A mixed-methods exploration of the mental health related help-seeking of young people attending post-16 settings in the South West of England.

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Abstract

The mental health needs of young people in the UK are an ongoing concern and are forecast to become worse. To receive support for their mental health needs, it is essential that young people feel able to ask for help when it is required. However, in the UK the level of mental health related help-seeking in young people is low, and for those who attend post-16 settings, seldom understood. Young people attending post-16 settings have an array of sources from whom help is available, and the role that education plays in supporting the mental health needs of young people has been highlighted in numerous policies and guidance as central to identification, prevention and intervention. Within this context, the present research aimed to:

- explore the mental health related help-seeking intentions of young people, including personal attitudes, the attitudes of significant others, and perceived behavioural control;
- identify the barriers and facilitators highlighted in the literature which impact help-seeking behaviour, and their relevance to the post-16 population;
- explore the views of young people to understand their various experiences and perceptions of help-seeking, the considerations they make when contemplating help-seeking, and the support available for mental health related problems; and,
- inform future development of mental health support within post-16 settings to be approachable and effective.

The research consisted of two phases. In the first phase, an online survey, informed by available literature and underpinned by the theory of planned behaviour, was carried out with 217 participants from two post-16 settings to answer the research questions related to help-seeking intentions and the factors mediating help-seeking. Data from phase one was analysed using SPSS and content analysis. The second phase consisted of eight semi-structured interviews conducted online to answer research questions related to student experiences of help-seeking, the help available to them and to inform mental health provision. Data from phase two was analysed using thematic analysis.

The findings demonstrate that young people attending post-16 settings face a number of barriers which deter them from help-seeking. They feel that more can be done to encourage help-seeking and support mental health needs within their settings but are

cognisant of the challenges that settings have with regards to resources. The implications for the work of educational psychologists in post-16 settings to support the mental health needs of young people, are explored.

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List of Abbreviations

Abbreviation	Meaning
AoC	Association of Colleges
APMS	Adult Psychiatric Morbidity Survey
BPS	British Psychological Society
CAMHS	Children and Adolescent Mental Health Service
CIS-R	Clinical Interview Schedule - Revised
DfE	Department for Education
DoH	Department of Health
EP	Educational psychologist
FE	Further education
GP	General Practitioner
HSB	Harmful sexual behaviour
MH	Mental health
MHL	Mental health literacy
NHS	National Health Service
ONS	Office for National Statistics
PBC	Perceived behavioural control
PCP	Personal Construct Psychology
PHE	Public Health England
PSHE	Personal, social and health education
PSI	Peer support intervention
RQ	Research Question
SD	Standard deviation
SEND CoP	Special Educational Needs and Disability Code of Practice
SN	Subjective norms
tMHFA	Teen mental health first aid
TPB	Theory of Planned Behaviour
UNCRC	The United Nations Convention on the Rights of the Child
WHO	World Health Organisation

Chapter 1: Introduction

This thesis concerned the mental health related help-seeking behaviour of young people attending post-16 settings. In it, I explored the real and hypothetical intentions of young people to seek help for mental health problems. To do this, the personal attitudes of young people towards seeking help, the perceived attitudes of those around them, and the ability they feel they have to seek help for mental health problems, were considered. Further, the factors thought to mediate help-seeking either through discouraging or encouraging, were explored. The purpose of this chapter was to provide a rationale for focusing on the mental health and more specifically the intentions of young people attending post-16 settings to seek help. Following this, I outlined my personal interest in the topic.

1.1 The Context of Mental Health Problems

1.1.1 The international context

In a report published by the Mental Health Foundation (2016), mental health problems were cited to be a growing health concern. This was evidenced by a systematic analysis on the global burden of disease conducted by Whiteford et al. (2013). Within this piece of research, mental health was identified as one of the main causes for the worldwide burden of disease (the impact of a health problem as measured by various indicators such as mortality, morbidity and financials implications), accounting for 21.2% of the total years lived with a disability worldwide. More recently, data from the Global Burden of Disease Study has highlighted that depression has increased by 49.86% between the years 1990 and 2017 (Liu et al., 2020). The treatment received for mental health needs depends on location i.e. developed or developing country, with the World Health Organisation (WHO) estimating that, for a variety of reasons, between 27.6-85% of people will receive no treatment (Demyttenaere et al., 2004; Evans-Lacko et al., 2018; Wang et al., 2007).

1.1.2 The national context

In England, identifying the prevalence of mental health difficulties experienced is fraught with problems, this is largely because definitions of mental health vary, and the

diagnostic procedures adopted in practice differ across region and over time. Despite this, it has been estimated that 28% of the total national disease burden is accounted for by mental illness (Mcmanus, Bebbington, Jenkins & Brugha, 2016), and is now the second largest contributor to disease in England (Public Health England (PHE), 2019).

In light of such estimations, an overview of mental health in England, has been provided by a collaboration between the National Centre of Social Research, and the University of Leicester's (for NHS Digital) Adult Psychiatric Morbidity Survey (APMS). The APMS is a survey which is carried out every seven years using the revised Clinical Interview Schedule (CIS-R). This is utilised because it is thought to offer the most reliable data on the prevalence and current trends of the 14 most common mental health problem symptoms experienced during the week prior to interview. According to the most recent survey conducted in 2014, on adults in England (aged 16 and over), 43.4% reported that at some point in their life they have had a diagnosable mental health condition. Of these adults, only a fifth of men (19.5%) and a third of women (37%) have sought help from professionals (McManus et al.,2016).

The regional picture of mental health, for the aforementioned reasons, varies slightly with evidence indicating that the rates of common mental health problems in the UK are the greatest in the South West (20.9%) and lowest in the East (14.4%) (McManus et al., 2016).

1.2 The Mental Health of Children and Young People

Unfortunately, the picture for the mental health of children and young people has followed a similar trajectory as for adult populations, with statistics often painting a picture which is more concerning. In this context, the definition used for a child comes from The United Nations Convention on the Rights of the Child (UNCRC), where a child is "every human being below the age of 18" (United Nations, 1989, Article 1), whereas a young person pertains to anyone between the ages of 10 and 24 (WHO, 2014).

Over the last 30 years, the mental health difficulties experienced by children and young people have increased significantly. According to the most recent APMS conducted in 2014, 17% of people aged 16 and over had a common mental health problem; an

increase of 0.8% since 2007 (Mental Health Foundation, 2016). More recently, this figure has increased to 20% (Vizard, Sadler & Ford, 2020). Of all health problems young people may face, depression is the leading disease burden in children and young people aged 10-24 (Gore et al., 2011). In 2015 it was reported by the Office for National Statistics (ONS) that in young people aged five to 19, suicide was the leading cause of death in boys and men, and the second in girls and women (ONS, 2015). In 2018, it was reported that the rate of suicide had increased by 22% over the course of the preceding year in young people aged 25 and under (ONS, 2019), which was greater than for any other age group. Such statistics demonstrate a concerning trend: a decline in the mental health of young people.

1.3 The Impact of COVID-19 on Mental Health

On March 11th 2020, the World Health Organisation declared COVID-19, known also as Coronavirus, a pandemic. The following day, Europe was placed at the centre of this and consequently a number of government regulations, including a full national lockdown to reduce social contact, were introduced in the UK to stop the spread of the virus. Simultaneous to the social isolation people were likely to face, other mental health risk factors were presented, such as increasing stress through economic hardship and uncertainty (Brooks et al., 2020), and subsequently, the mental health of the UK population became a concern. According to the work of Pierce et al. (2020), who conducted several waves of the UK Household Longitudinal Study, between 2018/2019 and April 2020 on adults aged 16 years and older, there was an 8.4% increase (18.9 to 27.3%) in the prevalence of clinically significant mental health disorders.

More recently, data published by Vizard et al. (2020) on the mental health of children and young people in the UK in July 2020, has evidenced the increasing prevalence of disorders specifically in young people aged 15 to 22-years–old. In this research it was identified that one in five (20%) of respondents has a ‘probable’ mental health disorder which, when compared to the data cited by the Mental Health Foundations (2016), would indicate a 3% rise. However, it is important to note that this deterioration in mental health of so many, was not experienced by all. For example, research conducted by Mansfield, Jindra and Fazel (2020) found that between 25% and 41% of the school children in their study reported feeling happier during the summer of 2020.

As a consequence of the overall increase in mental health need, the Centre for Mental Health developed a model with the aim to forecast mental health need and support following the COVID-19 pandemic. It has indicated that up to an additional 10 million people, equating to approximately 20% of the UK population, who did not require or receive mental health support prior to the pandemic, are likely to require it now. Of these people, it has been predicted that approximately 1.5 million will be children and young people under the age of 18, equating to 15% of that population (Durcan, O'Shea & Allwood, 2020). Of concern, this model was conducted prior to the second and third UK lockdown, and as such figures may now stand to underestimate the increase in mental health difficulties of the UK population.

1.4 The Role for Post-16 Settings

Before COVID-19, the mental health of children and young people (CYP) in the UK was already receiving increased attention. In 2015 the government pledged an additional £1.4 billion over the following five years in the hope of transforming Children and Adolescent Mental Health Services (CAMHS). However, in a period of financial austerity, where such financial injections were not ring-fenced, it has been identified that many of the clinical commissioning groups in receipt of this extra funding have not used it to increase their mental health budget, but instead to backfill cuts where they had been left under-resourced, due to the significant decrease in public spending (Young Minds, 2016). Such under-resourcing was made evident in the disparity in the number of referrals made to child and young people's NHS-funded mental health services a year (approximately 460,000), and the number who would receive NHS-funded treatment (approximately 200,000). This is further supported by the finding that just 26% of children and young people with a diagnosable mental health problem, during the 2018/19 financial year, would gain access to the treatment and care required (Crenna-Jennings & Hutchinson, 2020). Such a shortfall has increased the focus on the central role that schools and colleges play in supporting the mental health and wellbeing of young people in the form of prevention, identification, promotion, referral and joint working with support from specialists (Marshall, Wishart, Dunatchik & Smith, 2017), with a particular focus on support for self-help. Such concerns, and the rising need for educational settings to take on an increasingly frontline role to support mental health, have been reflected in the number of policies

that both the Department for Education (DfE) and the Department of Health (DoH) have produced over the last six years.

In 2017, the Mental Health Green Paper (DoH and DfE, 2017) "Transforming Children and Young People's Mental Health Provision", which sought to expand the access that children and young people had to mental health care, was published. Building on Future in Mind (DoH and National Health Service (NHS), 2015) and the Five Year Forward View for Mental Health (NHS, 2016) this collaborative approach set out a number of initiatives to address the mental health needs of children and young people in schools and colleges. These included: every school and college to have a designated mental health lead; to fund community mental health teams to increase capacity for early intervention and ongoing help; and, reduce waiting times to a maximum of four weeks. However, very quickly the publication was criticised as a 'missed opportunity', attributed to its lack of ambition, inadequate focus on preventative work and the failure to acknowledge the many factors contributing to issues with young people's mental health, such as exam pressure (BPS, 2018). It must also be highlighted that colleges were referred to and actively sought after infrequently, and where they were, the substantial differences between schools and colleges were not considered.

Alongside government initiatives, the role which schools and colleges play is highlighted explicitly by the Children's Commissioner (2017), whereby the support available to young people is divided into a system of tiers:

> **Tier 1:** Universal provision working at prevention, identification and early intervention.
>
> **Tier 2:** Targeted provision for young people with mild to moderate difficulties which can be delivered by mental health practitioners in their universal setting.
>
> **Tier 3:** Multidisciplinary and specialist units for young people with more severe and chronic difficulties. Provided either within the community or as an outpatient service.
>
> **Tier 4:** Highly specialised inpatient units for acute and rapidly declining difficulties and those that pose risk to self and others.

Whilst schools and colleges are not legally required to have a specific mental health policy, as a universal service, there is an expectation, and research to suggest, that they will support the mental health and wellbeing of children and young people, and are ideal sites for early intervention with the support of mental health professionals (Thorley, 2016). This has more recently been reiterated by the departmental advice, 'Mental health and behaviour in schools' (DfE, 2018), which is underpinned by statutory guidance such as 'Keeping Children Safe in Education (DfE, 2015) and 'Working together to safeguard children (2015). Both pieces of guidance have outlined the legal responsibility that schools have "to promote the welfare of their pupils" (p.6). Suggestions to achieve this include: prevention of difficulty through the provision of a calm and safe space which supports the development of resilience; accurate identification of emerging issues; providing early evidence informed support and interventions; and, working effectively with external agencies. This indicates that mental health, although not explicit, is the statutory responsibility of schools.

The important role that educational settings have in supporting the mental health needs of young people has also been recognised in the SEND Code of Practice (CoP; 2015). In this most recent version, categories such as Behavioural and Emotional difficulties (EBD) and Social, Emotional and Behavioural difficulties have been subsumed by Social, Emotional and Mental Health Difficulties, demonstrating the developing awareness that mental health difficulties underpin behaviour seen.

Despite this wealth of guidance for schools and colleges, it is down to the discretion of the setting, to a degree, to interpret and implement this. Further, it is important to recognise that much guidance is often based on research conducted in schools, with school aged children, and consequently implementation varies greatly. This will be discussed in greater detail in Chapter 2.

1.5 Personal Interest

I have always had an interest in mental health, particularly because I have personal experience of both requiring and providing support.

Prior to becoming a trainee educational psychologist, I spent much of my career as a teacher and tutor in a post-16 setting. During this time, I was acutely aware of the mental health needs of my students and concerned by the alarming number who would

not seek help or were reluctant to engage where it was offered. However, the central role that education can play in preventing, identifying and providing early intervention for mental health difficulties of children and young people was not clear to me until I left education for the NHS. The opportunity that education provides to meaningfully engage with all young people on topics such as mental health is not one that should be missed.

The present study is inspired by my experience as a teacher and my current training role. Reflecting on these experiences, and as someone who, as a student, required help but did not seek it at college, I wondered what factors mediate the help-seeking of young people, specifically within post-16 settings. As such, I decided to investigate the mental health help-seeking intentions of young people in post-16 settings and how it can be encouraged.

Chapter 2. Literature Review

This chapter will explore the literature which relates to the help-seeking behaviour of young people attending post-16 settings. Following an exploration of mental health and wellbeing definitions and frameworks, I will consider the mental health and wellbeing of young people attending post-16 settings and the varying support which is in place. Following this, I will clarify what help-seeking means in the context of mental health and the frameworks which have been used to understand the processes which it entails. In the following section, literature around the factors which act to facilitate and those which reduce help-seeking behaviour, will be explored. Then, I will look at the effect of the current context on help-seeking, specifically related to COVID-19. Finally, I identify the gaps in the literature and how there are still contributions to be made to current knowledge and understanding.

An electronic review of the existing literature was conducted between June 2019 and May 2021 using: EBSCO, Science Direct, ERIC and PsychINFO databases. Both, *Educational Psychology in Practice* and *Educational and Child Psychology*, journals were used as these seemed most specifically relevant to educational psychology practice in the UK. Furthermore, grey literature such as guidance produced by voluntary organisations and government publications were accessed also. The literature was selected based on its relevance to the focus of the study.

Table 1 Key terms used whilst searching the literature

Topic	**Population**	**Setting and age group**
Mental health	Young people Adolescence	Post-16 setting/s Further education College Sixth form Sixth form college Secondary school
Mental health related help-seeking	Young people Adolescence	Post-16 setting Further Education College Sixth form Sixth form college Online General practice Secondary school Professionals
Wellbeing/ well-being/ well being	Young people Adolescence	Post-16 setting/s Further education College Sixth form Sixth form college Secondary school

2.1 Defining Mental Health

2.1.1 Definition and model of mental health

Mental health definitions are varied and, within psychological and sociological literature, are unresolved due to its complexity and our evolving understanding of it (Dodge, Daly, Huyton & Sanders, 2012). Historically, positive mental health has been surmised as the absence of diagnosable mental illness such as depression and anxiety. However, for nearly 20 years, the widely acknowledged and accepted definition of mental health has been: "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization [WHO], 2005). Within this definition are two key components: *psychological functioning* and *social functioning*. To further understand these, the concepts underpinning them, wellbeing, will be explored.

Wellbeing literature has long been divided between two schools of thought: hedonic wellbeing (positive feeling) and eudaimonic wellbeing (positive functioning). Hedonic wellbeing, derived from the word *hedonism* concerns the pursuit of satisfaction, interest in life and of happiness, and is more informally, but commonly, known as emotional wellbeing (Keyes, 2007). On the other hand, eudaimonic wellbeing can be described as the quest for, and experience of, optimal functioning and fulfilling one's own potential (Ryan and Deci, 2001; Ryff, 1989). According to Westerhof and Keyes (2010), a combination of the emotional aspects of hedonic wellbeing, and the social and psychological elements of eudaimonic wellbeing, can be seen as a comprehensive definition of mental health. With regard to the continuum of mental health (Keyes, 2002), where an individual experiences high and optimal levels of the three core elements, that individual would be described as "flourishing", whereas low or sub-optimal levels would be described as "languishing" (p.112).

For the purpose of this research, both eudaimonic and hedonic elements of mental health are considered alongside mental illness, as research has indicated that mental health is not dependent on mental illness, and vice versa (Keyes, 2005). It is important to recognise that mental health and mental illness are terms often used interchangeably, and whilst they are related, they are in fact two distinct dimensions on their own

continua (Westerhof & Keyes, 2010). For example, research into the mental health of American adults, conducted by Keyes (2005, 2006), found that few, who were free from mental illness, could be classified as experiencing positive mental health, and vice versa.

2.1.2. Mental health problems

Finding an appropriate definition for *mental health problems* in the literature has proven challenging. Where the term is defined (such as Mental Health England, 2016) and used in research (such as Cartmill, Deane and Wilson, 2009), the psychopathological model of mental health has been subscribed to, that is, mental health is the absence of mental illness (a diagnosed mental disorder). This, as aforementioned, is not congruent with the definition used in this research.

On the other hand, research has also referred to *mental health problems* as an umbrella term for a variety of experiences (Rickwood, Deane, Wilson & Ciarrochi, 2005) including suicidal ideation (Cartmill, Deane & Wilson, 2009), hopelessness (Deane, Wilson & Ciarrochi, 2001) and emotional competence (Ciarrochi, Wilson, Deane & Rickwood, 2003). For the purpose of this research, *mental health problems* will be used as an umbrella term for both mental illness and mental ill-health. This will afford the study to go beyond understanding help-seeking for mental-illness, and those who may be diagnosed, to the help-seeking behaviours of young people for a broader spectrum of problems encompassed in the subjective experience of mental ill-health also.

2.2 Mental Health and Wellbeing of Young People

Adolescence is a critical age for the onset of mental health needs. It has been reported that before the age of 14, more than 50% of all lifetime diagnosable mental health problems would have begun (Royal College of Psychiatrists, 2010), and by the age of 18, over 70% (WHO, 2014).

A survey conducted by the Association of Colleges (AoC; 2017), of 105 further education colleges in the UK, found that over 85% of the respondents felt the number of students with mental health difficulties had increased over the past three years. The AoC (2017) attributed this increase to a number of factors including social media,

exams and challenging home circumstances. However, it is well documented that those in the period following the end of school experience significant changes, physically, emotionally and socially which they must navigate in a very short period of time. For example, when leaving school, a young person is likely to have: transitioned to full-time or part-time education, which may be associated with employment or training; begun to build and develop increasingly independent relationships; and, moved towards increasingly independent living (Coleman, 2011). Concurrently, they must manage challenges and changes to their self-identity, aspirations and their beliefs and values (Hayton, 2009). The transition between secondary and post-16 setting can increase these difficulties (Mental Health Foundation, 2016). Although an exciting time for many, the various changes highlighted above make young people aged 16 and over particularly vulnerable to developing mental health difficulties (Warwick, Maxwell, Statham, Aggleton & Simon, 2008). These difficulties have long been documented, with research in 2002 reporting that 26% of students in one FE college had experienced emotional and or psychological problems, and that 46% had experienced problems in the past (Schools Health Education Unit, 2002). More recently, the National Union of Students (2017) reported that in a survey of 1,093 further-education students, 40% reported experiencing mental health difficulties in their first year, and 33% in their second year, suggesting that the prevalence of mental health needs in post-16 settings is increasing. To exacerbate this issue, there is evidence to suggest that the mental health needs of 16- and 17-year-olds are often left unaddressed by both child and adolescent, as well as adult mental health services (Warwick et al., 2008) and that continuity of care, whilst valued, can be challenging (Cleverley, Rowland, Bennett, Jeffs & Gore, 2020).

2.3 The Importance of Mental Health and Wellbeing

Research conducted globally has indicated there is a strong relationship between mental health and outcomes in several important areas including education, employment and criminal behaviour (Patel, Flisher, Hetrick & McGorry, 2007). Further to this, research conducted by Brännlund, Strandh and Nilsson (2017) using data that covered the entire Swedish population between the years 1960 and 2010, found there to be a negative correlation between mental health problems and educational achievement. Explaining why there was a negative correlation was beyond the scope of the research, however one suggestion cited, based on the work of Breslau et al. (2011), was that a loss of

concentration, cognitive distortion and challenging behaviour, which are all symptomatic of mental health problems, can interfere with learning.

Whilst the research cited above has taken place in various countries and over different periods of time, government guidance and research in the UK would also seem to support a link between mental health and outcomes. For example, in a rapid review conducted by Public Health England (PHE; 2014) of the literature examining the link between educational outcomes and wellbeing, it was concluded they are positively correlated. And whilst caution must be taken with attributing cause with correlational data, further guidance released following this has reiterated that mental ill health in young people is the leading cause of other health related issues which can have 'adverse and long-lasting effects' (PHE, 2016). Therefore, it could be suggested that it is in the best interest of post-16 settings to prioritise mental health.

2.4 Mental Health Provision in Post-16 Settings

In 2015, education or training was made compulsory until the age of 18 in England (Education and Skills Act, 2008), which meant that young people would be enrolled at a post-16 setting. In England, post-16 settings come in a number of forms: FE colleges; sixth form colleges and sixth forms, each of which have a different focus on academic and vocational qualifications, and the range qualifications on offer (UK Government, 2015).

Mental health and wellbeing provision and activities in post-16 settings are broad. In 2017, the DfE conducted research into the mental health provision of schools and colleges to understand how they promote positive mental health and wellbeing, and how they support and prevent mental ill-health amongst their students. Despite only 17.1% of the 340 colleges approached to participate responding (which can be interpreted in several ways), the findings provide a useful contribution to the understanding of what colleges do to promote positive mental health. It was found that colleges felt it was their responsibility to: create an environment that felt safe and happy; identify mental health needs; provide support; refer to other provision; and, deliver therapy. When asked what they do to promote positive mental health and wellbeing, 92% of respondents felt that it was integrated into their day through: normalising mental health needs; making it clear how and where support can be accessed; and, supporting students to manage their own emotions. The activities and the provision to achieve this was varied but addressing

stigma was common. It was also noted that whilst the most common form of need identification was ad hoc, and often done by teachers, colleges do employ a range of screening tools to understand mental health need, whilst also relying heavily on self-referral from pupils. When asked about the specific support and interventions provided in colleges, the research findings are less clear with many indicating a number of challenges to providing support: a lack of funding, and difficulties in commissioning services were cited as the main antagonists (DfE, 2017).

Further to the findings earlier described in the survey conducted by the AoC (2017) into student mental health, it was highlighted that 56% of those who responded reported an increase in their internal resources over the previous three years, in a bid to support the increasing mental health and wellbeing needs of young people. Research conducted by Wallace (2012), on the effectiveness of college counselling services, found that positive outcomes were identified for student retention, achievement and experience, and employability. However, due to the previously mentioned funding cuts experienced in education, and particularly within FE, the number of counsellors provided by college have decreased with only 40% able to provide one full time counsellor (Wallace, 2012). In this research Wallace discovered that the factors young people value in the counselling relationships include having a safe space, being emotionally contained and understood, and being taught coping strategies, all of which will be explored in more detail later. In light of funding cuts, colleges have been forced to be creative and offer a myriad of support that offers many of these qualities, but in a significantly reduced and more cost-effective way, through the use of personal tutors, wellbeing officers, learning mentors and support assistants. However, it has been acknowledged that in order for staff in post-16 settings to feel able to support young people with mental health difficulties, more training is required (Graham, Phelps, Maddison & Fitzgerald (2011).

The importance of staff training has been demonstrated globally. For example, research by Graham et al. (2011), which explored the role of teachers in supporting the mental health of their pupils in Australian schools, found that, in line with previous research (Williams, Horvath, Wei, Van Dorn & Jonson-Reid, 2007) a teacher's response to student mental health was mediated by feelings of self-efficacy. Moreover, they identified that whilst 98% of the 508 teachers they surveyed saw mental health education and support in schools as very important, only 70% felt they had the skills necessary to deal with it confidently. A lack of training, experience and confidence were cited as the main source for these feelings. This has been reiterated by Ekornes (2017),

who found that teacher feelings of self-efficacy and the possession of adequate mental health knowledge was a low as 12%, with teachers citing adequate training as the source from which they gain the competency and skills required.

In the UK, the necessity for good quality training has been corroborated by Kidger, Gunnell, Biddle, Campnell and Donovan (2013) who found a lack of adequate professional learning opportunities reduce teacher capacity to support mental health. This is interesting in light of the finding that 90% of schools and colleges provide staff training on supporting the mental health and wellbeing of students (Marshall, Wishart, Dunatchik & Smith, 2017). However, it is unclear the quality of training, and the audience to whom it is delivered. Further, uncertainties have been reported by teachers about the extent of their role in relation to supporting the mental health needs of pupils (Kidger et al., 2013), demonstrating that a lack in competence, not a disregard for the importance of the role, may limit support that educational staff feel able to provide. Such findings suggest that, whilst teachers may be provided with training (which varies worldwide), it is not necessarily enough to enable them to feel confident supporting the mental health needs of pupils.

Optimistically, research has demonstrated where the mental health and academic study of young people is supported, stress is seen to reduce, and engagement increases (Murphy, 2017). However, despite the opportunities to seek help and support provided, not all young people will make use of it.

2.5 Help- Seeking

2.5.1 Definition of help-seeking

Help-seeking is a complex construct, defined in the literature in a variety of ways, depending on the discipline. One such definition that is not specific to health is: “the act of looking or going in search of a relief or cure to fulfil a need” (Cornally & McCarthy, 2011, p.281). Within the field of illness, help-seeking was originally explored in the context of ‘illness behaviour’. This was a term used in medical sociology to refer to human health behaviour; first introduced by Mechanic (1967), whose interest in illness behaviour came from the observation that not all people considered ill would consult healthcare professionals (Tuckett, 2013), thus generating interest and discussion in the behaviour displayed, or lack thereof, by those experiencing ill-health. In the context of

health, a definition of help-seeking behaviour has been provided by Rickwood, Deane, Wilson, Ciarrochi and Young (2005), whereby help-seeking is the process of an "individual communicating with other people to obtain help in terms of understanding, advice, information, treatment and general support in response to a problem or distressing experience" (p. 4). On the other hand, help-seeking intentions have been defined by White, Clough and Casey (2018) as "a conscious plan to exert effort to communicate about a problem, emotional pain or psychological issue, where that communication is an attempt to obtain perceived support, advice or assistance that will reduce personal distress" (p.65). Unlike earlier definitions this does not relate help-seeking to formal sources only and emphasises the importance of social relationships and interpersonal skills (Pescosolido, 1992). Further, it is important to note that despite some research treating disclosure as separate to help-seeking (Klein, 2012), this definition would suggest they are not, and as such disclosure will be conceptualised as a form of help-seeking as it is likely that advice and support will be offered.

2.5.2 Conceptual framework of help-seeking

From a psychological perspective, there are a number of aspects which underpin help-seeking behaviour: problem recognition; knowledge of, and willingness to approach, sources of help; ability to see help; planning and intention forming; and, making contact with help-source (Moyers & Rollnick, 2002; Rickwood & Thomas, 2012; Romano & Netland, 2008; White et al., 2018).

According to a review conducted by White et al. (2018) on the conceptualisation of help-seeking intentions, the conceptual framework thought best to clarify the attributes and antecedents of help-seeking behaviour was the theory of planned behaviour (TPB) (Ajzen, 1991). The TPB is a social psychological theory of human behaviour which suggests that people make reasoned decisions to act based on a number of inter-related factors which take into consideration societal norms. These are: attitudes, which focus on the evaluation of a behaviour, such as the consequences; subjective norms (SN), which include beliefs about what others think about a behaviour; and, perceived behavioural control (PBC), which consists of feelings of self-efficacy and controllability (Ajzen, 1991). These core components, together, inform an individual's intention to act, which predicts performance of a behaviour. This has been supported by a number of key studies which have demonstrated a positive correlation between the three components of

TPB and help-seeking for symptoms of depressions in American college students (Bohon et al., 2016) and German adults (Schomerus, Matschinger & Angermeyer, 2009). In both studies, attitudes appeared more important than PBC and SN. However, whilst these factors might partially explain intentions, one of the criticisms of the model is its predictive validity, that is, intentions do not necessarily mean a desired behaviour will be displayed (Tomczyk, Schomerus, Stolzenburg, Muehlan & Schmidt, 2020). For example, in a meta-analysis conducted by Sheeran (2002), it was found that intentions could only account for 28% of the variance in behaviour, reiterating the criticism that the TPB offers only a partial explanation of behaviour. The factors which might mediate the intention-behaviour gap, such as opportunity to perform the behaviour, will be discussed in more detail later.

2.5.3 Help-seeking behaviour of young people

The definition of help-seeking has already been clarified, however what is meant by 'young people', and the word used to represent young people, varies globally. So, for the purpose of this review and research, 'young people' and other associated words must be defined and differentiated.

As aforementioned, a young person includes anyone aged between 10 and 24, which combines both 'adolescence' (10 to 19) and 'youth' (15 to 24) (WHO, 2014). In the literature these terms are often used interchangeably and evolve with time and circumstance. For this research, the term 'young people' and 'young person' will be used, as my intention is to understand the help seeking behaviour of those attending post-16 educational settings and therefore 16 years and older.

It has been well documented that appropriate help-seeking behaviours reduce the experience of distress (Kalafat, 1997). However, between the ages of 16 and 24, the prevalence of mental health problems is high with approximately 20% of young people experiencing symptoms of anxiety or depression (ONS, 2014), which has more recently increased to 31% (ONS, 2020). Yet the level of help-seeking behaviour and service utilisation would not necessarily indicate this (Rickwood & Thomas, 2012). In a report by Slade, Johnston, Oakley-Browne, Andrews and Whiteford (2009) on the mental health of Australians, it was identified that at any age the level of need and service use is incongruent. The biggest discrepancy noted was that in young people aged between

16 and 24, with international findings corroborating this. In Switzerland, Mauerhofer, Berchtold, Michaud and Suris (2009) found that between 65 to 95% of young people do not seek help for emotional distress, and in the UK, Salaheddin and Mason (2016) found that only 35% of survey respondents, aged between 18 and 25, would seek help for mental health problems. More recently, in research conducted on behalf of the NHS, it was identified that 24.1% of children and young people aged five to 19 did not seek any help for mental health related problems (Sadler et al., 2018). Such findings highlight that whilst some young people do seek help, there are many who, for a myriad of reasons, do not. Subsequently, understanding both where young people attending post-16 settings go for help, and the factors which mediate help-seeking, is essential.

2.5.4 Where do young people seek help?

Help can be sought from both formal or informal sources. Formal help-seeking is "from professional sources of help; that is, professionals who have a recognised role and appropriate training in providing help and advice, such as mental health and health professional, teachers, youth workers and clergy" (Rickwood et al., 2005,p.4). On the other hand, informal help-seeking is from "social relationships, such as friends and family" (Rickwood et al., p.4). Regardless of the source of help, formal or informal, interpersonal interaction, as identified by Cornally and McCarthy (2011) is essential to some degree. However, more recently, there has been a growing trend for a third type of help-seeking behaviour: self-help, which is often computer-mediated or on smartphones and requires little to no contact with other people, bringing this attribute of help-seeking into question (Clement et al., 2015). Whilst self-help will be discussed in relation to mediating factors, it is beyond the scope of this research to explore it in great detail.

As can be seen above, the sources of help available to young people experiencing mental health difficulties are varied and many in number. However, research into the help-seeking preferences of post-16 settings is limited. In a bid to understand which sources of help are utilised by young people, Toren, Grieken, Lugtenberg, Boelens and Raat (2020) conducted focus groups with adolescents in the Netherlands, who had read two vignettes: one about a young person experiencing difficulties with intimacy and another about a young person with difficulties at home and in school. The students were asked to discuss how they would act if they found themselves in a similar situation. Findings indicated a clear preference for help from more informal sources such as

friends, which would appear to confirm earlier research that found young people are most likely to seek support for suicidal ideation from their social networks (Michelmore & Hindley, 2012). Further to this, seeking support from a parent or mentor within a school, although the role of the mentor was not defined, appeared preferable to seeking professional help. From this finding, one of the conclusions drawn was for further collaboration between schools, parents, and health care providers. However, when looking at the help-seeking preferences of secondary school pupils, Leavey, Rothi and Paul (2011) found that educational professionals (teachers, school counsellors, tutors and school nurses) were ill-favoured with only 15% of young people indicating they would be a help-seeking choice. This has been more recently corroborated by research with eleventh grade students (aged 16) in Italy, whereby teachers were excluded as a preferred source of help (D'Avanzo et al., 2012). Contradicting this is research conducted by Sadler et al. (2018), who found that of the five-to-19-year olds in receipt of professional help, teachers (48.5%) were cited as their main source of support. Other than teachers, professional sources of support cited included: primary care professionals (33.4%), mental health specialists (25.2%) and educational support services (22.6%), including educational psychologists (EP). These findings are interesting given that the capacity to self-refer (to medical and subsequently mental health professionals) and act independently, increases during adolescence. Such findings may be explained by research by Jorm, Wright and Morgan (2007) who, in their research on Australians aged between 12 and 25, and their cohabiting parent, found that only four to 13% of adolescents cited their General Practitioner (GP) as a source of help, depending on their specific mental health need. One reason for this may relate to the findings of Leavey et al. (2011), who found there to be a concerning lack of trust in GPs, and clarity in the role they play with regards to mental health.

Mobile phones, the internet and social media are embedded in the day to day lives of young people. In the research conducted by Toren et al. (2020), participants highlighted the role the internet has to play in help-seeking. For example, for issues that caused feelings of shame or were deemed 'small', the internet was the preferred source from which help might be sought, which is a prominent finding given the ubiquity of internet access. For example, of all young people in the UK aged 16 to 24, 98% use social media and 98% access the internet (Ofcom, 2020)). In 2019, it was reported that internet usage has increased to 99% of the population aged 16 to 44. (ONS, 2019). It is unsurprising then, that in 2015, Ofcom found that 73% of young people relied on the media, social

media and websites for information about mental health problems, and specifically self-harm. Such findings indicate that online information and interventions may reduce some of the many and significant barriers to seeking help that young people face when experiencing distress. For example, research by Andersson and Titov (2014) suggested that concerns related to anonymity, confidentiality, self-reliance (found to be preferable for many) and stigma may reduce, and subsequently increase help-seeking. This has been further reiterated by Pretorious, Chambers, Cowan and Coyle (2019), who found 18-to-25-year olds value the anonymity and confidentiality the internet can offer.

Use of the internet to seek help has been corroborated by more current work by Pretorius et al. (2019), who in their systematic review of 28 studies found that in six, young people made use of 'text-based queries' via the use of search engines the most. Social media, instant messaging and charity websites were also found to be frequently used. These findings should not be surprising as young people are likely to use the internet as part of their day-to-day life. However, whether help or information was sought, or whether self-help or guidance was the desired outcome, is not clear. Interestingly, the use of the internet has been associated with the time of day in some research (Best, Manktelow & Taylor, 2014; Burns, Davenport, Durkin, Luscombe & Hickie, 2010) with most online help-seeking happening after 11pm, emphasising the important role that online forums can play in creating access to support. Importantly, in the research conducted by Michaelmore and Hindley (2012) adolescents were able to cite the dangers associated with seeking help online and the importance of being able to differentiate between appropriate and inappropriate online sources.

2.6 Factors which Mediate Help-seeking

As has been demonstrated, the help-seeking of young people is varied. The factors which are thought to mediate help-seeking will now be discussed in turn.

2.6.1 Barriers to help-seeking

The reluctance to seek help (ONS, 2020) in the current climate, where the mental health needs of young people are only increasing, is problematic, but not exclusive to the UK. Through reviewing the literature, it is clear there are many potential factors which can act as barriers to help-seeking for young people experiencing mental health difficulties,

and might offer an explanation for the discrepancy between intention and actual behaviour. Each will be discussed below.

In a systematic review of the literature conducted by Gulliver et al. (2010) which looked into both barriers and facilitators of help-seeking behaviours for mental health problems, the barrier most prominent, and disproportionately deterring young people aged 12 to 25, was stigma associated with having or receiving help for a mental health problem. This finding is consistent with previous reviews of the literature (Rothi & Leavey, 2006) and has been corroborated more recently. In the research conducted by Salaheddin and Mason (2016), survey responses indicated that young people, aged 18 to 24, were specifically concerned with: appearing 'pathetic and weak'; the opinions of others and differential treatment; and finally, being labelled. A systematic review conducted by Clement et al. (2015) on the impact of mental health related stigma on help-seeking in people of any age found a 'small consistent negative association' between internalised stigma (shame and embarrassment) and help-seeking, indicating that an individual's own mental-health related stigma may act as a deterrent. Perceived stigmatising views of others and endorsed stigma (an individual's own attitudes towards others with mental health problems) were found to be less negatively associated with help-seeking behaviours.

Although the most prominent barrier noted in a number of research studies, it is important to recognise that the level of stigma young people perceive, and the detrimental impact which this has on help-seeking, differs. In research conducted by Wrigley, Jackson, Judd and Komiti (2005) on adults (aged 18 and above), it was concluded that the perceived stigma associated with help-seeking was greater in rural than in urban communities. Further, the level of stigma associated with different types of help has been found to vary. For example, Clement et al. (2015), found in their systematic review, that the stigma associated with treatment was greater than for seeking non-professional help.

The expectation that young people place on confidentiality is high (Hallett, Murray & Punch, 2000; Pretorious et al., 2019). Therefore, it is unsurprising that confidentiality and disclosure are further concerns recognised in the literature. In the research of Clement et al. (2015), disclosure and confidentiality was reported to be the greatest barrier to seeking professional help, with 32% of overall participants indicating this was

a deterrent. Aligned with this are the findings of Rickwood and Braithwaite (1994) who identified in their research that the help-seeking intentions of young people are greater towards sources they trust. Breaches of confidentiality, or at least the fear of them, act as a significant deterrent for young people in educational settings (Helms, 2003). It has been inferred that the fear young people have around a breach in confidentiality is associated with stigma (Gulliver et al., 2010).

Difficulty identifying mental health problems will affect whether a young person is likely to seek help, and the source they will go to. Research conducted in Australia has shown that young people are unlikely to seek help if they have poor mental health literacy (MHL; Ratnayake & Hyde, 2019). MHL is defined as "knowledge and beliefs about mental disorders that aid their recognition, management or prevention" (Jorm et al., 1997, p.1). This involves: "knowing how to prevent mental disorders, being able to recognise when a mental disorder is developing, knowing about help-seeking options and treatments available, knowing about self-help strategies, and mental health first aid skills to support others affected by mental health problems" (Jorm, 2015, p.1). Although the concept was developed based on research with adults, more recently frameworks of MHL in children and young people have been developed to increase validity (Bale, Grové & Costello, 2018). To demonstrate levels of MHL of young people, research by Wright et al. (2005), which assessed the ability of Australians (aged 12 to 25) to identify depression and psychosis, found that 50% of the young people who participated in his study could correctly identify depression. This corroborates the earlier findings of Marshall and Dunstan (2013) who, when examining the MHL of rural Australian adolescents, found that 68% were able to correctly label and identify depression when presented with vignettes. However, they were less likely to recognise the subtleties of depression when suicidal ideation was not present. Participant knowledge and understanding of illness trajectory, recovery times and support available was also found to be poor, acting as a potential barrier to seeking help. Such findings are suggestive that MHL transcends the correct identification of mental illness, but also entails the attitudes held and knowledge of where help can be obtained. For example, in research conducted by Biddle, Donavon, Gunnell and Sharp (2006), GPs were not considered a form of support for mental health problems, despite their frontline role. More recently, Farr, Surtees, Richardson and Michail (2021), in their research with eight 17-to-23-year olds, reiterated the uncertainty that young people have around the mental health role of GPs in the UK. The impact that MHL has on help-seeking behaviour has been

evidenced in schools. For example, where MHL interventions have taken place, the attitudes and intentions of pupils to seek help have improved (Milin et al., 2016). Despite the anticipatory and predictive nature of this latter piece of research, it is known that behaviour is often predicated, at least partly, by attitudes and intentions (Ajzen, 1985).

The characteristics of the provider have been cited as a deterrent to seeking help. Research conducted in schools has identified characteristics that young people saw as barriers. These included: 'active negativity', being judgmental, having favourites, being too busy, unhelpful responses, being out of touch, being 'psychologically inaccessible', and having dual roles (Gulliver et al., 2010). However, other research would seem to indicate young people are often more willing to speak with a member of staff in an educational setting than initially seek help and disclose to an external source (Murray, 2005; Sadler et al., 2018).

Other factors cited in the literature and thought to act as barriers to mental health related help-seeking include: perceiving problems as not serious enough (Salaheddin & Mason, 2016); perceiving services to be inadequate (Rothi & Leavey, 2006); favouring reliance on self (Salaheddin & Mason, 2016); and, instrumental difficulties such as cost, time, inflexible hours and travel (Gulliver et al. 2010).

2.6.2 Facilitators to help-seeking

There is a paucity of research on the factors which facilitate mental health related help-seeking behaviours for any population. For example, in a systematic review conducted by Gulliver et al. (2010), for the 13 pieces of research on barriers to seeking help for mental health related problems, there were three papers which looked explicitly at facilitators. For example, it was identified by Wilson and Deane (2001), when researching adolescent opinions on barriers to help-seeking and increasing help engagement, that help-seeking was likely if the individual felt their problem would be validated and normalised. In all three pieces of research, 'positive past experiences with help-seeking' was cited (Lindsey, Korr, Broitman, Bone, Green & Leaf, 2006; Timlin-Scalera, Ponterotto, Blumberg & Jackson, 2003; Wilson & Deane, 2001). However, it would be reasonable to argue that many of the barriers discussed can, if addressed, become facilitators. For example, in research conducted by Toren et al. (2019) trust was

identified to be the main facilitator, which would include confidence in confidentiality, which when lacking was cited as one of the most prominent barriers to help-seeking.

Another key facilitator identified by Toren et al. (2019) was that of a trusted adult, such as a parent or teacher, initiating a conversation about the problem. Whilst this deviates from the current definition of help-seeking as an active and intentional process, such findings provide useful insights. For example, it has been deduced from this research that proactive and open communication adopted by a whole school or college approach to mental health would act as a facilitator. However, as previous research has suggested (Bell, 2015; Ekornes, 2017; Graham et al., 2011; Kidger et al., 2010; Marshall et al., 2017) the support that can be provided by staff within a school or college setting varies for a myriad of reasons.

Research on online-help-seeking has also provided useful insights on facilitators of help-seeking. In the systematic review conducted by Pretorius et al. (2019), online help-seeking was motivated by reduced fear of judgement and negative stigma (including labelling), and privacy protection, suggesting these factors are important to young people.

2.6.3 The mediating role of gender on help-Seeking

Recent figures published by NHS digital, on the mental health of young people aged 17 to 22, would indicate that approximately 27.2% of young women and 13.3% of men experience difficulties with their mental health and are likely to have a diagnosable illness (Vizard et al., 2020). In a study conducted by Haavik et al. (2017), it was identified that gender did affect help-seeking. They found that women show greater intention to seek help and displayed higher levels of MHL but also identified more barriers. Interestingly, it was also demonstrated in this research that whilst gender does play a role, the impact of education was greater, with lower levels of education associated with reduced intentions to seek help. The disparity in help-seeking based on gender corroborates previous research by Biddle, Gunnell, Sharp and Donovan, (2004), who found that females, more so than males, felt that it was important to seek help for mental health problems. Further, it has been identified that females engage in more coping-strategies, which include help-seeking, than do their male counterparts (Herres, 2015).

Of the studies cited above, it is not clear how inclusive these statistics are. It has been identified by Stonewall Equality Ltd. (2018) that 46% of transgender people, who responded to a survey on LGBT (lesbian, gay, bi-sexual and transgender) health equality, have thought about taking their own life and that 41% of non-binary respondents had self-harmed within the last year. For those who have experienced hate crimes, the statistics were more concerning. Further, they found that 14% of respondents avoided seeking help due to the fear of discrimination based on their gender identity. Such findings would suggest that understanding the link between gender, in a more inclusive manner, and mental health and mental health help-seeking is essential, as research is scarce.

2.7 The Impact of COVID-19 on Help-Seeking Behaviour

On March 17th the Prime Minister, Boris Johnson, announced: "so looking at the curve of the disease and looking at where we are now – we think now that we must apply downward pressure, further downward pressure on that upward curve by closing schools" (Prime Minister's Office, 2020). Consequently, from Monday 23rd March all schools and colleges within England were to close, open only for children of keyworkers, and those deemed vulnerable. Over the course of the following year, post-16 settings remained closed until September 2020 and closed again between January 5th and March 8th 2021.

There is little research on the mental health help-seeking behaviours of young people since the outbreak of COVID-19, however within a month of the initial lockdown in the UK, Young Minds (2020) conducted a survey to find that 26% of young people in receipt of support prior to school and college closures, were no longer receiving help. In research conducted by Chen et al. (2020) in the UK, on referrals and presentation to health services, including mental health services, it was identified that the demand for these services initially dropped due to greatly reduced access to them, but increased shortly after.

Due to the unprecedented nature of a pandemic, to understand its impact on mental health help-seeking, it is useful to look at research related to previous pandemics. One study looking at the impact of Severe Acute Respiratory Syndrome (SARS) pandemic

in 2003, highlighted one of the positive effects that lockdown can have on mental health help-seeking behaviour. Lau, Yang, Tsui, Pang and Wong (2006) found that whilst residents of Hong Kong were in lockdown, they felt that they were better able to share feelings of mental ill-health with family and friends. However, the availability of comparable research to draw upon is scarce, as previous pandemics have happened in a time when mobile technology and the internet was not so widely available. Both of these are, as previously mentioned, used by 99% of the population aged 16 to 44. (ONS, 2019).

2.8 Gaps in the Literature and Contribution to Knowledge

The mental health of young people attending post-16 settings is a growing concern. The point at which young people transition to post-16 settings, and in the few years that follow, they go through a number of significant changes, all of which make them vulnerable to mental health problems, and less likely to seek help. Further, whilst guidance to support student mental health is written for both schools and colleges, more often than not colleges and their differing practices are rarely acknowledged.

Research into the mental health help-seeking behaviour of young people attending post-16 settings is innovative due to a dearth of research. Much of the research in this field has been conducted abroad, with adult populations or with school age children. This thesis aims to understand the help-seeking intentions and the actual mental health related help-seeking behaviours of young people attending post-16 settings. Further to this, I will explore the variables which are seen to act as barriers and, most importantly, facilitators to help-seeking and how help-seeking can be encouraged. The impact of a worldwide pandemic on help-seeking will also be explored in brief.

The intended outcome of this research is to develop a better understanding of the help-seeking intentions and behaviours of young people attending post-16 settings, to highlight what the current mental health related help-seeking barriers and facilitators are, and to understand how help-seeking can be encouraged and support be made more effective. This information can be used to understand what post-16 settings are doing to support the mental health needs of pupils in response to legislation and guidance (DoH and DfE, 2017) and inform how professionals, including EPs, can support post-16 settings building their capacity to support young people and optimise the existing

mental health and wellbeing support accessible to young people. This is essential because those experiencing a long-term mental health difficulty face unequal chances in life (Green Paper, 2017).

Chapter 3. Research Aims and Methodology

3.1 Introduction

The aims and research questions (RQ) will be set out in this chapter, providing a rationale for the methodology and research methods used. The process of data collection will be described, and ethical consideration made throughout the research process, outlined.

3.2 Research Aims and Questions

The aim of the research is to understand the mental health related help-seeking behaviour of young people attending post-16 settings in the South West of England and how it may be encouraged.

Phase one of the research explores the mental health related help-seeking intentions of young people. The impact of personal attitudes, the attitudes of significant others, and perceived behavioural control are each considered. This phase also seeks to identify the barriers and facilitators highlighted in the literature which impact help-seeking behaviour, and their relevance to the population. The impact of COVID-19 on mental health and help-seeking is briefly explored.

Phase two aims to gain the views of young people in order to understand their various experiences and perceptions of help-seeking, the considerations they make when contemplating help-seeking, the support available for mental health related problems and how it may be made more approachable and effective.

3.2.1 Research questions

Phase one

RQ1 What are the help seeking intentions of young people attending post-16 settings?

a. What are the attitudes of young people towards seeking help?
b. What are the attitudes of significant others towards seeking help?
c. Do young people feel able to seek help?

RQ2 What do young people perceive the barriers and facilitators to help-seeking to be?

RQ3 What impact has COVID-19 had on the experience of mental health problems in young people?

RQ4 Are there differences in experience of mental health problems, intentions to seek help and the impact of mediating factors, according to gender?

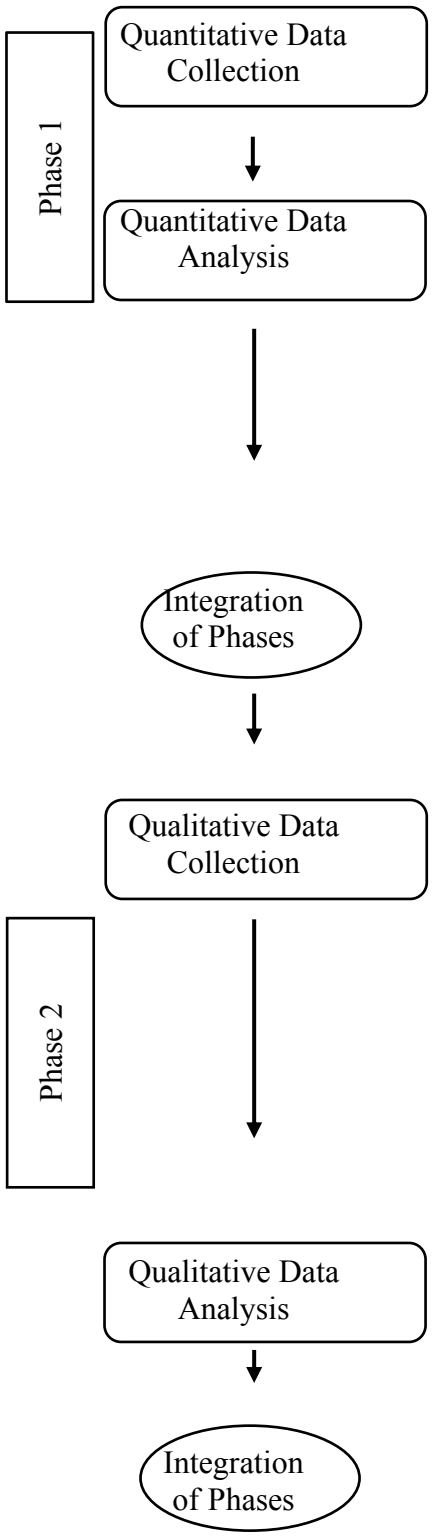
Phase two

RQ5 What are young people's expectations of seeking help for mental health related problems?

RQ6 How can the help-seeking behaviour of young people attending post-16 settings be encouraged?

RQ7 What would effective mental health support in education look like to young people?

Figure 1. Visual model of the mixed methods sequential design utilised



Phases	Procedure	Product
Quantitative Data Collection	• Mental Health Related Help-seeking Survey	• Numeric Data • Text Data
Quantitative Data Analysis	• Descriptive and inferential analysis using SPSS v.26 • Basic content analysis	• Numeric data • Descriptive and inferential statistics • Emergent categories • Cronbach's alpha • Discussion
Integration of Phases	• Selection of 8 participants • Development of interview questions	• Interview schedule
Qualitative Data Collection	• Individual semi-structured interviews conducted online via Microsoft Teams • Elicitation materials on Microsoft PowerPoint	• Text data • Interview transcripts
Qualitative Data Analysis	• Coding and thematic analysis • Microsoft Word	• Codes and themes • Thematic map • Discussion
Integration of Phases	• Interpretation and explanation of arising themes across both phase one and phase two.	• Overall discussion • Limitations • Implications • Future research

Note. Adapted from Ivankova et al. (2006)

3.3 Research Paradigm

When conducting research, researchers make a number of decisions based upon their philosophical assumptions. The outcomes sought will dictate the questions asked and the design of the research (Gray, 2019). This decision-making process, according to Crotty (1998) is hierarchical.

Traditionally, researchers will adopt or 'decide' ontological and epistemological positions that are inextricably linked. Ontology is concerned with the constitution of reality and the nature of existence (Gray, 2019), whereas epistemology focus on the theory of knowledge (Willig, 2008). Much research that is conducted, will fall into one of two epistemological camps depending on the researcher's stance towards the nature of knowledge: objectivism or subjectivism (Crotty, 1998). For objectivism, an objective reality (truth) exists external to the researcher, whereas for subjectivism, truth and reality are dependent on the perceptions of the researcher.

The notion that research should be positioned within a particular epistemology is challenged by pragmatism (Briggs, 2019). Rather than aligning approaches to specific epistemologies, pragmatism was developed on the belief that, whilst there is an external reality, the world as it 'is' can never be known as it is constantly changing (Sundström, Sjödin & Wahlström, 2017). As such, pragmatism is concerned with focusing instead on the utility of information gathered, to overcome problems within society (Morgan, 2007). Therefore, research which adopts a pragmatist philosophy is not bound to one approach to research, but instead can move between methodologies and methods, both data-driven and theory-driven, that will enable the aims of the research to be achieved.

Whilst the emphasis of pragmatic research appears to solely be on practicality, attention must be paid to the reasons underpinning research decisions: experience. Researchers hold beliefs and engage in actions, which are related and interpreted to provide meaning (Morgan, 2014). On the most part, this process occurs habitually, however where consideration is required, the process of inquiry (research) takes place. Therefore, according to Dewey (1920), research itself is a human experience. This research, and the decisions I made, are based on my own beliefs and prior actions. For example, having worked in both education as a teacher and the NHS (National Health Service) as an IAPT (improving access to psychological therapies) practitioner, the protective role

that education has to play for many young people, particularly in relation to their mental health and affording opportunities to seek help, was brought to the fore and informed not only the aims of the research, but also the research process itself. I not only wanted to understand *what* the help-seeking behaviours of young people are, but also to elicit *their* voices to understand their experiences.

As a researcher, the decisions I made were informed by the constructivist approach to inquiry. According to Lincoln and Guba (1985), constructivism sees knowledge as relativist (there is no objective truth), transactional (truth arises through interpersonal interaction) and subjective (the world is constructed) (Ratner, 2008). Like pragmatism, constructivism rejects the divide between epistemological assumptions as the "investigator and the object of investigation are… inextricably linked so that the 'findings' are literally created as the investigation proceeds" (Lincoln & Guba, 1985. P.207). Aligned with this, both phases of the research sought to explore the experiences and interpretations of young people seeking help for mental health related problems. Adopting the alternative philosophical stance of pragmatism afforded the freedom to utilise research methods that best met the aims of the study (Teddlie & Tashakkori, 2009), both of which are associated with post-positivism and constructivism and the belief that due to the symbiotic relationship between the researched and the researcher, they cannot be independent of one another.

A sequential explanatory mixed-methods design was used for this research. This design constitutes the collection and analysis of quantitative data, which is supplemented by the collection and analysis of qualitative data (Ivankova, Cresswell & Stick, 2006). The purpose of phase one was to identify the help-seeking patterns of young people and the factors which are associated with help-seeking, including COVID-19. The breadth of data obtained, through use of surveys in phase one, was followed by a second phase whereby student views and experiences of help-seeking were explored, with particular focus given to the mediating factors, and ways in which help-seeking and support can be improved. To do this, and to gain the depth required in phase two, semi-structured interviews were used. Whilst most sequential explanatory designs prioritise the quantitative phase of data collection and analysis (Morgan, 1988), this would not be appropriate due to the aim of the study and the importance placed on the views of young people. Priority, therefore, was given to the qualitative phase.

To ensure the requirements of the mixed method design are achieved, the process, and the data collected in phase one and phase two must be connected or integrated (Tashakorri & Teddlie, 1998). Therefore, in the present study, the phases were connected through phase one (quantitative) informing the development of phase two (qualitative) (Cresswell, Clark, Gutmann & Hanson, 2003) and the selection of phase two participants (case selection) (Ivankova et al. 2006). Further, the findings of phase one and two were integrated to form an overall discussion.

3.4 Research Tool: Phase One

3.4.1 Rationale for questionnaires

In phase one, online questionnaires were used to identify the help-seeking patterns of young people and the factors which are associated with help-seeking, including the impact of COVID-19.

The questions used were predominantly closed or multiple choice, eliciting mostly nominal level data, allowing comparisons to be made. However, because of the nature of closed questions, open questions were included to allow for new insights and unanticipated answers to be provided from the participants (Oppenheim, 1992).

Online questionnaires were developed using the computer software, Qualtrics and have many advantages. Due to the privacy in which the questionnaire can be answered, there is little social pressure to participate — a benefit when the topic of interest is of a sensitive nature. Whilst this may hinder the response rate, it has been suggested by Dörnyei (2007) that such anonymity and privacy can increase honesty as the social consequence of participation is reduced. Related to this, Dörnyei points out there is an increased chance that 'harder to reach' populations will participate and engage with online questionnaires. However, it must be recognised that questionnaires, particularly those completed online, leave little room for participants to expand on their answers (Gray, 2018).

3.4.2 Questionnaire construction

The questionnaire had three key areas of focus: attitudes, subjective norms, perceived behavioural control and intentions (based on the theory of planned behaviour (Ajzen, 1991)); barriers and facilitators to help-seeking; and, the impact of COVID-19. Each of which will be discussed in turn. For the full questionnaire, see Appendix A.

Part A

Table 2 displays RQ1 and the associated questionnaire questions which were developed based on the TPB (Ajzen, 1991).

Table 2

Questions associated with RQ1

TPB	RQ	Questionnaire
Intentions	1 What are the help-seeking intentions of young people attending post-16 settings?	If you were experiencing mental health problems, how likely is it you would seek help from [various people]? What method of contact would you prefer? How likely is it that you would seek information from [various online sources]? How likely is it that you would seek help from [various online sources]?
Attitudes	a) What are the attitudes of the young person seeking help?	Seeking help for mental health problems from [person] would be? Other people I would seek help from are

Subjective norms	b) What are the attitudes of significant others towards seeking help?	Most family members who are important to me think that seeking help for mental health problems is important. Most friends who are important to me think that seeking help for mental health problems is important. Most teachers/tutors who are important to me think that seeking help for mental health problems is important. If I had a mental health problem it would be expected by others that I would seek help.
Perceived behavioural control	c) Do young people feel able to seek help?	It is entirely up to me whether I would seek help for my mental health problems. I am confident that I could seek help for mental health problems if I wanted to. Seeking help for mental health problems would be easy.

Note. For brevity some questions have been paraphrased

Questions regarding actual and hypothetical intentions to seek help, depending on the presence or absence of mental health problems, were adapted from the General Help-Seeking Questionnaire (Deane, Wilsin & Ciarrochi, 2001) which has previously been validated for more general mental health related help-seeking. As before, questions were rephrased, added to, and omitted where appropriate. Participants were asked to indicated the likelihood of seeking help from various sources, such as psychologist, friend or school tutor, on a seven-point Likert scale. Participants could indicate 'not applicable' and were given the opportunity to add alternative people and sources of help where appropriate.

To further explore intentions to seek help, an additional question was added to understand participants' preferred method of contact. Participants were required to indicate their preferred method to seek help: face-to-face or indirectly (phone call, Teams meeting).

Questions regarding young people's attitudes towards help-seeking, subjective norms and perceived behavioural control were adapted from Tomczyk et al. (2020). To

account for the different focus of this research, questions were rephrased, added to, and omitted where appropriate.

To understand student attitudes participants were required to indicate on a seven-point Likert scale the extent to which they felt seeking help from various sources would be useful (totally useless to extremely useful). Similarly, to understand SN and PBC participants were asked to indicate the extent to which they agreed with a number of statements (four and three, respectively), on a seven-point Likert scale. In the research conducted by Tomczyk et al. (2020), the focus was on seeking help from professionals, whereas the present study sought to understand both formal and informal help-seeking. Therefore, the list of sources was influenced by those used in the General Help-Seeking Questionnaire (Deane et al., 2001). However, I felt that through my experiences with young people and from research conducted more recently (Ofcom, 2015; Toren et al. 2020) that additional sources were required. Participants could indicate not applicable where appropriate.

Part B

Table 3 displays RQ2 and the associated questionnaire questions.

Table 3

Questions associated with research question 2

RQ	Questionnaire
2 What do young people perceive the barriers and facilitators to help-seeking to be?	To what extent do {various factors} act as a barrier to seeking help? Are there any other barriers? To what extent do {various factors} act as a facilitator to seeking help? Are there any other facilitators? What are your hopes for help-seeking?

Note. Questions are paraphrased for brevity

To further understand help-seeking behaviours, participants were required to indicate the extent to which they agree, on a seven-point Likert scale, that various reasons would or would not affect help-seeking. The reasons included were influenced by previous

research that has looked at mental health related help-seeking behaviours in various populations. They have been grouped according to reason type. The barriers included: stigma (Wrigley et al., 2005; Rothi & Leavy, 2006; Clement et al., 2015; Salaheddin & Mason, 2016); confidentiality and trust (Rickwood & Braithwaite, 1994; Hallett et al., 2000; Helms, 2001; Gulliver et al., 2010; Clement et al. 2015); mental health literacy (Jorm et al., 1997; Wright et al., 2005; Biddle et al., 2006: Jorm, 2015; Marshall & Dunstan, 2013; Ratnayake & Hyde (2019), perception of problems (Salaheddin & Mason, 2016); usefulness of seeking help (Rothi & Leavey, 2006); self-reliance (Salaheddin & Mason, 2016); and, instrumental factors (Gulliver et al., 2010). Facilitators included: problem validation and normalisation (Wilson & Deane, 2001); positive past experiences (Wilson & Deane, 2001; Timlin-Scalera et al., 2003; Lindsey et al., 2006); trust and confidentiality (Toren et al., 2019); and adult initiated opportunities (Pretorious et al., 2019). Because of my experiences with young people, I felt that this list would not capture all reasons. Therefore, for both barriers and facilitators I included an open question so participants could share additional reasons. Further, research has indicated that hope can mediate goal directed behaviour, therefore an open question was included to account for this.

Part C

Table 4 displays RQ3 and the associated questionnaire questions.

Table 4

Questions associated with RQ3

RQ	Questionnaire
3 What impact has COVID-19 had on the experience of mental health problems in young people?	Has COVID-19 had an impact on your mental health? Has COVID-19 had an impact on support for mental health problems?

Note. Questions are paraphrased for brevity.

In light of COVID-19, I wanted to understand the its impact on the incidence and experience of mental health related problems, and whether the associated restrictions imposed in England on young people, via the government, had affected those in receipt of mental health services.

3.4.3 Pilot of questionnaire

A pilot was conducted with young people in the South West of England. The online questionnaire was completed by six young people between the ages of 16 to 19. An information sheet (Appendix B) was provided, and informed consent (Appendix C) was gained at the beginning of the questionnaire. Had participants not given consent, the online questionnaire would have automatically closed prior to the first question. Participants were aware that their role was to test the research tools, not to be included in the research.

Following completion of the questionnaire, I spoke with each participant to see if they had found any element of the questionnaire confusing or distressing. No issues were identified.

3.5 Research Tool: Phase two

3.5.1 Rationale for online semi-structured interviews

Research conducted by Atkinson et al. (2019), has indicated that the voices of young people are often lacking when mental health provision is developed and amended, a likely barrier to help-seeking. Therefore, the aim of phase two was to gain the views of young people in order to understand their various experiences and perceptions of help-seeking and the support available for mental health related problems. To achieve this, semi-structured interviews were used.

Semi-structured interviews are popular in the field of qualitative research (Braun & Clarke, 2013; Willig, 2008). Arising out of growing dissatisfaction for standardised methods of data collection in the social research field (Oakley, 1998), semi-structured interviews gather data that is relevant to the RQ, whilst simultaneously giving participants the freedom to discuss at greater depth issues that are important to them (Willig, 2008). Further, the flexibility of the interview schedule enables diversion, providing new insights and opportunities for the interviewer to seek clarification, which is conducive to the co-production of knowledge.

Due to COVID-19 and the associated restrictions in place in England from March 2020, the interviews were conducted online. Whilst it is felt that face-to-face interviewing is best practice (Krouwel, Jolly & Greenfield 2019), the internet is increasingly becoming a "natural communication environment" (Mason & Ide, 2014, p. 41) for young people, who are often referred to as "digital natives" (Prensky, 2001, p. 2), with 99% using the internet regularly (ONS, 2019), suggesting young people would be receptive to online interviews.

Research conducted by Shapka, Domene, Khan and Yang (2016) on the use of online semi-structured interviews with adolescents, has identified that despite rapport taking longer to develop, the level of self-disclosure, quality of information (number and depth of themes) and co-production of knowledge, remains high. Alongside the increasing ease with which young people communicate online, as aforementioned, a reduction in power imbalance (Horsfall, Cleary & Hunt, 2010) has also been used to explain this unexpected finding. Further, anonymity available online is conducive to disclosure (Dörnyei, 2007). This is pertinent to the research as participants were able to keep their cameras off.

Consistent with pragmatism and constructivism, frameworks offered by personal construct psychology (PCP) were used within the interview schedule to facilitate participants to articulate their experiences (Burr, King & Butt, 2014).

3.5.2 Interview construction

To effectively answer RQs 5, 6 and 7, a semi-structured interview (Appendix D) was designed in three phases. See Table 5 for interview questions used to answer the RQs.

Phase one of the interview was designed to answer RQ7. The introductory questions were constructed to elicit participant views (personal constructs) on what they do, and would, look for from sources of help when experiencing mental health related problems. A framework developed by Beaver (2011), a proponent of PCP methods, was used to explore the characteristics valued by participants, by understanding the importance of the characteristic, what the characteristic implies, the behaviour of someone displaying the favoured characteristic, and what the characteristic is not.

Phase two of the interview was designed to answer RQ5. To begin, a general question about expectations of seeking help from formal and informal sources was asked, followed by four prompts. The prompts were guided by interview questions developed by Watsford, Rickwood and Vanags (2013) in their research exploring youth expectations of mental health care services in Australia. Potential outcomes and role expectations, for both the help-seeker and the source of help, were explored.

Phase three of the interview was designed to answer RQ6. To expand on the information generated from the questionnaire, participants were asked to rank the top six barriers to help-seeking. Following this, the Salmon Line technique (Salmon, 1988) was used to elicit bi-polar constructs around the perceived barriers and the possibility for change, in light of research evidencing its use as a supplementary technique (Ross, King & Firth, 2005). The ranking and Salmon Line activities were conducted via Microsoft PowerPoint. For examples of participant ranking of barriers and the Salmon Line activity, see Appendix E.

Table 5

RQ and associated interview questions

RQ	Interview
5 What are young people's expectations of seeking help for mental health related problems?	Is there a difference between seeking help from a formal or informal source? • What outcomes would you hope for from an informal source? • What outcomes would you hope for from a formal source? • How might the role of the person be different? • How might your role be different? Have you sought help in the past?
6 How can the help-seeking behaviour of young people attending post-16 settings be encouraged?	What are the top three barriers to seeking help? • Is it possible for things to change? • How much could they change? • How could they change?
7 What would effective mental health support in education look like to young people?	Who would you seek help from? • What makes them someone you would seek help from? • What is important about (characteristic)? • What else can you tell me about someone who is (characteristic)? • What can you tell me about someone who is not (characteristic)? • How would you know if someone was (characteristic)?

Note. Questions have been paraphrased for brevity

3.5.3 Pilot of semi-structured interviews

The interview was piloted with six participants, who were aware their data would not be utilised in the research. This was conducted via Microsoft Teams to ensure the process mirrored that which would be used for the interviews. The pilot interviews last 60-75 minutes.

During the pilot interviews, I gave the participants control of my monitor for the ranking and scaling activities. However, due to technical issues, the ease with which

this was done, varied. Therefore, through feedback from the participants it was decided that I would remain in control of my screen at all times, with participants telling me where they would like items to be placed.

Further, feedback from participants indicated that the interview procedure was too long. Originally, in answer to RQ7, I had intended to explore three personal constructs using the prompts provided by Beaver (2011). However, after the pilots and the feedback about interview length, I reduced this to the exploration of one personal construct.

3.6 Sampling and Data Collection

3.6.1 Recruitment

Information about the research was shared with five post-16 settings within two local authorities in the South West of England. The settings contacted were done so opportunistically, via the Head of Student Support, SENCos or ex-colleagues. I spoke with two settings that expressed interest in distributing the questionnaire via email, to explain the aims and research process in greater detail. An information sheet was provided.

3.6.2 Phase one sampling

Participating settings circulated an email to students which contained an information sheet outlining the aims of the research, the research process and what participation would entail. Further, details of consent, confidentiality, the right to withdraw, potential risks of involvement, and the voluntary nature of participation were highlighted. My details were given for students to contact me with further questions. To participate, participants needed to attend a post-16 setting but did not need personal experience of mental health problems or mental illness, as has been the case in previous research (Tomzcyk et al., 2020), due to the knowledge mental health needs significantly increase between the ages of 14 and 18 (WHO, 2014), the desire to capture the views of people and to understand how young people, along both continua (Westerhof & Keyes, 2010), can be supported.

There was no limit to the number of pupils who could respond. Of the 2,600 pupils (approximately) from the two settings that agreed to distribute the emails, 217 completed the questionnaire.

3.6.3 Phase one data collection

In the email described above, students were invited to complete the online questionnaire. Prior to this, students were led to the information sheet and a consent form. Where consent was gained, pupils were directed to the survey, where it was not, students were redirected to a thank you page. Parents were not required to give consent as all students were aged 16 and over.

Students were given one month to complete the questionnaire allowing time to make an informed decision to participate once the information had been read, or to make contact with myself.

3.6.4 Phase two sampling

All participants from phase one were eligible to participate in the online interviews. At the end of the questionnaire in phase one, participants were given the opportunity to express interest in phase two by providing their email address. Braun and Clarke (2013) suggest that for relatively small qualitative studies, six to10 participants are required to allow for meaningful analysis of data. Therefore, I aimed for eight interviews. To recruit participants for phase two, those who provided their contact details were emailed and Microsoft Teams meetings were scheduled for those who wished to participate. Eight participants responded: six females and two males.

3.6.5 Phase two data collection

Although consent had previously been gained, prior to the interviews the information sheet was redistributed to ensure interested participants were fully informed of the research aims. Verbal consent was gained at the beginning of each interview and the right to withdraw was reiterated. No participants withdrew.

The interviews lasted approximately 45 to 60 minutes and were recorded, with consent, using a digital recorder. Results of the ranking and scaling activities were recorded on PowerPoint and anonymised.

Researchers, during the semi-structured interview are inextricably linked to their research topic. For this reason, it is likely, as aforementioned, that experience, values and physical presence of the interviewer will affect the knowledge that is produced. Whilst this is positively valued in qualitative research, Braun and Clarke (2013) caution that researchers must critically reflect on the role their experience and values have on both the process and the tools used, a process known as reflexivity. To facilitate reflexivity, I kept a diary to reflect on each interview after it happened. Reflections on the research process will be provided in Chapter 7.

3.7 Data Analysis: Phase one

The aim of the questionnaire was to develop an understanding of the factors associated with the intentions to seek help for mental health related problems, and actual (past and present) help-seeking behaviour. Further, barriers and facilitators, and the impact of COVID-19 were explored. Both open and closed question were used to obtain the required information.

3.7.1 Closed questions

IBM SPSS Statistic Version 26 software was inputted with numerical data. Descriptive statistics were generated to answer elements of RQ1, 2 and 3. Responses were analysed according to gender, allowing for comparisons to answer RQ4. Inferential statistics, where appropriate, were generated to analysis the significance of observed differences. Missing data, and respondents who identified as non-binary or no-gender (did not indicate gender) were omitted from descriptive and inferential analysis by gender.

3.7.2 Open questions

Content analysis, the systematic process of coding qualitative data and counting the frequency with which a code or category appears (Gray, 2018), was used to analyse the open questions.

Whilst it is common to decide on codes prior to data familiarisation, an inductive approach was adopted which allowed for the codes to emerge from the data. Due to the ease with which many of the codes were observed, manifest content analysis was adopted. However, to include as many of the responses to the open questions as possible, latent content analysis was utilised, where codes seemed less apparent or ambiguous. Latent content analysis requires the researcher to transcend the text, to discover the meaning of participant answers and experience (Kleinheksel, Rockich-Winston, Tawfik & Wyatt, 2020).

There are many benefits to content analysis: the option to perform statistical operations on qualitative data, and the richness of the data (Krippendorff, 2004). However, it must also be recognised that it is fraught with questions of reliability. Of great concern, is the accuracy, replicability and stability with which codes are generated and the errors associated with the human nature and unintended bias of researchers. As aforementioned, a reflective diary was kept for this purpose.

The findings of the basic content analysis are presented in Chapter 4. The process of content analysis used in this research is outlined in the Table 6.

Table 6

Analysis of qualitative data

Stage of Analysis	**Research actions**
Grouping of similar answers	The answers were read and similar answers grouped together.
Identification of codes	A set of working codes were identified and frequency counts conducted.
Creation of categories	Where appropriate, categories were made for related codes.
Generation of descriptive statistics	Descriptive analysis was run on the frequency count of the codes.

3.8 Data Analysis: Phase two

Interview records were transcribed by the thesis author. The online software used to provide the draft transcription was Otter (https://otter.ai), against which I could check the recordings, through listening to each of them, for accuracy. Where necessary, amendments were made.

To analyse the data, thematic analysis was used. Braun and Clarke (2006) describe thematic analysis as a six-stage method through which themes and patterns within qualitative data can be recognised. Whilst the aim of thematic analysis is to represent the views of participants, it is important to recognise that it is not a direct representation of views expressed, but instead a sensitive interpretation of them (Crowe, Inder & Porter, 2015). Please see Appendix F for an extract of my reflective diary. The aim of the interviews was to explore the experiences and views of young people. Therefore, when analysing the data, an inductive approach which seeks to determine themes through the identification of consistencies within the data, rather than theory and pre-existing literature, was adopted. Braun and Clarke's (2006) six stage process is outlined in Table 7 below.

Table 7

Analysis of qualitative data

Stages of analysis	Research actions
1. Data familiarisation	Interviews were transcribed verbatim using online software (Otter) and by the researcher to ensure accuracy, increasing researcher familiarity with the data.
2. Initial code generation	The data was read, notes were made to increase familiarity (Appendix G) and initial codes created in relation to the RQs in Microsoft Word (Appendix H).
3. Search for themes	The codes were collated into themes, ensuring the inclusion of all relevant data. Thematic maps were used to visually represent over-arching and subthemes. Any codes and themes that did not fit into the thematic map at this point were labelled 'miscellaneous'.
4. Review of themes	The themes were reviewed and revised where necessary to ensure they were supported by the data (Appendix I). Themes that were not supported by sufficient data, or themes that could be integrated, were. New thematic maps were created to visually represent the final themes and subthemes (Chapter 6).
5. Define and name the themes	The themes were refined and definitions were generated to ensure it was clear how the theme fit within the overall analysis.
6. Produce the report	A narrative was written for each theme: analysing it and making use of specific and compelling extracts. Reference to the RQ and existing literature was made and can be found in Chapter 6.

3.9 Ethical Considerations

Research ethics are the responsibility of the author and refer to: "the moral principles guiding research from its inception through to completion and publication of results" (BPS, 2014, p. 5). These principles are outlined in the British Psychological Society's Code of Ethics and Conduct (BPS, 2018) and Code of Human Research Ethics (BPS,

2014). In accordance with these codes, ethical approval was granted for this research by the University of Exeter Graduate School of Education Ethics Committee (Appendix J).

3.9.1 **Phase one**

Participants were emailed the questionnaire by the member of staff with whom recruitment has been agreed. In this email was an information sheet outlining the research aims and process, and the considerations participants might want to make before consenting. The voluntary nature of participation was emphasised. To gain access to the questionnaire, participants were required to read a consent form and give consent. To maintain anonymity, participant details were not taken, unless they expressed interest in participating in phase two of the research or wished to be informed of the research findings. All data obtained at this phase were reported anonymously.

3.9.2 **Phase two**

Prior to the interviews, participants were sent the information sheet previously received to refamiliarize themselves with the research. At the beginning of the interviews, participants were reminded of the voluntary nature of their participation and were given the opportunity to ask questions. Due to the remote nature of the interviews, verbal consent was gained to audio record the interviews for transcription. To respect participant privacy, they were given the option to not use their camera on Microsoft Teams, which some participants took. At the beginning of the interview, participants were told that confidentiality would be broken if safeguarding concerns arose throughout the interview. Data was reported and transcribed anonymously.

Chapter 4. Phase One Findings

This section details participant demographics and the finding of phase one. The findings will be presented according to research question. Gender differences will be reported where they are seen. Analysis of the findings will be provided in Chapter 5.

4. 1 Demographic Data

Participants were enrolled at a post-16 setting in the South West of England and were between the ages of 16 to18. Table 8 displays the number and percentage of participants who completed the questionnaire according to gender. Participants are not separated by setting, as this was not a mandatory question. In tables and figures, non-binary and no-gender participants will be referred to as 'non-bin' and no-gen', respectively.

Table 8

Demographic data for questionnaire participants

Male (%)	Female (%)	Non-bin (%)	No-gen (%)	Total
57 (26.27)	154 (70.97)	4 (1.84)	2 (.92)	217

For all tables, responses from non-binary participants (*n*=4) are reported because, whilst there is no accurate figure, it has been estimated by the charity Stonewall Equality Limited (n.d) that approximately 1% of the population identify as transgender, including non-binary. No-gender (*n*=2) responses, will also be reported. However, these findings will be omitted from analysis, according to gender, due to low participant numbers (McHugh, 2013).

4.1.1 Young people's experience of mental health problems and prior help-seeking behaviour

Participants were asked if they had experienced mental health problems. Below, Table 9 displays the frequency of responses and the percentage of respondents (in parentheses) who have experienced mental health problems, according to gender. "Total rows" display the frequency and percentage of respondents who gave each answer across gender.

Table 9

Experience of mental health problems

	Male (%)	Female (%)	Non-bin (%)	No-gen (%)	Total (%)
Yes	33 (57.9)	127 (82.47)	4(100)	2(100)	166 (76.50)
No	24 (42.1)	27 (17.53)	0 (0.0)	0 (0.0)	51 (23.50)

Findings displayed in Table 9 indicate that the prevalence of reported mental health problems for males (57.9%) is less than that for females (82.47%).

Following this, if participants indicated they had experienced mental health problems, they were asked to indicate whether they had sought help for this. Table 10 displays the responses across and according to gender.

Table 10

Prior help-seeking of young people with experience of mental health problems

	Male (%)	Female (%)	Non-bin (%)	No-gen (%)	Total (%)
Yes	18 (54.54)	71 (55.91)	4 (100)	1 (50)	94 (56.63)
No	15 (45.46)	56 (44.09)	0 (0.0)	1 (50)	72 (43.37)

Responses indicate that of those who have previously experienced mental health problems, more sought help (56.63%), than those who did not (43.37%).

To examine whether there was a significant association between gender and the prevalence of mental health problems, Chi-square tests of independence were performed. A further Chi-square test was performed to examine whether there was a significant association between prior help-seeking and gender. (Table 11). There was a significant association between gender and the reported experience of mental health problems, with females more frequently reporting mental health problems. However, no significant association was found between gender and historic help-seeking behaviour.

Table 11

Frequency of mental health problems and prior help-seeking behaviour according to gender: significance tests

According to gender	**Chi-square test of independence**	**Significance**
Experience of mental health problem	X^2 (1, *N*=211) = 13.706, $p \leq .001$	Yes
Prior help-seeking behaviour	X^2 (1, *N*=160) = .020, $p \leq .889$	No

4.2 Intentions of Young People to Seek Help

To assess the intentions of participants to seek help for mental health problems, they were asked if they would seek help from various sources. For each identified source of help, they were asked to indicate how likely they were to seek their help, on a scale of 1 (extremely unlikely) to 7 (extremely likely). Participants could also answer 'not applicable'.

For clarity and concision, the overall help-seeking intentions of participants, per gender were calculated using the mean ($\bar{x}$). Table 12 displays the number and mean intentions of participants, across and according to gender.

Table 12

Overall help-seeking intentions

	Male	**Female**	**Non-bin**	**No-gen**	**Total**
N	57	154	4	1	217
Mean	3.80	3.85	3.87	2.76	3.82
SD	1.12	1.01	.50	.69	1.03

Overall, the results show that young people are slightly to moderately unlikely to seek help for mental health related problems ($\bar{x}$ = 3.82).

Intentions to seek help from informal and formal sources

The sources of help can be broken into two sub-categories: formal and informal. Tables 13 and 14 show the informal and formal help-seeking intentions of participants, respectively. They display the frequencies and mean response (in parentheses) to each question, across and according to gender.

Table 13

Intentions to seek help from informal sources

Source	Male	Female	Non-bin	No-gen	Total	SD
Friend	57 (4.61)	154 (5.13)	4 (5.00)	2 (5.00)	217 (4.99)	1.69
Partner	43 (5.09)	111 (5.24)	4 (4.50)	1 (4.00)	159* (5.18)	1.72
Parent/ carer	57 (4.70)	154 (4.56)	4 (3.50)	2 (3.50)	217 (4.57)	2.08
Sibling	51 (3.43)	142 (3.49)	3 (2.00)	2 (2.50)	198* (3.44)	1.95
Other relative	55 (3.20)	152 (2.78)	4 (2.75)	2 (2.50)	213* (2.88)	1.76
Total Mean	4.20	4.20	3.70	3.43	4.18	1.30

Note. Missing values included the response 'not applicable'. Calculated means exclude this data.

As shown in Table 13, partners are the preferred informal source from whom to seek help ($\bar{x}$ = 5.18). Encouragingly, friends ($\bar{x}$ = 4.99) and parents (**$\bar{x}$** = 4.57) were also likely to be approached for help. However, on closer inspection it must be noted that males were less likely ($\bar{x}$ = 4.61) to seek help from friends than their female peers ($\bar{x}$ = 5.13).

Table 14

Intentions to seek help from formal source

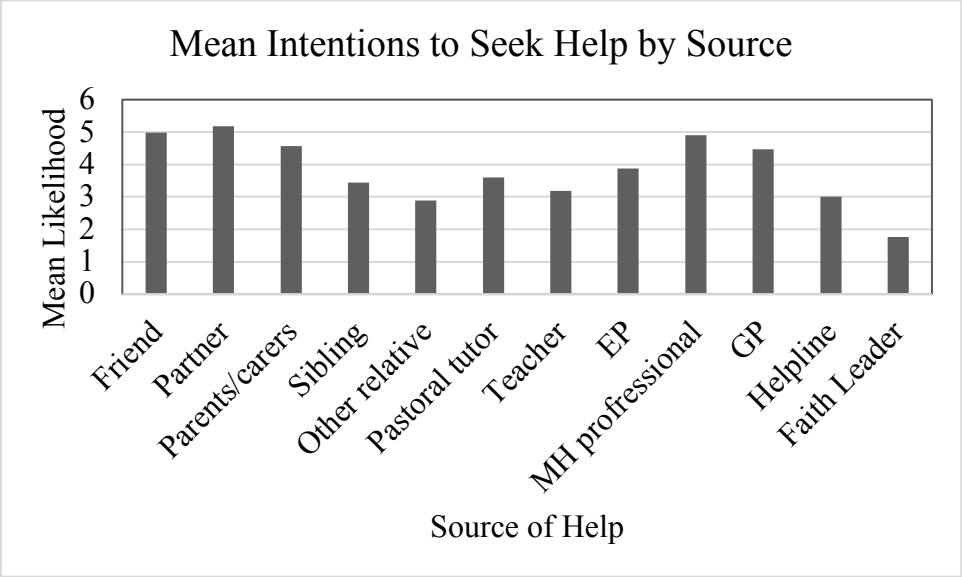
Source	Male	Female	Non-bin	No-gen	Total	SD
Pastoral tutor	56 (3.30)	154 (3.68)	4 (4.50)	2 (3.50)	216* (3.60)	1.84
Teacher	56 (2.88)	154 (3.25)	4 (4.75)	2 (3.00)	216* (3.18)	1.71
EP	53 (3.83)	146 (3.90)	3 (5.00)	2 (1.00)	204* (3.87)	1.71
MH professional	55 (4.82)	152 (4.94)	4 (6.00)	2 (2.50)	213* (4.91)	1.78
GP	55 (4.55)	154 (4.52)	4 (3.00)	2 (2.00)	215* (4.47)	1.74
Helpline	65 (2.89)	154 (3.05)	4 (2.75)	2 (3.50)	216* (3.00)	1.75
Faith Leader	47 (1.74)	132 (1.80)	2 (1.00)	2 (1.00)	183* (1.77)	1.41
Total Mean	3.46	3.63	4.04	2.36	3.58	1.19

Note. Missing values included the response 'not applicable'. Calculated means exclude this data.

As detailed in Table 14, participants demonstrated a preference for seeking help from mental health professionals (**$\bar{x}$** = 4.91), which is closely followed by GPs (**$\bar{x}$** = 4.47). Interestingly, participants indicated they would be more likely to seek help from a pastoral tutor (**$\bar{x}$** = 3.60) than their teacher (**$\bar{x}$** = 3.18). On the other hand, participants have stipulated that they would be unlikely to seek help from a faith leader (**$\bar{x}$** = 1.77).

Figure 2

Intentions to seek help from formal and informal sources



As can be seen in the figure 2, whilst the overall intentions to seek help from informal sources ($\bar{x}$ = 4.18) is greater than that for formal sources ($\bar{x}$ = 3.69), participants do indicate greater intentions to seek help from mental health professionals ($\bar{x}$ = 4.91) and the GP ($\bar{x}$ = 4.47) than many informal sources of help.

To examine whether there was a significant difference between help-seeking intentions towards informal and formal sources, a paired t-test was performed. The results indicated that participants had significantly greater intentions to seek help from informal than formal sources $t(209) = 6.631$, $p \leq 0.001$).

'Other' sources of help

Participants were asked if there were any other sources from whom they might seek help. This question was not mandatory. Basic content analysis was used to analyse the responses given. Participants were able to give more than one response. There were 7 responses given. Table 15 displays the most common answer that is not associated with the sources of help given in the previous question. It displays the frequencies and percentage of respondents who gave each

answer. Results must be interpreted with caution as the response rate to this question was very low (n = 5).

Table 15

Other sources of help

Source of help	Male (%)	Female (%)	Total
I**nternet** including online mental health services and social networking/ media	1 (20)	4 (80)	5

The internet: seeking help or information

To understand the differential use of the internet, participants were asked whether they used various internet-sources to seek help, or to seek information. Table 16 shows participant intentions to seek information (info) and help from various internet sources. Frequency of response and mean response (in parentheses) are reported, across and according to gender.

Table 16

Participant intentions of using the internet.

		Male	Female	Non-bin	No-gen	Total	SD
Info	Social media	57 (2.49)	154 (3.74)	4 (3.75)	2 (3.00)	217 (3.41)	1.93
	Google search	57 (3.77)	154 (4.62)	4 (5.25)	2 (4.00)	217 (4.40)	1.91
	Charity website	57 (4.32)	154 (4.42)	4 (5.75)	2 (2.00)	217 (4.39)	1.79
	Total	57 (3.53)	154 (4.26)	4 (4.92)	2 (3.00)	(217) 4.07	1.42
Help	Social media	57 (2.18)	154 (2.59)	4 (2.50)	2 (1.00)	217 (2.47)	1.65
	Google search	57 (2.65)	154 (3.08)	4 (2.75)	2 (3.00)	217 (2.96)	1.76
	Charity/website	57 (3.65)	154 (3.74)	4 (4.25)	2 (4.00)	217 (3.73)	1.87
	Total	57 (2.82)	154 (3.14)	4 (3.17)	2 (2.67)	217 (3.05)	1.33

Figure 3

Intended use of the internet for mental health problems

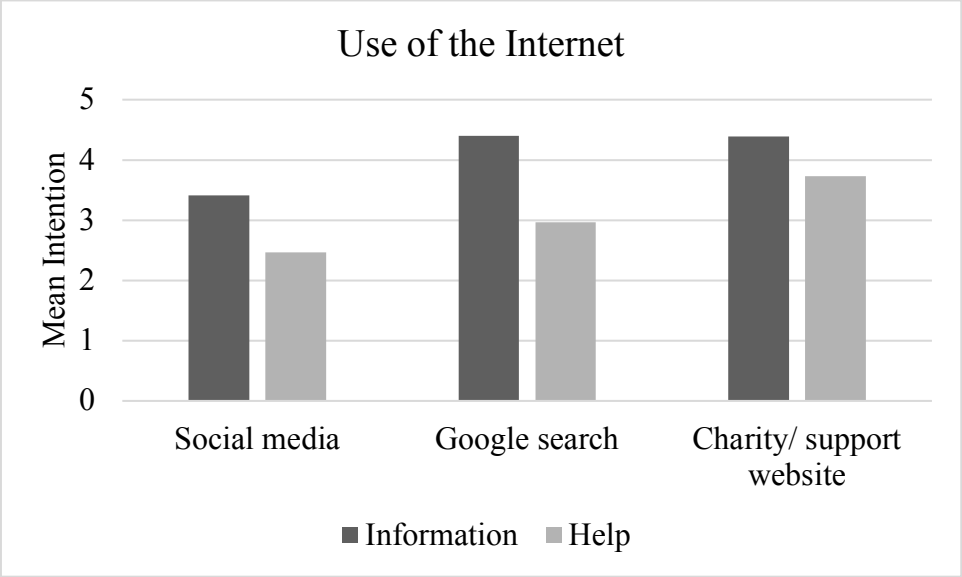


Figure 3 shows that overall, participants indicate a greater intention to seek information from the internet ($\bar{x}$ = 4.07) than to seek help from the internet ($\bar{x}$ = 3.05). Social media was the least likely source to which participants would go for information ($\bar{x}$ = 3.41) or help ($\bar{x}$ = 2.4) and interestingly, despite showing a relatively high intentions to seek information from charity websites ($\bar{x}$ = 4.39) and google search ($\bar{x}$ = 4.40) participants were less likely to seek actual help from them ($\bar{x}$ = 3.73 and $\bar{x}$ = 2.96, respectively).

To examine whether there was a significant difference in use of the internet, a Wilcoxon signed ranks test was performed. The results of the analysis indicated significantly greater intentions to seek information from internet sources, than help ($z = -9.978$, $p \leq 0.001$).

Preferred method of help-seeking

Participants were asked how they would prefer to seek help if given the choice. Table 17 displays the frequency and percentage of respondents who gave each response. “Total” rows display frequency and percentage of respondents who gave each answer.

Table 17

Preferred method of contact

Method of contact	Male (%)	Female (%)	Non-bin (%)	No-gen (%)	Total (%)
Face-to-face	45 (78.9)	116 (75.3)	3 (75)	1 (50)	165 (76)
Indirectly	12 (21.1)	38 (24.7)	1 (25)	1 (50)	52 (24)

As displayed in Table 17, there is a preference for seeking help face-to-face (n= 165) over seeking indirect help (n = 52). To examine whether this preference was statistically significant, a Chi-square test of independence was performed. This was found to be significant (X^2 (1, N=217) = 58.843, $p \leq .001$).

4.2.1 Help-seeking Attitudes

To understand student attitudes towards help-seeking for mental health related problems, participants were asked how useful it would be to seek help from various sources, on a scale of 1 (totally useless) to 7 (extremely useful). As before, participants could also answer 'not applicable'.

The overall attitudes towards help-seeking of participants were calculated using the mean. Table 18 displays the number of participants and in the parentheses, mean attitudes, towards help-seeking.

Table 18

Overall attitudes towards help-seeking

	Male	Female	Non-bin	No-gen	Total
N	57	154	4	2	217
Mean	4.47	4.47	4.03	4.14	4.46
SD	.86	.86	.81	1.10	.86

As shown in Table 18, participant attitudes towards help-seeking are relatively neutral ($\bar{x} = 4.46$) with a slight indication that seeking help would be 'somewhat useful'. No difference was found between male and female participants.

As done previously, to examine participant attitudes more closely, the sources of help were categorised as 'informal' and 'formal', to allow for comparison. Tables 19 and 20 display participant attitudes towards seeking both informal and formal help. The tables both display the frequency of participants who gave each response, across and according to gender. In the parentheses the mean response is given.

Table 19

Participant attitudes towards seeking informal help

	Male	**Female**	**Non-bin**	**No-gen**	**Total**	**SD**
Friend	57 (5.07)	154 (5.14)	4 (5.00)	2 (6.00)	217 (5.12)	1.31
Partner	46 (5.57)	116 (5.29)	4 (5.00)	1 (6.00)	167 (5.37)	1.30
Parent/ carer	57 (5.28)	154 (4.81)	4 (4.00)	2 (3.50)	217 (4.90)	1.76
Sibling	53 (4.15)	141 (4.13)	3 (2.67)	2 (4.00)	199 (4.12)	1.73
Other relative	54 (4.22)	147 (3.51)	4 (3.50)	2 (3.50)	207 (3.70)	1.51
Total	57 (4.84)	154 (4.56)	4 (4.18)	2 (4.45)	217 (4.62)	1.08

Table 20

Participant attitudes towards seeking formal help

	Male	**Female**	**Non-bin**	**No-gen**	**Total**	**SD**
Tutor	54 (4.28)	154 (4.33)	3 (4.00)	2 (4.50)	213 (4.13)	1.48
Teacher	54 (4.04)	150 (4.11)	3 (4.00)	2 (4.50)	209 (4.09)	1.44
EP	49 (5.10)	142 (5.23)	3 (4.00)	1 (7.00)	195 (5.19)	1.35
MH professional	53 (5.89)	150 (6.01)	4 (5.75)	2 (6.00)	209 (5.98)	1.38
GP/Dr	52 (5.29)	151 (5.11)	4 (3.25)	2 (4.50)	209 (5.11)	1.65
Social Media	55 (2.56)	153 (3.27)	4 (3.50)	2 (2.00)	214 (3.08)	1.63
Google Search	57 (2.89)	153 (3.03)	4 (3.25)	2 (2.50)	216 (2.99)	1.56
Charity website	51 (4.45)	145 (4.43)	3 (4.00)	2 (3.00)	201 (4.41)	1.39
Total	57 (4.84)	154 (4.56)	4 (4.18)	2 (3.98)	217 (4.34)	.97

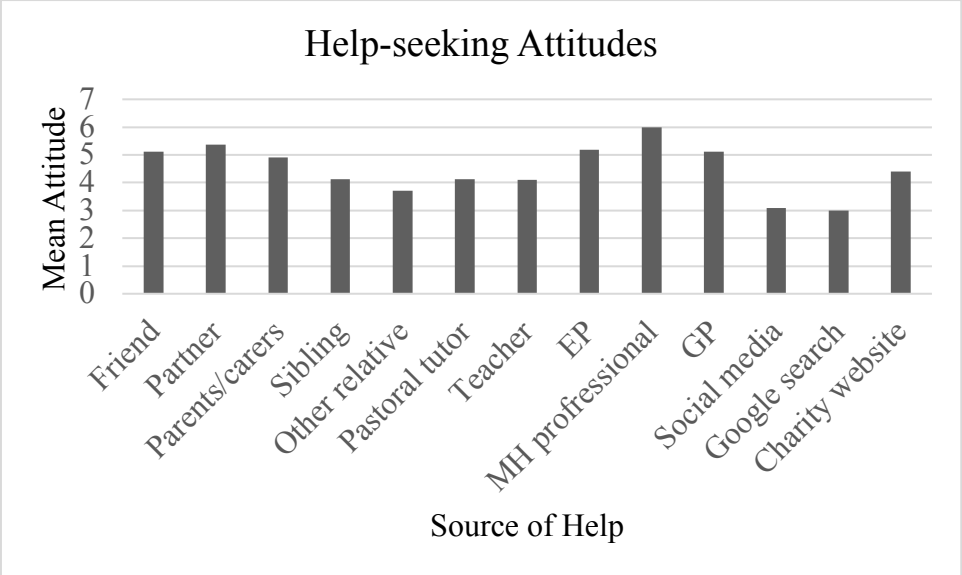
Overall, findings indicate that participants have marginally more positive attitudes towards seeking help from informal sources ($\bar{x} = 4.62$) than formal sources ($\bar{x} = 4.34$). To assess whether this difference was significant a Wilcoxon Signed Ranks Test was carried out. A significant difference was found suggesting attitudes towards informal sources are more positive than towards formal sources ($z = -3.327$, $p < 0.001$). However, on closer inspection, findings from all participants suggest that seeking help from a mental health professional, such as a counsellor or clinical psychologist would be the most useful ($\bar{x} = 5.98$), with partners ($\bar{x} = 5.37$), EP ($\mu = 5.19$) and friends ($\bar{x} = 5.12$) following closely behind. Across all participants, social media ($\bar{x} = 3.08$) and google search ($\bar{x} = 2.99$) are felt to be the least useful source of help for mental health problems.

Whilst male participants indicated a greater preference for informal sources, than females, no significant difference was found ($Z = -110$, $p \leq 0.05$).

Figure 4 illustrates the overall attitudes of participants towards all sources of help: informal and formal.

Figure 4

Overall participant attitudes towards sources of help



4.2.2 Subjective norms

To understand participant subjective norms towards help-seeking for mental health related problems, they were asked questions about the attitudes of significant people in their life, towards seeking help for mental health related problems. For each question, participants were asked the extent to which they would agree, on a scale of 1 (strongly agree) to 7 (strongly disagree). Responses to these questions were reverse coded for analysis, so that higher scores reflected ‘strongly agree’ and lower scores ‘strongly disagree’.

Table 21 displays the participant beliefs about the attitudes of significant others towards seeking help for mental health related problems. Frequency of response and mean response (in parentheses) are reported, across and according to gender.

Table 21

Participant subjective norms

	Male	**Female**	**Non-bin**	**No-gen**	**Total**	**SD**
Family members	57 (5.61)	154 (5.38)	4 (5.50)	2 (3.00)	217 (5.42)	1.49
Friends	57 (5.61)	154 (5.96)	4 (6.50)	2 (6.00)	217 (5.88)	1.02
Teachers/ tutors	57 (5.82)	154 (5.82)	4 (6.25)	2 (6.00)	217 (5.83)	1.01
People's expectations	57 (5.23)	154 (5.03)	4 (5.00)	2 (5.00)	217 (5.08)	1.36
Total	57 (5.57)	154 (5.55)	4 (5.81)	2 (5.00)	217 (5.55)	.89

As shown in Table 21 the findings would suggest participants feel significant others somewhat agree that seeking help for mental health related problems is important ($\bar{x} = 5.55$), with very little gender difference.

Figure 5

Participant subjective norms

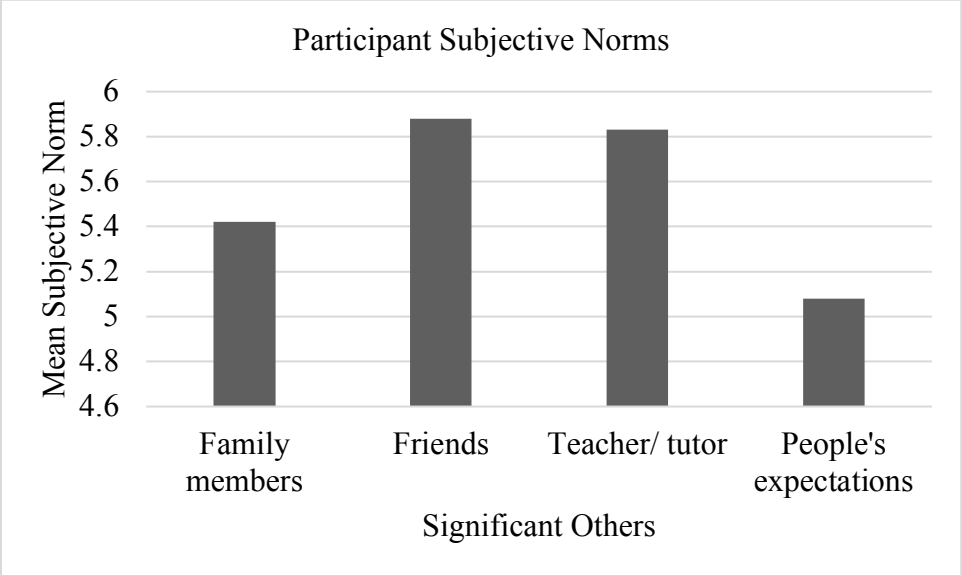


Figure 5 illustrates that participants felt that friends ($\bar{x}$ = 5.88) and teachers/ tutors ($\bar{x}$ = 5.83) would think seeking help for mental health related problems would be important. With regards to family expectations ($\bar{x}$ = 5.42), participants indicate that seeking help for mental health related problems would be important. Interestingly, when asked whether significant others would expect them to seek help for a mental health related problem, participants were less certain ($\bar{x}$ = 5.08).

4.2.3 Perceived behavioural control

Participants were asked questions that explored their PBC over seeking help for mental health related problems. For each question, participants were asked the extent to which they would agree, on a scale of 1 (strongly agree) to 7 (strongly disagree). Responses to these questions were reverse coded for analysis, so that higher scores reflected 'strongly agree' and lower scores 'strongly disagree'.

Table 22 displays the participant's PBC when seeking help for mental health related problems. It displays the frequency of participants who gave each response, and in parentheses the mean response, across and according to gender.

Table 22

Perceived behavioural control of participants

	Male	**Female**	**Non-bin**	**No-gen**	**Total**	**SD**
It is entirely up to me to seek help	57 (5.88)	154 (5.45)	4 (5.75)	2 (5.00)	217 (5.57)	1.28
I am confident I could seek help	57 (5.05)	154 (4.36)	4 (4.50)	2 (3.00)	217 (4.53)	1.76
Seeking help would be easy	57 (3.82)	154 (3.27)	4 (2.75)	2 (1.50)	217 (3.39)	1.68
Total	57 (4.92)	154 (4.36)	4 (4.33)	2 (3.17)	217 (4.50)	1.21

Results displayed in Table 22 suggest that female participants ($\bar{x}$ = 4.36) have lower PBC, than their male counterparts ($\bar{x}$ = 4.92). The findings also indicate that overall, participants agree that it is up to them whether they seek help or not, with males indicating the most 'personal choice' over seeking help ($\bar{x}$ = 5.88). A Mann-Whitney U test indicated that males do have significantly higher levels of PBC than their female counterparts (z = -2.806, p ≤ 0.005).

Figure 6

Participant perceived behavioural control

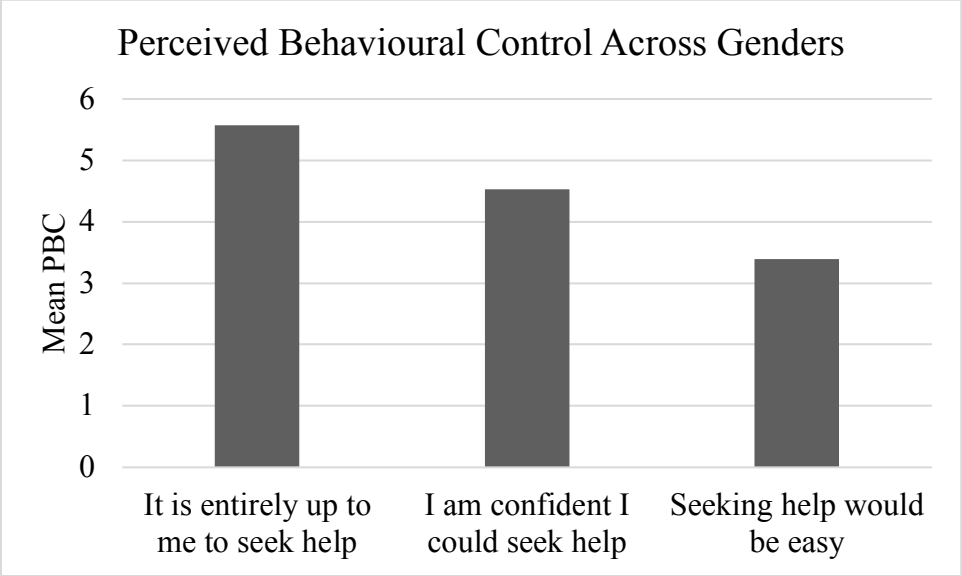


Figure 6 is a visual representation of participants' PBC. These findings would indicate that whilst participants feel that help-seeking is up to them ($\bar{x}$ = 5.57), the confidence they have ($\bar{x}$ =4 .53) and the ease with which they feel they could seek support ($\bar{x}$ = 3.39) is lower.

4.2.4 Correlations between measures

Non-parametric tests were run as the data was not normally distributed.

Intentions and attitudes

To explore if there was a correlation between overall attitudes towards help-seeking and intentions to seek help, a one-tailed Spearman's Rho Correlation was conducted. A significant moderate positive correlation was found ($rs = .549$, $p \leq 0.001$). This suggests the more useful participants perceive help-seeking to be, the greater their intentions to seek help.

Intentions and subjective norms

To explore the relationship between overall SN and help-seeking intentions and, a one-tailed Spearman's Rho Correlation was performed. A significant weak positive correlation was found ($rs = .327$, $p \leq 0.001$), indicating that if significant others are perceived to view help-seeking as important, then intentions to seek help are higher.

Intentions and perceived behavioural control

To explore the relationship between overall PBC and help-seeking intentions and, a one-tailed Spearman's Rho Correlation was performed. A significant weak positive correlation was found ($rs = .369$, $p \leq 0.001$), indicating the greater the PBC, the greater the intention to seek help.

4.3 Factors Mediating Help-seeking

4.3.1 Barriers to help-seeking

To understand barriers to help-seeking for mental health related problems, participants were asked to indicate the extent to which they agreed various identified factors would discourage help-seeking on a scale of 1 (strongly disagree) to 7 (strongly agree).

Table 23 displays six overall barriers to help-seeking for mental health related problems, by type. These are composites computed using individual barriers, which can be seen in Table 24. For example, the overall barrier of 'Mental Health Literacy' is a composite of: 'I don't know where to seek help'; 'I wouldn't know I had a MH problem'; and, 'discomfort talking about feelings'.

Table 23 displays the number of participants and the mean response (in parentheses) to each barrier type, across and according to gender.

Table 23

Overall barriers to help-seeking, by type

	Male	**Female**	**Non-bin**	**No-gen**	**Total**	**SD**
Stigma	57 (3.74)	154 (4.31)	4 (4.42)	2 (3.75)	217 (4.15)	1.20
Confidentiality	57 (4.16)	154 (4.42)	4 (4.75)	2 (4.00)	217 (4.35)	1.86
MH literacy	57 (3.91)	154 (4.19)	4 (4.08)	2 (4.17)	217 (4.11)	1.21
Practicality	57 (3.50)	154 (4.37)	4 (5.25)	2 (4.25)	217 (4.16)	1.46
Self-reliance	57 (4.53)	154 (4.95)	4 (3.75)	2 (3.00)	217 (4.80)	1.49
Usefulness of seeking help	57 (4.30)	154 (4.88)	4 (4.81)	2 (3.88)	217 (4.72)	1.12
Total	57 (3.94)	254 (4.47)	4 (4.53)	2 (3.88)	217 (4.33)	.94

Table 23 demonstrates that female participants ($\bar{x} = 4.47$) report greater barriers to help-seeking than their male counterparts ($\bar{x} = 3.94$). To examine whether there was a significant difference between male and female reported barriers to seeking help, a Mann-Whitney U test was performed. This difference was statistically significant ($Z = -3.420$, $p \leq 0.001$), indicating female participants do perceive greater barriers to help-seeking.

Figure 7

Overall barriers to help-seeking, by type

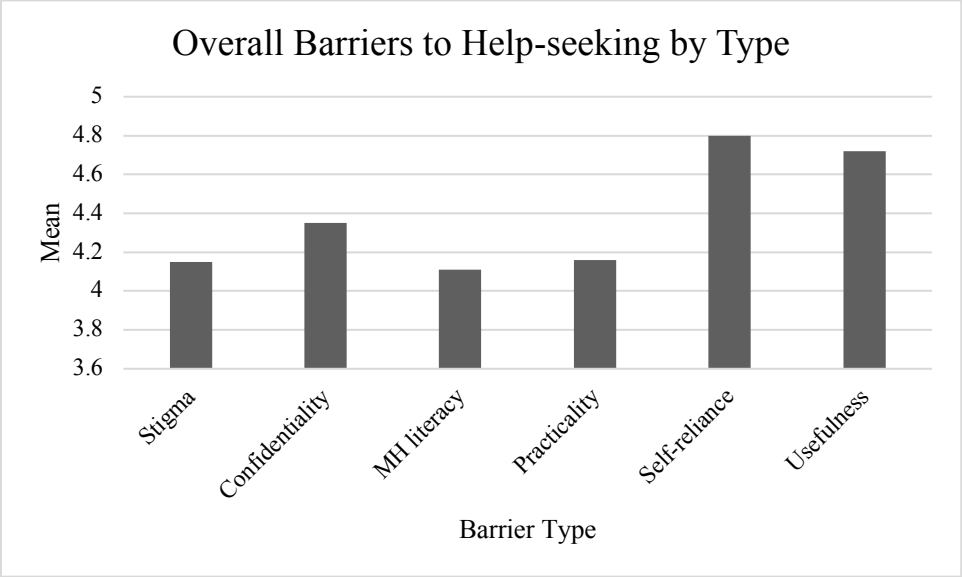


Figure 7 displays the mean response of participants to the six types of barrier to mental health related help-seeking. It shows that overall, participants agree that self-reliance ($\bar{x}$ = 4.80) is the biggest barrier to help-seeking, with females ranking this their greatest barrier to help-seeking ($\bar{x}$ = 4.95). Second to this, it is implied by the findings that the perceived usefulness of help-seeking is a barrier, particularly for females ($\bar{x}$ = 4.88), but less so for male participants ($\bar{x}$ = 4.30). However, figure 6 also indicates that stigma ($\bar{x}$ = 4.15) and mental health literacy ($\bar{x}$ = 4.15) are deemed less of a barrier, particularly by male participants ($\bar{x}$ = 3.74, $\bar{x}$ = 3.91 respectively).

Table 24 displays the individual barriers, which participants were explicitly questioned about and from which the composite 'type' of barriers were created. It displays the number of participants and in the parentheses the mean response to each barrier, across and according to gender.

Table 24

Barriers to help-seeking

Type	Barrier	Male	Female	Non-bin	No-gen	Total	SD
Stigma	Others will view me negatively	57 (4.47)	154 (4.98)	4 (5.50)	2 (3.00)	217 (4.84)	1.69
	Worried what family would think	57 (4.04)	154 (5.01)	4 (5.50)	2 (3.00)	217 (4.75)	1.97
	Concerned what friends would think	57 (3.65)	154 (3.66)	4 (3.00)	2 (4.50)	217 (4.50)	1.71
	Embarrassment	57 (4.30)	154 (4.97)	4 (5.25)	2 (4.00)	217 (4.72)	1.67
	Seeking help is scary	57 (3.95)	154 (5.32)	4 (6.25)	2 (6.50)	217 (4.00)	1.72
	People who seek help are weak	57 (2.02)	154 (1.99)	4 (1.00)	2 (1.50)	217 (1.97)	1.44
Confide-ntiality	Worried people would find out	57 (4.16)	154 (4.42)	4 (4.75)	2 (4.00)	217 (4.35)	1.86
MH literacy	I don't know where to seek help	57 (3.37)	154 (3.90)	4 (4.00)	2 (6.00)	217 (3.78)	1.69
	I wouldn't know I had a MH problem	57 (3.91)	154 (3.94)	4 (3.00)	2 (3.50)	217 (3.91)	1.71
	Discomfort talking about feelings	57 (4.46)	154 (4.73)	4 (5.25)	2 (3.00)	217 (4.65)	1.65
Practica l	Cost	57 (3.81)	57 (4.70)	4 (5.75)	2 (4.00)	217 (4.48)	1.85
	Time	57 (3.19)	154 (4.05)	4 (4.75)	2 (4.50)	217 (3.84)	1.73
Self-reliance	Want to solve the problem myself	57 (4.53)	154 (4.95)	4 (3.75)	2 (3.00)	217 (4.80)	1.49

Type	Barrier	Male	Female	Non-bin	No-gen	Total	SD
Usefulness of seeking help	Problem will get better by itself	57 (3.72)	154 (3.68)	4 (1.75)	2 (3.00)	217 (3.65)	1.67
	Seeking help would not help	57 (3.37)	154 (3.90)	4 (4.00)	2 (6.00)	217 (3.78)	1.62
	Not taken seriously	57 (4.56)	154 (5.21)	4 (5.25)	2 (5.02)	217 (5.02)	1.61
	I wouldn't be understood	57 (4.74)	154 (5.48)	4 (6.75)	2 (5.50)	217 (5.31)	1.58

Figure 8

Barriers to help-seeking

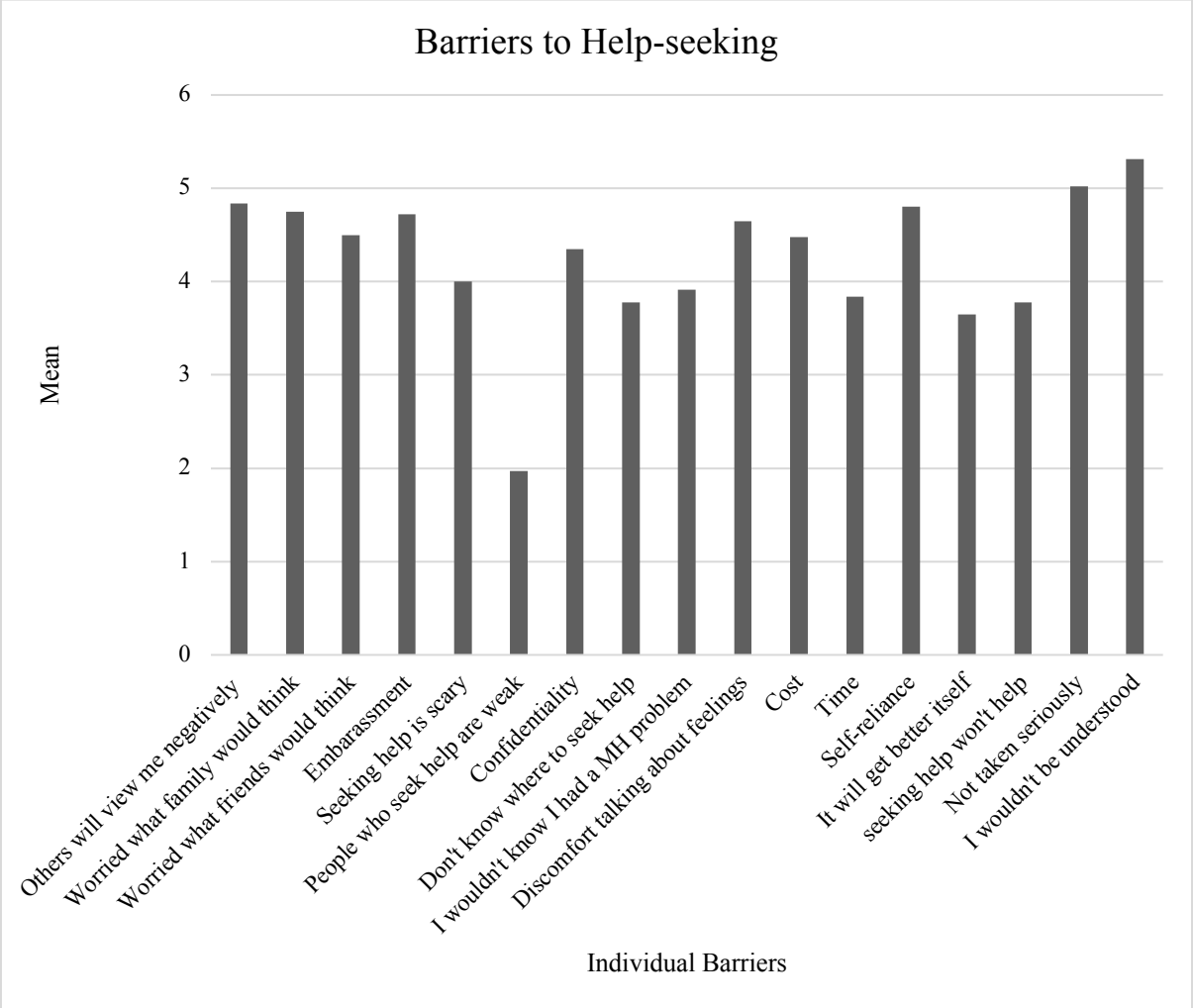


Figure 8 displays the mean response to each barrier to seeking help for mental health related problems. This would suggest that the greatest barrier to help-seeking would be the concern that 'I wouldn't be understood' ($\bar{x} = 5.31$) which is associated with the usefulness of help-seeking. This appears to be a greater concern for females ($\bar{x} = 5.48$) than males ($\bar{x} = 4.74$). To examine whether this difference was significant, a Mann-Whitney U test was performed. This difference was statistically significant ($Z = -2.929$, $p \leq 0.003$). Female participants ($\bar{x} = 5.21$) also appeared to be more concerned about being taken seriously, than male participants ($\bar{x} = 4.56$). This was also found to be a significant difference ($Z = -2.471$, $p \leq 0.013$).

On the other hand, the factor least likely to act as a barrier was 'people who seek help are weak' ($\bar{x} = 1.97$), despite overall stigma-related barriers being identified as greater ($\bar{x} = 4.15$).

'Other' types of barrier

Participants were asked to think of additional factors that act as barriers to help-seeking for mental health related problems. Participants were able to give more than one response. Basic content analysis was used to analyse responses. There were 49 responses: 11 from male respondents and 38 from female respondents. No responses were given by non-binary and no-gender participants. Responses that had already been covered were omitted, which left 30 responses to analyse. Table 25 displays the frequency and percentage of responses to each question, across and according to gender.

Table 25

Other barriers identified by participants

Barrier	Males (%)	Females (%)	Total (%)
Significance of problem: taking up resources, availability of help, worthiness, validation	3 (10.00)	15 (50.00)	18 (60.00)
Being a burden, causing others anxiety	1 (3.33)	0 (0.0)	1 (3.33)
Problem acceptance	1 (3.33)	1 (3.33)	2 (6.66)
Effort involved in seeking help - long process	1 (3.33)	1 (3.33)	2 (6.66)
Over-reaction/escalation of problem from teachers, friends	0 (0.0)	2 (6.66)	2 (6.66)
Fear of strangers	0 (0.0)	1 (3.33)	1 (3.33)
Articulating problems	0 (0.0)	2 (6.66)	2 (6.66)
No 'proof' of mental health problem	0 (0.0)	1 (3.33)	1 (3.33)
Initiating the conversation	0 (0.0)	1 (3.33)	1 (3.33)
Total (%)	6 (20.00)	24 (80.00)	30

Table 25 shows the most frequently given additional barrier was the feeling that the problem was not significant enough to need help (n=18), making up 60% of the responses given. This appears to be a greater barrier for females (n=15) than males (n=3). However, other responses given appeared to be infrequent and identified by few participants. Females (n= 24) identified more additional barriers than their male counterparts (n=6). However, findings must be interpreted with caution due to low response rates.

4.3.2 Facilitators to help-seeking

To understand facilitators of help-seeking for mental health related problems, participants were asked to indicate the extent to which they agreed various identified factors would encourage help-seeking on a scale of 1 (strongly disagree) to 7 (strongly agree).

Table 26 displays the facilitators to help-seeking for mental health related problems. It displays the number of participants and the mean response (in parentheses) to each facilitator, across and according to gender.

Table 26

Facilitators to help-seeking

	Male (%)	**Female (%)**	**Non-bin (%)**	**No-gen (%)**	**Total (%)**	**SD**
Positive past experience	57 (4.98)	154 (5.36)	4 (6.60)	2 (5.00)	217 (5.28)	1.49
An adult initiating the conversation	57 (4.93)	154 (5.19)	4 (4.50)	2 (5.50)	217 (5.11)	1.39
Validation and normalisation	57 (5.00)	154 (5.54)	4 (6.75)	2 (5.50)	217 (5.42)	1.33
Confidentiality	57 (5.54)	154 (5.74)	4 (6.50)	2 (5.50)	217 (5.70)	1.35
Knowing more about mental health	57 (5.30)	154 (5.38)	4 (4.25)	2 (6.50)	217 (5.35)	1.22
Knowing where help can be sought	57 (5.00)	154 (5.41)	4 (4.25)	2 (6.50)	217 (5.29)	1.41
Total (%)	57 (5.13)	154 (5.43)	4 (5.46)	2 (5.36)	217 (5.36)	.97

Table 26 demonstrates male participants ($\bar{x} = 5.13$) report fewer facilitators than female participants ($\bar{x} = 5.43$). To examine whether there was a significant difference between males and females and reported facilitators to seeking help, a Mann-Whitney U test was performed. The difference was significant ($Z = -2.230$, $p \leq 0.026$).

Figure 9

Facilitators to help-seeking

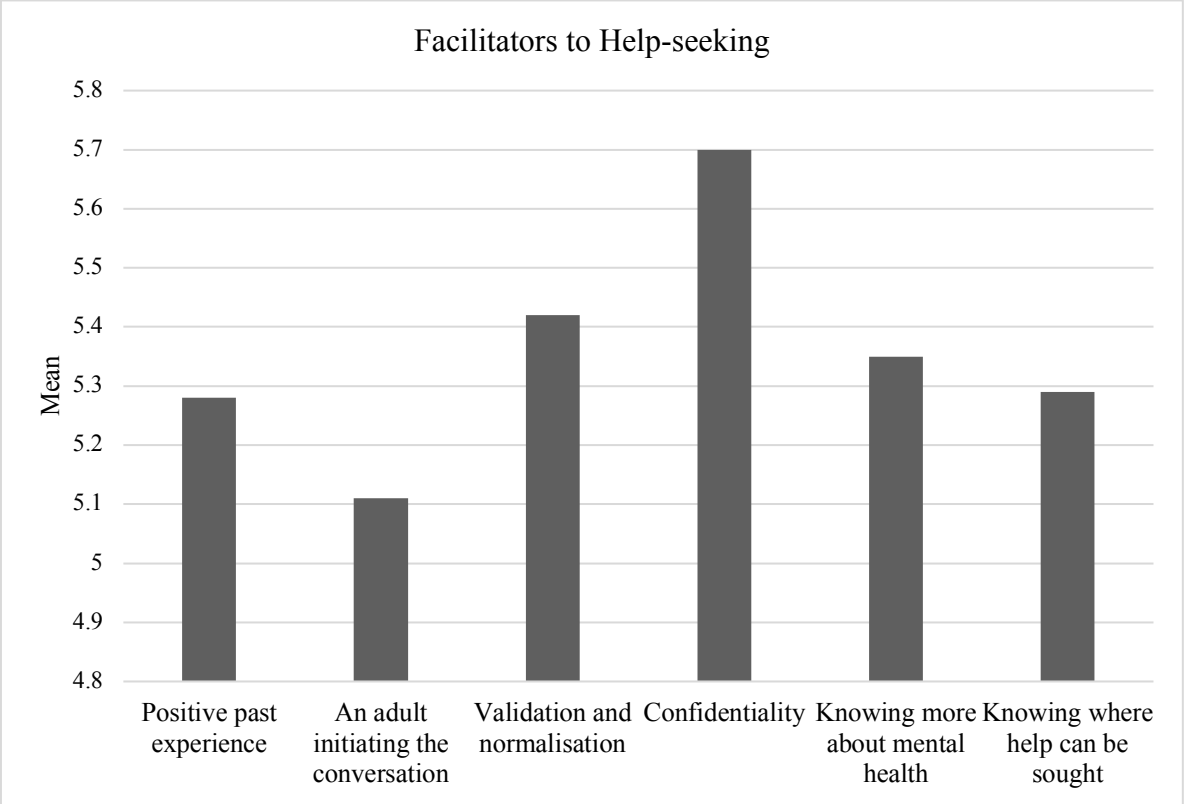


Figure 9 displays the extent to which respondents agree that various factors are facilitators to seeking help for mental health related problems. The responses given would indicate that the greatest facilitator to help-seeking is the assurance of confidentiality ($\bar{x}$ = 5.42) with participants indicating that they 'somewhat agree' this would be a facilitator. Whereas 'an adult initiating the conversation' appears the least agreed upon facilitator ($\bar{x}$ = 5.11).

'Other' facilitators

Participants were asked if they could think of any additional facilitators that had not been in the questionnaire. Participants were able to give more than one response. Basic content analysis was used to analyse the responses given. 40 responses were given: 8 from male respondents and 32 from female respondents. No responses were given by non-binary or no-gender participants. Responses that had already been covered were omitted, which left 27 responses to analyse. Table

27 displays the frequency of responses and percentage of respondent (in parentheses) who gave each response, across and according to gender.

Table 27

Additional facilitators to help-seeking

Facilitator	**Males (%)**	**Females (%)**	**Total (%)**
Accessibility (cost, time, time of day, where)	1 (3.70)	6 (22.22)	7 (25.93)
Normalisation of help-seeking	2 (7.41)	6 (22.22)	8 (29.63)
Recognition of limitations imposed by mental health problems	1 (3.70)	0 (0.0)	1 (3.70)
Characteristics of help source including friendly, non-judgmental, good listener	0 (0.0)	2 (7.41)	2 (7.41)
Others' positive experiences	0 (0.0)	4 (14.81)	4 (14.81)
Social support: encouragement from friends	0 (0.0)	2 (7.41)	2 (7.41)
Information about seeking help – who, what, where, how.	0 (0.0)	1 (3.70)	1 (3.70)
Having the right language	0 (0.0)	2 (7.41)	2 (7.41)
Total	4 (14.81)	23 (85.19)	27

Table 27 shows that overall, females (n = 23) could think of more additional facilitators than males (n = 4). The additional facilitator identified most frequently was normalisation of help-seeking itself (n = 8). This made up nearly 30% if the responses and would appear to be of greater importance to females (n = 6) than males (n = 2). Accessibility (n = 7), such as cost and time of day (n = 7), made up 26% of responses with females again highlighting that this would be a greater facilitator for them (n = 7) than males (n = 1).

4.3.3 Hopes of help-seeking

Participants were asked what they would hope to achieve from seeking help for mental health related problems. As before, participants were able to give more than one response. There were 231 responses, some of which contained more than one hope. Therefore, there were 241 separate hopes for seeking help, overall. Table 28 displays the frequency and percentage of responses to each question, across and according to gender.

Table 28

Hopes of help-seeking

Hope	**Male (%)**	**Female (%)**	**Non-bin (%)**	**No-gen (%)**	**Total (%)**
Improve MH/reduce distress	17 (7.54)	59 (24.48)	2 (.83)	0 (0.0)	78 (32.37)
Validation and normalisation	4 (1.66)	15 (6.22)	1 (.41)	0 (0.0)	20 (8.30)
To be understood	1 (0.41)	2 (.83)	0 (0.0)	1 (0.41)	4 (1.66)
Understand feelings / self	8 (3.32)	22 (9.13)	0 (0.0)	0 (0.0)	30 (12.45)
Coping strategies / guidance	7 (2.90)	57 (23.65)	2 (.83)	1 (0.41)	67 (27.80)
A safe space to talk	3 (1.24)	12 (4.98)	0 (0.0)	0 (0.0)	15 (6.22)
Diagnosis	0 (0.0)	5 (2.07)	0(0.0)	0 (0.0)	5 (2.07)
Personal growth	3 (1.24)	3 (1.24)	0 (0.0)	0 (0.0)	6 (2.49)
Medication	0 (0.0)	3 (1.24)	0 (0.0)	0 (0.0)	3 (1.24)
Immediate help/ not to go on waiting list	0 (0.0)	1 (0.41)	0 (0.0)	0 (0.0)	1 (0.41)
Not sure/ don't know	1 (0.41)	11 (4.56)	0 (0.0)	0 (0.0)	12 (4.98)
Total (%)	44 (18.26)	190 (78.84)	5 5 (2.07)	2 (.83)	241

Table 28 shows that, overall, more females (n = 190), which constitutes 78.84% of responses, were able to identify what their hopes would be for seeking help. The most common response to this question was to see an improvement in mental health/ to reduce the distress caused by the mental health problems (n = 78, 32.37%), particularly for females, who despite the greater number of participants proportionally still identify this as their greatest hope. This was closely followed by the hope that help would lead to guidance and the development of coping strategies (n = 67, 27.8%), which again appear to be more prevalent for females (n = 57) than males (n = 7) and non-binary (n = 2) respondents. However, caution must be taken when looking at these findings as two non-binary participants accounts for 50% of that group of participants. Interestingly, 12 participants indicated that they did not know what they would hope to achieve from seeking help, accounting for 5% of the responses.

4.3.4 Correlations between measures

Intentions and barriers to help-seeking

To explore if there was a correlation between overall intentions to seek help and the perceived barriers to seeking help, a one-tailed Spearman's Rho Correlation was conducted. Findings indicated that that there was a significant weak negative correlation between help-seeking intentions and perceived barriers ($rs = -.295$, $p \leq 0.001$), revealing the greater the perceived barriers, the lower the intention to seek help.

Intentions and facilitators to help-seeking

To explore the relationship between overall help-seeking intentions and perceived facilitators, a one-tailed Spearman's Rho Correlation was performed. A significant weak positive correlation was found ($rs = .342$, $p \leq 0.001$), demonstrating the greater the perceived facilitators, the greater the intention to seek help.

4.4 COVID-19 and Help-seeking

4.4.1 Impact of COVID-19 on mental health

Participants were asked whether COVID-19 had an impact on their mental health. Below, Table 29 displays the frequency of responses and the percentage of respondents who indicated the impact of COVID-19 on their mental health, across and according to gender.

Table 29

Impact of COVID-19 on mental health

	Male (%)	**Female (%)**	**Non-bin (%)**	**No-gen (%)**	**Total (%)**
Yes	26(45.6)	117 (76.00)	3 (75.00)	1(50.00)	147 (67.74)
No	31 (54.40)	37 (24.00)	1 (25.00)	1(50.00)	70 (32.26)

Findings displayed in Table 29 would indicate that the mental health of participants is more likely to have been impacted, than not, by the events of COVID-19. More specifically, female participants (76%) were more likely to perceive that their existing mental health problems were impacted by COVID-19, than male (45.6%) participants.

To examine whether there was a significant association between gender and the impact of COVID-19 on mental health, a Chi-square test of independence was performed. There was a significant association between gender and the reported impact of COVID-19 on mental health, with more females reporting its affects (X^2 (1, N=211) = 17.556, $p \leq .000$).

Following this, if participants indicated that COVID-19 had affected their mental health, they were asked to explain what the impact had been. Basic content analysis was used to analyse participant responses, of which they could give more than one. There were 149 responses to this question, which analysis indicates were both positive and negative. Table 30 displays the frequency of responses and the percentage of respondents who indicated the impact of COVID-19 on mental health support, across and according to gender.

Table 30

The impact of COVID-19 on participant mental health

		Males (%)	Females (%)	Non-bin (%)	No-gen (%)	Total (%)
Negative	**Anxiety, worry and stress** about exams and socialising	5 (3.68)	41 (30.15)	3 (2.21)	0 (0.0)	**49 (36.03)**
	Depression and suicidal ideation including apathy, and hopelessness	4 (2.94)	12 (8.83)	0 (0.0)	1 (0.74)	**17 (12.5)**
	Loneliness	11 (8.09)	38 (27.94)	1 (0.74)	0 (0.0)	**50 (36.76)**
	Relapse of eating disorder	0 (0.0)	8 (5.88)	0 (0.0)	0 (0.0)	**8 (5.88)**
	Recovery stopped	1 (0.74)	0 (0.0)	0 (0.0)	0 (0.0)	**1 (0.74)**
	Loss and grief of prom, exam results, seeing people	1 (0.74)	1 (0.74)	0 (0.0)	0 (0.0)	**2 (1.47)**
	Mental health got worse undisclosed	1 (0.74)	7 (5.15)	0 (0.0)	1 (0.74)	**9 (6.62)**
	Total (%)	**23 (16.91)**	**107 (78.68)**	**4 (2.94)**	**2 (1.47)**	**136 (91.28)**
Positive	**Improved mental health** (vague)	2 (15.38)	4 (30.77)	0 (0.0)	0 (0.0)	**6 (46.15)**
	Time to plan the future	1 (7.69)	1 (7.69)	0 (0.0)	0 (0.0)	**2 (15.38)**
	Decreased anxiety and stress	1 (7.69)	2 (15.38)	0 (0.0)	0 (0.0)	**3 (23.08)**
	Less social pressure	0 (0.0)	2 (15.38)	0 (0.0)	0 (0.0)	**2 (15.38)**
	Total (%)	**4 (30.77)**	**9 (69.23)**	**0 (0.0)**	**0 (0.0)**	**13 (8.72)**

As can be seen in Table 30, there were more responses pertaining to the detrimental impact of COVID-19 on mental health (91.28%) than positive (8.72%). 36.76% of participants indicated that loneliness (n = 50), and 36.03% of participants felt that anxiety (n = 49) had been the most detrimental impact of COVID-19, particularly for females. On the other hand, six respondents indicated that in fact their mental health had improved during the COVID-19 pandemic.

4.4.2 Impact of COVID-19 on mental health support

To understand the impact that COVID-19 has had on mental health support, participants in receipt of support were asked to indicate whether this has been affected. Table 31 displays the frequency of responses and the percentage of respondents who indicated that COVID-19 did or did not have an impact on their support, across and according to gender.

Table 31

Impact of COVID-19 on mental health support

	Male (%)	**Female (%)**	**Non-bin (%)**	**No-gen (%)**	**Total (%)**
Yes	5 (41.67)	32 (56.14)	0 (0.0)	0 (0.0)	37 (52.11)
No	7 (58.33)	25 (43.86)	1 (100.00)	1 (100.00)	34 (47.89)
	12 (16.90)	57 (80.28)	1 (1.41)	1 (1.41)	71

Table 31 illustrates that marginally more respondents (52.11%) felt that COVID-19 had impacted the support they were receiving, with 56.14% of females reporting this. Interestingly, 58.33% of male respondents reported COVID-19 has not had any impact on mental health support.

To examine whether there was a significant association between gender and the impact of COVID-19 on mental health support, a Chi-square test of independence was performed. No significant association was found between gender and the reported impact of COVID-19 on mental health support (X^2 (1, N=211) = .835, $p \leq .361$).

To understand what the impact of COVID-19 has been, participants were asked an open question to explain what they had meant. Participants were able to give more than one response. There were 34 responses from male and female participants, none from non-binary and no-gender participants. Basic content analysis was used to analyse responses. Table 32 displays the frequency of responses and the percentage of responses, which indicated the exact impact of COVID-19 on their support, across and according to gender.

Table 32

Impact of COVID-19 on mental health support

Impact on support	**Male (%)**	**Female (%)**	**Total (%)**
Support withdrawn when lockdown began	2 (18.18)	9 (81.82)	11 (32.35)
Access difficulties including college, GP, CAMHS	1 (20.00)	4 (80.00)	5 (14.71)
Medium of support changed created discomfort	3 (18.75)	13 (81.25)	16 (47.06)
Support delayed	0 (0.0)	2 (100.00)	2 (5.88)
Total	6 (17.65)	28 (82.35)	34

Table 32 shows that overall, females (28 responses), who were in receipt of more support, perceive greater impact on their support than their male (6 responses) peers. Of the responses received, the biggest impact of COVID-19 on support was the impact on method of communication (n= 16, with 47.06% of participants reporting this change. With regards to withdrawal of support, 32.35% of participants (n = 11) identified this was a result of COVID-19 and the associated measures. Caution must be taken when interpreting these findings due to the low response rate.

4.5 Reliability of Measures

To assess the internal consistency of the measures included, Cronbach's alpha was conducted. According to Cortina (1993) a result above 0.8 is good and anything below 0.5 is unacceptable. The results are displayed in Table 33

Table 33

Internal consistency of phase one measures

	Cronbach's alpha
Attitudes towards help-seeking	.820
Intentions to seek help	.820
Perceived behavioural control	.637
Subjective norms	.683
Barriers to seeking help	.867
Facilitators of help-seeking	.799

Whilst the reliability of all measures are deemed acceptable, caution must be taken when analysing the findings from measures assessing SN and PBC.

Chapter 5. Phase One Discussion

With reference to relevant literature, this section will analysis the findings of phase one. The research questions (RQs) this phase sought to answer were:

RQ1 What are the help seeking intentions of young people attending post-16 settings?

a. What are the attitudes of young people towards seeking help?
b. What are the attitudes of significant others towards seeking help?
c. Do young people feel able to seek help?

RQ2 What do young people perceive the barriers and facilitators to help-seeking to be?

RQ3 What impact has COVID-19 had on the experience of mental health problems in young people?

RQ4 Are there differences in the experience of mental health problems, intentions to seek help and the impact of mediating factors, according to gender?

For clarity, the discussion for phase one of the study is structured by RQ, and where relevant gender differences will be discussed.

5.1 The Help-seeking Intentions of Young People Attending Post-16 Settings

Key findings

- Overall, participants were more likely to not seek help, than to seek help.
- Female participants show slightly greater intention to seek help than their male counterparts.
- Overall, seeking help from informal sources was preferred to formal sources.
- Partners and friends were the source from which participants were most likely to seek help.
- Mental health professionals were also identified as a source from which participants were likely to seek help.

- Teachers and pastoral tutors were not seen to be a source from whom participants were likely to seek help.
- Participants indicated that they were more likely to seek *information* from internet-based sources of help, than *actual help.*
- If participants were to seek help, they would rather do this face-to-face, than via indirect means.

Interestingly, the overall help-seeking intentions of participants indicate that if they were to experience mental health related problems, they were slightly to moderately unlikely to seek help ($\bar{x}$ = 3.83) from various named sources. This is despite the demographic data indicating that, of those who have previously experienced mental health problems, more sought help (56.63%) than those who did not (43.37%). When looking at these findings more closely, it became apparent that female participants ($\bar{x}$ = 3.92) have greater help-seeking intentions than their male counterparts ($\bar{x}$ = 3.83). However, to contradict this, when asked directly to indicate the likelihood that they would not seek help for mental health related problems, female participants indicated a greater likelihood than male participants. One possible explanation for such an interesting finding could be that people do not necessarily attribute disclosing to friends, partners and family as 'seeking help'. It would be useful to understand the intent and function of disclosing to such people, as research has indicated that whilst disclosure is the first step to help-seeking (Klein, 2012), this is not always the outcome sought. Further, and as will be discussed later, past experiences of help-seeking have been found to affect future help-seeking intentions (Lindsey et al., 2006).

When exploring the type (formal or informal) of source from which help can be sought, participants demonstrated a preference for seeking help from less formal sources ($\bar{x}$ = 4.20), a finding which, in the present study was found to be statistically significant. Such a finding has previously been well-documented (Michaelmore & Hindley, 2012; Toren et al., 2020), particularly for young men (Rickwood & Thomas, 2012). Of the informal sources from whom participants could indicate their intentions to seek help, partners were the preferred source ($\bar{x}$ = 5.18), followed closely by friends ($\bar{x}$ = 4.99), demonstrating that closeness and familiarity may be key factors influencing help-seeking intentions. However, it is important to note that male

participants were less likely than all other participants to seek help from peers. This finding is consistent with those of De Goede, Branje and Meeus (2009) who, in their research with Dutch adolescents, found that male participants were less likely to disclose problems to peers than their female counterparts due to the power discrepancy and vulnerability that disclosure of a personal problem can cause in adolescent relationships. Therefore, the findings of the present study highlight the need to educate young people on how to support friends and partners with their mental health related problems. Interestingly, the third source from which participants were most likely to seek help was a mental health professional, a formal source ($\bar{x}$= 4.91), which is in line with research conducted by Tomczyk et al. (2020), in which it was found, that seeking professional help is favoured when viewed positively. Further, it might be suggested that the intentions to seek help from these professionals is higher, as providing mental health support is perceived to be a part of their role. On the other hand, participants were slightly unlikely to seek help from teachers **(**$\bar{x}$= 3.18), demonstrating that some educational and school-based professionals are not favoured sources of help, reiterating the findings of Leavey et al. (2011). However, despite participants indicating little intention to seek help from pastoral tutors **(**$\bar{x}$= 3.60), the slightly greater intentions are worth noting, as this difference may be attributed to their perceived role in supporting student mental health.

Across all participant, intentions to seek help from a Faith Leader were low **(**$\bar{x}$= 1.77). Whilst the reason for this is unclear, a recent report, which analysed data from the European Social Survey conducted between 2014 and 2016, found that of all 16- to 29- year-olds in the UK, only 30% had religious affiliations and 7% attend religious ceremonies regularly (Bullivant, 2018). Such findings might suggest that Faith Leaders are not viewed as sources of help for mental health related problems, by many.

When participants were asked to indicate if there were any additional sources of help not listed in the questionnaire, whilst very few gave a response, they were all related to the internet. To explore the use of the internet, in relation to mental health related problems and help-seeking, it was important to clarify *what* the internet was being used for: information or help. This is because the former may be interpreted as preference for self-help and self-reliance (Clement et al., 2015) which is a concerning barrier discussed in greater detail later. The findings clearly

indicate that despite suggesting the internet might be an additional source of help, in actual fact it was far more likely (significantly) to be used simply to seek information about mental health ($\bar{x}$ = 4.07), as has been found in previous research (Dooley & Fitzgerald, 2012). This is relevant because so many young people are utilising the internet (ONS, 2019), therefore effort must be made to ensure young people are seeking information from the right sources, as quality of resources can vary greatly.

Participants were asked about the medium through which they would prefer to seek help for mental health problems. Of statistical significance, face-to-face help-seeking was the preferred medium by 76% of the respondents, with only 24% showing a preference for more indirect methods, such as telephone or computer mediated help. Referring to previous research this finding is not surprising given that a significant barrier to help-seeking online is uncertainty around confidentiality and data privacy (Pretorius et al., 2019).

5.2 Young People's Help-seeking Attitudes

Key findings

- Overall, participants indicated that help-seeking might be 'somewhat useful'.
- Male and female attitudes towards help-seeking did not differ.
- Overall, attitudes towards informal sources were slightly better than for formal sources.
- Mental health professionals were deemed to be the most useful source of help, followed by partners and EPs.
- The perceived usefulness of the internet was varied.

Attitudes towards help-seeking are well known to contribute to the intention participants have to seek help for mental health related problems (Tomczyk et al., 2020). Findings from this study corroborate this.

Overall, participants demonstrated fairly neutral attitudes towards help-seeking, with a modest indication that it might be 'slightly useful' ($\bar{x}$ = 4.46). There was no observed difference overall

between male and female attitudes towards help-seeking ($\bar{x}$ = 4.47). On closer inspection, attitudes towards help-seeking from informal sources ($\bar{x}$ = 4.62) were slightly different than for formal sources ($\bar{x}$ = 4.34). Interestingly, participants indicated that the most useful source to seek help from would be a mental health professional ($\bar{x}$= 5.98), despite them not being the source that participants were most likely to seek help from. Such findings would suggest there are other mediating factors that outweigh the perceived usefulness of mental health professionals, which reduce participant intentions to seek help from them. Such factors may include access (Gulliver et al., 2010). Other sources identified to be the most useful were partners ($\bar{x}$= 5.37), then EPs ($\bar{x}$= 5.19), and friends ($\bar{x}$ = 5.12). What is striking about these findings is that the role of mental health professionals and EPs is different to that of partners and friends, perhaps suggesting that different sources would be able to provide different things. For example, research has shown that help-seeking often takes place within close relationships (Wilson, Rickwood, Bushnell, Caputi & Thomas, 2011), which might explain the positive attitudes towards partners and friends. However, it can be speculated that participant preference for mental health professionals and EPs may be attributed to their perceived role, knowledge and expertise in supporting mental health needs. Due to a lack of research on the perceived usefulness of mental health professionals and EPs, making this the focus of future work would be helpful to understand this specific preference.

Regarding the use of the internet for help-seeking, results were varied. Overall, participants indicated that charity/ support websites could be slightly useful ($\bar{x}$ = 4.41), which is encouraging in light of recent literature which has suggested there is a positive correlation between online help-seeking behaviour and mental health. On the other hand, attitudes towards google search ($\bar{x}$ = 2.99) and social media ($\bar{x}$ = 3.08) were less positive. These findings contradict those of Burns et al. (2010) who, in a report, highlights the majority of males (in their research), aged between 16 and 25, used search engines such as google, rather than specific support websites. Moreover, they identified that internet use was greater after 11pm, and was linked to psychological distress. This inconsistency in findings, between the present study and that of Burns et al. (2010), may indicate the differing levels of distress experienced by participants, its acute or chronic nature, and the perceived immediacy with which help or support is required. Exploring the use of online

platforms, the specific type of platform accessed and the reasons for this would have useful contributions to make to this field of work.

5.3 The Attitudes of Significant Others towards Help-seeking

Key findings

- Overall, the perceived attitudes of significant others would suggest seeking help for mental health related problems is important.
- Participants indicated that friends and teachers are most likely to think that seeking help for mental health related problems is important.
- Participants felt that family would think it was slightly less important to seek help.
- Participants did not feel as strongly that they would be expected to seek help for mental health related problems.

The perceived attitudes of significant others towards a behaviour are a significant predictor of intentions to seek help (Ajzen, 1991). The findings indicate that, overall, seeking help for mental health related problems was important in the eyes of significant others ($\bar{x}$ = 5.55). Of note, participants felt friends placed the most importance on seeking help for mental health related problems ($\bar{x}$ = 5.88). This has also been reported by Holyoak (2020) who, in her study of peer problem disclosure found that adolescents generally respond positively to help-seeking and problem disclosure. Such findings may be interpreted by the help-seeker as positive attitudes towards help-seeking for problems. One unanticipated finding was that, in light of low levels of intention to seek help from teachers, they were thought to place importance upon help-seeking for mental health related problems ($\bar{x}$ = 5.83). One possible explanation for this might be that whilst teachers are likely to talk about mental health difficulties and the importance of seeking help, as a part of their job (Graham et al., 2011), the accessibility both instrumentally and emotionally might be questionable.

On the other hand, participants indicated that family members would place less importance upon help-seeking ($\bar{x}$ = 5.42). Research into seeking help from family is mixed, with some indicating

that family are one of the favoured sources of help (Biddle et al., 2004), whereas others note low levels of association between child mental health and parental awareness (Motjabi & Olfson, 2008) and fear of parents finding out (Toren et al., 2020). Parental knowledge of mental health problems, and confidence to discuss them might offer an explanation of these findings, suggesting that parental mental health literacy would be a useful avenue to research.

Contrary to expectations, the present study found participants felt less strongly that they would be expected to seek help for mental health related problems ($\bar{x} = 5.08$). This is surprising and suggests that whilst help-seeking is seen as important, this does not translate to expectations to actually seek help.

5.4 Young People's Perceived ability to Seek Help

Key findings

- Male participants have more perceived behavioural control than female participants.
- Participants felt that it was up to them to seek help or not for mental health related problems.
- Participants felt seeking help for mental health related problems is not easy.
- Overall, participant confidence to seek help is low.

Questions regarding PBC have yielded incredibly interesting results and it would appear that males ($\bar{x} = 4.92$) have more PBC than their peers.

Of note, participants across all genders indicated that they 'somewhat agree' it is entirely their decision to seek help for mental health related problems ($\bar{x} = 5.57$). This finding could indicate one of two things: they feel that the views of others will not dictate their decision to seek help, or they take personal responsibly for seeking help. Despite these differing explanations, they both indicate that increasing a participant's sense of control over their actions is important. However, Ajzen (2002) has highlighted that whilst control is important, it is essential to provide participants and young people with the opportunities to display the desired behaviour, in this

case help-seeking. Therefore, work must be done on the increasing awareness and perceived opportunity of seeking help.

By contrast, participants indicated that seeking help would not be easy ($\bar{x}$ = 3.39), and a lack in confidence ($\bar{x}$ = 4.53) towards seeking help. Such findings would indicate that despite higher levels of controllability, as previously reported, participant experience of self-efficacy in relation to help-seeking is lacking. This is an important yet unsurprising finding, because self-efficacy has been recognised in the literature as a barrier in itself to help-seeking, particularly where there are additional barriers presented (Schmutte et al., 2009). In research conducted by Umubyeyi, Mogren, Ntanganira and Krantz (2016) on young adults seeking mental health care in Rwanda, low confidence was linked to difficulties overcoming structural barriers to care. Related to this, it is important to highlight that feelings of low self-efficacy are symptomatic of depression and anxiety. Therefore, the findings of the present study are likely to have important implications for exploring the self-efficacy and confidence of young people, how they can be increased, and removing structural barriers where possible.

5.5 The Relationship Between Attitudes, Subjective Norms, Perceived Behavioural Control on Intentions to Seek Help

Key findings

- Attitudes, subjective norms and perceived behavioural control are positively associated with help-seeking intentions.
- Attitudes are most positively associated with help-seeking intentions

Like previous research, intentions to seek help for mental health related problems are positively associated with attitudes, SN and PBC (Connor, McEachan, Taylor & Lawton, 2011). Contrary to the research conducted by Tomczyk et al. (2020), SN were not found to be the most strongly associated with intentions, but instead attitudes. As such, it would be interesting to examine the impact that enhancing and increasing student attitudes, through psychoeducation, would have on help-seeking intentions.

5.6 Barriers to Help-seeking

Key findings

- Overall barriers to seeking help were more prevalent for female participants.
- Barriers are negatively associated with help-seeking intentions.
- Overall, self-reliance is the greatest barrier to help-seeking, followed closely by usefulness of seeking help.
- Not being understood and not being taken seriously, both associated with usefulness, were the two greatest individual barriers to help-seeking.
- Overall stigma and MHL were less likely than expected to be seen as a barrier to help-seeking across genders.
- Personal weakness as a result of seeking help was least likely to act as a barrier to help-seeking.
- More barriers were identified by females than males.
- The most common 'other' barrier given by participants was around significance of the problem.

Gender is a significant variable with more female participants ($\bar{x} = 4.47$) indicating that the barriers presented in the questionnaire would act as a deterrent to seeking help for mental health problems that their male peers ($\bar{x} = 3.94$). Whilst this finding is consistent with the fact that female participants, when directly asked, were unlikely to seek help for mental health related problems, it is still surprising given the literature suggesting the opposite, that young males have low intentions to seek help (Jorm et al., 2007). Such findings would suggest, in line with the weak correlation identified between intentions and barriers in the present study, that the presence or absence of barriers alone do not dictate a young person's intention to seek help.

Participant responses to the questionnaire were grouped into categories. The category thought to be the greatest barrier to seeking help for mental health related problems was the participants desire to solve the problem on their own ($\bar{x} = 4.80$). This result corroborates the findings of

Salaheddin and Mason (2016) in their research with young adults exploring help-negation. In their research they found that 85.3% of their participants felt that wanting to solve the problem on their own was a barrier to help-seeking. Whilst it would be suggested that seeking help is preferable, if young people do wish to rely upon themselves to manage their own mental health problems, then they need to be equipped with knowledge and understanding of their symptoms, and strategies to manage and cope with them. Understanding the efficacy of young people, both perceived and real, to deal with their mental health related problems, would be research that would be worth conducting.

The second greatest barrier category reported by participants was the usefulness of seeking help for mental health related problems, which is unsurprising given the association between attitudes and intention uncovered in this research. Of particular concern to young people, particularly female participants, was the fear that they would not be understood if they were to seek help for their problems ($\bar{x} = 5.31$), which corroborates the work of Kuhl, Jarkon-Horlick and Morrissey (1997), who identified being understood by adults in particular, was of great concern. This finding may explain why young people often rely on partners and friends to help them with their problems. Related to not being understood, participants were also worried that they, and their problems, would not be taken seriously ($\bar{x} = 5.02$) which is interesting as one of the greatest facilitators to help-seeking, as will be discussed later, is validation.

In contrast to previous and expected findings, stigma as a category was not the greatest barrier identified in the present study, particularly for male participants ($\bar{x} = 3.74$) who 'somewhat disagreed' that it would discourage them from help-seeking. These findings are surprising, given the wealth of research that has reported the disproportionally negative affect of stigma on help-seeking intentions and behaviours when compared to other barriers, particularly for males (Barker, Olukoya & Aggleton, 2005; Gulliver et al., 2010; Rickwood et al., 2005). However, when analysing stigma in greater detail, and assessing the various types of stigma, it becomes clear in the present study that some are more problematic than others. For example, embarrassment and fear of what friends and family would think appear to be a barrier for females, which corroborates research conducted by Jorm et al. (2007) who, in their research with young people and their parents in Australia, found that the perceptions of others was key to

whether they sought help or not. On a more positive note, participants did not indicate that seeking help for mental health related problems was a sign of personal weakness ($\bar{x}$ = 1.97), which is suggestive that personal stigma and attitudes towards help-seeking are not entirely negative.

Another surprising finding is in relation to MHL. Whilst MHL is identified as a barrier by participants, previous literature which looks at the relationship between help-seeking intentions and MHL would suggest that it is of greater concern than identified in the present study. For example, research conducted by Reavley, McCann and Jorm (2011) found that lower levels of MHL, specifically the ability to recognise the symptoms of a problem, reduced the likelihood of seeking help. Whereas, findings of the current study suggest that participants somewhat disagree that recognition of problems is a barrier ($\bar{x}$ = 3.91), suggesting it is less of a prominent problem than anticipated, for young people in post-16 settings.

Of the 'other' barriers identified by participants, 80% came from females, which is consistent with the work of Haavik et al. (2017), who found that female adolescents perceived more barriers to mental health help-seeking. Whilst this finding may offer one explanation as to why females in the present study are less likely than their male peers to seek help when asked directly, caution must be taken as females represent 75% of the participants. The overall barrier appearing to be of most concern to young people, regardless of gender, is 'significance of the mental health problems'. Of the responses given, 60% of participants reported that this is an additional barrier to help seeking. Subcategories of this barrier included: guilt of taking up resources when others might need them, availability of help, feeling worthy of help and fear that their feelings would not be validated. The latter of which might be related to concerns of not being understood and/ or taken seriously. Such findings are consistent with previous literature (Salaheddin & Mason, 2016) and are incredibly concerning, yet with the reduction in public spending and with it a reduction in resources, are not surprising.

5.7 Facilitators to Help-seeking

Key findings

- Participants feel that confidentiality is the greatest facilitator to seeking help.
- Adults initiating conversations was least likely to encourage help-seeking.
- There was a slightly higher response rate from females to questions asking for any other facilitators to help-seeking than males.
- The most common reported additional facilitators were normalisation of help-seeking and accessibility.

A facilitator to help-seeking for participants was the promise of confidentiality ($\bar{x} = 5.70$). A similar finding was reported by Gulliver et al. (2010) who, in their research on barriers, found that young people show greater help-seeking intentions towards a source that they trust will keep their disclosure confidential. Of course, confidentiality, particularly when referring to seeking help from professional sources, is complex due to the duty of care that the professional will have. With regards to friends, the concern may be that the disclosure will become common knowledge and therefore, whilst stigma was not identified as the greatest barrier to help-seeking, it may be related to the concern of confidentiality, as suggested by Clement et al. (2015).

On the other hand, participants felt that being invited to seek-help, through an adult initiating a conversation ($\bar{x} = 5.11$), was slightly less of a facilitator to help-seeking. This is interesting because the question does not assess help-seeking in its most active form, but instead as a more passive behaviour. The reason that participants felt that this was less encouraging may be the fact that being asked to seek-help ignores the requisite attitudes (Ajzen, 1991). However, it could also be argued that invitation to seek help and disclose, would negate the perceived difficulties with control and self-efficacy to help-seek. It would be interesting to further explore the experience of being invited to seek-help to understand the positive and negative attributes of this behaviour.

Participants were asked to share other facilitators which they felt had been missed in the questionnaire. Of the responses given, 85.19% were given by female participants. Interestingly, 29.63% of participants suggested that normalisation of help-seeking itself would be a facilitator. Whilst it is known that normalisation and validation of mental health issues themselves is important for young people (Wilson & Deane, 2001), participants indicated that it would be

useful to make it seem normal to seek help. Such findings might suggest that stoicism and stigma, particularly when problems are related to mental health, still exists (Clement et al., 2015; Salaheddin & Mason, 2016). Second to normalisation of help-seeking, was accessibility of help, which was identified by 25.95% of respondents and reiterates the findings of Gulliver et al. (2010). Whilst this is related to cost and time to seek help, both of which are of great concern to young people, participants also suggested that knowing where help is, and the availability of help, means that the act of finding out where help is, to then seek it, is removed. Moreover, they indicated that quite often they wanted or needed help in the evening, when services and adults from whom help is offered are not available, which is consistent with the findings of Burns et al. (2010).

5.8 Hopes of Help-seeking

Key findings

- 95.02% of respondents had clear hopes for help-seeking.
- 32.37% of respondents would hope help-seeking would **i**mprove their mental health.
- Developing coping strategies was what 27.8% of respondents would hope for from help-seeking.
- Understanding feelings/ self was highlighted by 12.45% of respondents.
- The least common hopes were immediate help (0.41%), to be given medication (1.24%) and to be understood (1.66%).

A high proportion of participants were able to indicate that they knew exactly what they would hope to achieve by help-seeking, with only 4.98% of responses given suggesting they did not know or were not sure what they would hope to achieve. According to the psychology of hope (Snyder, 1994), such a finding can be interpreted as optimistic. Over the last 30 years, the concept of hope has been useful to understand the mental health related help-seeking of young people and has more recently been found to be associated with intentions (McDermott, Cheng, Wong, Booth & Jones, 2017). Whilst this research did not measure the construct of hope, it

would be reasonable to suggest that the presence of a desired outcome would motivate participants to engage in goal-directed behaviour.

Unsurprisingly, the greatest hope identified by participants for seeking help for mental health related problems was to improve their mental health, and consequently reduce feelings of distress (32.37%). On the other hand, the least frequent responses given by participants were to receive immediate help (0.41%) and to receive medication (1.24%). The former, perhaps indicates participant knowledge around support processes and the time that it can take to be given support. The latter, to receive medication, is more interesting, particularly when contrasted with the high frequency of young people indicating that they would hope to be given guidance and to develop coping strategies. Such a finding may demonstrate that participants, whilst they do hope to get better, recognise that they may have an active role to play in their mental health journey. Such hopes and expectations, according to research conducted by Duncan and colleagues (2011), would indicate that if these participants were to seek and subsequently receive support, they would achieve better outcomes due to their expectations around the active role they would play, aligning with reality. Related to this, 12.45% of participants also indicated that through the process of seeking help, they would hope to understand themselves and the feelings they experience. Whilst there is no information as to how participants would wish to achieve this, one interpretation might be that participants hope to achieve some mastery over their mental health, which could be likened to elements of eudaimonic wellbeing (Ryff, 1989).

Another response given infrequently was ‘to be understood’ (1.66%) which is particularly interesting, in light of the earlier finding in the present study, that a barrier to help-seeking was the fear of not being understood. This inconsistency might demonstrate that whilst young people are not necessarily seeking help to have their problems understood, the process is aided by understanding which can be likened to empathy, a characteristic which was highlighted as essential within a helping relationships (Rogers, 1959).

5.9 The Impact of COVID-19 on Mental Health of Young People

Key findings

- Participants perceived that COVID-19 had impacted their mental health.
- 93% of responses reported negative effects.
    - 36.76% of which were associated with feelings of loneliness.
    - 36.03% of which indicated that increased feelings of anxiety COVID-19.
    - 7% of responses reported benefits of COVID-19 on their mental health.
    - 15.38% reported improved mental health.

The impact of COVID-19 on the mental health of young people is something which is not currently understood, due to the ongoing nature of the pandemic. Two thirds (67.74%) of participants in the current study indicated that COVID-19 and the associated measures have had a significant impact on their mental health. Of these participants, 36.76% cite loneliness as a direct consequence of COVID-19, and 36.03% reported increased feelings of anxiety. To understand this finding, participants were asked to explain what the impact for them had been. Of the 149 responses, 136 (93%) indicated a negative impact, the greatest of which being the feeling of loneliness and social disconnection, both of which may be the cause of mental health problems, or the consequence. This corroborates the findings of Loades et al. (2020) who, in their rapid literature review, found that within the context of COVID-19, and the enforced isolation as a consequence of disease containment measures, young people are five times more likely to require mental health input than previously and are likely to experience post-traumatic stress. This suggestion was proposed in light of findings from research conducted during the outbreak of previous pandemics. However, it has been supported by models developed to forecast the mental health needs of the UK population following COVID-19, which have indicated an additional 1.5 million children and young people will have mental health needs.

Further to feelings of loneliness and increased anxiety, worry and stress related both to COVID-19 and college work, were reported by participants. Early results from the Co-SPACE (COVID-19 Supporting Parents, Adolescents and Children in Epidemics) study indicated that adolescents (aged 11 to 16 years) experienced increased work related worry. Further, research conducted by Cao et al. (2020), with college students in China, indicated that 25% of their population

experienced anxiety symptoms associated with the various effects of COVID-19 on their daily lives. Both of which substantiate the findings of the present study.

However, a decline in mental health was not reported by everyone, with 7% of participants reporting the positive effect that COVID-19 had. Reasons given included time to plan for the future, decreased anxiety and stress, and reduced social pressure, all of which are linked to mental health (Moksnes, Espnes & Haugan, 2012).

5.10 The Impact of COVID-19 on Mental Health Support Received by Young People

Key findings

- Marginally more participants in receipt of support for mental health problems felt that COVID-19 had a negative impact on mental health support.
- The greatest impact of COVID-19 was the way in which support was delivered.

Throughout 2020 and 2021, the UK has been in and out of various forms of lockdown and restrictions have remained in place. 52.1% of participants receiving support prior to COVID-19 indicated this has been affected. Optimistically, this would suggest that almost half of the participants did not think that support had been affected. To understand this, participants were asked to explain what the impact had been for them. Of the 34 responses given, almost half (47.06%) shared the way they were being supported had changed. Where participants had received face-to-face support prior to COVID-19, they were now being supported in a more indirect manner, for example over the phone or via video-calling. Participants cited discomfort and uncertainty about such indirect methods as a reason they stopped engaging with support. Which is consistent with the current study's previous findings and those of Pretorius et al. (2019), that face-to-face support is the preferred method of contact. Reasons for this have been offered by Bradford and Rickwood (2014) who found that the young people in their research felt face-to-face support is more personal, body language can be read, the environment feels safe and they know exactly who they were talking to.

Chapter 6. Phase Two Findings and Discussion

For clarity, phase two findings and the discussion of these have been structured by research question. A summary of findings is provided, followed by discussion of the themes and subthemes. The process of thematic analysis, which was used in the present study is outlined in Chapter 3.

Research questions

RQ5. What are young people's expectations of seeking help for mental health related problems?

RQ6. How can the help-seeking behaviour of young people attending post-16 settings be encouraged?

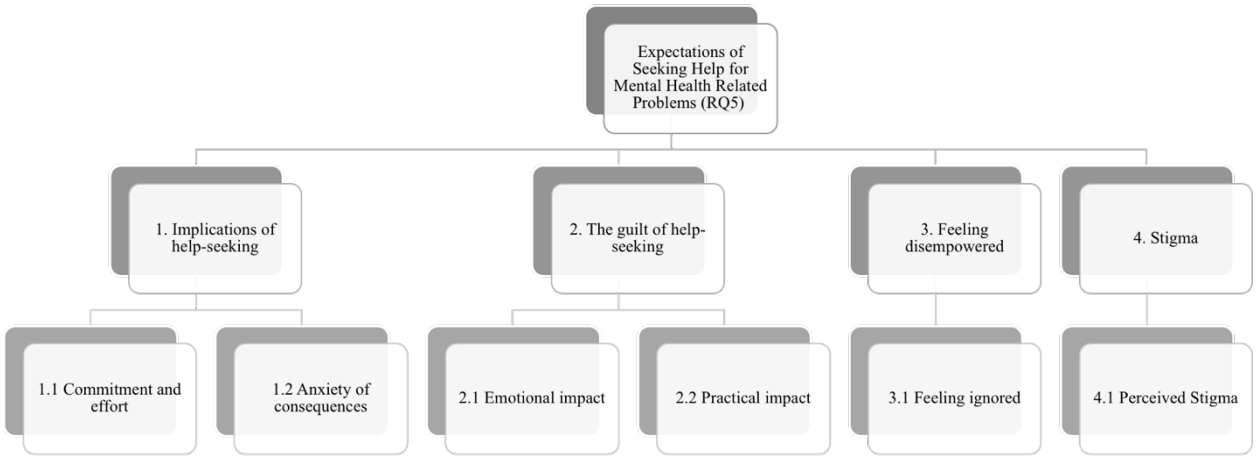
RQ7. What would effective mental health support in education look like to young people?

6.1 Expectations of Seeking Help for Mental Health Related Problems (RQ5)

Four themes were identified in answer to RQ5. Figure 10 provides a visual representation of the themes and subthemes.

Figure 10

RQ5 map of themes and subthemes



With reference to relevant literature, each theme and the associated subthemes will now be discussed.

6.1.1 Theme 1: Implications of help-seeking

Participants shared uncertainty around what would happen once help-seeking had occurred, or a disclosure made. Of particular concern were commitment, effort and the consequences.

Subtheme 1.1. Commitment and effort

The number of participants who shared their uncertainty about what would be required of them during and after they have sought help, was surprising. This is an important finding given the wealth of literature indicating that positive outcomes for young people seeking mental health support are directly related to the expectations they have for the support they receive with regards to their role and the role of the help-source (Gulliver et al., 2010). Participants of the present study explained that whilst struggling with mental health difficulties, the act of help-seeking itself, particularly from formal sources, often feels exhausting and that the commitment

this might require would be too demanding on their resources when they are already feeling emotionally and physically depleted. For example, participant 8 explained:

> When you're in that state, you kind of don't really want to put the work in... and seeking help does involve… obviously… a lot of work. Because it does... obviously take a lot of energy because you've got to really, like commit to that and I think that's quite difficult.

Such fears of commitment corroborate the work of (Watsford & Rickwood, 2014) who, in their research with 228 young people aged 12 to 25 in Australia, found, much like Gulliver et al. (2010), that personal commitment is associated with more positive client outcomes. Participants felt that this was one of the reasons that seeking help from friends, and other informal sources, was much easier. They explained that if a problem is shared with a friend the effort required to disclose, and the expected level of commitment, is less, as participant 2 highlights:

> I think you can be talking about something else random, like just enjoying the conversation, then maybe it [the problem] can slip in… which I think it's easier sometimes because… I think for a lot of people… directly seeking help is sort of like the first hurdle you have to get over. Whereas if you're just with someone you know, and you're just, you know, going for a walk, or you're just with friends, and you're just talking about it all, you can sort of imagine it's just a bit easier, and it can be more natural.

Further, participants felt that the subsequent freedom they have with friends, to move on from what they had shared, is greater. For example, participant 3 shared:

> With your friends you talk about it and then you change the subject to, you know to what you're doing at the weekend or whatever. It's like, it's not just the one thing. So, it's much more comfortable knowing that it is something you can bring up but it can also be put down.

The idea of something being "put down" not only relates to commitment, but also concerns about how one might be perceived by others.

On the other hand, participants explained that sometimes they recognised that more formal help is required for their problems and shared how help could be sought, but without the fear that it would require a commitment from them afterwards. For example, participant 8 explained they would: "...[email] the school. Since you wouldn't really know who receives it... so it's less like, a big, commitment thing."

The consideration of commitment and effort of young people is consistent with findings from research conducted by Clark, Hudson, Dunstan and Clark (2018) who, in their research with Australian adolescent males experiencing clinical anxiety symptoms, found that perceived effort of help-seeking was a barrier. Alternatively, they identified that if participants were presented with a high speed/ low effort option of support that was visible and accessible, help seeking intentions increased. This aligns with the perceived preference of ease and accessibility, as a motivation for disclosing to peers.

Subtheme 1.2. Anxiety of consequences

Participants were concerned about several expected consequences to help-seeking: consequences related to the self, and consequences related to others. They explained that often, as a form of self-preservation, young people will "deny" or "repress" their mental health problems. However, the very act of seeking help, would be a form of "facing-facts" and accepting the problem. This expectation was of great concern to participant 2, who shared:

> So, I know there's some people who would be like, "no, I'm just, you know, just a bit down at the moment or whatever." And I think when you do seek help, we sort of have to accept it. And that, and that can be quite hard to get over. I think.

This feeling was reiterated by others, such as participant 5, who felt by help-seeking you are "admitting it...and that makes it feel a lot more real." This concern is similar to those identified by Dew et al. (2007) who, in their research into the barriers adults face when help-seeking, included the fear of recognising and accepting their problem. Further, Clark et al., (2018), in

their research with young male adults, found that help-seeking was described as an emotionally confronting experience, particularly when professional help was sought. The concern of acceptance and emotional confrontation, according to the work of Vogel, Wade and Hackler (2007), is associated with personal stigma towards mental health, something which is related to RQ5 subtheme 4 and RQ6 theme 1.

Escalation of problems, particularly by teachers, was a major concern for most participants. Participant 4 explained they felt anxious that seeking help can result in something that you do not want because: "if you're talking to a teacher, you're worried that they might escalate it [mental health problem] to something else. And sometimes, you know, you might just want to talk to them about it." This relates to subtheme 1.1 from RQ5, and the concern that if help is sought, then it will result in a commitment, requiring significant effort, or an outcome that was not desired. For example, participant 7 shared that seeking help could be:

> Kind of like a domino effect…obviously, if you're going through something, you make them seem worse… so, you know, if you go to seek help, and then they tell, you know, some kind of service and then the service has to get involved at home, and then, you know, or get involved with you, or…. say you're just asking to talk to somebody …and it turns out that you have to go to therapy or something, but you don't want therapy, you just want to talk.

Despite concern around becoming overwhelmed and losing personal agency, when talking about the escalation of a disclosure, most participants did not display any frustration, but instead a high degree of understanding of a teacher's dogmatic obligation to pass on safeguarding concerns. For example, participant 7 stated: "well, I guess they have a duty of care and a reason for why they would escalate it. But umm, sometimes you just wish they, I don't know…just wouldn't." These findings corroborate those of Allnock and Atkinson (2019) who, in their research on barriers to help-seeking in relation to harmful sexual behaviour (HSB), found that whilst participants understood the safeguarding process, they felt it was inflexible. Such expectations of help-seeking raise significant challenges for young people.

In the present study, participants recognised that for certain problem-types, such as risk to self or others, immediate escalation would be required to mediate risk. Despite the concern of escalation, they also shared that they would want their help-seeking efforts to be acted on. For example, participant 5 shared: “I guess just being certain that doing something will result in you getting help… and know that action will be taken". Such findings are interesting considering the fear of escalation and commitment aforementioned, and the subsequent preference to seek help from friends to avoid the sharing of problems. One interpretation of this could be that personal agency and participation in the decisions being made about the process that followed, would be helpful and decrease anxiety, as highlighted by participant 4, because “there is always that sort of … you don’t know what they are going to do with the information that you give them”. Participants did not indicate apprehension about family and friends finding out.

6.1.2 Theme 2: The guilt of help-seeking

Participants were concerned about the impact their disclosure/ help-seeking would have on the source of help, both emotionally and practically.

Subtheme 2.1. Emotional impact

When explaining their expectations of help-seeking, participants made reference to past experiences of both themselves and peers. A prevalent theme across all participants was the expectation that they would feel guilty for “unloading” their problems onto their family and friends, despite displaying high levels of intention and preference to seek help from them. For example, participant 5 explained: “I guess if I was telling an informal source, such as a friend or family member, I would probably feel a little bit guilty for telling them I think, because I know that hearing that would not be obviously pleasant for them.” For some, this expectation of help-seeking was a significant deterrent to seeking help from friends and family because, as stated by participant 6, “that would be like one of the main things [barrier]... like me talking to one of my friends about something, and I wouldn't want to be a burden to them”. This was reiterated by participant 4 who shared: “they always say a problem shared is a problem halved, and it's like, it's a problem halved, but you're halving that on to a friend.” Worry of burdening others, particularly parents and friends, has been identified as significant barrier to help-seeking by

Schönbucher, Maier, Mohler-Kuo, Schnyder and Landolt (2012) in their research with victims of child sexual abuse (CSA). Whilst the nature of the problems explored in this research and the present study differ, the fear of burdening others is prevalent. Interestingly, participants of the present study did not feel that friends seeking help from them, would feel like a burden.

On the other hand, participants felt that seeking help from a formal source, such as a teacher, GP or counsellor would feel like less of an 'imposition' because, as participant 3 explained: "it's their job to listen and sort of intake information, I wouldn't feel as guilty unloading all of my like… uhhh… my thoughts and feelings onto them. I wouldn't feel like it's an imposition". The benefits of this, to the help-seeking process, were identified across many participants, with participant 4 explaining they would "much rather talk to like a teacher and be completely open with them...and not have to worry about someone my age being burdened with the same problems." The perceived role of help-sources, in supporting mental health, will be explored next.

Subtheme 2.2. Practical impact

Participants felt that, whilst teachers have 'probably' received mental health training, which may be interpreted as an indication that participants do recognise mental health and wellbeing of students is a part of the teacher role, they would feel guilty seeking help from them. One reason for this was provided by participant 4 who shared: "if you're talking to a teacher, you're wasting their break and their lunch...or you are using all of that time where they usually have their own time."

As can be seen, it is not the emotional impact of the disclosure that participants in the present study worry about, but instead the time it would take out of a teacher's day. For example, participant 7 shared:

> When I see my teachers its purely just for the lessons, I could talk to my teachers about other things. But in my consciousness, I know that like they've got other classes, they've

got other students they've got, you know, work to look at, they've got to mark things, as with your tutor you know, that its specifically for you.

The role of the teacher in supporting mental health of students is one that has received a lot of attention. Research conducted by Graham et al. (2011) with teachers in Australia, found that whilst 98% of teachers who responded to their survey felt that supporting wellbeing is a part of their role, the time they are afforded to support students in this manner was limited. Such findings would validate the feelings of the participants in the present study, demonstrating that teacher time is an ongoing concern.

For the reasons identified, many participants explained that they would expect pastoral tutors, who have a designated well-being role, to have significantly more time and mental health training. As such, they would be more likely to seek help from them. Time, as will be discussed throughout, has an important and invaluable role in effective mental health support within colleges.

6.1.3 Theme 3: Feeling disempowered

Referring to past experiences of seeking-help, participants explained how disempowered they had been made to feel, and the factors which contributed to this. Participants were concerned that their own personal characteristics would impact the support they received. Professional help sought via children's mental health services was emphasised.

Subtheme 3.1. Feeling ignored

In phase one of the present study, respondents to the survey indicated the highest intentions to seek help were towards partners and friends. It is likely the finding in phase two, that participants unanimously expressed the importance of personal agency when seeking help for mental health problems, can partly explain this. Central to personal agency, as alluded to by participants, was being listened to. This reiterates previous reviews conducted by Gilmour, Ring and Maxwell (2019), who found that children and young people who had sought mental health support for suicidal ideation felt they were not listened to. In the present study, when explaining why being

listened to felt important, they emphasised that it made them feel acknowledged and validated, but also that the source from whom they were seeking help was displaying interest, and valued what they were saying. However, many participants suggested that this had not been their experience of help-seeking from adults in the past, and as such informed their expectations of seeking help in the future. For example, participant 1 disclosed:

> They [CAMHS] weren't actually listening basically, it's like they wouldn't take my word for things when they asked me... and... umm and then afterwards they gave me some CBT … and… umm, I tried to tell them…and tried to explain that wasn't working for me and I just think all kind of stuff like that, for me just seems ridiculous…but they wouldn't listen to me.

This comment is concerning because it suggests that past help-seeking efforts, and experience of receiving support from professionals, had left them feeling ignored, with limited influence over their support and negative expectations of help-seeking. Both of these feelings have been found to have a negative impact on engagement, outcomes and likelihood of seeking help in the future (Rickwood et al., 2005). However, this does also highlight a distinction which must be made between what is important *to* someone, and what is important *for* someone; considering both is central to person-centred working. Associated to RQ5 subtheme 1.2, the desire to collaborate with professionals on the process following help-seeking, is consistent with research conducted by Simmons, Hetrick and Jorm (2011). In this research it was identified that young people with major depressive disorder (MDD) reported varying experiences of being involved in the decision-making process in both primary care and inpatient settings. Like participants of the present study, they emphasised the importance of being involved in decision-making.

Also highlighted in the comment above, is an underlying reason young people might not feel listened to: mistrust. This concern was corroborated by a number of other participants who felt that professionals might not take what they are saying seriously. For instance, participant 4 shared: "I don't know, just that you're sort of over exaggerating, or you're not actually… I don't know… you don't actually need help… that you're just sort of making it up." The implicit feeling of distrust highlighted by this participant was felt by many others. For example, so that people

could “get it more”, participant 1 felt that it would be helpful if the professional, from whom support was being sought, could witness people in their moments of heightened distress:

> It’s important to have those breakdowns as well I think… because, I don’t know umm, then they can really get a sense of how I’m feeling and what I’m going through… umm… and not just take my word for it, if I say I panicked in ‘this’ situation because of this, they can really see how it is.

The right of a child to be listened to and taken seriously, is one that has received a lot of attention in government guidance (SEND CoP, 2015) and literature (Smillie & Newton, 2020), and is highlighted in the UNCRC:

> Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child (p.5, Article 12, 1989).

As highlighted in the literature review, a child pertains to anyone aged 18 and below, and therefore participants of this research.

As a result of the perceived distrust that professionals have of young people’s experiences, participants explained that they might not feel able to ‘open up fully’ with a professional. Such findings indicate that expectations young people have about their own role and the role of professionals in the help-seeking relationships are negative. The finding of feeling disempowered by professionals is concerning, given the literature which indicates service user empowerment is central to positive outcomes (Lynch, Vansteenkiste, Deci & Ryan, 2010).

By some participants, the perceived distrusting and dismissive attitudes of professionals were attributed to personal characteristics such as the young person’s age. For example, participant 4 shared:

> It's sort of like you can go and maybe your feelings be passed off as like…childish… or something, or… I don't know. Because you're younger, you're more inclined to feel like that or, yeah, or… maybe you've misunderstood the situation or something. But I think… I don't know. Maybe they consider children to be more emotional. So, it's just they're more inclined to feel that way.

This comment is poignant as it demonstrates scepticism young people have about the seriousness with which their problems will be treated. Participants who discussed this appeared upset that personal characteristics such as age could diminish or invalidate the feelings they were experiencing and suggested it would be easier for them to seek professional help if they were able to do so anonymously. Such sociodemographic characteristics have been found to negatively affect professional evaluations of, and encourage stigmatising reactions towards, children and young people with mental health problems (Martin, Pescosolido, Olafsdottir & McLeod, 2007).

These findings highlight the importance that young people place on feeling heard. This will be discussed again with reference to RQ6, subtheme 1.2.

6.1.4 Theme 4. Stigma

Participants were concerned with the stigma associated with mental health problems. Personal and perceived social stigma are both considered. Participants explained that being comfortable was incredibly important to seeking mental health support, as this is a pre-requisite of speaking open and honestly. Conditions for comfort varied for participants and included familiarity and anonymity.

Subtheme 4.1 Perceived stigma

When discussing expectations of help-seeking and help-seeking preferences, the stigma of mental health problems was alluded to frequently. Firstly, participants felt concerned that

seeking help for mental health related problems would feel uncomfortable, particularly from people you know. For example, participant 7 explained:

> If they personally know you, it's really embarrassing, because they're going to see you all the time, whereas if you're slightly distant. You don't have that kind of frequency with them. So you'll be less embarrassed, or you'll think about it less often, because you won't see them as often.

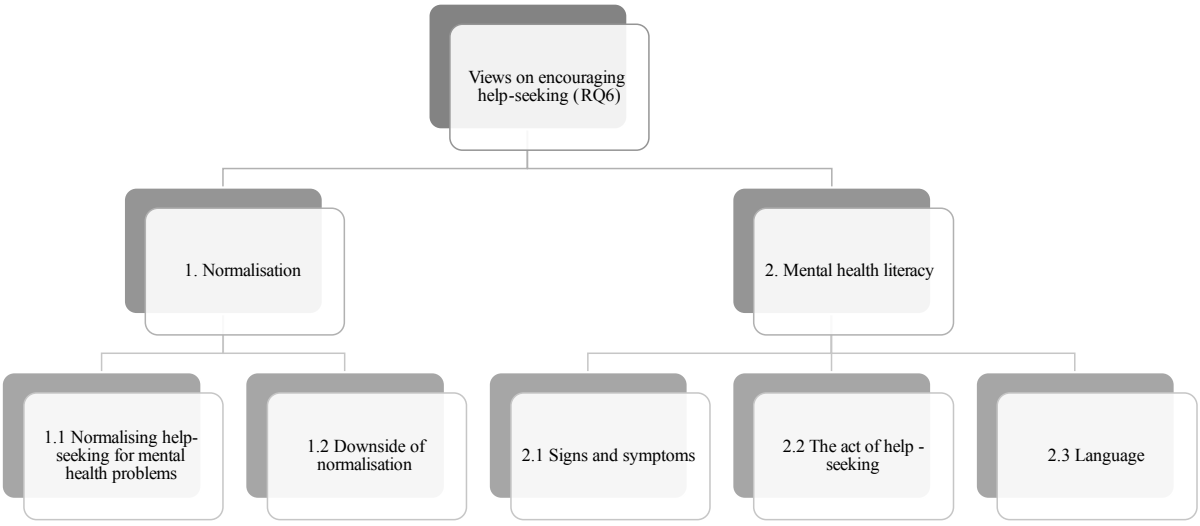
Moreover, participants were worried that attempts of help-seeking might affect the way they are perceived by others. For example, participant 3 shared their preference for seeking support from a professional because: "then I am not going to be seeing them all the time… and think that they perceive me differently." This finding is interesting because it would suggest that less frequent contact with the help-source would be helpful. On the other hand, participant 2 shared that they would much rather seek help from friends because, if they were to seek help from a teacher, "that's the last thing they will remember." Such findings indicate that young people might anticipate stigma for seeking help for mental health related problems. The role that stigma plays in seeking help for mental health problems is complex and has been well documented. Research conducted by Salaheddin and Mason (2016), with young adults in the UK, found that stigmatising beliefs about mental health and help-seeking were significant barriers. This has been further corroborated by Clement et al. (2015) in their review of the literature, which found stigma negatively affects help-seeking intentions. As a result of perceived and expected stigma, participant 3 explained that to avoid discomfort and embarrassment, they would try and "brush over" their problems: "I feel like I've convinced myself at this point, that given time, it'll just be… it'll be fine." Accordingly, they would not seek help.

6.2 Young People's Views on Encouraging Help-seeking (RQ6)

Two themes were identified in answer to RQ6. Figure 11 provides a visual representation of the themes and subthemes.

Figure 11

RQ6 map of themes and subthemes



With reference to relevant literature, each theme and the associated subthemes will now be described in greater detail.

6.2.1 Theme 1: Normalisation

Participants explained that normalising mental health problems and help-seeking would be beneficial to young people in post-16 settings. They explained that access to mental health support could be improved. Some described mental health provision in schools as 'hidden', making it difficult for pupils to know where they were could seek help from, if they were psychologically able to seek help. However, participants were mindful that normalising mental health problems, if not done carefully, could be detrimental to help-seeking.

Subtheme 1.1. Normalising help-seeking for mental health problems

To encourage mental health related help-seeking, participants explained that mental health problems, and specifically the act of disclosing problems or seeking help, needed to be more normalised, so that it is "less embarrassing" (participant 3). Closely related to RQ5 subtheme 4,

participants demonstrated concern that they should not be talking about mental health problems, and as such would be perceived as different for doing so. For example, participant 3 explained that they wanted "everyone to feel like the way they think is not irrational… well actually maybe it is… but they should not feel like… because of that… they are not allowed or shouldn't talk about it."

Participants attributed beliefs such as the above to the stigma associated with mental health, which makes it challenging to speak openly about it. This is consistent with a review of the literature conducted by Kaushik, Kostaki and Kyriakopoulos (2016), who found that of the 42 studies that met inclusion criteria, all identified young people with mental health difficulties experienced stigma. For example, participant 7 shared:

> With mental health, it's kind of looked down upon and looked as weak, because I just thought in my head like, oh, when you said the sick bug, I was thinking of taking a day off at home, because you're ill. And then I was thinking if somebody wants to take a mental health day, and they came back in and somebody went, 'oh why were you off?' and they go, 'Oh, because I had a mental health day', like people would take the mick out of them.

As highlighted in this comment, stigma associated with mental health is greater than that for physical health (Martin et al., 2007). Interestingly, participants drew further comparisons between physical and mental health problems to highlight why the attitudes towards them might differ. Participant 7 explained:

> I feel like physical health, if you cut something, a broken leg… it's completely obvious. And it's very common and normalised because it's happened forever. And it's not a modern thing as mental health is much more modern. Mental health, you know, people still don't know about it… you know, emotional wellbeing is very modern compared to physical wellbeing. And also… you can't see it.

This comment highlights two important reasons participants feel mental health has not been normalised, yet: knowledge of mental health is in relative infancy when compared to physical health; and, mental health is often not observable. The former is associated with RQ6 subtheme 1.2, and will be discussed in greater detail later; the latter however, relates to the ease with which people talk about and share their own mental health problems with others, particularly where it is invisible.

Participants explained that they were happy to talk to their friends in confidence about mental health problems, but that the ease with which mental health is openly discussed, is largely the consequence of the irregularity with which conversations take place in a larger forum. For example, participant 8 explained: "I feel like… talking about issues like that isn't... like a normal thing. It is not done all the time by everyone." Many participants attributed this to the "stigma around mental health" and "feeling embarrassed", a barrier identified in earlier research (Clement et al., 2015; Gulliver et al., 2010). To overcome this, participant 7 felt that understanding the ubiquity of mental health problems would be the first step towards encouraging talking about mental health and help-seeking: "I think getting to the point of seeing other people with problems, probably no one is just completely breezing through happy, whatever. So, I think to become properly comfortable, it has to be normalised which is no easy thing." In a narrative review of 23 studies looking at the impact of various educational interventions addressing mental health related stigma, Yamaguchi, Mino and Uddin (2011), found that in the short term, attitudes towards people with mental health problems and knowledge of mental health problems improve. However, the long-term effects of such interventions are unclear.

Gender was felt to play a role in the normalisation of mental health help-seeking by many participants because of socialisation, stigma and mental health visibility. Participant 2 explained that because of being brought up with the "masculinity thing" and "men don't cry" it is more challenging for males to openly discuss mental health problems, something which has been previously been recognised in the literature (Clark et al., 2018). Participants reflected on their experience at both school and college, highlighting that at times female peers had cried in class, or left class crying, but that male peers had never been observed doing this. This finding is

consistent with those of Clement et al. (2015) who, in their review of the literature, identified that young people, particularly males, are disproportionately deterred from seeking help because of stigma and the perception that it is not normal for men to have mental health problems. As such, participants in the present study felt that to normalise mental health problems and help-seeking, hearing stories from peers with whom they relate would be more beneficial than hearing stories from people with whom they struggle to identify: “I think young people in general to other young people, and that's a big part… and people that influence them” (participant 3). Relatability is well known to be a factor underpinning social influence (particularly for young people who seek affiliation with their peers and use them to make sense of social norms) and should be used to encourage positive behaviour change (Foulkes, Leung, Fuhrmann, Knoll & Blakemore, 2018) and increase mental health support (Clark et al., 2018).

To further encourage help-seeking, participants emphasised that barriers to accessing mental health support and the negative attitudes towards mental health support needed to be challenged as they fuel the narrative that needing help for mental health problems is not normal, For example, participant 6 shared: “I feel like it's that stigma, you know, other people, you know, therapy, just the stigma as a whole.” Participant 7 reflected on how hidden support felt at their school and the message this conveyed to the students: “we had a drop-in nurse clinic on Thursday. We could talk to them about mental health, but we didn't even know where the room was.” The feeling of resources being hidden was echoed by all participants, with some indicating that because mental health support was “hidden” it made them feel “different” for needing it. For example, participant 6 shared:

> It feels like your problem, you know, you're not so much cared about. And that, you know, your school system or area doesn't, you know, mental health isn't so much of a problem that actually, you know, that people suffer from, and that you are somebody who needs to go out your way and actually no one in your area … no one in your school needs these resources. So, you've got to find them online.

Such reports of feeling “different” or “embarrassed” for help-seeking are supported in the literature. In their research with American undergraduates on attitudes and willingness to seek

help, Vogel et al. (2007) found that perceived public stigma, the social acceptability of a person based on the perception of others, was found to predict self-stigma (one's own perception of the self as socially acceptable) and subsequent attitudes towards, and actual help-seeking.

Whilst it is concerning that participants of the present study feel stigma around the act of seeking help has been reinforced by some institutions, optimistically, they felt that things had significantly improved since their transition to post-16 education. They explained that, whilst experiencing mental health problems, and seeking help for them, is still not perceived as "normal" or a "normal thing" to talk about or do, as progress is being made, and mental health problems are becoming increasingly 'normalised', the negative attitudes and stigma towards mental health problems and help-seeking are reducing. Participants felt that empathy and support from teachers who felt comfortable talking about mental health was a key factor in normalising problems and encouraging mental health help-seeking. MHL of post-16 staff will be discussed later.

Subtheme 1.2. Downside of normalisation

Participants highlighted that in the process of normalising mental health problems, a set of new challenges to actual help-seeking have been created. They discriminated between two ways that normalisation can be problematic: comparing themselves to others; and, what other people say to them.

In relation to comparing themselves to others, participants felt, that because their friends share their mental health problems with them, they often minimised, "put up with" or 'brushed off' their own mental health problems. For example, participant 3 shared: "in comparison to them, my issues seem quite irrelevant, not irrelevant, but like, they didn't seem nearly as vast as they seem to me." Such findings are consistent with those of McDermott, Hughes and Rawlings (2017) who found that, due to normalising their emotional distress, young people would delay help-seeking until problems had escalated to the point at which they could no longer manage. A theory for understanding this phenomenon has been developed by Biddle et al. (2007) who explain that young people differentiate between 'real' distress and 'normal' distress. According

to Biddle et al. (2007) the threshold for the former, in part due to normalisation, is continually increased and subsequently help-seeking decreases. Whilst this can be understood as an avoidance strategy, participants of the present study felt that it was a barrier.

Participants also highlighted how normalisation can result in misappropriation of mental health problems through language, delegitimising their experiencing and making it harder to identify whether a problem is in need of help. For example, participant 4 shared:

> It's kind of… its always about how you phrase something… if you're feeling really stressed but then someone else says 'oh I am really stressed too... it's fine', then you're like... 'oh… okay it must be fine then'… like even if it has been normalised doesn't mean it is a good thing… it just makes it harder to go 'oh, there actually is something wrong.

Whilst the intention of peers may be to support, normalise and empathise, such flippant use of language was thought to be dismissive, and a challenge to help-seeking. The impact of language was considered by a number of participants, with participant 3 explaining:

> The thing is we all use the word stress… so if someone else is stressed you think 'I'm stressed too' and if they have gone 'it's fine', you feel like you should also go... 'oh yeah its fine'. So, it's sort of like… the actual vocab you use… I have just realised how much of a difference that makes.

It may be suggested from such findings that supporting young people to understand the impact of language would be beneficial to encouraging help-seeking, which is related to the next theme. However, participants were mindful that other people may be experiencing mental health problems, so were cautious not to minimise these.

6.2.2 Theme 2: Mental health literacy

Participants highlighted the need for more general psychoeducation around mental health problems, including identifying signs and symptoms of mental health problems, knowing the

process of getting better and knowing how to seek help. Further, language was felt to be a significant barrier to help-seeking. Participants were able to consider what mental health vocabulary would be needed to encourage and enable help-seeking.

Subtheme 2.1. Signs and symptoms

To encourage help-seeking, participants felt it was essential that more information was provided on recognising the signs and symptoms of mental health problems. A number of participants differentiated between mental health problems and mental illness, explaining that much of the information they had been given at school was about the latter. For example, when describing Personal, Social and Health Education (PSHE) sessions that focused on mental health problems they explained that, rather than exploring low mood or worry, they instead explored "mental disorders" such as anxiety, depression and anorexia nervosa. Whilst participants felt that this was undoubtedly useful, exploring the signs and symptoms of mental health problems unrelated to "mental health disorders" would have been more beneficial. For example, participant 8 explained that because they had been taught anxiety and depression in a "this is this and that is that" quickfire manner, unless things were "really bad", they would not recognise a mental health problem and that they needed to seek help. The reason for this, they explained, is that the message portrayed by schools is that it needs to be a "big illness" before it warrants help, which is related to RQ7 Subthemes 2.1 and 2.2. This would appear to be consistent with research conducted by Burns and Rapee (2006), who in their research with Australian young people aged 15 to 17, found that the ability to identify depression was hindered by the absence of more obvious and concerning symptoms such as suicidal ideation. This has more recently been corroborated by Reavley et al. (2012), who in their research with Australian university students and staff, found that 70% of respondents were able to correctly identify depression but were less likely to identify stress (students 6%; staff 10%) and more general psychological problems in need of support (both 3%). Instead, participants of the present study suggested that mental health education should be focused on more general feelings of mental ill health and the advantage of seeking help for the "smaller things". For instance, one participant felt adopting a "here are some of the signs, and even if you do feel something this way, but you don't necessarily think it's a mental health illness, it is important to talk about it" approach would be important to support

people in recognising when they should seek help. Further, participants also felt that the advantages of help-seeking, regardless of how big or small a problem may be, was an important message for school and college to share. For example, participant 5 explained that mental health education should be:

> Less specific to certain mental disorders… like…I know that depression and anxiety are mentioned a lot because obviously they are the most common, but… to not necessarily be specific…and just speak generally…and talk about the benefits of it [help-seeking].

Such findings suggest that understanding both eudaimonic and hedonistic elements of mental health (from flourishing to languishing), on top of understanding the second continuum of 'mental illness', would feel more helpful.

Participants also explained that they wished the signs of mental ill health had been explored so that they were able to recognise the challenge that they presented to help-seeking. For example, participants all reflected on the idea of deserving help or being worthy of help. It was suggested by participant 7 that "the first step in changing that [feeling of unworthiness] is recognising that feeling unworthy of help is one of the symptoms of most of the mental disorders… and that it's the mental disorder and not you." Participants felt that if such symptoms could be understood then the options to help-seek would feel greater for young people, because they would be able to understand and 'rationalise' feelings of unworthiness. This finding is consistent with those of Ratnayake and Hyde (2019), who in their research with 16- to- 18-year-olds in Australia, found a positive correlation between MHL and help-seeking behaviours.

Subtheme 2.2. The act of help-seeking

When talking about sources of help available, participants unanimously felt that there is a lot of information about where help can be sought around their post-16 settings, in the form of leaflets and posters. However, a few emphatically highlighted a number of concerns: knowing where to get the "right" help; and, knowing "how" to seek help. Participants felt that once both of these

concerns were addressed, it would be easier to seek help in post-16 settings. Both will be discussed in turn.

With regards to knowing where to get the "right" help, many participants explained that they can feel apprehensive about identifying which source would be most appropriate. For example, participant 4 explained: "so, it's like you want to ask, but you don't know who to ask because of the situation." The anxiety that there is an objectively 'wrong way' of seeking help was echoed by many participants who were reflecting on personal experiences of seeking help for themselves and/or their friends, and the concerns they had. Participant 4 went on to explain:

> I mean, you're always told like, where to get help. But like, I knew it was like… go talk to a teacher. There's like, I don't know... website's… and like, I don't know, I feel like, it's just getting the right help. Because you know, where all the sources are, but you just don't know which one to use, that's right for you.

Interestingly, only three participants explained that this anxiety was due to experiences of being told they had got it wrong. For example, participant 6 described one such incident: "I was told by her [school counsellor] that it was selfish of me to have gone and spoken to my teacher because that wasn't her responsibility." This would seem to correspond with participant perceptions of whose role it is to provide mental health health support (RQ5, subtheme 2.2). Further, participants shared that if they have sought help, they then ruminate on whether it was the right thing to have done. For example, participant 4 explained: "I don't know, if you talk to the teacher, and then realise that you might not have needed to, and you could have gone somewhere else that sort of makes you feel like you've done something wrong." When discussing the concern of knowing 'how' to get help, participants further demonstrated anxiety that there is a "right" and "wrong" way of seeking help. For example, participant 3 explained: "I guess like the anxiety that might come with that you don't know if you've actually done it right. …like 'have I sought help in the right way?" Related to RQ7 subtheme 2.1, participant 3 explained that 'disheartening' rejection from help sources over the years does not help to alleviate the belief that there is a correct way to seek help. It may be implied from this finding that young people have a fear of help-seeking failure. Discussions around the fear of help-seeking correctly, with

regards to mental health help-seeking, could not be found in the literature. However, fear of academic failure and help-seeking incorrectly for academic needs, has been widely reported as a barrier to learning engagement (Caraway, Tucker, Reinke & Hall, 2003).

To overcome the anxieties described above, participants explained that there needs to be some clarity about what help is available and, who or what help is appropriate for different situations. For example, participant 7 explained that in their setting it was made very clear *who* initial help could be sought from:

> Our personal progress tutor who helps us… like… the main reason we have them is to help us with you know, mental health and grades, and you know, well-being all of that area. So, it's like a designated person…who's also very friendly.

Participants at the setting felt that being afforded regular contact with someone who they know has well-being support as a part of their role, made help feel more accessible and facilitate the process of seeking it. However, participant 4 still felt that there was uncertainty about how much mentors could reasonably do and the usefulness of seeking help from them: "you don't know where the line is and what teachers will actually be able to do to help you."

With regards to knowing "how" to seek help, participant 5 felt it would be useful if there were clear instructions: "I feel like if you were seeking help, you need a bit more… like the instructions would need to be a bit more specific". Alternatively, participant 6 explained it would be more useful to challenge the idea that there is an objectively correct way of seeking help. They suggested the message post-16 settings should be giving to young people, to encourage help-seeking is: "the worst-case scenario is it [the mental health problem] will get better and the best-case scenario is you didn't need to go [seek-help] anyway." If such a message was disseminated in post-16 settings, this would mean the source of the problem, the belief that there is a right or wrong way to seek help, would be alleviated.

Further to knowing where help can be sought and how to go about this, participants felt that it would be useful to know what happens once help-seeking has occurred. Although this is partly

related to RQ6 subthemes 1.1 and 1.2, participants explained that whilst many videos are shared about people who have sought help, and how it has been successful, little is known about what that process entailed. For example, participant 8 explained their frustration of being shown videos of success stories, with little information about the process that followed the help-seeking: "and then they say [person on the video] 'and then I sought help', and they don't say anything beyond that… and it is like… well… 'what do I do when I get to that stage? How do I continue on?'" Such concerns about the unknown were highlighted in a review of the literature by Gulliver et al. (2010), who found that having pre-existing and transparent relationships with the source of help can abate fears of the unknown, encouraging help-seeking.

Subtheme 2.3. Language

Participants made a number of references to the language of mental health and help-seeking. They indicated both explicitly and implicitly that talking about mental health can be difficult, not only because of the emotions and perceived stigma associated with mental health, but also the difficulties associated with verbalising and communicating how they are feeling and what they need. For example, participant 8 explained: "mental health issues isn't really talked about... like, so I guess people wouldn't really know how… how to express it and how to tell people how they are feeling." Exacerbating the difficulties of finding the right mental health vocabulary was time. Participants expressed a real awareness that speaking with formal sources of help, such as teachers and GPs, meant that the time they have to express how they felt was limited. This was highlighted clearly by participant 4:

> I think… I don't know…sometimes if you… I mean like right now 'm struggling to find words for things and like… if I was with a friend... you can kind of sort of, I don't know, you might eventually get there. I don't know… if they know you quite well. But with a teacher, if you're sort of on the spot, and you're like, Oh, God, I don't know, actually, what I'm trying to say I don't know what's wrong, but there's something wrong.

Such findings indicate the troubling intersection between comfort of speaking about mental health, the actual vocabulary and the time that people have to share their problems.

Concerningly, research has indicated that the language young people use to describe their mental health has significant effects on how they are responded to. For example, research by Kessler, Lloyd, Lewis and Gray (1999) has identified that 'psychologising' symptoms, rather than using 'normalising' language, increased positive outcomes. These findings suggest that increasing mental health vocabulary will lead to beneficial outcomes for young people.

Interestingly, and associated with RQ6 subtheme 1.1, participants did not feel that verbalising physical problems was necessarily any easier, but that they are a much more 'shared experience' and are observable. For example, participant 6 explained: "if you go in [to a GP surgery] and you've got an injury, you can go in and be like, yep, I've broken my arm. I'm bleeding. But you can't show someone something [with mental health]." Where problems are physical, participants placed less emphasis on the need for language.

To overcome these difficulties and to make mental health support in post-16 settings more effective, participants felt that they should be supported to develop scripts around seeking help for mental health problems. For example, participant 1 suggested: "I guess… a way to solve that would be to give us some information… or giving us information specifically on how to start that conversation with someone. A few pointers I guess?" By developing such scripts, participants felt that asking for help would be easier and less anxiety provoking. For example, participant 5 shared:

> I guess, just giving people phrases that they can use, that they can say when they need help. So that when they recognise that they do [need help] then they know exactly what to say and that I guess takes the pressure off of it a bit.

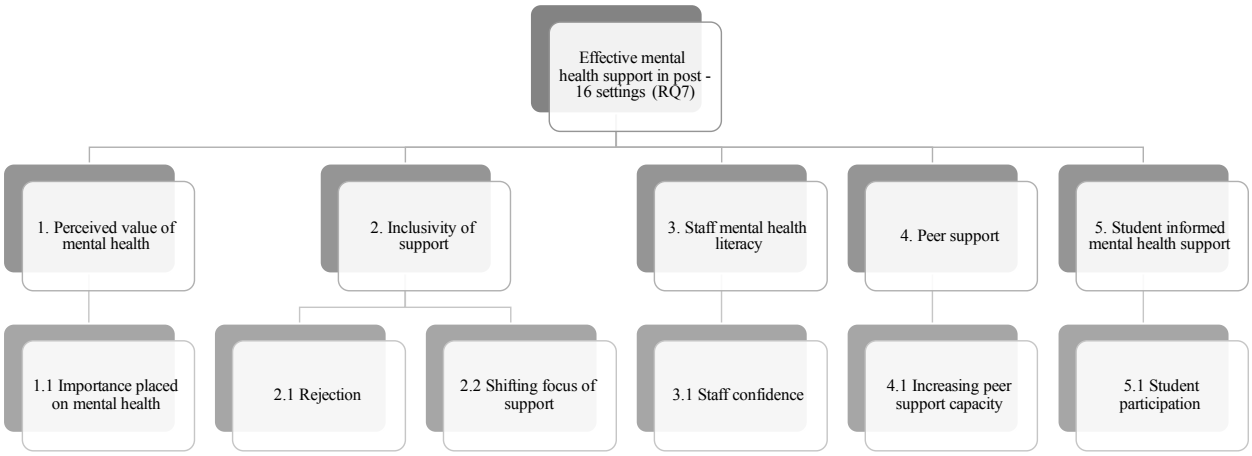
Whilst the literature around mental health related help-seeking scripts is limited, it has been suggested that academically focused help-seeking within the classroom may be encouraged through developing clear scripts with students (Karabenick & Dembo, 2011). Therefore, it is reasonable to suggest the same benefits would be observed if applied to mental health help-seeking.

6.3 Effective Mental Health Support in Post-16 Settings (RQ7)

Five themes were identified in response to RQ7. Figure 12 provides a visual representation of the themes and subthemes.

Figure 12

RQ7 map of themes and subthemes



With reference to relevant literature, each theme and the associated subthemes will now be described in greater detail.

6.3.1 Theme 1: Perceived value of mental health

Reflecting on mental health education and provision in both school and college, participants explained the limited value they felt had been placed on mental health. Some described the provision of some schools and colleges as a 'tick box exercise', impersonal and unaccountable for the mental health of its students. However, participants recognised systems within their post-16 settings which were beneficial and felt that embedding mental health within the culture of the setting, and ensuring inclusive practice which considered the voice of young people, was

essential. Participants also suggested equipping young people with the skills to support one another would be helpful.

Subtheme 1.1 Importance placed on mental health

Reflecting on their experiences in school and college, many participants felt that mental health support had been largely ineffective. Participant 8 explained that mental health was not "a main talked about issue" and the presence of mental health and support was sporadic, with many citing PSHE and infrequent assemblies as their only source of information. The irregularity with which mental health was "taught" or "discussed" was interpreted as representing the diminished value that schools and colleges placed on it, with participant 7 stating "it makes mental health seem like nothing really". Such comments would appear to be consistent with the findings of Formby and Wolstenholme (2012) who, in their research of PSHE in English secondary schools, found that the schools which place less value on the broader aims of the PSHE curriculum, afforded it little time within the timetable. Whilst PSHE is currently not a statutory requirement for schools, participants explained that learning about mental health should be a compulsory part of the curriculum. Many felt that whilst they are given lots of resources, such as websites and phone helplines to call, the lack of a "personal level" made it feel like they were being "brushed off" or the problems "passed on". For example, participant 7 went on to explain:

> You get given all this information and you're like 'yeah, okay that's fine, like I've got it' but there is no personal level to it, there is no connection, there is no emotion, there is no sense of help, it's just a sense of we're here… it's not... its showing 'we've got it if you want it, take it if you want it'. It's not like, you know 'we're here for you, we care about you', it's just like we have been told to give you these numbers, so take them.

As highlighted in this comment, participants also perceive this manner of mental health support as superficial, and a "box ticking exercise." Further, participants expressed dissatisfaction with the teaching methods utilised when delivering mental health sessions in assembly and PSHE. They explained that much of the delivery was didactic, with little opportunity for meaningful discussion. With regards to such pedagogy, participant 8 suggested that in order for mental

health support to be effective in school and college "you should be taught it... and actually explore it… rather than just know it" because of the emotional nature of mental health. The benefit of being afforded opportunities to discuss mental health with peers, whilst facilitated by a professional, was reiterated by many participants. Such findings are interesting in light of the research conducted by Davies and Matley (2020) who, in their research on teacher views on the content and delivery of PSHE, found that discussion and interactive teaching methods were favoured.

Optimistically, but in slight contradiction of the above findings, participant 6 explained mental health had a greater presence in college than school: "I haven't been at college long, but they have spoken a lot about if… if you know, if you need help, you can go to them [in-college support]." Through exploring the perceived difference between school and college mental health support, participants highlighted that staff appeared more equipped to talk about and engage in conversations of mental health, which subsequently made them feel like they were more cared for, despite the overall staff structure remaining the same i.e. having subject teachers and pastoral tutors. Participants explained that having mental health embedded in the college culture, and teachers taking advantage of natural opportunities to address mental health problems, not just in the allocated yearly one-hour session, made mental health seem less like a tick-box exercise. Such support, according to many participants, was more effective because mental health became less of a taboo and unspoken topic. These findings are consistent with the views of 89% teachers, who in Davies and Matley's (2020) research felt that embedding PSHE into other lessons was important. However, participants of the present study were cognisant that such embeddedness of mental health, relies largely on staff MHL and confidence, an issue which will be discussed later.

6.3.2 Theme 2: Inclusivity of support

The need for support for 'smaller things' was referenced by many participants. This was in light of the general feeling that mental health support was only for those who are 'high risk' and those who do not fulfil this criterion will be rejected. Consequently, participants felt that they would need to wait for their problems to get worse before they could ask for help.

Subtheme 2.1. Rejection

Despite the aforementioned increased mental health awareness in colleges, participants were concerned that if they were to seek help, they would still be rejected. Participants explained that when they or friends had sought help in the past from both education and health, they had "hit a brick wall", with participant 6 stating "the person who was there for mental health and stuff… she would turn people away straight away, and be like… 'if you are not on my list there is nothing I can do for you'." Participants shared that such an experience felt dismissive and disparaging, and the fear of rejection reduced the likelihood that they would seek help again. This finding is unsurprising given the increase in mental health needs in children and young people. Whilst school and colleges have increased their capacity to support pupils (AoC, 2017), the challenges to accessing mental health support have also increased, often resulting in colleges unable to meet student need (Prince, 2015). Further, research conducted by the Education Policy Institute (EPI) found that, on average, 25% of referrals to specialist services were rejected during the 2018-2019 financial year due to conditions 'not being serious enough' (EPI, 2019). Whilst this research has been criticized for not recognizing that CAMHS is available to young people with significant need, the narrative identified by participants, of help being available when needs are 'bad enough', is perpetuated.

Participants were concerned that knowledge of the above, and the lack of resources available to young people, partially accounts for the general feeling within schools and colleges, that mental health support is exclusive, reactive and often ineffective. Participant 3 explained that previous support appeared available only for people who were/are experiencing what they referred to as "significant and diagnosable" mental health problems, or were "at risk": "it's not like other people are more important than you… I understand that if they're a risk to themselves, it's really important that they be helped. But yeah, it's still just kind of like, it's still disheartening, I suppose." Participants, whilst recognising that help and support should be, and is theoretically, available to everyone, implied that such a belief of who support is available for is a variable which significantly reduces the effectiveness of mental health support. For example, participant 7 shared: "I've been told, you can only get therapy if you're on the verge of killing yourself. Like

somebody literally said that sentence to me. And it's awful." Participant 8 felt that comments such as this fuelled the narrative that they should not seek help as "it [their problems] won't be seen as important", because the person from whom help is sought ordinarily deals with 'things much worse'. Worryingly, participant 4 stated that consequently, "sometimes you just write off your own feelings as well. You are worried that other people are going to do it, so you do it to yourself." Further, participant 3 explained that they had been told by one of their friends that "they were going to stop trying, because they'd been on lists and waiting for so long. And nothing happened that they were just, they just thought I never would, and there was no point anymore." Reducing waiting times was a focus of the Green Paper released in 2017: Transforming Children and Young People's Mental Health Provision (DoH & DfE), in recognition of the significant impact that this has on young people. Unfortunately, recent statistics would indicate that this has not yet been achieved (Crenna-Jennings & Hutchinson, 2020). From these findings, it may be implied that some participants felt they were not entitled to help, as others have more significant difficulties. In the current climate, this is alarming and highlights a disquieting trend that young people "write themselves off, so others won't" as an act of self-preservation.

Participants also raised the concern, which is related to RQ6 subtheme 2.2, that being rejected or refused help when it is sought, made them feel like they were 'doing it wrong', substantiating their fear that they did not know where or how to get help. Participant 4 explained "I hate getting things wrong. So, it's sort of, I guess it depends on the person, but if you're already sort of in a state, and maybe you're really anxious about something… you can feel like you're making it even worse." The phenomenon of not knowing where to seek help and the anxiety of help not being available when required, has been identified in previous research by Fox, Blank, Rovnyak and Barnett (2001).

Subtheme 2.2 Shifting the focus of support

Participants felt that the narrative around entitlement to mental health support led to its ineffectiveness within schools and college. They explained that consequently, people would often put off seeking help for mental health problems until they were "really bad". Participants

identified two ways support in schools and colleges could be more effective: mental health education should be less specific to certain disorders, so that people don't write themselves off as not having them (previously discussed in answer to RQ6), despite experiencing some of the distressing symptoms that can be alleviated through support; and, a preventative rather than reactive approach to mental health problems should be adopted.

Participant emphasis on prevention, is consistent with the recommendation schools and colleges are an "important site for mental promotion and mental ill health prevention" (p. 66; DoE, 2017). Participants suggested such a shift in focus would increase the availability of support for those with "lesser problems." Most notably, participants wanted greater recognition and transmission of the message in college that help is available to everyone, despite the perceived severity of the problem experienced. Participant 5 explained this could be achieved through "affirmation that everyone is worthy of help… and just reminding people that no matter how silly or insignificant… if it is causing you like harm, then it's worth seeking help for." The frustration with the notion that a problem must be bad before help is sought was echoed by participant 7 who felt: "if you've got a small problem, it's still a problem… so you can talk to somebody about it, you can ask for help about it." The need highlighted by the participants for early identification and intervention for mental health problems is widely acknowledged to improve outcomes for young people and their families (Honeyman, 2007). However, in the present study participants indicated they are not taught to identify issues as they arise and as such they often escalate. For this reason, they stressed that learning to identify problems and strategies to manage these should be provided as part of an effective mental health strategy within colleges, rather than being taught that mental health support is only available for, and in reaction to, "a proper mental health issue" (participant 7). Whilst there is a paucity of research on universal prevention programmes with pupils attending post-16 settings, this is consistent with reviews of the literature which have found that early intervention programmes aimed at preventing the development of anxiety reduced the incidence of anxiety disorders in children and adolescents (Fisak, Richard & Mann, 2011; Neil & Christenson, 2009).

6.3.3 Theme 3: Staff mental health literacy and confidence

Participants highlighted that having staff in their setting who are happy to engage in conversations about mental health with confidence, and provide opportunities to talk about mental health, would encourage help-seeking.

Subtheme 3.1 Staff confidence

Related to RQ 7 theme 1.1, participants recognised the important role that college staff play in embedding mental health within the culture of the college, and suggested this is a significant indication of how effective mental health support is. Participants explained that the members of staff from whom they would seek help, embedded mental health within their lessons by being "open about things" and sharing stories from their personal life. Participants felt that when teachers are open about their own mental health difficulties, it supports the development of a "connection" between them and the class, and normalises talking about mental health. Further, participant 7 felt that it helped to address the power imbalance that exists between teacher and pupil, something which often deters help-seeking, by "giving people opportunities to be on the same level." Participant 7 went on to explain: "from my experience, when people have like opened up first, it's been much, much easier to come out and open up to them as well." Further, participants felt that the teachers who best support mental health also display 'interest' 'curiosity' and 'empathy' when they notice that pupils do not seem themselves, and often provide opportunities to talk about what is going on.

Reflecting on the differences between staff they would approach and staff they would not, participants felt that underpinning the ability of teachers to embed mental health within their lessons was: their MHL; confidence addressing mental health problems; and, whether they perceived they had a role promoting and preventing mental health problems. For example, participant 7 explained that some teachers are clearly "just there to teach". In research conducted by Graham et al. (2011) it was identified that whilst 70% (n=508 teachers in Australia) of teachers indicated that they would be willing to engage in universal and targeted mental health interventions, 25% felt they were ill-equipped. Further, they found that 30% of respondents lacked confidence to discuss mental health within their classrooms. Interestingly, they felt it was easier to support people in their personal lives, than their professional, indicating the different

expectations placed upon their various roles. This has also been highlighted in the work of Warwick et al. (2008) who, in their research of further education practitioners, found that whilst teachers can learn and demonstrate active listening and empathy, knowledge of referral processes and sources to signpost are essential. Further, they highlighted, as has been experienced by the participants of the present study, that not all teachers feel compelled to engage students in conversations about mental health, as a part of their role. More recently, research conducted by Shelemy, Harvey and Waite (2019), found through conducting interviews with seven secondary school teachers, that they felt unable to meet the emotional needs of their pupils, and as such required further training, resources and clearer guidelines.

6.3.4 Theme 4: Peer support

Participants suggested it would be beneficial to learn how to support peers with mental health problems due to the frequency of disclosures they receive.

Subtheme 4.1 Increasing peer support capacity

Consistent with the findings of phase one, participants shared they often seek help from friends and are the recipients of many friend disclosures, despite the guilt expressed in RQ5 subtheme 2.1. This finding is unsurprising given the evidence from neuroimaging and behavioural studies which show increasing importance is placed on relationships and social networks during adolescence (Blakemore & Mills, 2014). The benefits of seeking help from friends is well documented in the literature. For example, research conducted by Latina, Giannotta & Rabaglietti (2015) has shown seeking help from friends, and co-rumination of problems can decrease the likelihood that a young person will engage in self-harming behaviour. Such findings indicate that helping young people to support their peers should be included in any effective mental health strategy in post-16 settings. However, in accordance with previous research conducted by Olsson and Kennedy (2010), participants in the present study reflected on their experience of receiving disclosures from their friends, expressing concern that often they have not known how to support them. For example, participant 4 explained: “when my friends come to me… I haven’t really known what to do.” This feeling was shared by many participants, who

highlighted that there were a number of dimensions to supporting friends effectively: knowing how to respond appropriately; feeling equipped to say the right things, which is associated with the findings of RQ6 subtheme 2.3; and, understanding the point at which concerns need to be raised with professionals. The latter of which, participants explained they grapple with when told in confidence. For example, participant 4 went on to share: "friends would tell me stuff and specifically tell me not to tell other people and that's sort of where you don't know where the line is." Participants unanimously felt they wanted to continue to support their friends with mental health problems and were keen to emphasise that their friends had not been an imposition to them, nor that the information was a burden. However, they did feel that they had not been taught, or given the opportunity to explore what good peer support could look like. As such, participants felt that in order for mental health support to be more effective in post-16 settings, young people need to be equipped with the relevant skills to support each other. According to Naslund, Aschbrenner, Marsch and Bartels (2016)**,** schools are in a good position to encourage peer support in both formal and informal ways. Research conducted by Houlston and Smith (2009), with a school in West Sussex, specified the five key elements to good peer support, which included increasing student knowledge around: communication and active listening; ensuring a non-judgmental attitude; knowing limits of expertise and when to refer; confidentiality and ethical issues; and, child protection issues. Further, research conducted by Hart et al. (2018) in Australia, found that training students aged 15 to18 in 'teen Mental Health First Aid' (tMHFA), which includes knowing how to respond to disclosures, increased first aid intentions and MHL in young people. These findings suggest that whilst increasing knowledge is helpful, providing young people with a step-by-step action plan of how to respond is beneficial to increasing efficacy of support.

Such training was felt to be missing in the post-16 settings that participants attended. Participants suggested the opportunity to openly discuss mental health problems frequently faced by young people, and knowledge of what could reasonably be expected of a friend, would increase efficacy of mental health in colleges. For example, participant 8 stated:

> There could be like … probably like meetings set up where you can just go along and have a chat with people the same age as you, about the kinds of issues that you face and just have a safe space where you can talk about expectations.

Such peer support interventions (PSI) are already highly regarded within school settings, whereby support can be given on a one-to-one or group basis in a planned and structured manner (Coleman, Sykes & Groom, 2017). Participants of such interventions undergo training which enables them to fulfil their role within the intervention. Such interventions have been found to be successful in in the UK with primary and secondary age pupils (Baginsky, 2004) and University students in America (Shaw & Gant, 2002). However, there is little evidence to suggest that they have been utilised in the post-16 settings in the UK.

6.3.5 Theme 5. Student informed mental health support

Subtheme 5.1 student participation

As previously demonstrated (RQ5 subtheme 1.1), participants value being listened to, and having their views considered. As such, when discussing increasing the effectiveness of post-16 mental health support, participants explained that they would like their views to be taken into consideration so that their need informs provision. For example, participant 1 explained that in order for support, on an individual or whole-setting basis, to be more effective, then it would have to entail: "listening more to what young people say they need… umm… just yeah… listen to what they say they need, listen to what they say doesn't work." Policy in the UK has indicated that the support children and young people receive should be person-centred (SEND CoP, 2015). This means young people should be treated as experts in their own health, and with views which are not only worth eliciting, but used as a directive for decisions that are made about them and the support that is put in place.

The involvement of young people in developing mental health strategies has recently been researched by Atkinson et al. (2019) who, through employing the support of 12-to-18-year olds attending a grammar school in the development of a mental health strategy, found that in order

for systems to be effective, it was essential that models of mental health support were not taken from existing models used in adult mental health care. Instead, models of mental health care for young people should be informed by the experiences and needs of young people. Further, in light of previous findings from the present study, especially those discussed in RQ6 subtheme 1.1, having peers advocate the strategy would encourage other pupils with whom they relate, to engage with it. The idea that incorporating young people's views in a mental health strategy, and positioning them in the centre of their care, be it in education or health, has been supported by Wills, Appleton and Brooks (2008), who found that including the conceptualisations and experience of mental health, according to young people, will increase effectiveness and positive outcomes for them.

Chapter 7. Overall Discussion

The two phases of this study examined the mental health help-seeking behaviours of young people attending post-16 settings. From the outset the aim was to explore the intentions of young people to seek help, factors affecting help-seeking behaviour, and the impact that COVID-19 has had on mental health and the support available to young people. The present study also sought to examine what young people felt encouraged their help-seeking, what their expectations would be if help was sought, and what post-16 settings can do to ensure that mental health support is effective.

Through the use of a sequential mixed methods research design, I was able to gain a breadth of information about the help-seeking intentions of young people, mediating factors, hopes for help-seeking, and the impact of COVID-19 in phase one. This was followed by phase two, which enabled breadth of understanding around encouraging help-seeking and how young people feel support may be made more effective. As with a true mixed-methods design, it is imperative that the different phases of the research are integrated at some point throughout the research process (Tashakorri and Teddlie, 1998). Whilst phase two was developed in response to phase one, an integrated analysis, consisting of the findings from both phases, is helpful in responding to the aims of this research. To begin, the themes which are found to integrate both phase one and two will be considered. This will be followed by a discussion of the strengths and limitations.

7.1 Integrative themes

7.1.1 Feelings of disempowerment

Despite the centrality of the voice of children and young people in both education and healthcare practice in the UK (SEND CoP, 2015), feelings of disempowerment permeated through both phases of the research. In phase one, survey respondents indicated the greatest barrier to help-seeking was its perceived ‘usefulness’, which constituted ‘not being understood’ and ‘not being taken seriously’, both of which are highlighted as significant barriers in previous literature (Rothi

and Leavey, 2006). Whilst the latter is a clear indication of feeling disempowered, the former is not. In the second phase of the research, the concern of not being taken seriously was reiterated by a number of participants, who felt that if they were to seek help for mental health problems then professionals would not "take their word", or listen to them, when describing their problems. This shows that young people who might want to seek help anticipate rejection or have limited influence over the type of support they are given (Simmons et al., 2011). This is important because research indicates that the more involved young people are in decision making around their mental health, the better their psycho-social outcomes (Edbrooke-Childs et al., 2015). Interestingly however, one participant in the present study did feel the level of mental distress should dictate how involved they would be in the process of making decisions. The desire to be included in decisions about mental health support, regardless of the setting, is likely to contribute to help-negation if exclusion is perceived. Therefore, it might be suggested that post-16 settings may need to reassure their pupils that decisions around mental health support are made collaboratively where possible.

7.1.2 Mental health literacy

Many young people in post-16 settings have received some sort of mental health education through their previous schools (Formby and Wolstenholme, 2012). The present study demonstrated that such input had been delivered with varying effect. In phase one, it was interesting that, in contradiction to previous research (Jorm, 2015), participants did not feel identifying problems or knowing where to seek help was a problem. Whereas, in phase two participants explained that knowing where to seek help was synonymous with knowing 'how' to seek help, something that they do not report feeling competent in. According to participants, knowing how to seek help constituted of two things, knowing where to seek the *right* help and having the vocabulary to explain mental health problems. Interestingly, in phase two, participants alluded to an objectively right or wrong way of seeking help, which mediated intentions to seek help through fear of getting it wrong.

Phase two also showed participants were concerned about recognising 'lesser symptoms' of mental health problems. Participants in phase two felt that general MHL could be improved in a

number of ways: embedding mental health into the curriculum and culture of the school; and, supporting pupils to recognise symptoms, not just "illness." This finding suggests that education programmes and interventions aiming to increase MHL should focus on both eudaimonic and hedonistic elements of mental health, so that young people are better equipped to recognised both the feelings of languishing mental health and the functional implications such as difficulties with peers (Westerhof & Keyes, 2010). Whilst participants felt this would increase help-seeking, they recognised the central role that post-16 staff play in mental health support and the mediating effect their MHL and confidence addressing mental health problems will have. Such findings suggest that ensuring appropriate teachers are sufficiently trained and have enough time to manage and support mental health problems, is essential.

7.1.3 Stigma and normalisation

Stigma associated with seeking help for mental health problems was found to be a prominent theme across both phases, which is consistent with previous research (Clement et al., 2015; Gulliver et al., 2010; Salaheddin & Mason, 2016). In phase one, it was demonstrated that participants were worried that others would view them negatively for help-seeking, which is unsurprising given the importance placed on friendships (Troop-Gordon, 2017). In phase two, participants explained this concern: participants were worried that if they sought help from someone they know then it might feel uncomfortable seeing them all of the time; however, if help was sought from someone they did not know, they were concerned that this would be the person's lasting impression of them. Phase two also showed that there is a lot of stigma around mental health due to the narrative that you only need help if its "really bad" because help is only for "big illnesses", which accords with previous research (Clement et al., 2015). Phase two participants discussed the need to speak more openly about mental health and for it to be "normalised" within a post-16 setting. However, they were also concerned that by normalising mental health, people might make use of casual and flippant mental health language, which due to the dynamics of their friendship groups can be difficult to challege, invalidating their problems where they exist. Such findings highlight the desire for young people to be socially accepted by their peers and the complex task that post-16 settings have in supporting student mental health and managing peer relationships.

7.1.4 Making mental health support in post-16 settings more effective

Central to this research was how the help-seeking of young people in post-16 settings can be encouraged. Phase one explored the intentions of young people to seek help, and the various factors which mediate this intent. What participants felt was important when help-seeking, their expectations of help-seeking and their views on how mental health support can be improved in post-16 settings, were explored in phase two.

From both phases, findings would suggest that the support post-16 settings provide for mental health difficulties vary significantly, some with more perceived effect than others. In phase two, participants were cognisant and sympathetic of the pressures on post-16 settings and disclosed the guilt they feel when seeking help from class teachers and other members of staff who are "very busy" and don't appear to have a frontline role in supporting the mental health needs of students. This was reiterated by the findings of phase one: young people are unlikely to seek help from members of staff, particularly teachers, a finding that has been reported in previous research (Leavey et al., 2011), due to the lack of time they have as a result of teaching pressures. Consequently, participants felt that having members of staff in their post-16 setting, whose role was to support mental health would be, and is, helpful. Further, in phase two participants discussed the guilt of sharing their mental health problems with friends and how ill-equipped they had felt personally when friends have shared problems with them. Despite indicating in phase one that friends, and partners are the source from whom they were most likely to seek help, these findings suggest that young people are likely to refrain from sharing their problems out of concern about the emotional and practical impact that they might have on another person. In phase two, participants suggested that in order to overcome this issue, training and education in peer support would be beneficial. Such interventions already exist but have not be utilised regularly in post-16 settings (Coleman et al., 2017).

The perceived seriousness of the mental health problems in post-16 settings was prominent in both the first and second phase of the present study. In phase one, participants felt that this could be perceived as a barrier to seeking mental health support for a number of reasons: help only

seems available to those who "really need it"; guilt of taking the space of someone who "needs" it; feeling the problem was worthy of help; availability; and, fear of invalidation. In phase two, the anxieties that young people have about help-seeking efforts being rejected for various reasons, and not being 'ill enough', were further demonstrated. This, unfortunately, is a theme consistent with research that has found only one in four young people, with diagnosable mental health problems, will receive treatment due to increasing demand and decreasing resource (Young Minds, 2016), due to a significant period of austerity. In phase two, many participants felt that of the help available in their post-16 settings, very little of it was available for 'smaller things', often intervening too late, rather than preventing problems from developing. As such, they and their peers would often ignore the problems they were facing until they were unmanageable, which aligns with the theory of non-help-seeking developed by Biddle et al. (2007) whereby individuals place their own problems into one of two categories: 'normal' and 'real' distress, with the former often resulting in non-help-seeking. Contrary to this, however, some participants felt that their post-16 setting had accounted for this by developing a pastoral system that meant pupils had frequent contact with a tutor, who's role was to support wellbeing, rather than matters of wellbeing being restricted to specific counselling services, which is consistent with previous research (Broglia, Millings & Barkham, 2018). This finding reiterated those of phase one, that young people felt more able to seek help from a pastoral tutor than a teacher.

Shifting the focus of support and embedding it within the culture of the setting, to increase the perceived inclusivity of mental health support, was suggested by participants in phase two so that all people, regardless of the extent of their problems felt that help was available to them. The findings of phase one and two suggest that post-16 settings may need to provide pupils with opportunities to meet regularly with a specific member of staff to discuss non-academic wellbeing and mental health and ensure that young people recognise that support is available to anyone, with any level of distress. This finding implies that a more inclusive system of mental health support should be based on the two continua model of mental health (Westerhof & Keyes, 2010).

7.2 Strengths and Limitations

This research has provided a breadth of information about the help-seeking intentions of young people in post-16 settings and the factors thought to mediate this, and an in-depth account of how young people in post-16 settings can be supported to increase their intentions to seek help.

Pupil voice

The greatest strength of this study is the inclusion of, and centrality of pupil voice. Engaging in discussions with young people about mental health and listening to their hopes is essential for positive outcomes (Anderson & Graham, 2016). Further, as identified by Atkinson et al. (2019), due to external pressures, pupil voices have not been enlisted enough to inform what is available in educational settings, meaning support often overlooks the needs and preferences of young people. In this research, young people, both with and without personal experience of mental health problems (across both continua of mental health and illness (Westerhof & Keyes, 2010)), were engaged in discussions around the factors mediating help-seeking and their help-seeking needs and preferences with regards to the provision in post-16 settings and previous schools. This is an opportunity which young people in this research valued but did not feel they had previously been afforded.

Whilst this is clearly a strength, the voices of young people who identify as non-binary were lost due to the use of thematic analysis. In future research it would be helpful to consider the use of a methodology with an idiographic focus, such as interpretive phenomenological analysis, so that individual voices may be heard.

Sampling

One limitation of phase one of the research is the sample size. Due to COVID-19, and the subsequent closure of schools and colleges, phase one of the research had to be paused until September 2020. This created a number of recruitment issues: participation of settings, and time

to complete the survey. Following the return to school in September 2020, after the COVID-19 closures, understandably settings felt that their priority for the return was settling students back in and therefore did not want to overwhelm participants by distributing the survey. Consequently, three settings had to withdraw, meaning only two settings felt able to distribute the questionnaire. Secondly, the window of time that participants could answer the survey was limited. Consequently, the number of participants were lower than initially anticipated which meant descriptive and inferential analysis could not be conducted for two categories (non-binary and no-gender) of participants. Further, it must be recognised that participation may indicate personal interest in, or increased knowledge of, mental health problems. Therefore, whilst elements of the research can theoretically be generalised beyond the sample, generalisation of the phase one findings, to the wider post-16 population, must be done with caution.

As there was no inclusion or exclusion criteria, other than attending a post-16 setting, participation was down to each individual. Subsequently, there was a disproportionately low number of male participants. As above, this means that findings must be generalised with caution, but also might highlight the differing levels of interest in mental health by gender. Alternatively, as highlighted in Chapter 6, males are less likely to openly participate in discussions around mental health due to stigma.

Participants in the second phase were recruited through the first, which meant that despite their being variability in the provision and factors affecting help-seeking, cross setting comparisons were more difficult to make, particularly in a manner that respected the privacy of the participants and setting.

Phase one

The research tool utilised in phase one of the research was designed and constructed for the purpose of this research. Whilst the measures used within it were amended from those used in existing studies, they did not answer the research questions designed to meet the aims of this research, which the new tool did (Coughlan, Cronin & Ryan, 2007a). For example, the original instrument utilised to assess perceived behavioural control, subjective norms and attitudes

focused on help-seeking from professionals (Tomczyk et al., 2020), had a slightly narrower research focus. A strength related to this is the use of a pilot study, to ensure that the tool developed was clear, unambiguous and appropriate for the new participant group. However, it must be noted that two measures within the instrument (measures assessing SN and PBC) had an internal reliability which, although acceptable, was less than was hoped for, meaning these results must be interpreted with caution.

The phase one research tool was an online questionnaire with both open and closed questions. Whilst the overall response rate was lower than expected due to the COVID-19 pandemic, those that responded to open questions were often thorough and detailed, providing a breadth of insights that had been unexpected (Gray, 2018). Prior to COVID-19, it had been intended that participants would answer the survey with me in the room, however due to social distancing measures this was not possible. The flexibility afforded by online questionnaires meant that participants were able to begin, pause and continue filling in the survey in their own time, in an environment that felt comfortable, where the social consequences of participation or non-participation were removed (Dörnyei, 2007).

Phase one intended to capture participant intentions to seek help. However, not all participants will need to, or will have sought help in the past, as the general post-16 population was recruited, not a clinical or non-clinal sample. As such, it is hard to differentiate between the hypothetical and actual intentions of young people to seek help, and which of these would and have engaged in actual help-seeking behaviours (Wilson et al., 2005). To account for this, participants were asked if they have experienced mental health problems, and whether they sought help previously.

Phase two

Due to the COVID-19 pandemic, and the subsequent lockdown measure that English schools faced throughout 2020 and 2021, interviews were conducted online, which has both strengths and limitations. Whilst there is research to suggest that rapport is more difficult to build online (Shapka et al., 2016), the level of disclosure remains high. Young people are often referred to as "digital natives" (Prensky, 2001, p.2) due to their propensity to, and comfort with,

communicating via the internet. To reduce any discomfort that participants might have felt, they were given the choice to turn their cameras on, affording anonymity where it was sought, something which is often valued, particularly in relation to discussions around mental health (Janghorban, Roudsari & Taghipour, 2014).

Unlike quantitative methodologies and method, the purpose of qualitative research is not to develop a nomothetic rule that can be applied to the wider population, instead the purpose is to develop an understanding of the subjective reality experienced by each individual (Vishnevsky & Beanlands, 2004). Therefore, instead of being evaluated in terms of objectivity and generalisability, qualitative research is evaluated in relation to its rigour, or trustworthiness. To do this, the plausibility, integrity and credibility of research must be demonstrated (Coughlan, Cronin & Ryan, 2007b). To ensure the rigour of phase two of the present study:

- Pilot studies were conducted to test the interview schedule.
- The six-phase thematic analysis framework developed by Braun and Clarke (2006) was followed.
- Where possible, clarification was sought throughout the interview process.
- Constant reference was made to the original interview transcripts to ensure themes were derived from the data.

However, it must be recognised due to the very nature of interviews and thematic analysis, the beliefs, values, assumptions and biases of the researcher will impact the research at every stage (Lincoln & Guba, 1985). To account for this, reflexivity was practiced throughout the development of research tools and analysis of the data through conversations with supervisors, friends and colleagues, and personal reflections were kept in a research diary, some of which are outlined below.

7.3 Researcher reflections

Adopting a pragmatic approach to research, is the pursuit of finding solutions to problems in society (Morgan, 2007). According to Braun and Clarke (2013), reflexivity is essential if a researcher is to recognise and understand the role that they have in the research process, and how

past experiences impact decisions that are made, and influence interactions with participants and data. Below, two ways in which my personal interest and identity may have influenced the research process, are outlined.

I am conscious that I had pre-conceived ideas about the level of mental health help-seeking youg people engage in; and, towards mental health support available in post-16 settings. This was down to having both worked in a post-16 setting, and not seeking help for my own mental health difficulties whilst attending a post-16 setting. Therefore, I was mindful when conducting interviews that my disappointment in mental health support for post-16 students, either by their setting or other services, was likely to be communicated, despite efforts not to. However, the findings indicated that instead, students were more optimistic about mental health support in post-16 settings than school settings, and as such I am hopeful that I did not communicate my bias, and subsequently represented participant voice well when interpreting data.

Further to this, having had personal experience of mental health problems, I was aware that at times the participants were struggling to phrase things, or answer a question. So as not to answer the question for them, or offer them suggestions of what to say, which would have been through my own lens of experience, I decided instead to allow pauses, and moments of silence. I felt this was appropriate because, despite the discomfort that silence can often bring, participant experiences were at the fore of our conversations, not my own.

Chapter 8. Implications and Conclusions

8.1 Implications for Educational Psychologists

Educational psychologists are well placed to support the mental health of children and young people within educational settings from the ages of 0 to 25. However, as highlighted by Greig, MacKay and Ginter (2019):

> There is a significant gap between how educational psychologists view their role in relation to mental health of children and young people, and how the role is seen in wider society and, in particular, by those who have the greatest influence on policy and provision of services. (p.265).

This suggests that whilst EPs are equipped with knowledge and skills to support the mental health of young people, through years of extensive training, they are often overlooked when planning mental health support in school and colleges.

The findings of the present study have highlighted a number of ways that EPs can support the mental health of young people attending post-16 settings and increase their intentions to seek help. Each will be discussed in turn.

As aforementioned, schools and colleges have a central role in preventing and supporting the mental health of their students (DoH & DfE, 2017). However, several participants in the interviews explained that mental health did not feel embedded with the culture of the post-16 setting they attended and rather than being preventative, felt reactive. They were conscious that there were many reasons for this: some members of staff might not have seen mental health as a part of their role because “they are just there to teach”, or did not feel confident in talking about mental health within day-to-day lessons, or as it arises. Whilst EPs have a skill set that affords supporting individual young people and groups, which if often defaulted to CAMHS (Greig et al., 2019), their knowledge of systems, interactions and processes of change mean they are suited to support post-16 settings in developing and implementing their whole setting approach to

mental health. Further, EPs are well suited to eliciting the voice of young people (Smillie & Newton, 2020) and encouraging meaningful participation in policy and intervention development (Atkinson et al., 2019).

As a part of developing a whole setting approach, one of the key roles for EPs is delivering training for all members of staff. The focus of this should be in response to the skills members of staff feel they require and may include: supporting them in their understanding and knowledge of mental health difficulties in the classroom; appropriate and evidence-based strategies to help students; and, empowering staff to speak about mental health with confidence (Dunsmuir & Cobbald, 2016). It has been suggested by Stanforth and Rose (2018) that EPs may be able to make a meaningful contribution to initial teacher training, not only in developing SEND practice, but with a specific focus on mental health.

Participants were cognisant of the increasing onus on teachers and other members of staff to support the mental health needs of the school community. Therefore, recognising the increasing pressure placed on staff, and providing support, is essential. EPs can provide support to members of staff in various ways, including both supervision and consultation. Whilst often not used for general staff, EPs have long been providing effective supervision to emotional literacy support assistants, supporting their own mental health and wellbeing, and ensuring the quality of their work through case discussion, sharing of ideas and problem solving (Krause, Blackwell & Claridge, 2020). Through the process of staff supervision and consultation, EPs can more widely support the wellbeing of staff and maximise the internal resources to support student mental health (Gibbs & Miller, 2014).

8.2 Further research

It would be helpful if phase one of the research could be conducted with a larger and more representative sample of post-16 students, so that a more thorough analysis can be done on the role of gender and age on mental health help seeking behaviour, and the variables most likely to mediate help-seeking.

This research has highlighted the central role that post-16 staff can, and do, play in supporting the mental health needs of students. Further, it has drawn to the fore the variability in staff engaging in mental health support within settings and the difference in the assigned (role within the job description), assumed (teacher choice) and felt (what they think they should be doing) role (Ekornes, 2017) of staff. Participants of the present study were aware of the increasing pressures that staff face, and as such do not always disclose to them out of guilt. It would be helpful if future studies considered including the views of staff within post-16 settings to understand the role they perceive they play in supporting the mental health of students and triangulate this with student views to see where they do and do not align. This would inform what staff require in terms of training and supervision and a shared understanding between staff and students.

As discussed in Chapter 6, peer support interventions are used with regularity within school settings with success (Hart et al., 2018). Further research is needed to understand the role that peer support interventions could have in supporting the mental health of students in post-16 settings.

8.3 Conclusion

There are growing concerns around the mental health of young people within the UK. With this in mind, the present study examined the intentions of young people attending post-16 settings to seek help and sought to explore the factors which are thought to mediate these intentions and subsequently behaviour. It also explored the role that post-16 settings have in supporting mental health. The intended outcome was to understand the help-seeking intentions of young people, factors mediating help-seeking, how mental health help-seeking can be encouraged, and what can be done to make mental health provision in post-16 setting be made more effective.

This research has found that seeking help for mental health related problems can feel disempowering for young people, partially accounting for the preference to seek help from peers. Stigma, MHL (of both staff and students) and the culture of the post-16 setting all act as barriers to help-seeking and impact the effectiveness of mental health provision.

The findings have contributed useful insights into how some settings are working to overcome these barriers to help-seeking and increase effectiveness, through developing specific roles for staff to support student mental health and wellbeing through regular timetabled contact in both groups and on a 1:1 basis. Participants attending such settings were grateful to have a member of staff with whom they could share their concerns without feeling guilty for taking up their time, highlighting the desire that students have to seek help from their post-16 setting.

The research has identified that whilst students feel the stigma around mental health is reducing, and mental health problems are becoming increasingly normalised, there is still work to be done in post-16 settings to ensure that mental health is embedded within the wider culture of the setting, not just by those who have a specific mental health role. As such, there is a need for mental health to be supported as part of a 'whole setting approach' whereby mental health is embedded in everyday lessons, and underpins every interaction that staff have with students.

Chapter 9. References

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Chapter 10: Appendices

Appendix A: Questionnaire

Understanding Help-seeking Behaviour Questionnaire

Mental health problems

Lots of people experience mental health difficulties throughout their life. Mental health problems can include the experience of a diagnosed mental health disorder. However, they can also refer to the more subjective experience of, and the negative/challenging emotions associated with, feeling unable to:

- Deal with the stresses of life
- Fulfil your potential
- Work productively
- Contribute to your community (friends, family, college, work etc.)

Throughout this survey, there are questions which ask specifically about mental health problems.

Part A

Demographic information

Please state which post-16 setting you attend in the box below.

How old are you?

16-18	19-24

What best describes your gender?

Male	Female	Prefer not to say	Prefer to self-describe

If you would prefer to self-describe, please do so in the box below.

(I am asking about gender because there is research which suggests that responses may differ, you do not have to indicate how you identify if you don't want to).

Have you ever experienced mental health problems before?

Yes	No

Part B

Lots of people experience mental health problems throughout their life. This questionnaire is about what you might do if you were to experience mental health problems. There are also some questions about factors that might encourage or discourage you to seek help.

The question below are about factors which might impact whether you would seek help for these problems.

1. Seeking help for mental health problems, from the sources below, would be:

	Totally Useless	Useless	Somewhat Useless	Neutral	Somewhat Useful	Useful	Extremely Useful
A friend							
Partner (e.g. girlfriend, boyfriend, spouse)							
A parent/ carer							
Other relative/ family member							
GP/ medical professional							
Mental health professional (counsellor, clinical psychologist etc.)							
Educational psychologist							
School/ college tutor							
Social media							
Google search							

Charity website (MIND, Young Minds etc.)							

2. The statements below explore what the people around you would think about seeking support for mental health problems.

	Strongly Agree	Agree	Somewhat Agree	Neither Agree or Disagree	Somewhat Disagree	Disagree	Strongly Disagree
Most family members who are important to me think that seeking help for mental health problems is important.							
Most friends who are important to me think that seeking help for mental health problems is important							
Most teachers / tutors who are important to me think that seeking help for mental health problems is important							

If I had a mental health problem it would be expected by others that I would seek help							

3. Below are statements that relate to how able you would feel to seek help for mental health problems.

	Strongly Agree	Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Disagree	Strongly Disagree
It is entirely up to me whether I would seek help for my mental health problems.							
I am confident that I could seek help for my mental health problems if I wanted to.							
Seeking help for mental health problems would be easy.							

4. The following questions explore whether you would seek help if you were experiencing a mental health problem and who/ what you might seek help from.

4a. If you were experiencing mental health problems, how likely is it that you would seek help from the following people?

	Extremely Unlikely	Moderately Unlikely	Slightly Unlikely	Neither Likely or Unlikely	Slightly Likely	Moderately Likely	Extremely Likely
Partner (e.g. girlfriend, boyfriend, spouse)							
Friend							
Parent/carer							
Other relative/ family member							
School/ college teacher/ tutor							
Educational psychologist							
Other mental health professional (counsellor, clinical psychologist etc.)							
Phone helpline (Mindline, Childline etc.)							
Doctor/GP							
Faith leader (Vicar, Rabbi, Imam etc.)							
I would not seek help from anyone							

4b. If you would seek help from someone not listed above, please specify who in the box below.

4c. If you indicated that you would seek help from someone listed above, what is it about them that would enable this? Please provide your answer/s in the box below.

4d. If you indicated that you would seek help from someone listed above, would your first option to do that be:

Face-to-face	Indirectly (i.e. online e.g. Zoom, Teams, over the phone, text etc.)

4e. If you were experiencing mental health problems, how likely is it that you would seek *information* from the following sources?

	Extremely Unlikely	Moderately Unlikely	Slightly Unlikely	Neither Likely or Unlikely	Slightly Likely	Moderately Likely	Extremely Likely
Social media							
Google search							
Charity/ support websites (e.g. NHS, Mind, Young Minds etc.).							

4f. If you were experiencing mental health problems, how likely is it that you would seek *help* from the following sources?

	Extremely Unlikely	Moderately Unlikely	Slightly Unlikely	Neither Likely or Unlikely	Slightly Likely	Moderately Likely	Extremely Likely
Social media							
Google search							
Charity/ support websites (e.g. NHS, Mind, Young Minds etc.).							

4g. If you were to seek help or information via social media, how would you do this?

5. Research has found that many factors can discourage, delay or stop people from seeking help for mental health problems. Below is a list of such factors.

5a. Please indicate the extent to which you agree that these factors would get in the way of you seeking help for mental health problems.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither agree or Disagree	Somewhat Agree	Agree	Strongly Agree
I would be concerned that others might view me negatively.							
I would be concerned about what my family would think.							

I would be concerned about what my friends might think.							
I would feel embarrassed talking to someone about my problem.							
I think seeking help is scary.							
I think that people who seek help are weak.							
I would be worried that people I know would find out.							
I wouldn't know where to get help.							
I wouldn't recognise if I had a mental health problem.							
I wouldn't feel comfortable talking about my feelings.							
I wouldn't have time to seek help.							
I would be worried it might cost money.							

I would want to solve the problem on my own.							
I think the problem would get better by itself.							
I would be worried that seeking help would not help.							
I would be worried that another person might not understand my problems.							
I would be concerned I would not be taken seriously.							

5b. Are there any other factors which might discourage you from seeking help for mental health problems? Please write your answer in the box below.

6. Little is known about the factors which encourage people to seek help for mental health problems. Below is a short list of factors that have been found to encourage help-seeking for mental health problems.

6a. Please indicate the extent to which you agree that these factors would encourage you to seek help for mental health problems.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither agree or Disagree	Somewhat Agree	Agree	Strongly Agree
Positive past experience							

with seeking help for a mental health problem.							
Trust that my mental health problems will remain confidential.							
A trusted adult initiating conversation about a problem.							
Confidence that my problem will be validated and normalised.							
Knowing more about mental health.							
Knowing where and how I can seek help.							

6b. Are there any other factors that would encourage you to seek support for mental health problems?

Please provide your answer/s in the box below.

7. If you were to seek help for a mental health problem, or you have sought help in the past, what would you hope to achieve from this?

Part C

The following questions are exploring the impact that COVID-19 has had on the mental health related help-seeking behaviours of young people.

8. If you have experienced mental health problems, have they been impacted by COVID-19?

Yes	**No**	**Not applicable**

8a. If you answered yes to the above question, please explain how your mental health problems have been impacted in the space below.

9. If you were receiving support prior to COVID-19 for mental health problems, has this been adversely affected by lockdown? (e.g. college closures, surgery restrictions).

Yes	**No**	**Not applicable**

9a. If you answered yes to the above question, please explain your answer in the space below.

END OF QUESTIONNAIRE

Thank you for participating in this research.

Would you be happy to participate in the second phase of this research, which consists of a 45-minute interview using video-calling software (to follow social distancing guidelines)? Yes/No

Please write your email address in the box below.

Please note, if lots of participants display an interest for the second phase, it is not guaranteed that you will be contacted.

If you would like me to send you a summary of the findings from this study, please write your email address here.

I hope that you didn't find anything in the questionnaire upsetting. If you did, please talk to a staff member, or email me at sh903@exeter.ac.uk. If you are aged under 19 you can also call Childline at 0800 1111 or visit their website for support. If you are aged over 18 you can contact Mindline at 01823 276892 or visit their website for support.

Appendix B: Information Sheet

Graduate School of Education
College of Social Sciences & International Studies

Mental health related help-seeking behaviours of young people attending post-16 settings.

The mental health and psychological wellbeing of people in the UK has received much attention in recent years. In 2017, the Department for Education and the Department of Health published 'Transforming children and young people's mental health provision: a green paper'. This outlined the significant increase in need, and ways that educational settings can provide mental health support. However, research has identified that not all people who would be identified as requiring help, seek it. Much research about help-seeking behaviours has been conducted in the school-age population, and in the medical field, with little attention paid to post-16 settings. This research is a response such findings.

PROJECT AIMS

This project aims to explore the mental health related help-seeking behaviours of young people attending post-16 settings. With a particular focus on how help-seeking can be encouraged.

I am particularly interested in:

- The help seeking intentions of young people attending post-16 settings.
- The barriers and facilitators to help-seeking.
- How help-seeking can be encouraged.

WHAT IS INVOLVED AND WHEN?

- A short survey (approximately 20 minutes) in September 2020
- One interview October/ November 2020. The interview will take no longer than 45 minutes and will take place using video-calling software in order to meet social distancing guidance. With your permission, this interview will be audio-recorded and transcribed. This interview is optional.

WHAT ARE THE POTENTIAL BENEFITS?

- Develop an understanding of the factors which encourage and act as a barrier to the help-seeking of young people.

- Inform current provision for mental health and emotional wellbeing.

Through participating you will be contributing to the broader understanding of help-seeking behaviour of young people attending post-16 settings and how educational psychologists may support post-16 settings to encourage help-seeking in the future.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

There are little risks involved in participating in this research. However, discussing mental health can be emotional and upsetting for some. If you become upset by the content of the survey or interview, then it will be paused or stopped. You do not have to answer the questions if you do not want to.

If you do find that the topic is upsetting, then you will be signposted to the appropriate support.

WHAT WILL HAPPEN IF I DO NOT WANT TO CONTINUE WITH THE STUDY?

To participate in this research, you will be required to give your consent. If you decide that you no longer wish to take part in the study you will have until the time that the data is analysed, which will be approximately 3 weeks after the survey, and a further 3 weeks after the interview (if this is something you wish to participate in). If you decide that within this time frame you would no longer like to participate, no explanation is required and there will be no consequences. Your data will be destroyed and will not be included in the research.

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

No personal, or identifiable information will be required unnecessarily. If you wish to participate in the interview, then an email address will be required. Alldata, will be collected and stored on password encrypted files and devices. All data, including audio-recordings, transcriptions and personal data will be destroyed within five years of the research completion date. Confidentiality will only be broken if there is a safeguarding concern, or the law requires it.

As previously stated, any identifiable information will remain confidential and will not be discernible in my doctoral thesis, as well as any publications and work which result from this research. Pseudonymised data may be looked at by my supervisors, or professional transcribers, for the purpose of transcribing interview data. These individuals will not have access to personal data.

If you have any queries about the University of Exeter's processing of your personal data, that cannot be answered by myself, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk.

This research has been reviewed by the College of Social Sciences and International Studies Research Ethics Committee at the University of Exeter.

If you have any concerns about this research that I cannot resolve, you can contact my supervisors, Dr Christopher Boyle (C.Boyle2@exeter.ac.uk) or Dr Andrew Richards (A.J.Richards@exeter.ac.uk), or the Research Ethics and Governance Manager, Gail Seymour (g.m.seymour@exeter.ac.uk).

THANK YOU FOR YOUR INTEREST IN THIS RESEARCH

Sophie Hatcher is a trainee educational psychologist at the University of Exeter. If you have any questions, please contact her at:
Email: sh903@exeter.ac.uk

Appendix C: Consent Form

Research Study Consent Form

This project aims to explore the mental health related help-seeking behaviours of young people attending post-16 settings. With a particular focus on how help-seeking can be encouraged.

- I confirm that I have read the information sheet for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected.
- I understand that relevant sections of the data collected during the study may be looked at by members of the research team (at the University of Exeter) where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
- I understand that taking part involves the use of anonymised questionnaire responses.
- I understand that taking part may include anonymised interview transcripts and audio recordings.
- I understand that taking part means my data may be held for up to 5 years.
- I understand that taking part means my may be shared with other researchers for use in future research projects, reports published in an academic publication.
- I agree that my contact details can be kept securely and used by researchers from the Graduate School of Education at the University of Exeter so they can contact me about future research projects

I agree to take part in the above project. ☐

Please contact Sophie Hatcher if you would like more information. **Email:** sh903@exeter.ac.uk

Appendix D: Interview Schedule

How can help-seeking be encouraged?

Intro for interviewer: I want to understand how young people can be encouraged to help-seek. To do this, I would like to explore some of the considerations that you have made, or would make, when thinking about seeking help for mental health problems.

Part One: Characteristics of the help/er

To begin, I would like you to think of someone (or a source) from whom you would seek help (this doesn't have to be a real person, but can be an 'ideal' person)

- Who are they?
- What can you tell me about this person that makes them someone you would seek support from? (ask them to name a few qualities) – *these will be the **constructs***
    - *What is important to you about someone being _____?*
    - *What else can you say about someone/something who is _____?*
    - *What can you say about someone or something who is not_____?*
    - *How would you know if someone was _____?*

Part Two: Expectations

Much research has indicated that young people, and people in general, show a preference for seeking help from informal sources (friends, family etc.) over formal support (GP, therapy etc.). I would like to explore your expectations of seeking help from these different sources.

Do you feel there would be any difference between seeking help from a formal or informal source?

Prompts for interviewer

- *What outcomes would you be hope for from a formal source?*
- *What outcomes would you be hope for from an informal source?*
- *How might the role of the person be different?*
- *How might your role be different?*

Part Three: Encouraging help-seeking

On the screen in front of you are a number of reasons young people often do not seek help for mental health problems. Can you think of anymore?

Please select your top 6 and put them in order (1 being the greatest reason young people do not seek help)

Note for interviewer: Select top three, omit the rest.

Note for interviewer: Show the Salmon Line and place each construct at one end.

What would the opposite of this[barrier] be?

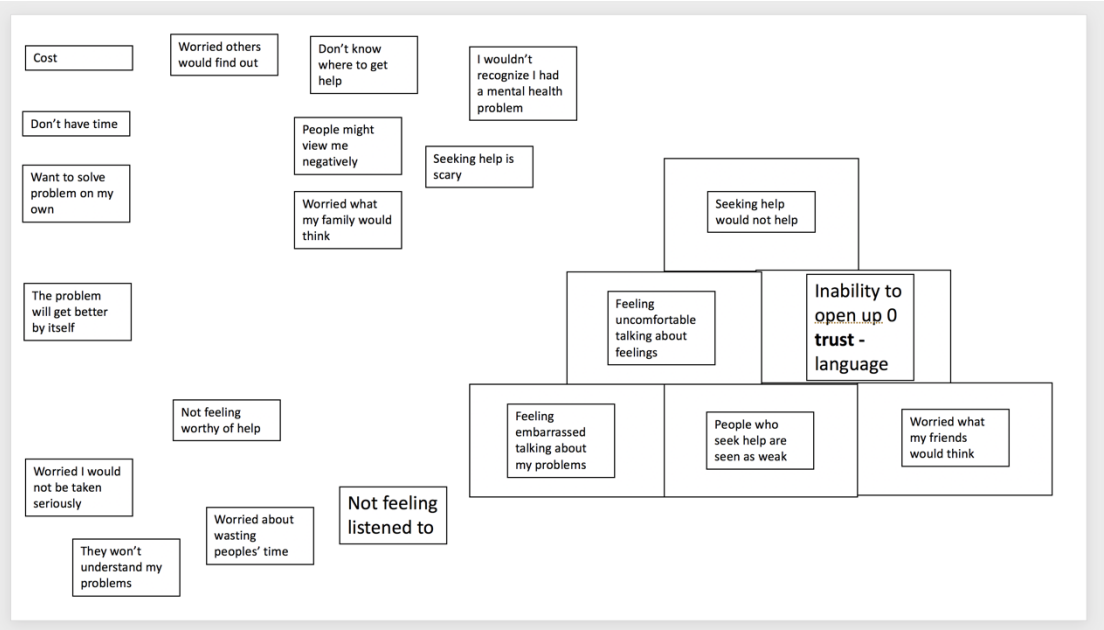
Where on the scale of [barrier] do you feel you are/ things are? (repeat for each reason)

Prompts for interviewer

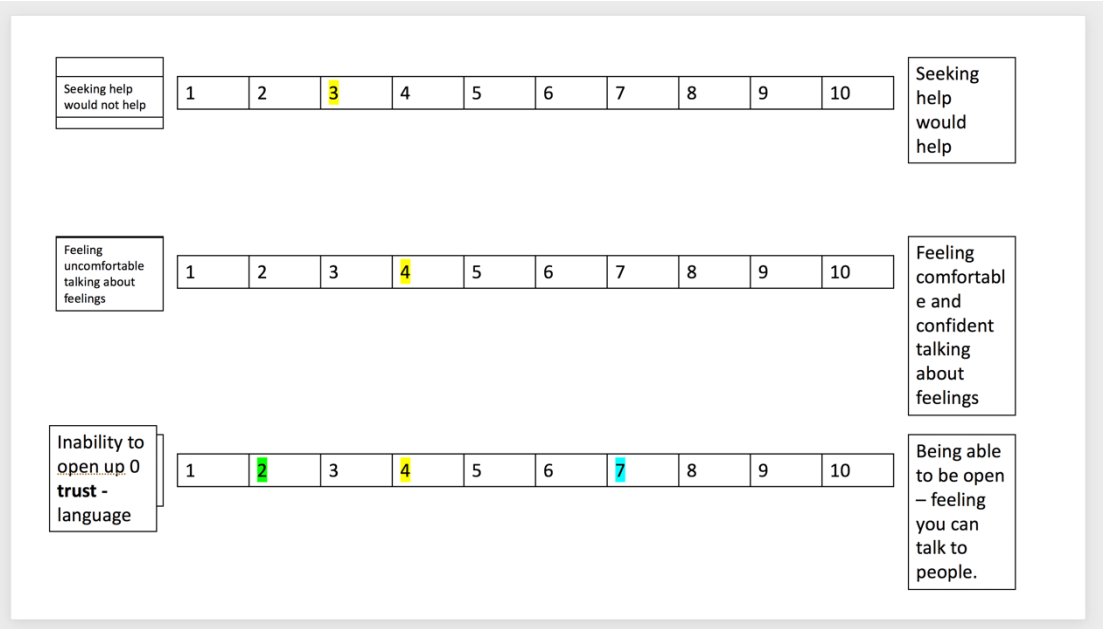
- *Do you think it is possible for things to change?*
- *How much could they change?*
- *What do you think would have to happen for that to occur?*

Appendix E: Elicitation Examples

Participant 1 ranking activity



Participant 2 Salmon line activity



Appendix F: Extract from reflective diary

Feb 2021.

Thematic analysis reflections

① Analysing the transcripts

→ This is where I am confused about how I make meaning. I felt that during the interviews, this was co-constructed. Help ~~fucking afraid~~

However, now I am not sure. Can I be a social constructionist (as above) and a constructionist? I feel like because I ~~transcript~~ I am interpreting or transcript on my own, that I am giving to re-construct the meaning through my own lense. Can I be a social constructionist and constructionist?

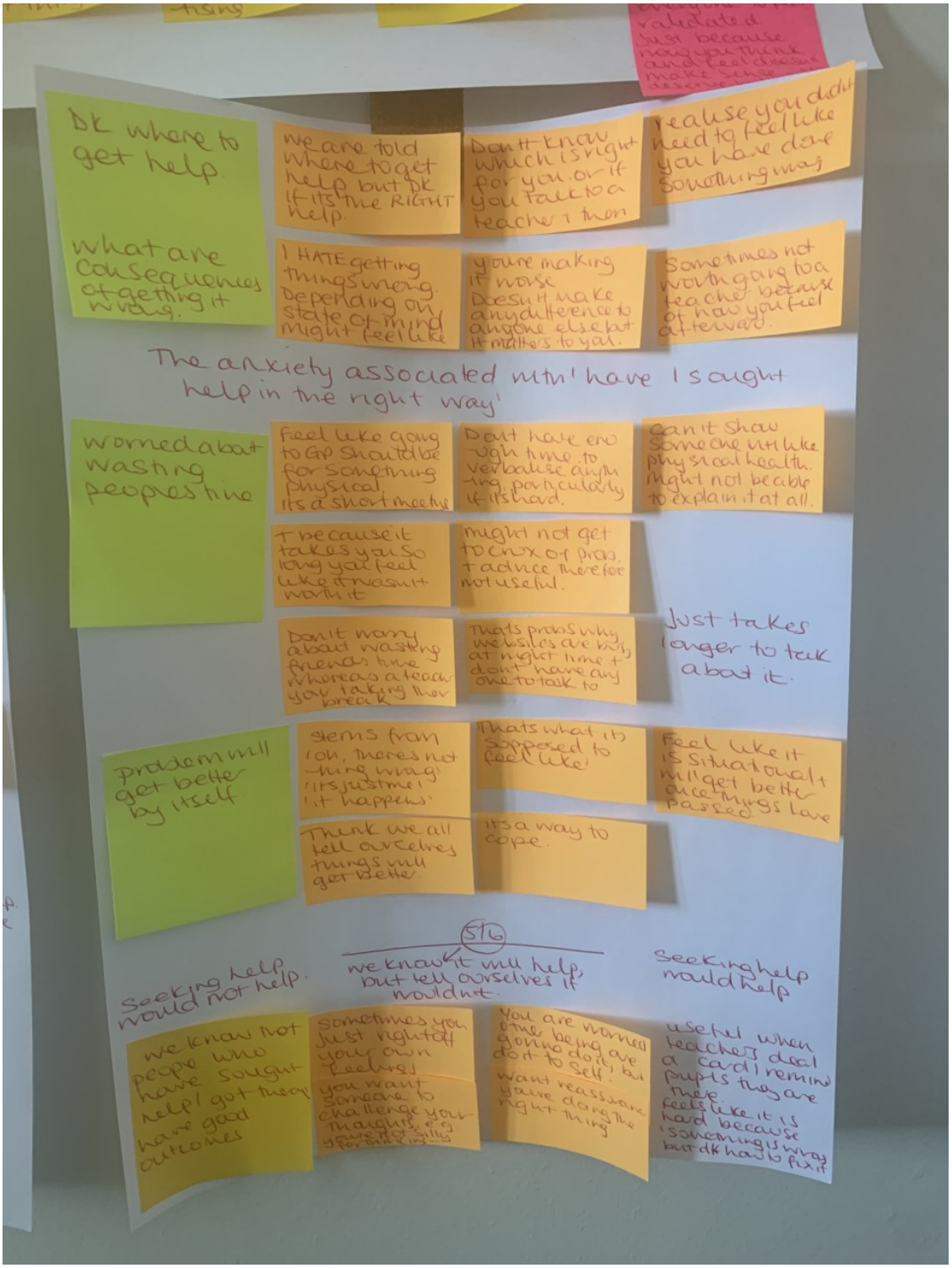
Can social constructionism preclude my personal construction, or do my constructions/ experience shape my part of the co-creation?

Other than sticking to the transcripts and listening back to the recordings, is there anything else I can do? I feel like I almost needed a running comment along side the transcript.

I suppose, all I can do is be aware of this.

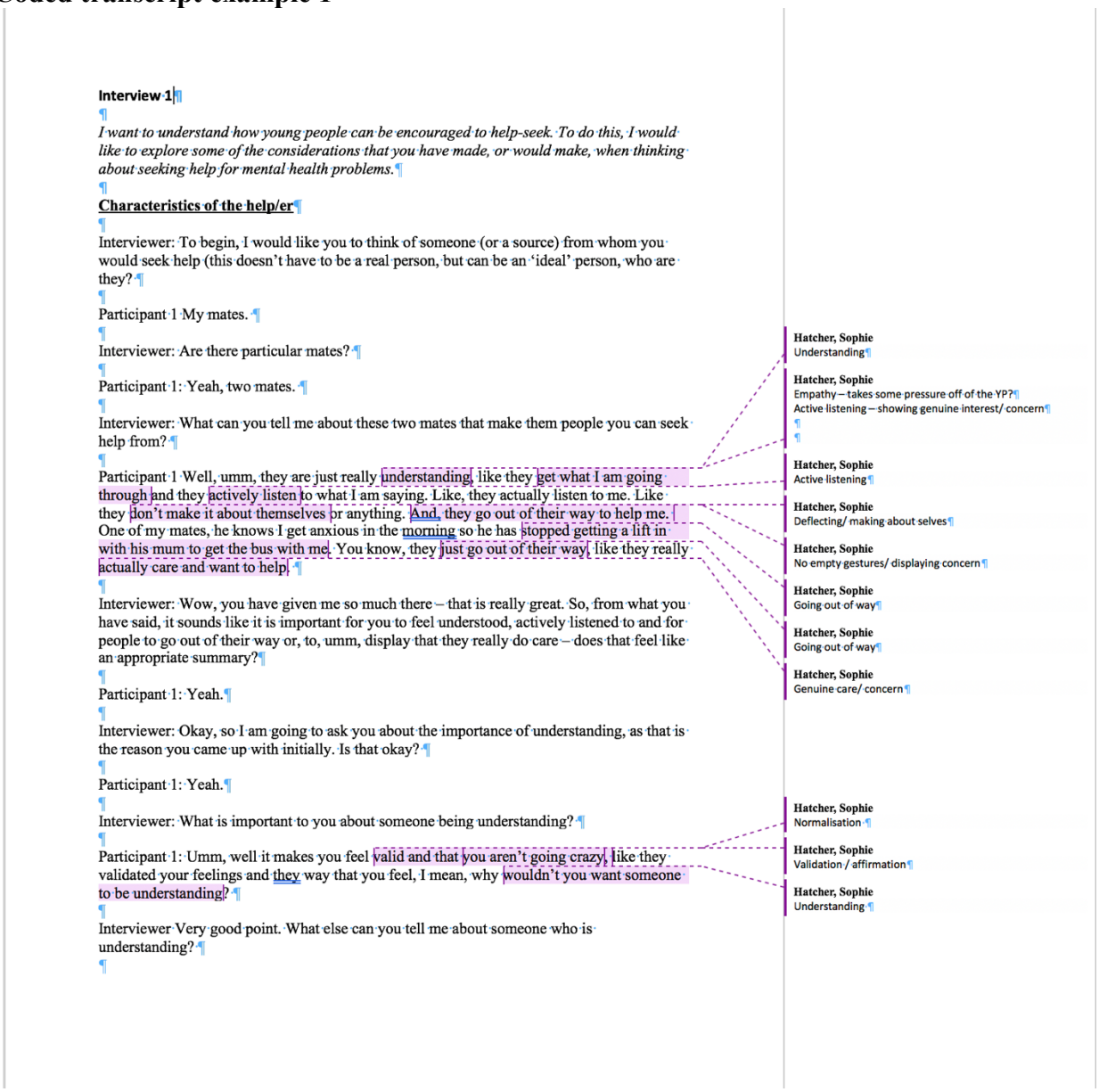
Appendix G: Transcription Notes

Example of notes made during the coding process



Appendix H: Examples of Coded Transcripts

Coded transcript example 1



Interview 1

I want to understand how young people can be encouraged to help-seek. To do this, I would like to explore some of the considerations that you have made, or would make, when thinking about seeking help for mental health problems.

Characteristics of the help/er

Interviewer: To begin, I would like you to think of someone (or a source) from whom you would seek help (this doesn't have to be a real person, but can be an 'ideal' person, who are they?

Participant 1 My mates.

Interviewer: Are there particular mates?

Participant 1: Yeah, two mates.

Interviewer: What can you tell me about these two mates that make them people you can seek help from?

Participant 1 Well, umm, they are just really understanding, like they get what I am going through and they actively listen to what I am saying. Like, they actually listen to me. Like they don't make it about themselves or anything. And, they go out of their way to help me. One of my mates, he knows I get anxious in the morning so he has stopped getting a lift in with his mum to get the bus with me. You know, they just go out of their way, like they really actually care and want to help.

Interviewer: Wow, you have given me so much there – that is really great. So, from what you have said, it sounds like it is important for you to feel understood, actively listened to and for people to go out of their way or, to, umm, display that they really do care – does that feel like an appropriate summary?

Participant 1: Yeah.

Interviewer: Okay, so I am going to ask you about the importance of understanding, as that is the reason you came up with initially. Is that okay?

Participant 1: Yeah.

Interviewer: What is important to you about someone being understanding?

Participant 1: Umm, well it makes you feel valid and that you aren't going crazy, like they validated your feelings and they way that you feel, I mean, why wouldn't you want someone to be understanding?

Interviewer Very good point. What else can you tell me about someone who is understanding?

Hatcher, Sophie
Understanding

Hatcher, Sophie
Empathy – takes some pressure off of the YP?
Active listening – showing genuine interest/ concern

Hatcher, Sophie
Active listening

Hatcher, Sophie
Deflecting/ making about selves

Hatcher, Sophie
No empty gestures/ displaying concern

Hatcher, Sophie
Going out of way

Hatcher, Sophie
Going out of way

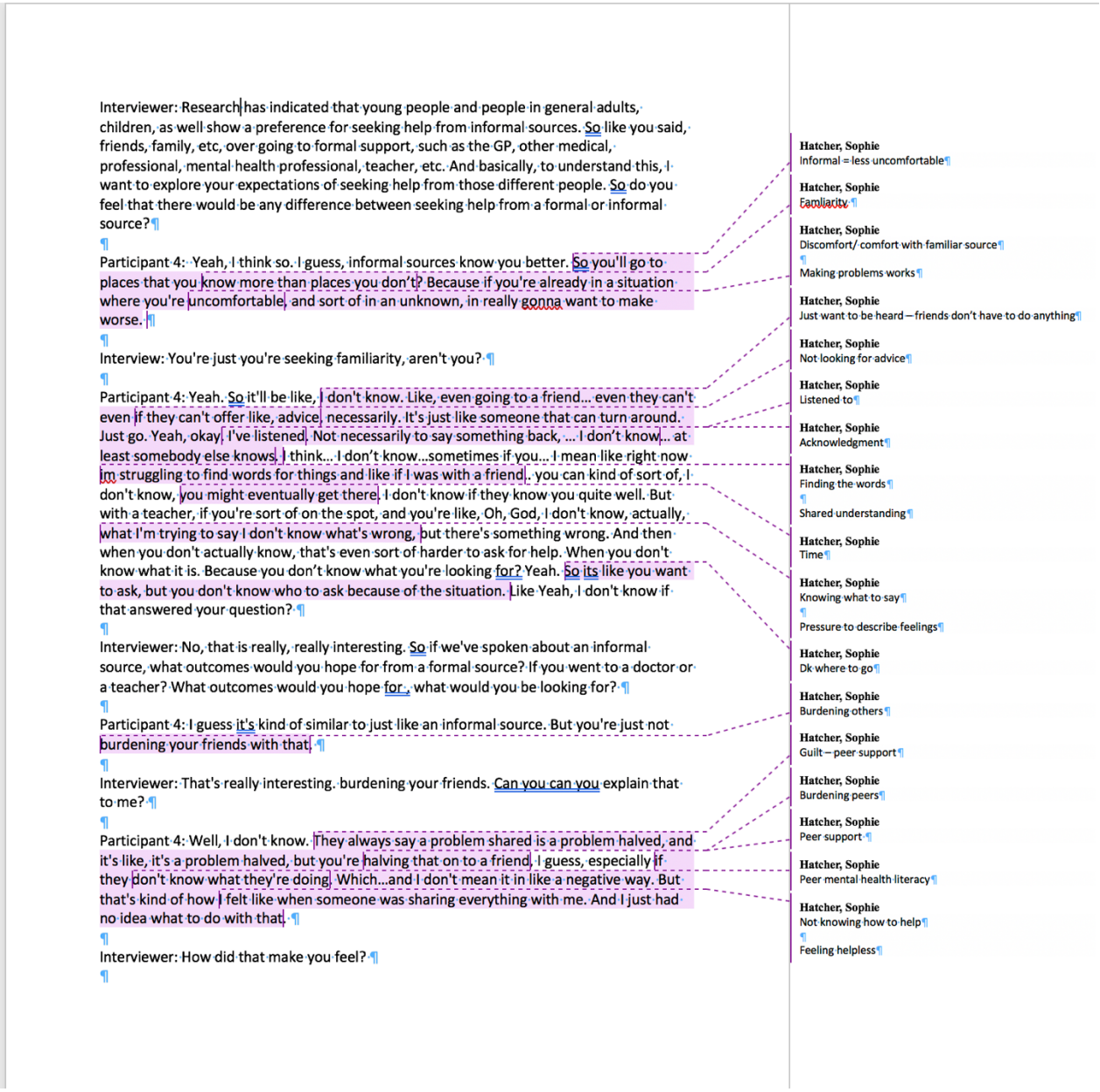
Hatcher, Sophie
Genuine care/ concern

Hatcher, Sophie
Normalisation

Hatcher, Sophie
Validation / affirmation

Hatcher, Sophie
Understanding

Coded transcript example 2



Interviewer: Research has indicated that young people and people in general adults, children, as well show a preference for seeking help from informal sources. So like you said, friends, family, etc, over going to formal support, such as the GP, other medical, professional, mental health professional, teacher, etc. And basically, to understand this, I want to explore your expectations of seeking help from those different people. So do you feel that there would be any difference between seeking help from a formal or informal source?

Participant 4: Yeah, I think so. I guess, informal sources know you better. So you'll go to places that you know more than places you don't? Because if you're already in a situation where you're uncomfortable, and sort of in an unknown, in really gonna want to make worse.

Interview: You're just you're seeking familiarity, aren't you?

Participant 4: Yeah. So it'll be like, I don't know. Like, even going to a friend... even they can't even if they can't offer like, advice, necessarily. It's just like someone that can turn around. Just go. Yeah, okay, I've listened. Not necessarily to say something back, ... I don't know... at least somebody else knows. I think... I don't know...sometimes if you... I mean like right now im struggling to find words for things and like if I was with a friend, you can kind of sort of, I don't know, you might eventually get there. I don't know if they know you quite well. But with a teacher, if you're sort of on the spot, and you're like, Oh, God, I don't know, actually, what I'm trying to say I don't know what's wrong, but there's something wrong. And then when you don't actually know, that's even sort of harder to ask for help. When you don't know what it is. Because you don't know what you're looking for? Yeah. So its like you want to ask, but you don't know who to ask because of the situation. Like Yeah, I don't know if that answered your question?

Interviewer: No, that is really, really interesting. So if we've spoken about an informal source, what outcomes would you hope for from a formal source? If you went to a doctor or a teacher? What outcomes would you hope for , what would you be looking for?

Participant 4: I guess it's kind of similar to just like an informal source. But you're just not burdening your friends with that.

Interviewer: That's really interesting. burdening your friends. Can you can you explain that to me?

Participant 4: Well, I don't know. They always say a problem shared is a problem halved, and it's like, it's a problem halved, but you're halving that on to a friend, I guess, especially if they don't know what they're doing. Which...and I don't mean it in like a negative way. But that's kind of how I felt like when someone was sharing everything with me. And I just had no idea what to do with that.

Interviewer: How did that make you feel?

Hatcher, Sophie
Informal = less uncomfortable

Hatcher, Sophie
Familiarity

Hatcher, Sophie
Discomfort/ comfort with familiar source

Making problems works

Hatcher, Sophie
Just want to be heard—friends don't have to do anything

Hatcher, Sophie
Not looking for advice

Hatcher, Sophie
Listened to

Hatcher, Sophie
Acknowledgment

Hatcher, Sophie
Finding the words

Shared understanding

Hatcher, Sophie
Time

Hatcher, Sophie
Knowing what to say

Pressure to describe feelings

Hatcher, Sophie
Dk where to go

Hatcher, Sophie
Burdening others

Hatcher, Sophie
Guilt—peer support

Hatcher, Sophie
Burdening peers

Hatcher, Sophie
Peer support

Hatcher, Sophie
Peer mental health literacy

Hatcher, Sophie
Not knowing how to help

Feeling helpless

Appendix I: Organisation of Codes into Themes with Associated Quotes

The guilt of help-seeking	Emotional impact Practical impact	Guilt Worry Concern Impact of others Less burden for professionals Wasting people's time Less burden = open to talk Role Job role Job	That would be like one of the main things [barrier]... like me talking to one of my friends about something, and I wouldn't want to be a burden to them. But I wouldn't want to go to her because she has already got a lot going on.. I guess if I was telling an informal source, such as a friend or family member, I would probably feel a little bit guilty for telling them I think, because I know that hearing that would not be obviously pleasant for them. When confiding in friends I wouldn't want to like, put anything too serious onto them. I wouldn't want to give them that pressure. So at least a professional knows how to handle that. If you're talking to a teacher, you're wasting their break and their lunch...or you are using all of that time where they usually have their own time." When I see my teachers its purely just for the lessons, I could talk to my teachers about other things. But in my consciousness, I know that like they've got other classes, they've got other students they've got, you know, work to look at, they've got to mark things, as with your tutor you know, that its specifically for you It's their job to listen and sort of intake information, I wouldn't feel as guilty unloading all of my like uhhh … my thoughts and feelings onto them. I wouldn't feel like it's an imposition. Much rather talk to like a teacher and be completely open with them...and not have to worry about someone my age being burdened with the same problems. They always say a problem shared is a problem halved, and it's like, it's a problem halved, but you're halving that on to a friend

Appendix J: Certificate of Ethical Approval

GRADUATE SCHOOL OF EDUCATION

St Luke's Campus
Heavitree Road
Exeter UK EX1 2LU

http://socialsciences.exeter.ac.uk/education/

CERTIFICATE OF ETHICAL APPROVAL

Title of Project:
Exploring the mental health and wellbeing related help-seeking behaviour of people attending post-16 settings in the south west of England.

Researcher(s) name: Sophie Hatcher

Supervisor(s): Andrew Richards
Chris Boyle
Liz Hampton

This project has been approved for the period

From: 11/03/2020
To: 31/08/2021

Ethics Committee approval reference: D1920-059

Signature: Justin Dillon Date: 26/08/2020

(Professor Justin Dillon, Professor of Science and Environmental Education, Ethics Officer)