A Qualitative Exploration of how Young Men in the UK Perceive and Experience Informal Help-seeking for Mental Health Difficulties

Lauren Burke

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School of Psychology
Faculty of Health and Medical Sciences
University of Surrey
Guildford, Surrey
United Kingdom
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Abstract

Background: Despite having a similar prevalence of mental health problems to adolescent females, adolescent males do not seek support for mental health difficulties at the same rate. Extensive research has highlighted the many barriers and facilitators for seeking support professionally. However, there is a paucity of qualitative research that explores how young males seek support from informal sources of support. This study aims to explore the proximity and intersubjectivity of informal relationships that young men possess and considers the impact on thoughts and experiences of help-seeking for mental health difficulties. **Method:** Using a qualitative approach, fourteen young males aged 16 to 18 years were recruited to participate in one-to-one semi-guided interviews. Interview data was analysed using thematic analysis. **Results:** Two key themes were identified: 1) *Proximity and familiarity*, 2) *Navigating feared outcomes and remaining silent*. These two themes explore in-depth how notions of perceived familiarity, masculinities, stigma, trust, and emotional burden are experienced in relation to the various proximal relationships that these young men hold. The themes explore the array of intricacies and dynamics perceived within proximal relationships, and the implications for seeking support from these sources, in relation to family, friends, and teachers. **Conclusion:** The findings illustrate the complexities of informal relationships that young males possess as well as the socio-cognitive, systemic, individual, and structural factors that influence help-seeking behaviour from these sources. The considerations that young men undertake must be understood to address the disparities in help-seeking behaviours for mental health problems. Future research should consider how ethnicity, culture, and socioeconomic background influences how young men seek help from informal sources of support.

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Part 1: Major Research Project, Empirical Paper

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Abstract

Background: Despite having a similar prevalence of mental health problems to adolescent females, adolescent males do not seek support for mental health difficulties at the same rate. Extensive research has highlighted the many barriers and facilitators for seeking support professionally. However, there is a paucity of qualitative research that explores how young males seek support from informal sources of support. This study aims to explore the proximity and intersubjectivity of informal relationships that young men possess and considers the impact on thoughts and experiences of help-seeking for mental health difficulties. **Method:** Using a qualitative approach, fourteen young males aged 16 to 18 years were recruited to participate in one-to-one semi-guided interviews. Interview data was analysed using thematic analysis. **Results:** Two key themes were identified: 1) *Proximity and familiarity*, 2) *Navigating feared outcomes and remaining silent*. These two themes explore in-depth how notions of perceived familiarity, masculinities, stigma, trust, and emotional burden are experienced in relation to the various proximal relationships that these young men hold. The themes explore the array of intricacies and dynamics perceived within proximal relationships, and the implications for seeking support from these sources, in relation to family, friends, and teachers. **Conclusion:** The findings illustrate the complexities of informal relationships that young males possess as well as the socio-cognitive, systemic, individual, and structural factors that influence help-seeking behaviour from these sources. The considerations that young men undertake must be understood to address the disparities in help-seeking behaviours for mental health problems. Future research should consider how ethnicity, culture, and socioeconomic background influences how young men seek help from informal sources of support.

1. Introduction

An estimated 20% of young people worldwide experience some form of mental health problem and it is thought that this is rising (The United Nations for Children's Fund, 2013; World Health Organisation, 2016). In England, one in eight young people aged five to nineteen have at least one mental health difficulty (NHS Digital, 2018). A recent Freedom of Information request from 26 mental health trusts across England shows that up to 110,000 young people aged 10-17 are turned away from services (Children's Society, 2019), resulting in less than one third of young people being able to access treatment and support (The NHS Long-Term Plan, 2019). This is despite the knowledge that 75% of mental health problems are established by the age of 24 (Kessler et al., 2005; Patel et al., 2007). Acknowledging the challenges for children accessing mental health support, the UK Government proposed that the promotion of resilience and preventative early intervention strategies should be at the centre of future mental health support (Future in Mind, 2015). In 2017, the UK government pledged that all secondary high schools would receive mental health training by 2020 (Department of Health [DoH] & Department for Education [DfE], 2017).

In the UK, prevalence rates for young people experiencing a mental health problem are similar for boys (12.6%) and girls (12.9%) (NHS digital, 2018). Despite the similarity in need, boys and adult men are underrepresented in mental health services; in the UK, adult data shows that men only account for 32% of people aged 18-35 accessing 'Improving Access to Psychological Therapies' (IAPT) (Children's Commissioner, 2016; NHS digital, 2020). Beyond the UK, a study showed that in Australia, only 13.2% of young men experiencing mental health problems access services, compared to 40.7% of young women (Slade et al., 2009). The underrepresentation of males receiving care from mental health services indicates discrepancies in how males and females respond to mental health problems, seek support and access services. These differences are thought to have severe implications for male mental

health; in the UK, Office for National Statistics (ONS) 2019 data shows that for young people aged 15-19, the rate of suicide was 7.2 males per 100,000 compared to 4 females. These disparities increase in young adulthood (age 20-24), where the rate of suicide was 16.6 males per 100,000 compared to 5 females per 100,000. ONS data shows that men accounted for three quarters of UK deaths by suicide in 2018.

Seeking support for mental health problems has been defined as “an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns” (Rickwood and Thomas, p.180, 2012) which includes both formal (e.g., health services) and informal (e.g., friends and family) sources of help. The processes of understanding, managing, and seeking support for mental health problems are determined by sociocognitive, individual and structural factors (Biddle et al., 2007; Cornally & McCarthy, 2011; Rickwood et al., 2007). Research has proposed many theories as to why young men do not access services at the same rate as women; young men are more likely to hold negative stereotypes of mental health difficulties compared to young females (Cotton et al., 2006; Martínez-Zambrano, 2013; Williams and Pow, 2007). Denial of emotions, negative attitudes, low mental health literacy and perceived stigma are also thought to contribute to non-help seeking behaviour in young males (Clement et al., 2015; Eisenberg et al., 2007; Hernan et al., 2010; Rickwood et al., 2007; Vogel & Wade, 2007;). Aspects of stigma associated with embodied hegemonic masculine ideals that discourages vulnerability, weakness, and emotional expression are associated with reduced help-seeking behaviour (Evans et al., 2011; Gonzalez et al., 2005; Judd et al., 2008; Nam et al., 2010).

Additionally, disclosing mental health difficulties may lead to young males experiencing a conflict between their individual and social group identity at a time when development of identity is paramount (Hogg & Turner, 1987; Kroger, 2005; Tajfel & Turner, 2004). Experiencing difficulties in communicating distress and fearing shame in asking for help can often result in young men becoming avoidant of help-seeking (Biddle et al., 2007; Hernan et

al., 2010; Rickwood et al., 2005). Despite recent campaign efforts to counter this message for men (e.g., Movember Campaign), it is widely recognised that more work is required to implement targeted campaigns for adolescent boys and young adult men (Rice et al., 2018).

Help-seeking is divided into two domains, formal and informal help-seeking. Definitions of formal support acknowledged in the literature vary in definition but generally include mental health professional, general practitioner, counsellor, psychiatrist, therapist, social worker (Rickwood et al., 2005, Rickwood et al., 2012). Existing research illustrates that adolescents generally do not personally decide to seek psychological support through professional or formal avenues such as mental health professionals (Biddle et al., 2007; Gulliver et al., 2012; Hernan et al., 2010; Mackenzie et al., 2006; Rowe et al., 2014). There has been substantial research to explore the barriers and facilitators for young people when seeking formal support for mental health difficulties. In a study of high school students aged 14-16, barriers on a personal and logistical level were thought to explain why three quarters of participants recognised signs of depression in a vignette and recommend that the character seek professional support, yet just less than half of participants said they would not see a doctor if they felt like the vignette character (Hernan et al., 2010). Personal barriers to explain this discrepancy included shame and embarrassment of needing help and logistical barriers included poor mental health literacy in relation to where and how to seek formal support. Qualitative research with adolescents has further illustrated personal barriers to seeking professional help such as distrust towards GPs and concerns about maintaining confidentiality (Corry & Leavey, 2017).

Personal, logistical, and cultural barriers have been highlighted in adolescent male literature; a systematic review of 22 studies showed that the following two themes, ‘concern about the characteristics of the provider’ and ‘prefer other sources of help’ were prominent barriers to for young men seeking help formally (Gulliver et al., 2010). In a qualitative study of 17 young

men, the main barriers to seeking professional support included acceptance from peers, personal challenges, cultural and environmental influences, perspectives around seeking professional help, and traditional masculine ideals (Lynch et al., 2016). Maintaining anonymity, confidentiality and self-image are also deemed crucial to the help-seeking process (Best et al. 2016). Related to notions of burden and autonomy, a fear of dependency and feelings of incompetency have also been shown to be barriers to seeking help professionally in young men (Chan, 2013; Judd et al., 2006; Rickwood et al., 2007).

Although there is no specified definition of informal help-seeking, informal sources of support are mostly recognised in existing literature as those that are from personal and proximal relationships, for example, family, friends or within an individual's social network (Rickwood & Thomas, 2012). Teachers have been categorised as both formal and informal sources of support in previous literature. For example, research has suggested that the professional element to the role of a teacher is similar to that of other formal source of supports such as GPs (Rickwood et al., 2005). However, teachers have also been recognised as informal sources of support for young people due to the opportunity for 'strong emotional bonds' to be formed (Barnes, 2019).

Informal sources of support are thought to serve two critical roles in the help-seeking process for adolescents, helping to identify the problem, and helping to transition an adolescent to formal sources of support (Pattyn et al., 2014; Rickwood et al., 2015). A systematic review exploring help-seeking amongst adolescents found that only 2% of studies solely focused on informal sources of support (Rickwood et al., 2012). Further, a recent systematic review of adolescent help-seeking research acknowledges that the majority of existing literature on help-seeking focuses on barriers and facilitators to formal avenues of support only (Velasco et al., 2020). Nevertheless, informal sources of support are favoured by young people (Rickwood et al., 2007; Rusch et al., 2014). Key benefits to seeking help from informal sources of support

are thought to be the immediacy in availability, ease of access due to proximity, and that these sources are perceived more positively compared to formal sources (Best et al., 2016; Rusch et al., 2014). In contrast, a recent meta-synthesis showed that many adolescents feel a lack of safety when disclosing personal information with proximal others and worry that information may be used against them and thus lead to stigmatisation (Barnes, 2019; Gulliver et al., 2012; Spence et al., 2016). Perceived trust and competency in support systems, as well as consideration of the position a source holds (e.g., a teacher or coach) are shown to be key factors that adolescent males consider when seeking support (Gulliver et al., 2010; Raviv, 2000). Linked to trust, having assurance that confidentiality will be maintained by the source of support is seen as essential (Gronholm et al., 2017; Recto & Champion, 2018).

In childhood, parents and carers play a significant role in recognising problems in young people and therefore often seek formal support on their behalf (Boulter & Rickwood, 2013); Rickwood et al., 2005) The influence of family in the help-seeking process is still established during adolescence; despite an increase in autonomy from parents, as well as capacity to self-refer, research illustrates that family still facilitate and support adolescents to seek professional support (Rickwood et al., 2015). In adolescent male literature, receiving positive support and attitude from a significant other such as a family member has been shown to positively influence how young males seek formal support for mental health difficulties (Gulliver et al., 2012; Harding & Fox, 2015).

However, a recent systematic review found that negative family beliefs towards mental health services and treatment were the second biggest barrier for adolescents when considering seeking support (Velasco et al., 2020). Other known barriers to help-seeking from family and friends have been established elsewhere such as negative and stoic attitudes from others, and perceived public and internal stigma (Gulliver et al., 2012; Judd et al., 2006; Rowe et al., 2014; Rusch et al., 2014; Spence et al., 2016; Vogel & Wade, 2007).

Adolescence represents a time of establishing independence, as well as personal and social identities; therefore, disclosing mental health to those familiar may feel like a greater threat to identity and perceived autonomy (MacLean et al., 2013; Mansfield et al., 2005). Characteristics of male gender socialisation (e.g., stereotypes of male roles within a family) may seemingly contribute to gender-role confliction in relation to seeking help for emotional difficulties (Addis & Mahalik, 2003). Nevertheless, this does not explain why young men seek help in some circumstances and not in others, and with whom do these dilemmas arise (Mansfield et al., 2005).

A systematic review exploring how various social networks influence help-seeking behaviour in young people showed that they often considered parental burden, parental problem perception and parental perception of need (Ryan et al., 2015). However, this study did not explore how these experiences and perceptions vary by gender. Further, while it is recognised that schools and colleges are an optimal setting to implement early intervention programmes for mental health awareness for young males (O’Neil et al., 2013), there is little research that explores how young men perceive and experience student-teacher relationships in relation to help-seeking for mental health difficulties (Halladay et al., 2020; Lynch et al., 2016). Despite there being research to demonstrate how informal relationships play an important role in accessing support, there is a paucity of exploration into how young people, especially young men, perceive seeking support from informal sources in the first instance.

Purpose

The adverse consequences of young men not accessing mental health support (ONS, 2019), and the current UK focus on supporting the mental health needs of the most vulnerable young people in society (Health Secretary, 2019; Public Health England, 2017), presents a clear context to exploring how young men experience their mental wellbeing and how they perceive seeking support from proximal others. Despite research illustrating how young people prefer

informal sources of support and the important role informal sources have in supporting young people with their mental health (Gulliver et al., 2010; Pattyn et al., 2014; Rickwood et al., 2007; Rickwood et al., 2015; Rusch et al., 2014)), there is a paucity of exploration into how young men perceive and experiencing seeking help through informal sources (Lynch et al., 2016; Salaheddin & Mason, 2016;). Therefore, this research aims to explore the proximity and intersubjectivity of informal relationships that young men possess and consider their impact on attitudes and experiences of help-seeking for mental health difficulties.

2. Methodology

2.1 Ontological and epistemological approach

A critical realist position was adopted throughout the study, recognising that my own, and participant's experiences and meaning-making, occurs within a socio-cultural context (Burr, 1995; Harper 2012; Willig, 1999). A critical realist approach assumes that the data is informative of participant's 'realities' but acknowledges that the data does not mirror actual reality as people's experiences and perspectives are constructed and influenced by their social, psychological, and material world (Hruby, 2001; Willig, 2012). Critical realism therefore signifies two positions; firstly, an ontological realist position which holds the assumption that there are underlying structures and mechanisms that generate phenomena that we make sense of through language (Willig, 2012), secondly, an epistemological relative position that considers knowledge to be valid only relative to the cultural, historic, individual, and social context (Harper, 2011). The aim for this research was to consider the thoughts, experiences, and perceptions of adolescent males in addition to considering the multifaceted social, historical, cultural, and political determinants that may have contributed to thoughts and experiences.

2.2 Participants

Fourteen male adolescents aged 16-18 were recruited from a sixth-form college in the North-West of England. This demographic was identified from calls from previous literature to

consider gender sensitive research in the area of adolescent boys' and young adult men's mental health (Rice et al., 2018). Further, this age group is likely to interact with multiple proximal 'micro-systems' during this time, for example, family, friends, and school (Bronfenbrenner, 1992; Moore et al., 2018).

2.2.1 Sampling strategy

Based on recommendations for qualitative research that adopts thematic analysis (Braun and Clarke, 2012), the current project aimed to have a minimum sample size of 10 and no more than 20 participants at the risk of the researcher losing a close relationship to the data (Crouch & McKenzie, 2006). The total sample consisted of fourteen participants, which based on the qualitative research literature is sufficient in providing a richness of data using thematic analysis (Fugard & Potts, 2015). Nevertheless, the author held in mind the reflexive thematic analysis approach being adopted for data analysis and the concept that analysis of data is continuous and fluid dependent on the deepening engagement from the researcher (Braun and Clarke, 2019a; Braun & Clarke, 2019b).

2.2.2 Recruitment

Two recruitment strategies were used to encourage participation from students. The researcher distributed a recruitment poster (see Appendix A) to staff at the college which was included in a weekly student bulletin sent to students' email addresses. Secondly, to promote engagement from students, form teachers reminded students of the opportunity to take part in this research project during form and assembly time. Interested students contacted the researcher via the researcher's email address on the poster and the researcher sent an information sheet (see Appendix B).

2.3 Design

A qualitative research design was chosen to allow for thorough exploration, analysis, and awareness of subjective viewpoints shared by participants (Flick, 2018), and to consider how

these views sit within a broader cultural, historical, and social context (Harper, 2011). A semi structured interview guide was used to prompt detailed exploration of subjective viewpoints shared by participants (Flick, 2018). Interview questions were developed collaboratively with a young adult peer support group in London. Alongside the researcher, the peer group discussed and adapted interview questions, considering the language used in questions to ensure accessibility for young males. Broad questions about what “mental health” or “well-being” meant to participants were used to start the interviews. This was then followed by more specific questions around seeking help for difficulties. Interviews lasted approximately 30-40 minutes and participants were given a copy of the interview in case it was easier to read the questions in addition to hearing them and so participants could hold the question in mind (see Appendix C).

2.4 Ethical considerations

Ethical approval to conduct this study was confirmed by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee (Appendix D). Participants were aware that they could withdraw from participation at any point and that they did not have to disclose any personal information during interviews. Interviews were audio recorded and transcribed verbatim by the researcher. All interviews were transcribed anonymously, and any identifying data were taken out. All recordings were stored securely on an encrypted device and erased following transcription.

Due to the nature of the research, the consent form (see Appendix E) informed participants about the purpose of the interview, the role of the interviewer, and that the topic may elicit personal and sensitive experiences of mental health that could cause distress. Participants were reminded verbally that the interviewer is a researcher and not someone that can offer counselling or advice in relation to their or someone else’s mental health.

2.5 Data analysis

Thematic analysis (Braun & Clarke, 2006) was used to analyse data to allow for development of themes that are interpreted from an occurring phenomenon across the data set. Adopting ‘reflexive thematic analysis’ (Braun & Clarke, 2019) allowed the researcher to construct patterns of shared meaning amongst participants, whilst maintaining reflexivity through the process, for example observing and acknowledging researcher assumptions and acknowledging that there is no objective truth. The use of qualitative semi-structured interviews allowed the researcher to explore how views and experiences shared by participants may be influenced by broader discourses in society (Braun & Clarke, 2006).

Braun and Clarke’s six stages of thematic analysis (2006) were utilised to guide data analysis and identify themes. A reflexive log was used during the process of the interviews (see Appendix F for example extracts). To gain familiarity with the data, the researcher read and reread transcripts and noted down any initial thoughts. Segments of the data that were interesting or meaningful to the research topic were initially coded, see Appendix G for example of initial coding. This was done by highlighting sections of data printed on physical copies of the transcripts. Using a reflexive diary, the researcher maintained awareness of what they were drawn to in the data, considering their own values, experiences, interests, beliefs, social identities and how this may have shaped the analysis as well as the wider research (Willig, 2001). The researcher adopted an iterative process of identifying, interpreting and defining potential ideas and themes across all fourteen interviews. To visualise the relationship between codes, themes and different levels of themes, ideas were initially were documented using a thematic map (see Appendix H). Candidate themes were then collaboratively reviewed alongside the researcher’s supervisors to ensure themes sat within the context of the whole data set. For example, earlier themes such as “*A shared understanding*” was later placed into a broader theme of “*Proximity and familiarity*”. Once themes were initially reviewed, themes

were defined and named to ensure they captured the essence of what the theme is about and what the themes collectively say.

2.6 Reflexivity

Using a reflective diary provided an opportunity to capture the researcher's own experiences and assumptions made during the interview and analysis process. This included critical reflection on the research process and both the 'outside' and 'inside' positions the researcher held with participants (Finlay 2002a, 200b; Gallais, 2008). For example, the researcher considered that they held an outsider status being an adult woman researching adolescent men. However, the researcher reflected that that they may share insider status if considering socioeconomic status and culture.

3. Results

Two overarching themes were constructed that explore the proximity and intersubjectivity of informal relationships and their impact on attitudes and experiences of help-seeking for mental health difficulties. The first theme, *Familiarity and distance* explores how participants perceive and experience dimensions of familiarity with proximal others and how this influences decisions about seeking help for mental health problems. Relational qualities according to proximity to the relationships are explored, for example, trust, familiarity and working alliance. The second theme, *Navigating feared outcomes and remaining silent* explores how participants consider possible adverse consequences of seeking support on their own identity and on proximal others. Notions of burden, stigma, and masculinities are explored in relation to the proximity of relationships that these young men hold.

1. Familiarity and distance

Throughout the corpus of data, it was apparent that proximity and familiarity felt within key relationships were important qualities when young men considered who to seek support from. Some participants highlighted the expected benefits that familiarity with others would bring to the help-seeking process. Joe discusses this in relation to family, "*Family are people that*

should know you the most and will be the most helpful” (Joe). Joe locates the advantages of seeking support from family who feel familiar and connects this with anticipation of receiving optimum support.

Familiarity is depicted as a key facilitator in the help-seeking process and thus the proximity to family that some adolescents experience may explain why family are a preferred source of support for mental health difficulties for young people (Rickwood et al., 2005; Rusch et al., 2014). Michael further explores the advantages of familiarity with family in the help-seeking process and associates this with the notion of feeling understood and heard:

I think that's (family) everyone's first one (choice of support) because they see them all the time and they know if you like you're not right or you're acting a bit different, and I think family, of nine times out of 10, are the most understanding ones to talk to.
(Michael).

The above extracts show that both Joe and Michael recognise their family as central to the support of their own well-being. The language chosen by Joe, *“should know you the most”*, and by Michael, *“the most understanding”*, could illustrate their expectation that the everyday proximity and familiarity of this type of relationship positions family members to better understand and support them. Similarly, John seemingly emphasises the importance of familiarity, as experienced through family, by making a comparison to the unfamiliarity of a GP:

You don't have to go through all the...like, if you go to the GP and that and you have to tell someone you don't really know about it, and I know, that if you tell family that they would try to help straightaway, they wouldn't just think well, I don't know if it's serious enough yet. Like they would know you are being serious. (John).

Like Joe and Michael, familiarity can be understood as a valuable mediator to John's help-seeking behaviour. John's description of disclosing to family *“they wouldn't just think well, I*

don't know if it's serious enough yet", perhaps highlights the intersection between familiarity and trust in the source to listen, understand, and provide support. Perceived competency and trust in support systems are shown to be key factors that adolescent males consider when seeking support (Raviv, 2000). Seemingly, for some participants, proximity to family can bring feelings of familiarity, trust, and confidence that families will continue to understand and value them. Additionally, previous experiences of open communication, opportunity to raise issues, and receiving support within families likely influences feelings of competency in sources of support (Noller and Callan, 1991). Thus, perhaps making the process of seeking help from family a less-threatening experience compared to others due to the proximity of the relationship (Coyne & Bolger, 1990; Wills, 1991).

Familiarity and trust were also identified as key considerations when participants contemplated seeking support from teachers, with some participants seemingly considering the unique attributes of this proximal relationship in the help-seeking process:

Yeah, because within college, you can be fairly familiar fairly quickly with like staff or people there so they know who you are, I think it would be often easier to go to them instead of like a GP or a doctor, because the familiarity between the two. (Sam).

Sam draws upon his experiences of feeling close with staff and refers to how quick these relationships are established, possibly to the frequency in which they see each other. For Sam, it appears that the teacher's acknowledgement of who he is as an individual offers a sense of familiarity within this relationship, which is key to Sam's thoughts of who to seek help from. Further, feelings of trust and proximity in their education environment seem to be reinforced by unique socio-contextual factors such as physical structure, ethos and school climate:

Because they actually listen, [...] I feel like colleges are about the students. (Paul).

So it's a good thing to have a place of security, and then people to help you in that place of security. So I think yeh, it's that bridge between good help and trust. (James).

Both Paul and James identify contextual factors within an environment that facilitate help-seeking behaviour, while acknowledging how this influences the quality of, and trust felt within, the teacher-student relationship (McLeroy et al., 1988).

Other dimensions of familiarity were explored when participants spoke about seeking support from friends for mental health difficulties. Participants recognised that friendships contain the qualities of familiarity and closeness that could facilitate seeking support. This may reflect a stage in adolescence in which friendships begin to fulfil attachment needs, proximity seeking, and emotional support (Bokhorst et al., 2010) and become increasingly important in the help-seeking process (Bokhorst et al., 2010; Rickwood et al., 2005). Alongside familiarity, Harry illustrates how friends of a similar age can facilitate help-seeking:

[...] like I think because I know them and they are the same age it is easier and I would if I had to but I don't think I could speak to a parent or someone older. (Harry).

Harry identifies similarity in age with his friends to perhaps reflect a sensed mutual understanding based on shared experiences and environment. Harry conveys seeking help from a friend would be easier compared to “*a parent or someone older*”.

It seems a shared understanding of roles in a relationship, depending on context, is important to some young men. Jack explores this idea within the student-teacher relationship:

You need something like a teacher who sees you most days who stands up and says ‘tell me what is wrong’ – it can be better to have someone that is open and warm. (Jack).

Jack refers to the familiarity within this student-teacher relationship and considers the unique interpersonal and relational characteristics. Student-teacher relationships or ‘working alliances’ (Bordin, 1974), encompass three components: bond, task and goal. Jack’s description of the relationship, “*open and warm*”, may reflect the ‘bond’ component of these relationships which comprises of positive attachment based on mutual trust, respect and care (Toste & Dallaire, 2010). Positive communication and immediacy behaviours within these relationships

have the potential to empower young people to feel confident and secure (Bainbridge & Houser, 2000). Jacks also draws on ideas of trust and hope in a teacher's position which can be understood as doing two things: a) notice changes in a student's emotional well-being and b) encourage them to discuss their emotional well-being. The anticipation of a positive reaction from a person of significance, is shown to be a key facilitator in adolescent male help-seeking literature, especially if they are considered to be in a position of trust (Gulliver et al., 2012). Aspects of trust in the teacher's position, alongside sensed warmth, and openness within the relationship, supposedly plays a role in helping these adolescent males feel like they will be noticed and listened to. Others highlighted the perceived professionalism and capacity of teachers that appeared to contribute to feelings of trust in teachers, as Michael notes:

Yeah, I feel like your peers could only do so much or say something to you, but if you speak to someone like associated with the college they've got the ability to pass it on to more like experienced people, it would help yeah. (Michael).

Michael refers to established trust and professionalism within a teacher's role with an expectancy that they are knowledgeable and responsible for providing support to their pupils and for signposting to more professional support if needed. This notion of trust in teacher's roles is further expressed by Callum:

I trust them to do what's best, if they're trained to do it. (Callum).

For other participants, familiarity that comprises shared previous experiences, especially concerning mental health, seemed to act as a facilitator to seeking support (Camara et al., 2017):

But also it just feels OK to feel like that when you talk to peers, especially if they suffer themselves. (Leon).

For Leon, shared experiences between friends perhaps negates feelings of perceived stigma and facilitates feelings of interpersonal trust (Rotenberg, 1994). Consequently, these feelings of trust increase the likelihood of sharing experiences with friends (Mortenson, 2009). As Joe

discusses, “*One of my friends - It took like for me to open up about it to him for him to then open up to me*”, the openness of others within social relationships accentuates the sense of self, enhancing feelings of security and diminishing feelings of anxiety (Stack-Sullivan, 1953). For many participants, shared values and propensity of trust were related to an expectation of mutual support (Harpham et al., 2010) with gender seemingly having an impact on likelihood of feeling judged or burdened by those in their social network (Perkins et al., 2018). The idea that there is a decreased sense of burden and judgement when seeking help from others that are familiar and trusted was explored by other participants:

I think the easiest thing that I would find to do is to consult with peers, because it's often harder to seek the professional support out of fear of being judged, it's much easier to go to friends...hence why it's easy to go with friends, because you've built that trust and connection between the two people. (Sam).

Sam further identifies the association between built trust with those familiar and decreased likelihood of judgement. The fear of judgement reflects the perceived threat to identity in the process of seeking support for mental health difficulties (MacLean et al., 2013). Seemingly, for some, this perceived threat was considered greater when thinking about seeking support from someone unfamiliar like a health professional. The views collected from these young men present different thought processes to those identified in adolescent male literature which suggests that seeking support from more formal and unfamiliar sources (e.g., a GP) allows for more control over self-image as it operates outside of a social network (Best et al., 2016). For other participants, having a physically separate space from family and friends such as college provided space that offers feelings of trust safety:

Yeah, it's given like, it's given the option like of safety, which is what often most people will seek to (...) So it's offering like a, like a secure, safe and private service among like

among other people (...) that makes you feel more comfortable to express how you feel.

(Sam).

Through reference to “*secure, safe and private*”, it is possible that seeking help from within an educational setting removes the established barriers to help-seeking such as perceived stigma or threat to identity that may be experienced when seeking help from family and friends (Chan 2013; Clement et al., 2015; Vogel & Wade, 2007). Further, seeking help from an educational setting may allow for distance from more emotive relationships such as family and provide the opportunity for young men to leave their distress in a secure place (DoE, 2018). For some young men, the proximity of student-teacher relationships entails emotional boundaries that can facilitate the help-seeking process. For example, as Nathan identifies, relations with teachers offer familiarity, but perhaps without the emotional intimacy and awareness that may be expected with friends and family:

I think it'd be a benefit because they've known you for since you came to the college but It means they don't know what you're going through and I feel it's easier to explain to them... if you speak some to someone you don't really know, they can't tell you different things, they don't know your upbringing or what you've been through so they can't judge you. (Nathan).

Nathan's description could indicate that the teacher-student relationship holds familiarity through proximity, however, there is a possible reference to the boundaries of this proximity: “*they don't know your upbringing or what you've been through so they can't judge you*”. For Nathan, these parameters to this proximity may mitigate feelings of judgement, emotional responsibility, or burden. The boundaries of this proximity are further highlighted by Paul:

But if it's with someone in college, I'm probably not going to see them outside of college and they're not going to be at home with me so it won't be awkward. I'll just say and

get off my chest and just say it out loud and talk about it there instead of having an embarrassing situation. (Paul).

Both Paul and Nathan highlight that seeking help from a teacher, in which the relationship sits within the context and environment of college, prevents feelings of embarrassment, awkwardness, and judgement, all known barriers to seeking support for mental health (Gulliver et al., 2010). The importance of familiarity with boundaries illustrated in the data is synonymous with previous research that shows that for secondary school students, availability to talk to a non-family member and having teachers that had gotten to know them, were associated with help-seeking behaviour in secondary school students (Mariu et al., 2012). The need for established social relationships that are based on established trust, whether friends, family, or teachers, is significant in facilitating disclosure (Rickwood et al., 2005). However, these experiences and thoughts shared show how this trust is established and maintained varies greatly depending on contextual and individual factors.

2. Navigating feared outcomes and remaining silent

Participants drew upon perceived notions of emotional burden across the data when talking about disclosing their mental health problems to those they have a proximal and emotional relationship to. Considering their gender and age, participant's accounts of burdening others often encapsulated notions of hegemonic masculinity (McKenzie et al., 2018), for example, not wishing to express 'weakness', and feelings of self-reliance; known barriers to help-seeking in young people in the UK (Salaheddin & Mason, 2016). Participants identified the complexity in disclosing their mental health difficulties to those they hold an emotional connection to:

I think seeking support from family is quite difficult for the fact that for a parent to hear that their child - I know especially - I got to the stage where I didn't want to be here anymore - for a parent to hear that from their child (it) must be very very hard. (Leon).

In Leon's account, he envisions how difficult it would be for his parent to hear of his struggles with mental health, possibly reflecting how the proximity and closeness of this relationship influences anticipated feelings of emotional burden. Leon further highlights the dynamic of the parent-child relationship, in which parents provide to keep their child healthy and safe, seemingly identifying existing feelings of burden that disclosing emotional difficulties would add to. As Leon comments:

(...) there was a part of her that was like as if she had failed me as a parent because they can't make their child feel the way they want their child to feel...because I don't want them to think they haven't done enough (...) Some people might be able to just tell them (parents) but I would worry about them afterwards. (Leon).

Like others, Leon's disclosure to parents presents a challenge, "*I don't want them to think they haven't done enough*". Although it is apparent that Leon wishes to avoid his parents worrying, this challenge also perhaps reflects a vulnerability in seeking support at an age in which adolescents are supported to take up opportunities to be more resourceful in increasing their independence (Balters & Silverberg, 1994; Larson & Richards, 1991; Steinberg & Morris, 2001). Leon's avoidance of disclosing to parents may also represent an evasion of his own felt experiences of indebtedness and perceived self-reliance; this may be sourced from not wishing his mother to feel as though she has not provided enough support for him, nor he may not wish to appear dependent on his mother (Ingersoll-Dayton & Antonucci, 1988; Lu, 1997).

Others spoke about the implicit rules, assumptions, and boundaries of reciprocity within families that impede opportunities to communicate concerns about mental health (Minuchin, 1974). For example, James discusses:

It's probably just more like a subconscious thing. Because whilst I've been growing up, my mum has basically done everything. So I've just grown up with this attitude of she

already does so much so I don't want to bother people so like, they must be going through their own issues, they don't want to hear about mine too. (James).

James's account possibly reflects the intersection between becoming increasingly independent, becoming reflective of the resources he has been given, and the paucity of reciprocity within the parent-child relationship (Emerson 1981; Gouldner 1960; Molm & Cook 1995). James illustrates how he has come to understand the role of his mother in his family as someone that *"has basically done everything"* and *"already does so much"*. Also perhaps contributing to perceived feelings of indebtedness, James may be cognisant of his mother having provided the majority of emotional support and care within the family that hasn't been reciprocated (Brummelhuis & Greenhaus, 2018; Chung, 2020; McMunn, et al., 2019).

Like James, it was apparent that other participants were conscious of the asymmetry and non-reciprocity in emotional support with parents and how this influences young men to pursue self-reliance and avoid feelings of burden. Whilst others reflected on notions of self-reliance and burden, Sam anticipates that contributing to parent's stress would feel emotionally burdensome as they do not burden him with their problems:

You don't want to add to that list of like priorities that already seemingly stressed them out. And you don't want to be even more of a stress on them (...) And often it would be hard to put more pressure on them when they basically give you none in return. (Sam).

Considering the demographics of the participants (White British males who attend a college in an area recognised as being 'most deprived', IMD quintile 1), notions of 'class' may influence how some of the participants experience masculinities, stigma, and help-seeking (Joseph Rowntree Foundation, 2016; Mahilik & Dagirmanjian, 2019; Thomson et al. 2018). It was particularly evident that the young men had experienced the influence of hegemonic masculinities throughout their childhood. Harry shares that he had learnt that it was easier to hide feelings or share them with someone anonymously:

I've been raised to like, well it's a weakness to show emotions so probably go online and find one of those anonymous things. (Harry).

Harry's reference to learnt masculine ideals of toughness and self-reliance are similar to those identified in existing research; for example, notions of physical strength, toughness, competitiveness, and heterosexual prowess were shown to be central to ideas of adolescent masculine norms in a systematic review of twenty-nine (majority Western) countries (Kågesten et al., 2016).

Like Harry, other participants expressed how notions of masculinity, such as not showing emotions to others, were things that had seemingly been learnt both explicitly and implicitly from a young age (Blakemore, 2003). As the following comment:

As males, you grow up with not showing emotion and not talking about any of that. (Jack).

Epecially within like males, it's like very, it's taught to you that it gets very hard to confide with like emotions and feelings and expressing them often leads to like ridicule from the male parent, where it's a case of that you shouldn't be feeling such like negative things or to be like the idea of a man is that you shouldn't necessarily be feeling these emotions. (Sam).

Feared outcomes of disclosure, such as Sam's fear "*ridicule from a male parent*", reflects research that suggests parental disapproval and perceived stigma is a barrier to adolescents seeking support (Chandra & Minkovitz, 2006) and the intersection between deprivation and attitudes towards mental health (Thornicroft et al., 2016). Considering the demographics of the participants, notions of 'class' may influence how some of the participants experience masculinities, stigma and help-seeking (Joseph Rowntree Foundation, 2016; Thomson et al., 2018).

These young men appear to be conscious of the impact of gender roles when interacting with others on an emotional level, for example, they perceive they will experience feelings of burden or judgement (Perkins et al., 2018). However, it was apparent that these young men were also able to identify how familial masculinities may have been shaped by aspects of culture and family scripts that inform men's roles within family. For example, Sam shares:

And it's harder with a parent who you view as a role model because you see that masculinity and it's the steps that you follow, and they don't often show the emotion side of it. And if it is, it's behind closed doors (Sam).

These felt experiences of intergenerational notions of masculinity from family members, particularly upheld by fathers and grandfathers are echoed in existing literature (Mahalik & Dagirmanjian, 2019). The rhetoric of avoiding disclosing emotions, or if you do, “*it's behind closed doors*”, highlights the importance for these young men to ensure emotions are kept private and away from the public gaze. Emotional restraint is just one element of normative, hegemonic, and dominant forms of masculinity in Western culture that are maintained in public to prove manliness and manhood (Berger et al., 1995; Connell, 1987; Connell, 1996).

Paul further describes identified masculine traditions within his family by identifying the contrasting roles between his mum and dad in providing support:

Like for example, my sister's going through things now and has gone through things in the past but my mum's more understanding, but my dad's more of the like the traditional – he was brought up by my grandad who was very masculine basically (...). (Paul).

Seemingly, Paul views his dad as someone who holds more negative attitudes towards mental health problems compared to his mum (Henderson, et al., 2016). With reference to his sister's difficulties, and his mum's “*understanding*” approach to difficulties, Paul may also be referring to aspects of femininity embedded within family rules that permit more opportunities for women to express emotions (Brody & Hall, 1993; Kring & Gordon, 1998). The contrast in

attitudes and roles within a family seemingly offers a feeling of uncertainty and uncomfortableness about the outcome of disclosing problems to family members (Time to Change, 2015). For both Sam and Paul, the decision on who to seek support from may be contingent on their felt sense of burden related to perceived roles as protectors and providers as young males (Robertson, et al., 2016).

Notions of masculinity appeared to underpin more discussions about seeking support from friends compared to family. There was a recurring worry amongst participants that they would not be taken seriously when disclosing mental health difficulties to friends, especially those that are male (Mackenzie et al., 2018). For example:

I think peers, there's sort of a thing, especially males, you don't talk about emotions, there isn't a big thing, erm, a lot of people, I would say, they would be aware of it but they just would make a joke out of it. (Jack).

Jack's quote encapsulates the issue of friends being aware of the mental health difficulties of others but that this awareness does not lead to conversation or exploration of difficulties. The paucity of conversation about mental health likely contributes to feelings of perceived social stigma and the belief that those who have mental health difficulties are socially undesirable (Latalova et al., 2014).

Another participant further expresses the feared consequences of talking to other male friends, highlighting the detrimental impact it can have on their mental well-being:

Also, if their friends are lads, they fear being judged by their other lad mates. Because quite a lot of the time, lads are being bravado and stuff like that but so if you go and tell some lads about your mental health, it doesn't always go well because they will bravado you and tell you to man up and it could have a detrimental effect on your mental health. (Liam).

Liam's sensed notions of masculinity within a male social group, "*(they will) tell you to man up*" appears to influence the prospect of seeking support from this group. Liam further identifies a possible negative outcome of disclosing problems: "*it could have a detrimental effect on your mental health*". This may be reflective of the conceptualisation of stigma as a stressor that in turn predicts symptoms of poor mental health, for example, depression (Link et al., 1997).

Seemingly, participants illustrate that asking for help from other male friends juxtaposes the notion of rigid aspects of male gender socialisation such as stoicism, invulnerability, and self-reliance (Addis et al., 2003; Lane & Addis, 2005 Vogel et al., 2011):

(...) because they are going to think they are not as manly if they go to help because I know a lot of people that think they can do everything by themselves and if they ask for people it shows they need other people and it threatens their masculinity. (John).

Here then, John highlights the notion of self-reliance and the apparent contradiction between asking for support and upholding internalised masculine ideals. Supposedly, keeping up a self-reliant identity to protect a certain masculine ideology within a group that values self-reliance inhibits communication and help-seeking due to the risk to identity (King et al., 2020). Notions of masculinities felt within group norms are further explored by another participant:

It's again, like masculinity will often prevent people from wanting to show weakness among other men. So they'll often like put that masculinity above anything else to keep their pride in check. And like, again, it's a feeling of being like anxious or judged for being less masculine than anyone else in a peer group or among a bunch of other men that will prevent people from wanting to like break through to get help. (Alex).

As Alex refers to when he says, "*they'll often like put that masculinity above anything else to keep their pride in check*", seeking help may be seen to deviate from these masculine norms and have implications socially and individually (Sirin et al., 2004). The sensed rigidity of

masculine norms within social groups and the importance of conforming to them is highlighted by Jack when he considers the consequences of non-conforming, “*judged for being less masculine*”. Conformity to masculine norms, such as not showing weakness, has been shown to be most strongly endorsed by younger males (Rice et al., 2011) and may reflect a time in which in-group identity is crucial to self-identity development (Hogg & Turner, 1987; Tajfel & Turner, 2004). The views expressed by these young men capture masculine gender role socialisation and how gendered attitudes and behaviours from cultural norms and ideologies can appear to conflict with ideas associated with help-seeking, for example, relying on others.

4. Discussion

Discrepancies in the rate of young males seeking formal support compared to females is first apparent in early adolescence and continues throughout early and middle adulthood (Marcell & Halpern-Felsher, 2007; Rickwood et al., 2012). High prevalence of suicide rates in young adult men show that these discrepancies have severe consequences (Mental Health Foundation, 2019; Samaritans 2019) and illustrate the importance of ensuring young men have access to support early. Barriers to identify why some young men do not seek formal support for mental health difficulties have been extensively researched (Hernan et al., 2010; Gulliver et al., 2010; Lynch et al., 2016; Rickwood et al., 2007). The general adolescent literature suggests young people prefer informal sources of support and that they often act as gateways to professional support (Rickwood et al., 2007; Rickwood et al., 2015). Despite this knowledge, there is paucity of research that explores avenues of informal support (Velasco et al., 2020), especially for young men (Lynch et al., 2016; Salaheddin & Mason, 2016).

This study therefore aimed to explore the proximity and intersubjectivity of informal relationships that young men possess, and to identify how this impacts how they seek mental health support from these sources. Two main themes were constructed from semi-structured

interviews with males in a sixth-form college in the North West of England: 1) *Proximity and familiarity*, 2) *Navigating feared outcomes and remaining silent*.

The findings from this study illustrate an array of complex and unique challenges that young men perceive and experience when seeking support from informal sources of support. The findings reflect wider research that suggests there are multiple considerations for young men when seeking support generally, for example, self-reliance, masculinities, stigma (Clement et al., 2015; Eisenberg et al., 2007; Evans et al., 2011; Gonzalez et al., 2005; Hernan et al., 2010; Judd et al., 2008; Rickwood et al., 2007; Nam et al., 2010; Vogel & Wade, 2007) However, the themes from this paper explore in depth how such notions, alongside others, such as perceived familiarity and emotional burden, are experienced in relation to the various proximal relationships that these young men hold. It is evident throughout the two themes that the intricacies, sensed connectedness, and dynamics of proximal relationships with others such as family, friends, and teachers, influences how young men perceive and experience help-seeking for mental health difficulties.

For some participants, proximity and emotional closeness with others were embedded with feelings of familiarity, trust, and confidence in the source of help; known facilitators to seeking help (Rickwood et al., 2007; Vogel & Wade, 2007). For others, a shared environment or experience (for example, college), or shared attribute (for example, a similarity in age seen with friends) with a source, offered a working alliance that seemingly facilitated the disclosure of mental health difficulties (Bordin, 1979). In contrast, for others, confiding difficulties to proximal others such as friends and family led to sensed or experienced feelings of burden, stigma, or judgement.

Notions of emotional burden were most apparent when participants spoke about seeking support from family. The fear of emotionally burdening parents was seemingly linked to how participants intersubjectively experienced their relationship with their parent(s) and possibly

reflects the growing awareness of independence at this age, the asymmetry of reciprocity in the parent-child relationship, and the felt sense to be appear self-reliant (Wilson et al., 2005). Seemingly tied to notions of burden, notions of masculinity such as self-reliance and toughness were explored. Participants were aware of the modelling of minimisation or avoidance of help-seeking behaviours within families and communities (Rice, 2018), for example, awareness of masculine traits in fathers and grandfathers, family attitudes towards mental health and gender roles within the family. Maintaining masculine ‘ideals’ within friendship groups, such as self-reliance, invulnerability, and stoicism, appeared to be imperative to these young men. There was recognition that some masculinities acted as barriers to disclosing to male friends and were paired with anticipated worry of being judged for being “*less masculine*” and keeping “*pride in check*”.

Notions of masculinities also wove through many of the participants discussions concerning feared outcomes of disclosing to others such as ridicule and judgement which were more apparent when participants spoke about more proximal relationships such as with friends and family. This possibly illustrates that young men perceive a greater threat to self-identity in disclosing mental health problems to people they have an emotional connectedness to (MacLean, 2013; Mansfield et al., 2005).

This was seemingly less apparent in more distal relationships, most noticeably when young men discussed seeking support from teachers. In addition to providing a sense of familiarity and trust, caring and warm attributes of teachers were poignant to creating a working alliance with young men that facilitated help-seeking (Toste et al., 2010). Participants acknowledged the positioning of the familiar but distal student-teacher relationship within the context of a safe and exclusive environment in which they could leave their distress. Participants were able to reflect that the student-teacher relationship, although familiar, holds boundaries, for example, teachers do not know everything about them. These unique attributes to the student-

teacher relationships therefore perhaps does not necessitate emotional intimacy, potentially mitigating feelings of emotional burden, judgement, or responsibility.

4.1 Implications for practice

The findings highlight that while informal sources of support play an important role for young men in accessing support, there needs to be better understanding of the different challenges that young men face when considering disclosure of mental health difficulties. The findings illustrate that young men experience their informal relationships differently, as well as their own personal and group identities. Therefore, facilitators and barriers to disclosing mental health difficulties needs to be understood in relation to how young men interact with others based on the proximity of relationships, theirs, and others gender, as well as the social context that surrounds relationships (Schofield et al., 2000). Considering the interaction of these will allow for a more thorough understanding of how men's mental health outcomes are informed by the social contexts and social relationships they find themselves in (McKenzie et al., 2018). Secondly, due to the interconnected system of students, teachers and parents, schools and colleges have been identified as an ideal setting for interventions around mental health attitudes (Eriksson et al., 2018). While providing services within a school environment may address systemic and structural barriers to accessing mental health services (Wolpert & Cortina, 2018), interventions in schools and colleges should focus on specifically addressing or incorporating masculinity-based factors. For example, using male-tailored language (Blazina & Marks, 2001; McKelley & Rochlen, 2010; Wahto & Swift, 2016 and offer group interactions and shared activity in informal spaces (Margalit & Ben-Ari, 2014; Oppen et al., 2014; Robertson et al., 2015). This may lead to greater acceptability, engagement, and impact with young men (Calear et al., 2017). Given that the findings further illustrate that many young men fear judgement from others for speaking about mental health, local and national awareness campaigns need to take a developmentally targeted approach that considers this demographic (Rice et al., 2018).

Thirdly, as part of the interviews, some participants discussed the need for a dedicated space for males to discuss issues that matter to them, with the help of a male role model that can facilitate conversations. Initiatives like ‘Becoming a Man’ aims to provide a space for young men in their educational setting to express how they feel and what matters to them. Targeted mental health programmes for both young and adult men have shown to positively impact men’s mental well-being (Gwyther et al., 2019; Seaton et al., 2017;). Creating the opportunity for young males to participate in group work concerning mental health may promote help-seeking behaviour by reconfiguring the notion that help-seeking is unmasculine and normalising mental health difficulties (Jorm et al., 2008). This is evident in groupwork for adult male populations that have been seen to facilitate the opportunity of reciprocity and creating a sense of normativeness (Addis & Mahalik, 2003).

Finally, despite the barriers that young men face when discussing mental health, most participants were able to speak comfortably and articulate their thoughts and experiences concerning disclosing mental health to their families, friends, and teachers. This highlights the importance of including their voices in future research and in intervention development (Lynch et al., 2016; Rickwood et al., 2007).

4.2 Limitations and future direction

The aim was to explore an under-researched area and gain a deeper understanding of how young men experience relationships with informal others and how this influences how they seek support for mental health difficulties. As the sample of participants were White British and were from an area ranked at the lowest decile of deprivation, the findings may not be suggestive of experiences of young men from other ethnicities, cultural or socioeconomic backgrounds. Given that notions of masculinities manifest in the male help-seeking research, masculine norms also need to be understood from those that are not from majority white,

heterosexual, Westernized countries (Cole & Davidson, 2019; Kaya et al., 2018; Pederson & Vogel, 2007; Salgado et al., 2019).

Further, participants were a specific sub-group of young males who were recruited from a sixth form college and were attending further education beyond compulsory education. Therefore, the voices of young men who do not participate in further education are not included. Given that association between young men's mental health and higher exclusion rates at school compared to girls (DoE, 2019), future research should consider gathering the views of these young men. Lastly, it should be acknowledged that as a female researcher interviewing young male participants, uneven gendered power dynamics negotiated through explicit and implicit interactions will have influenced how participants expressed themselves and therefore what data is generated (Holmgren, 2011; Lefkowich, 2019).

4.3 Conclusions

Adolescent males have been identified as needing early psychological intervention strategies due to the onset of mental illness occurring in early adulthood (Gonzalez et al., 2005) and the known high rates of suicide in early adulthood (Klineberg, Biddle, Donovan, & Gunnell, 2011; Richardson, Clarke, & Fowler, 2013). Facilitators and barriers to males seeking formal support have been outlined earlier in research (Clement et al., 2015; Hernan et al., 2010; Rickwood et al., 2007; Vogel et al., 2007;). This has indicated the importance of informal sources of support for adolescents (Rickwood et al., 2007; Rickwood et al., 2015), however there was a paucity of how young men experience informal sources of support. This study aimed to take a more in-depth exploration of how young men experience the proximity and intersubjectivity of informal relationships and identify how these experiences influence seeking support for mental health difficulties from these sources. The findings illustrate the complexities and intricacies of informal relationships that young males possess as well as the socio-cognitive, systemic, individual, and structural factors that influence help-seeking behaviour. These complexities

must be understood in order to address the disparities in help-seeking behaviours for mental health problems. Therefore, this study concludes with the suggestion that future research should consider how young men perceive their proximal relationships in the context of help-seeking from a wider perspective, exploring how ethnicity, culture, and socioeconomic background influences help-seeking from informal sources of support such as friends, family and teachers. Given that young males experience their proximal relationships differently, future early intervention work should ensure that support can be accessed through multiple channels.

5. References

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Part 2: Major Research Project, Empirical Paper Appendices

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Appendix A: Research poster

PARTICIPANTS NEEDED!

**Would you like to
participate in mental
health research?**

WHY?

My name is Lauren Burke and I'm training to become a Clinical Psychologist. I am researching what mental health means to young men aged 16-18 and how they seek support.

WHAT WILL IT INVOLVE?

It will involve a short discussion that will cover these themes:

1. How do you understand mental health?
2. What is your experience of education around mental health?
3. What are your thoughts around seeking support (for example, visiting the GP, speaking to friends)?

WHEN and WHERE?

I will be visiting [redacted] to carry out one-to-one discussions in a private space on the college site on these days:

NOVEMBER: Wednesday 13th Thursday 14th Friday 15th

WHY SHOULD I PARTICIPATE?

By participating, you will be contributing towards important mental health research that will benefit society in the future and you will also have some insight into what research in the field of psychology looks like! Further, this research will allow you to have the space and time to reflect on what has shaped your own views about mental health.

If you want to sign up to participate or know more, please contact
[redacted] **or Lauren Burke**
(lb01106@surrey.ac.uk)

This study has been granted ethical approval from University of Surrey, Faculty of Medical & Health Sciences.

Appendix B: Participant information sheet

Participant Information Sheet

How do young men understand their mental well-being and experience mental health interventions in educational settings?

Introduction

I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand. Talk to others about the study if you wish.

What is the purpose of the study?

Research has shown that there is a rise in young people experiencing mental health difficulties in the UK. Despite young men and women experiencing mental health difficulties at the same rate, it seems that young men do not seek support as much. This includes seeking support from friends, family and health professionals.

I want to understand how young men experience:

1. their mental well-being
2. how they seek support (whether this is through online resources, peers or health professionals)
3. educational-based well-being/mental health lessons or resources

What is involved?

If you wish to participate, you will take part in a one-to-one conversation with me, the researcher, and this will last around 30-45 minutes. The discussion will be around how you experience your own mental well-being, how you understand mental health and how you might seek support for your mental health. All one-to-one discussions will be held on the college/school site in a private space.

If you agree to take part, we will then ask you to sign a consent form. You will be offered a copy of the information and consent form to keep if you wish. The research will last 18 months but your involvement would only be 30-45 minutes.

Why have I been invited to take part in the study?

You have been invited to take part in this study to help us understand what impacts young men's perceptions of their well-being and what impacts how they look for and access support when they need it. You are welcome to participate whether or not you have experienced mental health difficulties.

To be eligible to take part in the study, you must meet the following criteria:

- Identify at male
- Be aged 16-18 years old
- Have participated in a school or college educational mental well-being intervention

Do I have to take part?

No, you do not have to participate. There will be no adverse consequences in terms of your education or access to mental health support. You can withdraw your participation at any time. You can request for your data to be withdrawn without providing a reason and without prejudice until the data is analysed, expected to be September 2020.

Recordings of one-to-one discussions will be collected via an audio recorder and stored on an encrypted memory stick. Discussions will then be transcribed anonymously and will be held on a password protected computer.

If you withdraw from the study this will mean the following for your participation and data*:

All identifiable and anonymised data collected would be withdrawn from the study. Data which is not identifiable to the research team may be retained (because we cannot trace this information back to you). No further data would be collected or any other research procedures would be carried out on or in relation to you.

What will happen to data that I provide?

Research data are stored securely for at least 10 years following their last access and project data (related to the administration of the project, e.g. your consent form) for at least 6 years in line with the University of Surrey policies.

Personal data will be handled in accordance with the {UK} General Data Protection Regulations (GDPR) 2018

What are the possible disadvantages or risks of taking part?

Although the researcher won't be asking direct questions about mental health difficulties you might have experienced, it is possible due to the topics surrounding mental health and help-seeking that you may become distressed during the discussion. If this happens, you are allowed to stop the discussion at any time and withdraw from the study at any time also. If you need support after the interview, the researcher can signpost you to relevant websites and phone lines that can offer support.

If you feel you are concerned about this risk ahead of consenting to take part, feel free to ask for more information about what will be discussed from myself (email: lb01106@surrey.ac.uk)

What are the possible benefits of taking part?

Although there is no direct benefit to taking part, if you are interested in a career in psychology and/or mental health, this may provide a good opportunity to see how research in the clinical psychology field is conducted.

What happens when the research study stops?

Once the research study stops, the findings will hopefully be published in a journal and will be available to read. If you would like to receive a copy of the findings, please email the researcher in August 2021 and they will provide more information.

What if there is a problem?

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed. In the first instance, please contact: Lauren Burke (researcher) using the email address: lb01106@surrey.ac.uk. Further, you can contact:

Mary John (Principal supervisor)

m.john@surrey.ac.uk

University of Surrey, Department of Psychology, AD building, room 35AD04

Phone number: 01483 689267

OR:

Dr Paul Hanna (supervisor)

p.hanna@surrey.ac.uk

University of Surrey, Department of Psychology, Duke of Kent building, room 30DK04

01483 686336

You may also contact the Head of the Psychology department if you remain unhappy or wish to file a complaint:

Dr Chris Fife-Shaw

c.fife-schaw@surrey.ac.uk

University of Surrey, Department of Psychology, AD building, room 36AD04

01483 686873

Will my taking part in the study be kept confidential?

Yes. Your details will be held in complete confidence and we will follow ethical and legal practice in relation to all study procedures. Personal data (in this case, audio recordings) will be handled in accordance with the UK General Data Protection Regulations, (GDPR), 2018 so that unauthorised individuals will not have access to them.

Your personal data will be accessed, processed and securely destroyed by Lauren Burke (researcher), Mary John (supervisor) and Paul Hanna (supervisor). In order to check that this research is carried out in line with the law and good research practice, monitoring and auditing can be carried out by independent authorised individuals. Relevant audio data collected during the study, may be looked at by authorised individuals from the University of Surrey, where it is relevant to your taking part in this research. All will have a duty of confidentiality to you as a participant and we will do our best to meet this duty.

The data you provide will be anonymised and any personal data will be stored securely (separately from those anonymised data). Data collected via an audio recorder will be transferred immediately to an encrypted and password protected memory stick and university hard drive that is also encrypted and password protected. You will not be identified in any reports or publications resulting from this research and those reading them will not know who has contributed to it. To participate, you will be asked to consent to us using anonymised verbatim quotes from audio recordings in reports.

In certain exceptional circumstances where you or others may be at significant risk of harm, the researcher may need to report this to an appropriate authority, in accordance with the UK General Data Protection Regulations, (GDPR) 2018. This would usually be discussed with you first.

Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others

Full contact details of researcher and supervisors:

Researcher:

Lauren Burke

Email: lb01106@surrey.ac.uk

Supervisors:

Dr Mary John

Email: m.john@surrey.ac.uk

Dr Paul Hanna

Email: p.hanna@surrey.ac.uk

Who is organising and funding the research?

This research is not funded; however, it is supported by the University of Surrey.

Who has reviewed the project?

This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favourable ethical opinion from the University of Surrey Faculty of Medical and Health Sciences Ethics Committee.

Thank you for taking the time to read this Information Sheet.

Appendix C: Semi-structured interview guide

Interview guide

1. {Getting to know you question}

i. what subjects are you taking this year? Are you AS or A Level?

2. How would you describe mental health?

Prompt questions

i. Do you have your own words to describe mental health (offer examples; well-being, how you feel in yourself, thoughts and feelings)

ii. What does it mean to you?

iii. What has shaped your understanding of mental health? What comes to mind when you think about mental health (what images). {Provide examples: community, religion, peers, experiences of mental health}

3. In what ways do you think you might seek support if you experienced changes to how you feel and think/changes to your mental well-being?

Prompt questions

i. What are your thoughts about seeking support from peers & family?

ii. What are your thoughts about seeking support from a health professional such as a GP?

iii. What are your thoughts about seeking support online or through phone lines?

iiii. What are your thoughts about seeking support from college staff such as teachers?

iv. What experiences and thoughts influence your decision of who to seek support from?

4. What has been your experience of the _____ programme?

Prompt questions

i. How has this programme shaped how you think about mental health?

ii. Has this influenced how you view your mental health?

iii. What aspects were helpful and in what way?

iii. How has this programme influenced or changed how you talk about mental health?

iiii. Has this programme influenced how you would seek support and in what way?

Appendix D: Ethical Approval from University of Surrey

FHMS Chair's Action

Reference	FER-1819-064
Name of student	Lauren Burke
Title of Project	How do young men from socioeconomically disadvantaged areas understand their mental well-being and experience mental health interventions in educational settings?
Supervisor	Mary John
Date of Submission	12/09/2019
Date of outcome	04/11/2019

The above Research Project has been submitted to the Faculty of Health and Medical Sciences Ethics Committee and has received a favourable ethical opinion on the basis described in the protocol and supporting documentation.

The final list of revised documents reviewed by the Committee is as follows:

Ethics Application Form
Detailed Protocol for the project
Participant Information sheet
Consent Form
Risk Assessment (if appropriate)
Insurance Documentation (if appropriate)

All documentation from this project should be retained by the student/trainee in case they are notified and asked to submit their dissertation for an audit.

Professor Bertram Opitz, Co-Chair, FHMS Ethics Committee

Appendix E: *Consent form*

Consent form

Study: How do young men understand their mental well-being and experience mental health interventions in educational settings?

Please initial each box

- I have read and understood the Information Sheet provided (version 1, date 09/08/19). I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. ☐
- I have been advised about any disadvantages/risks/discomfort/ on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. ☐
- I agree to comply with the requirements of the study as outlined to me to the best of my abilities. I shall inform the investigators immediately if I have any concerns in regards to changes in my well-being ☐
- I agree for my anonymised data to be used for this study and be used in the report ☐
- I give consent for the one-to-one interview to be audio recorded ☐
- I give consent for anonymised verbatim quotes to be used in the report ☐
- I understand that all project data will be held for at least 6 years and all research data for at least 10 years in accordance with University policy and that my personal data is held and processed in the strictest confidence, and in accordance with the {UK} General Data Protection Regulations May 2018 ☐
- I understand that all data collected during the study, may be looked at for monitoring and auditing purposes by authorised individuals from the University of Surrey. I give permission for these individuals to have access to my records ☐
- I understand that I am free to withdraw from the study at any time without needing to justify my decision, without prejudice ☐
- I understand that I can request for my data to be withdrawn until September 2020 and that following my request all data already collected from me will be destroyed ☐

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation.

Name of participant (BLOCK CAPITALS)

.....

Signed

.....

Date

.....

Name of researcher/person* taking consent

.....

Signed

.....

Date

.....

Appendix F: *Reflexive Log*

13/11/2018

After the first five interviews completed today, I feel myself feeling unsure as to whether the interview guide questions are open enough to engage these young men in conversations about mental health and help-seeking. I think this possibly reflects my confidence in carrying out interviews for research. I feel a sense of needing direction as try to put myself in their position of entering a room with an older female, and likely someone they see as a ‘professional’ and how power dynamics might make it difficult for participants to openly discuss their thoughts with me. I am conscious of my own gender in my interactions with participants. For example, I notice myself almost wanting to offer reassurance to those participants that look nervous and I wonder whether this stems from feminine gender performance of being nurturing.

15/11/2018

My last day of interviews and I’m really excited about some of the things standing out to me from the interviews. I get the sense that college has provided a space for these young men to discuss mental health more easily as it is on the curriculum, however, I also think the ethos of this college (independence, shared values, respect) play into this. It made me think of how things have changed in schools and colleges since I was at sixth form ten years ago. There seems to have been a shift in recognising the importance of learning about emotions. I wonder whether this is what is being reflected in the interviews?

I have also noticed that many of the participants use distancing language when sharing personal reflections, using plural pronouns such as ‘they’ or ‘we’. I reflect on whether it is easier for these participants to share thoughts and experiences if they distance themselves from it and locate the thought/experience/problem elsewhere. Despite the presence of distancing language, I was struck by how articulate participants were when they talked about help-seeking and

mental health. It made me challenge some of my own assumptions about their ability to communicate about mental health.

Appendix G: Example of initial coding

Initial codes		Further codes & theme ideas
<i>Easier to stay quiet</i>	P07: in myself, I wouldn't really do too much, I'd probably just sort of live with it. As I feel like, I don't really want to trouble people.	
'enough on their plate'	P07: so like, they must be going through their own issues, they don't want to hear about mine too.	
<i>Emotional burden</i>	P04: I think seeking support from family is quite difficult for the fact that for a parent to hear that their child... I know especially - I got to the stage where I didn't want to be here anymore - for a parent to hear that from their child must be very very hard. I know when I went to the GP. I remember telling my mum on the Thursday and we went to the gp on the Friday. My mum got scared when I told her on the Thursday and you could see there was a part of her that was like as if she had failed me as a parent because they can't make their child feel the way they want their child to feel. It's not anything she has done wrong but I personally think it's my biology and from my biological family, it runs from the family, it's not something she's done or done wrong. It's more so, I think speaking to my parents about it is quite hard because I don't want them to think they haven't done enough and this is just how I'm feeling and I need support from outside the family to overcome it. But I understand a lot of parents want to think of a solutions to help them through it to sort it but it's not always the case. I'm one of them, I always think about what other people think of what I told them. Some people might be able to just tell them (parents) but I would worry about them afterwards	Not wanting parents to worry
<i>Parent view of wanting to help - responsibility</i>	P04: I think they felt they had let me down because they couldn't help me with what I was going through and how I was feeling. Because I needed support outside of that and it turns out medication was actually the thing that I needed. So I think for a parent to try and have to deal with that, and I think they don't know how you're feeling or what you're thinking so I think for them, it's quite hard to try and put themselves in your shoes, especially if they hadn't had it themselves and it's hard for them	Avoiding burdening parents
<i>Worry about others worrying and the consequences on your MH</i>	P05: it's like if you go to your family they'll be worried about you all the time and things of that you might not want that weight on your shoulders on top of the mental health issues. So you go to someone anonymous instead because they don't know you so maybe they will be not as caring but still be extremely helpful about it.	A sense of needing to be responsible for own mental health
<i>Conscious of parents doing everything - burdening others with problems when they already do so much</i>	P07: Well, it's probably just more like a subconscious thing. Because whilst I've been growing up, my mum has basically done everything. So I've just grown up with this attitude of she is already does so much so I don't want to bother people so like, they must be going through their own issues, they don't want to hear about mine too.	Independence
<i>A bother/burden - problems of their own</i>	P10: people are more likely to go to friends than they are their family, because it often feels that it's a bother, especially in like families who parents who display, like stress, or maybe have like, problems of their own. You don't want to burden them almost. So it's a lot easier to go to friends. P10: Yeah, you'll find it often probably find it with more children in the household. It's like saying that they have a job to withhold, or there's other kids that they have to look after. You don't want to add to that list of like priorities that already seemingly stressed them out. And you don't want to be even more of a stress on them. P10: And often it would be hard to put more pressure on them when they basically give you none in return.	Becoming conscious of reciprocity in parent-YP relationship

Appendix H: *Thematic map*

Part 3: Major Research Project, Review Paper

Universal School-Based Programmes to Promote Mental and
Emotional Wellbeing in the UK: What do the Pupils Say? A
Systematic Review of the Qualitative Literature

Abstract

Background: Evidence suggests that one in eight young people aged 5-19 living in England experiences a common mental health difficulty. In recent years, schools have been identified as an appropriate setting for providing preventative universal emotional wellbeing support. The review explores two aims; What are young people's experiences of engaging in universal mental health interventions and do young people participating in universal school-based mental health interventions feel their needs are being met? **Methods:** Using PRISMA guidelines, a systematic search was conducted using health and educational psychology databases and one general database for grey literature. Five qualitative studies in the UK were found to explore the views of young people (aged nine to seventeen) who had been recipients of a universal intervention to promote the mental health and wellbeing of pupils in schools. **Results:** Five themes were found that explore the reviews two aims. The first three themes explore the varying factors that influence how young people engage with the programmes such as concerns with maintaining confidentiality, finding trust with facilitators, and how the programme was delivered. The final two themes explore young people's views about the programme being relevant to their needs and the common difficulties that young people face. **Conclusion:** The findings of the review suggest that mental health stigma can be a barrier for young people to engage in programmes and therefore collaboratively defining rules of confidentiality throughout is considered important. Young people expressed that facilitators should be trust-worthy, have expertise and deliver psycho-educational content that is both age-appropriate and relevant to the difficulties that young people and their families encounter. To increase usefulness of such programmes, future interventions and research should consider young people as stakeholders in the design and delivery of whole-school mental health interventions.

1. Introduction

Approximately 20% of young people worldwide experience some form of mental health difficulty and this is thought to be rising (The United Nations for Children's Fund, 2013; World Health Organisation, 2016). In England, research shows that one in eight young people aged 5-19 have at least one mental health difficulty (NHS Digital, 2018). There is consensus that the foundation of good mental health is laid in the early years of childhood and adolescence and that 75% of mental health problems are established by the ages of 18-24 (Kessler et al., 2005; Murphy & Fonagy, 2013; Patel et al., 2007; WHO, 2010;). Nevertheless, in England, 110,000 young people aged 10-17 are turned away from services as their difficulties are not considered 'serious' enough (Children's Society, 2019).

In 2016, the World Health Organisation (WHO) promoted the adoption of mental health promotion programmes in schools (WHO, 2016). As a result, 'whole-school approach' interventions have been implemented across the world, for example, in the USA, Australia, and the UK (Slee et al., 2009; UK Department for Education 2010; Weist & Murray, 2007). These programmes take a 'preventative' approach to mental health in a school setting and are thought to reach a more diverse population of children. For example, reaching those with emerging difficulties who find it difficult to access services and those vulnerable to mental health difficulties, such as those who are eligible for free school meals or have acquired a 'child in need' status (Deighton et al., 2018; Masia-Warner et al., 2006; Wolpert et al., 2018). Whole-school approaches to mental health are thought to enable collaboration between students, staff and families and could aid the identification of common mental health difficulties earlier and enable staff to address difficulties within the school environment (Graetz et al., 2008; Office for Standards in Education, 2020).

In the UK, no school is required to have a mental health policy (Department of Education: Mental Health and Wellbeing in Schools, 2018). However, in a recent effort to support whole-school initiatives, the UK government have sought to upskill teaching staff by offering training in Mental Health First Aid (DfE & DHSC, 2017; Whittaker & Staufenberg, 2017;). Further, they have provided training for teachers to help them to recognise what mental wellbeing material should be covered in a newly reformed statutory curriculum that includes mental health content (DfE, 2020). In line with whole-school approaches to mental health, the government recently commissioned the new 'Mental Health in Schools Teams' (MHSTs) programme to provide early intervention for 470,000 young people with mental health difficulties issues (such as mild to moderate anxiety) by 2022/23 (NHS England, 2019).

Universally delivered mental health interventions and programmes are considered one aspect of a whole-school approach that aims to promote good mental health (Public Health England, 2015). Good mental health has been recently defined to include several core domains: for example, mental health literacy, attitudes toward mental health and self-management strategies (Fusar-Poli et al., 2020). Historically in the UK, the provision of universal interventions has been dependent on individual schools, rather than national initiatives and therefore provision has been considered 'inconsistent' (Young Minds, 2017). The literature argues that universal interventions may help to decrease the chances of vulnerable children experiencing mental health difficulties in later life (Merrell & Gueldner, 2010) and additionally avoid the stigmatisation that may result from targeted interventions (Gronholm et al., 2018).

Research to date has found mixed results concerning the effectiveness of universal school-based mental health interventions (O'Connor et al., 2017; Salerno, 2016; Wei et al., 2013;). Findings suggest universal interventions can increase the mental health

literacy of young people; however, it has been noted that a major limitation of these evaluations is the paucity of qualitative feedback from the target group, weak internal validity and lack of long-term follow-up (Salerno, 2016; Wei et al., 2013). In a systematic review exploring the effectiveness of 29 universal school-based interventions across the world, interventions were shown to have a positive impact on help-seeking behaviour, social and mental health, and an increased knowledge of mental health (O'Connor et al 2017). However, the review acknowledged that the interventions were heterogenous and interventions lacked clear theoretical frameworks and detail.

More recently, a systematic review by MacKenzie and Williams (2018) reviewed quantitative articles in the UK to assess the quality, content, and efficacy of school-based universal interventions. Results illustrate mostly neutral to medium effects on young people (effect sizes ranged from $d = 0.01$ to $d = 0.66$). The authors note that a prominent limitation of evaluating universal interventions is the diverse range of measures, length of follow-up across studies and lack of research that use wellbeing or resilience measures. The authors also highlight the need for a review of qualitative findings to ensure that young people's views as stakeholders are represented. A further recent mixed-methods review aimed to explore the effectiveness of evidence-based mental health promotion interventions in schools (O'Reilly et al., 2018a). Although the review includes three qualitative papers, the article did not collate qualitative findings, instead it synthesised them alongside quantitative findings that focus on outcomes, frameworks used in the intervention and long-term impact of such interventions. The review concluded that the current evidence is of low-to-moderate quality, most notably, the review highlighted the paucity of the 'child's voice' in the

design and implementation of interventions and the review recommended that more qualitative work in this area is needed to ensure that interventions are child-centred. Despite calls for increased exploration of how young people engage in such programmes in literature (O'Connor et al., 2017; O'Reilly et al., 2018a), and in national and local policy (; CYMRU, 2010; DfE & DHSC, 2017; Scottish Government, 2016), to the researcher's knowledge, there are no reviews that collate the existing views of young people despite there being qualitative research that explores this. Therefore, this review aims to respond to the recent proposal for a systematic review of qualitative findings from young people who have participated in universal school-based interventions in the UK by Mackenzie and Williams (2018). As the UK government continues to develop their plans to increase a whole-school preventative approach to mental health in schools, this review will synthesise existing evidence exploring the ways in which young people experience universal school-based interventions to provide an account that has direct relevance for the development and implementation of future universal programmes.

Aims

The review aims to systematically review qualitative research that explores young people's views on universal school-based mental health interventions in the UK that promote good mental health. The review aims to provide a critical synthesis of the existent evidence and establish the key themes in the findings that cut across the individual articles. The review has the following questions that will be explored from the perspective of young people engaging in such interventions:

- i. What are young people's experiences of engaging in universal school-based mental health interventions?

- ii. Do young people participating in universal school-based mental health interventions feel their needs are being met?

2. Methods

2.1 Inclusion and exclusion criteria

The search was limited to articles that used qualitative methods to explore emotional wellbeing programmes or preventative mental health intervention that are delivered to pupils in a school or sixth form college setting in the UK and was universal in its delivery (all pupils received the intervention). Universities were not included as recent UK government guidance has a focus on ensuring there is preventative mental health support for young people in schools and colleges (DoH & DoE, 2017). This is in accordance with evidence that suggests this can decrease the prevalence of mental health difficulties in later years and negative life experiences that impact early adulthood (DoH & DoE, 2017). Articles were also limited to those that provided qualitative research that explored pupils' experiences of having participated in an emotional wellbeing or a preventative mental health programme. Mixed methods articles where qualitative information from young people is limited will be excluded based on the judgement that they will not enrich the overall findings. Due to the context of the research field and to broaden the scope, the search was not limited to articles that were peer-reviewed.

2.2 Search strategy

Electronic databases were searched for relevant published research in February 2020: PsycINFO, PubMed, ERIC and SCOPUS, Child Development and Adolescent Studies, Cochrane Library. In addition, the Google Scholar database was also searched for grey literature. The 'Population, Exposure and Outcome' (PEO) framework was used to clarify the main topics in the search relevant to the study question (Bettany-

Saltikov, 2012). Firstly, the population of interest were young people in primary and secondary schools in the UK, secondly, the exposure of interest was universal interventions that concerned preventative mental health and thirdly, the outcome of interest were the views of young people who had engaged in such interventions. Key search terms were identified and Boolean operators ‘AND’ and ‘OR’ were used to link search terms (See Appendix A). Note, Google Scholar does not function with Boolean operators and therefore a decision was made to search through the first 10 pages.

Previous literature has highlighted the challenge of summarising heterogenous study designs (e.g., O’Connor et al., 2017). Nevertheless, synthesising qualitative evidence from diverse sources is also considered of value in providing support to policy makers and identifying new areas of exploration (Pope et al., 2008). As a result, study design criteria were left wide to account for this whilst searching databases. Any universal mental health programme was included in this review if it aimed to promote mental health or emotional wellbeing of pupils in any format and were inclusive of programmes focusing on all aspects of mental health. A limit date was set from 2005 to February 2020. A decision to select this initial date was based on the knowledge that research in this field has mostly been promoted by UK governments in the last two decades (Mental health of children and young people in Great Britain, National Statistics, 2004). Further, the government led launch of the universal ‘National Healthy Schools Programme’ initiative was developed in 1999 and the definition of ‘healthy school’ was clarified in 2005 to include emotional health and wellbeing (Arthur et al., 2011).

2.3 Study selection

The PEO framework was used to select included studies. Titles and abstracts were screened to identify articles that met the inclusion criteria (see Table 1) and where

abstracts were insufficient to assess against the inclusion criteria, full articles were assessed. Duplicate articles were deleted, and full-text articles were then reassessed for inclusion. Figure 1 identifies the number of papers identified and rejected at each stage of the selection process using PRISMA guidelines (PRISMA, 2017).

Table 1.

Table Depicting Inclusion and Exclusion Criteria for the Systematic Search of Literature

Criteria	Criteria information
Inclusion Criteria	<p>Written in in English.</p> <p>Published between 2005 and February 2020.</p> <p>Articles that used qualitative methods to explore young people's thoughts having participated in a universal whole school mental health intervention.</p> <p>Young people participating in the research were from either a primary school, secondary schools or sixth form college, located within the United Kingdom only.</p> <p>Either peer reviewed or non-peer reviewed.</p>
Exclusion Criteria	<p>Not published in English.</p> <p>Guidance, policy, or editorial documents.</p> <p>Mental health interventions that were targeting children with pre-existing mental health difficulties</p>

2.4 Data extraction

Information about the studies were extracted in accord with PRISMA guidelines (PRISMA, 2017); this included extracting the title, abstract, introduction, methods, results, and discussion. Qualitative data (in the form of quotes, themes, and sub-themes) were identified and extracted by reading and re-reading the results and

discussion sections of included articles. As well as extracting direct quotes from young people, interpretations of the qualitative data made by the authors were also extracted.

2.5 Data analysis and synthesis

Thematic analysis was used to analyse and synthesise findings informed by methods outlined by Braun and Clarke (2006). There were six stages to this process; familiarisation with the data; identifying initial codes; searching for themes; reviewing themes; defining and naming themes; producing the report. To gain familiarity with the data, the researcher read and reread the results sections and quotes from papers and noted down any thoughts. Quotes that were interesting or meaningful to the research topic were initially coded. The researcher identified, interpreted, and defined potential themes across all five papers. Potential themes were then collaboratively reviewed alongside supervisors to ensure themes sat within the context of the whole data set from the five papers. Once reviewed, themes were defined and named to ensure they captured the essence of what the theme is about and what the themes collectively say. Qualitative data extracted were coded using NVivo version 12 (QSR International, 2018).

2.6 Quality appraisal

Quality was assessed using the Critical Appraisal Skills Programme (CASP, 2018) checklist which is specifically for qualitative research designs and has been found to be used in similar fields (Bastounis et al., 2017; Wolpert et al., 2019). Articles were assigned ‘yes’, ‘no’, or ‘can’t tell’ for criteria that assesses the quality of the study aims, methodology, research design, participant recruitment, data collection, ethical issues, data analysis, findings, and local utility. Quality appraisal was not used to determine study eligibility but was used to determine the strength of the findings. This allowed for the flexibility that qualitative design demonstrates (Dixon-Woods, 2004)

but also permits for study quality to be considered in relation to the relevance of findings and to the overall synthesis (Edwards et al., 2000).

2.7 Ontological and Epistemological stance

A relativist ontological approach was taken during analysis of data extracted from the five papers. Two recent reviews (MacKenzie & Williams, 2018; O'Reilly et al., 2018a) highlight the heterogeneity in existing approaches to such programmes across schools in the UK and therefore the researcher acknowledges there will be diversity of experience and thought amongst students. Further, the researcher acknowledged the potential multifaceted social, cultural, and political determinants that may have contributed to the construction of young people's perceptions about participating in a universal emotional wellbeing programme. For example, the researcher acknowledged the impact of inequalities and disparities in the education system in the UK; The Education Policy Institute report (Hutchinson et al., 2020). A recent survey of 28,160 pupils in England found that gender, deprivation (Free School Meal eligibility), child in need status, and ethnicity all altered the likelihood of experiencing mental health difficulties (Deighton et al., 2019). The paper also highlights the relationship between risk factors being higher in concentration in schools (such as a higher proportion of free school meal eligibility) and the increased prevalence of mental health problems. As there is no a priori hypothesis or theory, an interpretative epistemological approach was taken to allow for flexibility during data analysis.

3. Results

10,148 studies were initially identified, and this was reduced to five peer-reviewed papers after excluding duplicates and applying the inclusion and exclusion criteria (see Figure 1).

Figure 1.

PRISMA Flow Diagram of Included Studies

3.1 Study characteristics

An overview of study characteristics from the five qualitative studies can be found in Table 2. All studies explored the experiences of young people who had received a universal emotional wellbeing programme at their school. Two studies (Coombes et al., 2013; Kidger et al., 2009) explored young people's views on current emotional health and wellbeing programmes across multiple secondary schools in the UK. One study gathered views from young people who had received mental health educational lessons within Personal and Social Education (PSE) lessons (Woolfson et al., 2008). The remaining two studies interviewed young people that had received universal interventions underpinned by Cognitive Behavioural Therapy (CBT) principles; one study interviewed young people from one school (Taylor et al., 2014), and the other interviewed young people from across nineteen schools (Skryabina et al., 2016).

The age of participants ranged from nine to nineteen. Three studies consider the socioeconomic background of students participating in interviews and focus groups (Coombes et al., 2013; Kidger et al., 2009; Woolfson et al., 2009). For example, one study recruited from a range of schools including grammar and comprehensive high schools (Coombes et al., 2013) and another used free school meals to stratify a sample that was representative of young people from a range of socioeconomic backgrounds (Kidger et al., 2009). Only two studies state the number of females and males participating in their research (Taylor et al., 2014; Woolfson et al., 2009), providing a relatively equal split. Individual ethnicity of the young people participating in the research was not recorded, however, Coombes et al (2013) provides overall ethnicity data for the schools participating in the intervention and Skryabina et al (2016) states that the trial sample was majority White British (94%).

Table 2.

Table Depicting Characteristics of Studies Included for Review

First author, date & location	Sample	Study aim/hypothesis	Intervention / mental health or well-being promotion programme	Results (in relation to young people)
Coombes et al (2013) Location: unknown	<i>N</i> = unknown 8 focus groups across 5 secondary schools <i>Gender</i> : not stated <i>Age</i> : 13-14 <i>School sample</i> : 1 x all-boys grammar school 1 x all-girls high school 1x mixed grammar school 2x community colleges <i>Ethnicity and socioeconomic background</i> : Ethnicity of sample unknown	Aimed to examine universal Emotional Health and Well-Being (EHWB) classes in secondary schools from the perspectives of young people.	Universal programmes relating to Emotional Health and Well-Being.	Difficulties in keeping EHWP policies coherent. Mental health deemed to be a neglected aspect of EHWP curriculum (especially self-harm). Difficulties in communicating; young people preferred to talk to friends about EHWP and worried about confidentiality in a class setting. There needs to be greater involvement of young people in the planning, implementation, and evaluation of EHWP programmes.
Kidger et al, 2009 Location: England	<i>N</i> =154 students <i>Gender</i> : not stated <i>Age</i> : 12-14 <i>School sample</i> : 8 secondary schools. Free school meals data were used to stratify a sample to	Collate student (and staff) views regarding current school-based emotional health provision.	Universal programmes relating to Emotional Health and Well-Being were used in all schools.	Mental health deemed to be neglected and not prioritised amongst other topics and participants wanted more lessons on understanding feelings, coping with emotional distress and where to access helpful resources.

	ensure participants were from a variety of socioeconomic backgrounds <i>Ethnicity and socioeconomic background:</i> Ethnicity of sample unknown			Some students voiced their concern over the relationship between discussing such issues in classrooms with teachers and stigma.
Skryabina et al, 2016 Location: UK	N=115 students Staff (n=47) and parents (n=20) of children involved in intervention also interviews Age: 9-10 Gender: not stated School sample: 19 schools <i>Ethnicity and social economic background:</i> individual not recorded but overall participant pool was majority White British (94%)	A qualitative evaluation, using focus groups, to summarise the views of children, parents and school staff about a universal school-based anxiety prevention programme FRIENDS.	FRIENDS is a universal classroom-based CBT programme delivered by either trained school staff or external health staff. The programme consists of 45-60 min sessions over 9 consecutive weeks and helps children develop emotional awareness and regulation skills, coping strategies such as relaxation and problem-solving skills.	The overarching theme was related to an increased 'awareness and management of emotions and relationships' as well as learning to 'recognise feelings in others' and understanding how 'people feel, think and react differently'. Some children thought it was helpful to share their feelings with others in the class and become more social. The majority of young people interviewed agreed that the problem-solving techniques and relaxation strategies taught were useful and boosted confidence.
Taylor et al, 2014 Location: South West and East	N=42 Gender: 19 males, 23 females Age: 12-16 School sample: 8 schools	The study aimed to gather the views of students who had participated in a classroom-based CBT depression prevention programme.	The CBT programme, underpinned by CBT and interpersonal therapy principles, comprised of nine 40-50 minutes classroom sessions that covered stress management,	Young people highlighted the usefulness of sessions that looked at other people's points of view using visual illusions and recognising physical signs of depression and anxiety.

Midlands, England	<p><i>Ethnicity and socioeconomic background:</i> not stated</p> <p>Teachers and facilitators were also interviewed (n=28)</p>		<p>self-esteem, affect regulation, cognitive restructuring, problem solving, conflict resolution, interpersonal skills and social networks.</p> <p>These sessions were held by external facilitators and teachers, depending on which arm of the study was in place.</p>	<p>Some young people commented that they found facilitators that aren't teachers were easier to talk to about personal issues and that talking to teachers could be uncomfortable due to the role they hold.</p>
<p>Woolfson et al, 2009</p> <p>Location: Scotland</p>	<p>N=44 students</p> <p>Gender: 23 males, 21 females</p> <p>Age: 11-17</p> <p>School sample: 8 schools</p> <p><i>Ethnicity and Socioeconomic stats:</i> Ethnicity not stated.</p> <p>Study participant criteria request for range of young people from low-high socioeconomic backgrounds</p>	<p>To gather the perspectives of young people across three secondary schools in Scotland who have universal received mental health education.</p>	<p>Each school carried out mental health education within Personal and Social Education (PSE) classes with class teachers usually delivering material although external providers were occasionally recruited to deliver sessions.</p> <p>Methods of teaching varied across schools but were not limited to videos, workbooks, group discussions, practical classes and seminars from external professionals.</p>	<p>There were mixed perspectives on the preferences for who delivers the mental health education classes with some young people preferring a familiar figure, for example, a teacher. Some young people thought it might be strange for a teacher to teach a topic they do not usually teach.</p> <p>Young people expressed the importance of the right teaching environment to learn about mental health, preferring a dedicated classroom for the topic.</p> <p>Young people disliked whole year group delivery (in assembly for example) as they often felt inhibited by larger groups and are more intimidating.</p> <p>Participants found useful content in topics such as: the knowledge, prevention and coping with depression, eating disorders,</p>

sexual health problems, self-harm, autism, ADHD, dementia, and schizophrenia. They also talked about the impact of these discussions on reduction stigma.

3.2 Study quality

Study quality was assessed using the Critical Appraisal Skills Programme (CASP, 2018) and an overview can be found in Appendix B. Across the five studies, it was apparent there was mixed quality concerning study aims being clearly stated, methodology used and results. All studies, except Skryabina et al (2016) presented a clear statement of aims. Methodology and design of studies were considered for their quality, for example, recruitment strategy, data collection and consideration for the relationship between researcher and participants. There was a mixed presentation of methodology and design considerations across the studies. No study scored a ‘yes’ on the CASP checklist reporting consideration to the relationship between researcher and participants. All studies presented a clear statement of findings. Only two studies provided enough detailed information to score ‘yes’ to ‘Was the data analysis sufficiently rigorous?’ (Taylor et al., 2014; Skryabina et al., 2016). Further, two studies considered ethical issues clearly (Kidger et al., 2009; Taylor et al., 2014). Overall, four papers were rated high to medium quality (Kidger et al., 2009;; Skyrabina et al., 2016; Taylor et al., 2014; Woolfson et al., 2009) and one study was rated medium to low quality (Coombes et al., 2013).

3.3 Synthesis of results

The qualitative findings across all five papers mostly relate to the implementation of interventions and how the universal interventions were received. These findings are therefore contrary to existing quantitative literature that explores the impact of such interventions on wellbeing, mental health literacy or help-seeking using quantitative measures (Merrell et al., 2008; Rickwood et al., 2004) and policy articles, reflective papers and reviews that explore approaches and policies to whole-school mental health. A summary of emerging themes can be seen in Appendix C. Five main themes are discussed below.

3.4 Themes

The first three themes explore how young people engaged with the universal programmes and were highlighted across all five qualitative studies. There are many ways in which engagement could be described, however, in this context, these themes explore how young people narrated their experience participating in a universal mental health intervention or programme in their school environment. It appears there are several considerations that impact a young person's likelihood to engage with the programme material confidently; the impact of discussing sensitive and potentially stigmatising topics amongst their peers, being able to trust facilitators with their expertise and confidentiality and the need for the content to be delivered in a creative and interactive manner.

1. Stigma and confidence. Results from two papers (Coombes et al., 2013; Kidger et al., 2009) highlighted the concerns that young people have when discussing sensitive topics such as emotional wellbeing in front of their teachers and peers. Despite some young people acknowledging the positive impact that engaging in discussion about common mental health difficulties would have on reducing stigma (Woolfson et al., 2008), others felt that the lack of clarity around rules of confidentiality was an initial barrier to engaging in lessons around emotional health (Coombes et al., 2013). The paper argued that this seemingly impacted their confidence to contribute to lessons as well their likelihood to approach potential helpers outside of lessons. Young people discussed the need for universal programmes to provide spaces that are explicitly communicated as non-stigmatising and promotes confidentiality. Seemingly, young people felt that if these two aspects were made explicit to them and their peers, they would feel more confident in seeking additional support from a professional within the school. Some young people expressed the concern that spaces that facilitate open discussions around feelings might be difficult due to existing stigma and that this could potentially lead to pupils

being ‘laughed at’ or treated differently. For example, this is highlighted in a young person’s quote from Kidger et al’s (2009) research:

“Some people would just laugh, like if someone had been bullied or the class doesn’t like them and they get up and say something everybody would just laugh at them” (Kidger et al., 2009, p.9).

This quotes collectively perhaps reflects that for young people, mental health stigma is a significant concern and further indicates that there is value in having facilitators support young people to engage in a conversation around confidentiality and stigma prior to any intervention starting.

It seems that for some young people, there were real concerns of confidentiality not being maintained and that this might lead to judgement from both peers and their teachers:

“There’s no confidentiality ... no trust between teachers and pupils ... Teachers talk in the staff room... they suggested I had ADD [attention deficit disorder] ... one teacher said it in front of the class” (Coombes et al., 2013, p.230).

From the views gathered, stigma regarding mental health is a real and significant concern for young people in their school environment, especially when engaging in sensitive topics. In interviews with over 2,000 young people aged between 11-24, 75% believed that those with mental health difficulties are treated negatively as a result of stigma (YMCA, 2016). Mental health stigma is perhaps compounded by, and part of, other existing concerns within schools such as bullying; The Organisation for Economic Co-operation (OECD) and Development conducted a survey with teachers and leaders from 250,000 secondary schools in England and found 29% of schools reported cases of bullying (OECD, 2019). Research has shown that students who have been screened for, or engaged in, a targeted mental health intervention in school have experienced stigma from peers and have consequentially experienced bullying (Gronholm, Nye & Nicholson, 2018). Further, it is well acknowledged that discrimination leads

to poorer psychological and physical health outcomes (Pasco & Smart Richman, 2009), and can lead to internalisation of problems amongst peers (Reijntjes et al., 2010). While previous research shows that whole-school interventions can reduce mental health stigma and are associated with less stigma than targeted mental interventions (Essler et al., 2006; Macklem, 2013), the findings from this review shows how educational settings still need to consider the impact of existing stigma when introducing a new concept to students in which mental health is discussed as part of a whole-class. The young people's views demonstrated in these studies imply the significance of communicating and maintaining clear rules around confidentiality to all those delivering and receiving a universal programme. The notion of explaining 'ground rules' surrounding confidentiality prior to a mental health intervention is recognised as a facilitator to young people accessing mental health support in a recent systematic review (Radez et al., 2020).

2. *Trust*. A further theme relating to ability for young people to engage was the need for young people to be able to trust the facilitator of the programme. This theme was prominent amongst three studies (Kidger et al., 2009; Taylor et al., 2014; Woolfson et al., 2008). It was clear that building a trusted rapport with facilitators, whether they be teachers or external facilitators, was of unequivocal importance for young people to feel they can engage comfortably. This is consistent with findings in a meta-aggregation conducted in 2016 (Bastounis et al., 2017) in which young people appreciated having a well-established trusted rapport with facilitators. Nevertheless, it is apparent that young people had mixed views about whether teachers or external facilitators were best placed to deliver programmes regarding emotional wellbeing. Some young people suspected that familiar teachers would not keep problems raised confidential or would think differently about them outside of the programme in other school classes:

“If you talk in front of a teacher they'll sort of always like be, probably every time they look at you you'll be thinking "oh no are they thinking about this, what I've talked about" and it'll be kind of awkward” (Kidger et al., 2009, p.9).

“It might be a bit weird...because you know a teacher and then we've never really talked to (the teacher) about anything like that before” (Woolfson et al., 2008, p.792).

Maintaining confidentiality and cross-systems contact were highlighted by teachers as two barriers to supporting young people with their mental health in previous research (Graham et al., 2013 Ekornes, 2015).

In contrast to others, some young people felt their familiarity with teachers enabled them an opportunity to talk to them more confidently about thoughts and feelings. Similarly, some young people expressed that sharing problems with facilitators they did not know was more difficult.

“If they teach you other subjects, then you'll probably know them better and you'll be able to talk to them better” (Woolfson et al., 2008, p.792).

“Some pupils were reticent about sharing their thoughts with facilitators they did not know well” (Taylor et al., 2014, p.5959).

Seemingly in a balance between trust and knowledge, some young people thought that external facilitators were more knowledgeable, experienced, and therefore helpful. Nevertheless, they highlighted that preferences varied depending on the quality of the facilitation and the topic discussed (Kidger et al., 2009; Woolfson et al., 2008). Interestingly, there was no information relating to different preferences according to gender of the facilitator.

It is noted in the Taylor et (2014) article that due to very real practical constraints, having the same external facilitators for all sessions of the programme was not always possible and this seemed to impact the ability to build a trusted rapport with facilitators:

“It made it a bit awkward because we got to know the people and all of a sudden they were swapped” (Taylor et al., 2014, p.5959).

Nevertheless, views from teachers show that they often lack confidence in delivering and sustaining mental health promotion in their pupils and can be resistant to holding too much responsibility (O’Reilly et al., 2018a; Young Minds, 2019). Further challenges to teacher facilitation have been explored in a recent study that interviewed teachers in the UK (Hanley et al., 2019); teachers expressed that ever-changing policy drives from government were not always matched with adequate financial resources, especially during the recent period of economic austerity. There was consensus amongst teachers that they were often facing multiple priorities and were having to take on additional non-teaching roles. It is thought that the new MHSTs initiative will provide extra capacity to deliver psychological based interventions in schools and create better links with other existing mental health services (BPS, 2019). Thus, teachers will be working alongside trained Educational Mental Health Practitioners (EMHP) and Senior Mental Health Leads to share as well as co-produce mental health support across the school community.

3. *Delivery*. Linked to trust and confidence to engage, young people across two studies highlighted the potential negative implications for contributing to emotional health and wellbeing lessons in a larger groups and suggested delivery of lessons to be in smaller groups to aid confidence (Kidger et al., 2009; Woolfson et al., 2008).

“If it is smaller groups you’d be less intimidated to say something...Not whole year assembly” (Woolfson et al., 2008, p.792).

There was be consensus amongst four papers that creativity in programme delivery was valued and influenced how young people engaged with the material. Young people discussed the difference in delivery between teachers that approached the classes in a creative and

inspirational way compared to teachers who were “*just going through the motions*” (Coombes et al., 2013, p.227) and the impact this had on their confidence.

“Teachers are really going for it ... teachers, pupils think there is something to work for ... there’s confidence in us, confidence in ourselves”. (Coombes et al., 2013, p.227).

Young people across three studies highlighted the advantages to having a hands-on, multi-resourced and interactive approach that was comparably different in style to other learning in the school curriculum (Woolfson et al., 2008, Taylor et al., 2014 & Skryabina et al., 2016).

“I preferred doing the hands-on stuff... the discussions, sometimes I think they kind of just went off a bit because some people lost concentration ” (Taylor et al., 2014, p.5957).

‘Um, I really liked the way they put educational stuff into fun games. And sort of made it, like the different side of learning ’ (Skryabina et al., 2016, p.490).

Further remarked upon were the creative skills, positive attitudes, and high professional standards that facilitators brought to sessions, seemingly motivating young people and maintaining their interests during lessons (Coombes et al., 2013). Comparable features were also acknowledged by teachers, for example, teacher engagement, attitude shown, and support were deemed imperative for a successful session in which young people engaged (Taylor et al., 2014).

4. Relevance of topics. Young people across four studies addressed the need for topics discussed in the universal programme to be appropriate and relevant to the common issues that young people face today. The World Health Organization recognise that the leading mental health difficulties for young people and adolescents are eating disorders, psychosis, suicide and self-harm (WHO, 2019). Young people expressed how they are aware of the mental health difficulties that their peers are struggling with, most notably, self-harm and eating disorders. However, some felt that the programmes they received excluded these relevant topics or when they were included, they felt teachers did not understand the difficulties themselves.

“I think people don't know enough about that really like how to stop yourself feeling depressed or sad or something or how to make yourself feel happy” (Kidger et al., 2009, p.9).

“Self-harm is attention seeking, but for some it's because of depression ... we're not taught about it, we need to know, the school doesn't want to admit it ... cutting is attention seeking ... it's normality now” (Coombes et al., 2009, p.229).

Young people shared that they felt some topics such as sex and drugs were more commonly taught than emotional health and that they needed more pertinent topics that covered how to understand feelings, how to cope with emotional distress and how to access support (Kidger et al., 2009). Others felt reassured that they had received content that covered a wide-range of topics such as depression, eating disorders, self-harm, autism, ADHD, dementia, and schizophrenia (Taylor et al, 2014). In contrast, others felt although they had covered some mental health difficulties, however aspects of preventative wellbeing were not included (Woolfson et al., 2008).

“They could teach us about the long-term effects. We already learn about it with anorexia, but not with things like dementia or schizophrenia” (Woolfson et al., 2008, p.793).

Further, there seemed to be agreement amongst some young people that CBT-based lessons covered topics that felt like minor everyday issues and less relevant to the difficulties that they or their peers had experienced (Taylor et al., 2014). The researchers pointed out that this seemed especially so for older pupils (13-16) who felt lessons were targeted at difficulties that younger pupils may face and therefore less useful:

“However, the programme was generally not considered to be age appropriate for older pupils, some of whom found it patronising or felt they had already learnt some of the skills” (Taylor et al., 2014, p.5960).

In consensus, teachers and facilitators also expressed that content was less relevant to older pupils and that they were being taught CBT skills that they had likely already acquired:

“There was a general feeling from facilitators and teachers that the older groups considered that they already knew the principles and content” (Taylor et al., 2014, p.5960).

From a pedagogical viewpoint, whilst re-learning strategies are helpful, these views demonstrate the importance of having educational resources that are relevant and age appropriate according to the difficulties they and their families may face. This will ensure young people have the opportunity to gain a broader understanding of varying mental health difficulties that impact people their own age as well as families, for example dementia. This sentiment is further supported in policies from government such as the Challenge on Dementia (2020) that highlights the importance of educating young people in schools and communities to raise awareness and reduce stigma surrounding dementia.

5. Availability of resources and signposting. Young people across three studies felt there was a lack of accessible and confidential support available beyond the intervention programme they received (e.g., psychoeducational class), with some discussing their concern that schools did not put policies concerning emotional health into practice (Coombes et al., 2013, Kidger et al., 2009, Taylor et al., 2014). One young person felt that although their school had policies about bullying, their school were ignorant of the bullying taking place.

“The fact that there’s a piece of paper on the wall saying ‘bullying won’t be tolerated’ doesn’t mean that it doesn’t happen. They ignore what’s happening a lot of the time” (Coombes et al., 2013, p.227).

The implications of not having a programme that is relevant to the needs of its participants has been demonstrated in research elsewhere; for example, it has been shown that young people are more likely to seek help for mental health difficulties if they have prior knowledge about

the mental health issue, have knowledge of sources of help and feel emotionally competent to express their feelings (Rickwood et al., 2005).

Young people additionally felt there was a lack of sympathetic sources of support within school that were non-stigmatising and felt that a priority for schools is to have more readily available sources of support for students (Kidger et al., 2009). Further from the same study, there was consensus amongst some young people that felt schools should assist students to access external sources of support by providing leaflets and posters. Nevertheless, some young people felt that signposting should be carried out discreetly and in a non-stigmatising way, further highlighting the concern of mental health stigma for young people in schools.

One pupil highlighted the unhelpfulness in schools displaying posters with information about where to access mental health support in school hallways (Kidger et al., 2009) as they could not access the material discreetly. Keeping signposting to mental health services discreetly seems to be important for some young people. Nevertheless, this perhaps would contrast many a schools' positions in moving towards creating an ethos that aims to increase awareness of mental health and reduce stigma in school environments.

One young person noted that it could be beneficial and effective to intersperse universal CBT-based lessons across the yearly PSHE curriculum rather than having a 'block' of classes (Taylor et al., 2014). Similar to the views of young people, integrating mental health into the ethos of the school is considered to be a leading principle to the whole-school preventative approach as this has been shown to impact physical, emotional and mental health wellbeing of pupils (Jamal et al., 2013; Public Health England, 2015). Teachers interviewed in the same study discussed how PSHE classes are under-valued and under-funded; likely compounding the view that learning around mental health is an 'extra' to the school curriculum and maintaining the barrier to interspersing mental health within school curriculum. Findings from a survey conducted with 2,780 schools in the UK found only 64% of schools were seen to be integrating the

promotion of positive mental health and wellbeing into the school day and 63% were signposting to external support (National Children's Bureau, 2017).

This illustrates the very real challenges for schools and colleges in creating a whole-school ethos around mental health beyond classroom-based interventions. Undoubtedly, a considerable amount of resources are needed to ensure that the many components come together to create a whole-school approach beyond including mental health on the curriculum or signposting. For example, Public Health England discuss eight core principles to promote emotional health and wellbeing in schools and colleges that includes curriculum teaching and learning, an ethos and environment that promotes respect and values diversity, and enabling student voice to influence decisions, to name a few (Public Health England, 2015, p. 6).

These findings indicate that the success of an intervention can be influenced by both individual and organisational factors relating to school ethos, school leadership, and teachers' capabilities (Rowling, 2009). Beyond the school setting, there are concerns that training teachers alone cannot tackle mental health promotion in isolation and that it can only be part of a process that is supported by a greater amount of financial support for children's mental health services (Karim & O'Reilly, 2017).

4. Discussion

Including young people's views as stakeholders is increasingly considered paramount when conceptualising and delivering universal school-based mental health programmes (De Loach McCutcheon et al, 2014; Harden et al, 2001; McAllister et al., 2018). It is also understood to be a recent priority in UK health and education policy (Public Health England, 2015). In response to a call to collate young people's views that have participated in a universal school-based mental health intervention (Mackenzie and Williams, 2018), this paper systemically reviewed the literature and identified existing qualitative studies conducted in the UK.

Given existing research has focused on quantitative outcomes of universal programmes (Mackenzie and Williams, 2018; O'Reilly et al., 2018), this systematic review is unique in its synthesis of qualitative findings that offer insight into how young people experience participating in school-based universal mental health programmes in the UK. Through the synthesis of young people's voices, these findings offer useful recommendations to stakeholders and policy makers regarding design, content, and delivery of universal mental wellbeing programmes in schools.

The first synthesised finding from the studies highlighted the many contextual factors that influence how young people engage in universally delivered mental wellbeing programmes with their peers. These factors were seemingly connected to their identity, foremost, a concern regarding the impact of confidentiality breaches on their identity amongst peers (Rowe et al., 2014). This is supported in research that shows that young people's anticipation and experience of mental health stigma in schools can lead to numerous fears such as being 'labelled negatively' according to stereotyped attitudes, receiving discriminatory reactions such as bullying, hostility and rejection (Gronholm et al., 2018). There was a sense from young people that the paucity of any shared discussion around the rules of confidentiality prior to the intervention was a potential barrier to engaging with interventions comfortably and confidently. Interestingly, no study included in the review discussed whether confidentiality was discussed with young people prior to the intervention, nevertheless, a study in 2014 that scoped the landscape of current school-based mental health interventions concluded that the clarification of rules concerning consent and confidentiality should be priority area for future research and design of interventions (Fazel et al., 2014).

Another factor related to engagement was whether the programme was facilitated by a teacher or external facilitator, such as a health professional. Some young people felt that programmes delivered by a familiar teacher offered a trusted relationship in which they could engage with

more confidently or ask for support. In contrast, others felt reticent about teachers facilitating because they felt they were less-experienced, had less availability to support young people or would not maintain confidentiality. A whole-class intervention in a school context may differ in ways to traditional one-to-one therapy, nevertheless, therapeutic alliance within a group setting should still be considered when thinking about the efficacy of whole-school programmes. For example, Ardito and Rabellino (2011) highlights the multiple therapeutic agents within a group setting to consider: the therapist (or in a school context, a facilitator), the members of the group, and the group as a whole. Further, a sense of support, trust, belonging, and the collective movement towards a common goal can be seen to improve self-esteem and reduce symptomology (Yalom, 1995).

Although reviews of quantitative research assessing the effectiveness of universal programmes have been restricted by heterogeneous methodology, there is an indication that there is a larger effect size for programmes delivered by mental health professionals, relative to programmes delivered by teachers (Calear & Christensen, 2010; Stallard et al., 2014). Nevertheless, studies that have explored integrating external support staff, such as mental health professionals, into schools have highlighted significant practical barriers to working together (Cooper et al, 2016). It is clear from the stakeholder views collected, as well as existing research, that there are multifaceted challenges when determining who is best placed to facilitate programmes concerning mental health. For example, the challenge of young people preferring facilitators to have a thorough knowledge of the subject but the expense of employing external facilitators (Berry et al., 2009; Stallard et al., 2013; Woolfson et al., 2009). Therefore, the needs of both young people and teachers need to be considered alongside consideration for the type of programme or class most appropriate, delivery of the programme and the training required.

The collation of young people's voices highlighted that the content of programmes were not always age-appropriate or that they omitted topics they felt were relevant to them and their

peers such as self-harm, depression and anxiety. Interestingly, some young people had felt reassured that they had received learning covering diseases and mental health difficulties that they may be apparent in their family now or in the future, such as dementia. Young people that did not receive education surrounding syndromes such as dementia noted that this was a missed opportunity. This shows the imperativeness of consulting with young people and utilising research to assess what difficulties young people experience, first or second-hand, and acknowledging that this may vary at different ages across the school life span.

Young people expressed that although their schools had emotional wellbeing policies and programmes in place, their schools did not always put policies into practice. Young people across the studies included call for mental health promotion to be incorporated into the school ethos and not be separate to the rest of their educational and school community experience. This perhaps reflects the need for schools to think beyond classroom based interventions and to address the many other aspects of the whole-school approach to mental health documented in government policy (Public Health England, 2015; DoE & DoH, 2017). Nevertheless, it has been well documented that developing a school environment that promotes mental and physical wellbeing is a substantial challenge that requires time, training, supervision and inevitably, flexibility and willingness of schools to change and adapt their system and curriculum (O'Reilly et al., 2018a). Further, collaborations between health and educational sectors need to be established to support the opportunity for meaningful change (Svirydzenka et al., 2014). The need to include several stakeholders to ensure the efficacy of such programmes can be seen elsewhere in other western countries (Nielsen et al., 2015; Rowling, 2009).

Findings from this review suggest that additional help to access external sources of support through posters and leaflets were considered important for some young people and helped foster a supportive school climate around mental health. However, for others, posters in a school hallway did not provide a space for young people to access support in a confidential

way. A review that formed part of the Governmental Green Paper in 2017 (Department of Health and Department of Education) highlighted that school environments can trigger social anxiety and that the school environment needs to be non-stigmatising, personal, graduated, accessible and age-appropriate if young people are to engage. Further analogous to young people's thoughts is the suggestion of integrating social and emotional skills in all subject areas within a curriculum. This concept has also been recommended by NICE (Public Health England, 2015). Nevertheless, the findings show, the challenges in reaching stakeholder consensus amongst differing views in developing a whole-school environment that promotes mental health and considers existing stigma.

4.1 Limitations

This systematic review synthesises the material available and highlights the paucity of qualitative literature with the young person's voice at the centre. The findings need to be cautiously understood within the context of the wider population of young people who are likely to have different opinions and cannot be considered representative of other young people in the UK. Further, the studies did not seek to explore how young people engaged with or experienced a whole-school approach to mental health, rather, it explored how young people experienced a universal programme or intervention, which is one aspect of a whole-school approach to mental health. Although this area of research has only been established in the last two decades in line with government guidelines and policy, this review provides evidence to urge schools and local authorities to reliably evaluate their efforts in delivering such programmes and add to the literature to inform future policy, at which the young persons' voice is at the centre.

4.2 Implications for future research

This review presents findings that deliver insight into the factors that influence how young people engage with universal mental health programmes and provides further support for the

inclusion of young people in the design and delivery of any school-based universal programme in the future (Weare & Nind, 2011). No study in this review provided information to suggest that there was young-person involvement in the design of programmes they had participated in. Conclusions from one study (Skryabina et al., 2016) suggested that to address concerns raised by teachers during programme delivery, school staff should help co-produce the CBT-based universal programme. Whilst teacher involvement in co-reproducing programmes has been recommended elsewhere (O'Reilly et al., 2018b) future research should aim to gather views on what young people expect from universal programmes in school as well as exploring which aspects appear to make a difference to their wellbeing. This is further support by Cefai and Cooper (2017) who highlight the importance of gaining young people's views to ensure universal programmes meet the needs of young people to ensure the usefulness of programmes. A further suggestion is for future research and policy to consider young people's views from a diverse range of social, geographical, cultural, socioeconomic, and ethnic backgrounds and to include these young people as stakeholders when designing and evaluating whole-school mental health interventions. The United Nations Convention on the Rights of the Child (UNCRC) declares that all children and young people have the right to express their views freely in all matters affecting them and for their views to be given due weight in accordance with the child's age and maturity (UNCRC, 2013). Nevertheless, there is a paucity of qualitative research that explores the impact of cultural, educational, socio-economic and gender differences in how programmes are delivered and received. For example, the acknowledged relationship between mental health and socioeconomic status (Holman, 2015; von dem Knesebeck et al., 2012) and the perceived barriers to accessing mental health support in black and minority ethnic communities (Memon et al., 2016). Further, despite the call to promote the welfare of all pupils (DoH & DoE: Special Educational Needs and Disability code of practice 0-25 years), to our knowledge, there is no existing research that assesses how

universal mental health interventions can be adapted to meet the needs of those with special educational needs. Given that young people with learning disabilities are four times as likely to have a diagnosable emotional mental health difficulty (Emerson & Hatton, 2007), this is a priority area for future research.

Further, teachers and facilitators should also be consulted and trained to a competent and confident level; ensuring that they have the capacity and capability to attend to the needs of young people (Weare, 2015). If teachers are to facilitate universal mental health programmes, exploration of their own emotional health needs need to be considered in future research given the evidence available that suggests teacher wellbeing to be critical to student learning and wellbeing (Kidger et al, 2010). Finally, alongside the need for additional outcome measures that measure the long-term impact of mental health interventions in schools, such as changes in perceived stigma (Weare & Nind, 2011), qualitative information regarding the impact of such interventions (e.g., help seeking, mental health literacy) should also be synthesised where evidence is available.

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Appendix A: *Search Terms*

(((((mental health OR mental health intervention OR early intervention)) AND (school based OR school* OR educat*)) AND (united kingdom OR UK OR britain OR england OR wales OR northern Ir* OR scotland)) AND (youth OR young pe* OR pupil* OR student* OR teen* OR adolescen*)) AND (qualitative OR interview* OR thought* OR view* OR facilitat* OR barrier*)

Appendix B: CASP Quality Checklists

Study: Coombes et al (2013)			
	YES	CAN'T TELL	NO
Section A: Are the results valid?			
Was there a clear statement of the aims of the research?	✓		
Is a qualitative methodology appropriate?	✓		
Was the research design appropriate to address the aims of the research?		✓	
Was the recruitment strategy appropriate to the aims of the research?			✓
Was the data collected in a way that addressed the research issue?		✓	
Has the relationship between researcher and participants been adequately considered?			✓
Section B: What are the results?			
Have ethical issues been taken into consideration?			✓
Was the data analysis sufficiently rigorous?		✓	
Is there a clear statement of findings?		✓	
Section C: Will the results help locally?			
How valuable is the research?	The study provides useful information that is called upon by government (e.g. young people should be involved in the design of interventions) and it provides information and recommendations for the future. It acknowledges that the small sample means it cannot be representative to other populations.		

Study: Kidger et al (2009)			
	YES	CAN'T TELL	NO
Section A: Are the results valid?			
Was there a clear statement of the aims of the research?	✓		
Is a qualitative methodology appropriate?	✓		

Was the research design appropriate to address the aims of the research?	✓	
Was the recruitment strategy appropriate to the aims of the research?	✓	
Was the data collected in a way that addressed the research issue?	✓	
Has the relationship between researcher and participants been adequately considered?		✓
<i>Section B: What are the results?</i>		
Have ethical issues been taken into consideration?	✓	
Was the data analysis sufficiently rigorous?		✓
Is there a clear statement of findings?	✓	
<i>Section C: Will the results help locally?</i>		
How valuable is the research?	Sufficient discussion relating to future research, policy and evaluation. The study adds to existing literature and discusses the mismatch between survey data and qualitative data which is useful.	

Study: Skryabina et al (2016)			
	YES	CAN'T TELL	NO
<i>Section A: Are the results valid?</i>			
Was there a clear statement of the aims of the research?		✓	
Is a qualitative methodology appropriate?	✓		
Was the research design appropriate to address the aims of the research?	✓		
Was the recruitment strategy appropriate to the aims of the research?	✓		
Was the data collected in a way that addressed the research issue?	✓		

Has the relationship between researcher and participants been adequately considered?	✓
<i>Section B: What are the results?</i>	
Have ethical issues been taken into consideration?	✓
Was the data analysis sufficiently rigorous?	✓
Is there a clear statement of findings?	✓
<i>Section C: Will the results help locally?</i>	
How valuable is the research?	Discusses the implications of research and possibility for schools in the future to consider evidence-based interventions. Also discusses implication for future research in context of own limitations and calls for more ethnically diverse population research.

Study: Taylor et al (2014)			
	YES	CAN'T TELL	NO
<i>Section A: Are the results valid?</i>			
Was there a clear statement of the aims of the research?	✓		
Is a qualitative methodology appropriate?	✓		
Was the research design appropriate to address the aims of the research?	✓		
Was the recruitment strategy appropriate to the aims of the research?	✓		
Was the data collected in a way that addressed the research issue?	✓		
Has the relationship between researcher and participants been adequately considered?		✓	
<i>Section B: What are the results?</i>			
Have ethical issues been taken into consideration?	✓		
Was the data analysis sufficiently rigorous?	✓		

Is there a clear statement of findings?	✓
<i>Section C: Will the results help locally?</i>	
How valuable is the research?	The paper highlights the difficulties in creating an intervention across schools from both a teacher and young person perspective. The conclusions hints at what future research is needed but does not go into detail.

Study: Woolfson et al (2009)			
	YES	CAN'T TELL	NO
<i>Section A: Are the results valid?</i>			
Was there a clear statement of the aims of the research?	✓		
Is a qualitative methodology appropriate?	✓		
Was the research design appropriate to address the aims of the research?	✓		
Was the recruitment strategy appropriate to the aims of the research?	✓		
Was the data collected in a way that addressed the research issue?		✓	
Has the relationship between researcher and participants been adequately considered?			✓
<i>Section B: What are the results?</i>			
Have ethical issues been taken into consideration?		✓	
Was the data analysis sufficiently rigorous?			✓
Is there a clear statement of findings?	✓		
<i>Section C: Will the results help locally?</i>			
How valuable is the research?	The paper suggests that recommendations and findings can be used locally and highlights the importance of future research as well as research that involves young people.		

Appendix C: Theme Table with Quotes Extracted from Studies

Themes	Theme references
Engagement	<p>(1) Pupils identified the key characteristics of a pupil support service — it should be delivered in ways which were non-stigmatising, was private and offered young people confidentiality.</p> <p><i>“No, I think they shouldn’t tell anyone unless we give them permission, unless it’s something that’s life-threatening to us, that’s when they should”</i></p>
Subtheme: Stigma and confidentiality	<p>(2) Some participants raised concerns that students may find speaking openly about their feelings difficult due to fears of being laughed at</p> <p><i>“Some people would just laugh, like if someone had been bullied or the class doesn’t like them and they get up and say something everybody would just laugh at them”</i></p> <p>(2) Student discussion about best formats for learning about EHWP within lesson time was a concern about stigma, both the stigma of experiencing emotional difficulty, but also the stigma attached to talking about emotions.</p> <p>(2) This explained the concerns voiced by several students that they might be laughed at or treated differently if they contributed to EHWP lessons delivered by teachers or tutors, in whole class, mixed gender situations.</p> <p>(3) Focus group participants disliked whole year group delivery, as they often felt inhibited by large groups.</p> <p><i>“if it is smaller groups you’d be less intimidated to say something. (Secondary 1/2) Not whole year assembly”</i></p>
	<p>(1) Motivating pupils by using creative and inspirational methods of teaching helped them enjoy your classes than those teachers who were ‘just going through the motions’.</p>

“teachers are really going for it ... teachers, pupils think there is something to work for ... there’s confidence in us, confidence in ourselves ... you can talk about any topic, issues at home, drop-ins are available”.

Sub-theme: Delivery

(3) They preferred to receive lessons in a specific, suitably decorated classroom.

(3) Participants identified various methods currently used in school to teach mental health education, some of which they find useful (videos, posters, group work with friends, practical workshops).

“When you’re watching a video and it’s like about bullying or something you see how other people got over it, when it’s something like that, and it’s better than listening to a teacher”.

(4) With greater use of interactive approaches, and in general, young people preferred the hands-on activities to discussion

“I preferred doing the hands-on stuff... the discussions, sometimes I think they kind of just went off a bit because some people lost concentration”.

(4) Some young people expressed a desire for more drama-related sessions and use of other electronic resources, such as interactive white boards and laptops.

(5) Children were positive about FRIENDS, finding the programme both ‘helpful’ and ‘fun’.

“I found it quite helpful as well because it gave you like different steps to like stop worrying and stuff”.

(5) They showed particular enthusiasm for the activity- based element of the programme finding it a refreshing change from their usual lessons.

“Um, I really liked the way they put educational stuff into fun games. And sort of made it, like the different side of learning”.

(2) *"If you talk in front of a teacher they'll sort of always like be, probably every time they look at you you'll be thinking "oh no are they thinking about this, what I've talked about" and it'll be kind of awkward".*

(2) Learning mentors, counsellors and teachers had a mixed reaction, with some students regarding them as helpful, whereas others expressed concerns that they would not keep problems confidential, that they were not be understanding, or that they were not available to everyone enough of the time.

Sub-theme: Trust

(3) *"If they teach you other subjects, then you'll probably know them better and you'll be able to talk to them better".*

(3) *"It might be a bit weird...because you know a teacher and then we've never really talked to (the teacher) about anything like that before. (Secondary 1/2)".*

(4) Some pupils were reticent about sharing their thoughts with facilitators they did not know well.

(4) Some young people commented that they liked the facilitators, found them to be friendly, and felt that it was easier to talk to them about personal issues than their teachers.

(4) Pupils may feel uncomfortable about talking to teachers about mental health because they see them in a very different role.

Meeting their needs

(1) Referred to the pressure on the curriculum 'to fit everything in', and that some topics such as EHWP suffered as a result

(1) Notable omissions from the EHWP curriculum in terms of recognising and managing common mental health problems, particularly related to self-harm.

"Self-harm is attention seeking, but for some it's because of depression ... we're not taught about

(1) Piercing, cutting and even burning were cited as extreme behaviours that some pupils demonstrated especially in response to academic pressure and, more often, in connection with mental health problems. One pupil said their school completely ignored the problem of self-harm in spite of it being a very common occurrence.

(1) In general, pupils felt there was a general lack of understanding about self-harm and that teachers were unsure how to handle it, or how to best help young people.

(1) "Eating disorders are rare, but it's hard to know what to do, hard to understand ... it's hush-hush ... people don't eat anything all day, or just chocolate".

(1) Some young people thought that anxiety and depression were common in peers, but were 'hardly mentioned in PSHE'.

(2) A few students suggested depression and self-harm as potentially useful topics to be covered

"I think people don't know enough about that really like how to stop yourself feeling depressed or sad or something or how to make yourself feel happy".

(2) All participants agreed that very little lesson time was spent on EHWPB, with comments indicating that other topics, notably sex and drugs, were more commonly taught.

(2) Nevertheless, it is noteworthy that many participants wanted more lessons that dealt overtly with emotional health, covering topics such as understanding feelings, coping with emotional distress and accessing help sources

(3) "We don't know what to do if you get it. It would help reduce stigma because people might think once you've got it you can't get cured. (Secondary 3/4) They

could teach us about the long term effects. We already learn about it with anorexia, but not with things like dementia or schizophrenia. (Secondary 3/4) Should be taught how to prevent it”.

(4) Useful content included knowledge, prevention and coping with depression, eating disorders, sexual health problems, self-harm, autism, ADHD, dementia and schizophrenia.

(4) A Year 9 pupil reported that the hypothetical scenarios in the classroom-based CBT tackled subjects that were minor everyday issues for them and some teachers agreed that the role plays were not always targeted at topics that were relevant to the older pupils.

(1) However, one pupil responded to this last comment saying that they knew what the School’s EHWP policies were, but the problem was that they were not put into practice

“The fact that there’s a piece of paper on the wall saying ‘bullying won’t be tolerated’ doesn’t mean that it doesn’t happen. They ignore what’s happening a lot of the time”.

Sub-theme: Availability of resources and signposting

(2) Few students also suggested that schools could do more to assist them in accessing external help sources, for example by providing leaflets and posters. All the schools displayed various posters relating to mental health, but one student pointed out this was not always helpful, due to concerns of being seen by others standing in front of a poster trying to memorise a phone number.

(2) The importance of having someone to talk to, a lack of confidential, accessible and sympathetic help sources within schools, the importance of having easily accessible safe spaces within school to work through emotions, and the need to find non-stigmatising ways of providing support.

(2) Students felt that a priority for schools should be having more help sources with the right attributes available.

(4) One pupil questioned whether it would be more effective to intersperse specific classroom-based CBT sessions with other activities across the yearly PSHE curriculum.

Part 4: Clinical Experience

Year 1 (Adult): Recovery and Support Team Service

In my first year, I worked with adults aged 18-65 years old. The focus of my work within two community recovery and support teams was developing core skills in undertaking psychological assessments and delivery therapy. Cognitive Behavioural Therapy (CBT) was the predominant model used; however, elements of systemic therapy, Acceptance and Commitment Therapy (ACT) and Compassion Focused Therapy (CFT) were also used integratively with CBT. I gained experience in developing these skills in areas of OCD, social anxiety, generalised anxiety, OCD, Schizophrenia, and Borderline Personality Disorder (BPD). I worked alongside psychiatrists, mental health nurses and community key workers and saw clients at the service as outpatients but also within the community.

I conducted a cognitive assessment for a woman who had been diagnosed with bipolar disorder but also had suspected cognitive difficulties and I met with family and other health professionals involved in her care to discuss recommendations as to how this woman could be supported post-assessment. Through this placement, I had the opportunity to work alongside service users who contribute to the Patient Quality Forum Group. Through attending the group, and conducting a service evaluation, I aimed to review and map the current service user and carer groups and activities across the trust.

Year 2: Older People's Community Mental Health Service

On this placement I worked across two teams for older adults aged 65 and over. This included working in the Memory Assessment Service (MAS), administering, and interpreting neurocognitive assessments to determine whether people were presenting with dementia or other executive difficulties. In this service, I also worked alongside a community nurse to

deliver a ten-week psychoeducational group for clients who had recently been diagnosed with dementia.

In the second team, I gained further experience in delivering therapy with older adults with a range of mental health difficulties, for example, depression, social anxiety, and adjustment to physical health difficulties. Both teams offered the chance to have group supervision with other health professionals.

Year 2: Children and Adolescent Mental Health Service

My role within CAMHS consisted of working with young people (aged 4-17) experiencing moderate to severe mental health and/or behavioural difficulties. I further developed knowledge and skills in adapting models of therapy such as CBT, ACT, narrative, systemic-informed approaches to this population. This placement was undertaken remotely during the COVID-19 pandemic. Despite the challenges that this posed, this also gave way to opportunities to evaluate new ways of working and delivering therapy. Alongside other trainee clinical psychologists, I delivered and evaluated (with service users) a pilot intervention that consisted of 4 ACT sessions for young people who were 17 and on the waitlist for therapy.

I gained further experience with using thorough risk assessments and questionnaires used to measure mental well-being and quality of life of young people.

On this placement, I also supervised the work of an assistant psychologist who was collecting questionnaires from schools and families prior to neurocognitive assessments.

Year 3: Community Learning Disability Team

On this placement, I worked within a community team that incorporated mental and physical health for adults (18+) diagnosed with a learning disability. This placement offered the opportunity to develop knowledge of systemic models and expand my therapeutic and clinical

skills in working with multiple systems. Working systemically, I used PBS frameworks to support clients in residential homes who were displaying challenging behaviour. I gained confidence and skills in consulting with health professionals within my team but also with external service leaders, for example, care home managers and community nurses. I also had the opportunity to participate in a systemic family consultation with other health professionals. I also furthered my experience in adapting and delivering cognitive assessments for clients with suspected dementia.

Year 3: Specialist placement, Paediatric Oncology

Within this placement, I have worked with both young people (6-17 years of age) diagnosed with cancers/tumours and with their parents. Individual therapy has taken place within both an inpatient and outpatient setting. I have drawn upon models of CBT, ACT, narrative, and systemic family therapy. Sessions with young people have involved adjusting to diagnosis, low mood, behaviour difficulties, procedural anxiety, and liaison work with other agencies such as school, CAMHS and charities. I co-facilitated a parent support group for parents of children with cancer/tumour(s) with another clinical psychologist and have gained experience being within a reflecting team in a family therapy clinic. I have also gained experience and knowledge in conducting neurocognitive assessments for young people who have been diagnosed with brain tumours and had received treatment such as radiotherapy which can have an impact on developing cognitive function.

Part 5: Assessments

Year I Assessments

ASSESSMENT	TITLE
WAIS	WAIS Interpretation and Administration
Practice Report of Clinical Activity	Assessment for Cognitive Behavioural Therapy for a woman in her sixties with depression
Audio Recording	Audio recording of Clinical Activity: A critical appraisal of a CBT session with a man in his late twenties with experiences and symptoms relating to Generalised Anxiety Disorder.
Report of Clinical Activity N=1	A Cognitive Behavioural Assessment and Intervention with a woman in her twenties experiencing depression and anxiety.
Major Research Project Proposal	How do young men from socioeconomically disadvantaged areas understand their mental well-being and experience mental health interventions in educational settings?
Service-Related Project	Mapping current service user and carer involvement groups and activities that service users can contribute to.

Year II Assessments

ASSESSMENT	TITLE
Report of Clinical Activity/Report of Clinical Activity – Formal Assessment	A cognitive assessment of a woman in her early eighties with a reported decline in cognitive functioning.
PPD Process Account	Personal and Professional Development logs. Implications for self & reflective practice (27 logs in total covering PPD groups and systemic teaching)
Presentation of Clinical Activity	Systemically informed cognitive behavioural therapy for a girl in her teens with obsessive compulsive disorder

Year III Assessments

ASSESSMENT	TITLE
Major Research Project Review Paper	Universal School-Based Programmes to Promote Mental and Emotional Wellbeing in the UK: What do the Pupils Say? A Systematic Review of the Qualitative Literature

Major Research Project Empirical Paper	A Qualitative Exploration of how Young Men in the UK Perceive and Experience Informal Help-Seeking for Mental Health Difficulties
Reflection on Integrating Systemic Ideas into Clinical Practice	Structured group discussions and written account evidencing integration of systemic ideas into clinical practice
Application of Systemic Ideas to a Clinical Scenario	Systemic assessment and intervention with a male adolescent and his family who was referred for depression
Report of Clinical Activity/Report of Clinical Activity – Formal Assessment	A Positive Behavioural Support Assessment and Plan for a man with a learning disability in his late sixties.