports and corroborates that the above are validated features of a successful MHL programme.

I shall now proceed to answer RQ4.

10.4 Research Question 4

In order to answer the research question 'What are the views of SENCos regarding prospective MHL programmes in school?' SENCos were interviewed. SENCos views regarding how their school currently supports YP MH and ways in which they could improve this as part of a MHL programme, were explored. In doing so, six key themes regarding prospective programmes emerged: supporting staff, including their wellbeing and knowledge of MH; students supporting each other; safe space; working with the community, including parents and carers; support from external services; MH to become an integral part of the curriculum, including more MH knowledge and self-help skill building. I shall discuss each theme in turn, linking SENCo views to existing research.

10.4.1 Supporting staff

10.4.1.1 Staff Wellbeing

It is widely accepted that teaching staff experience high levels of stress compared to the general public (Evans et al., 2018; Kidger et al., 2016; Harding et al., 2019; Naghieh, Montgomery, Bonell, Thompson & Aber, 2015) and SENCos within this study suggested that elevated stress levels, impedes their ability to support pupils' MH. This is a view supported by research. For example, Harding et al., (2019) obtained quantitative cross-sectional data from 3216 Year 8 pupils and 1182 teachers across England and Wales. The authors found that higher levels of depressive symptoms amongst teachers, was associated with lower levels of wellbeing and higher levels of psychological distress amongst students. Teachers experiencing symptoms of depression are more likely to have periods of time off work (Naghieh et al., 2015) therefore less time at work equates to fewer opportunities to recognise their pupils MH symptoms (Harding et al., 2019). However, whilst an association between student and teacher wellbeing was found, cause an effect is not clear; it may be that teaching pupils who are experiencing psychological distress impacts negatively on teachers' wellbeing.

Nonetheless, these findings resonate with previous studies which also stress the importance of staff wellbeing on pupils MH (Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010; Kidger et al., 2016; Jennings & Greenberg, 2009; Naghieh et al.,

2015; Wyn, Cahill, Holdsworth, Rowling & Carson, 2000). For example, Jennings and Greenburg (2009) evaluated research and proposed a model detailing the importance of teachers' wellbeing and social and emotional competence (SEC) on pupils MH. The model explained that when teachers have lower levels of wellbeing and SEC, they are less likely to develop and build positive teacher-student relationships. The authors suggested that supportive teacher-student relationships reassure pupils to feel safe and connected to school. This view resonates with that of Fattore, Mason & Watson (2008) who proposed that positive teacher-student relationships facilitates students to feel secure enough to attempt challenges and to manage anxiety in new situations. In contrast, inadequate teacher-student relationships promote pupil dislike of school and alienation. Moreover, pupils who participated in the current research suggested that they would be far less likely to disclose a MHP to a teacher that they did not have a good relationship with, therefore supporting the notion that a positive teacher-pupil relationship promotes positive pupil MH.

Aside from teacher-pupil relationships, research identifies other explanations as to why teachers' MH is associated with pupils MH. Kidger et al., (2012) conducted a systematic review of evidence for the importance of the school environment on adolescents MH, exploring nine studies using YP aged 11-18, including five controlled trials. Kidger et al., (2012) concluded that the school environment impacted upon YP MH, including the classroom environment itself. Jennings and Greenberg (2009) corroborated this finding by previously explaining that teachers experiencing stress have been shown to be less able to facilitate an optimal classroom environment, which includes teachers' ability to develop and maintain behavioral management as well as a calm, problem solving and cooperative ethos.

To sum up so far, the above evidence supports SENCo views within this study, suggesting that teacher MH is an important factor when considering the MH of students. The SENCos within this study therefore proposed that, when designing a MHL programme for pupils, provisions should be made to support the MH of teachers. Such interventions have been implemented and evaluated, demonstrating promising results. For example, the following programmes have provided positive effects on teacher wellbeing: Comprehensive Approach to Learning Mindfulness (CALM); Stress Management Relaxation Techniques

(SMART); Cultivating Awareness and Resilience in Education (CARE). Benefits included, increased ability to recognise emotional states, physical sensations and regulate emotions (Schussler, Jennings, Sharp & Frank, 2016). Harris, Jennings, Katz, Abenavoli and Greenberg (2016) evaluated the programme CALM using 64 teachers and control groups. The intervention included offering gentle yoga and mindfulness practice, four days a week for sixteen weeks. Quantitative measures of participants wellbeing were taken pre-and posttreatment, indicating increased positive mood, classroom management and distress tolerance, compared to that of the control group.

However, whilst research is suggestive that programmes are beneficial, there is limited clear guidance regarding their implementation with particular ambiguity over the duration and exact instructions of a mindfulness intervention (Felver & Jennings, 2016). Furthermore, caution should be taken when interpreting the results as longitudinal studies are lacking, as is a deeper exploration of the interrelated issues within the association between teacher and pupil MH (Harding et al., 2019). Moreover, research exploring gender differences with regards to mindfulness interventions is lacking, and as such more research is required to investigate individual differences and suitability (Carsley et al., 2018). Nagheigh et al., (2015) attempted this by evaluating organisational interventions. They found that 'stress management' included the following: offering a flexible working system; coaching support for teachers delivering the same piece of work; financial bonus and professional opportunities. These approaches did not demonstrate a positive impact on teacher mood.

Recognising the limited research regarding interventions aimed at improving teacher wellbeing, Evans et al., (2018) propose to conduct a randomized control trial using 25 secondary schools across England and Wales. The intervention will include: a staff peer support service; a one day MH training course equipping teachers to better support pupils' MH; a MH awareness session, promoting teacher MH. Quantitative and qualitative methods will be adopted, potentially offering useful insight into the concept of peer support and positive student-teacher relationships, further contributing to the evidence base for teacher MH interventions.

10.4.1.2 Increasing teacher mental health literacy

Schools have been suggested to be an ideal environment to enhance the MHL of YP (Coles et al., 2016; Sisask et al., 2014; Moon et al., 2017) with a need for MH awareness to be embedded throughout the whole school (YoungMinds, 2017). If the government is to successfully ensure that the MH of students is a shared responsibly amongst all school staff (DfE & DoH 2017), then it is vital that teachers have the skillset to fulfil this role (Wei et al., 2015; Mazzer & Rickwood, 2015; Kutcher et al., 2015).

This was the opinion of SENCos within this study who proposed that, in order to support YP MH, teachers require upskilling. Relatively few scholars have explored educators' views regarding their MHL, however the limited research does suggest that teachers feel under skilled and ill-equipped to deal with the increasingly high MH needs of pupils (Walter et al., 2006; DfE, 2015; Moon et al., 2017; Cane & Oland, 2015; Short, Ferguson & Santor, 2009). As such, teachers have reported low levels of self-efficacy in supporting pupils MH (Cane & Oland, 2015) and a desire to increase their knowledge and skillset (Moon et al., 2017; Short et al, 2009).

Previous attempts have been made to increase teacher MH knowledge. In 2008, the Government endorsed the Targeting Mental Health in Schools (TaMHS) agenda, which adopted a whole school, ecological framework (Cane & Oland, 2015). The programme involved two aspects: building parents' problem-solving skills within community settings and staff MH training. Cane and Oland (2015) evaluated the intervention across four schools in England and reported that the intervention yielded encouraging results. Staff reported having more awareness, empathy, knowledge, skills and confidence when supporting a YP with a MHP. Moreover, a positive effect on staff attitudes was noted, leading to a more understanding whole school ethos (Cane & Oland, 2015). However, difficulties with the implementation of such a programme were highlighted and should be considered as part of the Governments current agenda to raise MH awareness across pupils and staff. For example, teachers reported challenges in cascading the training to other staff members. Furthermore, three out of the four schools noted significant difficulties initiating contact with parents. Previously, Willocks (2014) reviewed TaMHS and also noted positive outcomes, however they added

that the employment of the intervention was not as successful in secondary schools, due to inconsistency of implementation. That said, the TaMHS was reported to have aided school staffs' internal referral systems to external agencies, empowering schools to intervene early (Cane & Oland, 2015). Neufeld, Dunn, Jones, Croudace and Goodyer (2017) support this view by advocating for teacher training focused on the identification of MHP in YP, to improve the referral system to external services.

In summary, the SENCos within this study highlighted an important factor to be considered when designing a MHL programme for YP: the wellbeing and skillset of staff.

10.4.2 Peer support

When asked to detail an effective MHL programme in schools, SENCos explained that support groups could be a successful way to encourage YP to support each other. As discussed in section 10.2.2 there is evidence that peer support groups can indeed promote positive outcomes for YP experiencing MHPs, such as problem-solving skill building and reduced negative affect, including depression (Gould & Clum, 1993; Soloman, 2004; Salzer, 2002; MacArthur, Harrison, Caldwell, Hickman & Campbell., 2016; Salzer, 2002; MacArthur et al., 2016).

SENCos perception that peer support can be a protective factor against MHPs has been widely accepted (Gould & Clum, 1993; Solomon, 2004; Salzer, 2002; MacArthur et all., 2016). However, research also suggests that having strong relationships with peers can have a negative effect on MH and substance abuse (Fletcher & Bonell, 2013). Studies have shown that MHPs and substance abuse are comorbid amongst YP (Lai, Clearly, Sitharthan & Hunt, 2015) and scholars suggest that, when YP have limited support from home, influence from negative peers is exacerbated (Moore, Rothwell & Segrott, 2010; Fletcher & Bonell, 2013). Furthermore, it has been suggested that, as YP develop through adolescence, the role of peer support gains increasing importance and the protective effect from family support dissipates (Klineberg et al., 2006).

Thus, whilst creators of MHL programmes should attempt to facilitate peer support, they should also be mindful of how potentially influential some of the YP

with MHPs may be and as such, ensure monitoring of the dynamics of the group (Klineberg et al., 2006). Moreover, interventions should also focus on forming healthy relationships within the home (Moore et al., 2018). The concept of family involvement is discussed in more detail in section 10.4.4.

10.4.3 Safe spaces

SENCOs within this study suggested that YP experiencing a MHP would benefit from having access to safe spaces within their school. It was explained that, currently, schools do not have spaces intended for the sole use of those with a MHP or that YP can access the safe space without referral. SENCos explained that, for safeguarding reasons, it is not appropriate to allow YP access to the entire school at any given time. Participating schools had made provision for pupils who had been identified as having SEN and as such those individuals were given permission to access a prearranged safe space as and when required.

In order to prevent repetition within this thesis, please refer to section 10.2.1 for evidence and discussion regarding the concept of safe spaces within schools as part of MHL programme.

10.4.4 Working within the community, including parents and carers.

In line with Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979) SENCos within this study suggested that, in order to support the MH of YP, efforts should be made to support the systems around the individual. This view resonates with existing literature, which stresses the influence that family, friends and society have upon a YPs MH (Moore et al., 2018; Rothon, Goodwin & Stansfield, 2012; Klineberg et al., 2006; Wang & Sheikh-Khalil, 2014).

The connections that one has with people within their surrounding systems can be described as 'social capital' (Rothon et al., 2012; Putman, 2001). Research suggests that building a YPs social capital can improve their MH, with parental support having particular impact (Bond et al., 2007; Rothon et al., 2012). For example, Rothon et al., (2012) conducted a longitudinal study in England where the following was measured: family social support (parental relationships,

parental surveillance, family meals); community social support (parental involvement at school, activities outside of the home); levels of MH. Measures were taken at baseline (14-15 years of age) and one year later. Good parental relationships, high parental surveillance and high frequency of family evening meals, were associated with lower odds of MHPs. Interestingly, Rothon et al., (2012) found that no element of community social support was associated with MH. Similarly, Stice, Ragan and Randall (2004) found that low parental support predicted depressive symptoms later in life. However, Klineberg et al., (2006) explored the relationship between levels of family, peer and overall social support, and psychological wellbeing, amongst 2790 11-14 year olds in Colombia. Results demonstrated that low levels of all types of support was associated with depressive symptoms. However, all studies explore differing elements of social support, meaning that comparisons across studies are difficult to be drawn (Cohen & Syme, 1985).

Nonetheless, research suggests that both parental support (surveillance, family meals) and parental involvement at school (participating in fundraising, attendance on school trips) is beneficial to YP MH (Moore et al., 2018; Rothon et al., 2012; Klineberg et al., 2006; Wang & Sheikh-Khalil, 2014). Explanations for the association have been suggested. For example, Hill and Tyson (2009) propose that parental support and involvement at school demonstrates their concern over their child and scaffolds independence. Pomerantz, Moorman, & Litwack (2007) suggest that parental involvement at school models positive, interpersonal relationships.

Given that both parental support and involvement has been demonstrated to have an influence on YP MH, scholars advocate for educational parental programmes that aim to ensure parents are practising support to the best of their ability (Cripps & Zyromski, 2009; Arango et al., 2018; Marshall & Smith, 2018). This resonates with the ideas proposed by SENCos within this study, who suggested that an efficient MHL programme should include parental involvement such as upskilling and supporting.

The questions that naturally follow surround the specifics of such a programme. In an attempt to investigate this, on behalf of the Department of Education (2018) Marshall & Smith (2018) conducted qualitative research. The aim was to identify

achievable practice with regard to supporting MH in schools and colleges and involved 36 educational settings across England. I shall be focusing on their findings regarding engagement of parents. Firstly, benefits were as follows: more positive outcomes for CYP; support for parents; support for staff from parents; consistency for CYP across settings; reduced stigma; increasing parental MHL; empowering parents. In terms of elements required to ensure parental involvement was successful, participants identified the following factors: time for staff to spend with parents; collaborative working with other schools; supporting teachers to communicate with parents with limited trust of school settings; informal and unintimidating sessions (e.g. tea and coffee morning); available room at morning drop off; information mornings; support groups; maintaining a non-judgmental approach.

In summary, SENCOs within this study suggested that, as part of a MHL programme, school and parent involvement should increase. I have provided evidence that suggests parental involvement has benefits for CYP MH and suggested ways in which this could be achieved.

10.4.5 More support from external services

When asked about current MH provision in their schools, all three SENCos talked about the usefulness of support from external services and how school staff and YP would benefit if this support was to increase. To clarify, external services include organisations outside of the school that offer guidance and/or provision for YP with MHPs. Examples include: CAMHS; Educational Psychologists (EPs); Kooth (online counselling service); behavioural support; substance abuse specialists.

SENCos reported to me that, in particular, access to CAMHS is inadequate with a significant number of referrals being rejected and waiting lists for assessments and admission increasing. SENCos explained that during this time, YP MH deteriorates and the capacity to deal with other YP MH needs is severely limited. This is a barrier to implementing whole school practice, as staff resource is drained.

Previous studies echo these findings, suggesting that schools require more support from external services (Frith, 2016; Marshall & Smith, 2018; Wolpert et al., 2015; Patalay, Giese, Stankovic, Curtin, Moltrecht, Gondek, 2016; Sharpe, Ford, Lereya, Owen, Viner & Wolpert, 2016; Kennedy, 2010). With nearly a quarter of YP being turned away from CAMHS and average waiting times for an initial assessment of 26 weeks (Frith, 2016), school staff are reportedly inundated with YP MHPs that they feel unqualified to deal with (Marshall & Smith, 2018). This, in turn, impacts negatively on both staff and YP wellbeing and MH (Kidger et al., 2009). Arguably, YP experiencing MH difficulties require more advanced support than school staff can offer (Marshall & Smith, 2018) and as such, staff have benefited from the guidance of external agencies (Sharpe et al., 2016). Examples of such guidance include regular consultations with a single point of contact within an external agency, providing the opportunity to discuss caseloads and wider whole school approaches, facilitating collaborative problem-solving (Sharpe et al., 2016; Marshall & Smith, 2018).

Sharpe et al., (2016) advocated this type of guidance however stressed the need for external support to also include targeted interventions. Sharpe et al., (2016) conducted a qualitative survey exploring the views of school staff in relation to the support they receive from MH external services. The authors found that the main source of specialist support was from EPs and that school staff were particularly positive about EP involvement. Sharpe et al., (2016) added that the positive links between schools and EPs should be replicated between school and CAMHS, but noted that the limited capacity with CAMHS is a barrier to this. However, this study used a non-randomised sample of schools, meaning that there is a possibility that the schools that chose to take part had greater interest in MH; thus, the sample population may be over representative of schools with extensive MH support.

As previously mentioned, Marshall & Smith (2018) conducted a large-scale review across 36 educational settings in England, seeking productive ways to support MH. Findings included a need for support from external agencies to relieve the burden on staff. Marshall & Smith (2018) found that having a single point of contact within the external service helped build relationships and provided specialist support to staff.

The argument for a need of increased provision from external services, is supported by data obtained from the Education Policy Institute (2018). Within their report Crenna-Jennings & Hutchinson (2018) highlight that the number of referrals to CAMHS has increased by 26% over the last five years and that 1/5 of YP referred to specialist services are deemed inappropriate for specialist treatment. Reasons provided for rejecting YP include, conditions not being severe enough, trauma in YPs life, and a lack of YP engagement. Regardless of the explanation, there is a lack of specialist support for YP, raising concerns about the welfare of the 'rejected' YP whom often do not get followed up and are forced back into an educational system with inadequate MH support (Crenna-Jennings & Hutchinson, 2018).

In summary, there is extensive evidence to suggest that school staff feel overwhelmed by the MH needs of pupils and welcome initiatives to increase capacity within external services to ensure better outcomes for YP (Sharpe et al., 2016; Kennedy, 2010).

10.4.6 Mental health to become an integral part of the curriculum, including mental health knowledge and self-help skill building

SENCos expressed the view that MH should be integrated into the curriculum, specifically by increasing the MH knowledge content and by teaching YP self-help skills. Again, to prevent repetition with this thesis, I would like to draw the reader's attention to section 10.1.1.2 and 10.1.1.3 where both MH knowledge within the curriculum and developing self-help skills are discussed. Within these sections, it is explained that the students also suggested these two means of increasing MHL amongst YP in schools and this was discussed in relation to existing literature.

10.5 Summary to Research Question 4

Semi-structured interviews with three SENCos, revealed that SENCos felt positive about MHL programmes in schools and suggested six main ways in which they could be better designed to support YP MH needs. Suggestions were as follows: supporting staff, including their wellbeing and knowledge of MH;

students supporting each other; provision of a safe space; working with the community, including parents and carers; more support from external services; MH to become an integral part of the curriculum, including more MH knowledge and self-help skill building. Evidence is largely supportive of these views.

The next section of this thesis will bring findings from phase 1 and phase 2 together and as such put forward an evidence based proposal for MHL programmes within secondary schools in England. In doing so, I will answer RQ5: How might EPs facilitate MHL programmes in schools?

11.0 Overall Discussion

11.1 Introduction

This thesis adopted a pragmatic approach by embracing methods that were most appropriate in terms of answering the research questions; mixed-methods (Feilzer, 2010). A pragmatic approach allowed me to focus on the research problem and aims of the research throughout, thereby attempting to solve the problem of raising MHL amongst YP in the 'real world' (Feilzer, 2008; Creswell & Clark, 2017).

In this section, I will attempt to bring together findings from phase 1 and phase 2 by proposing an effective MHL programme. I will also answer RQ5 (How might EPs facilitate MHL programmes in schools?) Firstly, I would like to take this opportunity to highlight links found between the findings thus far.

11.2 Link Between Phases 1 and 2

11.2.1 Stigma: prevalence and implications

Findings from phase 1 identified that YP have high levels of perceived societal stigma; the extent to which YP perceived their peers to hold stigmatising views around MH. Findings also indicated a discrepancy between personal and perceived societal stigma, suggestive of misconceptions of stigmatising views of peers (Pedersen & Paves, 2014). Findings from phase 1 also identified that the more MH knowledge a YP has, the less societal stigma and personal stigma they have. When considering these findings with those of phase 2, implications become apparent. For example, phase 2 allowed me to explore YP views on stigma further. In doing so, it was identified that perceived societal stigma acts as a barrier to seeking help. Therefore, if MHL programmes are to successfully increase the extent to which YP seek help, they must tackle MH knowledge which will in turn address levels of perceived societal stigma.

11.2.2 Awareness of support in schools

When considering findings from the FGs together with the semi-structured interviews, discrepancies between YP and SENCo views were found. By and large, pupils and staff had consistent ideas as to how schools could better support the MH of YP. However, when it came to the resources available to YP in schools (e.g. counsellors, safe space) YP were largely unaware of what resources were available to pupils within their school. All SENCos, on the other hand, reported a selection of resources available to their pupils, including safe spaces, pastoral support, school counsellors and links to online resources, such as Kooth. Only two participants in this study were aware of the MH support available in their school and it was explained to me that this was because they had personally accessed it. In fact, pupils in the FGs highlighted that not knowing what resources were available and how to access them, was a significant barrier to seeking help for a MHP. The inference here is that, of course it is important to increase the supportive MH resources available to YP, but it is of paramount importance that this is communicated to all pupils, not just those who have been identified by staff as high need.

11.2.3 Physical health social emotional lessons

Another inconsistency found between pupil and SENCo views, were their thoughts regarding PSHE lessons. SENCos identified PSHE lessons as a current means of increasing pupil MHL, whereas pupils regarded PSHE lessons to be an inadequate way of teaching pupils about MH. This study goes some way to communicate to staff and policy leaders that YP require more explicit knowledge surrounding MH, including symptoms, prognosis and treatment. If society is to successfully raise the MHL of YP, PSHE lessons appear to require radical development.

11.3 Links to the Theory of Planned Behaviour

At this point, I would like to return to of the theory of planned behaviour (TPB) (Ajzen, 1991) and apply it to the findings of this study.

According to TPB (Ajzen, 1991) one's behaviour is determined by their intentions and perceived behaviour control. Intention is ==ones== motivation and is determined by attitude and social norms. Thus, in order to increase ones intention to seek MH support, one needs to know that they will benefit from such help. Furthermore, lower perceptions of societal stigma will impact positively upon intention. Perceived behaviour control refers to the extent to which one feels they have control over receiving help. For example, the ease of accessing help. Thus, in order to impact positively upon ones perceived behaviour control, YP need to be made aware of available support and how to access it, as illustrated in figure 14.

Figure 14 Illustration of the theory of planned behaviour (Ajzen, 1991) applied to seeking help for a mental health problem.
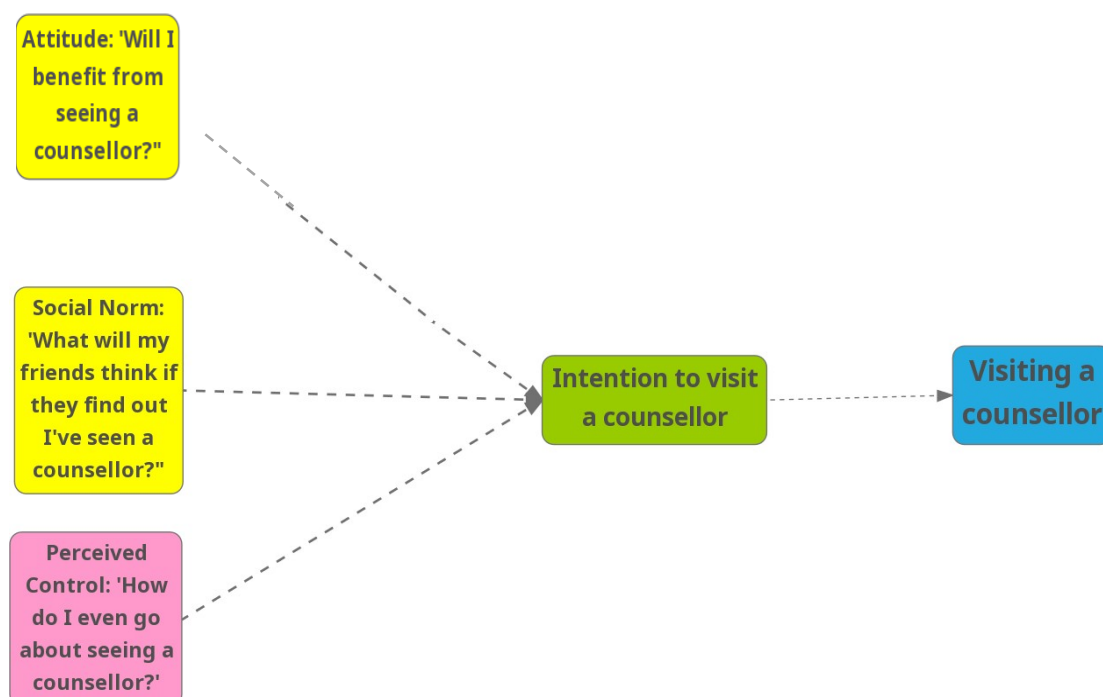
The application of the TPB towards YP seeking help for a MHP is supported by this research; YP in this research demonstrated limited knowledge regarding the benefits of MH support and high levels of perceived societal stigma (INT). Also, overall, participants did not demonstrate a high level of perceived control of accessing

support (PBC). Therefore, when applying the TPB to the participants in this research, one can deduce that impacting upon participants levels of INT and PBC will positively influence participants likelihood to seek help for a MHP. The implementation of MHL programmes has the potential of making said impacts upon YPs levels of INT and PBC.

I shall now go on to summarise the elements of a MHL programme, based on the combined views of the participants in this study and existing research within the field.

11.4 Elements of Mental Health Literacy Programme

Combined findings from phase 1, 2a and 2a suggest that a programme designed to raise the MHL of Year 8 pupils should have the following elements:

6   For MH to be integrated into the curriculum and for sessions to be interactive. Lesson content should include explicit information regarding symptoms, prognosis and treatment of MHPs. Sessions should also include teaching YP skills to cope with stress, such as relaxation and mindfulness.

7   For a whole school ethos to be adopted whereby the following is provided: opportunities for peer support; more support from external services (e.g. educational psychologists, CAMHS, counsellors); involvement within the community, including parents and carers; increased staff MHL; support for staff MH and wellbeing.

Support for the above suggestions exists as MHL programmes containing these elements have been shown to raise YP MHL (Bulanda et al., 2014; Chisholm et al., 2016; Marshall et al., 2018). Furthermore, schools are widely accepted as well placed to take on a central role in the implementation of such MHL programmes (Moon et al., 2017). However, it has been argued that schools alone cannot raise MH awareness and facilitate the changes required to ensure YP recover from MHPs (Rothi, Leavey & Best, 2008) and that integration across education, health and social care is lacking (Wolpert et al., 2015). Part of a YPs recovery is changing their environment which requires support from the

community, family and school (Wolpert et al., 2015; Moore et al., 2018; Wang & Sheikh-Khalil, 2014). The educational psychology profession is well placed to tackle such challenges. I shall now go on to explain how, as I answer RQ 5.

11.5 Implications for Practice

11.5.1 Research Question 5: How might educational psychologists facilitate mental health literacy programmes in schools?

Educational psychologist (EPs) are a main specialist external provision of MH support to schools (Sharpe et al., 2016) and are at the centre of many interventions and research (Roffey, Williams, Greig & MacKay, 2016). Schools have been identified as a well-placed setting to facilitate MH awareness (Moon et al., 2017) with government policies offering guidance on how schools should support pupils MH (DoH, 2017; DoH & DfE, 2017). However, there is no mention of EPs within government documents as means of MH support (Grieg et al., 2019). There is arguably a pressing need for EPs to have a higher profile in MH promotion (Sharpe et al., 2016) by utilising their ideal position of working between education and health (Rothi et al., 2008). Wolpert et al., (2015) suggested that integration between education, health and social care is necessary to ensure that MH care is focused on the person as opposed the problem, by making changes to the individual's environment. EPs work across many layers of a YPs ecosystem and have the capacity to facilitate communication and change across health, education, social care, community and family (Rumble & Thomas, 2017). Furthermore, EPs have extensive knowledge of both psychology and education, meaning they can make a valuable contribution to MHL programmes in schools (Rothi et al., 2008). If EPs are not proactive in promoting their unique skills and position to support YP MH, the profession is at risk of not receiving the resources and staffing required to fulfil this role (Greig et al., 2019).

There are several ways EPs can facilitate MHL programmes within schools and promote their distinctive skill-set. I will address each suggestion in turn and in relation to the themes identified in the Phase 2 analysis.

11.5.1.1 Teacher training

As identified in theme 9.8.1 (teacher skills) the SENCos within this research highlighted the importance of teachers' level of MHL when supporting pupils MH. By offering whole school MH training to school staff, EPs could help teachers to recognise MHPs amongst YP (Schulte-Korne, 2016). Genuine involvement from all members of school staff is required if schools are to implement the value of MH being 'everyone's business' (Weare, 2015, p.5) and as such all members of staff need to receive MH training. Logistically, this could prove difficult and so EPs could help teachers cascade the training to all staff members (Cane & Oland, 2015). Such an approach was attempted as part of the 2008 Government endorsed TaMHS agenda as three members of school staff attended MH training and had the responsibility to feedback principles and strategies to remaining school staff. Cane and Oland (2015) evaluated this framework, concluding that it had a positive effect on staff attitudes towards MH as well as a whole school ethos. Cane and Oland (2015) identified challenges with a minority of staff having the responsibility to cascade training across all staff, and suggested that EPs could support this process.

By raising the MHL of staff, teachers would be more able to recognise symptoms of MHPs, potentially leading to earlier intervention and referral to external agencies (Cane & Oland, 2015; Beaudry, Swartz, Miller, Schweizer, Glazer & Wilcox, 2019; Neufeld et al., 2017). Beaudry et al., (2019) stress the importance teachers' ability to identify early signs of MHPs, in order to signpost YP to the correct specialist service. In addition, Harland (2015) conducted a survey on behalf of the Department of Education with over 2000 teachers in the UK. When asked how they could best support YP MH, over 52% said via staff training to increase their MH knowledge and skillset.

As identified within theme 9.4.2 (relationship to teacher) other benefits of raising teachers MHL via staff training includes increasing teachers' capacity to interact with pupils about MH issues. Teachers are at the forefront of delivering interventions and communicate with YP on a daily basis. These interactions have been shown to be fundamentally important in terms of YP disclosing a MHP (Beaudry et al., 2019). As such teachers need to be capable and prepared to handle conversations appropriately by demonstrating understanding and trustworthiness (Kendal, Keeley & Callery, 2011). Furthermore, teachers need to

be aware of their own preconceptions and stereotypes (Rothi & Leavey, 2006).

The idea of EPs delivery MH training is not a novel one, with suggestions of EPs and CAMHS delivering training together (Cole, Sellman, Daniels & Visser, 2002) Of course, this is arguably an idealistic suggestion as EPs work as part of a traded service and so it may not be clear where the responsibility of payment lies (Hulme, 2017).

11.5.1.2 Staff supervision

Also identified within themes 9.8.1 and 9.4.2 is the view that teachers require support regarding their own MH. Teachers have repeatedly reported feeling overwhelmed, under skilled and unsupported when dealing with the MH needs of pupils (Walter et al., 2006; DfE, 2015; Moon et al., 2017; Cane & Oland, 2015; Short et al., 2009). EPs are well placed to offer supervision to teachers on an individual or group basis (Reichardt, 2016; Rae, Cowell & Field, 2017). Hills (2016) evaluated the emotional literacy support assistant (ELSA) intervention which was both designed and supervised by EPs. Hills (2016) found that CYP valued the aspect of being listened to; a skill that EPs helped to facilitate within support assistants and also a role fulfilled by EPs to assistants via supervision.

However, ELSA is one of the few examples of EPs offering ongoing supervision to teachers (Rae et al., 2017) suggesting that supervision is an underdeveloped role of the EP. Rae et al., (2017) explored this idea by conducting semi-structured interviews with teachers across two special schools within England. Findings suggested that teachers expressed a desire for objective, solution focused, confidential support, offering an opportunity to offload and reflect. However, there was a lack of consensus amongst teachers as to what 'supervision' entailed and whether EPs were best placed to conduct it. This lack of clarity is understandable, when we consider the traditional role of the EP which was centred around individual casework with CYP (Boyle & Lauchlan, 2009).

Thus, there is a role for EPs to be explicit with staff as to the benefits of planned, regular supervision and how, given EPs in-depth knowledge of the school system and links between staff MH and work efficacy, EPs are well placed to conduct supervision to staff (Rae et al., 2017). Supervision can take different forms, including group or individual. EPs can offer more general and regular supervision whereby staff can discuss wider whole school approaches, which in turn builds

relationships and relieves the burden on staff (Sharpe et al., 2016). In addition, EPs can offer supervision throughout teachers' implementation of a MH intervention, in order to resolve dilemmas and problem solve (Dunsmuir & Cobbald, 2016).

11.5.1 3. Direct therapeutic work

As identified in themes 9.9.4 and 9.8.3, SENCos expressed a desire to receive more support from external services. Participants explained that some YP require specialist support and intervention of which teachers are not qualified to deliver. As such, I suggest that EPs fill this gap by increasing the extent to which they work therapeutically with YP in school settings.

The extent to which EPs work therapeutically varies between authorities, services and individuals (Wade, 2016) with Farrell, Woods, Lewis, Rooney, Squires and O'Connor (2006) reporting that EPs spend 1% of their time working therapeutically. With therapeutic approaches demonstrating positive outcomes for YPs MH (Stobie, Boyle & Woolfson, 2005; MacKay, 2007) and other MH services reporting insufficient capacity (Sharpe et al., 2016; Kennedy, 2010) there is an argument for its prevalence to increase (Boyle, 2007; Cane & Oland, 2015). Rothi et al., (2008) explored teachers' perspectives regarding EP involvement with YP with MHPs, and found that EPs were highly valued. However, teachers expressed a view that EPs did not spend enough time working directly with YP and suggested that this was partly due to underfunding.

Another explanation for limited EP therapeutic work is a previous government focus on targets, achievement and attendance (MacKay, 2007). Thus, with schools commissioning EP work, there has been an expectation from teachers for EPs to support YPs cognitive development, with social, emotional and MH needs being neglected (MacKay, 2007). With the promotion of MH in schools being a current government agenda (DoH & DfE, 2017) EPs are well positioned to advocate for more therapeutic work with YP by offering evidenced based interventions (Winward, 2015). However, EPs themselves may require professional development to increase their confidence and specialist competence in order to promote their therapeutic skills (Dunsmuir & Cobbald, 2016).

11.5.1.4. Improve community and parental involvement

Highlighted within theme 9.9.5 is the idea that improved links between school, community and home has a positive effect on YP MH. Research stresses the importance of considering wider systems around YP when supporting their MH (Atkins et al., 2010; Rothi & Leavey, 2006; Wolpert et al., 2015) and the necessity to involve the community when working preventatively (Banyard, Plante & Moynihan, 2004). With such wider systems involving multi agencies, cooperation is paramount if services are to come together to facilitate change within the environment (Rothi & Leavey, 2006). However, with no defined model to follow and differing opinions existing regarding role responsibility, interventions involving parents and the community can prove difficult to implement (Hulme, 2017; Marshall & Smith, 2018).

EPs are well placed to support the bringing together of communities as part of a MHL programme by helping schools to become more receiving to the community. EPs can guide teachers' communication with parents who have limited trust of school settings (Marshall & Smith, 2018). Marshall & Smith (2018) found that when schools invited parents into school for tea and cake, parents viewed the school environment to be less intimidating. Also, providing a 30-minute drop in session after morning drop off for face to face contact with a teacher, resulted in parents viewing the school to be a more approachable place. This helped staff to educate parents on MH, empowering parents to identify MH needs and seek support. Furthermore, EPs are well placed to facilitate collaborative working between schools, empowering school staff to share experiences and problem solve.

EPs can also help to involve the community by attending community centre group sessions, such as parent and toddler groups. With current government focus on MH awareness (DoH & DfE, 2017) the educational psychology profession could provide evidence based interventions, working both preventatively with parents within the community and reactively by supporting targeted parents.

11.5.1.5. Improving relationships between external agencies and schools

As previously mentioned, within themes 9.4.4 and 9.8.3, participants expressed a desire to receive more support from external services. One way to facilitate this is by improving the relationship between external agencies and schools. Challenges exist within the joining up of services across England with little consensus on how best to integrate education and health (Atkins et al., 2010; Roffey et al., 2016; Rothi & Leavey, 2006; Wolpert et al., 2015). Parents and carers report feeling frustrated by the lack of coordination between services (Kennedy, 2010) and schools describe feeling isolated and unsupported (Wolpert et al., 2015). Wolpert et al., (2015) reported that typically, general practitioners refer YP to CAMHS, and schools leave YPs care to CAMHS with the expectation that they return to school healed. Increasing demand is put on CAMHS with capacity at a minimum (Sharpe et al., 2016). Roffey et al., (2016) suggested thaT the EP 'offers something additional to both education and medical perspectives and can act as a buffer between the two' (p.6). One way this could be achieved is by joint consultation as EPs have the knowledge of the school system, psychology and external service protocols (Rothi et al., 2008). Furthermore, EPs can facilitate collaborative problem-solving (Reichardt, 2016; Wagner, 2000). EPs have consultative skills meaning they are able to help elicit the views of all parties whilst demonstrating empathy, understanding and an ability to define clear outcomes and actions (Wagner, 2000). Furthermore, EPs have an understanding of the evidence demonstrating links between learning and MH, again bridging the gap between education and health (Reichardt, 2016).

11.5.1.6. Research

EPs work at every level of YPs ecosystem and are well placed to conduct research exploring the efficacy of MHL programmes that involve various systems around the YP (Rumble & Thomas, 2017). Such systems include external services, the community, parents/carers, educational settings and medical profession (Rumble & Thomas, 2017). There is a timely need for more evidence based interventions, focusing on both targeted and universal MH support in schools (O'Reilly et al., 2018). As such, there is a role for EPs to conduct research measuring EP impact upon YPs MH in an attempt for policy leaders to recognise the value of the EP profession (Greig et al., 2019). By producing research

evidence EPs also have the potential to improve the practice of school staff when supporting YPs MH, by providing clear guidelines with clarity and structure (Boyle & Kelly, 2016). However, fundamental to the success of such evidence based practice, is the correct implementation of the intervention (Boyle & Kelly, 2016). Thus, the EP role does not end with the production of evidenced based practice, as discussed in section 11.5.1.2, EPs have a role to supervise staff ensuring effective implementation of interventions (Boyle & Kelly, 2016).

11.5.1.7 Whole school support

When considering the above recommendations as a collective, it becomes clear that a whole school approach is indeed required. Evidence suggests that effective models aimed at raising the MHL of both staff and pupils, adopt a whole school approach (Arango et al., 2018; Weare, 2015; Marshall & Smith, 2018; Cane & Oland, 2015; Banjeree et al., 2016). A whole school approach describes all parts of the school organisation working coherently together, encompassing the totality of the school experience (Weare, 2015; Cane & Oland, 2015). Such an approach requires genuine involvement from all staff members, pupils, governors, parents, community and outside agencies (Weare, 2015). However, the complexity of such an approach can be difficult to implement and as such whole school approaches have sometimes been too vague and diluted to be effective (Banjeree e al., 2016). Durlak et al., (2011) observed that multi-component whole school approaches to promoting MH were no more successful than single component approaches, consisting of classroom/curriculum only. Durlak et al., (2011) suggested that this could be due to the difficulties encountered trying to organise a multi-component model.

EPs are well placed to support schools, via incremental steps, to achieve a whole school approach to MH, where the following is targeted: staff MHL; staff wellbeing; pupil MHL; MH curriculum; in-school resources; school ethos; parental engagement; community engagement; school organisation; school and external services relationships. When considering the findings from this thesis, within a whole school approach, there is a role for EPs to help staff to communicate their resources to all pupils. EPs have access to all layers of a YPs ecosystem (Rumble & Thomas, 2017) as exampled in Figure 15.

Figure 15 Diagram representing the ways in which the educational psychologist can facilitate change at every level of the child or young person's ecosystem (Bronfenbrenner, 1979).

Chronosystem:
Research, impacting upon policies

Macrosystem:
Community psychology e.g drop in centres

Exosystem
Facilitating communication between school and external services

Mesosystem:
Improving parental involvement with school

Microsystem:
Increasing MHL of teachers, peers; supporting teachers; school resources

CYP:
Direct therpapeutic work; elicting views

Anderson, Boyle and Deppeler (2014) re-conceptualised Bronfenbrenner's ecological systems theory to account for the contextually diverse and evolving educational environment. Anderson et al., (2014) established the ecology of inclusive education, delivering a framework in which the EP role within promoting

MH in schools can be understood. Application of the ecology of inclusive education (Anderson et al., 2014) helps guide EPs to support the MH of YP in schools, as it explains not only the different layers of the YP ecosystem but the relationships between the systems. Therefore, when considering the ecology of inclusive education, EPs are well placed to support the YP at each level of their ecosystem, whist being mindful of the fluctuating interactions between the systems of a complex educational system which differs for each individual.

11.6 Limitations

Within this section, both reflective and methodological considerations of the strengths and limitations of this study are discussed.

11.6.1 Questionnaires

There is a possibility that, when completing the personal stigma items on the PHMSS, participants may have underestimated their true levels of stigma due to social desirability; the extent to which participants do not want to admit stigmatising beliefs to themselves (Michaels & Corrigan, 2013). In an attempt to combat this, I ensured that all participants were verbally informed that there were no right or wrong answers and that I required their honest thoughts. Furthermore, participants were told that they need not attach their names to their questionnaires and that all responses would be anonymous.

11.6.2 Experimenter effect

It could be argued that the subjects in phase 2 experienced the expectancy effect; the idea that I, the researcher, conveyed my expectations of the findings to participants via body language (e.g. gestures, tone of voice) resulting in participants consciously or unconsciously conforming to a perceived lead (Thomas, 2017). In response to this I would argue that the benefits of gaining the rich data enabled from such qualitative methods, outweigh the risk of expectancy effect. Furthermore, I was mindful of the risk of experimenter bias and verbalised to all participants that there were no right or wrong answers and that I was interested in their experiences.

11.6.3 Generalisability

The data from phase 1 could be criticised in terms of not being generalisable to secondary schools pupils as a whole, as participants were Year 8 pupils only. It may therefore be beneficial to extend this methodology to a wider range of ages, for example Year 7 through to Year 11.

The data from phase 2a and 2b could be criticised in terms of not being generalisable as the population sample was small (22 and 3 participants retrospectively) and therefore may not be representative of the wider population; Year 8 students and SENCos throughout England. However, in an effort to improve the sample representativeness, a stratified sample was taken. Each FG was required to contain an equal proportion of below, at the level of, and above ARE, plus at least 1 individual with SEN. Furthermore, phase 2 sought to gain a rich explanation of participants views and experiences, adding to the data obtained in phase 2 via triangulation; not necessarily to generalise findings to the wider population.

11.6.4 Focus groups

Seeking the views of a group of individuals has its limitations, one being the risk of the group being dominated by one or two stronger characters. This would of course lead to an inaccurate reflection of views. However, I would argue that I made efforts to counter balance any dominance by being mindful of this potential and managing the conversation flow between participants. Also, I would suggest that, conversely, some YP within a group are more likely to express their views as they are less intimidated than they may be in a 1:1 interview.

11.6.5 Thematic analysis

Due to the time and financial constraints of a doctoral research study, I was not able to arrange for an additional individual to review the themes generated. This leads to the criticism of interpreter bias. In response, I would argue that the study adopted a mixed-method, resulting in both objective and subjective data. This

has the advantage of compensating the weaknesses from both methods whilst benefitting from the strengths of both methods (Creswell & Clark, 2017). That is to say, the strength of objective data gathered in phase 1, added support to the subjective data gathered in phase 2.

11.6.6 Uneven distribution of questionnaires across schools

Within Phase 1, the questionnaires were distributed to approximately 100 Year 8 pupils per school. However, this was not the case for school 4 as the questionnaire was administered to all Year 8 pupils (n= 176). This uneven distribution may have introduced an element of bias.

11.7 Future Research

Within this thesis I have explored the extent of YP MHL and ways in which adults around YP, including EPs, can help to develop YP MHL. However, this thesis did not explore reasons for the increased prevalence of YP MHPs. On reflection, perhaps any MHL programmes should be influenced by this knowledge so as to maximise the preventive element.

On that note, other prevention avenues could be explored. For example, the concept of resilience has been touched upon in section 6.1.5 of this thesis. Specifically, the notion of YP holding negative views towards seeking professional help for MHPs, due to a belief that they should be resilient, and as such, deal with the situation alone (Wilson et al., 2005; Brown & Carr., 2018; Gulliver et al., 2010). Given recent political guidance (DfE, 2016) which explicitly encourages building YPs resilience, the link between resilience and attitudes towards seeking help should be explored.

A possible explanation for the increased prevalence of YP MHPs, is social media use. According the Office for National Statistics (2018) 29.4% YP experiencing a MHP spent more than four hours a day on social media, compared to only 12% of YP without a MHP. Thus, links between social media and MHP should be explored.

In addition, when seeking the views of YP with regards to MHL programmes, I would suggest widening the population sample to include participants from Year

7 to Year 11. This would increase the extent to which findings can be generalised to the wider secondary school population.

Findings from this thesis identified that females had a greater differential between their perceived societal stigma and personal stigma than males. In terms of reducing societal stigma, it may be beneficial for future research to explore the gender differential. Participants in this study did not demonstrate positivity towards seeking support via the internet, whereas existing research suggests that online peer to peer support is increasingly common (Naslund et al., 2016). Research surrounding online peer to peer support is argued to include a limited number of high-quality randomised control trials (Ali, Farrer, Gulliver & Griffiths., 2015). Thus, I propose that it is difficult to draw firm conclusions regarding the efficacy of online peer to peer support and that the concept should be explored further by the neutral profession of EPs.

Finally, an implication from the current research is for EPs to have a prominent role in supporting school staff to implement MHL programmes by adopting a whole school approach. I suggest that it would be useful for future research to evaluate the EP role in supporting schools in this way, by seeking the views of a wider range of school staff (e.g. teachers and teaching assistants). Quantitative data could also be obtained by using the questionnaires within the current research. However, to ensure any progress was not the result of chance, confidence intervals would need to be calculated. Evaluation could also include effects to YPs learning as part of a longitudinal study. This could potentially lead to evidence based interventions, which is a valued means of EP involvement in a traded service. The inference being that schools are more likely to commission an EP to undertake work, if evidence of previous success exists. Furthermore, with government focus moving towards that of MH awareness, now is the time for EPs to ensure schools are aware of the evidence base for MHL interventions.

11.8 Concluding Comments

Adolescent MHPs are increasingly prevalent within the UK (Ohrnberger et al., 2017) with vast and detrimental lifelong impacts, including sleeplessness, drug and alcohol addiction, family conflict and suicide (Gaddis et al. 2017; Lo et al., 2017). Many YP do not receive timely professional support (Frith, 2016)

worsening symptoms of their MHP (Pinfold et al., 2005). Educational settings have been identified as a prime location to deliver MHL programmes, aimed at raising pupils MH knowledge and attitudes towards seeking help, as well as reducing stigmatising views (Moon et al., 2017). This research explored the views of both pupils and educators, by adopting a 2 phased mixed-methods design. Results of phase 1 echoed that of existing research by identifying an opportunity to increase Year 8 pupils MHL. Furthermore, findings highlighted that levels of participants' perceived societal stigma were higher than personal stigma. Findings from phase 1 identified that higher levels of MH knowledge is correlated with lower levels of both personal and perceived societal stigma. Additionally, lower levels of both societal and personal stigma were correlated to more positive attitudes towards seeking help.

Findings within phase 2 has begun to fill a gap within existing research as it explored the views of both pupils and educators with regards to prospective MHL programmes in the UK. Suggested aspects were as follows: for MH to be integrated into the curriculum; sessions to be interactive; content to include explicit information regarding symptoms, prognosis and treatment of MHPs; sessions to include teaching YP skills to cope with stress, such as relaxation and mindfulness. In addition, views expressed a requirement for a whole school ethos to be adopted whereby the following is provided: opportunities for peer support; more support from external services (e.g. EPs, CAMHS, counsellors); involvement within the community, including parents; increased staff MHL; support for staff MH and wellbeing.

With the current government pledging to raise MH awareness within UK schools and providing more MH support for YP (DoH & DfE, 2017) EPs are well placed to support schools to implement whole school MHL programmes. EPs work within all layers of a YPs ecosystem (Rumble & Thomas, 2017) and as such EPs can support YP both directly and indirectly in the following ways: MHL training to staff; staff supervision; facilitating parental and community involvement; facilitating relationships between schools and external services; direct therapeutic work.

In summary, this research adds to the literature supporting the legitimacy of MHL programmes within educational settings. Furthermore, this thesis adds to a much-required small body of research, exploring the views of both pupils and educators during a period of recognition, information seeking and MH action from the

government (DoH & DfE, 2017).

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12.0 References

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Chapter 13

13.0 Appendices

Appendix 1:

Application for ethical approval

Ref (for office use only)

D/17/18/28

COLLEGE OF SOCIAL SCIENCES AND INTERNATIONAL STUDIES

When completing this form please remember that the purpose of the document is to clearly explain the ethical considerations of the research being undertaken. As a generic form it has been constructed to cover a wide-range of different projects so some sections may not seem relevant to you. Please include the information which addresses any ethical considerations for your particular project which will be needed by the SSIS Ethics Committee to approve your proposal.

Guidance on all aspects of the SSIS Ethics application process can be found on the SSIS intranet: https://intranet.exeter.ac.uk/socialsciences/staff/research/researchenvironmentandpolicies/ethics/

All staff and postdoctoral students within SSIS should use this form to apply for ethical approval and then send it to one of the following email addresses:

ssis-ethics@exeter.ac.uk This email should be used by staff and postdoctoral students in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology.

gseethics@exeter.ac.uk This email should be used by staff and postdoctoral students in the Graduate School of Education.

Applicant details	
Name	**Katie Atkins**
Department	**DEdPsych**
UoE email address	**Ka372@exeter.ac.uk**

Duration for which permission is required		
You should request approval for the entire period of your research activity. The start date should be at least one month from the date that you submit this form. Students should use the anticipated date of completion of their course as the end date of their work. Please note that <u>retrospective ethical approval will never be given</u>.		
Start date: 07/03/2018	**End date: 27/07/2019**	**Date submitted: 07/02/2018**

Students only	
All students must discuss their research intentions with their supervisor / tutor prior to submitting an application for ethical approval. The discussion may be face to face or via email. Prior to submitting your application in its final form to the SSIS Ethics Committee it should be approved by your first and second supervisor / dissertation supervisor/tutor. You should submit evidence of their approval with your application, e.g. a copy of their email approval.	
Student number	**660053049**
Programme of study	**Doctor of Educational Psychology (DEdPsych)**
Name of Supervisor(s)/tutors or Dissertation Tutor	**Andrew Richards & Chris Boyle**
Have you attended any ethics training that is available to students?	Yes, I have taken part in ethics training at the University of Exeter For example, the Research Integrity Ethics and Governance workshop: http://as.exeter.ac.uk/rdp/postgraduateresearchers

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Page 1 of 13

182

Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change radically I will complete a further ethics proposal form.

Katie Atkins

Double click this box to confirm certification ☒

Submission of this ethics proposal form confirms your acceptance of the above.

TITLE OF YOUR PROJECT

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools.

ETHICAL REVIEW BY AN EXTERNAL COMMITTEE

N/A

MENTAL CAPACITY ACT 2005

N/A

SYNOPSIS OF THE RESEARCH PROJECT

As a guide - 750 words.

The prevalence of common mental health disorders is on the rise among the populations of western nations (Ohrnberger, Fichera & Sutton, 2017). Research shows that half of all mental health problems manifest by the age of 14 years, with 75% manifest by age 24 years (Kessler et al., 2005). Furthermore, almost a quarter of children and young people in the United Kingdom (UK) show some evidence of mental ill health, including anxiety and depression (Frith, 2016) and 90% of school leaders have reported an increase in the number of students experiencing anxiety or stress over the last five years (Association of School & College Leaders, & National Children's Bureau, 2016).

As such, there has been an increasing focus on the mental health of young people and ways to raise awareness within schools. Current Government have pledged to investigate ways in which schools can support the mental health of pupils and research suggests that one way to do this is to raise the mental health literacy of young people.

This research seeks to explore the mental health literacy of young people in schools. Furthermore, in line with current Government goals, the research seeks to explore both young people and educator's views regarding current and potential ways in which schools can support mental health awareness of young people.

Aims of this study are to:

1. To gain a broad sense of the young person's (ages 12-13 years) mental health literacy
2. To explore the link between mental health literacy and stigma
3. To identify what needs there are for mental health programmes in schools
4. To explore the views of the young person regarding prospective mental health literacy interventions
5. To gain the perspective of educators regarding existing mental health literacy in schools
6. To explore the views of educators regarding prospective mental health literacy interventions
7. To explore how educational psychologists might facilitate mental health literacy

programmes in schools

What is involved:

The study will take place in 2 parts from March 2018 until July 2019 by trainee educational psychologist, Katie Atkins, under the supervision of Andrew Richards and Chris Boyle.

Part 1: Approximately 500 KS3 pupils (year 8) will complete the following measures: Mental health Knowledge Schedule (MAKS); Peer Mental Health Stigmatisation Scale (PMHSS); Mental Health Seeking Attitudes Scales (MHSAS). These are well-established questionnaires used in international studies including English children. I plan for this phase of the research to be completed by the end of April, 2018.

Part 2a: A sub-sample of pupils (approximately 18-30 KS3) will take part in focus groups whereby they will asked about both existing and potential ways in which schools support their awareness of mental health.

Part 2b: 4 special educational need co-ordinaters (SENCos) will participate in a semi-structured interview where they will be asked about existing and potential ways in which schools could support pupils' mental health literacy.

Output:

Schools will receive:

   i.   a confidential and anonymised summary of the questionnaire findings compared with other local schools' results using the questionnaires
   ii.   an account of views from both pupils and SENCOs with regards to ways in which schools could raise the mental health literacy of pupils.

INTERNATIONAL RESEARCH

N/A

The following sections require an assessment of possible ethical consideration in your research project. If particular sections do not seem relevant to your project please indicate this and clarify why.

RESEARCH METHODS

Part 1

Approximately 100 pupils in Year 8 from each secondary school will be selected by the school for participation in the questionnaires.

Data from the questionnaire will be analysed using SPSS, providing a range of descriptive statistics.

Part 2a

6-10 pupils from Yr8 from 3 secondary schools will be selected to participate in focus groups, lasting approximately 1 hour each. The focus groups will be structured using Krueger and Casey's guidance on 'Designing and Conducting Focus Group Interviews' including guidance around questioning, number of participants, environment and moderator skills.

The interviews will be audio recorded to ensure accuracy. These notes will then be analysed qualitatively. The programme NVIVO will be used to assist the analysis.

Part 2b
4 SENCos will participate in semi-structured interviews, lasting approximately 1 hour.

PARTICIPANTS

Part 1
Participants will include pupils between the ages of 12 and 13 (Yr8). They will be attending 5 secondary schools in the south-west of England. Approximately 500 secondary school pupils will complete the questionnaires (100 participants per school x 5 schools = 500 participants in total). Part 2 6-10 children from Year 8 from 3 of the 5 secondary schools will be selected for three separate focus groups (one at each secondary school). Schools will be asked to identify children for focus groups according to the following criteria: equal gender split across three levels of attainment (high, medium, low), including one student with highlighted special educational needs (SEN). Given that the criteria for interviews include some pupils with SEN, schools will be asked to identify the nature of the SEN, in order that the researcher (trained in SEN) can be mindful of the child's needs during the focus group session.

THE VOLUNTARY NATURE OF PARTICIPATION

185

Part 1

Participants will be recruited by school staff. An information and consent form will be sent to parents/guardians prior to the children completing the questionnaire. Passive consent will be gained from parents, i.e. parents will contact the school if they do not wish for their child to take part. The letter will inform parents that their child's identity will be confidential and the data will remain anonymous. Parents /guardians will also be informed that data will be destroyed once it is analysed and that their children have the right to withdraw at any time. Parents will be informed that the questionnaires will not contain any of their child's persona data. The aims of the study will also be explained. Identity will only be revealed if a child protection issue arises.

Written into the beginning of the questionnaire will be information for the child about the nature of the study and that their participation is voluntary. Those administrating the questionnaire (researcher or by agreement with staff) will be made aware of their importance of children understanding the voluntary nature of their participation.

Part 2a

Participants will be recruited by school staff according to criteria set by the researchers (see above). A separate consent letter will be sent to parents/carers regarding consent for their child to participate in phase 2a (the focus group). Consent for this phase will be active; parents and carers will need to 'opt in' to the research by responding with permission for their child to participate tin the focus group.
As above, the letter will contain information regarding the aims of the research and also that their child's identity will remain anonymous and confidential. The letter will explain that their child's data will be destroyed once it has been analysed and that their child will have the right to withdraw form the process at anytime.

At the beginning of the interview, participants will be informed verbally that their participation is voluntary, that they have a right to withdraw at any time, and that all information will be treated anonymously. The children will be informed verbally of the purpose and nature of the study.

Part 2b

SENCOs will invited to participate in a semi-structured interview via a letter. The letter will inform SENCos of the aims of the research and that their identity will remain confidential and anonymous. The letter will also explain that participants have the right to withdraw at anytime.
Consent for this phase will be active; SENCOs will need to respond in writing, agreeing to participate.
At the beginning of the interview, participants will be reminded verbally of their right to withdraw at anytime.
Interviews will be audio recorded to ensure accuracy.

SPECIAL ARRANGEMENTS

N/A

THE INFORMED NATURE OF PARTICIPATION

Part 1

Information about the study will be sent to parents prior to the children completing the questionnaire. Passive consent will be gained from parents, i.e. parents will contact the school if they do not wish for their child to take part. The letter will inform parents that their child's identity will be confidential, and the data will remain anonymous. Parents will also be informed that the questionnaires will not contain any of their child's personal data. Identity will only be revealed if a child protection issue arises.

Written into the beginning of the questionnaire will be information for the child about the nature and

purpose of the study.

Part 2a

A separate letter will be sent to parents regarding consent for their child to participate in phase 2a (focus group). The letter will contain information regarding the aims of the research and also that their child's identity will remain anonymous and confidential. The letter will explain that their child's data will be destroyed once it has been analysed and that their child will have the right to withdraw form the process at anytime.

Part 2b

Participants will be written to, inviting them to participate in phase 2b of the study; the semi-structured interview. The letter will contain an overview of the aim of the study and information explaining that their identity will remain confidential and anonymous. The letter will also explain that their data will be destroyed once their data has been analysed and that they will have the right to withdraw at anytime during the process.

ASSESSMENT OF POSSIBLE HARM

It is not anticipated that any harm to participants will occur, as these are established international instruments, which take cognisance of the age of the child. One possible risk is that some content of the questionnaire or focus group sessions may evoke some emotional distress in a small number of children. In order to alleviate potential distress, the content of the focus group will not contain direct questions to individual children and questions will not explore children's personal experiences of mental health, thus allowing the participants to remain in control of whether they respond to certain questions or not. Questions are aimed at exploring children's views of existing and potential mental health awareness programmes, as opposed to their own mental health per se.

The same risks applies to the SENCos being interviewed in phase 2b. Again, no direct questions will be asked surrounding the participants' personal experiences of mental health.

Questioning will stop in both phase 2a and 2b should any participant show signs of distress. Participants will be informed that the researcher will be available to discuss any matters at the end of the session. The researcher will signpost the participant to the relevant professional should the researcher feel the participant requires additional support.

I am a doctoral trainee psychologist with experience and training in dealing with distress in children, in the unlikely event that this should occur. Appropriate school staff will also be aware of the participation of students and will be able to respond, in the first instance, to students who may experience any difficulty. I have enhanced DBS clearance through the university.

DATA PROTECTION AND STORAGE

Part 1

Questionnaires will be collected by myself and stored in a locked cabinet. The paper copies of the questionnaires will be destroyed within one year. Data will be transferred from the paper questionnaires to SPSS without names or personal details attached to raw data. It will be saved on a password protected computer and backed up on a secure server (University of Exeter U: drive). It will be deleted permanently within one year.

Part 2

Interviews will be audio recorded. Voice data will only be kept for transcription purposes on a password protected computer. It will be backed up on a secure server. Voice data will be deleted within one year. Written notes from the interviews will not contain any names or personal data, and

will be destroyed after analysis. Data will be transferred to NVivo without names or personal details attached to raw data. All research will be presented in anonymised form.

DECLARATION OF INTERESTS

No commercial interests.

USER ENGAGEMENT AND FEEDBACK

N/A

INFORMATION SHEET

Information for schools and attached consent form:

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This project aims to explore young people and educators' views about mental health and ways that schools can support pupils' mental health awareness. An aim of the research is to provide insight into practical implications which may improve overall mental health literacy. This will involve completion of the Mental Health Knowledge Schedule (MAKS), the Peer Mental Health Stigmatisation Scale (PMHSS) and the Mental Health Seeking Attitudes Scales (MHSAS).
It also involves, for up to 10 children, the potential to participate in a focus group whereby existing and prospective mental health programmes will be discussed. The project also involves the potential for your SENCo to participate in a semi-structured interview whereby their views regarding existing and prospective mental health literacy programmes will be explored.

The focus group session and interview will be carried out by myself, a trainee educational psychology doctoral student (TEP). I have experience working with young people and dealing with sensitive issues. I have an enhanced DBS clearance through the University of Exeter.
The research will comprise 2 stages:

Stage 1 – Questionnaires:

- I will supply you with up to 100 sets of questionnaires to be distributed evenly to your Year 8 cohort. Ideally, I will distribute and administer the questionnaires to the pupils, however convenient arrangements for distribution and collection of these can be discussed. Completion of the questionnaires should take no more than 20-30 minutes.
- The questionnaires will be: Mental health Knowledge Schedule (MAKS) Peer Mental Health Stigmatisation Scale (PMHSS); and the Mental Health Seeking Attitudes Scales (MHSAS).
- There are 45 questions in total

Stage 2a – Focus group:

- I will come into school at a mutually agreed convenient date/time to conduct the focus group session. The session will explore current mental health awareness in schools; that is how much knowledge pupils have about existing mental health support and their attitudes towards accessing it. The focus group will also discuss potential mental health awareness programmes, that is the ways in which the pupils think they could potentially learn about mental health and the support available.
- Questions will be indirect and as such will not explore pupil's personal experiences of mental health.
- The focus group session will last approximately one hour and will cease prior to that, should a child become distressed in any way. I will ensure I am available to speak with the participants post session should any child need support.
- We will ask you to identify 6-10 children for the session selected from year 8 with an even distribution of the following criteria:

- high attaining children, medium attaining children and low-attaining children
- males and females
- one of these children should have identified SEN.

Stage 2b- Semi structured interview:

- I will come into school at a mutually agreed convenient day/time to conduct the semi-structured interview with the school SENCo. The interview will explore the SENCos views regarding pupils' current mental health literacy and ways in which the school currently supports mental health awareness. Questions will also be asked surrounding potential mental health literacy programmes within schools.
- Questions will not seek explore the SENCOs personal experiences of mental health
- At the beginning of the interview, SENCos will be reminded of their right to withdraw from the study at any point. If the SENCo displays any signs of distress, questioning will cease.

Schools will receive:

A confidential and anonymised summary of the questionnaire findings from your school, compared with other local schools' results. In addition, your school will receive an anonymised summary of the views of both SENCOs and pupils of all schools involved in the research with identified themes of suggested ways in which schools can enhance the mental health literacy of its pupils.

Please note: You are invited to participate in all parts of the research (1, 2a and 2b). However, participation in phases 2a and 2b is not essential.

Next Steps:
We will supply a template letter for phase 1 of the research to be distributed to parents/ guardians. This will contain information about the study and give parents the option to withdraw their child from the study before the agreed date for questionnaire completion. Schools are free to administer this how they wish.

Data Protection:
All data will be treated as anonymous and confidential. It will be accessible only myself, the researcher, and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If you would like to discuss this further, have any questions or concerns about this, please email myself, Katie Atkins at ka372@exeter.ac.uk

<u>Consent:</u>
I have read about the Mental Health Literacy project and understand the basis for our involvement and consent to take part. I understand that I can withdraw from this study at any time:

For head teacher or member of senior leadership team to sign:
Name:……………………………………………………………………………………………

Role:…………………………………………………………………………………………….

Signature:……………………………………………………………………….

Date:……………………………………………….

Information and consent letter for parents for phase 1:

Dear Parents/guardians,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This project aims to explore students views and knowledge about mental health and ways in which their school can promote mental health awareness. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This will involve Year 8 pupils completing the following three questionnaires: Mental health Knowledge Schedule (MAKS); Peer Mental Health Stigmatisation Scale (PMHSS); Mental Health Seeking Attitudes Scales (MHSAS). There are 45 questions in total

As your child/children falls into the age range applicable for this project, they have been selected by school to take part. Should you not wish for your child to be involved in this project, you withhold the right to contact the school and ask that they be withdrawn. If you wish to do this please contact (school link here)

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. The data obtained from the questionnaires will not contain any personal information about your child. Once the analysis is completed the data will be deleted. Your child has the right to withdraw from the study at any time and this will be explained to them verbally prior to participation.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information around your child, and will simply be a resource at the schools disposal. You, as a parent/guardian, will also receive a letter summarising the outcomes of the research.

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at ka372@exeter.ac.uk.

Consent and Information Section: attached to the front of the questionnaire for children:

This questionnaire is about your knowledge, views and feelings about mental health.

There are no right or wrong answers, only what you believe and feel. You can leave out any questions you don't want to answer.

We will not know who you are. The answers you give won't be shared with anyone. In other words it will be confidential. Nobody except yourself will know your answers; in other words it will be anonymous. You only have to fill in this questionnaire if you want to. If you would not like to fill it in, just tell your teacher and they will give you something else to do.

For each question, please tick the box or circle the number of the option that best matches what

you think.

If you have any questions about the questionnaire, talk to your teacher.

If you understand this and are happy and willing to attempt to complete the questionnaire, please fill in your details and sign your name below. Many thanks

Signature:_____

Name: _____

Name of School: _____

School Year: _____

Age (years): _____

Gender: Male / Female

Date today: _____

Information and consent letter for parents/guardians for phase 2a:

Dear Parents/guardians,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This project aims to explore students views and knowledge about mental health and ways in which their school can promote mental health awareness. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This part of the project involves focus group sessions whereby I will meet with small groups of children (6-10 children) and discuss ways in which mental health could be supported. I will be asking children questions surrounding their views about ways in which their school currently supports mental health and also potential ways in which schools could help raise mental health awareness.

Children will not be asked direct questions and will not be asked to discuss personal experiences of mental health. Children involved will be informed of their right to withdraw at anytime and I will ensure that I am available post session should any child need additional support. If any child appears distressed at any point during the session, questioning will stop.

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted. Your child has the right to withdraw from the study at any time and this will be explained to them verbally prior to participation.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information around your child, and will simply be a resource at the schools disposal. You, as a parent/guardian, will receive a letter summarising the outcome of the research.

As your child/children falls into the age range applicable for this project, they have been selected by school to take part. If you give your permission for your child to take part in this phase of the project, please complete the attached consent form and return it to school.

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at ka372@exeter.ac.uk.

Information and consent letter for students for phase 2a:

Dear student,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

I am researching what young people know and think about mental health and ways in which their schools can help them to know more. This is an opportunity for children in Year 8 to tell me what they think.

This part of the project involves focus group sessions, which means that I will meet with small groups of children (6-10 children) and talk about ways in which their school teaches them about mental health. I will also be asking children questions about what they think their school could do to help them learn more about mental health.

As you are in Year 8 I am inviting you to come along to a focus session. The session will be at your school during school time. You will not be asked direct questions and will not be asked to talk about your personal experiences of mental health. You will not be asked to talk about anyone you know who has a mental health problem. You will have the right to leave the session at any time and I will be available afterwards to talk to you if you would like.

All data will be treated as anonymous and confidential. This means that no one outside of the group will know what you have said as your name will not be mentioned or written down.

When the project is over, I will write to you to let you know what I have found out and how you helped.

If you are happy and willing to take part in the focus group session, please sign and fill in your details below and return it to the school.

Many thanks,

Katie Atkins

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at ka372@exeter.ac.uk

Information and consent letter for SENCos for stage 2b:

Dear (insert name),

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

I am a trainee educational psychologist carrying out my doctorate research project and invite you, the school SENCo, to participate in the project.

This project aims to explore educator's views of ways in which their school currently supports pupil mental health awareness. It also aims to explore educator's views regarding prospective ways that schools could enhance the mental health literacy of its pupils. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This part of the project involves semi-structured interviews with secondary school SENCos whereby I, the researcher and trainee educational psychologist, will meet with yourself in your school setting. The interview will last around an hour and will be audio recorded to ensure accuracy.

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted. You have the right to withdraw from the research at any time.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information about yourself, and will simply be a resource at the schools disposal. You, as a participant, will receive a letter summarising the outcomes of the research.

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at ka372@exeter.ac.uk.

CONSENT FORM

(See above)

SUBMISSION PROCEDURE

Staff and students should follow the procedure below.

In particular, students should discuss their application with their supervisor(s) / dissertation tutor / tutor and gain their approval prior to submission. <u>Students should submit evidence of approval with their application, e.g. a copy of the supervisors email approval</u>.

This application form and examples of your consent form, information sheet and translations of any documents which are not written in English should be submitted by email to the SSIS Ethics Secretary via one of the following email addresses:

ssis-ethics@exeter.ac.uk This email should be used by staff and postdoctoral students in Egenis, the Institute for Arab and Islamic Studies, Law, Politics, the Strategy & Security Institute, and Sociology, Philosophy, Anthropology.

gseethics@exeter.ac.uk This email should be used by staff and postdoctoral students in the Graduate School of Education.

Appendix 2:

Certificate of ethical approval

CERTIFICATE OF ETHICAL APPROVAL

Title of Project:

Researcher(s) name: Katie Atkins

Supervisor(s):   Andrew Richards
Chris Boyle

This project has been approved for the period

From: 07/03/2018
To: 27/07/2019

Ethics Committee approval reference:

D/17/18/28

Signature: Date: 02/03/2018

(Professor Dongbo Zhang, Graduate School of Education Ethics Officer)

Appendix 3:

Letter to parents and guardians, phase 1

Dear Parents/guardians,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This project aims to explore students views and knowledge about mental health and ways in which their school can promote mental health awareness. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This will involve Year 8 pupils completing the following three questionnaires: Mental health Knowledge Schedule (MAKS); Peer Mental Health Stigmatisation Scale (PMHSS); Mental Health Seeking Attitudes Scales (MHSAS). There are 45 questions in total.

As your child/children falls into the age range applicable for this project, they have been selected by school to take part. Should you not wish for your child to be involved in this project, you withhold the right to contact the school and ask that they be withdrawn. If you wish to do this please contact xx@xx.co.uk within a week of receiving this email.

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. The data obtained from the questionnaires will not contain any personal information about your child. Once the analysis is completed the data will be deleted. Your child has the right to withdraw from the study at any time and this will be explained to them verbally prior to participation.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information around your child, and will simply be a resource at the schools disposal. You, as a parent/guardian, will also receive a letter summarising the outcomes of the research.

Data Protection Notice

The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at xx@exeter.ac.uk.

Thank you,

Katie Atkins

Trainee Educational Psychologist, The University of Exeter

Appendix 4:

Letter to parents and guardians, phase 2a

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Dear Parents/guardians,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This project aims to explore students views and knowledge about mental health and ways in which their school can promote mental health awareness. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This part of the project involves focus group sessions whereby I will meet with small groups of children (6-10 children) and discuss ways in which mental health could be supported. I will be asking children questions surrounding their views about ways in which their school currently supports mental health and also potential ways in which schools could help raise mental health awareness.

Children will not be asked direct questions and will not be asked to discuss personal experiences of mental health. Children involved will be informed of their right to withdraw at anytime and I will ensure that I am available post session should any child need additional support. If any child appears distressed at any point during the session, questioning will stop.

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted. Your child has the right to withdraw from the study at any time and this will be explained to them verbally prior to participation.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information around your child, and will simply be a resource at the schools disposal. You, as a parent/guardian, will receive a letter summarising the outcome of the research.

As your child/children falls into the age range applicable for this project, they have been selected by school to take part. If you give your permission for your child to take part in this phase of the project, please complete the attached consent form and return it to school.

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you would like to discuss this further, have any questions or concerns about this, please email myself at ka372@exeter.ac.uk.

Appendix 5:

Letter to SENCos, phase 2b

Dear ,

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

I am a trainee educational psychologist carrying out my doctorate research project and invite you, the school SENCo, to participate in the project.

This project aims to explore educator's views of ways in which their school currently supports pupil mental health awareness. It also aims to explore educator's views regarding prospective ways that schools could enhance the mental health literacy of its pupils. An aim of this research is to provide insight and practical implications as to how schools can better raise mental health awareness amongst their students. This part of the project involves semi-structured interviews with secondary school SENCos whereby I, the researcher and trainee educational psychologist, will meet with yourself in your school setting. The interview will last around an hour and will be audio recorded to ensure accuracy.

All data will be treated as anonymous and confidential. It will be accessible only to myself and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted. You have the right to withdraw from the research at any time.

From analysis of the data, a summary report will be created and shared with school. This report will contain no identifying information about yourself, and will simply be a resource at the schools disposal. You, as a participant, will receive a letter summarising the outcomes of the research.

Data Protection Notice
The information provided will be used for research purposes and personal data will be processed in accordance with current data protection legislation and the University's notification lodged at the Information Commissioner's Office. Personal data will be treated in the strictest confidence and will not be disclosed to any unauthorised third parties. The results of the research will be published in anonymised form.

If you understand the information and agree to participate in the interview, please sign below.

Name _____

Signature _____

Thank you for your time,

Katie Atkins

Appendix 6:

Questionnaire, phase 1

Exploration of young people and educators' views of mental health literacy and ways to increase mental health literacy within schools

This questionnaire is about your knowledge, views and feelings about mental health.

There are no right or wrong answers, only what you believe and feel. You can leave out any questions you don't want to answer.

We will not know who you are. The answers you give won't be shared with anyone. In other words it will be confidential. Nobody except yourself will know your answers; in other words it will be anonymous. You only have to fill in this questionnaire if you want to. If you would not like to fill it in, just tell your teacher and they will give you something else to do.

For each question, please tick the box that best matches what you think.

If you have any questions about the questionnaire, talk to your teacher.

If you understand this and are happy and willing to attempt to complete the questionnaire, please fill in your details and sign your name below. Many thanks

Signature: _____

Name: _____

Name of School: _____

School Year: _____

Age (years): _____

Gender: Male / Female

Date today: _____

1

Peer Mental Health Stigmatization Scale

When you are ready, please read each sentence and decide your answer (you may read quietly to yourself). There are five possible answers for each question - 'Disagree completely', 'Disagree', 'Neither agree nor disagree', 'Agree', 'Disagree completely'. Choose your answer to a sentence and tick ✔ the box for the answer you choose. You may only choose one answer.

	Disagree completely	Disagree	Neither agree nor disagree	Agree	Agree completely
1. Most people believe that children with emotional or behavioural problems are just as intelligent as other children.					
2. Most people look down on children who visit a counsellor because they have emotional or behavioural problems.					
3. Most children would be happy to be friends with somebody who has emotional or behavioural problems.					
4. Most people believe that children with emotional or behavioural problems are dangerous.					
5. Most people believe that children with emotional or behavioural problems are not as trustworthy as other children.					
6. Most people believe that children with emotional or behavioural problems are to blame for their problems.					
7. Most people believe that children with emotional or behavioural problems will get better some day.					
8. Most employers believe it is a bad idea to give a part-time job to a young person with emotional or behavioural problems.					
9. Most people believe that children with emotional or behavioural problems can get good grades in school.					
10. Teachers believe that children with emotional or behavioural problems do not behave as well as other children in class.					
11. Most people believe that children with emotional or behavioural problems are not as good as other children at taking care of themselves.					
12. Most people are afraid of children who visit a counsellor because they have emotional or behavioural problems.					

2

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	Disagree completely	Disagree	Neither agree nor disagree	Agree	Agree completely
13. I believe that children with emotional or behavioural problems are just as intelligent as other children					
14. I look down on children who visit a counsellor because they have emotional or behavioural problems					
15. I believe it is good to be friends with someone who has emotional or behavioural problems					
16. I believe that children with emotional or behavioural problems are dangerous					
17. I believe that children with emotional or behavioural problems are not as trustworthy as other children					
18. I believe that children with emotional or behavioural problems are to blame for their problems.					
19. I believe that children with emotional or behavioural problems can get better					
20. I believe that it is not a good idea for employers to give part-time jobs to young people with emotional or behavioural problems					
21. I believe that children with emotional or behavioural problems can get good grades in school					
22. I believe that children with emotional or behavioural problems do not behave as well as other children in class.					
23. I believe that children with emotional or behavioural problems are not as good as other children at taking care of themselves					
24. I would be afraid of someone if I knew that they had emotional or behavioural problems.					

3

Mental health Knowledge Schedule (MAKS)

Instructions: For each of statements 1-6 below, respond by ticking one box only. Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree strongly	Disagree slightly	Don't know
1. Most people with mental health problems want to have paid employment						
2. If a friend had a mental health problem, I would know what advice to give them to get professional help						
3. Medication can be an effective treatment for people with mental health problems						
4. Psychotherapy (e.g. talking therapy or counselling) can be an effective treatment for people with mental health problems						
5. People with severe mental health problems can fully recover						
6. Most people with mental health problems go to a healthcare professional to get help						

4

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Instructions: Say whether you think each condition is a type of mental illness by ticking one box only

	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree strongly	Disagree slightly	Don't know
7. Depression						
8. Stress						
9. Schizophrenia						
10. Bipolar disorder (manic-depression)						
11. Drug addiction						
12. Grief						

5

Mental Health Seeking Attitudes Scale (MHSAS)

Instructions: For the purpose of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers and counsellors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g. losing a loved one) to mental illness (e.g. anxiety or depression).

Please tick the box that best represents your opinion. For example, if you feel that your seeking help would be extremely useless, you would tick the box closest to useless. If you were undecided, you would tick the box under '0'. If you thought that seeking help would be slightly useful, you would tick the box '1' that is closet to useful.

If I had a mental health concern, seeking help from a mental health professional would be....

	3	2	1	0	1	2	3	
USELESS								**USEFUL**
IMPORTANT								**UNIMPORTANT**
UNHEALTHY								**HEALTHY**
INEFFECTIVE								**EFFECTIVE**
GOOD								**BAD**
HEALING								**HURTING**
DISEMPOWERING								**EMPOWERING**
SATISFYING								**UNSATISFYING**
DESIRABLE								**UNDESIRABLE**

You have now finished the questionnaire. Thank you for your participation.

6

Appendix 7:

Descriptive statistics,

responses to MAKS questions 1-12

Question	Agree Strongly (5)	Agree Slightly (4)	Neither Agree or Disagree (3)	Disagree Slightly (2)	Disagree Strongly (1)	Missing	Mean	SD
1. Most people with mental health problems want to have paid employment	23.5 %	26.6 %	46.1 %	0.8 %	1.3 %	1.8 %	**3.72**	**0.88**
2. If a friend had a mental health problem, I would know what advice to give them to get professional help	18 %	38.2 %	28.1 %	9.4 %	4.1 %	2.3 %	**3.58**	**1.03**
3. Medication can be an effective treatment for people with mental health problems	10.9 %	29.9 %	44.8 %	6.8 %	5.6 %	2 %	**3.34**	**0.97**
4. Psychotherapy (e.g. talking therapy or counselling) can be an effective treatment for people with mental health problems	33.9 %	34.2 %	26.1 %	2 %	1.5 %	2.3 %	**3.99**	**0.92**
5. People with severe mental health problems can fully recover	8.1 %	21.3 %	47.1 %	17.2 %	4.1 %	2.3 %	**3.12**	**0.94**
6. Most people with mental health problems go to a healthcare professional to get help	14.7 %	26.6 %	40.5 %	10.4 %	5.8 %	2 %	**2.65**	**1.05**

Question Say whether you think each condition is a type of mental illness	Agree Strongly (5)	Agree Slightly (4)	Neither Agree or Disagree (3)	Disagree Slightly (2)	Disagree Strongly (1)	Missing	Mean	SD
7. Depression	56.7 %	23 %	13.4 %	2.3 %	2 %	2.5 %	**4.34**	**0.94**
8. Stress	17.5 %	24.6 %	22.8 %	18.7 %	13.7 %	2.8 %	**2.86**	**1.31**
9. Schizophrenia	28.4 %	10.1 %	54.7 %	1 %	2 %	3.8 %	**3.64**	**0.98**
10. Bipolar Disorder (manic-Depression)	55.9 %	20 %	17.7 %	2.3 %	1 %	3 %	**4.32**	**0.92**
11. Drug addiction	20 %	19.7 %	29.1 %	12.2 %	15.7 %	3.3 %	**3.17**	**1.34**
12. Grief	11.9%	18.7 %	39.2 %	13.7 %	13.7 %	2.8 %	**2.98**	**1.18**

Questions 6, 8 and 12 were reverse coded

Appendix 8:

Descriptive statistics,

responses to PHMSS questions 1-12

Peer Mental Health Stigmatization Scale, question 1-12

Question	Agree Strongly (5)	Agree (4)	Neither Agree or Disagree (3)	Disagree (2)	Disagree Strongly (1)	Missing	M	SD
1. Most people believe that children with emotional or behavioural problems are just as intelligent as other children	6.3 %	28.6 %	39 %	23.8 %	1.5 %	0.8 %	3.15	0.91
2. Most people look down on children who visit a counsellor because they have emotional or behavioural problems	1.5 %	30.6 %	35.2 %	26.6 %	4.3 %	1.8 %	3.02	0.91
3. Most children would be happy to be friends with somebody who has emotional or behavioural problems	13.9 %	33.2 %	40 %	11.6 %	0.5 %	0.8 %	3.49	0.89
4. Most people believe that children with emotional or behavioural problems are dangerous	2.5 %	15.7 %	35.7 %	34.2 %	10.6 %	1.3 %	3.35	0.96
5. Most people believe that children with emotional or behavioural problems are not as trustworthy as other children	2.8 %	29.1 %	33.2 %	26.6 %	6.8 %	1.5 %	3.06	0.98
6. Most people believe that children with emotional or behavioural problems are to blame for their problems	1.5 %	13.4 %	23.8 %	38.2 %	22.3 %	0.8 %	3.67	1.02
7. Most people believe that children with emotional or behavioural problems will get better some day	6.6 %	32.9 %	40.3 %	14.9 %	3.8 %	1.5 %	3.24	0.92
8. Most people believe it is a bad idea to give a part-time job to a young person with emotional or behavioural problems	3.3 %	21.8 %	43 %	24.6 %	6.6 %	0.8 %	3.09	0.93
9. Most people believe that children with emotional or behavioural problems can get good grades at school	9.9 %	38.7 %	30.6 %	16.2 %	2.8 %	1.8 %	3.37	0.97
10. Teachers believe that children with emotional or behavioural problems do not behave as well as other children in class	7.3 %	43.3 %	32.7 %	12.7 %	2.5 %	1.5 %	2.59	0.90
11. Most people believe that children with emotional or behavioural problems are not as good as other children at taking care of themselves	5.1 %	33.7 %	41 %	13.9 %	4.6 %	1.8 %	2.79	0.91
12. Most people are afraid of children who visit a counsellor because they have emotional or behavioural problems	2.3 %	12.9 %	38.5 %	34.4 %	10.9 %	1 %	3.39	0.93

Questions 2, 4, 5, 6, 8, 10, 11 and 12 were reverse coded

Appendix 9:

Descriptive statistics,

responses to PHMSS questions 13-24

Peer Mental Health Stigmatization Scale, question 13-24

Question	Agree Strongly	Agree	Neither Agree or Disagree	Disagree	Disagree Strongly	Missing	M	SD
1. I believe that children with emotional or behavioural problems are just as intelligent as other children	21%	52.9 %	19 %	4.3 %	1.8 %	0.8 %	**4.01**	**2.72**
2. I look down on children who visit a counsellor because they have emotional or behavioural problems	0.8 %	3.5 %	15.7 %	36.7 %	42.3 %	1 %	**4.17**	**0.88**
3. I would be happy to be friends with somebody who has emotional or behavioural problems	24.8 %	43.5 %	27.1 %	2.5 %	0.3 %	1.8 %	**3.92**	**0.81**
4. I believe that children with emotional or behavioural problems are dangerous	1 %	3.8 %	23.8 %	41.5 %	29.1 %	0.8 %	**3.95**	**0.88**
5. I believe that children with emotional or behavioural problems are not as trustworthy as other children	1 %	9.9 %	30.9 %	37.2%	19.7 %	1.3 %	**3.66**	**0.94**
6. I believe that children with emotional or behavioural problems are to blame for their problems	1 %	3.3 %	16.7 %	28.9 %	48.6 %	1.5 %	**4.23**	**0.92**
7. I believe that children with emotional or behavioural problems will get better some day	20 %	43.3 %	29.1 %	4.1 %	1.5 %	2 %	**3.78**	**0.87**
8. I believe it is a bad idea to give a part-time job to a young person with emotional or behavioural problems	1.3 %	7.1 %	24.6 %	39.7%	26.1 %	1.3 %	**3.83**	**0.94**
9. I believe that children with emotional or behavioural problems can get good grades at school	34.2 %	43 %	14.9 %	4.6 %	0.8 %	2.5 %	**4.08**	**0.87**
10. I believe that children with emotional or behavioural problems do not behave as well as other children in class	2.5 %	22 %	44.8 %	22.3 %	5.8 %	2.5 %	**3.07**	**0.89**
11. I believe that children with emotional or behavioural problems are not as good as other children at taking care of themselves	2.3 %	14.7 %	46.1 %	25.8 %	9.1 %	2 %	**3.25**	**0.90**
12. I would be afraid of someone if I knew they had emotional or behavioural problems	2 %	3.3 %	13.4 %	28.6 %	51.4 %	1.3 %	**4.26**	**0.95**

Questions 14, 16, 17, 18, 20, 22, 23 and 24 were reverse coded

Appendix 10:

Descriptive statistics,

responses to MHSAS

Mental Health Seeking Attitudes Scale

	Totally (7)	Mostly (6)	A little (5)	Undecided (4)	A little not (3)	Mostly not (2)	Totally not (1)	Missing	MEAN	SD
Useful	28.6 %	31.4 %	14.7 %	7.8 %	1 %	2 %	1.3 %	13.2 %	**5.78**	**1.29**
Important	28.1 %	23.3 %	14.2 %	10. 9 %	4.1 %	5.1 %	1.5 %	12.9 %	**5.45**	**1.57**
Healthy	25.6 %	23.3 %	15.9 %	18.2 %	2 %	0.8 %	0.3 %	13.4 %	**5.54**	**1.32**
Effective	21. 8 %	23 %	15.7 %	16.5 %	3.3 %	2.3 %	2.5 %	14.9 %	**5.31**	**1.51**
Good	36.2 %	21.3 %	13.2 %	10.4 %	3.8 %	1.5 %	1 %	12.7 %	**5.77**	**1.40**
Healing	21.3 %	20 %	18.7 %	19.2 %	5.1 %	1.5 %	1.3 %	12.9 %	**5.27**	**1.41**
Empowering	12.7 %	13.2 %	18.5 %	32.7 %	3.5 %	2 %	2.3 %	15.2 %	**4.81**	**1.39**
Satisfying	8.9 %	11.4 %	15.9 %	37.5 %	5.1 %	3.8 %	3.8 %	13.7 %	**4.48**	**1.43**
Desirable	9.9 %	10.6 %	12.2 %	38 %	6.8 %	4.3 %	3.8 %	14.4 %	**4.42**	**1.48**

Appendix 11:

SPSS output,

Pearson correlation t tests

Correlations

		MAKS	STIGMAOTHERS
MAKS	Pearson Correlation	1	.281**
	Sig. (1-tailed)		.000
	N	384	355
STIGMAOTHERS	Pearson Correlation	.281**	1
	Sig. (1-tailed)	.000	
	N	355	363
**. Correlation is significant at the 0.01 level (1-tailed).			

Correlations

		STIGMASELF	MAKS
STIGMASELF	Pearson Correlation	1	.133**
	Sig. (1-tailed)		.006
	N	371	361
MAKS	Pearson Correlation	.133**	1
	Sig. (1-tailed)	.006	
	N	361	384
**. Correlation is significant at the 0.01 level (1-tailed).			

Correlations

		HELP	STIGMASELF
HELP	Pearson Correlation	1	.136**
	Sig. (1-tailed)		.009
	N	319	299
STIGMASELF	Pearson Correlation	.136**	1
	Sig. (1-tailed)	.009	
	N	299	371
**. Correlation is significant at the 0.01 level (1-tailed).			

Correlations

		HELP	STIGMAOTHERS
HELP	Pearson Correlation	1	.088
	Sig. (1-tailed)		.065
	N	319	297
STIGMAOTHERS	Pearson Correlation	.088	1
	Sig. (1-tailed)	.065	
	N	297	363

Appendix 12:

SPSS output,

Cronbach's alpha reliability

Mental Health Knowledge Schedule items 1-6

Reliability Statistics	
Cronbach's Alpha	N of Items
.125	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
MAKS1-employment	16.70	5.171	.068	.091
MAKS2-advice	16.83	4.505	.150	-.001[a]
MAKS3-medication effective	17.08	4.932	.083	.074
MAKS4-psychotherapy effective	16.42	5.002	.092	.068
MAKS5-fully recover	17.29	4.984	.085	.074
MAKS6-recieve professional help	17.75	5.843	-.142	.292
a. The value is negative due to a negative average covariance among items. This violates reliability model assumptions. You may want to check item codings.				

Peer Mental Health Stigmatization Scale items 1-12

Reliability Statistics	
Cronbach's Alpha	N of Items
.769	12

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
stigma1- intelligence-other people	35.03	31.372	.325	.762
stigma2- look down on-other people	35.13	31.225	.339	.760
stigma3- happy to be friends with-other people	34.66	30.279	.450	.749
stigma4-dangerous-other people	34.79	29.411	.508	.742
stigma5- trustworthy-other people	35.09	29.362	.494	.743
stigma6-blame-other people	34.47	29.736	.427	.751
stigma7-get better-other people	34.90	32.998	.154	.780
stigma8-employers think bad idea-other people	35.07	29.433	.524	.740
stigma9-good grades-other people	34.79	30.208	.406	.753
stigma10-behave-other people	35.56	31.620	.301	.764
stigma11-taking care of self-other people	35.35	29.904	.477	.746
stigam12-afraid-other people	34.76	29.896	.468	.746

Peer Mental Health Stigmatization Scale items 13-24

Reliability Statistics

Cronbach's Alpha	N of Items
.729	12

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
stigma13-intelligent-own view	42.24	33.659	.273	.812
stigma14-look down-own view	42.08	44.816	.423	.708
stigma15-good to be friends with-own view	42.35	45.206	.426	.709
stigma16-dangerous-own view	42.31	43.342	.545	.695
stigma17-trustworthy-own view	42.60	42.788	.550	.693
stigma18-blame-own view	42.02	44.461	.421	.707
stigma19-get better-own view	42.48	46.692	.258	.723
stigma20-employment-own view	42.41	44.221	.430	.706
stigma21-good grades-own view	42.17	44.337	.474	.703
stigma22-behave-own view	43.18	44.549	.434	.706
stigma23-taking care of self-own view	43.00	44.213	.450	.704
stigma24-afraid-own view	41.99	43.298	.507	.698

Mental Health Seeking Attitudes Scale

Reliability Statistics	
Cronbach's Alpha	N of Items
.860	9

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
MHSAS1-uselful	41.18	63.025	.607	.843
MHSAS2-important	41.51	61.270	.541	.850
MHSAS3-healthy	41.39	65.187	.499	.853
MHSAS4-effective	41.61	60.925	.595	.844
MHSAS5-good	41.18	61.313	.643	.840
MHSAS6-healing	41.68	60.690	.670	.837
MHSAS7-empowering	42.12	62.938	.571	.847
MHSAS8-satisfying	42.46	62.155	.586	.845
MHSAS9-desirable	42.52	61.540	.574	.846

Appendix 13:

Focus group schedule,

phase 2a

Focus Group Schedule

Hi. Thanks so much for coming. Do you know why you're here?

(Respond to comments)

Some of you may have completed a questionnaire earlier in the year, asking what you knew about MH. For this, I'd like to know about how your school teaches you about MH and then I'd like to find out, from you, how you think your school could be better teaching MH. I'd Like to start by asking you all what you think MH means. So… what do you think it means?

(Respond to comments)

*Does anyone is school talk about mental health?

Prompts:

- o teachers? Assemblies? Lesson? Visiting speakers?

(Respond to comments)

Do you think that, if a YP at this school had a MHP, they would know where to go to help?

Prompts:

- o speak to a teacher? Friend? Family? School nurse? Social media?

(Respond to comments)

Would it be hard or easy for the pupil to get help in those ways?

Prompts:

- o why would it be difficult to ask a teacher? Go to a school nurse?

Further prompts:

- o would people be bothered about what other people think of them?

(Respond to comments)

How helpful would it be to learn more about MH at school?

(Respond to comments)

How could you learn about mental health at school?

Prompts:

- A MH care module/course whereby all students participate for a minimum of six weeks
- A set MH lesson per week, throughout the year
- A particular teacher having responsibility for MH care
- A designated room allocated for MH care
- All teachers having joint responsibility for MH care
- MH conversations and topics fed into all lessons
- Assemblies where MH is talked about
- Visiting speakers talking about MH
- Smart phone app e.g. live chat, Q&A, myth buster, signs and symptoms
- School web page with the MH app
- More opportunities to participate in creative subjects whereby there is the scope to discuss feelings and express emotions

Thank you or those ideas. What about the other ideas? Or some of your own?

Thank you so much for all of your ideas is there anything else you'd like to add? Anything we haven't talked about are you think would help young people to learn more about mental-health? Or anything you ask me?

Can we just go over your thoughts using this mind map, so that I don't miss interpret what you've said or miss anything out?

Thank you so much for your time. I'm going to be in this room for about half an hour or so. If any of you want to talk to me feel, you are very welcome to pop in.

Appendix 14:

Semi-structured interview schedule,

phase 2b

Semi Structured interview schedule Phase 2B

1. Thank you for meeting with me. I would like to remind you that this interview will be recorded and that, as soon as it has been transcribed, it will be deleted. Are you happy to go ahead?

2. What do you understand by the term mental health literacy?

3. Do you think staff have a good level of mental health literacy?

Prompts:

can you tell me more about that?
do teachers get enough support?

4. Do you think pupils have a good level of mental health literacy?

Prompt:

can you tell me more about that?

5. Who is responsible for pupils MH in school?
6. What do you think an ideal MHL programme would look like?

Prompts:

A MH care/module course whereby all students participate for a minimum of six weeks a year
A set MH lesson per week, throughout the year
A particular teacher taking responsibility for MH care
A designated room allocated for MH care
All teachers taking joint responsibility for MH care
MH conversations/topics being fed into all lessons
Assemblies where MH is talked about
Visiting speakers talking about MH
Smart phone apps e.g. live chat, Q&A, myth buster, signs and symptoms
School web page with the MH app
More opportunities for pupils to participate in creative subjects whereby there is the scope to discuss feelings and explore emotions

7. What are the barriers to that?
8. Thank you for your time. Is there anything else you would like to add?

Appendix 15:

Example of focus group collective mind map,

phase 2a

Don't know how

People would make a joke

'You're weak'

Especially aimed at boys

Boys have to be big men

Overwhelming

Peer pressure

It's harder for popular people- further to fall

Would you ask for help? Why/why not?

N0- everyone

People won't listen

People would belittle the problem e.g 'you'll get over it'

It's treated like a disability

Need to protect other people
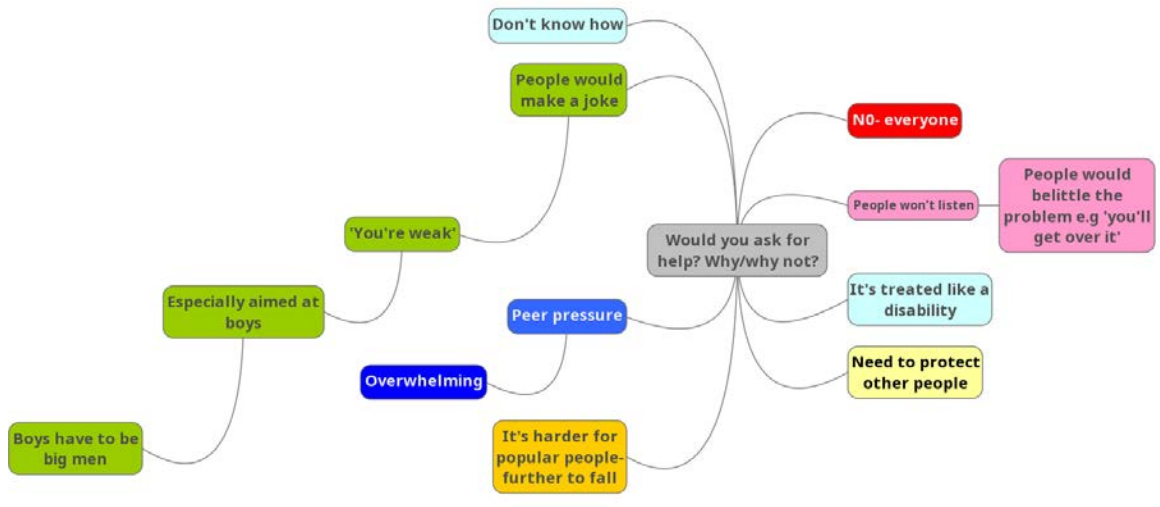
Appendix 16:

Transcript from focus group one,

phase 2a

5 Participants

Hi. Thanks so much for coming. Do you know why you're here?

A - Yeah, to help you with your research or something

B - To do with mental health?

Yes, it is. Some of you may have completed a questionnaire earlier in the year, asking what you knew about MH. For this, I'd like to know about how your school teaches you about MH and then I'd like to find out, from you, how you think your school could be better teaching MH. I'd Like to start by asking you all what you think MH means. So… what do you think it means?

 D- Well I think it means like whether you're stable you know in the head

 A- I think we've all are got mental health but it's different for everybody

 B - It's basically how healthy you are in your head

D - Yeah… I think the same as them!

Thank you for that. Yes, we all have MH and it can change. Lots of us go through times in our lives where we have difficulties with our mental health, for example we can feel very low. I'd like to know more about how schools can support young people like yourselves to learn more about mental health. Does anyone in school talk about MH?

A- No

B- Nope

C- No, not really

D- No.

pause

B- Anything I know about MH is from what my parents have told me

C- To be honest, I know quite a bit but that's 'cos my dad has MH problems so we talk about it at home.

A. We don't talk about mental health the School at all. We have his lessons called PSHE that we just talk about bullying friendships and stuff

B. They don't tell us anything that we don't already know. It's about cyber bullying and safe on the internet and things like that. You don't learn about MH

So if a YP at this school had a MH problem, do you think they would know where to go to get help?

E- No idea. Is there?

A. Yes…I've been

D - Don't know

B. Think maybe there is someone you can go to but I don't know who or how to see her, or who to ask to get to see her

C. I dunno really, think there is someone, but not sure.

Ok. Let's suppose there is support in the school, somewhere you can go. Do you think YP would find it easy or hard to go and ask for that help?

C. I think it would be scary making that first step. I'd worry what my mates would think

A. I was really scared about getting help as I thought 'oh my god…my friends are gonna find out!' I was worried they would think I was crazy and treat me differently. I know that's not true now, my mates were great, so great. But at the time I was feeling so down and I hadn't been through anything like that before so I didn't know. *"*

B. I reckon some people would be scared to find out if they had something wrong with them so they just wouldn't go and get help…"

A- Yeah totally

C- Mmm, yeah true

A. The scariest thing was the very first time I told my mum. I was sooo scared. I was so worried about what she would say and think. Embarrassed, everything. So yeah, I think actually telling someone for the first time is so scary that it stops people from getting help

B – I would have no idea how to start the whole process of getting help anyway

D. But if you did know, it would still be really hard 'cos You'd be really worried about what people would think of you if they found out you were getting help for mental health problems. They might think you're mad or something. Having a MH problem is treated like having a disability or something.

B. I agree with 'c'; it would be so hard to make the first step, you'd be so scared of finding out something bad about yourself

D - Yeah, it would. But people should get help

A- Yeah

Do you think someone might talk to a teacher?

C - I think you would want the teacher to come to you

C. No, I wouldn't approach one of my teachers. There isn't anyone I know well enough, if that makes sense.

D. Um, not sure I could tell a teacher. There was one I got on really well with but she's left now. There isn't really anyone else I'd trust not to tell everyone.

B - Not sure

A - Yeah, I know what you mean. And people might find out and they'd be loads of gossip.

Research says that if people knew more about MH they would be more likely to seek help if they needed it. So how do you think your school could help you to learn about MH? For example, a lesson every week or a 6 week course, or someone coming in to talk to you in assembly. Or maybe an app? They are just some ideas...I'd like to know what you think?

A - Well I don't think assemblies would work as no one listens in them

C - I think lessons, for everyone. Like PSHE but better, where you actually learn stuff

B - Yeah 'cos they're rubbish, such a waste of time

C. And the lessons would be good if you could chat to the teacher, you know like ask questions

D. I think we should get rid of a 'drop and read' session and just have a chat with the teachers about issues and stuff. We don't need a drop and read every day

A - Or just chill in 1 session, and relax and not have to always do something

B. Definitely lessons, for everyone. But small lessons actually, like small groups like this so you can talk easier. It's hard to talk in a big class. That would be good

Ok, so lessons for all sounds like a good idea. What about an app on your phone, with Q and A section, or symptom checker.

C. That's just like google though, you can do that anyway. It would have to have something where you could talk to someone

A - Or a link to book an appointment or something, that would be good

D - Apps are Ok, but yeah it's better to talk to someone if you had a problems

D. There is a someone here you can talk to, I think, but maybe schools should have more counsellors to talk to. Maybe that's what they should do

D. I think there should be more counsellors at school so that we can get help quickly. You could sign up to have an appointment, like the next week or something

A. Having more counsellors, definitely. Talking to someone that wasn't in my family really helped me.

I guess having someone to talk to is great when you have a problem, but in terms of learning more about MH, what else do you think the school could do?

B - Not sure.

A. I think the lessons but where you actually lean stuff. We should have lessons where you can actually talk, have discussions in class. Not just the teacher telling you stuff. Like what we're doing now, that would be good

D.Learning about things that we don't already know, what are all the mental health problems and how to get better. In PSHE we just get told load of stuff we already know. You know, about bullying and things. It's quite patronising

A. It would be useful to learn about ways to sort of help yourself

Ok so how else can schools support YP MH? Can you think of things the school could have?

A - Yeah, somewhere to go… like a chilled room.

D- There is a room you can go to here, but you not just anyone. You have to be given permission by a teacher

A - Oh yeah, down the x corridor…where all the kids go that have special needs and stuff.

B- It would be good to have somewhere else you can go, when you need a break and you can just relax.

A - Yeah, and you can go when you need to.

D - Yeah.

Thanks for those ideas. Can you think of anything else? Has anyone heard of mindfulness for example?

A - Oh yeah I've heard of that. I tried it once but I was rubbish at it!

D - Mind what?

A - Its where you like, breathe and think about your breathing.

D -Oh like relaxation…Yeah, we could learn stuff like that in school.

A. There is this app 'worry time'. That's where you can like put your worries in an app and store then so you can leave them be and go back to them late. That's quite good…I've used that.

Ok, so it might be useful for the school to let you know about these apps and others things you can do to help yourself to relax.

ALL: yeah.

Is there anything else anyone else would like to ask me or tell me.

ALL: No

Thank you so much for your time. I'm going to be in this room for about half an hour or so. If any of you want to talk to me feel, you are very welcome to pop in.

Appendix 17:

Transcript from interview 3,

phase 2b

Interview 3, Phase 2b

Interviewer: What do you understand by the term mental health literacy?

Interviewee: So, understanding what mental health difficulties are, getting over the barriers or I can't think of the word but they're you know, the opinions that people have about it the negative opinions and actually having a bit more of an educated understanding and for us first, well students and adults, that they know they can recognize when they're having a bad mental health day and when they need to do something to try and overcome that maybe.

Interviewer: Yeah brilliant. Do you think staff in the school have a good level of mental health literacy?

Interviewee: Yeah, I do. I think we're really lucky actually in this school. There might be one or two teachers and I think maybe cover teachers find it much harder when the coming in, you know, they've been speaking to some of our children recently about it in PSHE and because they don't know the kids so they don't know whether to trust when they're being genuine about how the feeling or whether it's just an avoidance tactic. But yeah, I think generally most of our staff do understand and they're quite, just genuinely caring for kids yet. And I think they find it easier to understand when a kid is crying and showing, you know, sad emotion than when they're angry and it's you know that they're shown that emotion. I think they understand the crying lot more as being poor mental health than, than perhaps the aggression, that grey.

Interviewer: Do you think the pupils have a good level of mental health literacy?

Interviewee: I think that's getting there. I think there's still this, you know, there are still words just like there are with other needs. There are still words that kids use and you know, call people crazy or 'she's mental' and not necessarily understand that that is linked to mental health and to what we're learning about mental health. But yeah, I think we I think we're getting there with that. I think there's still a long way to go.

Interviewer: But you feel you're getting there. Great. You mentioned earlier about negative views and issues around stigma. Do you think the stigma is a barrier for the young people to then get help?

Interviewee: Maybe certain children. I don't know why, I'd probably think maybe more boys might find that barrier and that, you know, there are a lot more teenage suicides and things are boys, aren't they? So yeah, I think yeah, I think thinking of the kids that have had, you know quite recent sort of breakdowns they don't really care about the words that people say and but yeah, I think there are some that would it would hold them back from coming to ask for help.

Interviewer: Or if they would feel it was a weakness?

Interviewee: Yeah, and again particularly boys. I think boys would see that that was a weakness in asking for help or admitting that they're not able to cope. I think you still hear things today about boys who should 'man up'. Still so much today... and 'grow a pair' you know. People always think that's a really big problem. And that's all male based, isn't it? And then, yeah implying that a man doesn't cry I guess and show emotions, that shouldn't happen.

Interviewer: So in this school, who was responsible for the mental health of the pupils.

Interviewee: So jointly me and Mrs X, vice principal. She is going to be our mental health lead over the school. We've just decided that this morning just coincidentally because we had had a meeting. I've just been to this early help summit last week actually. So, whilst I will do the PSHE side of it, I've invited the people in to do these and different programs and she is at the moment coordinating a lot of staff mental well-being. So, we've had things going on there's a lot of running groups now in school and they're doing nice little short sessions after school. We did a survey of all of the staffs mental health and how much they work and at home and their stress levels, tools, work and things and came up with a sort of list of things that staff wanted and well-being house really topped the list. So, we'll doing yoga on a Monday now (30 staff that do yoga on a Monday after school and someone comes in from there Yoga Center), Lots of runs and

bike rides and actually it's really brought the staff together. So we're just kind of then rolling out a similar thing to the kids. So we've got room starting after halftime. Yeah for like a drop in with this' early help for mental health'. They are coming in to do training for ambassador's.

Interviewer: So, these are people that run this Early Help for Mental Health and they're coming to teach some members of your staff?

Interviewee: So they're going to work through a strategy with me and staff. Yeah, so we'll come up with a whole school policy and an action plan of what that's going to look like over the next three years and then they'll train up kids who get these cool little broaches and they'll be mental health ambassadors. They'll work with a small group of kids first, like a dozen, to work out what those kids think that needs to happen in school and then they will all formulate it together.

Interviewer: I am so pleased other that the YP will be consulted.

Interviewee: Yeah, we'll bring them in and talk about it. It is hot on the PSHE curriculum already, but we do a spiral curriculum. So we do a different thing for each year group so that they're not then repeating the same subject. So the only things that might repeat might be a more, a more in-depth view of like sex education. When they get to year nine or ten, the topic might be more in-depth than they had in year 7. So they had the 'living life to the full' program last year. They had this part of with PSHE; managing and looking after one's internal scripts and experiences that can impair our emotional well-being.

Interviewer: Do you have any other ways of supporting YP MH?

Interviewee: We have 8 counsellors and a pastoral welfare coordinator. Okay, so she's paid for two days a week by us. And then for one day which is paid by X caring towns committee. So we started this committee following the death of a student in the summer two years ago. He had just finished his GCSEs and took a formally legal high and jumped in the river and died. So members of the X parish council, police, chaplains, me, the Head, parents, a few local business owners

got together. So we all started meeting up (probably about 25 of us) and came up with an idea of what the issues were in X for our children. We discussed what we could do in order to support them and talked about how to bridge the gap between school and mental health. So they put all the funding bids in so they've got money from the lottery and a few other grants to pay X to have a third day with us and then in that third day, she can supervise more volunteers. So, basically, there's one or two that we pay through this through this scheme, but the majority of them are volunteers.

Interviewer: I'm very impressed.

Interviewee: Yeah. X meets the kid and talks through what their issues are and then she puts them with a specific person. Who ever has got a certain specialism. So we've got one guy, he works for the suicide prevention and team. So he's meeting a couple of our more high-end kids who are you know, quite constantly thinking about suicide and he's meeting them and doing a brilliant, brilliant job and then we have four who are voluntary. We always have trainee counsellors every year. It's just been such a good model for us. I don't know why more schools don't do it, but we have to pay X as a supervisor. And so she does supervision with them every day that they meet kids, but they have to do a hundred hours of counselling to qualify.

So we've got four that are trainees but the rest are all qualified and you know, some with like 30 odd years of experience through it.

Interviewer: That sounds like an effective model.

Interviewee: Yeah, I think so. I think, from talking to other schools, I don't know if we've either got people here are a lot more in touch with their you know with understand with that and you know mental health literacy or whether we have a particular area that there are more students prone to it or whether we've just realized sooner and we've got a good process going. I don't know really, but I mean, there are 60 kids going through that on a fortnightly basis. So going through eight counsellors, so it's quite a high, you know amount of children that are needing support regularly and to stay in school and just manage on a day-to-day.

And then we have the ones that start with CAMHS-we then don't use counselling in school because it conflicts. So, we do then have another sort of 15 kids who are seeing CAMHS regularly on top of that. We really need that external support for such complex needs.

Interviewer: So just going back to ways if you could increase mental health literacy and have a program in school. It sounds like the ball is already rolling with that. Do you know about much of what that will entail or I'm guessing from you're saying that's not going to be drawn out yet until you get pupils in and you talk about it together?

Interviewee: Well yes, it will be it will be led by them. But I think, from what I heard at a session I went to about this, they had done a lot of work in the schools and students were saying they wanted somewhere that they could go at break and lunch time that they could have a chat with somebody and just offload. They didn't necessarily want it to interrupt the lesson or be particularly formal or going to sitting in a one-to-one, but just have a room where they could go in and feel that everyone was in tune with the fact that they were feeling a bit rubbish and to just, you know, have a hot chocolate and just be quiet for five minutes or talk to somebody. So, I think that's probably what it would look like here because we don't have many spaces like for lunch. I mean we have the SEN classroom, but then there's a stigma of it being for kids with teaching assistants. And yeah, we have about 40 kids in and out of there for different reasons, but not necessarily some of the older ones and I think maybe the older ones might just need something a bit different.

The early help for mental health has been really good for us. They've done training on Mental Health First Aid. Oh yeah and training in 'normal magic' and they are coming in to do that with the whole staff. Unfortunately, we had to cancel it at the end of term, but they're coming in to do it soon.

Interviewer: Can you tell me a bit more about that?

Interviewee: What they call 'normal magic' is teaching the kids to do the little things that will really boost our well-being. just like for staff to notice things and

to just do certain little things that actually will really boost the well-being. It's really quite common sense things that you know, you don't necessarily think about those being the things that make you feel good. They've given me these posters to put up. It is something that we've presented quite a lot of and done quite a few assemblies on it.

We have an online app too, it's a bit more teenage friendly. They basically can have a one-to-one with trained counsellor or they go into chat rooms with other children who are feeling the same but it's monitored really heavily. So, there's no like suicide pact type. It's running 24 hours a day and completely free so they just need to make a log in but it doesn't, you know, it doesn't know who they are. It's completely anonymous so we have got kids using it. We had one issue with a girl who had an EHCP and couldn't type very fast. So, they were asking her pinging questions back and then she wasn't responding quickly enough because she typed quite slowly and then and then they kept sending messages back. 'Are you okay?' 'Is everything all right? 'Do I need to call you?' but she was fine! So, she's topped and using it and is using counsellors instead. Eventually went to CAMHS anyway. But other kids have really liked it.

Interviewer: That's great. I think we've covered a lot. It sounds like you have a lot in the pipeline. Something else that has been discussed in the research, is the prospect of CYP having the opportunity for informal chats. And how the encouragement of an ethos of MH awareness throughout the whole setting, in all classes.

Interviewee: I think that's good. To increase young people's mental health literacy, it needs to be talked about more generally. But I think the difficulty that we have, and probably most schools will have, is the teachers doing it/talking about it on a day to day basis...then not knowing how. Because PSHE and sort of social sciences were kind of cut from the curriculum a few years ago and we carried on doing these curriculum enrichment days. So, we were still doing PSHE but not in lessons and actually we found that our kids were really emotionally illiterate and their behavior to each other was changing and we had sort of almost gang mentality and your seven and eight where they'd suddenly all come from a primary and now they met with a massive group of people and they're all just wandering around and being rude and not in a necessarily overly aggressive way,

but just saying nasty things that we hadn't had before. We thought that it was because we'd lost PSHE, but we lost lot of Specialists teachers, you know. It's almost like there were sort of older breed of teachers who have been teaching social sciences for 30-odd years and then it kind of got thrown out with the you know, baby in the bath water and then they haven't been new staff coming through the train just in that because it's there are so few lessons in the curriculum. So the people that teach PSHE tend to be plugging gaps on a timetable and then because of that you've got people who might feel really comfortable teaching some things but not others, you know, so in my last school, I had to pick up all the sex education lessons for one of the teachers. She just felt so uncomfortable teaching it and you can't, you know, you can't have kids asking questions getting the right advice if teacher doesn't feel like they answer them.

Interviewer: Good point...the teacher has to be skilled and able to talk about sensitive subjects.

Interviewee: Yeah, but we have just, I think, we've just recruited somebody actually who is a PSHE and PE teacher or something so they'll be doing both but yeah the way it is through the curriculum. It's just quite difficult to make sure there is that quality of teaching in the same way that there is for all the other subjects as well. It's like, you know, it was like with everything at the moment we're told at the moment ...we're told mental health is something we all really need to support and everyone needs to have a mental health lead in your school yet all the funding that we've had has been cut and it's the first thing that gets cut in your school budget. MH needs to be given funding and apriority within the curriculum so schools don't skip it. So, we're kind of doing stuff with no money. We're so lucky that this community group has been funding X. And they've got funding now to go on till the end of this Academic Year, but you know, we don't know beyond that, but now it's gone really well and if I know the plan from the government is for funding for mental health, but it's the way each County then sends the money out. I think that's where certainly here where it falls down for SEN and MH.

Interviewer: Thank you Mrs X. You have given me a lot to think about. Is there anything else you want to say?

Interviewee: No, that's about it I think.

Interviewer: Well thank you so much

Interviewee: Pleasure

Appendix 18:

Full thematic table,

phase 2a

Thematic Table Phase 2a

Theme	Sub-themes	Sub theme categories
Attitudes towards seeking help	Fear	Concerned about other peoples' views Worried about discovering something is wrong with you Concerned about upsetting a family member
	Apathy	People won't listen Help won't make any difference
Stigmatising views around mental health	Perceived Weakness	Boys are strong It's a disability
	Embarrassment	Uncool Different to peers
Barriers to seeking help	Lack of Knowledge	Unaware of how to access support Unaware of what support is available Unaware of symptoms
	Relationship to Teacher	Unsure of confidentiality Unable to approach teacher
	Fear	Fear of initial step Fear of other people's views Fear of discovering something negative about oneself
Ways to Support CYP MHL	Safe Space	Separate to SEN Accessible
	Peer Support groups	
	Access to More Resources	Counsellors Accessible
	Creative Subjects	
	MH lessons	Interactive sessions Explicit Knowledge Skill Building

Appendix 19:

Full thematic Table,

phase 2b

Thematic Table phase 2b

Theme	Sub-theme	Sub-theme categories
Barriers to improving YP MHL	Teachers skills	Pressures Level of MHL
	Funding	
	Lack of support from external services	
Barriers for CYP getting help	Stigma	
	Lack of support from external services	
Ways to improve MHL	Staffing	Supporting staff wellbeing MH training for all staff
	Students supporting each other	
	MH to become integral part of curriculum	Self-help skill building More MH knowledge
	School resources	Safe space
	Working with the community, including parents/carers	
	More support from external services	

Appendix 20:

Participant codes,

phase 2a

Title	Code
Focus Group 1, participant 1	FG1 A
Focus Group 1, participant 2	FG1 B
Focus Group 1, participant 3	FG1 C
Focus Group 1, participant 4	FG1 D
Focus Group 1, participant 5	FG1 E
Focus Group 2, participant 1	FG2 A
Focus Group 2, participant 2	FG2 B
Focus Group 2, participant 3	FG2 C
Focus Group 2, participant 4	FG2 D
Focus Group 2, participant 5	FG2 E
Focus Group 2, participant 6	FG2 F
Focus Group 2, participant 7	FG2 G
Focus Group 2, participant 8	FG2 H
Focus Group 3, participant 1	FG3 A
Focus Group 3, participant 2	FG3 B
Focus Group 3, participant 3	FG3 C
Focus Group 3, participant 4	FG3 D
Focus Group 3, participant 5	FG3 E
Focus Group 3, participant 6	FG3 F
Focus Group 3, participant 7	FG3 G
Focus Group 3, participant 8	FG3 H
Focus Group 3, participant 9	FG3 I

Appendix 21:

Phases of thematic analysis

Phases of Thematic Analysis Braun et al., (2014)

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re- reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic „map" of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix 22:

SPSS output,

Multiple t tests

Group Statistics

	gender	N	Mean	Std. Deviation	Std. Error Mean
PERSONALSTIGMA	male	180	45.1667	8.03380	.59880
	female	166	47.4940	5.64801	.43837
SOCIETALSTIGMA	male	182	38.9066	5.60358	.41536
	female	172	37.1977	6.17829	.47109
MAKS	male	189	20.1587	2.50875	.18248
	female	175	20.5543	2.39640	.18115
MAKSDETAIL	male	186	20.9301	3.04923	.22358
	female	170	21.7706	2.88236	.22107
HELPSEEKING	male	159	46.9937	8.70872	.69065
	female	147	46.8299	8.96903	.73975

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
PERSONAL STIGMA	Equal variances assumed	2.186	.140	-3.093	344	.002	-2.32731	.75238	-3.80715	-.84747
	Equal variances not assumed			-3.136	321.957	.002	-2.32731	.74211	-3.78732	-.86730
SOCIETAL STIGMA	Equal variances assumed	1.714	.191	2.728	352	.007	1.70892	.62633	.47711	2.94073
	Equal variances not assumed			2.721	343.876	.007	1.70892	.62806	.47361	2.94423
MAKS	Equal variances assumed	.735	.392	-1.536	362	.126	-.39556	.25759	-.90211	.11100
	Equal variances not assumed			-1.538	361.644	.125	-.39556	.25713	-.90121	.11010
MAKS DETAIL	Equal variances assumed	.280	.597	-2.666	354	.008	-.84048	.31522	-1.46041	-.22055
	Equal variances not assumed			-2.673	353.593	.008	-.84048	.31442	-1.45885	-.22212
HELP SEEKING	Equal variances assumed	.065	.799	.162	304	.871	.16378	1.01087	-1.82541	2.15296

			.162	300.48 6	.872	.16378	1.01204	- 1.8278 1	2.1553 6
Equal variance s not assumed									