

MILLENNIAL MENTAL HEALTH:
EXAMINING CURRENT APPROACHES AND EXPLORING
CHALLENGES TO THE MEASUREMENT AND PROMOTION
OF MENTAL HEALTH IN YOUNG AUSTRALIANS

Emmelin Teng

Bachelor of Psychology (Hons)

Thesis submitted for the degree of
Combined Doctor of Philosophy / Master of Psychology (Clinical)

School of Psychology
Faculty of Health Sciences
The University of Adelaide

November, 2016

LIST OF TABLES	V
LIST OF FIGURES	VI
LIST OF APPENDICES	VII
KEY TO ABBREVIATIONS	VIII
ABSTRACT	IX
DECLARATION	XIII
ACKNOWLEDGEMENTS	XV
OVERVIEW	XVIII
CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW	1
1.1 PREAMBLE	1
1.2 KEY CONCEPTS.....	2
1.3 GLOBAL AGENDA FOR YOUTH HEALTH	9
1.4 MILLENNIAL MENTAL HEALTH	12
1.5 CURRENT APPROACHES TO MEASUREMENT AND CONCEPTUALISATION OF MENTAL HEALTH IN YOUNG PEOPLE	16
1.6 CURRENT APPROACHES TO POLICY AND PRACTICE TO MENTAL HEALTH PROMOTION AMONG YOUTH	21
1.7 SUMMARY AND AIMS OF THE THESIS	30
CHAPTER TWO: EXEGESIS	33
2.1 PREAMBLE	33
2.2 THESIS CONTEXT AND POPULATION OF INTEREST	33
2.3 CHOICE OF METHODOLOGY AND RATIONALE FOR MIXED-METHODS APPROACH ...	35
2.4 ‘SCHOOL LEAVER’ STUDY WITH EMERGING ADULTS (PAPER ONE)	37
2.5 QUALITATIVE STUDY WITH ADOLESCENTS (PAPER TWO AND PAPER THREE).....	39
2.6 SINGLE SCHOOL STUDY WITH FEMALE ADOLESCENTS (PAPER FOUR)	49

CHAPTER THREE: PAPER ONE	53
3.1 ABSTRACT	56
3.2 INTRODUCTION	57
3.3 METHOD	62
3.4 RESULTS	68
3.5 DISCUSSION	73
CHAPTER FOUR: PAPER TWO	80
4.1 ABSTRACT	83
4.2 INTRODUCTION	84
4.3 METHOD	89
4.4 RESULTS	93
4.5 DISCUSSION	108
4.6 CONCLUSIONS AND PRACTICAL IMPLICATIONS	117
CHAPTER FIVE: PAPER THREE	120
5.1 ABSTRACT	123
5.2 INTRODUCTION	124
5.3 METHOD	131
5.4 ANALYSIS AND DISCUSSION	135
5.5 CONCLUSIONS	155
CHAPTER SIX: PAPER FOUR	165
6.1 ABSTRACT	168
6.2 INTRODUCTION	169
6.3 METHOD	174
6.4 RESULTS	180

6.5	DISCUSSION.....	184
6.6	CONCLUSION	192
	CHAPTER SEVEN: DISCUSSION AND CONCLUSIONS	193
7.1	OVERVIEW	193
7.2	ORIGINAL CONTRIBUTIONS.....	194
7.3	META-INFERENCE AND PRACTICAL IMPLICATIONS	198
7.4	STRENGTHS AND LIMITATIONS	209
7.5	FUTURE DIRECTIONS	214
7.6	FINAL COMMENTS	231
	CHAPTER EIGHT: REFERENCES	233
	CHAPTER NINE: APPENDICES.....	277

LIST OF TABLES

Table 1. Phases of thematic analysis (Braun & Clarke, 2006).	45
Table 2. Criteria used to categorise Complete Mental Health State	67
Table 3. Measures of mental wellbeing and mental illness	69
Table 4. Comparison between measures of mental health and mental illness in young Australians.	71
Table 5. Participants across school level and approximate ages for year levels in Australia	91
Table 6. Categories and themes related to help-seeking behaviour among adolescents .	136
Table 7. Breakdown of participants across school year levels	174
Table 8. Means and standard deviations for knowledge about mental health scale (Knowledge Test; Watson et al, 2004).	180
Table 9. Means and standard deviations for stigmatising attitudes about mental illness scale (r-AQ, Corrigan et al., 2002, 2003).	182
Table 10. Mental health knowledge, stigmatising attitudes and correlation coefficients for Pearson correlations by mental health state (CSM Group).....	184

LIST OF FIGURES

Figure 1. Schematic diagram of the mixed-methods approach to the current thesis	36
Figure 2. Dual continua model (Keyes & Lopez, 2002).....	66
Figure 3. Adapted dual-continua model using single dimension measures (SWLS and GHQ) to represent mental health and illness*	70
Figure 4. Prevalence break-down of CSM states within dichotomous SWLS and GHQ categories	72
Figure 5. Adolescents' descriptions of mental health grouped into illness, neutral and wellbeing themes	95

LIST OF APPENDICES

Appendix 1. Study information sheet and consent form for Paper One	277
Appendix 2. Information sheet and assent form (students), consent form (parents) and information sheet (school staff) for qualitative study (Paper Two & Paper Three)	278
Appendix 3. Interview protocol for qualitative study (Paper Two & Paper Three)	284
Appendix 4. Audit trail sheet for qualitative study (Paper Two & Paper Three)	286
Appendix 5. Participant information sheet (name of school removed to maintain confidentiality) and consent form (Paper Four).....	288
Appendix 6. Ethics approval (all papers) and data licence agreement (Paper One).....	291
Appendix 7. Conference poster and oral presentations from the current PhD	300
Appendix 8. Feedback report prepared for MindMatters and school staff	301

KEY TO ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Acceptance and Commitment Therapy
ARC	Australian Research Council
CBT	Cognitive Behavioural Therapy
CESD	Center for Epidemiological Studies
CSM	The Complete State Model of Mental Health
DASS-21	The Depression Anxiety Stress Scale
DECD	The Department of Education and Child Development
DoHA	Australian Department of Health and Aging
DSM-5	Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition
F	Female
GHQ	The General Health Questionnaire
HBM	Health Belief Model
HPS	Health-Promoting Schools
HREC	The University of Adelaide Human Research Ethics Committee
KT	The Knowledge Test
LGBTI	Lesbian, Gay, Bisexual, Transgender and/or Intersex People
M	Male
MHP	Mental Health Promotion
N	Total Number in Sample
PWBS	The Psychological Well-being Scale
r-AQ	The Revised Attribution Questionnaire
SD	Standard Deviation
SES	Socio-economic Status
SWBS	The Social Well-being Scale
SWLS	The Satisfaction With Life Scale
TPB	Theory of Planned Behaviour
WHO	World Health Organization
YEP	Youth Empowerment Process

ABSTRACT

Millennials, the current generation of young people (born 1982-2004), now comprise more than a quarter of the world's population – the largest proportion in history. Mental disorders are a key cause of disease burden among young people (aged 12-24 years) who face unique challenges to building and maintaining mental health. Good mental health in adolescence decreases the likelihood of developing mental health problems across the lifespan, but young people are the least likely group to seek help and receive treatment for mental disorders compared to older populations. With this in mind, and knowing that lack of mental disorders does not necessarily equate to good mental health, the present thesis sought to investigate current approaches and explore new challenges to the measurement and promotion of mental health in young people, encompassing children, adolescents and young adults.

Paper One reports a preliminary exploration into the differences between three measurement approaches to mental health and illness in an Australian sample of emerging adults (aged 23-27 years; N=117): an exclusive mental illness approach, an exclusive mental wellbeing approach and a dual continua approach. The results illustrated discrepancies between the three approaches, which resulted in vastly different depictions of the collective mental health of a group of young people. A significant proportion of cases fell outside of a single dimension model, and moderate mental health categories were identified as a challenge to gaining a comprehensive and informative picture of groups of emerging adults when using single dimension measures, suggesting that adopting a dual continua approach to measurement can provide a more comprehensive picture of mental health.

Paper Two reports the results of a cross-sectional, qualitative study aimed to explore how a non-clinical sample of adolescents (aged 12-18 years; N=16) speak about mental health and illness and to gain insight into their perceptions and experiences. When discussing mental health concepts and appropriate behaviours towards sufferers of mental illness, adolescents conveyed a sense of acceptance and understanding of the potential complexity and severity of mental illness. In contrast, when discussing mental health in the context of their own lives, a stronger sense of scepticism was conveyed. Students expressed difficulty with the lack of visible markers of mental health and confusion determining authenticity in the mental health states conveyed by their peers. Interestingly, adolescents commonly expressed the notion that young people may exaggerate or ‘fake’ a mental illness for personal gain.

Paper Three involved further analysis of the same sample to explore the topic of help-seeking for mental health specifically from the perspectives of young people. Findings highlighted that even among a non-clinical sample of adolescents who had participated in a school mental health promotion program, there was a strong reluctance to seek help due to complex and interrelated personal, social and institutional influences. Students conveyed that they would strongly avoid seeking help for their mental health, referencing themes including self-reliance, positive thinking, doubt about significance of problems, peer acceptance, burdening others, informal help-seeking, concerns about confidentiality and negative perceptions of mental health services and professionals. Students spoke about the concept of “first world problems”, and described their personal problems as minor or trivial in comparison to large-scale or global issues.

Paper Four reports the results of a cross-sectional quantitative study utilising survey methodology to test the traditional assumption that knowledge influences behaviour by exploring whether knowledge about mental illness was related to stigmatising attitudes towards mental illness and intentions to seek help, within a sample (aged 13-17 years; N=327) of adolescent girls. Results indicated that a weak negative relationship existed between knowledge about mental health and stigmatising attitudes about mental illness, but no relationship between knowledge about mental health and intentions to seek help for mental health problems was found. When mental health was categorised (e.g., optimal vs. poorer mental health), a significant relationship between knowledge about, and attitudes toward, mental health was shown in those with poor mental health, but not for adolescents categorised as having moderate or good mental health.

The series of studies presented in this thesis add to understandings of youth mental health knowledge, attitudes and behaviour in Australia. Practical implications include the usefulness of conceptualisation that includes both positive and negative aspects of mental health, the need to consider adolescent mental health within the broader sociocultural context, the potential for a knowledge-behaviour gap related to mental health among young people and insights about mental health in the context of Millennials (and subsequent generations) as “digital natives”. The results draw attention to several key areas of focus for future research, policy and practice to explore, including the predictive power of mental health states according to a dual continua model, further consideration of current practice (including universal programs and individual approaches applied to populations), reshaping the role of education in mental health promotion and broadening focus to include a socioecological model of mental health emphasising community and interconnectedness, while prioritising youth participatory approaches. Taken together, the

four journal articles (1 published, 1 accepted with minor revisions, 2 submitted) that make up this PhD thesis draw attention to the complexity of youth mental health, including aspects that are salient to young people, within a developmental and social context.

DECLARATION

I, Emmelin Teng, certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

I acknowledge that copyright of published works contained within this thesis resides with the copyright holder(s) of those works.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Published work:

Chapter Three: *Paper One*

Teng, E., Venning., A., Winefield, H., & Crabb, S. (2015). Half full or half empty: The measurement of mental health and mental illness in emerging Australian adults. *Social Inquiry into Well-being*, 1, 1-12. doi: 10.13165/SIIW-15-1-1-01.

Emmelin Teng

Signed:

Date: 25/11/2016

ACKNOWLEDGEMENTS

As I reflect on the highs and lows of this journey, I am overwhelmed with the number of people who have helped me get this far. Nelson Mandela said *“Do not judge me by my successes, judge me by how many times I fell down and got back up again.”* I would not have gotten back up in the face of the many challenges, uncertainties and pressures that characterise any PhD process without the help of some important people. Whether dealing with a computer virus disaster or an existential crisis, I owe my gratitude to the many people who supported me and encouraged me along the way.

Firstly, thank you to my academic supervision panel - my principal supervisor Prof. Helen Winefield and co-supervisors Dr. Anthony Venning and Dr. Shona Crabb - for guiding and supporting me throughout the past few years. Your professionalism, expertise, guidance and hard work have helped me beyond words. You have helped me to develop and grow in ways that extend far beyond academia, and shaped my outlook on life. I hold so much respect for each of you on both a professional and a personal level. I entered this program nervous and excited with a severe case of Imposter Syndrome, and now I reach the end feeling empowered, capable and resilient, thanks to your contributions.

Helen, thank you for your wisdom, kindness and patience, and for knowing when to make suggestions and when to allow me the freedom to work independently, while always making yourself available when I required support. Your ability to remain calm and insightful during challenging times will never cease to amaze me. I have learnt so much from you, and it has truly been a privilege to be your student.

Anthony, your encouragement and unwavering commitment to my research helped me to perceive new challenges as opportunities, rather than as threats. Thank you for your sense of humour and compassionate outlook, practical advice, statistical assistance and insight into navigating the academic world - all of which have helped me to evolve as a researcher.

Shona, thank you for your generosity in going over and above to support me, particularly in helping me to master the new skills I needed to develop to conduct qualitative research. I appreciated your uplifting and bubbly personality, and attention to detail in refining my analysis – you have been an inspiration to me and a pleasure to work with.

Thank you to my clinical supervisors – Karen Davies, Elissa Spence, Richard Balfour and Kari Walsh - for helping me develop my clinical judgement and interviewing skills which undoubtedly contributed to my qualitative interviews, as well as to my writing and insight on a clinical PhD topic. To the teaching and administrative staff at the School of Psychology, I am very grateful for all your support and assistance in completing this PhD. Thank you also to my teachers and supervisors at UniSA - in particular, Charli Sargent for fostering my interest in research, and Rob Ranzijn for helping me develop a greater appreciation for theories of social and developmental psychology that ultimately shaped my understanding of the findings and conclusions of this thesis. A big thank you also to my managers, colleagues and friends at Youth Justice and the Department for Correctional Services for extending your support while I took on the task of completing my thesis while working full-time.

Thank you to all the PhD and Masters students that I've crossed paths with across the years. As we all know, the research process can be an isolating one, and I would not have survived it without a wonderful group of fellow postgrads to share the pain and laughs with along

the way. Most of all, thanks to Stacey – my office buddy and partner in crime – for being a rock to rely on with my problems both inside and outside the realms of study.

Thanks to my closest friends (Celeste, Simone, Eegs, Fi, Nick, Ben, Bakes and many others) who have stood by me and cheered me on throughout my seemingly eternal student life, and for making the rollercoaster ride as fun as possible. Thanks especially to Steph for offering to proofread my thesis, and to Lysh for listening for countless hours to all the ins and outs of my work over the years – no doubt you now know far more about research and psychology than you ever needed, but your support has been invaluable to me.

Tom, thank you for always believing in me, even at times when I didn't believe in myself. You have shown your support in so many ways – your amazing cooking, driving to uni late at night to help me move offices, being able to sense when a welcome distraction from writing was needed, checking drafts, and your ongoing encouragement and interest in my work and my wellbeing – for this I will always be grateful.

Thank you to my family. Corinne, for being a supportive big sister who encouraged me every step of my education, and Jason, for our late night 'clinical discussions' and study breaks (procrastination) - it's been pretty great to have a sibling to share the extra-long uni journey with. Finally, Mum and Dad, I can't thank you both enough for making the difficult move to Australia, and for sacrificing so much to provide opportunities for your children that would not have been possible otherwise. Dad, thank you for instilling values of lifelong learning, working hard and perseverance in me, for inspiring me with your own career and drive to succeed, and for always supporting me. Mum, thank you for your patience, generosity and eternally kind heart. I will never forget how much you have done for me, and without your unconditional love and support I would never have made it this far.

OVERVIEW

Outline of thesis

This thesis sought to investigate the mental health of young Australians in order to contribute to future development of mental health promotion initiatives. In this thesis, the term young person encompasses children, adolescents and young adults. More specifically, this thesis aimed to examine current approaches to mental health measurement and promotion in young people, with the aim of uncovering factors that are salient to young people in the 21st century. *Chapter One* of the thesis provides an introduction to the field of youth mental health and a review of the current literature. *Chapter Two* provides an exegesis, which aims to contextualise the research and present a rationale for the decisions made throughout the research process. *Chapters Three, Four, Five and Six* contain the four independent but related journal articles that address the overarching aim of this thesis. *Chapter Seven* provides a critical discussion of the research findings, their implications for approaches to youth mental health, future directions and a concluding statement. References and appendices used throughout this research are presented in *Chapter Eight* and *Chapter Nine*.

Outline of candidature

The current thesis was undertaken to fulfil the requirements of the degree of Combined Doctor of Philosophy / Master of Psychology (Clinical) undertaken at the University of Adelaide, South Australia. This program combines a Master of Psychology (Clinical) course load (*equivalent to two years of full time study*), and a Doctor of Philosophy research program (*equivalent to three years of full time study*) into one program (*equivalent to four years of full time study*), and specifies that the research must adopt a clinical psychology focus. The four papers from this work, along with nine Masters subjects and three clinical placements (a total of 1359.5 placement hours) were completed within this period of study. A total of \$4400 in funding was received over and above the standard support provided to Doctor of Philosophy students from the School of Psychology, including a publication incentive award and funding for conference travel. All subject and practical requirements of the Master of Psychology (Clinical) program have been fulfilled. The following thesis is submitted for the requirements of the Doctor of Philosophy program.

CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

1.1 Preamble

This chapter begins with an introduction to key concepts, and an overview of the background literature in the area of youth mental health. Then, the global agenda for youth health, and specifically youth mental health, is discussed. This is followed by a review of the unique challenges to improving the mental health of our current generation of young people, known as ‘*Millennials*’ or *Generation Y*, with birth dates spanning approximately 1982 to 2004 (Howe & Strauss, 2000). Next, an overview of current approaches to measurement and conceptualisation of mental health and illness, and then current policy and practice addressing mental health in young people will be presented. Finally, a review of the current gaps in the literature and the resulting aims of the thesis are presented. While certain aspects of these topics will be discussed in further detail in the literature reviews provided within each of the individual papers that form this thesis, this chapter will focus on providing a broader overview of topics relevant to the improvement of mental health in young people.

The current thesis is presented in *publication format*, which according to The University of Adelaide Graduate Centre guidelines, may be chosen as an alternative to the conventional written thesis. The guidelines specify that a thesis by publication is presented as a portfolio of publications which have been published and/or submitted for publication and/or comprise unpublished and un-submitted work written in manuscript style. Manuscripts presented in a publication format thesis must be closely related in terms of subject matter, form a cohesive research narrative and derive from research

undertaken within candidature. For further information please see

www.adelaide.edu.au/graduatecentre/handbook/07-thesis/02-publication-format-thesis/.

1.2 Key concepts

1.2.1 Young people

The terms *young people* (or *youth*) are used to refer to individuals spanning both the adolescent and emerging adulthood age range from approximately 10 to 24 years (Sawyer, Afifi, et al., 2012). Adolescence and emerging adulthood represent critical stages of transition, within both physical and mental development (Australian Bureau of Statistics, 2007). While youth is a unique developmental period that often involves challenging or stressful experiences including biological changes, shifting social networks, academic pressures, commencement of work and increasing independence and identity formation, it can also be portrayed in a positive light due to the array of opportunities it provides for growth, and the potential to build a strong foundation of health and wellbeing for the rest of the lifespan (Peterson, 2004). For the purpose of this thesis, which encompasses research conducted across both the adolescent and emerging adulthood range, the term *young people* will be used to refer to individuals across both of these age groups.

1.2.2 Adolescence

The WHO (2001) defines *adolescence* as the period between the ages of 10 and 19 years. The term is derived from the Latin *adolēscere* and the present participle *adolēscēns*, meaning ‘growing up’ (Sawyer, Afifi, et al., 2012). Despite this traditional age-bound definition, adolescence has been referred to as a fluid concept, in that it is a phase of life that is profoundly influenced by a combination of a wide range of social, environmental

and cultural factors (Patel, Flisher, Hetrick, & McGorry, 2007). Historically, biological markers of puberty have signalled the onset of adolescence, while key social-role transitions have signalled the end – however, globally, such markers of adolescence are less distinct in the present day compared to the past (Sawyer, Afifi, et al., 2012). The definition of adolescence as a developmental stage is further complicated through consideration of other more recently established and understood factors that may influence a young person’s behaviour and wellbeing, such as neurocognitive development (Sawyer, Afifi, et al., 2012).

1.2.3 Emerging adulthood

Arnett (2000) coined the term ‘*emerging adulthood*’ to refer to the stage of life roughly spanning the ages of 18 to 25, as a reflection of the ‘developmental delay’ witnessed among young people in this age group across factors such as extended tertiary education, more frequent job changes, and marriage and becoming parents occurring later than in previous generations. Arnett (2000) argued that emerging adulthood should be recognised as a distinct period across three levels: demographically, subjectively and in identity exploration. Demographically, Arnett stated that between the ages of 18 and 25, it is difficult to predict an individual’s status in areas such as residential status, marriage, or having children based on age alone. Arnett called this demographic diversity and unpredictability between the life stages of adolescence and young adulthood, “a *reflection of the experimental and exploratory quality of the period*” (p.471). Subjectively, it was reported that the majority of young people in their late teens and early twenties did not define themselves as adolescents, but also did not view themselves as having completely entered into young adulthood yet. In terms of identity exploration, Arnett cited Erikson

(1968) who proposed that industrialised societies allowed for a ‘prolonged adolescence’, where extended identity explorations could occur. It was reasoned that while most research on identity formation focuses on adolescence, such studies have rarely shown identity achievement to be reached by the end of high school, but rather that it continues into the twenties (Valde, 1996; Waterman, 1982; Whitbourne & Tesch, 1985). Importantly, Arnett (2000) acknowledged that the period of emerging adulthood was not a globally experienced phenomenon, but a life stage that appeared to exist only in cultures that allow for postponed entry into adult roles and responsibilities beyond the teenage years, particularly in highly industrialised countries.

1.2.4 Mental health

The World Health Organisation (2013) defines mental health as the ability of a person to reach his or her potential, cope with burdens of everyday life and contribute to their communities. Mental health is an indispensable component of general health, which is defined as a state of complete physical, mental and social wellbeing (WHO, 1946). For the purpose of this thesis, a ‘complete’ perspective of mental health is utilised, encompassing both positive mental health and mental illness or psychopathology (Keyes, 2002).

1.2.5 Mental illness

For this purpose of this thesis, the term ‘mental illness’ refers to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) definition of mental disorder. The DSM describes mental disorder as a “syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a

dysfunction in the psychological, biological, or developmental processes underlying mental functioning”. Mental illness is associated with significant distress or disability in social, occupational and other activities (American Psychiatric Association, 2013).

1.2.6 Positive psychology

Positive psychology is an umbrella term used to define the investigation and practice of conditions and processes that foster happiness, optimal functioning and psychological wellness (Seligman & Csikszentmihalyi, 2000). Rather than focusing on treating illness alone, positive psychology aims to build and foster nurturing aspects of human psychological functioning such as hope, gratitude, resilience, and character strengths (Allen & McKenzie, 2015).

1.2.7 Wellbeing

There is a lack of consistency in the literature regarding definitions of wellbeing (Allen & McKenzie, 2015). However, the term is generally considered to refer to a positive approach to an individual’s experience, with indicators including health, resilience, self-concept, self-efficacy and achievement (Frydenberg, Care, Freeman, & Chan, 2009). The concept also may incorporate aspects of emotional wellbeing, such as having close friends who can be trusted, and feeling supported, safe and valued.

1.2.8 Resilience

Resilience refers to the ability to employ a collection of protective factors in order to restore or maintain positive mental health following disadvantage or adversity (Dray et al., 2015). Thus, resilience-focused interventions aim to strengthen protective factors and

foster the development of coping mechanisms and positive mental health (Fergus & Zimmerman, 2005).

1.2.9 Help-seeking

While there are few agreed upon definitions of help-seeking, the general concept refers to the process of gaining both informal and professional networks to gain support with coping with mental health problems (Michelmores, 2012; Rowe et al., 2014). The World Health Organisation proposes youth help-seeking for mental health problems to be “any action or activity carried out by an adolescent who perceives herself/himself as needing personal psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way” (Barker, 2007, p. 2). This encompasses seeking help from informal sources (e.g. peers, friends, family, other adults in the community) and formal services (e.g. psychologists, medical staff, counsellors, religious leaders, youth programs) (Barker, 2007). Among adolescents, informal sources are the most likely support systems accessed (Rowe et al., 2014).

1.2.10 Mental health stigma

Mental health stigma refers to four social cognitive processes: cues, stereotypes, prejudice and discrimination (Corrigan, 2004). Cues refer to ways in which the public may identify mental illness in others, such as physical appearance, impaired social skills, symptoms and labels. Stereotypes refer to common ideas about individuals suffering from mental illness, such as that they are incompetent, weak or dangerous. Societal views such as these can lead to prejudice and discriminatory behaviour towards those who have, or are perceived to have, mental illness. Stigma has been identified as a key barrier to

professional help-seeking for mental illness and treatment (Gulliver, Griffiths, & Christensen, 2010).

1.2.11 Mental health literacy

Mental health literacy is defined as knowledge and skills related to mental illness that aid in its recognition, management and prevention, including understanding of risks, causes and effective treatments, resources and services (Jorm, 2000). The construct extends beyond basic knowledge about mental health to mastery of skills related to care seeking and participation such as preventing disorders, mental illness recognition, help-seeking and skills to support others experiencing distress. A recent review of current measures of mental health literacy (including measures of knowledge, stigma and help-seeking) identified significant gaps in the psychometric properties of available scales, particularly among youth (Wei, McGrath, Hayden, & Kutcher, 2015).

1.2.1 Risk factors

Risk factors to mental health problems and disorders are characteristics, variables and hazards that increase the likelihood that an individual will develop a disorder, when compared to someone randomly selected from the general population (Mrazek & Haggerty, 1994). These factors may include stressors or events that increase the likelihood of negative outcomes and decrease the likelihood of positive outcomes are multifactorial and span biological, psychological and social domains. Poverty and social disadvantage are considered strong risk factors for disorder, as well as violence and child abuse (Patel et al., 2007). Genetic and biological factors are known to interact with environmental factors such as family and school, to influence the risk of mental illness

(Eley et al., 2004). Other more recent factors have been found to have an influence on mental health, such as globalisation of the media reportedly associated with an increase in eating disorders in societies that previously demonstrated extremely low prevalence of such disorders (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002).

1.2.12 Protective factors

Protective factors refer to those factors that contribute to the level of resilience an individual demonstrates towards psychological difficulties in the face of adverse risk factors (Scanlon, 2002). Protective factors are often categorised as either internal factors that exist within the individual (e.g. coping skills, self-esteem, problem-solving skills) and external factors relating the wider social environment (e.g. social support, family and peer relationships, meaningful participation in home, school or community) (Dray et al., 2015). Social support is a protective factor that has been reported to exhibit a buffering effect against the effects of other risk factors (Birmaher et al., 1996; Greening & Stoppelbein, 2002). Other studies suggest that sense of connection, low levels of conflict and environments facilitative of expression of emotions protect against the emergence of behavioural and emotional disorders (Patel et al., 2007). Psychological support during early childhood has also been considered an important foundational protective factor for wellbeing and resilience, due to the undeniable role that early childhood experiences and parenting play in shaping an individual's ability to cope with difficult circumstances and events (Bartley, 2006).

1.3 Global agenda for youth health

Youth is a phase of life that is often characterised as being a time of great change, rapid development and vast possibilities. In terms of physical health, young people are generally perceived to be healthy. By the time they reach their second decade, they have survived the diseases of childhood and are still far from the health problems associated with ageing processes (WHO, 2001). Despite this assumption, the World Health Organisation (2001) reports that an overwhelming number of young people die prematurely every year, with the primary contributors being mental illness and suicide, accidents, violence and sexual and reproductive behaviour. Despite exceptional physical health, during adolescence, the risk of injury or death rises to that of 2-3 times that of childhood, with a primary cause being heightened risk-taking across behaviours such as drinking, driving, smoking, drugs and unprotected sex (Pharo, Sim, Graham, Gross, & Hayne, 2011). This heightened risk-taking has been suggested to be related to limited integration and efficiency in brain systems, particularly within the prefrontal cortex. Further, of these common causes of death and disability in young people, most are either preventable or treatable. WHO (2001) argues that 70% of premature death in adulthood “has its roots” in the adolescent period, signifying the importance of building a strong focus to improving the health of young people. Globally, the present generation of young people aged 10 to 24 years is the largest it has ever been, contributing to more than a quarter of the world’s population (Sawyer, Afifi, et al., 2012). In light of this, a focus on youth health can be viewed as an investment for the future by laying the foundation for health in adulthood.

1.3.1 Youth mental health

In relation to mental health specifically, young people are at an increased risk of being diagnosed with a mental illness (WHO, 2001) and young people carry mental health problems disproportionate to the size of their population (Burns & Birrell, 2014). The most recent figures from the Australian Bureau of Statistics indicate that one in four of Australia's young people (aged 16 to 24) are currently experiencing a mental illness (ABS, 2007). A high proportion of mental health disorders such as depression, anxiety, drug and alcohol problems (leading to further repercussions such as self-harm and suicide) increase significantly in prevalence during adolescence and young adulthood. Vulnerability to mental illness is heightened during this period of major life change, with over three-quarters (76%) of people who experience mental disorder during their lifetime experiencing an age of disorder onset younger than 25 years (ABS, 2007). Furthermore, the bulk of cases of mental disorder tend to emerge within the relatively narrow time frame between 12 and 24 years (Patel et al., 2007).

Mental disorders in young people can have a devastating effect through creating a disruption to growth and development and eroding quality of life by influencing critical aspects such as self-esteem, level of independence, social relationships, education and employment (DoHA, 2004). Additionally, young brains are particularly vulnerable to the effects of trauma, abuse, substance use and addiction. For example, a young person's brain neurobiology is still rapidly changing, which makes the reinforcing properties of substances to be experienced as especially positive to young people, while their inhibitory structures remain relatively weak (Sussman & Arnett, 2014).

1.3.2 Developmental context of mental health in young people

Youth is a time of life when many people begin and complete education, enter employment and establish long-term friendships and relationships (Patel et al., 2007). The pressures and challenges that typically define adolescence and emerging adulthood can often result in young people feeling inadequate, or lacking confidence in their abilities, which in turn then reflects a barrier to optimal mental health (Tucci, Mitchell, & Goddard, 2007). It has been found that an individual's state of mental health has a powerful impact on the likelihood of important milestones (e.g. education and training, finding and keeping a job, creating and maintaining relationships) being completed successfully (Patel et al., 2007). Conversely, if these milestones are not completed successfully, the resultant repercussions of poor mental health in adolescence have significant and long-lasting effects on an individual's social and economic outcomes as they progress into adulthood (Norrish & Vella-Brodrick, 2009). Moreover, left untreated or inadequately treated, mental health problems are associated with a vast array of short and long term impairment factors including poor education and employment outcomes, comorbidities such as drug and alcohol problems and antisocial behaviour, violence and aggression (Burns & Birrell, 2014).

From a health psychology perspective, adolescence is characterised by the emergence of many critical health behaviours, with poor mental health during this period having the potential to affect future physical health outcomes in adulthood (Williams, Holmbeck, & Greenley, 2002). The role of health behaviours emerging in a young person's world in shaping their developmental trajectory and health into adulthood emphasises the value focusing on adolescent and youth populations (Walker & Rowling, 2007; Williams et al.,

2002). Important aspects of brain development continue to progress well into the young adult years; for example the myelination of systems within the prefrontal cortex, with changes resulting in increasing executive functioning skills throughout emerging adulthood (Giedd et al., 1999).

1.4 Millennial mental health

When considering mental health during youth from a developmental framework, it is also necessary to acknowledge that our current generation of young people will face unique challenges to building and maintaining mental health, compared to previous generations. *Millennials* or *Generation Y* are broad terms applied to our current generation spanning young adults and adolescents born from 1980 through to the early 2000's (Howe & Strauss, 2000). As they are "*digital natives*", the way in which young people learn and interact has changed dramatically in the past 15 years as a result of rapidly advancing technology and the introduction of social media (Giedd, 2012). With the evolution of the Internet, smart phones and social media, young people have more ways to connect with peers and family than ever before (Owen & Rodolfa, 2009). However, the benefits and failures of technology for the Millennial generation - who grew up amidst this rapid cultural shift - are still being explored, and in addition to positive aspects, potential negative consequences for youth mental health must be considered. For example, it has been proposed that with the digital revolution and increasing reliance on online social interactions, exposure to "real-world" experiences necessary to develop social skills, empathy, attention and tolerance for unpleasant experiences (such as boredom or distress) may be compromised among the current cohort of adolescents growing up in a world immersed in technology (Giedd, 2012; Turkle, 2011).

The delay in transition to adulthood and Arnett's concept of emerging adulthood is a relatively recent phenomenon that has been witnessed globally, and has been particularly prominent in developed nations such as the United States, Canada, Western Europe, Japan and Australia. Recent research has indicated that with the decline in perceived importance of traditional role transitions (such as marriage or completion of education) among subjective definitions of adulthood, young people now tend to place more weight on individual or psychological attributes as alternative indicators of achieving adulthood (Silva, 2014).

Generation Y have been described as a crop of sheltered, confident, achievement-focused and team-oriented individuals (Howe & Strauss, 2000). In regards to their career expectations, popular literature suggests that Millennials "*want it all*" and "*want it now*", referring to the perception that the current generation of young people entering the workforce demand competitive salaries, fulfilling careers and rapid advancement, all while maintaining a healthy sense of work-life balance (Ng, Schweitzer, & Lyons, 2010). While the media refer to our current generation of young people as an entitled, lazy and narcissistic 'Peter Pan generation' that refuse to grow up (see Time Magazine's (2013) cover story: "*The Me Me Me generation*"), others argue that individualistic and self-focused accounts of adulthood are reflective of the challenges of the larger cultural and social context facing millennials today (Silva, 2014). In light of these sociocultural pressures, including a rising inequality and distrust in institutions and declining job security (Silva, 2014), Millennials have been prompted to seek a greater understanding of their own identities, their directions in life and their relationships with others, while on the road to reaching their potential, whatever that may be (Owen & Rodolfa, 2009). Similarly, in Settersten and Ray's book '*Not Quite Adults*', the authors argue that

remarkable changes have occurred, creating a “*new rule book on what it means to be an adult*” (2010, p. xxii). They acknowledge changing social, economic and social factors that are occurring in the developed world that result in small mistakes on the road to adulthood being substantially more disastrous than they were a decade ago. For example, while Millennials commonly experience a delay in the steps towards adulthood (Arnett, 2000), ‘taking too long to get there’ has a potentially far-reaching effect for the trajectory of their lives in today’s economy that limits the luxury of choice. Delaying education delays entering a professional career, and even after finding a job, the likelihood that young people will find stable or long-term employment has decreased considerably in the past couple decades (GenerationOpportunity, 2016; Settersten & Ray, 2010). This pattern further delays financial stability, which can result in young people being disconnected, and potentially postpone relationships, marriage and children (Settersten & Ray, 2010). Mizen (2002) discusses how the organisation of social relations in modern society has changed the concept of youth from being defined by Keynesian state policies from the 1940’s through to the 1970’s (while the Baby Boomers were coming of age) to the current situation for young people, where monetarist policies dominate, and economic goals are primary. Key differences between these two distinctive phases outlined – 1) Keynesianism: with a focus on direct state support for parents, free higher education, guaranteed full employment and a rise in youth wages and welfare benefits, and 2) monetarism: with a focus on reduction in welfare benefits and harsher eligibility criteria for young people, promotion of age-standardised testing, selection and competition in schooling and shifting higher education costs from the state to young people and their parents. In Australia, this has resulted in an overall reduction of public support for young people, including a significant withdrawal of public education and development of

categories of ‘deserving vs. underserving’ youth (Wyn & Woodman, 2006). While the distinctive political features of the current youth generation are often invisible to them, and operate against the knowledge that their parents have gained through their own youth experiences - a large group of Millennials will struggle to negotiate new economies (Wyn & Woodman, 2006), and will be the first generation to be ‘worse off’ than their parents (Settersten & Ray, 2010). For example, Millennials are the first in the modern era to have higher levels of student loan debt, poverty and unemployment, and lower levels of wealth than their two immediate predecessor generations (Generation X and Baby Boomers) had at the same stage of life (Generation Opportunity, 2016). These factors create a climate where the stakes are high, and the traditional markers of adulthood (such as marriage, full-time and stable employment and home ownership) are simply not available or, if they are achievable, exist in different forms compared to previous generations (Wyn & Woodman, 2006).

While the literature concerning Millennials grows, and as we witness the vast cultural shift occurring in the 21st century, it is clear that continued research is needed to explore and understand the unique factors facing young people today. The utilisation of the Internet as a source of information for mental health concerns is on the rise, demonstrating the need to address and prioritise the role of the online setting for the provision of mental health services and support among youth (Burns & Birrell, 2014). Further, it must be acknowledged that social systems in almost all societies worldwide are rapidly evolving at an unprecedented rate - to some degree, a result of the effects of globalisation influencing values, culture and attitudes. In turn, this changing global culture among youth has created a higher standard of expectations held by young people (Patel et al., 2007). Today’s young people may exhibit ‘elevated expectations’, in contrast

to the view that they are spoiled, other authors argue that they have simply been raised to believe in themselves. Yet this attitude creates a challenge when coupled with an increasingly ‘winner-takes-all’ society, where expectations can easily lead to disappointment (Settersten & Ray, 2010). In order to build a worldwide agenda for the health of young people, scholars and researchers have called for an increase in the visibility of young people’s needs, including the many challenges to their health and development (Sawyer, Afifi, et al., 2012).

1.5 Current approaches to measurement and conceptualisation of mental health in young people

1.5.1 Single continuum models

In the conventional paradigm, mental health and illness are conceptualised to exist on either ends of a single continuum. According to this view, a point on a single continuum (with positive wellbeing on one end and psychopathology on the other) represents mental health status (Antaramian, Scott Huebner, Hills, & Valois, 2010). In this model, the emphasis is placed on the presence or absence of pathological symptoms (Peter, Roberts, & Dengate, 2011). Indicators of clinical significance have therefore been based on categorisation of an individual into ‘functional’ vs. ‘dysfunctional’ populations (Ronk, Korman, Hooke, & Page, 2013). Consistent with this paradigm, the discipline of clinical psychology has traditionally had an emphasis on abnormal psychology and mental illness in contrast to the study of wellbeing (Norrish & Vella-Brodrick, 2009).

1.5.2 Measuring positive constructs in mental health

The World Health Organisation (2013) defines mental health as the ability of a person to reach his or her potential, cope with burdens of everyday life and contribute to their

communities. Yet historically, there has been a focus on psychopathology that has implied that if one does not display symptoms of mental illness, they are mentally “well enough” by default (Suldo & Huebner, 2006). While the measurement and conceptualisation of mental health has had a tendency to focus primarily on problematic behaviours, psychological disorders and negative life outcomes, investigation of strategies for promoting positive development among young people has been somewhat neglected (Marques, Pais-Ribeiro, & Lopez, 2011). This bias towards negative conditions and mental health states has been proposed to reflect an incomplete representation of the human experience (Herrman & Jané-Llopis, 2005).

Myers (2000) conducted a search of psychological abstracts dating back to 1887, and reported that in the sample collected, studies of negative emotions (such as anger, anxiety and depression) far outnumbered studies of positive emotions (such as happiness and life satisfaction) at a ratio of 14:1. The author contended that questions about positive psychological constructs have historically remained largely unasked by psychologists focused on illness more than health (Myers, 2000). More recently, a notable shift towards efforts to investigate human strengths and positive mental states has been witnessed in the field, leading towards a more holistic understanding of human experience (Norrish & Vella-Brodrick, 2009). As positive psychology has gained momentum, a focus has more recently fallen on the science of optimal human functioning, mental wellness and happiness (Marques et al., 2011).

1.5.3 Dual continua models of mental health

Empirical evidence has gathered to support the notion that mental health is not merely the absence of mental illness, but a complete state that also necessitates the presence of

subjective wellbeing (Keyes, 2002). For example, Ryff and Keyes (1995) reported that in two separate studies, measures of psychological wellbeing reported only moderate negative correlations (-.51 and -.55) with standardised depression scales (the Zung depression inventory and the Center for Epidemiological Studies depression (CESD) scale). Similarly, it has been reported that scales of emotional wellbeing, involving levels of happiness and life satisfaction report modest correlations (ranging from -.40 to -.50) with depressive symptoms (Frisch, Cornell, Villanueva, & Retzlaff, 1992; Keyes, 2002). It has been proposed that mental health and mental wellbeing are not merely opposite ends of the same continuum, prompting the emergence of dual continua models of mental health (Keyes, 2002). Winefield, Gill, Taylor, and Pilkington (2012) proposed that the extent to which psychological wellbeing and psychological distress are independent constructs may vary depending on the external and internal environmental challenges faced by the individual. A dual continua model maintains that mental illness and mental health are two related yet distinct dimensions (Westerhof & Keyes, 2010).

The Complete State Model of Mental Health (CSM) is a dual continua framework which takes into account both the absence of symptoms of mental illness, and the presence of symptoms of mental health through social, emotional and psychological wellbeing (Keyes & Lopez, 2002). The CSM perspective categorises individuals into one of four categories of mental health status: flourishing, languishing, struggling and floundering. Statistical diagnosis criteria are used to categorise individuals as *flourishing*, if they report no signs of mental illness in addition to high emotional wellbeing and high positive functioning. Individuals are categorised as *languishing* if they report no signs of mental illness, but relatively low levels of emotional wellbeing. They are categorized as *struggling* if they display high levels on some signs of mental illness, yet also display high levels of

emotional wellbeing and positive functioning. Finally, the category of *floundering* is used to describe those who display high symptoms of mental illness, combined with low levels of emotional wellbeing and positive functioning. The argument in favour of the CSM perspective is that positive emotions can and do co-exist alongside significant adversity, stress, and symptoms of mental illness, and therefore we cannot assume that having some negative aspects of mental health automatically result in the absence of positive aspects. Individuals displaying a combination of both mental illness symptoms and mental health indicators simultaneously have been reported to represent a significant proportion of the population. Park (2004) argued that single continuum approaches may fail to capture the complexity of mental health and the human experience.

1.5.4 The ‘moderately mentally healthy’ young person

Although the majority of youth do *not* have a psychological disorder (Norrish & Vella-Brodrick, 2009), Keyes (2006) reported that more young people displayed *moderate* mental health (with average or low levels of emotional, psychological and social well-being, or with seemingly contradictory levels of both mental illness symptoms and positive mental health) than those that were actually flourishing (with high levels of emotional, psychological and social well-being and no mental illness) and that moderate mental health is nearly as good a predictor of future mental illness as past mental illness (Keyes, 2010). A key challenge to the measurement of mental health in young people is that a significant proportion of young people may exhibit moderate or contradictory levels on mental illness versus positive mental health. For example, some young people may not be detected using screening measures of psychological distress, but still report low life satisfaction, while others may experience significant psychological problems, but not

necessarily report low life satisfaction (Bastiaansen, Koot, & Ferdinand, 2005; Greenspoon & Saklofske, 2001; Keyes, 2006). Such findings have served to highlight the importance of investigating and gaining a better understanding of ‘moderately mentally healthy’ young people, in addition to those perceived as mentally ill or at-risk.

In the past decade or so, investigation into moderately mentally healthy young people has increased. One study that assessed mental health in youth populations has reported that individuals with high levels of emotional and psychosocial functioning and low levels of mental illness experience more desirable outcomes than those that were moderately mentally healthy (Norrish & Vella-Brodrick, 2009). Beyond the absence of disorder, it has been reported that less than 50% of Australian young people are ‘flourishing in life’ (Venning, Wilson, Kettler, & Elliott, 2013), a term referring to an individual’s optimal state of wellbeing, incorporating the absence of mental illness and the presence of positive emotions and psychosocial functioning (Keyes, 2003). Venning et al. (2013) conducted a survey of Australian adolescents and reported that a relatively small proportion of adolescents were flourishing (42%), with the majority who were not flourishing, including those with ‘moderate’ mental health, engaging in significantly more health-risk behaviour (smoking, drinking, poor exercise and sleep habits) than those who were flourishing. Howell (2009) reported that in an adolescent sample, ‘flourishing’ students were found to have higher academic grades, higher self-control and lower procrastination than those students categorised as moderately mentally healthy. Another study conducted by Suldo and Huebner (2004) reported that when compared to adolescents that reported moderate life satisfaction, adolescents who reported high life satisfaction had less chance of developing externalised behaviour problems after a stressful life event.

Another study by Antaramian et al. (2010) which utilised a dual continua model of mental health reported that the traditionally neglected group of adolescents with low subjective wellbeing and low psychopathology were nonetheless at risk for academic and behaviour problems in school and performed no better than the most troubled group of adolescents. Such research highlights the need to extend beyond efforts to target, treat and prevent mental disorder, but to strive towards an optimal state of wellbeing, which can have far-reaching effects for young people and lay the foundations across domains such as education, health behaviour and life satisfaction for a positive developmental trajectory. Conversely, poor health behaviours and outcomes such as educational achievement, or socio-economic status are also detrimental to mental health, serving to perpetuate a negative cycle for those in already unfavourable circumstances (Allen & McKenzie, 2015).

1.6 Current approaches to policy and practice to mental health promotion among youth

1.6.1 The ‘treatment gap’ in young people

Poor mental health during youth is strongly related to other risk factors to healthy development, such as lower education level, substance abuse problems, violence and poor reproductive and sexual health (Patel et al., 2007). Yet, adolescents and young adults are also the least likely group to seek help and receive access to professional treatment and services for their mental health compared to other populations (Burns & Birrell, 2014). Even in high-income and developed countries, most mental health needs in young people remain unmet. The difference between true prevalence and treated prevalence that exists among young people may be referred to as the ‘treatment gap’ (Henderson, Evans-Lacko, & Thornicroft, 2013).

Some of the key challenges that still stand to be addressed include the shortage of trained mental health professionals to provide quality services for young people and the stigma associated with mental disorder (Patel et al., 2007). Stigma in particular, although a key barrier to anyone seeking assistance and receiving timely and appropriate care and support, has been reported to play a particularly powerful role in young people (Burns & Birrell, 2014), possibly due to the importance of peer acceptance and social factors during adolescence and emerging adulthood (Block, Gjesfjeld, & Greeno, 2013).

A similar pattern of issues and challenges to providing mental health services for young people has been reported to exist across most economically developed countries including Australia, the UK, the United States and Canada. Malla et al. (2016) describe these to include 1) poor penetration rate of services for young people in need and high rates of untreated prevalence, 2) delay between first contact and eventual treatment, 3) treatment when available may not be appropriate for the stage of illness and 4) serious problems with transitions in services between child and adult systems (usually based on age of legal adulthood – 18 years).

In an Australian context, the Government responded to the above problems in 2006 by establishing *headspace (the National Youth Mental Health Foundation)*, with the goal of building a national youth mental health service stream. This stream was designed to provide ‘youth-friendly’ centres to promote and support early intervention for mental disorders as well as physical health care and vocational services for young people (Malla et al., 2016). The initiative involved setting up enhanced primary care services for young people aged 12-25 years, and was intended to overcome stigma attached to traditional services, address the ‘treatment gap’ (high prevalence of disorder and low levels of help-

seeking) and break down the age divide between adolescent and adult mental health services (Jorm, 2015).

1.6.2 Population approaches to mental health

Rose (2001) stated that although it is necessary within the health care system to continue to focus on individuals from a case-centred approach, the central priority of research and practice should be to discover and prevent the causes of incidence, from a population approach. A comprehensive public health approach that encompasses prevention, treatment, rehabilitation and promotion of positive mental health is necessary to reduce the social and personal costs of mental health, because it requires changes to be made both at the individual level (with people being able to make informed choices about their behaviour), and at the policy level (with governments and businesses taking steps to improve the level and implementation of mental health practices) (Russell-Mayhew, 2006). Because many protective and risk factors for mental health are generic rather than specific to certain disorders, it has been argued that such factors should be addressed simultaneously through collaboration across government and community sectors (Scanlon, 2002). Providing services that concurrently target prevention of mental disorders and promotion of mental health has also been found to provide cost-effective outcomes (Jané-Llopis, 2005).

It is relevant to note that the majority of social determinants of mental health such as income, socioeconomic status, education and employment, remain outside the scope of mental health services, and even of health services more broadly (Scanlon, 2002).

Therefore, the population-health perspective advocates for a ‘continuum of response,’ ranging from targeting individuals in specialist services to community-focused

approaches which could be disseminated through channels such as educational settings and the Internet. In particular, schools and colleges have been proposed to offer a unique and valuable setting for non-clinical mental health promotion programs to be disseminated, using methods designed to appeal to young people (Patel et al., 2007).

1.6.3 Mental health promotion

The concept of mental health promotion (MHP), in a similar manner to physical health promotion, seeks to develop and foster an individual's competencies, resources, and strengths in order to reduce risk factors for mental health problems (Barry, 2007; Kobau et al., 2011; Patel et al., 2007). Rather than targeting only those with mental illness or those vulnerable or 'at-risk', mental health promotion seeks to promote maintenance or elevation of positive mental health and protect against its loss, even in those with optimal mental health (Keyes, Dhingra, & Simoes, 2010). Consistent with a traditional conceptualisation of mental health that emphasised illness and disorder, Larson (2000) argued that numerous research-based programs existed for youth targeting substance use, violence, suicide and other problem behaviours, but that there was a lack of a rigorous applied psychology of how to promote positive youth development (Larson, 2000), arguing for further exploration of approaches aimed at supporting young people to become motivated, socially competent, directed and compassionate adults.

Longitudinal research investigating mental health promotion has demonstrated that gains in mental health predict future decline in mental illness, and that loss of mental health predicts future increase in mental illness (Keyes et al., 2010). The positive outcomes of mental health promotion can theoretically benefit individuals as well as the whole community, by strengthening preventative resources, reducing the disease burden and

enhancing productivity, wellbeing and quality of life (Kobau et al., 2011). For example, increasing wellbeing in individuals may prevent psychological disorders in the future, while contributing to a positive ‘spill over effect’ into other areas of life, such as social and economic domains (Norrish & Vella-Brodrick, 2009). Johnson et al. (2011) proposed a buffering hypothesis where positive psychological symptoms can have a powerful impact in moderating the effects of risk factors on psychological disorder and suicidality. Mental health promotion aims to shift society’s views and attitudes towards mental health and draw attention to its importance in the minds of individuals, families, and communities, by targeting the whole population to achieve positive mental health while concurrently addressing the needs of those at risk of, or currently experiencing mental health problems (Barry, 2007; Herrman & Jané-Llopis, 2005). Similarly, Patel and Goodman (2007) argued that the research agenda to inform mental health policy and practice should not be simply to reduce or protect individuals and societies against harm, but to build understanding among groups and individuals to empower them to understand psychological problems, while simultaneously promoting positive mental health.

1.6.4 The school as a fundamental setting for mental health promotion

The school setting has been recognised as a key environment that can and should be used to promote positive mental health within young people (Allen & McKenzie, 2015; Evans, Mullett, Weist, & Franz, 2005; Weist, 2005). The school is the frontline of service delivery for young people, and holds a unique opportunity for delivery of educational programs that build skills about mental health and teach awareness to promote early identification (Allen & McKenzie, 2015). Jané-Llopis and Barry (2005) outline several reasons for schools as a fundamental setting for mental health promotion. Firstly, the

sweeping access that the school setting provides to almost all children and adolescents is unparalleled by any other community setting. Secondly, there is efficiency of implementation, given that most students spend a large proportion of their time within the school environment. Thirdly, the school setting not only reaches a vast audience of young people, but has also been found to exert a significant influence on the development and behaviour of students (Jané-Llopis & Barry, 2005). Finally, the school setting also connects students to fundamental opportunities to develop strengths that protect and promote good mental health, such as stable social networks, academic achievement, effective coping strategies, and self-esteem (Jané-Llopis & Barry, 2005; Park, 2004). As it has been reported that for the majority of those with a mental disorder, the age of onset was below the age of 24 years (Patel et al., 2007), it is further acknowledged that youth is a critical time period at which early intervention and prevention of psychological disorders and mental health promotion should occur.

1.6.5 Indicated, targeted and universal programs

School-based mental health promotion programs can be categorised into 3 distinct groups: indicated programs, targeted programs and universal programs, based on the classification system originally proposed by Gordon (1983) for physical disease prevention (Wells, Barlow, & Stewart-Brown, 2003). *Indicated programs* refer to those aimed at individuals who already display symptoms of mental health problems. *Targeted programs* refer to those aimed at individuals who are at increased risk of mental health problems. The above two categories adopt a mental illness prevention approach. Conversely, *universal programs* refer to those programs aimed at improving the mental health of the whole-school population, by adopting a mental health promotion approach

(Wells et al., 2003). The overall aim of all three categories of Gordon's preventive intervention is the reduction of the occurrence of new cases (Gordon, 1983; Mrazek & Haggerty, 1994; Sanders & Morawska, 2010). Since many mental disorders are characterised by either chronic or relapsing paths resulting in high personal and economic costs, it is logical to include universal mental health promotion approaches aimed at preventing new occurrences of mental disorders (Mrazek & Haggerty, 1994).

1.6.6 Mental health programs and interventions in Australian schools

Throughout the 1990's and 2000's, Australian mental health care for young people began to develop at an unprecedented rate (Weist, 2001), with mental health programs implemented within schools becoming aimed at promoting good mental health from a whole-school approach, with a focus on building psychological strengths (Rowling, 2007). Program development adopted the more comprehensive 'health-promoting schools' (HPS) model, rather than typically narrow illness-focused curriculum approaches previously implemented (Trevor, Karen, Trevor, & Lewin, 2002). Many Australian schools and school systems have embraced prevention initiatives, campaigns and programs including MindMatters, KidsMatter, Act-Belong-Commit and the National Safe Schools Framework (Allen & McKenzie, 2015). There are also a growing number of online programs that aim to support and assist students and provide them with information about mental health. However, previous studies have reported that Australian teachers may lack confidence and expertise to endorse mental health programs in their own schools, despite supporting the initiatives (Askill-Williams & Cefai, 2014; St Leger, 1998). There remains a need for further development of evidence-based approaches to

improve the mental health of populations, specifically within the school setting (Weist, 2005).

1.6.7 Ties between conceptualisation, measurement and mental health programs

It has been argued that despite good intentions, many of the mental health promotion programs that are currently being implemented within Australian schools are lacking in rigorous evaluation (Jané-Llopis, 2005; Trevor et al., 2002). Evaluations of similar school-based mental health interventions have utilised vastly different outcome measures, from instruments designed to assess mental illness (such as depression or problem behaviour), to those used to assess positive aspects of mental health (such as self-esteem) (Wells et al., 2003).

If we hope to increase the implementation of mental health programs on a more widespread basis throughout Australian schools, quantifiable, extensive and ongoing demonstration that such programs are effective will be necessary (Russell-Mayhew, 2006; Weist, Nabors, Myers, & Paul, 2000). In order to build evidence to assist in the successful implementation of mental health promotion programs in schools, research must also further examine unique mental health needs relevant to a population of adolescents and young people. Given that the goal of a population-health approach is to shift the whole distribution of exposure to risk factors in a positive direction, it is necessary to also explore ways of engaging young people of all mental health states.

1.6.8 Need for youth perspectives on mental health and illness topics

While young people are often the subjects of research, their voices are rarely heard directly (Roose & John, 2003; Schelbe et al., 2015). Data is commonly collected from

proxy sources such as parents, teachers, case workers or health professionals, and children and young people are very rarely involved in the process of service development (Roose & John, 2003). In line with historical treatment of other minority groups, the views of young people have been excluded from society and research about them, based on the reasoning that their immaturity and ignorance warrants their needs to be defined by powerful and privileged experts (Mason & Hood, 2011; Schelbe et al., 2015).

Youth participation, defined as “*a process where young people, as active citizens take part in, express views on, and have decision-making power about issues that affect them*” (Farthing, 2012, p. 73), is built on a respectful relationship between service providers and young people, with a genuine interest in the opinions and views of young people translating to improving their visibility to communities, stakeholders and policy makers and ensuring the relevance of interventions to this diverse group (Sawyer, Afifi, et al., 2012). A young person’s personal views of mental health and illness shape both their interactions with others with mental illness, and their own actions if faced with the experience of mental illness themselves. Further, a young person’s perspectives shape their responses towards programs that aim to educate and empower young people through the applications of such concepts. Health promotion initiatives are more likely to be successful if they take people’s own understanding, beliefs and concerns into account (Armstrong, Hill, & Secker, 2000), and a lack of consultation with young people can lead to the development of inappropriate services because the views of adults do not always represent those children or adolescents for whom the service is being developed (Lightfoot, Wright, & Sloper, 1999).

Young people's experiences of mental illness are undeniably different to those of adults, and young people are in the best position to judge what is "youth-friendly" and to judge whether the style, content and delivery of a service or program works for them and respects their opinions (James, 2007). Current arguments in mental health promotion suggest that the development of health in young people is not possible without inclusion, communicated through the old slogan "*nothing about us without us*" (Rowling & Martin, 2002). Today's young people are tomorrow's leaders, and the current generation of young people are the largest in global history. In a rapidly evolving world that creates new and poorly understood challenges to improving the mental health of young people, it is now more important than ever to hear their voices, ideas and experiences.

1.7 Summary and aims of the thesis

1.7.1 Summary

Youth is a critical period that provides opportunities to develop the foundations for achieving optimal mental health, and preventing mental health problems (Weare & Nind, 2011). However, the developmental milestones associated with this period of life create a complex and multidirectional relationship between such factors and a young person's mental health. The current state of youth mental health in Australia indicates a considerable 'treatment gap' for those with mental illness, and beyond mental illness, a relatively small proportion of 'flourishing' youth. In a rapidly evolving modern world that has redefined ideas about connection, identity and success, there are significant influences on mental health that are unique to Millennials. As such considerations are poorly understood at present, current approaches may be failing to address the needs of young people. The current thesis was constructed to explore and expose such factors and potential shortcomings of current approaches, in order to inform future programs and

interventions and contribute to our understanding of youth mental health and its promotion.

Previous research and practice in the development of youth mental health has historically had a tendency to focus on the notion of ‘avoiding the negative’. Risk factors have been investigated as aspects of the environment or individual that can be modified or changed in order to ‘lessen the risk’ or reduce harm or treat mental disorders. More recently, protective factors (such as self-esteem, resilience and coping strategies) have been explored, providing good evidence for the importance of such strengths. However, there remains confusion in the literature regarding how to conceptualise and measure mental health in young people, in order to guide and evaluate current approaches to mental health promotion. Furthermore, open discussions with young people are desperately needed to build understanding about their own perspectives of mental health concepts and related attitudes and behaviours if we are to create approaches that are truly appropriate, effective and engaging for young people. As current approaches to mental health promotion are primarily education-based and rest on the assumption that education will improve health behaviour, it is necessary to examine the relationships between attitudes, behaviour and mental health of young people within educational contexts.

1.7.2 Aims of the thesis

To address gaps identified in the literature to date, the overarching aim of the thesis was *to examine current approaches and explore challenges to the measurement and promotion of mental health in young people*. This overall objective informs and shapes the development of the content of this thesis through *four research aims*:

1. The first aim of this thesis was to examine measurement and conceptualisation of mental health in young people in order to identify a favourable framework of assessment for mental health promotion and evaluation (*Paper 1*).
2. The second aim of this thesis was to explore perspectives of a non-clinical sample of young people in relation to their understanding of mental health concepts and attitudes (*Paper 2*).
3. The third aim of this thesis was to explore the perspectives of a non-clinical sample of young people about factors that influence mental health help-seeking behaviour among themselves and their peers (*Paper 3*).
4. A fourth and final aim of this thesis was to examine the relationships between mental health related knowledge, stigmatising attitudes and help-seeking intentions among young people, and the differences in these relationships between adolescents categorised with poor, moderate and optimal mental health (*Paper 4*).

The following chapter is an exegesis which provides a detailed explanation of the development and methodological approach for each of the four contributing papers. This chapter also provides information outside of the scope of the individual papers in journal article format.

CHAPTER TWO: EXEGESIS

2.1 Preamble

The literature review presented in *Chapter One* highlighted four key areas to address the overall PhD thesis aims: to examine measurement and conceptualisation of mental health in young people in order to identify a favourable framework of assessment for mental health promotion and evaluation (*Paper One*), to explore perspectives of young people in relation to their understanding of mental health concepts and attitudes (*Paper Two*), to explore the perspectives of young people on factors that influence mental health help-seeking behaviour among themselves and their peers (*Paper Three*) and to examine the relationships between mental health related knowledge, stigmatising attitudes and help-seeking intentions among young people (*Paper Four*). Each of the four empirical reports will be presented in the form of articles for peer-reviewed journals in *Chapters Three, Four, Five* and *Six*. The final chapter of the thesis will then draw overall conclusions and consider implications of findings for both psychological knowledge and the practice of youth mental health promotion.

This chapter, the exegesis, provides a critical explanation and rationale of the decisions made regarding the research process and provides complementary contextual and methodological information that were not covered within the individual qualitative papers.

2.2 Thesis context and population of interest

The overall aim of the current thesis was to investigate the measurement and promotion of mental health among young people. Varied definitions of the term ‘young people’ (or youth) exist in the literature, but generally these terms refer to individuals across two key

developmental stages: adolescence and emerging adulthood (Sawyer, Afifi, et al., 2012). While this definition of young people encompasses a range of individuals, from children and adolescents under the age of 18 through to those considered legal adults in Australia, it was considered that young or ‘emerging’ adults still face many of the same challenges, barriers and issues to those under 18 (Arnett, 2000; Youth Affairs Council of South Australia, 2015). Thus, participants included in studies that make up the current thesis were selected to span across the developmental periods of adolescence and emerging adulthood (12 to 27 years) to reflect current definitions of ‘youth’.

While many previous studies had focused on at-risk or clinical populations (Block et al., 2013; Czyz, Horwitz, Eisenberg, Kramer, & King, 2013; French, Reardon, & Smith, 2003; Rüscher et al., 2013), the current thesis was intended to address the perspectives of a community (non-clinical) sample of young people. The rationale for the current thesis to study a non-clinical sample of youth was based on the need to assess community beliefs in order to aid the development of mental health promotion interventions that are perceived as meaningful and relevant to their target audience (Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000). Examination of a non-clinical sample acknowledges the importance of understanding lay views to better inform prevention (rather than treatment) approaches on a population level, for which qualitative information in particular is limited (Gilchrist & Sullivan, 2006). From a mental health promotion perspective, it was anticipated that using a ‘wide-angle lens’ to examine the general population including those that are mentally well (rather than exclusively focusing on those with mental disorder, at-risk or in need of treatment) would provide insight into the measurement and promotion of youth mental health on a population level. While participants with a clinical disorder or diagnosis were not sought after specifically in the current research, they were

invited to participate throughout the recruitment process. Accordingly, those who had previously suffered, or were currently suffering from a mental illness, had the same opportunity (notwithstanding possible practical or personal barriers to participating) as those with moderate or optimal mental health to be represented in the findings.

2.3 Choice of methodology and rationale for mixed-methods approach

When comparing qualitative and quantitative approaches to research, it is necessary to consider the unique strengths and weaknesses of each approach. Qualitative methods are generally more appropriate for hypothesis generation, while quantitative methods are considered more appropriate for hypothesis testing (Lund, 2012). Mixed-methods research is defined as *“the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority and involve the integration of the data at one or more stages of the process of research”* (Creswell, Plano Clark, Gutmann, & Hanson, 2003, p. 212). The basic rationale of a mixed-methods approach is that combining qualitative and quantitative approaches makes it possible to utilise their respective strengths while evading their respective weaknesses (Lund, 2012; Teddlie & Tashakkori, 2009). Further, mixed methods designs allow researchers to gain a deeper understanding of the phenomenon of interest, through collection of both forms of data. For example, researchers are able to test theoretical models and modify them based on participant feedback, and results generated using specific tools and instruments may be augmented by broader contextual, field-based information (Hanson, Creswell, Clark, Petska, & David, 2005). Mixed-methods designs can also be defined more broadly to include blending of qualitative and quantitative approaches within a coordinated cluster of individual studies (Lund, 2012), as was done

for the collection of separate, but related, studies that formed this PhD thesis. Figure 1 illustrates the schematics of the mixed-methods approach to the current thesis.

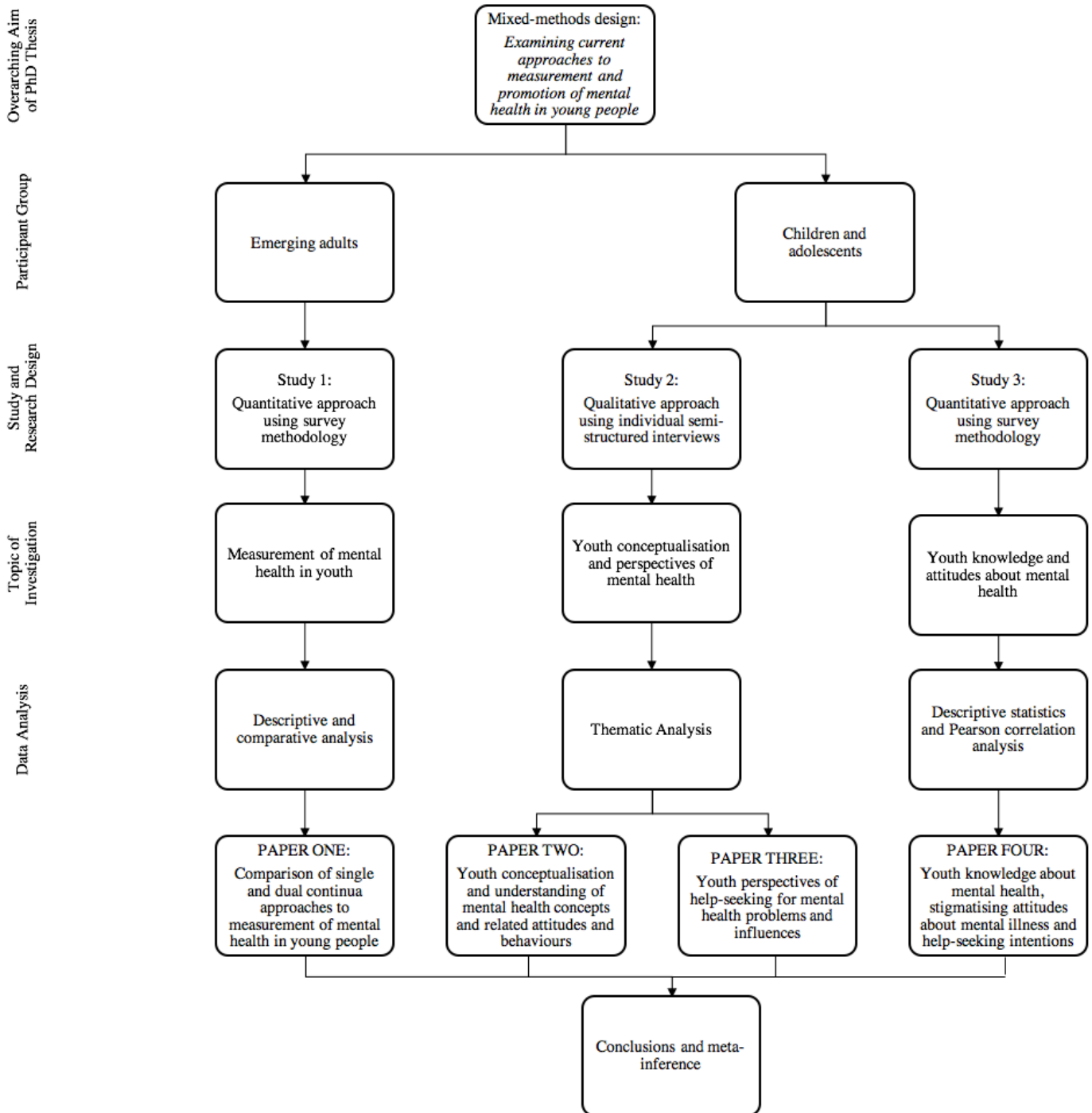


Figure 1. Schematic diagram of the mixed-methods approach to the current thesis

2.4 ‘School Leaver’ study with emerging adults (Paper One)

At the outset, *Paper One* aimed to examine current approaches to the measurement of mental health and illness in young people and compare conceptualisation models to determine if different approaches indicated similar results. Data were collected from a sample of young Australian adults (mean age: 24 years). Efforts towards evaluating and improving mental health are informed and shaped by the methods used to collect data (including varied measures, scores, cut-offs and classification systems) which are, in turn, essentially dependent on theoretical models used for the conceptualisation of mental health (Zimmerman, Chelminski, Young, & Dalrymple, 2011). Consequently, consideration of measurement and conceptualisation approaches underpinning data presented is needed in order to adequately design interventions to improve the mental health of a target population as it will be unclear how to tailor such approaches and what measures indicate that an intervention was successful (Paternite, 2005).

Paper One therefore aimed to compare an exclusive mental wellbeing approach, an exclusive mental illness approach and a complete mental health approach to investigate whether different approaches to measurement cause inconsistencies between the interpretations of a sample’s mental health.

2.4.1 Recruitment

Paper One employed a sample of emerging adults ($n=117$), recruited from a pre-existing pool of participants involved in a 10-year longitudinal investigation to examine the transition of young people from school into the workplace and/or higher education (*“Transition from School to Work: A 10-year longitudinal study of unemployment,*

underemployment, social exclusion, and mental health in young people” ; funded by the Australian Research Council).

The parent study commenced in 2001 as a planned 10-year longitudinal cohort study of school leavers, following participants from approximately 15 to 25 years of age. Data were collected on three cohorts: one beginning in 2001, the second in 2002, and the third in 2003, and the parent study received ethical approval from the University of South Australia Human Research Ethics Committee. At baseline, participants were recruited from a broad cross-section of South Australian schools including metropolitan (72.8%), rural (27.2%), government (68.3%), private (31.7%), coeducational (82.9%) and single-sex schools (17.1%). At baseline, 45 South Australian schools were randomly selected (based on type of school and area) and contacted to participate, with a 55% response rate (25 schools). Among these schools, an information letter was posted to all year 10 students (aged approximately 15 years) explaining the aims of the study with a consent form. Students who provided consent were briefed on the study and informed that participation was voluntary and confidential. During the first wave of data, amalgamated participant numbers from the three cohorts was 2499 (male = 1030, female = 1469, mean age = 15.2). By wave 10, participation had decreased to 446 (male = 126, female = 316, mean age = 25).

Paper One involved analysis of data drawn only from Wave 10 (final wave of data collection) of Cohort 2 ($N=579$ at baseline) and Cohort 3 ($N=627$ at baseline) of the longitudinal study, as at the commencement of the current study the final wave of data for Cohort 1 had already been collected (in January 2012). From these 2 cohorts, 210 responses were returned for the longitudinal study, and 124 of these contained the

additional questionnaires required for the current study (59% response rate). The final sample size was 117 following data screening.

2.4.2 Procedure

All participants in Cohort 2 and Cohort 3 of the *Transition from School to Work* study received information in the post with the longitudinal survey, inviting them to complete an additional survey. Data collection took place in May 2012. The questionnaire for the current study was provided in hard copy with a reply-paid envelope, and an online version was also made available as an alternative. The information sheet (see Appendix 1) that was included in the longitudinal data collection mail informed readers that participation was voluntary, and included a link to complete the survey online if preferred.

2.5 *Qualitative study with adolescents (Paper Two and Paper Three)*

2.5.1 Rationale and link to Paper One

Following quantitative examination of measurement and conceptualisation of mental health in *Paper One*, it was considered important to further examine conceptualisation of mental health from the perspective of young people themselves, utilising qualitative methodology. Measures of ‘good’ mental health (and consequently, ‘positive outcomes’ of mental health promotion programs) are difficult constructs to define, and thus measures of ‘success’ in mental health interventions are widely varied. Some of these outcomes for youth populations include: increased self-reported student understanding of topics, decreased symptoms of anxiety and depression in students, improvements in social problem-solving, reduction in school bullying reports, reduced antisocial behaviour, improved teacher-rated peer relationships and behaviour, better student stress

management strategies or improved awareness of mental health issues amongst families and friends (Hazell, Vincent, Waring, & Lewin, 2002). Evaluations of mental health promotion program efficacy have focused on a diverse range of health, social and economic outcomes (Jané-Llopis, 2005). Since ‘wellbeing’ and related concepts are subjective experiences, it was considered important to examine such constructs from the subjective perspectives of young people, reflecting their personal experiences and beliefs. There is also a gap in the availability of quantitative measures that are sensitive enough to detect positive mental health change (particularly in already healthy populations), and thus qualitative methods can assist in filling this gap by gathering data about the subjective experiences of participants and what they perceive to be positive mental health (Broughton, 1991; Dehar, Casswell, & Duignan, 1993; Russell-Mayhew, 2006).

In line with the above considerations, the second and third papers in this thesis aimed to describe the experience and perceptions of mental health concepts and related attitudes and behaviours from the perspectives of young people. *Paper Two* and *Paper Three* both utilised the same research setting, recruitment timeframe and informed consent processes. *Paper Two* aimed to gain a better understanding of how youth conceptualise mental health concepts and to explore how they interpret, perceive and speak about mental health related attitudes and behaviours. *Paper Three* involved interviewing adolescents to explore their narratives and experiences related to their own mental health in order to understand the process of help-seeking from the young person’s perspective. It was anticipated that the cross-sectional design and maximum variability sampling technique, would allow for unique needs and perspectives of young people (across schools, gender and age ranges) to emerge. The basic rationale for employing qualitative methodology is discussed below.

2.5.2 Qualitative research methods

This study employed a qualitative research design to collect in-depth data in order to gain insight into ideas and issues related to mental health which are salient to Australian adolescents. Qualitative methods are used to provide a “thick description” or depth of understanding that can serve to complement the breadth of understanding provided by quantitative methods, explore issues that are not well understood, draw on the perspective of those being studied, evaluate the process of a phenomenon and develop conceptual theories (Palinkas, 2014). In eliciting the perspectives of people being studied, qualitative methods “*allow people to speak in their own voice, rather than conforming to categories and terms imposed on them by others*” (Sofaer, 1999, p. 1105), which “*enables the investigator to compare their own perception of reality with the perception of those being studied*” (Palinkas, 2014, p. 852). As such, use of qualitative methods is considered the ‘ideal approach’ for research seeking to understand and represent child and youth experiences, as it views children as active agents in constructing and communicating their own realities (Schelbe et al., 2015). Block and Greeno (2011) argued that qualitative methods are needed, to allow for the identification of new issues in regards to youth engagement in mental health help-seeking, and Patel et al. (2007) proposed that young people themselves need to be at the centre of policy-making and program development concerning their own mental health. Further reasoning behind this approach relates to the potential discrepancies between researcher perceptions of mental health and illness and the views of young people themselves (Russell-Mayhew, 2006).

2.5.3 Research setting and the MindMatters program

The participants for the qualitative study were South Australian students (aged 12-18 years) involved in a school-based mental health program (*MindMatters*) at various levels of implementation, in order to explore perceptions among a non-clinical sample of adolescents who had been exposed to a school-based mental health promotion program. *MindMatters* is a universal school-based mental health promotion, prevention and early intervention program. The approach aims to target the entire school population, with the overall goal of enhancing strengths in order to reduce the risk of later problem outcomes and increase likelihood of developing protective factors for wellbeing and resilience (MindMatters, 2012). In contrast to previous studies on clinical samples (Block et al., 2013), 'at-risk' youth (Czyz et al., 2013; French et al., 2003; Rüschi et al., 2013) or general youth (Gilchrist & Sullivan, 2006), the study aimed to capture the knowledge and perceptions of young people who have participated in a school-based mental health promotion program, and therefore been educated on the various social and emotional learning topics emphasised through the *MindMatters* program.

2.5.4 Data collection

The qualitative study employed individual interviews to explore young people's views. Open-ended questions and a semi-structured interview schedule was utilised to allow flexibility in depth and content of responses provided by young people interviewed, and the schedule was carefully designed with the aim of minimising influence on participants and responses (See Appendix 3). The semi-structured interview method is characterised by the utilisation of a pre-determined interview schedule which allows flexibility for the participant to guide the direction of the interview (Green & Thorogood, 2010). The PhD

candidate developed the interview schedule in conjunction with a supervisor who specialised in qualitative research methods, and questions were informed by a review of the literature, particularly related to confusion of the general public around mental health and illness concepts.

Individual interviews were utilised in consideration of the developmental importance of peer acceptance to adolescents, as qualitative research conducted in an individual format has been suggested to provide greater levels of information (when compared to focus groups) in capturing views of adolescents that may differ from that in their groups (Garmy, Berg, & Clausson, 2015). Data collection occurred between August and November 2013. South Australian middle school and senior high school students involved in the *MindMatters* program were invited to participate, with information about the study presented by the author to student groups engaged in the *MindMatters* Youth Empowerment Process (YEP) workshops at four different schools. Those students who indicated interest in participating in the study were handed information sheets (see Appendix 2) and consent forms to return, signed by a parent or guardian to approve their participation (if under the age of 18 years at the time of the study). In addition, assent forms were returned by students to indicate their own understanding and approval of participation in the study. Participants were then scheduled an interview time with the PhD candidate, to be conducted within the individual student's school grounds. In line with recommendations by Guest, Bunce, and Johnson (2006) for qualitative interview samples, an initial sample size of 12 participants were recruited. However, following completion of the first 12 interviews, data collection continued with several additional interviews until *data saturation* (the point when no new or relevant information emerges and the main themes become common and repetitive (Braun & Clarke, 2006)) was

reached at 16 participants. Data were audio-recorded and manually transcribed verbatim. Following analysis, a feedback report was prepared for *MindMatters* and school staff who had indicated an interest in utilising information regarding youth perspectives on mental health as well as qualitative program evaluation data (See Appendix 8).

2.5.5 Thematic analysis

For the qualitative research that formed *Paper Two* and *Paper Three*, data were analysed using thematic analysis framework, as proposed by Braun and Clarke (2006). This approach was chosen due to the flexibility of the method, accessibility of results, and the potential for analyses to generate unanticipated insights and inform policy development (Braun & Clarke, 2006). Thematic analysis involves specific phases of analysis, beginning with familiarisation with the data, then coding, searching, defining and reviewing themes, through to producing the report (see Table 1). An external reviewer was employed to independently code 20% of the data set during the familiarisation stage, and findings were compared for agreement to ensure inter-rater reliability and improve the consistency of interpretations. Initial coding was then completed for each transcript individually, and potential themes were named and data was collated relevant to each theme. Following this, themes were reviewed and considered in relation to the coded extracts and the entire data set. Themes were then refined and discussed frequently through an ongoing collaborative process with the second author. No major discrepancies arose as a result of this process. Final data analysis involved selection of extract examples and the relating back of the analysis to the research questions and literature. As highlighted by Braun and Clarke (2006), thematic analysis is not a linear process but rather a *recursive* process, where movement occurs back and forth through the phases as

needed to develop the analysis over time, and therefore the process should not be rushed. Reflecting these guidelines, data collection for the current study occurred as early as possible to allow flexibility in time for data analysis, which occurred throughout 2014.

Table 1. Phases of thematic analysis (Braun & Clarke, 2006).

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

2.5.6 Qualitative rigour

Qualitative research is at times criticized, with authors arguing that the processes lack scientific rigour and objectivity (Malterud, 2001; Mays & Pope, 1995). In response to such criticisms, researchers have formulated guidelines for improving the quality and rigour of qualitative findings (Cutcliffe & McKenna, 2004; Malterud, 2001; Mays & Pope, 1995; Tracy, 2010). For the current thesis, a number of methods for improving

quality were utilised throughout the process of data collection, analysis and interpretation. An audit trail (see Appendix 4) was used to document the process of data collection and analysis, in order to improve qualitative rigour (Tracy, 2010). The audit trail has been described as a principal technique for establishing the ‘confirmability’ of qualitative research findings (Lincoln & Guba, 1985). Emerging themes, challenges, methodological issues and interview observations were documented and utilised during meetings with supervisors, which occurred frequently throughout the process of data collection and analysis. The author also documented reflexivity considerations (discussed in greater detail below) such as preconceptions, expectations and observations of the interview process to make known any preconceiving biases (Malterud, 2001).

2.5.7 Reflexivity

Reflexivity in qualitative research is considered to be a validity procedure, through its addressing of researcher beliefs, values and biases that could potentially shape their inquiry (Creswell & Miller, 2000). It is useful for researchers to acknowledge and describe their entering beliefs and biases early in the research process, and reflect on the social, cultural and historical forces that shape analysis. Berger (2015) suggests three practical measures for maintaining the necessary balance between the researcher’s experience and that of participants including the use of a log, repeated review and seeking peer consultation. For this purpose, reflexivity considerations were documented after the completion of each interview, and the author critically reflected on her reactions, body language and speech and level of rapport and empathy with each participant (see Appendix 4). Several characteristics of the author were noted to potentially impact on

participant engagement and disclosure throughout the interview process and these are discussed below.

Not being a school staff member was a key characteristic of the researcher that was noted to have a positive influence on students' disclosure of information, particularly in light of the verbalised concerns they held (reported in *Paper Two* and *Paper Three*) about confidentiality when speaking to school staff and/or external mental health professionals about their problems. For example, some participants explicitly expressed fear that doctors would tell their parents about their situation, and that school counsellors would speak to other school staff and/or students about them, but stated that they felt at ease knowing that the interviewer was not a school staff member and would not disclose information to their friends or family.

Age of the interviewer appeared to encourage students to disclose greater detail about their experiences, as several students commented during the interview process that the interviewer's age (in her early twenties at the time of data collection) helped them to feel more comfortable and open during the interview, as they perceived she would be able to relate to their experiences and not express judgment about their opinions and beliefs.

The clinical interviewing skills of the researcher were also likely to impact the level of trust and rapport established between participant and interviewer. At the time of qualitative data collection, the author was a provisional Psychologist who had obtained clinical and communicative skills (e.g. reflective listening skills, clinical judgment, demonstrating empathy and validation of participants' thoughts, feelings and experiences) throughout her training and placements. These skills were considered likely to positively influence the level of detail elicited from participants. In addition, the interviewer's

genuine interest in working with adolescents and previous experience working with a range of young people across settings (e.g. volunteer counselling, sports coaching and mentoring roles) likely influenced the level of comfort that participants felt throughout the interview process.

Being female was another characteristic that may have had both positive or negative effects on the interview process, depending on the participant. For example, some female students' disclosure of topics covered across interviews such as relational bullying between girls, body image issues and relationship breakdowns may have been more likely discussed with a female interviewer, but it is possible that other topics (such as those more salient to male students) may have been withheld from discussion based on the interviewer's gender.

2.5.8 Youth participation

A youth participation model was employed to increase the likelihood that qualitative interviews were experienced by youth participants as empowering and respectful of their needs and wishes. Farthing (2012) defines youth participation as "*a process where young people, as active citizens take part in, express views on, and have decision-making power about issues that affect them*" (p. 73). The importance of youth participation in the development of mental health and wellbeing services for young people has recently been observed as a critical element in engaging, appropriate and relevant services. Burns and Birrell (2014) stated that models of youth participation are being embraced by both government and not-for-profit sectors "*as a strategy to improve social inclusion, community connectedness and intergenerational dialogue*" (p. 306) in Australia. Youth participation is built on a respectful relationship between service providers and young

people, with a genuine interest in the opinions and views of young people translating to improving their visibility to communities, stakeholders and policy makers and ensuring the relevance of interventions to this diverse group (Sawyer, Afifi, et al., 2012).

Accordingly, youth participation was considered an important aspect of the current thesis, in an effort to develop a better understanding of youth perspectives regarding mental health and illness, help to recognise the competence of young people, and give them a stronger voice to influence policy and practice that concerns their own development (Armstrong et al., 2000).

2.6 Single school study with female adolescents (Paper Four)

2.6.1 Rationale and link to previous papers

Paper Four aimed to build on findings of *Papers One, Two and Three* by quantitatively examining the level of mental health knowledge and stigmatising attitudes among a cross-sectional sample of adolescents. Mental health literacy interventions have been identified as a promising means for promoting positive help-seeking attitudes (Gulliver, Griffiths, & Brewer, 2012). However, the findings of the qualitative study (*Paper Two* and *Paper Three*) indicated a contrasting view from students. For example, *Paper Two* suggested that young people held concerns that increased knowledge about mental illness may actually serve to increase the incidence of faking mental illness, misdiagnosis, and lack of understanding about mental illness, thus contributing to a trivialisation of mental illness among young people, rather than improving attitudes. *Paper Three* reported that even among youth that had participated in a mental health program at their schools, and who were able to demonstrate knowledge about helpful coping strategies, an overall strong reluctance to seek help existed. Taken together, results reported in *Paper Two* and *Paper Three* suggested the social environment as being pivotal in influencing (encouraging or

discouraging) mental health related attitudes and behaviours. Most mental health programs focus on changing individual behaviour through education, and personal responsibility for improving mental health, rather than broader social and environmental influences (Corrigan, Druss, & Perlick, 2014). Therefore, *Paper Four* sought to explore the assumption that knowledge influences behaviour in young people, and examine the relationship between knowledge about mental health and attitudes about mental illness (particularly in relation to help-seeking). Additionally, since universal mental health programs target the whole school population, it was considered important to measure mental health knowledge and stigmatising attitudes among young people across the full range of mental health states. Previous research has conveyed the importance of considering different mental health states when considering ways to improve the mental health of adolescent populations. For example, adolescents experiencing severe mental health difficulties and those most in need of support are also least likely to seek help for their problems (Sawyer, Borojevic, et al., 2012), and moderate mental health is nearly as good a predictor of future mental illness as past mental illness (Keyes et al., 2010). Thus, the dual continua model (Complete State Model of Mental Health) reported in *Paper One* was utilised to provide information regarding differences between the four mental health groups: flourishing, languishing, struggling and floundering.

2.6.2 Recruitment and data collection

A sample of female adolescents ($n=327$) was recruited to participate from an all-girls private school in Adelaide, South Australia. Participants were aged from 13 to 17 years and were drawn from school grades 8 to 11. An opportunistic sample was utilised for *Paper Four*, due to staff at the participating school initiating contact with the School of

Psychology at The University of Adelaide, in order to express interest in, and request assistance with, assessing the wellbeing of their students. The PhD candidate worked in collaboration with her supervisor and a Psychology Honours student at the University of Adelaide to generate ideas and then approach the school via email with a plan for the study. A meeting with the school principal and counsellor was then held, when the PhD candidate discussed the purpose of measuring mental health knowledge and stigmatising attitudes about mental illness among students. Thus, the school from which the sample was recruited had a particular focus and interest in student wellbeing and sought to understand more about the mental health and related characteristics of their students.

2.6.3 Procedure

The data collected for *Paper Four* were part of a larger research study of whole school measurement of wellbeing, strengths and bullying in high school students (see Appendix 5). School staff were provided with a consent form and parent information sheet, and parental consent was sought prior to commencing data collection. Parents and students were notified that participation was voluntary and that responses would remain anonymous. Letters regarding the study were distributed and collected by classroom teachers. Students who returned completed consent forms were eligible to participate in the study. An online survey was created and data were collected during school hours on computers provided by the school. In order to assist students with any potential issues understanding questions, and to ensure confidentiality of responses among students, teachers supervised the data collection. The portion of the questionnaire for the current study consisted of 20 questions and took approximately 10 minutes for students to complete. Following analysis, the school were provided with information about the outcomes of the study.

The following four chapters present each of the four journal articles produced as part of this PhD thesis in greater detail. The final chapter of the thesis will then draw overall conclusions and consider implications of findings for both psychological knowledge and the practice of youth mental health promotion.

CHAPTER THREE: PAPER ONE

***Half full or half empty: The measurement of mental health and mental illness in
emerging Australian adults***

PAPER PUBLISHED

Emmelin Teng, University of Adelaide

Anthony Venning, Flinders University

Helen Winefield, University of Adelaide

Shona Crabb, University of Adelaide

Statement of Authorship

Title of Paper	Half full or half empty: The measurement of mental health and mental illness in emerging Australian adults.
Publication Status	Published
Publication Details	Teng, E., Venning., A., Winefield, H., & Crabb, S. (2015). Half full or half empty: The measurement of mental health and mental illness in emerging Australian adults. <i>Social Inquiry into Well-being</i> , 1, 1-12. doi: 10.13165/SIIW-15-1-1-01

Principal Author

Name of Principal Author (Candidate)	Emmelin Teng		
Contribution to the Paper	Participant recruitment, designed survey for data collection, data entry, performed statistical analysis, interpreted data, wrote manuscript and acted as the corresponding author.		
Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	25/11/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anthony Venning		
Contribution to the Paper	Assistance with forming research questions, practical assistance with statistical analysis, helped with data interpretation and provided advice on responding to editors and reviewers.		
Signature		Date	18/11/2016

Name of Co-Author	Helen Winefield		
Contribution to the Paper	Supervised development of work and refining of the research questions, assisted with manuscript evaluation and provided advice on responding to editors and reviewers.		
Signature		Date	22/11/2016

Name of Co-Author	Shona Crabb		
Contribution to the Paper	Contributed to development of study design, assisted with manuscript evaluation and editing and provided advice on responding to editors and reviewers.		
Signature	(Signed by HW on behalf of Dr Crabb during her absence on maternity leave)	Date	22/11/2016

Teng, E., Venning, A., Winefield, H. & Crabb, S. (2015). Half Full or Half Empty: The measurement of mental health and mental illness in emerging Australian adults. *Social Inquiry into Well-being*, 1(1), 1-12.

NOTE:

This publication is included on pages 56 - 79 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.13165/SIIW-15-1-1-01>

CHAPTER FOUR: PAPER TWO

*Crying Wolf? Australian adolescents' perceptions of the ambiguity of visible indicators
of mental health and authenticity of mental illness*

PAPER ACCEPTED WITH MINOR REVISIONS

Emmelin Teng, University of Adelaide

Shona Crabb, University of Adelaide

Helen Winefield, University of Adelaide

Anthony Venning, Flinders University

Statement of Authorship

Title of Paper	Crying Wolf? Australian adolescents' perceptions of the ambiguity of visible indicators of mental health and authenticity of mental illness.
Publication Status	Accepted for Publication
Publication Details	Teng, E., Crabb, S., Winefield, H., & Venning., A. (2016). Crying Wolf? Australian adolescents' perceptions of the ambiguity of visible indicators of mental health and authenticity of mental illness. <i>Qualitative Research in Psychology</i> . Accepted for publication with minor revisions on 29 September 2016.

Principal Author

Name of Principal Author (Candidate)	Emmelin Teng		
Contribution to the Paper	Developed study design, organised participant recruitment and data collection, conducted qualitative interviews, transcribed and analysed data, wrote manuscript and acted as the corresponding author. Dr. Stacey McCallum of the University of Adelaide acted as a second reviewer in the data analysis process to achieve consistency of findings.		
Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	25/11/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Shona Crabb		
Contribution to the Paper	Supervised design of research study, assisted with the development of the semi-structured interview protocol, refined and discussed themes frequently through an ongoing collaborative process with the Principal author, and assisted with interpretation of data, analysis and manuscript editing.		
Signature	(Signed by HW on behalf of Dr Crabb during her maternity leave)	Date	22/11/2016

Name of Co-Author	Helen Winefield		
Contribution to the Paper	Supervised the development of work, assisted with data interpretation and manuscript evaluation.		
Signature		Date	22/11/2016

Name of Co-Author	Anthony Venning		
Contribution to the Paper	Helped to provide suggestions in the presentation of findings and contributed to evaluating and editing the manuscript.		
Signature		Date	18/11/2016

4.1 Abstract

A young person's perspectives about mental health concepts shape both their interactions with sufferers of mental illness and their actions related to their own mental health. The current study employed a cross-sectional qualitative design to explore how adolescents (aged 12-18 years) speak about mental health and illness, in order to gain insight into young people's perceptions and experiences and contribute to shaping approaches to policy and practice. When discussing mental health concepts and appropriate behaviours towards sufferers of mental illness, adolescents conveyed a sense of acceptance and understanding of the potential complexity and severity of mental health problems. In contrast, when discussing mental health in the context of their own lives, a stronger sense of scepticism was conveyed, with students expressing difficulty with the lack of visible markers of mental health and confusion determining authenticity in the mental health states conveyed by their peers. Interestingly, adolescents interviewed commonly conveyed the notion that young people may exaggerate or 'fake' a mental illness for personal gain. Adolescent perceptions of mental health and illness hold practical implications for policy and school-based programs aimed at improving mental health knowledge, attitudes and behaviours among youth.

Keywords: adolescence, youth, mental health, mental illness, perceptions, qualitative

4.2 Introduction

4.2.1 Youth mental health

Although mental disorders are a key cause of disease burden in young people aged 10-24 years of age (Sawyer, Afifi, et al., 2012), young people are generally reluctant to seek help for mental health problems (Rickwood et al., 2007). Young people carry mental health problems disproportionate to the size of their population (Burns & Birrell, 2014) with one in four of Australia's young people (aged 16 to 24) experiencing a mental illness in the previous year (ABS, 2007). Vulnerability to mental illness is heightened during this period of major life change, with the majority of cases of mental disorder emerging within the relatively narrow time frame between 12 and 24 years (Patel et al., 2007). The high prevalence of mental health problems, coupled with the low utilisation of mental health services in this age group, has highlighted the need for population health-based approaches to mental health promotion and prevention through schools. A young person's ability to seek help for mental health relies upon sufficient understanding of mental health and illness concepts, so that they are able to identify various symptoms of mental illness in themselves and their peers, and recognise when they should seek help and support. Whole school mental health promotion programs, such as the Australian MindMatters program, reflect current understandings around the importance of developing mental health literacy as a foundation for promoting help-seeking behaviour in young people, with goals of educating young people about mental health and illness, reducing the stigma of having mental health problems, and providing information related to recognising symptoms, and where and how to access services if needed (Evans et al., 2005).

4.2.2 Challenges to improving the mental health of young people

It is clear that improving knowledge is an important aspect of promoting behavioural change, and doing so is one of the central goals of public health campaigns. However, rather than being a straightforward process where a young person 1) experiences psychological distress and 2) consequently seeks help, there is a wide range of individual, family, economic and cultural factors that can influence help-seeking in young people for mental health problems. These can include the young person's understanding and appraisal of the problem, and attitudes towards help-seeking, social influences including stigmatisation, as well as access to appropriate and youth-friendly services (Charman, Harms, & Myles-Pallister, 2010; Rickwood et al., 2007; Sawyer, Sawyer, et al., 2012). For example, adolescent boys tend to express more negative attitudes towards help-seeking compared to adolescent girls, likely due to social norms and gender differences in the acceptability of help-seeking actions for psychological problems (Sawyer, Sawyer, et al., 2012). Parents play a significant role in contributing to adolescent behaviour around mental health issues, yet it has been reported that parents demonstrate considerable difficulty recognising specific disorders such as depression in adolescents (Logan & King, 2002; Wu et al., 1999). Adolescent help-seeking is further complicated by the role of peer acceptance, stigma and perceived need for self-reliance among youth, with Curtis (2010) reporting that young people are willing to seek help for each other, but are comparatively far less likely to seek help for themselves. With media campaigns and school-based mental health programs aimed at raising awareness and improving knowledge, illnesses such as depression, anxiety and eating disorders are becoming more commonly known and spoken about among young people. It is important to consider

what mental health and illness concepts actually represent to a young person, as well as their perceptions about mental health related attitudes and behaviours.

4.2.3 Need for youth perspectives on mental health concepts

While there has been some substantial research focusing on young people's reluctance to engage in professional mental health care (Rickwood et al., 2007), considerably less research has explored the broader views of young people themselves on their understanding and perceptions of mental health and illness, and related attitudes and behaviours. One study conducted by Roose and John (2003) explored understanding of mental health in children aged 10 to 11 years, demonstrating that young people show a sophisticated understanding and interest in mental health, and, as a result, can offer valuable contributions to discussions about mental health service development. Similarly, Armstrong et al. (2000) interviewed young people aged 12 to 14 years to explore their attitudes and perceptions about mental health and mental illness, with findings demonstrating that young people can hold extremely strong views about what they want and need when it comes to support for mental health issues. Some of the ideas communicated by the young people in that study related to concerns about confidentiality and trust within the context of seeking help from a professional, perceptions of young people's problems as generally less important than those of adults, and a heavy emphasis on internalising or 'bottling up' feelings as a popular coping strategy; all of which are likely to influence a young person's approach and attitude towards professional help-seeking behaviours.

More broadly, studies have examined definitions of mental health and illness terminology from the perspectives of the general public, but tend to focus on adult interpretations

(Jorm & Reavley, 2012; Rüsçh, Evans-Lacko, & Thornicroft, 2012). Among this body of research on adult populations, it has been shown that mental health terms (e.g. '*what exactly constitutes a mental illness?*') tend to evoke confusion (Rüsçh et al., 2012).

Generally, it has been reported that the public interpretation of the term 'mental illness' is more strongly associated with severe disorders such as schizophrenia, rather than more prevalent conditions of depression or anxiety, indicating a discrepancy between the broader conceptualisation of mental health professionals and the narrower view of mental health from a public perspective (Jorm & Reavley, 2012). Discrepancies that exist between the views of adolescents and professionals are vital to acknowledge, considering the potential influence of such differences on the effectiveness of mental health policies and programs that are developed by professionals, but aimed at youth populations.

Similarly, the discrepancies that may exist between adult and adolescent perceptions in regard to mental health have been documented, with Wahlin and Deane (2012) reporting disagreement between parent and adolescent (aged 14-18 years) interpretations of mental health problem severity and need to seek treatment. Wu et al. (1999) also reported that while teachers and parents play an important role in recognising and encouraging service utilisation in young people, adults may interpret disruptive disorders being experienced by a young person as more severe and more in need of treatment than depressive disorders. Such potential discrepancies between adult and adolescent perceptions of mental health demonstrate the need to fill this gap in the literature by considering and exploring young people's perspectives in the process of developing services to improve youth mental health.

4.2.4 Youth participation in program and policy development

While it is clear that many factors are related to the likelihood and ability of a young person to successfully seek help, their personal views of mental health and illness shape both their interactions with others with mental illness, and their own actions if faced with the experience of mental illness themselves. Further, a young person's perspectives shape their responses towards programs that aim to educate and empower young people through the applications of such concepts. Health promotion initiatives are more likely to be successful if they take people's own understanding, beliefs and concerns into account (Armstrong et al., 2000). Despite this, children and young people are very rarely involved in the process of mental health service development (Roose & John, 2003). It has been argued that lack of consultation with young people can lead to the development of inappropriate services because the views of adults do not always represent those children or adolescents for whom the service is being developed (Lightfoot et al., 1999). Given the opportunities that a school setting provides for implementation of public health interventions, universal school mental health programs are a valuable platform for educating and influencing young people's attitudes about mental health (Paternite, 2005), but in order to operate effectively they must be implemented in engaging ways that reflect youth conceptualisations of mental health.

4.2.5 The present study

In light of the above research, the aim of the current study was to gain a better understanding of how youth conceptualise mental health terms and to explore how they interpret, perceive and speak about mental health related attitudes and behaviours. Efforts to develop a better understanding of youth perspectives regarding mental health and

illness help to recognise the competence of young people and give them a stronger voice to influence policy and practice that concerns their own development (Armstrong et al., 2000). This study employed a qualitative research design to collect in-depth data in order to gain insight into ideas and issues related to mental health which are salient to Australian adolescents.

4.2.6 The MindMatters Program

Participants were recruited through involvement with the mental health promotion program *MindMatters* being implemented at their schools. *MindMatters* is a universal school-based mental health promotion, prevention and early intervention program. The approach aims to target the entire school population, with the overall goal of enhancing strengths in order to reduce the risk of later problem outcomes and increase likelihood of developing protective factors for wellbeing and resilience (MindMatters, 2012). The program provides resources and materials to schools in order to address areas such as curriculum and learning, school organisation, ethos and environment and partnerships and services.

4.3 Method

4.3.1 Recruitment

Data collection for the current study occurred between August and November 2013. South Australian middle school and senior high school students involved in the *MindMatters* program were invited to participate. Students' level of involvement in the program varied from having participated in a two-day Youth Empowerment Process (YEP) workshop, to having several years of involvement in the program, including participation in numerous workshops at their schools and delivering training and support

to younger students within their schools on *MindMatters* topics¹. Information about the study was presented by the first author to student groups engaged in the *MindMatters* YEP workshops at four different schools. Those students who indicated interest in participating in the study were handed information sheets and consent forms to return, signed by a parent or guardian to approve their participation (if under the age of 18 years at the time of the study). In addition, assent forms were returned by students to indicate their own understanding and approval of participation in the study. Participants were then scheduled an interview time with the first author, to be conducted within the individual student's school grounds.

4.3.2 Participants

Participants in the current study were 16 middle and secondary school students aged 12-18 years, who had participated in the *MindMatters* program. A maximum variability sampling approach was used to select the four participating schools to deliver study information to in the initial recruitment phase, in an effort to reflect gender, year level, and government vs. non-government school students present within the population. For example, it was noted that individual schools implemented the program in varied ways, such as targeting YEP workshops at either middle school students or senior high school students, and schools were selected for recruitment accordingly. The sample consisted of 56% female students and 44% male. Of the students in the sample, 69% were in government schooling and 31% of students were in non-government schooling (including Catholic and independent schools); an approximate reflection of the 65% of Australian

¹ A possible limitation of recruitment via the *MindMatters* program is discussed in the 'limitations and future directions' section.

students in government schooling and 35% in non-government schooling in 2014 (Australian Bureau of Statistics, 2014). Due to the distribution of volunteering students across categories, it was not deemed necessary by authors to select individual students for participation. All students that reflected interest, met criteria and returned their consent forms within the specified time period were accepted to take part in the study (until the point of data saturation, discussed below). All participants were Anglo-European Australians. Table 5 details numbers of participants across school year level, and approximate ages for year levels in Australia.

Table 5. Participants across school level and approximate ages for year levels in Australia

School Year Level	Approximate Ages for Year Levels in Australia	Number of Participants
Year 7	12	1
Year 8	13	3
Year 9	14	2
Year 10	15	3
Year 11	16	5
Year 12	17	2
		<i>Total: 16</i>

4.3.3 Data collection and analytical approach

The current study employed individual semi-structured interviews to explore young people's views. The semi-structured interviews involved each participant being asked a series of questions (using prompts where necessary) for the purpose of allowing a degree of flexibility in discussion within the context of the overall topic (see Appendix 3).

Interview prompt questions were structured in two parts, with Part A focusing broadly on students' perspectives of mental health concepts and related attitudes and behaviours, and Part B focusing more specifically on students' views of the *MindMatters* program, in relation to their personal experiences with the program at their schools. This paper will

focus solely on discussions that emerged from Part A of the interview process. Prior to interviews commencing, participants were reminded that they could decline to answer any questions, and could choose to cease participation in the interview at any time. The interviews varied in length from 35 minutes to 75 minutes, with an average interview time of approximately 45 minutes. In line with recommendations by Guest et al. (2006) for qualitative interview samples, an initial sample size of 12 participants were recruited. However, following completion of the first 12 interviews, data collection continued with several additional interviews until *data saturation* (the point when no new or relevant information emerges and the main themes become common and repetitive (Braun & Clarke, 2006)) was reached at 16 participants. Data were audio-recorded and manually transcribed verbatim.

Transcripts were de-identified using a coding system and analysed by the first author using thematic analysis framework, as proposed by Braun and Clarke (2006). Thematic analysis as a qualitative method (see Merton, 1975, building on the work of Gerald Holton) was chosen due to the flexibility of the method, accessibility of results, and the potential for analyses to generate unanticipated insights and inform policy development (Braun & Clarke, 2006). Thematic analysis involves specific phases, beginning with familiarisation with the data (including re-reading transcripts and recording notes following interviews, based on observations made during the interview process). An external reviewer was employed to independently code 20% of the data set during the familiarisation stage, and findings were compared for agreement to ensure inter-rater reliability and improve the consistency of interpretations. Initial coding was then completed for each transcript individually, and potential themes were named and data was collated relevant to each theme. Following this, themes were reviewed and considered in relation to the coded

extracts and the entire data set. Themes were then refined and discussed frequently through an ongoing collaborative process with the second author. No major discrepancies were identified during the collaborative analysis process. Final data analysis involved selection of extract examples and the relating back of the analysis to the research questions and literature. An audit trail (see Appendix 4) was used to document the process of data collection and analysis, in order to monitor qualitative rigour (Tracy, 2010).

4.3.4 Ethical considerations

Ethical approval was obtained from The Department of Education and Child Development (DECD), The Catholic Education Office, Adelaide, and The University of Adelaide Human Research Ethics Committee (HREC). Only demographic information of a general nature (age and gender) was recorded on the data set for statistical purposes, to ensure the participants' privacy and confidentiality.

4.4 Results

The interviews explored students' understandings, interpretations and conceptualisations of mental health and illness and the behaviours or experiences that they related to these concepts. The key analytic points from these discussions will be presented here under three main headings, 1) *Definitions of mental health and mental illness*, 2) *Mental health and illness in real life* and 3) *Summary: Tensions between perceptions of mental health concepts and mental illness in real life*.

Participants communicated their understanding in different ways when discussing mental health and illness on a conceptual level, compared to their ideas and perspectives of how mental health and illness can manifest in real life. Accordingly, we will first briefly

describe some of the ways in which participants described concepts in response to questions directly related to mental health terminology, before going on to examine their responses to other questions in more depth, where participants drew upon and shared their personal experiences related to mental health and illness.

Verbatim quotes are provided to support the themes presented, where each quote is accompanied by the gender (*male (M) or female (F)*) and the age of the participant.

4.4.1 Definitions of mental health and mental illness

Adolescents expressed uncertainty surrounding mental health and illness concepts and terminology. Interviews were structured so that discussion opened with the question ‘What does the term mental health mean to you?’ When students were asked about their understanding of the term ‘mental health’, both illness and wellbeing themes were present, as well as themes that appeared neutral (with no emphasis or focus on positive or negative symptoms). These responses are summarised in Figure 5.

Mental Health. Negative aspects of mental health discussed included notions of illness, such as psychological distress, traumatic experience or mental disorder (*‘someone who has trouble in their mental state’ - F, 13 years; ‘when you need help, but it’s not physical, it’s more in your head’ - F, 16 years*). Positive interpretations of mental health included notions of wellbeing, such as self-esteem, happiness and resilience (*‘how I think about and overcome issues’ - M, 16 years*). Some wellbeing-focused responses also included some personality traits such as extraversion and intelligence, which were perceived by some adolescents to be linked to good mental health. Finally, some responses appeared to be more neutral: for example, referring to ‘thoughts and emotions’ with no emphasis on

either positive or negative aspects of mental health. Additionally, some interesting neutral themes that were explored included expressed confusion over whether mental health was a positive or negative concept, interpreting the term mental health to refer to notions of knowledge and awareness (e.g. *'just making people aware of what's out there, what information there is to help them if they are in need'* - M, 16 years), and concern or difficulty communicated by students due to the lack of visible indicators of mental health (e.g. being unable to determine the state of someone's mental health).

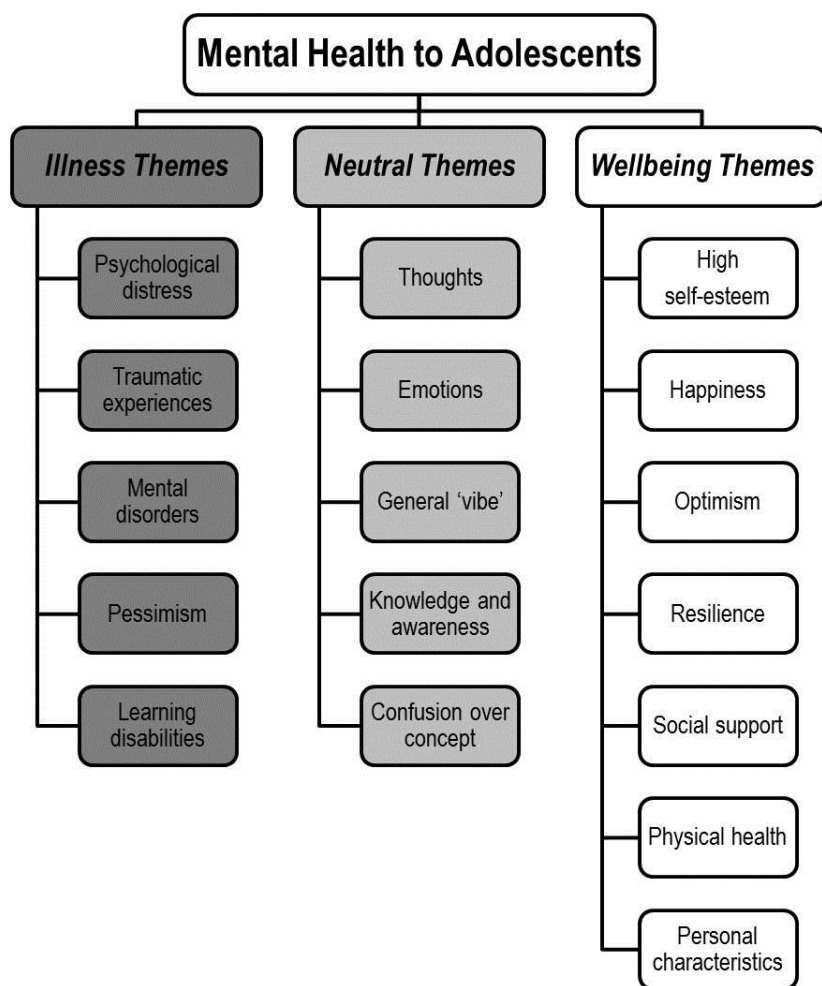


Figure 5. Adolescents' descriptions of mental health grouped into illness, neutral and wellbeing themes

Mental Illness. When asked to talk about the term ‘*mental illness*’, students expressed a varied understanding of the term, with strong negative themes present (‘*Mental illness is ... when in your mind you’re sick, but not on the outside*’ - M, 13 years; ‘*Mental illness... it’s hard to explain actually... it’s like a disability sort of thing, but still mental. It’s kind of a disease; you can’t really get better, like you have it through your whole life*’ - F, 17 years). Depression and bipolar disorder were the mental illnesses mentioned most often.

For the most part, respondents appeared to acknowledge the challenges and complexities of living with mental illness (‘*It’s not just something you can get over, like if you’re just told to be happy.*’ - F, 16 years), but also communicated their difficulty grasping the apparent complexities present in understanding mental health and illness.

Mental illness kind of stays with you forever and it’s kind of in your brain and it’s very scientific. Like people think it’s like the flu or it’s like a broken leg - it just heals itself and goes away like... that’s not how it works. And people around the person with the mental illness need to understand that, like it can come back at any time and like anything can trigger it... Not meaning you have to be on your toes your entire life but there needs to be that level of understanding... um, that it will be there. But you know, it can go away and it doesn’t have to come back... but it’s all about managing it. And it doesn’t mean when it goes away that you’re managing it really well. (F, 17 years)

In the above extract, the student speaks about how she perceives mental illness as a permanent and ongoing aspect of an individual’s life, but also conveys the somewhat contradictory idea that if mental illness is managed well, an individual can experience full recovery. Finally, she communicates that appropriate management of a mental illness can

prevent the illness from ‘coming back’, but, on the other hand, that she does not perceive recovery as necessarily being dependent on how well someone manages their mental health. Taken together, her statement conveys considerable difficulty in defining her stance on mental illness, considering the several apparent opposing ideas present in her understanding of psychological disorders.

Wellbeing. In contrast to student descriptions of ‘mental illness’, perceptions of the term ‘*wellbeing*’ appeared to reflect a more holistic, complete view of health. Students’ responses incorporated physical and spiritual aspects, as well as direct psychological aspects of thoughts and feelings, and social aspects of engaging and interacting with others in positive ways. The below extracts illustrate some of the varied representations of wellbeing, as conveyed by the students interviewed:

Wellbeing... uh... I guess that’s your own personal set of happiness, kind of a thing for each person individually. How you’re feeling and how that affects other people. Exterior influences in your life... you wanna make sure you are really hanging around the right people. Self-talk... like if you doubt yourself I guess it can really distort the way you think of things and feel and act. (M, 16 years)

Just keeping healthy... looking after yourself. Go to the doctors... check-ups... you eat the right thing... you look after your body, you treat yourself with respect. (F, 17 years)

In summary, young people’s responses to the first few interview questions about their understanding of the terms *mental health*, *mental illness* and *wellbeing* overall

demonstrated both accurate knowledge and understanding of the complexity of mental illness. Their attitudes were communicated as tolerant, accepting and sympathetic towards sufferers of mental illness. While many participants responded to these questions with some degree of uncertainty about how specifically to define these concepts, they were, for the most part, able to demonstrate both an acknowledgment of mental health and illness as a prominent issue in society, and an appreciation of the severity and complexity of mental illness.

4.4.2 Mental health and illness in real life

In contrast to the tolerant and accepting views offered when discussing the *concepts and terminology* used to conceptualise mental health and illness, students spoke about mental health and illness in *real life* (i.e., in relation to themselves and friends) in a somewhat dissimilar manner. When prompted to discuss mental health in relation to themselves and their peers with questions including ‘*What are some things that might affect someone’s mental health?*’ and ‘*What might you do if you were feeling down, stressed or overwhelmed?*’, there was a notably higher level of scepticism about mental illness conveyed across participant responses. These accounts typically centred around others’ mental health issues (referring explicitly to their peers and classmates), as demonstrated in the quote below:

And they’re saying they have all these terrible issues but they’re not willing to do anything about it and I’m like “well is that a mental illness or is that you just not being motivated?” It just kind of, I dunno. (F, 17 years)

Concerns surrounding *authenticity* of mental illness were often related to the difficulties adolescents experienced in trying to discern between those with good or poor mental health.

4.4.2.1 *Authenticity*

The concept of authenticity was raised repeatedly by students in relation to accounts of mental health and illness in their lives. In particular, students expressed uncertainty and concern related to a perceived ambiguity surrounding mental health and illness in others. This ambiguity related to the lack of visible ‘proof’ of mental illness or, conversely, the ability for students to ‘hide’ their mental or emotional problems. Most obviously, adolescents reported experiences of doubt about whether peers reporting mental illness were ‘pretending’ or ‘exaggerating’ symptoms. This doubt about whether mental illness was ‘real’ was, in some cases, communicated as being the respondent’s personal doubt towards others:

It may or may not be true, but if they’re your friend I guess it’s gonna be true.

(M, 16 years)

Other students communicated that while they personally may not hold doubt about the presence of mental illness in others, they were convinced that at least some of their peers did:

I think some people think that they’re [people with a mental illness] putting it on... but they’re really not... they’ve actually got something that’s harming them in some way. But some people think they’re putting it on. (M, 14 years)

Um... some people, if you say that you've got it [mental illness], they may like, not believe you. They'll say 'look, you're just trying to get attention from this issue' or something. (F, 16 years)

In contrast to doubt about the *presence* of mental illness in others, some adolescents also expressed concern that *genuine* mental illness symptoms can often be 'hidden' from others. These descriptions included accounts of the difficulty students experienced with being able to tell whether their friends were mentally well, or, of considerable concern, about being able to recognise symptoms of mental illness in their friends in order to provide them with social support or direct them to help if needed. The view that it can be a challenge to determine whether their friends are genuinely well or just 'putting on an act' was commonly expressed by students. This example was typical:

'Cause you can tell when your friends are feeling upset and stuff, and you can tell when they're happy and that. But sometimes people are a lot better at hiding it so it could take a few conversations to delve into seeing what's going on in their mind and stuff. (F, 15 years)

Some people put on an act... everyone has insecurities but people have a good way of hiding it... some people are better at it than others... It's just hard to tell. (M, 14 years)

Authentic diagnosis. One way in which notions of authenticity were drawn on in students' discussions of mental illness was through talk about the ways that mental illness can be diagnosed. Students who shared personal experiences of mental illness and

speaking to mental health professionals appeared to place high importance on the process of testing and diagnosis:

It's like there's no medical back-up. When people are talking to me about [their mental disorders] I'm like "well, did you do the tests?"... I've been through a couple psychiatrists and psychologists and doctors and stuff. To me, that's like the traditional way to do it. And there's these people who have never been to like, a counsellor! (F, 17 years)

Concerns over self-diagnosis were also expressed, particularly in relation to the large amount of information, resources and tests related to mental illness that were now available and easily accessible on the internet:

With teenagers, they're always on the internet. And my, well there's a girl I know and she's self-diagnosed herself with like 3 eating disorders and like depression. (F, 17 years)

Here, this student conveys her scepticism surrounding the process of self-diagnosis. This risk, as expressed by the student, touches on concerns about public access to potentially misleading or inaccurate information and tests on the internet. This idea links with the concept of authenticity, through the idea that widespread and easy access to specific mental illness symptoms or diagnostic criteria can lead to young people (perhaps unintentionally) misdiagnosing themselves with one or more psychological disorders.

Markers of mental health. While students expressed confusion related to the lack of visible markers of mental health, they also communicated that there were certain ways that people could demonstrate to others that their mental illness was genuine.

Predominantly, indicators of mental health status that students evaluated to provide fair indication of authenticity came in the form of medical documentation, representing tangible ‘proof’ of a mental disorder. This idea is related to the notion of authentic diagnosis, and likely to reflect the ease of self-diagnosis and misdiagnosis as a result of information about mental illness symptoms and diagnostic tools available to the public.

For example:

Her boyfriend told her that he had depression... she was very blunt with him and said ‘look, I’m not gonna believe you unless I’ve seen a medical certificate’ – so this is her boyfriend, this is someone that she should be trusting, but people... you know, won’t believe you unless you’ve got stuff like that. (F, 17 years)

Furthermore, several students described the idea that if a mental illness was ‘real’ or serious, people might be less inclined to talk about it. As a result, students conveyed that when peers went into explicit details when sharing their experiences of mental illness, they could be interpreted as less ‘credible’ or truthful.

I think with actual mental illness, it’s debilitating. And I think when you have a mental illness, you’re so debilitated that you can’t talk openly about it... I’ve had like personal experiences, I would never dream of saying it. ‘Cause like, it’s a personal thing? So I wouldn’t like, say it in a conversation like “oh, I have this.. I have this” ... because I don’t know what people really get from that. To me, having a mental illness these days, people talk about it openly but I think it should be a personal thing that you should be working on. (F, 17 years)

Why fake it? The concept of ‘faking a mental illness’ was prominent among the student responses given. Several reasons for ‘faking’ a mental illness were proposed. Some of these reasons referred to exaggerating or creating a mental illness to serve as an ‘excuse’ to resort to in their lives, or as a means of gaining sympathy from others:

I reckon people will kind of use it as a gateway to have an excuse for something. So, yeah if they're going through a rough time and they're not dealing at all, then they might just say they have a mental illness because it's kind of difficult to determine whether you actually do and stuff. But yeah, I reckon as it becomes more accepted, it will be more like, made up kind of thing, like people will just pretend to get sympathy. (F, 18 years)

Similarly, students proposed that adopting a ‘fake’ mental illness could be perceived as a means for students to gain attention in a social context, as demonstrated by the following extract:

I don't know, people just think that they're pretending because they're looking for attention. That's the main issue. Because some people like attention so they attention-seek. (M, 14 years)

In summary, when discussing the impact of mental health in their own lives it was common for students to convey scepticism and concerns about the authenticity of mental illness among others. This scepticism tended to contrast with the generally open and accepting attitudes that students conveyed initially when prompted to discuss mental health on a purely conceptual basis (i.e. not in relation to themselves or their friends and family). Interestingly, students did not tend to place much emphasis on the point that

feeling the need to deceive your loved ones by fabricating a mental illness would likely be representative of considerable social and emotional difficulties, regardless of whether the self-proclaimed mental illness was 'authentic' or not.

4.4.2.2 Attitudes and behaviours towards someone with a mental illness

When asked to share their thoughts on appropriate attitudes and behaviours to exhibit towards someone with a mental illness, student responses can be discussed in the context of two main themes: firstly, contradictions and confusion about the right way to act around someone with a mental illness, and secondly, the concept of 'triggering', referring to the importance of 'treading lightly' around someone with a mental illness.

Contradictions and confusion. When asked about how they should treat someone with mental illness, students conveyed contradictions in ideas related to appropriate attitudes and behaviours towards those with mental health problems. For example, participants spoke about the importance of treating someone with mental illness 'normally' so as not to cause them to feel uncomfortable, but also the necessity to simultaneously provide sufferers with extra support and attention. Students openly expressed their difficulty managing this confusing mix of seemingly opposing ideas when trying to establish the 'right' behaviours and attitudes towards someone with mental illness. It is likely that this confusion about appropriate attitudes and actions stems from the uncertainty expressed by adolescents about the lack of visibility and issues of authenticity relating to mental health and illness. As the following extracts illustrate, most students conveyed a sense of hesitation and concern about the possible consequences of acting the wrong way around someone with mental illness:

When you act around someone with a mental illness, I think you should act like you usually do, but be careful where you step, don't force them into anything or don't be rough, just act normally, but be careful where you tread. Just take small steps at first and then move from there. (M, 14 years)

I wouldn't really overly sympathise for them. I'd just treat them as they would normally be treated, 'cause I guess they wanna feel normal, you know, just like everyone else... but kinda just that they know someone's there to help them... And you should treat them.... I dunno? (M, 16 years)

Triggering. In addition, concern over 'triggering' a friend who was experiencing mental health problems was frequently expressed. Students spoke about people with mental illness as being highly reactive to seemingly trivial words or actions, such as a passing comment made by a friend. As a result, several students strongly stressed the need to 'tread lightly' and exercise caution at all times when approaching the topic of mental health with a friend. The following extracts represent ideas about 'triggering' that were conveyed to some degree by the majority of students interviewed:

Well you should sort of tread lightly I guess... Don't go and say things that you think could offend anyone because you never know what could trigger them or set them off or anything. (F, 12 years)

You would be careful with how you say things and everything. You wouldn't be joking about a lot of things, just in case it might offend 'em, you wouldn't know. So... you wouldn't quite be yourself around 'em. In some ways, you'd probably try and give 'em more attention because sometimes mental illness

can happen very quickly. You never know, you could be having a great week, and the next week you'd be really down, and you don't know... so people would be more careful. (F, 17 years)

You're more aware of what to say. 'Cause some people might say something bad, that might be offensive.... you don't know if they do have depression, or some people hide it really well, and that one thing you say could just trigger it and bring them down. (M, 16 years)

The following student expressed their concern that even mentioning the word anxiety or depression around a peer who is struggling with mental illness could be enough to 'set them off':

Offer support... um, don't kind of raise or say stuff that is not necessary, like you know, maybe mentioning anxiety or depression around them... you've just gotta be kinda careful around them to not, you know, activate anything serious that could happen. (M, 18 years)

4.4.3 Summary: Tensions between perceptions of mental health concepts and mental illness in real life.

Several tensions were observed between students' understanding of abstract mental health and illness concepts and their perceptions of mental health in real life, when they referred to their own experiences or those of their peers. One example of this is that when asked about the nature of a mental illness, students typically conveyed an appreciation for the complicated challenges a mental illness can pose for a sufferer. The below extract

portrays student perspectives on how mental illness may represent an ongoing struggle in an individual's life that is significantly debilitating to their functioning:

Mental illness to me seems like someone that's suffering from something hard, but they're still themselves, just there's something different about them that they could use help with or need like advice... there'll still be that one part of you that's still affected, but you can kind of hide it. (M, 14 years)

However, when discussing mental illness experiences of their peers, students spoke about mental illness in a considerably more dismissive manner, as though they were confident that many of their peers' behaviours related to disclosing mental health problems related to 'looking for attention' as opposed to being indicative of a serious mental illness. The concept of authenticity of mental illness was prominent among adolescent discussions of mental health, with most students expressing the idea that mental illness has become an overused term among young people, as illustrated in the below extract:

Mental illness is the bad side of mental health. And it's really broad. And my generation has kind of killed the word. It was a very strong word like a while ago. If someone had a mental illness it was very serious but kind of like now... if someone has a mental illness, like everybody has some sort of mental illness. It's kind of just... desensitized the word.... Someone's sad for a week, oh no – they have depression. (F, 17 years)

Adolescents expressed considerable difficulty when talking about their perceptions of appropriate ways to behave around someone with a mental illness. Most participants conveyed concern about 'triggering' someone with a mental illness, by unintentionally

saying or doing something to offend or hurt them. These findings reflect those reported by Secker, Armstrong and Hill (1999), who reported student expressions of fear that someone with mental illness could display aggression and unpredictability towards them. While the majority of students were able to convey a strong sense of appreciation of the impact that their attitudes and behaviours could potentially have on another person, it was clear that confusion remained surrounding practical directions for how to behave in the company of someone with a mental illness. Through these responses, it could be observed that when discussing hypothetical situations outside of their own lives, all participants demonstrated an accepting and non-stigmatising attitude towards sufferers of mental illness. Specifically, this high level of tolerance and understanding towards those with mental illness was conveyed by young people when discussing mental health definitions and terminology as well as talking about their perceptions of the ‘right’ way to act around someone with a mental illness. In contrast, when discussing mental illness in real life – in the context of their own personal experiences or their own friends and family – a much stronger sense of scepticism was conveyed, as questions of authenticity of mental illness were raised.

4.5 Discussion

The primary aim of this research study was to gain insight into the views of young people in relation to their perceptions of mental health and illness. It is the first, to our knowledge, that qualitatively investigates Australian adolescent perspectives on mental health and illness concepts, attitudes and behaviours in a general sense (as opposed to youth experiences of a particular service, treatment or disorder). The strengths of this study lie in the interview methodology to provide useful in-depth insight into youth perspective and the relevance of findings to inform policy and practice. In line with

previous research in children aged 10-11 years, participants in the current study demonstrated that they are cognitively able to understand concepts of mental health, and have an appreciation of the often complex needs of those with mental illness (Roose & John, 2003). However, in the current study there were clear discrepancies observed between adolescent descriptions of mental health on a conceptual basis and their representations of mental health relevant to their own lives and experiences.

Through the responses collected, it became apparent that the lack of visible markers of mental health and illness represent a significant challenge to young people's understanding of how to effectively and appropriately approach matters of mental health among their peers. This confusion is in contrast to findings reported by Armstrong et al. (2000), who reported that young people defined concepts of mental illness relatively easily and comprehensively, but expressed greater difficulties defining mental health. Interestingly, when discussing concepts of mental health and illness, a number of the respondents in the present study referred to the notion of adolescents 'faking' a mental illness. Some respondents discussed the belief that their peers may exaggerate symptoms or fabricate a mental illness entirely, in order to gain attention, sympathy or to have an 'excuse' for something (e.g. to justify low performance at school or work), while others expressed that this was not their personal view, but a perception that they believed to be present among other students at their school. These ideas about authenticity of mental illness were apparent across the four participating schools, and expressed by both male and female students.

The scepticism about mental illness conveyed by young people when discussing mental health in the context of their own lives, and in particular, the blame they expressed

towards others (e.g. “*well is that a mental illness or is that you just not being motivated?*”) could be theorised to reflect the influence of dominant ideologies on young people’s beliefs about mental health. For example, neo-liberal ideology in contemporary Western society emphasises a strong ideal of self-fulfilment and heightened concern for the self, and thus weakens the willingness for individuals to take responsibility for other people, and to accept and defend collective interests (Nafstad, Blakar, Botchway, & Rand-Hendriksen, 2009). Timimi (2010) argued that children in Western countries are socialised into a value system that creates an ethos of ‘winners and losers’, inimical to values of compassion and social harmony. Similarly, the tendency for students interviewed to be suspicious of others, and at times assume their peers to be ‘faking’ mental illness for selfish reasons may reflect broader cultural values, such as individualistic identity. When discussing notions of authenticity, students also spoke about mental illness as an overused term. It was considered that there is some legitimacy to this idea, which may speak more broadly about aspects of current approaches to mental health conceptualisation, treatment and promotion. Mental illness and related terms may be arguably ‘overused’ due to the increase in information about mental illness and potential for self-diagnosis, the lack of visible indicators of mental health, and the overall tendency for the field of psychology to deal with aberrant behaviours or emotions in children through diagnoses and technical interventions, resulting in an increasing number of diagnoses (Bassett & Baker, 2015; Timimi, 2010). Through these student perspectives, important questions are also raised about how we define mental illness, including cross-cultural issues and the debate about what is considered ‘normal’ in society. These are somewhat problematic and unresolved questions where considerable confusion exists among mental health practitioners, and there is a need for ongoing critical exploration of

such questions to disentangle the links and boundaries between culture and psychopathology (Bassett & Baker, 2015).

4.5.1 Stigma vs advantages of mental illness

It is critically important to understand the role of stigmatisation in shaping an adolescent's beliefs and attitudes related to mental illness and mental health, which is reflected in our participants' comments about individuals 'hiding' their mental health state from others. Stigmatisation is likely to play a role in such behaviours, as they suggest underlying perceptions among students that they would be judged or treated differently if they were to disclose details of their own mental health problems to their peers. It has been argued that stigma is of particular concern for youth populations due to the school environment and its role in developing a sense of self-esteem, independence and self-efficacy, as adolescents engage in and build relationships outside of the family (Kranke, Floersch, Townsend, & Munson, 2010). The notion of 'hiding mental illness', discussed by students in the current study, has been described as indicative of 'self-stigma', referring to behaviours of the stigmatised individual (e.g. secrecy and limiting interaction with others) leading to feelings of rejection (Corrigan & Kleinlein, 2005).

On the other hand, the responses in this study also drew light to the 'other side' of stigmatisation around mental illness: the perception or belief that an individual may somehow *benefit* from having a mental illness. It should also be recognised that, of those adolescents interviewed, the majority demonstrated little understanding that if a peer was suspected to be 'faking' a mental illness for attention, then, even in the absence of a severe mental disorder, that person could be experiencing some psychosocial difficulties given that they felt compelled to fabricate a disorder for the purpose of perceived social

gain. Hence, it appeared that stigma and a lack of understanding of more subtle emotional and behavioural problems in the absence of a severe mental disorder were conveyed in the representations constructed by adolescents in this study.

It is known that it is not uncommon for individuals to simulate illness, but the ways in which this is done can vary between cases. The current DSM-5 refers to *Factitious Disorder* as the intentional falsification of physical or psychological signs or symptoms of illness, and *malingering* as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives” (e.g. financial compensation, evading criminal prosecution avoidance of work) (American Psychiatric Association, 2013). The type of falsification described by the adolescents interviewed conveyed a similar notion that mental illness could provide some sort of benefit.

However, in comparison to the clinical disorder, the specific advantages emphasised by the type of falsification described by students were fundamentally social factors (e.g. looking for attention or sympathy), rather than clear extrinsic reward (such as financial gain).

4.5.2 Authenticity and identity

When considering concerns about mental health authenticity articulated by students, it is important to acknowledge the large role that peers and social factors play in identity development amongst adolescents. During adolescence, peer interactions become more frequent and more influential, as concerns for status as well as intimacy among peers increase (Ojanen, Sijtsema, & Rambaran, 2013). Developmental research has established that peer relationships and social contexts are central to the process of identity formation, a key developmental task of adolescence in Western societies (Davis, 2012). In relation to

the perspective expressed by some students on the possibility of ‘faking’ a mental illness, the perceived motives for doing so may make sense in the context of potential functions of self-disclosure during adolescence. Self-disclosure has been framed as an important means for young people to create intimacy between friends, and establish and articulate their sense of selves, while differentiating themselves from others (Davis, 2012). From this perspective, perhaps the importance of developing one’s own identity during this developmental stage may increase the likelihood that an adolescent would seek to embellish or exaggerate a personal experience of mental illness, in order to create intimacy between friends or a unique identity for themselves. Another plausible theory is that adolescent mental health factors, such as depressive symptoms, could provide a mechanism for peer socialisation. There is a growing field of literature that suggest that young people are likely to seek peers who have similar internal states to themselves (Van Zalk, Kerr, Branje, Stattin, & Meeus, 2010). One study reported evidence for selection and deselection of friends on the basis of adolescent depression (Kiuru, Burk, Laursen, Nurmi, & Salmela-Aro, 2012), suggesting that self-disclosure and discussion of mental health and illness with peers can function to help adolescents establish peer networks reflective of interpersonal similarity.

4.5.3 Self-diagnosis and the internet

The concerns voiced by participants in the current study about ‘authenticity’ of mental illness could also be theorised to be to somewhat related to the prevalence of self-diagnosis in the digital age, due to the ease of accessing large amounts of potentially inaccurate information on the internet about symptoms and treatments for mental disorders, as well as online tools and ‘quizzes’ for self-diagnosis. White and Horvitz

(2009) employ the term *cyberchondria* to refer to the escalation of health-related concerns about common symptomatology, through public access to abundant medical information on the internet. In line with concerns voiced by young people in the current study, previous research has highlighted the danger of the vast amounts of medical information available to the public that can potentially mislead those without medical training into self-diagnosis and treatment (Benigeri & Pluye, 2003).

In relation to the field of mental health specifically, self-diagnosis can be particularly concerning because the outcome following self-diagnosis may be less likely to lead to treatment-seeking or consultation with a professional of any kind, when compared to a physical condition that may lead to consultation with a doctor in order to access medication or treatment such as surgical procedures (Giles & Newbold, 2011). Instead, online communities can offer users potential alternatives to mental health treatment-seeking through access to advice and peer support through internet forums. The use of online information-seeking and self-diagnosis is fundamentally tied to notions of authenticity and identity, both of which were discussed in detail by adolescents in this study. For instance, the process of diagnosis has been observed to assist individuals by providing a means of biomedical framing of their condition, consequently validating their pain and legitimizing their identities (LaFrance, 2007). Diagnosis is also referred to as an organising structure for identity (Giles & Newbold, 2011), but has been warned to have potentially damaging consequences for individuals should those diagnostic criteria change, or fail to be confirmed by a professional (Charland, 2004). Cruwys and Gunaseelan (2016) explored the link between mental illness and identity among adults with depression, and reported that a large proportion of participants (49%) endorsed the notion that depression informed their identity. Further, social identification as mentally ill

was associated with poorer wellbeing and the experience of discrimination. Thus, despite the obvious benefits of diagnosis for guiding formulation and treatment, the extent to which an individual defines themselves in terms of their mental illness and the perceived permanency of their condition, could potentially have harmful consequences for a young person's wellbeing.

Despite the above concerns, the internet has also been reported to provide some promising directions in adolescent mental health care, through supporting self-reflection and self-management (Kurki, Koivunen, Anttila, Hatonen, & Valimaki, 2011). Therapy delivered through computer programs (Fleming, Robyn, & Merry, 2012) or online psycho-education interventions (Taylor-Rodgers & Batterham, 2014) have also been suggested to offer promising contributions to overcoming barriers to help-seeking (e.g. stigma) in young people. Given that the widespread access to the internet only continues to grow in Western society, it is paramount that young people are educated about both the potential advantages and disadvantages of online information, forums and diagnostic tools. The knowledge and education provided through school-based mental health programs could therefore be used as a means of safe-guarding against the effects of potentially misleading or inaccurate information and tests on the internet available to young people at the click of a button. This is a point that was emphasised by some of the participants themselves in this study.

4.5.4 Limitations and future directions

The current study has shed light on several areas for future research to investigate – in particular, the prevalence of attitudes related to inauthenticity of mental illness - in order to learn more about how these attitudes function and influence behaviour in young people.

Although some ideas and themes communicated about mental health in the context of the adolescent developmental stage are likely to be salient to adolescents in other developed countries, the characteristics of the current sample and limited generalisability to the broader global population of adolescents must be considered.

First, the students spoken to in the current study had participated in the *MindMatters* program within their schools, which aimed to educate and empower young people on the topic of mental health and wellbeing and it could be hypothesised that their level of knowledge and interest in mental health issues may be higher than that of a typical student. This limitation also suggests that the confusion and uncertainty present in the general youth population's understanding of mental health may be comparatively even more drastic, further highlighting a need for a broader investigation of adolescent perspectives. Secondly, despite employing a non-clinical sample, several participants expressed personal interactions with counsellors, doctors and psychologists in relation to mental health concerns, which may have influenced their views. This may be particularly relevant to consider when interpreting beliefs communicated by students reflecting one or two negative experiences with clinicians that may have strongly shaped their general opinion of all mental health professionals. Third, Secker, Armstrong, and Hill (1999) reported differences between attitudes of students in rural schools compared to metropolitan schools, with lower levels of tolerance and sympathy demonstrated by rural students. Although the current study incorporated views of students from rural schools to reflect a maximum variability sampling approach, the methodology was not designed to compare views between groups and thus, more in-depth exploration of youth perspectives in rural areas may be necessary. Finally, the Anglo-European Australian ethnicity of the students interviewed must be considered. The background literature indicates lower levels

of mental health problem identification (Verhulp, Stevens, Van De Schoot, & Vollebergh, 2013), lower levels of service utilisation (Garland et al., 2005; Tiwari & Wang, 2008) and higher levels of depressive symptoms (Wickrama, Merten, & Elder, 2005) among minority ethnic groups compared to dominant cultures in developed countries such as Australia, the United States and Canada. Therefore, it is relevant to note that all young people who self-selected to be interviewed for the present study were of Anglo-European descent, in contrast to the range of ethnic backgrounds represented among the wider *MindMatters* program participant group that were invited to be interviewed. Accordingly, it is necessary for future research to focus on increasing diversity and incorporating views of minority groups in Australia, particularly among Indigenous Australians and refugee populations in light of the cross-cultural challenges we currently face in engaging these groups for the provision of quality mental health service delivery (Benson, Al Haris, & Saaid, 2010; Jorm, Bourchier, Cvetkovski, & Stewart, 2012).

Future research could also examine whether adults hold similar beliefs about authenticity of mental illness, or explore the possibility that such beliefs are more dominant in young people, possibly due to the influence of primary adolescent developmental tasks related to identity formation and social development. Further, the relationships between mental health knowledge and related attitudes and behaviours are important to explore in the context of young people's perspectives, as these mechanisms are necessary to consider and address in the development and modification of mental health promotion initiatives.

4.6 Conclusions and practical implications

The above findings suggest a number of ways in which the views of young people can be taken into account in the design of mental health promotion initiatives. Regardless of

whether it is actually common for young people to ‘fake’ mental illness or not, the very belief that others may do so (mentioned by students across both government and private schools, and across gender and age) may present a significant barrier or deterrent to help-seeking behaviours which is necessary to address. It has been established that health promotion initiatives are more likely to be successful if they take people’s own understanding, beliefs and concerns into account (Armstrong et al., 2000). One practical implication that could be drawn from this study is the possibility of youth-based mental health programs (such as *MindMatters*) specifically addressing the issues and confusion surrounding lack of visibility of mental health, and helping young people understand that this should not be a deterrent to talking about and seeking help for mental health problems. Whole-school approaches can assist this process by aiming to make mental health a priority for the entire student body, rather than just those students experiencing symptoms of mental illness.

The contrast between students’ descriptions of mental health on a conceptual basis compared to their representations of mental health in ‘real life’, highlighted authenticity of mental illness as a prominent issue of concern to young people. In this way, the abundant information accessible to students through both internal school mental health programs, as well as external sources such as the internet, can represent a downside of mental health education, where misleading information and self-diagnoses could serve to trivialise mental illness in society. It is important that future program development processes attempt to tackle these concerns, by prompting open discussion of such issues among young people, and encouraging students to consider the potential effects of judgemental attitudes and perceptions of inauthenticity towards peers who disclose mental illness. Perhaps promoting an understanding of mental health and illness on a dual

continuum, where an individual can possess both positive mental health and negative mental illness symptoms simultaneously (Dengate, 2011) would be a useful way to address this confusion. Considering that concepts of mental health are complex even for adults (Rüsch et al., 2012), a focus on students learning to understand and appreciate seemingly opposing ideas when considering mental health and illness may be a useful first step in the endeavour to develop mental health knowledge and understanding in adolescents (and, in turn, in adults).

Students interviewed also expressed considerable uncertainty about how to behave towards someone with a mental illness, with a heavy focus on the fear of ‘triggering’ someone - suggesting that a general perception of mentally ill people being in a perpetual state of high reactivity and sensitivity may exist among youth. This uncertainty and confusion further highlights the need to provide practical information, clarity and advice on this topic. This is particularly imperative to discuss because the portrayal of anyone with a mental illness as being highly reactive could serve to reinforce stigmatising attitudes and behaviours, through fear or avoidance. The overall confusion related to the ambiguity of visible indicators of mental health and authenticity of mental illness reported by youth in the current study represents a considerable gap in our understanding for further research to explore, in order to target and reduce such confusion more effectively through school mental health programs.

Acknowledgements

The authors wish to acknowledge the contributions of MindMatters and Principals Australia for their assistance with organising data collection, and the second reviewer, Stacey McCallum of the University of Adelaide, for assistance in data analysis.

CHAPTER FIVE: PAPER THREE

“First World Problems” and coping alone: Adolescent perceptions of help-seeking and implications for school-based mental health programs

PAPER SUBMITTED

Emmelin Teng, University of Adelaide

Shona Crabb, University of Adelaide

Helen Winefield, University of Adelaide

Anthony Venning, Flinders University

Statement of Authorship

Title of Paper	"First World Problems" and coping alone: Adolescent perceptions of help-seeking and implications for school-based mental health programs
Publication Status	Submitted for Publication
Publication Details	Teng, E., Crabb, S., Winefield, H., & Venning., A. (2016). "First World Problems" and coping alone: Adolescent perceptions of help-seeking and implications for school-based mental health programs. Submitted to the journal <i>Child and Youth Services</i> on 23 September 2016.

Principal Author

Name of Principal Author (Candidate)	Emmelin Teng		
Contribution to the Paper	Developed study design, organised participant recruitment and data collection, conducted qualitative interviews, transcribed and analysed data, wrote manuscript and acted as the corresponding author. Dr. Stacey McCallum of the University of Adelaide acted as a second reviewer in the data analysis process to achieve consistency of findings.		
Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	25/11/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Shona Crabb		
Contribution to the Paper	Supervised design of research study, assisted with the development of the semi-structured interview protocol, refined and discussed themes frequently through an ongoing collaborative process with the Principal author, and assisted with interpretation of data, analysis and manuscript editing.		
Signature		Date	22/11/2016
	(Signed by HW on behalf of Dr Crabb during her maternity leave)		

Name of Co-Author	Helen Winefield		
Contribution to the Paper	Supervised the development of work, assisted with data interpretation and manuscript evaluation.		
Signature		Date	22/11/2016

Name of Co-Author	Anthony Venning		
Contribution to the Paper	Helped to provide suggestions in the presentation of findings and contributed to evaluating and editing the manuscript.		
Signature		Date	18/11/2016

5.1 Abstract

Youth mental health is critical to address, given that young people experience a high prevalence of mental disorders and are particularly resistant to seeking help. The present study employed a cross-sectional qualitative design and semi-structured interviews with a non-clinical sample of adolescents (aged 12-18) to explore the process of help-seeking from the young person's perspective. Findings illustrate the strong reluctance for adolescents to seek help due to complex and interrelated personal, social and institutional influences. Students spoke about the concept of "first world problems", and described their personal problems as minor or trivial in comparison to large-scale or global issues.

Key words: Youth, mental health, help-seeking, qualitative

5.2 Introduction

Young people with mental health problems represent a vulnerable group in our society. In addition to mental disorders being one of the largest contributors to disability among young Australians (Gilchrist & Sullivan, 2006; Matthews, Hall, Vos, Patton, & Degenhardt, 2011), a wide range of international studies report that young people are particularly resistant to seeking help for their mental health problems (O'Connor et al., 2014; Rickwood et al., 2007). As few as one sixth of young people with a diagnosable mental disorder receive treatment, an estimate that does not include the many more who are considered 'at risk' and would similarly benefit from psychological help or support (Paternite, 2005). Of further concern is that previous research has indicated that adolescents experiencing severe mental health difficulties and most in need of support are also least likely to seek help for their problems. For example, Sawyer, Borojevic, et al. (2012) reported that adolescents exhibiting high symptoms of depression report that they would seek help less frequently than those with low symptoms of depression. Additionally, this 'high symptom' group were four times more likely than others to report that they would not seek help from *anybody*, including informal support from friends and family members in addition to professional help sources (Sawyer, Borojevic, et al., 2012). The consequences of failing to receive adequate treatment for mental health problems in adolescence are significant, with long-term studies demonstrating that an adolescent onset of mental disorders is closely related to mental health, social adjustment, substance use and suicide in adulthood (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001; Martínez-Hernández, DiGiacomo, Carceller-Maicas, Correa-Urquiza, & Martorell-Poveda, 2014). In light of these complexities, help-seeking behaviour for mental health difficulties

has been established as a significant focus and ongoing challenge to address for mental health interventions targeting young people.

Help-seeking behaviour - rather than being a straightforward process where a young person 1) experiences psychological distress and 2) consequently seeks help – involves a wide range of factors that can contribute to the likelihood of successful treatment and recovery among youth with mental health problems. A variety of individual, family, economic and cultural factors can represent barriers to help-seeking among youth populations. Some of these barriers relate to individual factors, such as the type of mental health problem, gender, attitudes toward mental illness and help-seeking, beliefs about the helpfulness of treatment, concerns about having to face or accept a mental health problem, or a preference for independence in handling a problem on their own (Sawyer, Sawyer, et al., 2012). Other barriers relate to external factors including stigma, financial concerns, institutional aspects and social and cultural influences. Of course, it is also necessary to acknowledge that these factors are complex and often interrelated (e.g. social norms in Western society make it more acceptable for girls to seek help, further influencing individual attitudes towards help-seeking) (Sawyer, Sawyer, et al., 2012). Stigma has been identified as a key barrier to young people seeking professional help for mental illness (Gulliver et al., 2010). It could be hypothesised that among youth populations, the effects of stigma on help-seeking behaviour could be particularly influential, due to the heightened importance of peer group acceptance during this developmental stage (Block et al., 2013). Rüsç et al. (2013) refer to the labelling of mental illness as a double-edged sword, with benefits including facilitation of help-seeking, awareness and insight into one's condition, and risks related to individuals being

stigmatised by their peers leading to potential delay or avoidance of help-seeking in order to escape the mental illness label that comes with service utilisation.

Knowledge and beliefs about the health benefits or risks of behaviours do not necessarily predict behaviour, particularly among young people. This finding has been demonstrated in previous studies on adolescents' and young adults' smoking habits (Ganley & Rosario, 2013), safe sexual behaviours (Letamo, 2011) and sun tanning behaviours (Cokkinides, Bandi, Weinstock, & Ward, 2010). While help-seeking undoubtedly depends to some extent on the young person's understanding and appraisal of the problem, individual willingness, and attitudes towards help-seeking, it is clear that environmental and social influences including stigmatisation, as well as access to appropriate and youth-friendly services also play an important role (Rickwood et al., 2007). With these complex and often interrelated barriers to help-seeking operating across multiple socioecological levels, there is a need for population-based approaches to promote early intervention, education and prevention of mental illness.

The school setting has been recognised as a key environment that can and should be used to promote positive mental health for young people (Dray et al., 2015; Evans et al., 2005; Jané-Llopis & Barry, 2005; Weist, 2005). For example, a study by Jané-Llopis and Barry (2005) outlines several reasons for this including the centralised access to large proportions of children and adolescents; the potential for schools to strongly influence development and behaviour; and the opportunities to enhance and develop strengths among students that can protect and promote good mental health (e.g. academic achievement, social networks, self-esteem). The advantage of centralised access to young people over long periods of time and at a critical point in development mean that the

school setting offers an opportune setting for the implementation of whole-school or universal mental health promotion programs (Dray et al., 2015). Universal mental health programs refer to those programs aimed at improving the mental health of the whole population, rather than targeting only people identified as being at risk of mental health problems (Wells et al., 2003). Rather than focusing purely on individual behaviour and targeting only 'at-risk' groups, previous studies have acknowledged the importance of communities taking responsibility for the problem and acknowledging the social organisation of help-seeking behaviour in young people (Gilchrist & Sullivan, 2006). Thus, universal interventions represent a potential platform for addressing the mental health of young people on a population level (Dray et al., 2015). So far, the majority of universal school mental health programs have been based on principles of Beck's cognitive-behavioural therapy (Garmy et al., 2015) and at present, a number of studies have demonstrated effectiveness of school-based universal mental health programs, through measurement of outcomes such as the overall improvement of mental health, or reduction in mental health symptoms among young people (Dray et al., 2015; Holen, Waaktaar, Lervåg, & Ystgaard, 2012; Shochet et al., 2001; Wells et al., 2003). However, further and ongoing evaluation of these programs is required, in particular to gather the perspectives of adolescents participating in these programs (Garmy et al., 2015).

While there has been some substantial research focusing on young people's reluctance to engage in professional mental health care (Rickwood, Deane & Wilson 2007), considerably less research has explored the broader views of young people themselves about mental health and illness, and their own perceptions about help-seeking behaviour. We know very little about the complex concerns of young people, their perceptions of mental health and illness, and how they impact on help-seeking preferences (Leavey,

Rothi, & Paul, 2011). One study conducted by Roose and John (2003) explored understanding of mental health in children aged 10 to 11 years, demonstrating that young people show a sophisticated understanding and interest in mental health, and, as a result, can offer valuable contributions to discussions about mental health service development. Similarly, Armstrong, Hill and Secker (2000) interviewed young people aged 12 to 14 years to explore their attitudes and perceptions about mental health and mental illness, with findings demonstrating that young people can hold extremely strong views about what they want and need when it comes to support for mental health issues. Some of the ideas communicated by the young people in that study related to concerns about confidentiality and trust within the context of seeking help from a professional, perceptions of young people's problems as generally less important than those of adults, and a heavy emphasis on internalising or 'bottling up' feelings as a popular coping strategy; all of which are likely to influence a young person's approach and attitude towards professional help-seeking behaviours. Another study by Garmy et al. (2015) that explored adolescents' experiences of a school-based mental health program reported that while students viewed the program as beneficial and meaningful, they expressed a desire for a more health-promoting approach, arguing that the program focused too heavily on negative matters.

Other studies have examined youth perspectives about mental health treatment among clinical samples, or 'at-risk' groups. One American study conducted by Block et al. (2013) examined adolescent perspectives of outpatient mental health treatment. Authors reported that adolescents who participated in interviews regarding their decision to accept or decline referral to mental health care expressed a strong need for autonomy, concerns about privacy from their parents and stigmatisation from their peer group. A qualitative

study by French et al. (2003) of Australian at-risk youth explored perspectives of clients of a mental health service, reporting themes including the importance of considering the young person and their life experiences, the attractiveness and accessibility of the mental health service, and the follow-up care offered by the service provider. Another study of American college students at elevated risk of suicide provided findings related to self-reported barriers to professional help seeking among young people at elevated risk for suicide, including perception that treatment is not needed, lack of time, and preference for self-management (Czyz et al., 2013). In contrast, Gilchrist and Sullivan (2006) investigated the experiences of ‘ordinary’ members of the community to explore how young people who had not contemplated, attempted or been affected by suicide think and behave. Authors reported that the lack of trust most young people expressed in other community members was likely linked to the fear and stigma that surrounds help-seeking and suicide, and that it was commonly suggested by participants that a young person seeking professional help would be perceived as ‘uncool’ or ‘weak’.

Lack of help-seeking in young people is further complicated as it is largely determined by the ability of adults and professionals to recognise and respond to their difficulties. As health professionals, we have a responsibility to gain a deeper understanding of the complex individual, social and environmental factors that influence likelihood of young people seeking help, in order to enhance the engagement process and improve service delivery (French et al., 2003). While early intervention and education programs may have been designed with the hope to increase help-seeking, we need to better understand adolescent views of help-seeking behaviour in order to engage young people fully in such programs and appropriately address young people’s needs. Interviewing young people from a non-clinical sample acknowledges the importance of understanding lay views of

help-seeking among youth in order to better inform prevention (rather than treatment) approaches on a population level, for which qualitative information is limited (Gilchrist & Sullivan, 2006). There exists a gap in research between exploring views of ‘mentally well’ young people with no history of mental illness symptoms and more severe at-risk or clinical groups, with a paucity of studies examining views of youth exposed to a mental health promotion program. As such programs are based on a population-health model, participants reflect a wide range of mental health levels and it is necessary to explore how programs aimed to educate and improve mental health attitudes and behaviour across a whole youth population are received by participants. As highlighted by Barry et al. (2000), assessment of community beliefs is necessary to ensure interventions and programs will be perceived as meaningful and relevant to their target audience.

5.2.1 The present study

In order to understand the process of help-seeking from the young person’s perspective, the current study involved interviewing adolescents (aged 12-18 years) to explore their narratives and experiences related to their own mental health. The participants were students involved in a school-based mental health program (*MindMatters*) at various levels of implementation, in order to explore perceptions among a non-clinical sample of adolescents who had been exposed to a school-based mental health promotion program. Due to the importance of peer acceptance among adolescents, individual interviews have been recommended to provide further information when compared to focus groups, particularly in relation to capturing views of adolescents that may differ from that in their groups (Garmy et al., 2015). In contrast to previous studies on clinical samples (Block et al., 2013), ‘at-risk’ youth (Czyz et al., 2013; French et al., 2003; Rüscher et al., 2013) or

general youth (Gilchrist & Sullivan, 2006), the present study will shed light on the knowledge and perceptions of young people who have participated in a school-based mental health promotion program, and therefore been educated on the various social and emotional learning topics emphasised through the *MindMatters* program. Implications of findings for the development and modification of school-based mental health programs are discussed.

5.3 Method

5.3.1 Participants

Participants in the current study were 16 middle and secondary school students aged 12-18 years, who were recruited because of their involvement with the mental health promotion program *MindMatters* being implemented at their schools. This level of involvement in the program varied between participants from having participated in a two-day Youth Empowerment Process (YEP) workshop, to having several years of involvement in the program, including participation in numerous workshops at their schools and delivering training and support to younger students within their schools on *MindMatters* topics. A maximum variability sampling approach was used in an effort to reflect gender, year level, and government vs. non-government school students present within the population. The sample consisted of 56% female students and 44% male. Of the students in the sample, 69% were in government schooling and 31% of students were in non-government schooling (including Catholic and independent schools); an approximate reflection of the 65% of Australian students in government schooling and 35% in non-government schooling in 2014 (Australian Bureau of Statistics, 2014). All participants were Anglo-European Australians. The students were recruited from school year levels 7-12.

5.3.2 Data collection and analytical approach

The current study employed individual semi-structured interviews to explore young people's views. Data collection for this study occurred between August and November 2013. South Australian middle school and senior high school students involved in the *MindMatters* program were invited to participate in the current study. Information about the study was presented by the first author to student groups engaged in the *MindMatters* Youth Empowerment Process (YEP) workshops at four different schools. Those students who indicated interest in participating in the study were given information sheets and consent forms to return once signed by a parent or guardian to approve their participation (if under the age of 18 years at the time of the study). In addition, assent forms were returned by students to indicate their own understanding and approval of participation in the study. Participants were then scheduled an interview time with the first author, to be conducted within the individual student's school grounds.

The semi-structured interviews involved each participant being asked a series of questions (using prompts where necessary) for the purpose of allowing a degree of flexibility in discussion within the context of the overall topic (see Appendix 3).

Interview prompt questions were structured in two parts, with Part A focusing broadly on students' perspectives of mental health concepts and related attitudes and behaviours, and Part B focusing more specifically on students' views of the *MindMatters* program. The current paper will focus on discussions that emerged from both Parts A and B of the interview process, related to the topic of help-seeking for mental health problems. Prior to interviews commencing, participants were reminded that they could decline to answer any questions, and could choose to cease participation in the interview at any time. The

interviews varied in length from 35 minutes to 75 minutes, with an average interview time of approximately 45 minutes. In line with recommendations by Guest, Bunce, and Johnson (2006) for qualitative interview samples, an initial sample of 12 participants was recruited. However, following completion of the first 12 interviews, data collection continued with several additional interviews until *data saturation* (the point when no new or relevant information emerges and the main themes become common and repetitive (Braun & Clarke, 2006), was reached at 16 participants. Data were audio-recorded and manually transcribed verbatim.

Transcripts were de-identified using a coding system and analysed by the first author using a thematic analysis framework, as proposed by Braun and Clarke (2006). This approach was chosen due to the flexibility of the method, accessibility of results, and the potential for analyses to generate unanticipated insights and inform policy development (Braun and Clarke, 2006). Thematic analysis involves specific phases, beginning with familiarisation with the data (including re-reading transcripts and recording notes following interviews, based on observations made during the interview process). An external reviewer was employed to independently code 20% of the data set during the familiarisation stage, and findings were compared for agreement to ensure inter-rater reliability and improve the consistency of interpretations. Initial coding was then completed for each transcript individually, and potential themes were named and data collated relevant to each theme. Following this, themes were reviewed and considered in relation to the coded extracts and the entire data set. Themes were then refined and discussed frequently through an ongoing collaborative process with the second author. No major discrepancies arose as a result of this process. Final data analysis involved selection of extract examples and the relating back of the analysis to the research questions and

literature. An audit trail (see Appendix 4) was used to document the process of data collection and analysis, in order to monitor qualitative rigour (Tracy, 2010). In conducting the analysis, authors were informed by the socio-ecological model (Stokols, 1996) to stimulate consideration of different levels of influence on adolescent help-seeking behaviour.

5.3.3 The MindMatters Program

MindMatters is a universal school-based mental health promotion, prevention and early intervention program. The approach aims to target the entire school population, with the overall goal of enhancing strengths in order to reduce the risk of later problem outcomes, and increase the likelihood of increasing protective factors for wellbeing and resilience (MindMatters, 2012). The program provides resources and materials to schools in order to address areas such as curriculum and learning, school organisation, ethos and environment and partnerships and services. However, the level of choice in implementation of the program also represents a specific challenge to program evaluation, with school leadership given the choice to incorporate universal, selective and targeted components, allowing for variation in the ways in which the *MindMatters* program is implemented between schools (Hazell, Vincent, Waring, & Lewin, 2002).

5.3.4 Ethical considerations

Ethical approval was obtained from The Department of Education and Child Development (DECD), The Catholic Education Office, Adelaide, and The University of Adelaide Human Research Ethics Committee (HREC). Only demographic information of

a general nature (age and gender) was recorded on the data set for statistical purposes, to ensure the participants' privacy and confidentiality.

5.4 Analysis and discussion

Students were recruited from a population of young people who had been involved in a primary prevention program with the purpose of interviewing a non-clinical sample of young people about their views of mental health and illness. Despite this approach, throughout data collection it became apparent that several students interviewed had experienced clinical diagnosis and/or professional mental health support. Given the prevalence of mental disorders among young Australians (Sawyer, Afifi, et al., 2012), these sample characteristics were not surprising. However, despite the diversity of mental health characteristics that existed among the sample, it is noteworthy that the clear themes presented in the current study were expressed across the sample, regardless of previous experience of help-seeking.

Students interviewed generally expressed a strong sense of reluctance towards seeking external help of any kind. While some students were able to articulate why 'some people' may need to talk to someone or require professional help in a hypothetical sense, when prompted to discuss whether they personally would consider talking to someone (a friend, a parent, teacher or professional) when feelings of being stressed, sad or overwhelmed persisted for a considerable length of time, the below response was fairly typical:

Well if I was to be honest, I'd probably just keep trying to tell myself that I can cope with it and I can deal with it and that it'll probably get better, that sort of thing. I don't tend to tell people. (F, 16 years)

Reflecting a socioecological framework applied to health promotion behaviour (Stokols, 1996), the analysis presented is structured according to 1) personal 2) social and 3) institutional influences on help-seeking behaviour for mental health problems in adolescents. Table 6 gives an overview of this structure and the themes to be discussed in the following section. Verbatim quotes are provided to support the themes presented, where each quote is accompanied by the gender (*male (M) or female (F)*) and the age of the participant.

Table 6. Categories and themes related to help-seeking behaviour among adolescents

Categories	Themes discussed by adolescents related to mental health help-seeking
Personal influences	Self-reliance Positive thinking Doubt about the significance of mental health problems
Social influences	Peer acceptance Burdening others Informal help-seeking
Institutional influences	Concerns about policies and confidentiality Negative perceptions of mental health services and professionals

5.4.1 Personal influences

This category of themes relates to intrapersonal approaches, strategies and ideas that students reflected throughout the interviews. The themes identified were self-reliance, positive thinking and doubt about the significance of problems.

5.4.1.1 *Self-reliance*

When talking about help-seeking for mental health problems, the majority of students shared their experiences dealing with stress or challenges with a strong emphasis on being independent and with reference to their individual coping strategies. Most of the students were able to name and explain the factors that they felt were generally helpful for people, in general, to improve and protect their mental health, including good social support from family and friends. However, when it came to dealing with their own specific problems or mental health concerns (in comparison to theoretical recommendations for others), the overwhelming majority of students discussed only self-reliant methods, particularly the importance of ‘looking on the bright side’ and thinking positively, to prevent problems in their daily lives from affecting them negatively.

I went through a lot, and I was able to now be a lot stronger for that. And I've been able to build up a good mindset... where, you know, I just surround myself with good people that I can trust... I just don't think negatively as much anymore. You know, you always think, and look on the bright side of things... (F, 16 years)

The theme of self-reliance was common and consistent across all students interviewed, reflecting a desire to demonstrate their independence through their own wellbeing.

I find it's doing things myself which helped me... by just doing things by myself I can overcome it. (M, 18 years)

The theme of self-reliance was related to the notion that a student's mental health was solely their own responsibility. In a previous study investigating self-reported barriers to

professional help-seeking among American college students, Czyz et al. (2013) reported that young people commonly reported a preference for managing their problems on their own, including using self-help strategies. Self-reliance for dealing with psychological distress has been suggested to be related to a range of underlying factors, such as lack of perceived need for help, lack of perceived resources such as social support, or broader concerns related to stigma (Hom, Stanley, & Joiner, 2015). In the context of an Australian culture, it has also been suggested that Australian social norms can exacerbate self-reliance as a barrier to help-seeking by endorsing the belief that people should just ‘get on with it’ (Gilchrist & Sullivan, 2006).

Previous research has highlighted the distinction between ‘self’ and ‘other’ referral among adolescents, and has demonstrated that young people are far more willing to refer another person to services than to seek help for themselves (Raviv, Sills, Raviv, & Wilansky, 2000). It was proposed by Raviv et al. (2000) that referring help for a friend may be a less threatening experience for adolescents than help-seeking for themselves, as it places the problem outside of their personal identity, along with any potential feelings of weakness, dependence or inferiority.

When prompted to share their coping strategies for dealing with hardship in their lives, most of the respondents spoke openly and with a sense of pride about their own ‘tried and tested’ methods. A number of solo coping strategies and activities for overcoming distress were described by students, which varied in nature but featured the common factor of coping alone. These included writing as a coping strategy (*“I would write down my feelings... it helps me to figure them out” - F, 16 years*), audio-recording themselves talking (*“I’ll record myself and I’ll talk and I’ll just vent and vent and vent. And then I’ll*

listen back and then I'll be like "that doesn't sound right" ...and then it's fixed" -F, 17 years) and problem-focussed strategies for addressing the source of stress (*"If it's at school then try and study hard... and if it's like got to do with bullying and stuff, just don't listen to it" - F, 13 years).*

Of the students interviewed, none mentioned talking to or seeking advice from anyone as a coping strategy (from any source including informal support from friends or family) until later prompted by the interviewer. These findings echoed previous research that reported that adolescents frequently display beliefs that they should be able to manage problems on their own rather than require help from others, and these ideas tend to be reinforced by others (Sawyer, Sawyer, et al., 2012). Indeed, Steinberg (1985) identified that a sense of increased autonomy in the adolescence stage indicates a movement towards independence and away from dependence on parents. Based on our analysis, it is necessary to seek ways to engage adolescents in help-seeking and service utilisation without compromising their sense of autonomy and independence.

5.4.1.2 Positive thinking

Most of the students interviewed strongly emphasised their ability to control their own emotions, using positive self-talk while ignoring negative thoughts. Many credited the broad approach of thinking in optimistic ways as their 'go-to' strategy for dealing with stress and strong negative emotions across varied situations, with an emphasis on individual control and personal responsibility for one's mental health. These beliefs about positive thinking, with a strong focus on avoidance of negative thoughts, appeared to further extend to students' approaches towards helping friends in need of support.

Positive self-talk... like even sometimes if you don't believe it, if you just repeat it to yourself then you start to believe it. (F, 16 years)

In the below extract, a student articulated his view that his positive or negative thoughts directly influence positive or negative outcomes in his life. In speaking about this, the student also expressed the difficulty he sometimes experienced trying to avoid negative thoughts when faced with disappointing circumstances (i.e. attaining poor academic grades):

Stay optimistic. So don't sort of... don't keep thinking that it's really bad, 'cause then it will get worse. But if you think it's gonna get better, it will get better. Yeah... don't think bad thoughts otherwise you're gonna get worse. I think it is hard. Like if you go bad at school, you might think "oh no, I'm rubbish, I can't do anything..." (M, 13 years)

Similarly, another student spoke about pressure they experienced with schoolwork, and the importance they placed on 'ignoring problems' and focusing on the positives in their lives:

Um a big challenge for me would probably be just like grades at school. Like 'cause I'm trying to work up to the job I want so trying to get good grades and trying to keep a healthy mind to be able to achieve those grades and like, ignore problems that come my way and really bad things like bullying and stuff, and just think of the good stuff. (F, 13 years)

The below extract depicts a student contemplating how they would best support a friend dealing with symptoms of mental illness:

I'd tell them to not fully focus on the negative things in life – focus on the positives. 'Cause if they focus on negatives it's just going to bring them down and put them into a mental state that won't be the best for them... But if you can get them off thinking bad things, that's just gonna make their life better, they're gonna be happier. (M, 14 years)

Some authors have advocated helping young people to adopt positive coping styles and optimistic thinking styles to reduce the risk of depressive symptoms (Sawyer, Pfeiffer, & Spence, 2009). Indeed, a previous qualitative study investigating adolescents' experiences of a school based mental health program reported that according to students, learning to turn negative thoughts into positive thoughts made them feel happier and more alert (Garmy et al., 2015). However, it has also been argued that cognitive-restructuring techniques based on Beck's approach were originally designed for treatment of depression, and are now being applied as a preventative strategy in school-based programs (Lindholm & Nelson, 2015). Researchers have argued that this form of treatment is designed to target and treat a specific health problem such as depression being experienced by the individual, rather than for prevention of mental illness among young people in general (Mrazek & Haggerty, 1994).

5.4.1.3 Doubt about significance of mental health problems

Most of the students interviewed conveyed feelings of illegitimacy and doubts about the significance of their problems, representing a further barrier to help-seeking. Several students mentioned comparisons of their personal or mental health concerns to large-scale or global issues, as a means of trivializing or dismissing their problems within the home or school environment. The concept of '*first world problems*' (a term defined by Oxford

dictionary (2016) as “a relatively trivial or minor problem or frustration, implying a contrast with serious problems such as those that may be experienced in the developing world”) was commonly referenced by young people across gender and age when discussing both internal and external barriers to help-seeking:

Sometimes people are like “oh yeah people in Africa are starving to death, it’s not that big of a deal” ... I mean, the situations are completely different and we still have our own issues and I know I have to deal with them. So why are they belittling my problems? And then people are like “first world problems”, it’s like “well sorry I was born here!” (F, 15 years)

In line with concerns expressed by other students regarding doubt of the significance of their problems in the context of sharing mental health problems with friends, another student spoke about feeling that seeking professional help was a ‘big thing’ that, on reflection of the limitations of resources and services, should be reserved for those that really need it. Of particular interest is that the student referred to adults requiring help as their point of contrast, suggesting a perception that adolescent problems are less severe or critical than those of adults.

I know I do this, like I put things in relation to the world... I think – “ah who cares, there’s wars going on here and I’m nothing compared to this”. I guess psychologists are ... a psychologist is a big thing, and there’s like you know, 7 billion people in the world, and there’s a lot of adults that also need help. (M, 16 years)

The trivialising of participants' own mental health problems, and those of their adolescent peers (as compared to those of adults) reflects ideas reported by Armstrong et al. (2000), who described young people as tending to view their problems as far less important than those of adults. These findings are concerning as, in line with the Health Belief Model, it has been noted that people must first perceive themselves as either being susceptible to, or having, a mental health condition in order to progress through the steps of help-seeking (O'Connor et al., 2014). Thus, this trivialising may reduce appropriate help-seeking behaviour. Indeed, previous studies have reported on the association between perceived need for help and mental health service utilisation. For example, one American study reported that 50% of students with a mental health problem *and* a perceived need for help received treatment, compared to 11% of those with a mental health problem who *did not* perceive that they had a problem (Eisenberg, Hunt, Speer, & Zivin, 2011). It is important for school-based mental health programs to address the confusion that young people may experience in differentiating between clinical mental health conditions and the normal stressors of everyday life.

5.4.2 Social influences

The second category of themes relates to interpersonal factors. The themes identified were peer acceptance, burdening others and informal help-seeking. When discussing mental health concerns and help-seeking from friends, all students interviewed placed some degree of emphasis on the importance of social factors and peer acceptance having an effect on their sense of identity and overall wellbeing.

5.4.2.1 *Peer acceptance*

Most students discussed concerns about acceptance or judgment from friends as the *primary* reason for avoidance of sharing their problems with peers directly, and with adults when they perceived that there was risk of information reaching their peers indirectly. This concern was emphasised in the context of the school environment, with reference to teachers and school counsellors. Developmentally, adolescence is a unique stage that places heightened importance on peer group acceptance, making adolescents' decisions highly reliant or susceptible to peer influence (Block et al., 2013). Further, as adolescents begin to integrate into society as adults, building and maintaining a unique identity is perceived to be a critical developmental task (Erikson, 1968). During interviews, this emphasis on peer group acceptance and personal identity was expressed through students' fears of being subjected to stigmatisation by peers for disclosing mental health issues. This concern was conveyed by students to relate to their reputation among the school community more broadly (rather than their close friends) through being labelled characteristics such as 'weak', 'crazy' or an 'attention-seeker'.

When people say 'mental health', everyone thinks like 'crazy person' blah blah blah, and that sort of thing... (F, 15 years)

I think some people would [hide mental illness from others], because you would be labelled as being weak and you know, or even an attention-seeker or something like that, because you're trying to make yourself better. (F, 16 years)

Other students expressed fears of more direct stigmatisation and discrimination through bullying as a deterrent to sharing mental health concerns with peers:

If some other people found out, they might laugh at them and that's why people might be scared to tell people. (M, 13 years)

Other students perceived that negative responses from friends could result in well-intentioned but ultimately unhelpful attempts at providing support, as illustrated in the following extract:

“What are my friends going to think about it?” That's the main thing. Like family, yeah they can understand because they see how you act at home, but your friends are like one of the closest things to you, and the main thing is 'how are my friends going to take it?' 'Cause it [mental health issue] might be because of them, or you never know... they might act differently around you and everything... and then some will try to help you... but suffocate you, to where you can't be around them, but you know they're trying to help you. So... it's difficult in ways.” (F, 17 years)

The student noted here the complicated dynamic that can arise where peers may act as both a social support and a source of stress. Indeed, adolescents have been reported to consider conflicts in interpersonal relationships to be a primary source of distress, and friends overreacting or minimising their problems can lead to withdrawal of help-seeking, even when they need it (Camara, Bacigalupe, & Padilla, 2014).

Some students described their experiences of having their own friends behave secretly towards them, illustrating how mental health concerns may be an avoided topic of conversation, even among close friends.

I'm her best friend but she hasn't told me [about her mental illness]..I think it's because she doesn't wanna hurt us or anything, or feel like you know, she's weak or anything. (F, 16 years)

Previous research has argued that while young people may want someone to confide in, it may be difficult to find someone with whom they feel comfortable, and even close friends can be viewed with distrust (Gilchrist & Sullivan, 2006). Despite some advantages of seeking help informally from friends including familiarity and accessibility (Griffiths, Crisp, Barney, & Reid, 2011), in relation to close friends, there are also complexities that arise related to self-disclosure and concerns about friends' reactions to sharing information. The conflict that can sometimes arise between the adolescents' needs for both peer acceptance and social support were illustrated through their experiences of either hiding their own mental health problems among friends, or conversely having friends behave in this way towards them.

5.4.2.2 Burdening others

Adolescents interviewed also expressed concerns about burdening both family members and friends with their problems, and often used this perspective to reiterate the importance of managing their problems independently wherever possible. Of concern is that several students spoke about experiencing significantly stressful events such as being a victim of bullying, yet expressed they would still avoid telling their parents because they were scared it would cause them to 'worry'. This is illustrated in the following extract, where a student spoke about an experience which was so emotionally distressing that they would not discuss it with anyone, from fear of 'breaking down' in front of them.

Um, sometimes if I got really bullied, and was really scared, I'd be too scared to tell my parents and bottle it all up... I'd be too scared 'cause then I'd have like a massive breakdown and then my parents would just worry... you're just too scared to talk about it. (F, 13 years)

Previous research has suggested that while parents are the strongest source of influence on adolescent decisions to seek help, parents are often less concerned about or unaware of the severity of emotional problems experienced by their adolescent children (Wahlin & Deane, 2012). Thus, the level of understanding and recognition of problems required to motivate parents to suggest their children access mental health services can be challenging for parents (Wu et al., 1999). This discrepancy between perceptions of parents and children has been suggested to be even greater in relation to internalised problems as opposed to externalised problems, due to parent perceptions that emotional issues are simply a normal aspect of growing up (Logan & King, 2001). In contrast, other research reports that parents are likely to overreact to situations when adolescents seek help from them (Camara et al., 2014), also decreasing likelihood of continued help-seeking behaviour from the adolescent's perspective.

Stemming from the theme of perceived illegitimacy of their problems, other students referred to concerns about burdening friends with their issues, when it was likely that they had their own issues to deal with.

So I don't really like talking about other people, and I feel like, especially my friends, when a lot of them they've got a lot of stuff, other stuff going on too, I don't feel like I should be dumping it on them as much. (F, 16 years)

While the theme reflected a reluctance to speak to others from fear or concern of burdening them with their problems, there appeared to be a different motivation for this concern towards friends when compared to family. A stronger sense of obligation or protection was communicated towards parents, but this was not conveyed as strongly in discussions relating to friends.

5.4.2.3 Informal help-seeking

When prompted by the interviewer to consider if they would seek help from family members, some respondents conveyed that if they felt it necessary, they would be much more likely to discuss their problems with family members than any professional help sources. Younger students in particular made reference to positive experiences of receiving support or advice from their parents, when asked whether they ever sought help from them. In some cases, reluctance to seek professional help was based on the view that doing so would signify that they were experiencing an ‘official’ struggle, when compared to the more informal alternative of talking to a parent:

I think that if you have someone who's not so official, like just a parent or whatever, who can just sort of relax and help you in a different way, it's better. (F, 18 years)

The positive effects of social support through informal help-seeking was also communicated with several students noting that sharing their problems with peers at times could operate as a buffer against negative outcomes. The importance of having good, supportive friendship networks at school was discussed, with some adolescents expressing their belief that while peers would likely act differently around them, at times social support from peers could have positive effects on their wellbeing.

You'd be like self-conscious of what other people would think, but it depends on who the people are. I think if you've got good friends, then it's possible that they might act a bit weird... but if you've got good friends they should be supportive about it. (F, 16 years)

This finding was in line with previous research that indicates young people are much more likely to seek help from friends and family rather than from professional services (Curtis, 2010). For example, DeLeo and Heller (2004) researched a sample of Australian school students, reporting that of those students who had engaged in deliberate self-harm, fewer than half had sought help, and of those that did, 81% had sought help from a friend, rather than a professional. Raviv et al. (2000) also reported that regardless of whether the help-seeking was self-referred or not, informal support was the preferred source over professional help. Griffiths et al. (2011) identified some advantages of informal help-seeking such as the informal source of help having previous knowledge of the person seeking help and the ease of accessibility. It has also been proposed that informal help-seeking can be helpful through support sources encouraging young people to later engage with professional mental health services (Labouliere, Kleinman, & Gould, 2015; Vogel, Wade, Wester, Larson, & Hackler, 2007). Vogel et al. (2007) reported that individuals who were prompted to seek help by a friend or relative or knew someone who had previously sought help displayed significantly more positive attitudes towards seeking mental health services than those who had not. In this way, students' positive perceptions of informal help-seeking may provide them with a preferred alternative to, or a potentially helpful 'first step' towards, seeking professional support for their mental health.

5.4.3 Institutional influences

This category of themes relates to factors that students perceived to influence their help-seeking behaviour outside of their personal and social worlds. The themes identified concerns about policies and confidentiality and negative perceptions of mental health services and professionals.

5.4.3.1 *Concerns about policies and confidentiality*

When referring specifically to seeking help from staff within in their own schools (i.e. teachers or school counsellors), most students made at least some reference to issues surrounding confidentiality and lack of trust representing a major deterrent to help-seeking among themselves and their peers.

Students expressed strong concerns that talking to a school staff member or counsellor could lead to their personal information and details ‘getting around the school’. The following extracts related to deterrents to talking to school counsellors at their own schools specifically:

Some people, they just don't wanna give other people that sort of information about their lives, in case it gets back to like, anyone else that doesn't like them, and then it gets spread around the school and then everyone knows, sort of thing. (F, 16 years)

It's just hard to tell people stuff, without that trust. (F, 16 years)

In addition to concerns about peers finding out, concerns about confidentiality within the school context also related to their parents being told about their personal problems. The

following student spoke about her experience being told to see a school counsellor by another teacher:

It took a lot of convincing, yeah. Because it was like “what if they find out? What if my mum finds out?” what if this happens? (F, 17 years)

Another student expressed an understanding that school counsellors had the right to contact parents regarding their child, but emphasised that such circumstances made it less appealing to speak about personal issues with a school counsellor, using the example of a friend’s experience:

One counsellor another friend went to... told her parents, and she didn’t want her parents to know. I mean, I guess they can, but I don’t think it helped at all. (F, 18 years)

Concerns about confidentiality as an important theme have been discussed in previous studies as particularly salient to young people, related to the importance of peer group acceptance among this age group (Sawyer, Sawyer, et al., 2012). Muir, Powell, and McDermott (2012) suggested that the reluctance of young people to seek help for mental health concerns was related to multiple factors, including embarrassment and associated confidentiality concerns.

5.4.3.2 Negative perceptions of mental health services and professionals

In contrast to discussions about seeking support informally from friends or family, which reflected some positive or neutral ideas communicated by a number of students, participants’ descriptions of help-seeking from trained mental health sources such as school counsellors, psychologists and psychiatrists were overwhelmingly focused on

negative ideas, founded either on unfavourable perceptions of the process or on their own firsthand experiences of help-seeking.

A general sense of scepticism about a mental health professional's ability to offer genuine assistance was conveyed by most of the students interviewed. This was expressed as a result of various perceived limitations or shortcomings of the process of talking to a school counsellor, doctor, psychologist or psychiatrist. Some of these perceived shortcomings included the discomfort associated with discussing their own distress in depth (*"because they just remind you of your problems, and how much you've messed up and stuff, whereas they should be focusing on like the positive side or like how to get better"* - F, 18 years) or the lack of capacity for professionals to relate effectively to young people with understanding rather than judgment (*"when I went to see psychologists, they're all sort of older and I just felt they are really out of touch with this generation, so you couldn't really say anything to them 'cause you felt like they were going to judge you"* - F, 15 years). In a qualitative study conducted by Muir et al. (2012) of young service-users aged 12-25, it was reported that young people felt it was critical for practitioners to possess the skills to work with young people, make them feel comfortable and relate to them in a non-judgemental manner and this was communicated by participants to be more important than the service having a 'youth-friendly' look. Several students in the current study shared their previous negative experiences talking to professionals and explained in detail why they had not believed the interaction to be helpful or beneficial for them (e.g. feeling as though they were not taken seriously or treated like a child, being offered unhelpful advice, feeling uncomfortable 'opening up' to a stranger, not feeling 'listened' to, not being offered enough guidance), as illustrated in the below extracts:

I just felt it was too awkward, I just didn't really know what to say. (F, 15 years)

It didn't help, it just made it worse. (F, 12 years)

I would sit there and talk, and I'd just kind of keep talking but then I'd stop and I'd expect them to try and say something and they're like "you're figuring it out yourself" like... they didn't even know what to do.... so I just stopped going. (F, 17 years)

Students also discussed the conditions or environments and associated anticipated discomfort involved with seeking help. The below extract demonstrates a student's concerns about the clinical nature of service delivery and aspects of the broader health setting as well as the therapist's demeanour that she found uncomfortable.

But it's hard when you get referred to someone that you've just met. I find it's really clinical, the way they go about it, and you can't really open up to them because like, they sit you down and they have like a checklist and they go "okay, do you self-harm?" and then like, "yes or no"... "do you have thoughts about suicide?" and it's like "I don't wanna talk about this stuff if you're just gonna ask me like that". It doesn't make you wanna tell the truth and that. It makes you feel really uncomfortable. (F, 15 years)

Lack of perceived benefits is a particularly important factor that was communicated by adolescents to potentially influence youth help-seeking behaviour, at times based on negative previous experience with mental health professionals. In line with the Health Belief Model, it is clear that lack of perceived benefits of help-seeking is a factor that can

theoretically be targeted and therefore modified through health promotion programs (Taylor-Rodgers & Batterham, 2014). Therefore, school-based mental health promotion programs should aim to address the evidence behind the benefits and success rates for mental health service treatment.

When discussing negative perceptions about mental health services and professionals, students also conveyed the sense of social distance they felt from adults, and the lack of effective communication between them. This was described as having an impact on their reluctance to seek help, as the below extract illustrates. Here, the student spoke about adults in a general way in the context of her perception of mental health professionals, conveying the belief that as young people they would be judged and dismissed as ‘moody teenagers’.

I think adults need to be a lot kinder to teenagers, because I find that the whole stigma about it is like “oh yeah teenagers are just moody, blah blah blah”, that sort of thing...I guess we need to learn how to break down the barriers and try to communicate with teenagers a bit better. (F, 15 years)

Difficulty approaching adults for help, in being unable to identify a trustworthy adult in their lives is a significant issue that has previously been reported as adolescent-specific in reviews of studies on help-seeking behaviour (Hom et al., 2015). This is a complex and important issue salient to adolescents in particular, due to the often pivotal role adults such as parents and teachers typically play in assisting adolescents to connect with mental health care services.

5.5 Conclusions

In order to understand the process of help-seeking from the young person's perspective, the current study aimed to explore adolescents' narratives and experiences related to their own mental health. The participants were students aged 12 to 18 years, involved in a school-based mental health program *MindMatters* at various levels of implementation, to take into account the context of the knowledge and experiences they have gained from the program. It is clear that although some positive perceptions of help-seeking were conveyed, the qualitative data typically emphasised deterrents to help-seeking across multiple levels of influence. While most students conveyed understanding on a conceptual basis that seeking help informally or formally is useful for mental wellbeing, almost every student interviewed also communicated that they would strongly avoid seeking help and sharing their problems, referencing complex and often interrelated themes including self-reliance, positive thinking, doubt about significance of problems, peer acceptance, burdening others, and informal help-seeking. In addition, they expressed themes related to concerns about confidentiality and negative perceptions of mental health services and professionals. In contrast to previous research examining barriers to help-seeking in young people, structural factors such as uncertainty about how and where to seek treatment, accessibility, lack of time or financial resources, lack of available resources, and inconvenience were not emphasised by students in the current study (Hom et al., 2015). This may reflect that among youth that have participated in a mental health program at their schools, such knowledge is more apparent, and thus their reluctance to seek help relates to personal beliefs, social factors and negative perceptions about the experience of help-seeking, rather than practical barriers.

Perceptions of professional help were discussed in a sceptical manner both on a social and institutional level, with most students conveying that they did not believe it likely that they would find a professional to whom they could relate. These findings reflect the worrying lack of trust that young people place in mental health professionals to help them with emotional difficulties (Leavey et al., 2011; Martínez-Hernández et al., 2014).

Previously it has been reported that a discrepancy exists between service providers (who have a tendency to view themselves as approachable) and the strongly-held concerns of young people regarding lack of trust and rapport with mental health professionals (Gilchrist & Sullivan, 2006). Our findings highlight the complexity of motivating help-seeking behaviour among adolescents, and the potential futility of focusing exclusively on individual knowledge and attitudes through education in order to influence behaviour.

It is important to note that the current study was not designed to explore students' negative perceptions about help-seeking or to focus on barriers to help-seeking specifically. The interview protocol aimed to generate general discussion among young people about how they perceived mental health concepts and the *MindMatters* program broadly. However, the students' overall tendency to emphasise barriers to help-seeking, communicated through predominantly negative language, serves to highlight the concern that even among young people who had been exposed to an educational program aimed to improve mental health related knowledge and attitudes, a clear reluctance to seek help for mental health problems may exist. In turn, these findings suggest that negative or reluctant attitudes towards help-seeking, and the emphasis on perceived barriers may be even more pronounced among young people who have not been given the opportunity to participate in a school-based mental health promotion program.

5.5.1 Limitations and future directions

Although some ideas and themes communicated about mental health in the context of the adolescent developmental stage are likely to be salient to adolescents in other developed countries, the characteristics of the current sample and limited generalisability to the broader global population of adolescents must be considered. Although the current study incorporated views of students from rural schools to reflect a maximum variability sampling approach, the methodology was not designed to compare views between groups. Secker et al. (1999) reported differences between attitudes of students in rural schools compared to metropolitan schools, with lower levels of tolerance and sympathy demonstrated by rural students; thus, more in-depth exploration and comparison of youth perspectives in rural areas may be necessary. Secondly, despite employing a non-clinical sample, several participants expressed previous personal interactions with counsellors, doctors and psychologists in relation to mental health concerns. This is unsurprising given the prevalence of mental health concerns among this young Australians, but nevertheless participants' perceptions may have been influenced by these previous experiences with mental health professionals. Finally, the Anglo-European Australian ethnicity of the students interviewed must also be considered. The background literature indicates lower levels of mental health problem identification (Verhulp et al., 2013), lower levels of service utilisation (Garland et al., 2005; Tiwari & Wang, 2008) and higher levels of depressive symptoms (Wickrama et al., 2005) among minority ethnic groups compared to dominant cultures in developed countries such as Australia, the United States and Canada. Therefore, it is relevant to note that all young people who self-selected to be interviewed for the present study were of Anglo-European descent, in contrast to the broad range of ethnic backgrounds represented among the wider *MindMatters* program participant group

that were invited to be interviewed. Accordingly, it is necessary for future research to focus on increasing diversity and incorporating views of vulnerable, disengaged or minority groups in Australia, particularly among Indigenous Australians and refugee populations in light of the cross-cultural challenges we currently face to providing quality mental health service delivery among these groups (Benson et al., 2010; Black, Walsh, & Taylor, 2011; Jorm et al., 2012).

5.5.2 Implications for practice

It is necessary to consider barriers to help-seeking within the context of the developmental stage of adolescence, and to endeavour to explore the distinct views and experiences of young people. Our findings suggest that perceived barriers to help-seeking among youth populations may be extremely resistant to change, due to the importance of social factors in motivating help-seeking. The themes that were salient to adolescents that participated in the current study highlighted issues around peer acceptance, stigma, impression management and negative perceptions of social responses from peers towards help-seeking. However, youth may feel more confident to seek help if a heavier emphasis on confidentiality is conveyed to students, so that they understand the service protocol as well as limitations to confidentiality prior to help-seeking.

As seen in our data, there was an emphasis on independence and autonomy which can be viewed as a positive quality for adolescents. Similarly, seeking help and support from friends and family is a well-established effective coping strategy for dealing with life stressors through supportive interactions and encouragement (Gulliver et al., 2010; Vogel et al., 2007). However, at acute levels of mental illness, self-reliant coping strategies and informal support may not be considered adequate, and additional consultation with a

mental health professional may be required. A recent study by Labouliere, Kleinman, et al. (2015) reported that extreme self-reliance was associated with reduced help-seeking, and the maintenance of clinical symptoms such as depressive symptoms and serious suicidal ideation among adolescents. Furthermore, for at-risk youth, extreme self-reliance was a predictor of suicidal ideation and depressive symptoms at follow-up two years later (Labouliere, Kleinman, et al., 2015). Thus, it could be helpful for school-based mental health programs such as *MindMatters* to educate students about the wide range of mental health problems and differing severity levels, in order to promote the skill and understanding among young people to help them differentiate between problems they can solve on their own, when to reach out to friends and family for support, and when to seek professional help. In order to counteract negative perceptions, health promotion and school-based programs should portray the experience of help-seeking in a positive light. O'Connor et al. (2014) propose that in improving youth perceptions of help-seeking, the benefits of mental health services and success rates of psychological treatment should be emphasised, as well as help-seeking behaviour being promoted by trusted individuals.

Students interviewed reflected a strong emphasis on positive thinking and self-talk, while ignoring negative thoughts as a method of dealing with mental health problems. While optimistic thinking styles have been reported to improve depressive symptoms among young people (Sawyer et al., 2009) and make students feel happier and more alert (Garmy et al., 2015), concern was raised about students perceiving the strategy to provide an alternative to other forms of help-seeking even if their situation was “really bad”, with some students expressing that they would respond to circumstances such as bully victimisation by simply “thinking of the good stuff”. While positive thinking approaches emphasises individual control and personal responsibility for one’s mental health, there is

concern that generalising approaches (such as cognitive-behavioural restructuring strategies) that were originally designed as a specific treatment for a mental illness rather than a universal prevention strategy may be inappropriate, ineffective or even detrimental for healthy populations (Lindholm & Nelson, 2015; Mrazek & Haggerty, 1994). This concern is greater when such techniques focusing on individual self-regulation are taken as a potentially problematic message (i.e. *positive thinking alone will prevent mental illness*), while neglecting the broader social and structural determinants of health (Ayo, 2012). A previous study investigating youth perspectives of a school mental health program reported that young people conveyed that the program focused too heavily on negative topics, and authors advocated for programs designed to be more positive and health-promoting to improve appropriateness and youth perceptions of such programs (Garmy et al., 2015). While teaching positive thinking may have positive outcomes for students (Patton et al., 2011), the emphasis on optimism as a broad solve-all approach also raises some concern, especially as students in the current study conveyed a sense of fear that allowing themselves to experience negative thoughts would result in their external situation getting worse. There may be important consequences for a developing young person's self-esteem and sense of self-efficacy if they are faced with a serious mental health condition or event which they were unable to resolve by simply thinking happy thoughts, especially when they believe that they should be able to always 'think themselves better'. Such beliefs may also influence help-seeking, as Yap, Wright, and Jorm (2011) reported that attributing a mental disorder to a personal weakness was associated with less intention to seek help, and less positive beliefs about professional help sources. The current findings highlight the importance of exercising caution when teaching CBT principles to a universal population and helping students to develop the

skills to differentiate between situations where reframing of negative thoughts may be helpful and appropriate, and more complex concerns when active problem-solving strategies or further help-seeking is necessary to address the situation. Venning et al. (2016) discuss the need review key elements for engaging adolescents in CBT-based school interventions including consideration of how are programs framed, where they are located, the level of intensity and platform (e.g. face-to-face, online) and who was involved in service design (e.g. professionals, caregivers, youth). Such guidelines provide a framework to review programs by, in order to encourage a more comprehensive, preventative and integrated model of service delivery and ensure that programs are as effective as possible.

When considering help-seeking behaviour, we need to go beyond a focus on individual knowledge and attitudes, and therefore on education, to also acknowledge the influence of broader social factors. Students in the current study reported concerns about anticipated negative reactions of friends and family if they disclosed that they were struggling with a mental health issue, further complicated by concerns about “burdening” others with their “first world problems”. While these are predominantly personal and social issues, there is potential for these problems to be ameliorated through the influence of broader institutional and community influences. The importance of social influence on help-seeking behaviour points to the need to foster safe school environments where discussion of mental health issues can occur openly, in order to increase the normalisation and acceptance among the school community of having mental health concerns and help-seeking. It should be noted that mental health promotion programs such as *MindMatters* already endeavour to improve collective values with ‘school ethos and environment’ being included in their implementation model (MindMatters, 2012). While social norms

including attitudes and beliefs about what those in one's social network would do in a similar situation can have a powerful influence on an individual's likelihood of seeking mental health treatment (Vogel et al., 2007), it remains a key challenge to program implementation to comprehensively modify a school culture and such approaches are yet to be evaluated extensively (Sawyer et al., 2010).

New strategies may provide opportunities for increased youth help-seeking, including technology and mobile phone applications used to provide information and online support for young people with mental health concerns. Based on our analysis, we suggest that approaches that allow young people to receive help without having to seek face-to-face contact with mental health services (such as computerised therapy or 'e-help') may be a useful step in tackling the challenge of stigma among youth with mental illness (Charman et al., 2010; Fleming et al., 2012). Due to strong concerns around stigma and peer acceptance in young people, it is likely that online mental health services, which are often self-directed, anonymous and non-confronting, may assist considerably in improving help-seeking and service utilisation outcomes (Fleming et al., 2012; Taylor-Rodgers & Batterham, 2014). A recent meta-analysis provided tentative evidence that online mental health promotion interventions can have a positive impact on adolescent mental health, but the relatively small number of studies to date, and considerable heterogeneity across content and delivery of interventions, make it difficult to be conclusive about the effectiveness of such programs at present (Clarke, Kuosmanen, & Barry, 2015). Such approaches have also been framed as a gateway service, encouraging young people to seek professional help (Collin et al., 2011). However, there is currently a paucity of evaluation research on online approaches to mental health care and effects on facilitation

of readiness for face-to-face services, and further studies are needed (Kauer, Mangan, & Sanci, 2014).

Our findings suggest that even among a sample of adolescents who had participated in a mental health promotion program in their schools, a strong reluctance to seek help for mental health problems may exist due to complex and interrelated personal, social and institutional influences. Involving young people in the development and improvement of mental health programs will help us to better understand such influences and their meaning to young people, in order to design mental health programs and services that are engaging, appropriate and relevant to young people. Youth participation, defined as “*a process where young people, as active citizens take part in, express views on, and have decision-making power about issues that affect them*” (Farthing, 2012, p. 73), is built on a respectful relationship between service providers and young people, with a genuine interest in the opinions and views of young people translating to improving their visibility to communities, stakeholders and policy makers and ensuring the relevance of interventions to this diverse group (Sawyer, Afifi, et al., 2012). Youth participation is beneficial for both the young people and the organisation involved, and is fundamental to mental health service design and delivery (Coates & Howe, 2016). Hart’s Ladder of Participation (Hart, 1992) is a model that has been used in developing youth participation projects, with the various ways to engage with youth audiences ordered by levels (or ‘rungs’) of participation. The ladder ranges from the lower levels which are not considered active youth participation but may provide a pathway to move towards engagement (e.g. *manipulation* and *tokenism*) up to higher levels that demonstrate how to fully integrate young people into decision making processes (e.g. *consultation* and *adult-initiated shared decisions*, with the highest ‘rung’ of the ladder of participation being

child-initiated shared decisions with adults). Hart's model reminds us to examine the power relations between child and adult and to strive for an equal partnership in decision making processes.

Young people's experiences of mental illness are different to those of adults, and young people are in the best position to judge what is "youth-friendly" and to judge whether the style, content and delivery of a service or program works for them and respects their opinions (James, 2007). Current arguments in mental health promotion suggest that the development of health in young people is not possible without inclusion, communicated through the old slogan "*nothing about us without us*" (Rowling & Martin, 2002). Our study highlights the negative perceptions of mental health services (and consequently help-seeking) held by a non-clinical sample of adolescents, pointing to the need for ongoing youth participation and collaboration to better understand youth perspectives. As health professionals, we must strive to combine our expertise with the needs and wishes of young people in order to develop a winning formula for youth mental health.

Acknowledgements

We would like to thank the students who participated in this study, MindMatters and Principals Australia and staff at the participating schools for their contribution to this research. Furthermore the authors would like to acknowledge the assistance of the second reviewer, Stacey McCallum of the University of Adelaide.

CHAPTER SIX: PAPER FOUR

Is knowledge enough? The relationship between knowledge about mental health and stigmatising attitudes among Australian female adolescents

PAPER SUBMITTED

Emmelin Teng, University of Adelaide

Anthony Venning, Flinders University

Helen Winefield, University of Adelaide

Shona Crabb, University of Adelaide

Statement of Authorship

Title of Paper	Is knowledge enough? The relationship between knowledge about mental health and stigmatising attitudes among Australian female adolescents
Publication Status	Submitted for Publication
Publication Details	Teng, E., Venning., A., Winefield, H., & Crabb, S. (2016). Is knowledge enough? The relationship between knowledge about mental health and stigmatising attitudes among Australian female adolescents. Submitted to the journal <i>School Mental Health</i> on 27 October 2016.

Principal Author

Name of Principal Author (Candidate)	Emmelin Teng		
Contribution to the Paper	Participant recruitment, background research informing survey development and measures chosen, performed statistical analysis, interpreted data, wrote manuscript and acted as the corresponding author.		
Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	25/11/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Anthony Venning		
Contribution to the Paper	Designed the framework for the questionnaire, assistance with study design, statistical analysis, interpretation and presentation of data, and editing and evaluating the manuscript.		
Signature		Date	18/11/2016

Name of Co-Author	Helen Winefield		
Contribution to the Paper	Supervised the development of work, provided suggestions for presentation of data and contributed to manuscript evaluation and editing.		
Signature		Date	22/11/2016

Name of Co-Author	Shona Crabb		
Contribution to the Paper	Contributed to ideas informing the study design and assisted in refining the research questions.		
Signature	(Signed by HW on behalf of Dr Crabb during her maternity leave)	Date	22/11/2016

6.1 Abstract

Young people carry mental health problems disproportionate to the size of their population, and rates of help-seeking are low. School mental health programs have been developed to address these issues, founded on an educational approach to target mental health literacy, and indirectly improve help-seeking. However, it has been suggested that knowledge does not necessarily predict health behaviour in young people. A cross-sectional study was conducted to explore whether knowledge about mental illness was related to attitudes towards mental illness and intentions to seek help in a sample of adolescent girls ($N=327$). Results indicated a weak negative relationship between knowledge about mental health and stigmatising attitudes about mental illness, but no relationship between knowledge about mental health and intentions to seek help for mental health problems. When mental health was categorised (e.g., optimal vs. poorer mental health), a negative relationship between knowledge about and stigmatising attitudes toward mental health was shown in those with poor mental health, but not for adolescents categorised as having moderate or optimal mental health. Findings suggest that while the traditional adage - more information on mental health equals better attitude to mental health - may be true for those with 'poorer' levels of mental health (e.g., high levels of psychological distress), it may not reduce stigma associated with mental illness or motivate positive health behaviour in adolescent girls with 'optimal' mental health (e.g., low or no levels of psychological distress).

Key words: Youth, adolescent, mental health, help-seeking, school psychology

6.2 Introduction

Very little is known about the relationship between an adolescent's knowledge of, and attitudes towards, mental health and illness across the full range of mental health states (i.e., those with and those without mental illness), given that help-seeking research often focuses exclusively on clinical or at-risk samples of young people (Block et al., 2013; Czyz et al., 2013; French et al., 2003; Hom et al., 2015; Michelmore, 2012). With this in mind, and since young people carry mental health problems disproportionate to the size of their population, despite having collectively good physical health (Burns & Birrell, 2014), the current study sought to examine the relationship between knowledge and attitudes around mental health and illness, to inform the direction of school-based mental health strategies.

In order to target the mental health of young people, school mental health programs have increased in popularity in recent years due to appreciation of the school setting as a key environment that can be used to promote mental health within young people (Evans et al., 2005). Jané-Llopis and Barry (2005) outline reasons for the school as a fundamental setting for mental health promotion, including the unparalleled access to children and adolescents, the time spent at school, the significance of influence on student development and behaviour and the connections to further protective factors, such as educational achievement and social support. School-based mental health programs are categorised into 3 distinct groups: indicated, targeted and universal programs based on the classification system originally proposed by Gordon (1983) for physical disease prevention (Wells et al., 2003). *Indicated programs* refer to those aimed at individuals who already display symptoms of mental health problems. *Targeted programs* refer to those aimed at individuals who are at increased risk of mental health problems. The above

two categories adopt a mental illness prevention approach. Conversely, *universal programs* refer to those programs aimed at improving the mental health of the whole-school population, by adopting a mental health promotion approach (Wells et al., 2003).

The concept of Mental Health Promotion (MHP), in a similar manner to physical health promotion, seeks to develop and foster an individual's competencies, resources, and strengths in order to reduce risk factors for mental health problems (Barry, 2007; Kobau et al., 2011; Patel et al., 2007). Rather than targeting only those with mental illness or those vulnerable or 'at-risk', MHP seeks to promote maintenance or elevation of positive mental health and protect against its loss, even in those with optimal mental health (Keyes et al., 2010). Since many mental disorders are characterised by either chronic or relapsing paths resulting in high personal and economic costs, it seems logical to include universal MHP approaches aimed at preventing new occurrences of mental disorders (Mrazek & Haggerty, 1994). School MHP programs are often founded on an educational approach, as insufficient or inaccurate knowledge about mental illness and its treatment has been argued to lead to stigmatising attitudes and behaviours that reduce the likelihood of help-seeking for mental health concerns (Corrigan et al., 2014). Mental health literacy is defined as knowledge and skills related to mental illness that aid in its recognition, management and prevention, including understanding of risks, causes and effective treatments, resources and services (Jorm, 2000). The construct extends beyond basic knowledge about mental health to mastery of skills related to care seeking and participation such as preventing disorders, mental illness recognition, help-seeking and skills to support others experiencing distress. Improving health-related knowledge is understood to be an important aspect of promoting behavioural change, and targeting knowledge is one of the central goals of public health campaigns.

Knowledge, however, does not necessarily predict behaviour, particularly among young people. Research that has investigated health-related behaviours among adolescents and young adults, including studies of youth smoking (Ganley & Rosario, 2013), safe sexual behaviours (Letamo, 2011) and sun tanning behaviours (Cokkinides et al., 2010), demonstrate that knowledge about the health effects of behaviours is not necessarily enough to determine a young person's subsequent actions. This theory applied to help-seeking behaviour suggests that merely being aware that seeking help and support from friends, family or a mental health professional can be beneficial for an individual's mental health may be inadequate to motivate help-seeking action. It is well known that adolescents are particularly resistant to seeking help for their mental health problems (O'Connor et al., 2014; Rickwood et al., 2007) with only one sixth of adolescents with a diagnosable mental disorder receiving treatment (Paternite, 2005). While low engagement with services may be reflective of a range of factors, including competing priorities and logistical barriers, reluctance to seek help may be one reason for the low proportion of young people who receive treatment (Rickwood et al., 2007). Help-seeking behaviour for mental health is not a straightforward process and involves a wide range of factors that can contribute to the likelihood of a young person following through with taking action. These can include the young person's understanding and appraisal of the problem, willingness and attitudes towards help-seeking, social influences including stigmatisation, as well as access to appropriate and youth-friendly services (Rickwood et al., 2007).

Theories of behaviour have been developed to explain factors that influence health behaviours of individuals. For example, the Health Belief Model (HBM) is based on core health beliefs and perceptions. These include 1) level of perceived susceptibility, 2) perceived degree of severity of the consequences resulting from the conditions, 3)

perceived benefits from taking a specific health action, 4) level of perceived physical, psychological financial and other barriers or costs related to initiating or continuing the behaviour and 5) positive health values or general health motivation (O'Connor et al., 2014). Another popular theory is the Theory of Planned Behaviour (TPB; Ajzen (1991)) which proposed that intentions to perform health behaviours can be predicted by 1) attitudes toward the behaviour, 2) subjective norms and 3) perceived behavioural control, and these intentions, in turn, predict performance of the behaviour itself. *Attitudes toward the behaviour* refers to the degree to which a person has a favourable or unfavorable evaluation of the behaviour, *subjective norms* refer to the perceived social pressure to perform or not to perform the behaviour, and *perceived behavioural control* refers to the perceived ease or difficulty of performing the behaviour. In line with the concept of subjective norms, stigma has been identified as a key barrier to young people seeking professional help for mental illness (Gulliver, Griffiths, & Christensen, 2010). It could be hypothesised that among youth populations, the effects of stigma on help-seeking behaviour could be particularly influential, due to the heightened importance of peer group acceptance during this developmental stage (Block, Gjesfjeld, & Greeno, 2013).

Adolescence is a time of major life change. Accordingly, it is a positive time associated with developmental opportunities and increased freedom, but it is also a time of heightened vulnerability to mental illness (WHO, 2001). The WHO (2001) defines *adolescence* as the period between the ages of 10 and 19 years. Despite this traditional age-bound definition, adolescence has been referred to as a fluid concept, in that it is a phase of life that is profoundly influenced by a combination of a wide range of social, environmental and cultural factors (Patel et al., 2007). Research has also suggested potential differences in help-seeking behaviours depending on level of mental health or

illness, and it has been proposed that adolescents experiencing severe mental health difficulties and most in need of support are also least likely to seek help for their problems. For example, Sawyer, Borojevic, et al. (2012) reported that adolescents exhibiting high symptoms of depression report that they would seek help less frequently than those with low symptoms of depression. Additionally, this 'high symptom' group were four times more likely than others to report that they would not seek help from *anybody*, including informal support from friends and family members in addition to professional help sources (Sawyer, Borojevic, et al., 2012). In addition, Keyes (2006) reported that more adolescents displayed *moderate* mental wellbeing (i.e., average emotional, psychological and social mental health) than those that were actually flourishing in life, and that moderate mental health is nearly as good a predictor of future mental illness as past mental illness (Keyes, 2010). As universal mental health programs target the whole school population, it is important to measure mental health knowledge and stigmatising attitudes among adolescents across the full range of mental health states. Consideration of both positive mental health (e.g. life satisfaction, emotional and psychological wellbeing) and negative symptoms of mental illness (e.g. depression, anxiety, stress) can form a more comprehensive representation of a young person's mental health state (Teng, Venning, Winefield, & Crabb, 2015).

6.2.1 The current study

An educational model of MHP focuses on improving knowledge about mental illness to improve health behaviour, improve attitudes about mental illness, build acceptance, and remove barriers to access services for adolescents (Wahl, Susin, Kaplan, Lax, & Zatina, 2011; Watson et al., 2004). However, as it is suggested that knowledge alone may not be

sufficient to change attitudes and facilitate help-seeking, the current study sought to explore the assumption that knowledge influences behaviour in adolescents, and examine the relationship between knowledge and attitudes about mental health / illness (particularly in relation to help-seeking). The specific research questions to be explored are: (1) What is the relationship between knowledge about mental health and stigmatising attitudes among adolescent females?, (2) What is the relationship between knowledge about mental health and intentions to seek help among adolescent females?, and (3) How do these relationships differ between adolescents categorised with poor, moderate or optimal mental health?

6.3 Method

6.3.1 Participants

A sample of female adolescents ($N=368$) from an all-girls private school in Adelaide, South Australia were recruited to participate in the current study. Participants recruited were aged from 12 to 18 years and were drawn from school grades 8 to 12. A response rate of 95% was obtained ($n=351$), however 24 participants were removed for reasons outlined in the data analysis section below, resulting in an age range of 13-17 ($M=14.71$, $SD=1.18$) across school year levels 8-11. The final sample size was 327. Table 7 illustrates the breakdown of the final sample of participants across school year levels.

Table 7. Breakdown of participants across school year levels

School Year Level (Approximate Age in Australia)	N (%)
Year 8 (13 years)	70 (21.4)
Year 9 (14 years)	79 (24.2)
Year 10 (15 years)	83 (25.4)

Year 11 (16 years)	95 (29.1)
Total	327 (100)

6.3.2 Measures

6.3.2.1 Knowledge and attitudes

The Knowledge Test (KT) (Watson et al., 2004) was utilised to determine an adolescent's level of knowledge about mental health. The KT consists of 13 true or false items (with the option of choosing "not sure") related to mental health knowledge and literacy, including causes, treatment and recovery from mental illness. A score of 1 represented a 'True' response, 2 represented a 'False' response and 3 represented a 'not sure' response. To calculate a total knowledge score, a dichotomous scoring system was utilised, where the total knowledge score was calculated by the sum of the total number of 'correct' items. Both 'incorrect' and 'not sure' responses were scored as 0, resulting in a total Knowledge score out of 13 being calculated for each case. The 'not sure' response option was included for the purpose of decreasing the likelihood of students guessing items they did not know the answer to (Watson et al., 2004).

The Revised Attribution Questionnaire (r-AQ) was used to determine an adolescent's stigmatising attitudes about mental illness. The r-AQ is a short form version of the Attribution Questionnaire (Corrigan et al., 2002) adapted for use with children (Watson et al., 2004). The first 8 items of the measure are based on the attribution and dangerousness models of mental illness stigma developed by Corrigan et al. (2002) which includes the constructs of responsibility, blame, anger, pity, help, dangerousness, fear, avoidance and segregation attitudes towards mental illness. Participants were asked to respond to the questionnaire items in reference to their attitudes towards a new student who they had

heard had a mental illness. The final question relates to attitudes towards help-seeking behaviour, identified as strongly related to stigma among adolescents (Watson et al., 2004). A Likert scale (1 = strongly disagree to 7 = strongly agree) was used. Of the 9 items in the scale, 5 questions were negatively loaded and 4 were positively loaded. Those that were negatively loaded on the scale were then reverse scored for the purpose of consistency for the calculation of total attitude scores (where higher scores indicated more stigmatising attitudes). To calculate a total attitude score, all item scores were added together after reverse scoring. The highest possible score for the total attitude score was 63, lowest possible was 9. Actual scores obtained ranged from 9 to 40. The Cronbach alpha coefficient for the current sample was 0.59.

6.3.2.2 *Mental health states*

The Complete State Model of Mental Health (CSM) (Keyes & Lopez, 2002) was used to categorize participants into one of four mental health groups: flourishing, languishing, struggling and floundering. In order to categorise adolescents into CSM states, the authors applied the approach previously utilised in Venning et al., (2013), adapted from Keyes (2002). The statistical diagnostic criteria incorporated scores on emotional wellbeing, positive functioning and mental illness and compared them against pre-determined cut-off scores (using median splits) based on the relative proportion of positive and negative symptoms reported for each individual. Participants were categorised as *flourishing* in life if they reported low levels of mental illness symptoms combined with high levels of emotional wellbeing and positive functioning. They were categorised as *languishing* if they reported low levels of mental illness (e.g., depression, anxiety and stress) and low levels of emotional wellbeing and positive functioning. They were categorised as *struggling* if they reported high levels on some (not all) symptoms of mental illness, and

relatively high levels of emotional wellbeing and positive functioning. Individuals were categorised as *floundering* if they reported high levels on all symptoms of mental illness, in addition to low levels of emotional wellbeing and positive functioning. The measures used to do this were:

The Satisfaction with Life Scale (SWLS; Diener et al., 1985). The SWLS consists of 5 items scored on a 7-point Likert scale from one '*strongly disagree*' to seven '*strongly agree*', respondents indicate the extent to which they agree with each of the five questions: scores between 5-14 indicate dissatisfaction, 15-19 slight dissatisfaction, 21-25 slight satisfaction, and 26-35 satisfaction with life (a score of 20 is neutral). The SWLS has shown good internal consistency (.80 to .89) and exhibited good convergent and discriminant validity (for a review, see Pavot and Diener (1993)). The Cronbach alpha in the current sample was .90.

The Psychological Well-being Scale (PWBS; Ryff, 1989). The PWBS consists of 18 items across six subscales (self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, and positive relations with others) to provide an indication of how much an individual perceives himself or herself as thriving in life. Scored on a 6-point Likert scale from '*strongly disagree*' to '*strongly agree*', the three item version was used to reduce administration time and has shown excellent internal consistency in other non-clinical samples (.81, Waterman et al. (2010)), and exhibited good convergent and discriminant validity (for reviews see Ryff, 1989, and Ryff & Keyes, 1995). The Cronbach alpha in the current sample was .81.

The Social Well-being Scale (SWBS; Keyes, 1998). The SWBS consists of 15 items across five subscales (social acceptance, social actualization, social contribution, social

coherence, and social integration) to provide an indication of how much an individual perceives himself or herself as thriving in their personal life. Scored on a 6-point Likert scale from 'strongly disagree' to 'strongly agree', the three item version was used to reduce administration time and has shown excellent internal consistency in other non-clinical samples (.81, Keyes (1998)). The Cronbach alpha in the current sample was .84.

The Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 consists of 21 items across three subscales to measure the negative emotional states of depression, anxiety, and stress). Scored on a 4-point Likert scale (scores 0-3), the DASS-21 has demonstrated good psychometric properties (Henry & Crawford, 2005; Lovibond & Lovibond, 1995). The Cronbach alphas coefficient for the current sample was .91 (depression), .83 (anxiety), and .85 (stress).

6.3.3 Procedure

School staff first initiated contact with the School of Psychology at the University of Adelaide, in order to measure the wellbeing of their students. The author then approached the school via email and a meeting with the principal and school counsellor was held to discuss the opportunity to measure mental health knowledge and stigmatising attitudes about mental illness among students. This initial meeting outlined the rationale for the present study and secured verbal agreement with school staff. Ethics approval was attained from the University Human Research Ethics Subcommittee at the University of Adelaide. School staff were then provided with a consent form and parent information sheet, and parental consent was sought prior to commencing data collection. Parents and students were notified that participation was voluntary and that responses would remain anonymous. Letters regarding the study were distributed and collected by classroom

teachers. Students who returned completed consent forms were eligible to participate in the study.

The online survey was created using the survey development software program Survey Monkey. Data were collected during school hours on computers provided by the school, and students were sent a link to the survey via their school email account. Students who did not have consent or chose not to participate ($n=36$) were given the opportunity to complete their own school work during the time other students completed the online survey. In order to assist students with any potential issues understanding questions, and to ensure confidentiality of responses among students, teachers supervised the data collection. The portion of the questionnaire for the current study consisted of 22 questions and took approximately 10 minutes for students to complete. The data collected for the current study were part of a larger research study of whole school measurement of wellbeing, strengths and bullying in high school students, and additional demographic variables collected for the larger study were also utilised in the current study.

6.3.4 Data analysis

Data were analysed using SPSS version 20 (IBM Corporation, 2011). Incomplete responses were removed from the data set, in addition to responses from 12-year-olds ($n=1$) and 18-year-olds ($n=6$) due to very small numbers that would be insufficient to make representative conclusions about these age groups. Year 12 students ($n=12$) were also removed for the same reason. Descriptive statistics and Pearson product-moment correlations were used to assess the relationships between variables. An alpha level of 0.5 was used to indicate significance and effect sizes were classified as weak ($r=.10$), moderate ($r=.3$) and strong ($r=.5$) based on Cohen (1992).

6.4 Results

6.4.1 Descriptive statistics

6.4.1.1 Knowledge about Mental Health (KT)

To understand the students' baseline level of knowledge about mental health, frequencies for each KT item were examined. Results indicated that students displayed highest levels of knowledge on *items 1, 10 and 13*, which collectively acknowledge that mental illness is serious and complex, and that individuals may require significant support to treat their condition but that they are not necessarily severely impaired in their functioning. The highest proportion of students answered *items 2, 3, and 11* incorrectly, indicating a lack of understanding of the biological basis of mental illness and influence of genetic factors on mental health. The highest rates of 'unsure' responses were recorded for *items 9 and 12*, indicating general levels of uncertainty regarding treatment for psychological problems amongst the sample. Table 8 indicates the numbers and percentages within the sample for 'correct', 'unsure' and 'incorrect' responses to each item in the Knowledge About Mental Health Scale, and mean and standard deviation for the total scores.

Table 8. Means and standard deviations for knowledge about mental health scale (Knowledge Test; Watson et al, 2004).

Knowledge About Mental Health Scale (KT)	Correct	Unsure	Incorrect
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
<i>Depression is the same thing as being sad. (F)</i>	269 (82.3)	30 (9.2)	28 (8.6)
<i>Mental illness is like other diseases because a person who has it has symptoms that a doctor can diagnose. (T)</i>	113 (34.6)	61 (18.7)	152 (46.5)
<i>Individuals who have a family member with a mental illness are more likely to have a mental illness themselves. (T)</i>	96 (29.4)	88 (26.9)	143 (43.7)

<i>The brain of a healthy person works the same as that of a mentally ill person. (F)</i>	219 (67)	72 (22)	36 (11)
<i>A person who does not get treatment for depression may feel better after a while, but there may be some long-lasting effects. (T)</i>	178 (54.4)	70 (21.4)	78(23.9)
<i>How bad a person’s mental illness is depends on many things, including his or her genes and family environment. (T)</i>	228 (69.7)	61 (18.7)	38(11.6)
<i>A person uses his or her brain to learn, but the heart controls a person’s feelings. (F)</i>	144 (44)	68 (20.8)	114 (34.9)
<i>Most people with mental illness can do normal things like go to school or work at a job. (T)</i>	209 (63.9)	57 (17.4)	60 (18.3)
<i>Treating mental illness can change the way the brain works. (T).</i>	185 (56.6)	102 (31.2)	39 (11.9)
<i>People with depression don’t need to see a doctor – they just get over it. (F)</i>	279 (85.3)	27 (8.3)	21 (6.4)
<i>Depression is a disease. (T)</i>	128 (39.1)	65 (19.9)	133 (40.7)
<i>There are not treatments that work for most mental illnesses. (F)</i>	177 (54.1)	98 (30)	51 (15.6)
<i>Students and other people who have a mental illness can’t learn. (F).</i>	276 (84.4)	38 (11.6)	13(4)
Total Knowledge Score	Mean	SD	
	7.65	2.3	

6.4.1.2 Stigmatising Attitudes about Mental Illness (r-AQ)

Stigmatising attitudes about mental illness were compared by examining means and standard deviations, and summary scores for each item of the r-AQ. Results indicated that students displayed similar levels of stigma across items, but the highest levels of stigmatising attitudes were displayed in relation to attitudes towards help-seeking behaviour for themselves (*item 9*) as opposed to general attitudes towards others with a mental illness (*all other items*). Feeling sorry for a student with a mental illness (*item 2*) was the second highest stigmatising attitude, and institutionalisation of mentally ill people (*item 3*) demonstrated the lowest level of stigmatising attitude amongst the sample. Table 9 indicates the mean and standard deviations for the total sample for the attitudes about

mental illness measure, where higher scores indicate more stigmatising attitudes for all items.

Table 9. Means and standard deviations for stigmatising attitudes about mental illness scale (r-AQ, Corrigan et al., 2002, 2003).

Stigmatising Attitudes About Mental Illness Scale (r-AQ)	Mean (SD)
<i>The new student is not dangerous</i>	2.7 (1.6)
<i>I feel sorry for the new student</i>	3.0 (1.5)
<i>The new student should be locked in a mental hospital</i>	1.6 (1.1)
<i>I will try to stay away from the new student</i>	2.4 (1.5)
<i>It is not the student's fault he or she has a mental illness</i>	2.5 (1.7)
<i>The new student makes me angry</i>	2.0 (1.4)
<i>I would help the new student</i>	2.5 (1.3)
<i>I am scared of the new student</i>	2.4 (1.5)
<i>If I thought I had a mental illness, I would talk to my parents about taking me to a doctor or counsellor</i>	3.2 (1.9)
Total Attitude Score	22.13 (6.6)

6.4.2 Research Questions

6.4.2.1 Relationship between mental health knowledge and stigmatising attitudes

To explore the first research question, the relationship between knowledge about mental health and stigmatising attitudes (total scores) was investigated using a Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. There was a significant weak negative correlation between the variables $r=-0.16$, $n=327$, $p=.004$, with greater knowledge about mental health associated with lower levels of stigmatising attitudes towards others with mental illness.

6.4.2.2 Relationship between mental health knowledge and help-seeking intentions

To explore the second research question, a second Pearson product-moment correlation was conducted to investigate the relationship between knowledge about mental health and help-seeking intentions specifically, using Item 9 from the Attitudes about Mental Illness scale (“*If I thought I had a mental illness, I would talk to my parents about taking me to a doctor or counsellor*”). This relationship was explored because results indicated that the highest levels of stigmatising attitudes were displayed in regards to this item. There was no significant correlation between the variables ($r=-.029, p=0.608$), indicating a lack of relationship between knowledge about mental health and specific help-seeking intentions.

6.4.2.3 Comparison of relationship between mental health knowledge and stigmatising attitudes between mental health groups

To explore the third research question, Pearson product-moment correlations were conducted to compare the strength of the relationship between mental health knowledge and stigmatising attitudes according to mental health states, with cases split by CSM group (Keyes & Lopez, 2002). The floundering group was the only group where a significant negative relationship was evident between mental health knowledge and stigmatising attitudes. Table 10 indicates mental health knowledge, stigmatising attitudes, and correlation coefficients for the relationship between knowledge and attitudes by mental health group (flourishing, languishing, struggling and floundering).

Table 10. Mental health knowledge, stigmatising attitudes and correlation coefficients for Pearson correlations by mental health state (CSM Group)

Mental health state (CSM Group)	Prevalence (%)	Knowledge About Mental Health (Mean)	Stigmatising Attitudes About Mental Illness (Mean)	Relationship between mental health knowledge and stigmatising attitudes (<i>r</i>-value)
Flourishing	32.7%	7.29	21.25	-.141
Languishing	6.7%	8.27	21.00	-.309
Struggling	53.2%	7.72	23.00	-.114
Floundering	7.3%	8.25	20.86	-.651*

*Correlation is significant at the 0.05 level (2-tailed).

6.5 Discussion

To test the traditional assumption that knowledge influences behaviour, a cross-sectional study was conducted to explore whether knowledge about mental illness was related to attitudes towards mental illness and intentions to seek help in a sample of adolescent girls ($N=327$). Results indicated that a weak negative relationship existed between knowledge about mental health and stigmatising attitudes about mental illness, but no relationship between knowledge about mental health and intentions to seek help for mental health problems was found. When mental health was categorised (e.g., optimal vs. poorer mental health), a significant relationship between knowledge about, and attitudes toward, mental health was shown in those with poor mental health (floundering), but not for adolescents categorised as having moderate or good mental health (flourishing, languishing and struggling). Findings suggest that while the traditional adage - more information on mental health equals better attitude to mental health - may be true for those with 'poorer' levels of mental health (e.g., high levels of psychological distress), it may not reduce stigma associated with mental illness or motivate positive health behaviour in adolescent girls with optimal mental health (e.g., low or no levels of psychological distress).

The significant relationship observed between knowledge and attitudes in the ‘floundering’ mental health group may have been influenced by the young person previously experiencing mental illness symptoms and learning about mental illness and/or seeking help as a result. For example, a high symptomology group may have greater knowledge and lower stigmatising attitudes about mental illness, and potentially more positive attitudes towards help-seeking because their experience of psychological distress motivates them to get better. Comparatively, perhaps adolescents without current symptoms of mental illness had not yet felt the need to identify symptoms or take steps to improve their mental health, and therefore may have been preoccupied attending to other priorities besides their mental health, such as socialising, schoolwork, part-time jobs and extracurricular activities. Lower average knowledge levels were noted in the groups that indicated the presence of positive mental health (struggling and flourishing) compared to those without, suggesting that gaining an understanding of mental health may become more relevant to youth in the absence of other protective factors (e.g. social wellbeing). Mental health literacy has been associated with recognition and management of mental health problems, reduction of self-stigma related to mental illness, and increase in likelihood of seeking help from professional services for treatment (Goldney, Fisher, & Wilson, 2001; Jorm, 2000). However, the current findings suggest the delivery of knowledge and information about mental illness alone may be insufficient to motivate health behaviour change in adolescent females, particularly among those with moderate or optimal mental health.

A challenge of measuring help-seeking behaviour among a general sample of youth is that doing so through clear behavioural outcomes (e.g. contact with a mental health service, recorded visits to a school counsellor) requires a problem to emerge that is

deemed significant enough by the young person to warrant seeking help in the first place. However, theoretical models designed to predict health behaviour such as the Theory of Planned Behaviour (Ajzen, 1991) have proposed intentions to be proximal determinants of behaviour (Allom, Mullan, & Sebastian, 2013; Wiedemann, Schüz, Sniehotta, Scholz, & Schwarzer, 2009). The theory argues that the stronger the individual's *intention* to engage in a behaviour, the more likely it will be that the individual will perform the behaviour (Ajzen, 1991). It has also been recognised that people often fail to act on their intentions (Wiedemann et al., 2009) resulting in an 'intention-behaviour gap': an inconsistency between forming a behavioural intention and carrying out the intended behaviour (Allom et al., 2013). Thus, it should also be considered that examining *intentions* to seek help among adolescents in the current study may reflect a somewhat overestimated indication of adolescents who would actually take action, suggesting that the lack of relationship between knowledge and help-seeking intentions in the current study is even more concerning. Consistent with the potential for an intention-behaviour gap in youth mental health help-seeking, previous studies have demonstrated that programs designed to improve help-seeking have demonstrated effects on the intention to seek help, but this intention did not translate to significant improvements in actual behaviour (Gulliver et al., 2012; Muehlenkamp, Claes, Havertape, & Plener, 2012). For example, Gulliver et al. (2012) reported that while mental health literacy significantly improved *intention* to seek help, no effect was found for help-seeking behaviours. Similarly, Muehlenkamp et al. (2012) reported that a school-based program aimed at addressing self-harm in adolescents resulted in improved attitudes and intentions to seek help for self-harm, yet no significant changes in actual help-seeking for self-harming.

Nevertheless, further research is warranted to explore more detailed measurement of help-seeking attitudes, intention and behaviour in young people.

6.5.1 Implications for practice: Is knowledge enough?

Findings of the present study suggest that knowledge and attitudes may not be as strongly linked as conventional wisdom might assume. If intention to seek help (as discussed above) reflects an underestimated proportion of adolescents who would actually seek help, then the difference between *learning* about mental health and *doing something* about one's mental health may be an even larger gap to bridge. These results align in some aspects with previous literature which draws attention to potential limitations of mental health programs aimed at youth, which have a focus aimed purely at knowledge and education. Reavley, McCann, Cvetkovski, and Jorm (2014) employed a cluster randomised trial to examine the effects of a mental health literacy intervention to facilitate help-seeking and reduce psychological distress and alcohol misuse among university students in Australia. They reported no effects of the intervention on psychological distress or alcohol use, concluding that although education and awareness may have an influence on knowledge and mental health literacy, to achieve changes in psychological distress, more intensive and personalised interventions would be necessary. Moreover, a recent Australian study of a large-scale three-year universal school-based intervention designed to reduce depressive symptoms among adolescents reported that over a five-year period, compared to adolescents who did not receive the intervention, there were no significant effects in improving risk factors or reducing levels of depressive symptoms, and no evidence that the intervention enhanced individual protective factors including optimistic thinking, interpersonal competence, problem solving/coping style or

social support (Sawyer et al., 2010). Overall, the benefits of psychological and educational interventions adapted to school populations have been reported to often result in weak and short-term effects (Merry et al., 2012).

Consistent with previous literature, the current results allude to the limits of mental health education and raise questions about the role of universal-school based mental health programs aimed specifically at increasing knowledge and improving attitudes towards help-seeking among adolescents. While such findings may seem disheartening, it should also be considered that mental health is influenced by a range of social, cultural and biological factors. Spence and Shortt (2007) propose that when examining ways to effectively prevent depression in young people, we must draw more upon socioecological models and consider ways of influencing the environment surrounding the young person (by increasing protective factors and reducing risk factors), rather than an exclusive focus on the individual. Most school-based interventions targeting youth mental health are based on approaches designed to target and treat a specific health problem that is experienced by an individual. For example, the majority of school-based mental health programs to date have been based on Beck's cognitive behavioural therapy designed to treat depression (Garmy et al., 2015). These primarily individual treatment techniques are then applied to population health models for prevention of mental illness and promotion of mental health across populations (Mrazek & Haggerty, 1994). However, such approaches place the emphasis on individual self-regulation and health behaviour and thus can neglect the broader social and structural determinants of health (Ayo, 2012). Interventions and programs that overvalue self-sufficiency and individualistic notions may contribute to an extreme self-reliance and dangerous form of perceived invincibility,

because adolescents find it difficult to recognise the point at which they need to seek help from others (Labouliere, Kleinman, et al., 2015).

In order to extend beyond a focus on individual knowledge and attitudes through education, the influence of the social context and group effects on help-seeking behaviour should be recognised. When considering models of health behaviour, the HBM model acknowledges the influence of demographic and environmental factors such as age, social support, knowledge and education, but places the emphasis of change in health on individual beliefs, knowledge and skill development aimed at improving overall health outcomes. From a socioecological perspective, external factors such as social or community factors are largely overlooked. In contrast, the TPB model allows for consideration of the influence of social factors (and pressures) on an individual's intentions to perform a health behaviour, such as help-seeking (Ajzen, 1991). Previous studies have demonstrated the importance of the social group in influencing a young person's beliefs and behaviours in relation to mental health help-seeking. Vogel et al. (2007) explored the influence of social network on help-seeking and reported that college students who had been prompted to seek help by a friend or relative, or knew someone who had previously sought help, displayed significantly more positive attitudes towards seeking mental health services than those who did not. Similarly, Wahlin and Deane (2012) found that 94% of young people who had accessed help from a mental health service reported that someone in their social network had influenced their decision. This points to the need to foster safe environments within the school where discussion of mental health issues can occur openly, in order to increase the normalisation of having mental health concerns, seeking help and engaging in treatment. Further, programs that utilise peers as a source for affecting stigma change through youth-led interventions may

represent a meaningful direction for future research and practice to explore and evaluate (Bulanda, Bruhn, Byro-Johnson, & Zentmyer, 2014; Corrigan et al., 2007). Universal programs do acknowledge broader social factors on mental health behaviours and therefore aim to influence the school's culture to create an environment that fosters the development of positive mental health. However, at present, it remains difficult to ascertain whether activities or approaches employed by universal mental health interventions in order to create a "whole school climate" supportive of student wellbeing (e.g. positive relationships and student participation) are robust enough to create clear, long-term changes to school climate and students' perceptions of this (Sawyer et al., 2010; Suldo, McMahan, Chappel, & Loker, 2012). Future research should explore the effects (and potential limitations) of education in motivating long-term changes in attitudes towards help-seeking in young people, and explore what specific topics, sources or methods of delivery are most effective in shifting attitudes and behaviour in a positive direction to support mental health.

6.5.2 Limitations

The current study contained several limitations. Firstly, this study examined knowledge and attitudes about mental health among female adolescents only, due to being conducted with a convenience sample of students at an all-girls school. Gender is known to be one of the most consistent predictors of help-seeking behaviour: women generally hold much more positive attitudes than men regarding seeking professional help for mental health (Vogel et al., 2007) and rates of help-seeking have been reported to increase with age for adolescent females and decrease for adolescent males (Mariu, Merry, Robinson, & Watson, 2011). In light of recognised gender differences, further research is needed to

examine the relationship between knowledge about mental illness and stigmatising attitudes in young males in addition to females. Similarly, results were drawn from only one school and therefore may not be generalisable to the broader population of adolescent girls. However, despite being conducted only at one school, the high response rate (95%) likely provided a sound representation of the range of mental health states that exist within a school.

Results must be interpreted with caution, particularly in relation to the measures employed. In particular, the single item measure of help-seeking behaviour measured intention to seek help, rather than actual help-seeking behaviour, for which there are currently no psychometric validated measures (Wei et al., 2015). Further, it was noted that the wording of this single item in the r-AQ referred to parental involvement and therefore may not have reflected an accurate estimation of intention to help-seek among young people but rather to involve parents in the help-seeking process. However, at present, there are significant gaps in the available scales for measuring mental health literacy (including knowledge, stigma and help-seeking), particularly among youth (Wei et al., 2015), pointing to a need for further development and standardisation of measures to improve the quality of future research in the area. The additional analysis utilising this single-item measure (Item 9 of the r-AQ) was conducted due to the finding that this item reflected the most stigmatising attitudes among adolescents. It was noted retrospectively that this item reflected intention to engage in personal help-seeking behaviour, in contrast to attitudes towards others with mental illness, and thus it was deemed important to conduct exploratory analysis of this item separately due to relevance for educational interventions with a focus on individual capacity for students to actively promote their own mental health. The Knowledge Test utilised consisted of 13 true or false items (with

the option of choosing ‘not sure’) related to mental health knowledge and literacy, including causes, treatment and recovery from mental illness. The measure may also limit the findings, as forced-choice measures have been criticized for testing surface-level knowledge – students may be able to guess some answers correctly without possessing knowledge that relates to real-world situations (Labouliere, Tarquini, Totura, Kutash, & Karver, 2015). While the ‘not sure’ response option was included for the purpose of decreasing the likelihood of students guessing items they did not know the answer to (Watson et al., 2004), future research could include free-recall questions to comprehensively evaluate levels of knowledge about mental health among youth.

6.6 Conclusion

Improving mental health and preventing mental illness in adolescents remains a complex challenge for researchers and practitioners alike. The current study indicated that knowledge about mental health was weakly related to stigmatising attitudes towards sufferers of mental illness (i.e., more knowledge = more understanding towards others with mental illness), but no relationship between knowledge about mental health and intentions to seek help for mental health problems. Future research and practice should explore the effects (and potential limitations) of mental health education to motivate sustainable changes in attitudes towards help-seeking in adolescents, and explore what content and methods of delivery are most effective in shifting attitudes and behaviour in a positive direction to support mental health.

Acknowledgements

The authors wish to thank the students who took part in the study and the school staff that made data collection possible.

CHAPTER SEVEN: DISCUSSION AND CONCLUSIONS

7.1 Overview

The aim of the current thesis was to examine existing approaches and explore new challenges to the measurement and promotion of mental health in young people. Three separate studies were conducted, resulting in the four journal articles that are central to this thesis. Data were collected across samples of children, adolescents and young adults to reflect current definitions of ‘young people’ within the literature. The work reported in this thesis examined the measurement and conceptualisation of mental health among emerging adults, explored the perspectives of adolescents on mental health concepts, attitudes and behaviours and investigated the link between knowledge about mental health and stigmatising attitudes in a youth sample. Findings from the journal articles produced suggest that there are complex aspects relevant to youth mental health in Australia that remain unaddressed by current approaches to mental health measurement and promotion. Hence, the current thesis adds to the field of knowledge on youth mental health, and offers new pathways for further exploration that are relevant to the current generation of Millennials and potentially the mental health of generations thereafter.

This final chapter presents a critical discussion of the findings of this thesis. First, the original contributions from each individual study are presented. Next, a meta-inference of the combined studies and practical implications for youth mental health policy and practice are considered. The combined strengths and limitations of the present thesis are then discussed. Finally, future research directions and a concluding statement are presented.

7.2 *Original contributions*

Paper One reported the results of a preliminary exploration into the differences between three measurement approaches to mental health and illness in an Australian sample of emerging adults (aged 23 to 27 years): an illness perspective, a wellbeing perspective and a dual continua perspective. The results illustrated discrepancies between the three approaches, which each resulted in very different depictions of the collective mental health of a group of young people and demonstrated the importance of considering young people with moderate mental health. It was reported that the same individuals can be classified in various ways depending on the measurement approach used. For example, of those that were classified as '*not satisfied with life*' on the Satisfaction With Life Scale (SWLS), 16.1% were *flourishing in life* according to Complete State Model of Mental Health (CSM) criteria, which are contradictory labels. Similarly, of those classified as a '*case*' for depression, anxiety or stress on the General Health Questionnaire (GHQ), a significant 43.5% could be classified as *flourishing* according the CSM criteria. There was a strong negative correlation between the total GHQ scores and SWLS total scores ($r = -.573$, $n = 117$, $p < .05$ level). However, it was noted that a significant proportion of cases fall outside of a single dimension model, and these *languishing* and *struggling* categories of moderate mental health present a significant challenge to gaining a comprehensive and informative picture of groups of emerging adults with a single dimension measurement approach. *Paper One* was, to the authors' knowledge, the first comparison between measures of a positive mental health, a mental illness and a combined (dual continua) mental health approach, conducted within an Australian sample. The discrepancies observed between measurement approaches serve to emphasise the need for further exploration into the varying representations that can be constructed in both community

and clinical samples, dependent on measurement approach. If combined measures are to become more commonly considered when assessing the baseline mental wellbeing of groups and individuals, it will be necessary for future research to develop and standardise these measures for application within different settings and populations. From a clinical perspective, *Paper One* emphasised the need to be wary of the weight we place on standardised measures of young adult psychological functioning, and underscored the importance of using clinical judgement in addition to questionnaires and survey instruments. From a population health perspective, findings held relevance for the role of conceptualisation in both the design and outcome evaluation of mental health policies and program.

In *Paper Two*, a cross-sectional qualitative design was employed to explore how a non-clinical sample of adolescents (aged 12 to 18 years) speak about mental health and illness, in order to gain insight into young people's perceptions and experiences and contribute to shaping approaches to policy and practice. To the author's knowledge, it is the first study that qualitatively investigates Australian adolescent perspectives on mental health and illness concepts, attitudes and behaviours in a general sense (as opposed to youth experiences of a particular service, treatment or disorder). The strengths of this paper lie in the interview methodology to provide useful in-depth insight into the youth perspective and the relevance of findings to inform policy and practice. When discussing mental health concepts and appropriate behaviours towards sufferers of mental illness in general, adolescents conveyed a sense of acceptance and understanding of the potential complexity and severity of mental health problems. In contrast, when discussing mental health in the context of their own lives, a stronger sense of scepticism was conveyed, with students expressing difficulty with the lack of visible markers of mental health and

confusion determining authenticity in the mental health states conveyed by their peers. Interestingly, adolescents interviewed commonly conveyed the notion that young people may exaggerate or ‘fake’ a mental illness for personal gain. The contrast between students’ descriptions of mental health on a conceptual basis compared to their representations of mental health in ‘real life’, highlighted authenticity of mental illness as a prominent issue of concern to young people. The overall confusion related to the ambiguity of visible indicators of mental health and authenticity of mental illness reported by youth in *Paper Two* represents a considerable gap in our understanding for further research to explore, in order to target and reduce such confusion more effectively through school mental health programs.

Paper Three involved further analysis of the same dataset of interviews reported in *Paper Two*, with the aim to explore the topic of help-seeking from a young person’s perspective. Findings highlighted that even among a non-clinical sample of adolescents who had participated in a mental health promotion program in their schools, there was a strong reluctance to seek help due to complex and interrelated personal, social and institutional influences. In contrast to previous research, structural factors such as uncertainty about how and where to seek treatment, accessibility, lack of time or financial resources, lack of available resources, and inconvenience were not emphasised by students in the current study, a possible indication that among youth that have participated in a mental health program at their schools, such knowledge is more apparent. The qualitative data typically emphasised deterrents to help-seeking across multiple levels of influence. While most students conveyed understanding on a conceptual basis that seeking help informally or formally is useful for mental wellbeing, almost every student interviewed also communicated that they would strongly avoid seeking help and sharing their problems,

referencing personal themes (self-reliance, positive thinking, doubt about significance of problems), social themes (peer acceptance, burdening others, informal help-seeking) and institutional themes (concerns about confidentiality and negative perceptions of mental health services and professionals). Adolescents reflected a strong emphasis on positive thinking and self-talk, while ignoring negative thoughts as a method of dealing with mental health problems. Students also spoke about the concept of “first world problems”, and described their personal problems as minor or trivial in comparison to large-scale or global issues. Taken together, findings emphasised the need to involve young people in the development and improvement of mental health programs to better understand such themes and their meaning to young people, in order to design mental health programs and services that are engaging, appropriate and relevant to young people.

Paper Four involved a cross-sectional quantitative research design, utilising survey methodology to explore whether knowledge about mental illness was related to attitudes towards mental illness and intentions to seek help, within a sample of adolescent girls (aged 13 to 17 years). The aim of the study was to test the traditional assumption that knowledge influences attitudes (and associated behaviour). Results indicated a weak negative relationship between knowledge about mental health and stigmatising attitudes about mental illness, but no relationship between knowledge about mental health and intentions to seek help for mental health problems. Consistent with previous literature, these results allude to the limits of mental health education and raise questions about the role of universal-school based mental health programs for young people. As universal mental health programs target the whole school population, it would be hoped that mental health knowledge and stigmatising attitudes were strongly related among young people across the full range of mental health states. However, in *Paper Four*, when

participants' mental health was categorised (e.g., optimal vs. poorer mental health), a negative relationship between knowledge about mental health and stigmatising attitudes was shown in those with poor mental health, but not for adolescents categorised as having moderate or optimal mental health. Thus, findings suggested that while the traditional adage - more information on mental health equals better attitude to mental health care - may be true for those with 'poorer' levels of mental health (e.g., high levels of psychological distress), it may not reduce stigma associated with mental illness or motivate positive health behaviour in adolescent girls with 'optimal' mental health (e.g., low or no levels of psychological distress). Taken together, results of *Paper Four* suggested that future research and practice should explore the effects (and potential limitations) of mental health education to motivate sustainable changes in attitudes towards help-seeking in young people, and explore what content and methods of delivery are most effective in shifting attitudes and behaviour in a positive direction to support mental health.

7.3 Meta-inference and practical implications

7.3.1 Usefulness and relevance of a mental health conceptualisation that includes both positive and negative aspects

Findings across studies provided collective support for a conceptualisation of mental health that includes both positive and negative factors. *Paper One* demonstrated the potential for an illness perspective, a wellbeing perspective and dual continua models to create very different depictions of mental health state in youth populations. This paper highlighted moderate mental health categories (languishing and struggling) as important groups to recognise, particularly as their overall mental health could be classified as relatively 'good' or relatively 'poor' depending on the measurement or conceptualisation

approach employed. *Paper Two* added to the findings of *Paper One*, by recognising that youth conceptualisations of mental health also encompass positive, negative and neutral aspects. For example, young people reflected themes that suggested that lack of mental illness was not their only concern when considering their own mental health, recognising the complexity of the concept and the importance of aspects such as self-esteem, happiness, social support and resilience. It was also suggested in *Paper Two* that confusion about the lack of visible markers of mental health and related judgmental attitudes of young people and perceptions of inauthenticity towards peers who disclose mental illness could potentially be addressed through promoting an understanding of mental health and illness on a dual continuum, where an individual can possess both positive mental health and negative mental illness symptoms simultaneously. Finally, *Paper Four* further supported the relevance of dual continua models, by demonstrating the need to look for differences between groups of mental health categories (i.e. considering differences between mental health groups on the relationship between mental health knowledge and stigmatising attitudes). Considering that universal mental health promotion initiatives in the school setting aim to improve the mental health level across the whole school population, this implication points to future directions regarding the application and efficacy of such programs to young people of various mental health states.

7.3.2 Need to consider adolescent mental health within the broader social and cultural context

The work presented in this thesis supported the notion that sociocultural influences are a vital part of understanding adolescent mental health. *Paper Two* highlighted the

significance of concepts of ‘authenticity’ and identity for Australian adolescents when navigating their own mental health related attitudes and behaviours, and interpreting attitudes and behaviours of their peers. These ideas reflect notions of the young person and their personal attitudes and behaviours as firmly rooted within the context of their social environment. By emphasising the need to be authentic in their mental health states, adolescents acknowledged the ways in which they monitor how they are perceived by peers, and strive to be seen in a favourable light to promote a sense of belonging and acceptance. *Paper Three* further drew attention to broader influences on mental health that exist outside of individual thoughts, feelings and behaviours, particularly in regards to personal themes (i.e. self-reliance, positive thinking and doubt about the significance of problems) being strongly connected to the reported social (i.e. peer acceptance, burdening others, informal help-seeking) and institutional themes (i.e. concerns about policies and confidentiality, negative perceptions of mental health services and professionals). For example, the preference for self-reliance was expressed by students to be influenced by the concept of “first world problems”, because adolescents perceived their own difficulties as trivial in the context of cultural factors and when weighed up against the severity of large-scale or global issues. Similarly, worrying about burdening their friends and family with their personal problems may strengthen the perceived need to be self-reliant and coping alone. Findings also brought into the spotlight the potential influence of Australian culture, as Gilchrist and Sullivan (2006) argued that Australian social norms could exacerbate self-reliance as a barrier to help-seeking by endorsing the belief that people should just ‘get on with it’. School programs typically aim to improve an individual’s capacity to recognise symptoms, cope effectively and seek help. However, this approach places the responsibility of mental health on an individual rather than

community level. *Paper Four* indicated only a weak relationship between mental health knowledge and stigmatising attitudes in young people, thus emphasising the potential of extending approaches beyond the development of personal knowledge and skills to include greater consideration of social and community levels.

7.3.3 Potential knowledge-behaviour gap in relation to mental health among young people

Taken together, the studies that make up this thesis suggested a potential knowledge-behaviour gap among young people in relation to their mental health. *Paper Two* implied a tension between conceptual knowledge about mental health and attitudes and behaviours in the context of their real lives. Students discussed the lack of visibility of mental health, which they communicated to blur the lines between what is considered 'authentic' or legitimate. Students expressed their beliefs that their peers may 'fake' a mental illness for personal gain, resulting in an element of scepticism, mistrust and suspicion tied to mental health attitudes among young people. These findings suggested that while adolescents may grasp mental health concepts on a cognitive level, sceptical and judgmental attitudes (and consequently their own mental health related behaviour such as help-seeking) may remain more difficult to shift, at a time where a young person is developmentally primed to strive for peer acceptance and establish an identity for themselves.

On the topic of help-seeking for mental health, *Paper Three* reported adolescent perspectives that emphasised an overall reluctance to seek help, despite the fact that all students interviewed had participated in a mental health promotion program (*MindMatters*). In contrast to previous research examining barriers to help-seeking in

young people, structural factors such as uncertainty about how and where to seek treatment, accessibility, lack of time or financial resources, lack of available resources, and inconvenience (Hom et al., 2015) were not emphasised by students in the current study. This may reflect that among youth that have participated in a mental health program at their schools, such knowledge is more apparent. So, as knowledge did not appear to be the key barrier to help-seeking, it was hypothesised that reluctance to seek help could relate more to personal beliefs expressed by participants (e.g. need to be self-reliant), social factors (concern about burdening others) and negative perceptions about the experience of help-seeking, rather than practical barriers. As reported in *Paper Three*, most of the students were able to demonstrate some mental health knowledge (e.g. helpful coping strategies). However, when it came to dealing with their own specific problems or mental health concerns (in contrast to hypothetical recommendations for ‘others’), the overwhelming majority of students emphasised self-reliant methods, particularly the importance of ‘looking on the bright side’ and thinking positively, to prevent problems in their daily lives from affecting them negatively. Of the students interviewed, none mentioned talking to or seeking advice from anyone as a personal coping strategy (from any source including informal support from friends or family) until later prompted by the interviewer. Consistent with this apparent gap between conceptual knowledge and behaviour, previous research has highlighted the distinction between ‘self’ and ‘other’ referral among adolescents, and has demonstrated that young people are far more willing to refer another person to services than to seek help for themselves (Raviv et al., 2000). Adding to these findings, *Paper Four* suggested that among youth populations, knowledge was only weakly associated with stigmatising attitudes about mental illness, and was not associated with personal intention to seek help. These findings suggest that

we consider the potential limitations of an educational approach and provision of information for affecting long-term positive change in youth mental health related attitudes and behaviours. In short, ‘knowing’ may not equal ‘doing’ when it comes to youth mental health. Hom et al. (2015) suggest that youth interventions aimed at changing stigma, negative attitudes towards service use and improving help-seeking behaviours may require approaches beyond knowledge dissemination and education, due to the fact that beliefs are often deeply ingrained in culture and strongly held among individuals. While further investigation is needed to shed light on youth mental health knowledge, attitudes and behaviours in more detail, the current findings hint at potential implications for mental health promotion initiatives founded on increasing knowledge and understanding about mental illness through primarily education-based approaches.

7.3.4 Insights about mental health in the context of Millennials and subsequent generations as “digital natives”

As discussed in *Chapter One*, youth is a time of life when many people begin and complete education, enter employment and establish long-term friendships and relationships (Patel et al., 2007), with associated pressures and challenges that can reflect a barrier to optimal mental health (Tucci et al., 2007). Poor mental health in adolescence also compromises the development of critical health behaviours, shaping a young person’s developmental trajectory into adulthood (Burns & Birrell, 2014; Walker & Rowling, 2007; Williams et al., 2002). In addition, important aspects of brain development continue to progress well into the young adult years; for example the myelination of systems within the prefrontal cortex, with changes resulting in increasing executive functioning skills throughout emerging adulthood (Giedd et al., 1999).

However, in addition to developmental considerations, certain characteristics of the current generation of youth should also be contemplated, in relation to potential impact on mental health. Some of these specific aspects that are particularly relevant to Millennials (born 1982-2004) are outlined below, after a quick overview of some of the more generation-specific aspects to consider. While it was not within the scope of this thesis to fully explore these aspects of the current social and cultural climate, it is useful to speculate what the current results, coupled with previous literature, might mean for youth mental health promotion in order to guide future research in interesting and relevant directions.

7.3.4.1 *Rapid, unprecedented change*

It is common for generations to experience difficulty understanding each other, and many of the struggles faced by youth are repetitive and cyclical across generations (Giedd, 2012). However, certain aspects of the current socioecological climate have evolved rapidly and in unprecedented ways throughout the 2000's and 2010's, with possible implications for a young person's mental health in the current age. Settersten and Ray (2010) proposed that for young people today, "*remarkable changes have occurred in what feels like the blink of an eye, changes that have intertwined and overlapped in just such a way as to create a new rule book on what it means to be an adult*". The authors argued that cultural, social and economic changes are "*playing out in a myriad of ways*" (p. xxii). Social isolation is also an increasing issue in developed countries. McPherson, Smith-Lovin, and Brashears (2006) reported that in America over the span of just two decades, social networks decreased by a third, with people having fewer connections and confidants than ever before. The digital age has been proposed as a panacea for shrinking sets of ties (Settersten & Ray, 2010), as the possibilities for learning and interaction

evolve due to rapidly advancing technology and the introduction of social media (Giedd, 2012). With the evolution of the Internet, smart phones and social media, young people have more ways to connect with peers and family than ever before (Owen & Rodolfa, 2009). As expressed by one 17-year-old female participant in *Paper Two*, young people are “*always on the internet*”. However, the benefits and failures of technology for the Millennial generation - who grew up amidst this rapid cultural shift - are still being explored.

Turkle (2011) stated “*today’s young people have a special vulnerability: although always connected, they feel deprived of attention... we did not sufficiently teach the importance of empathy and attention to what is real*” (p. 294). She further argued that “*there is an empathy gap among young people who have grown up emotionally disconnected while constantly connected to phones, games, and social media*” (Turkle, 2015, p. 360).

Similarly, Giedd (2012) argued that the development of social tasks (e.g. identifying mood and intentions of others, differentiating between honest and false communication, recognising enemies and forming alliances with friends) are among the most complex and important of tasks for humans, as they are biological imperatives of staying alive. He proposed that with the digital revolution and our increasing reliance on digital social interactions, exposure to “real-world” experiences that are needed to promote mastery of these necessary social skills may be hindered, particularly in the current cohort of adolescents growing up in a world immersed in technology. Ultimately the perpetual tasks of adolescent development – to learn about the world, establish independence and form identity - are altered. Such changes could have potential impacts on mental health, as Millennials may experience greater difficulty tolerating the spontaneity, attention and genuine emotion of face-to-face interactions than previous generations (Giedd, 2012;

Turkle, 2011). Several implications of the current thesis findings that are considered applicable to the Millennials more specifically (e.g. social/cultural climate, information and technology use) are discussed below.

7.3.4.2 *'Cyberchondria' and information overload*

Giedd (2012) contended that the ways in which young people learn, play and interact has seen greater change in just the past 15 years than in the previous 570 years, since the popularisation of the printing press, and that the internet and technology has unleashed a “*virtual gusher of information to the plugged-in teen brain*” (p. 101). *Paper Two* held implications related to the influence of technology and the internet on youth mental health, with students discussing concerns related to the ‘Age of Google’ and information overload. Concerns were voiced by participants about ‘authenticity’ of mental illness, which was theorised to be related to the digital age, due to the ease of accessing large amounts of potentially inaccurate information on the internet about symptoms and treatments for mental disorders, online tools and ‘quizzes’ for self-diagnosis. White and Horvitz (2009) employed the term *cyberchondria* to refer to the escalation of health-related concerns about common symptomatology, through public access to abundant medical information on the internet. In line with concerns voiced by young people, previous research has highlighted the danger of the vast amounts of medical information available to the public that can potentially mislead those without medical training into self-diagnosis and treatment (Benigeri & Pluye, 2003). When discussing notions of authenticity, students also spoke about mental illness as an ‘overused’ term. As one 17-year-old student stated “*Mental illness... my generation has kind of killed the word... like everybody has some sort of mental illness*” (*Paper Two*). The idea of mental illness as an overused term potentially reflected the increase in information about mental illness and

self-diagnosis, and was perceived to lead to the trivialisation of mental illness among young people in this study. Nevertheless, the internet is not all bad news for youth mental health. Online interventions have also indicated some promising directions in adolescent mental health care, such as computer therapy programs and online psychoeducation interventions to support self-management and help overcome barriers to help-seeking such as stigma (Fleming et al., 2012; Kurki et al., 2011; Taylor-Rodgers & Batterham, 2014; Vogl, Ratnaik, Ivancic, Rowley, & Chandy, 2016). Given that the widespread access to the internet only continues to grow in Western society, it is paramount that young people are educated about both the potential advantages and disadvantages of online mental health information, forums and diagnostic tools. There will always be benefits and risks of new technologies, and thus further research into the interaction of technology and mental health for young people must be pursued.

7.3.4.3 *First world problems*

The relatively recent concept of ‘first world problems’ was raised during youth discussions reported in *Paper Three*. This was another aspect of the current culture that was perceived to impact youth mental health, as students conveyed feelings of illegitimacy and doubts about the significance of their problems. Added to the Oxford dictionary in 2012, ‘First world problems’ is defined as “a relatively trivial or minor problem or frustration (implying a contrast with serious problems such as those that may be experienced in the developing world)” (First World Problem definition, 2016). As reported in *Paper Three*, when speaking about help-seeking, students across gender and age commonly compared their personal or mental health concerns to large-scale or global issues, as a means of trivialising or dismissing their problems within the home, social or school environment. In line with concerns expressed by other students regarding doubt

about the significance of their problems in the context of sharing mental health problems with friends, one 16-year-old male student spoke about feeling that seeking professional mental health was a “*big thing*” that, on reflection of the limitations of resources and services, should be reserved for those that really need it. As a relatively new phenomenon, the ‘first world problems’ concept reflects doubt about the significance of personal problems which may foster self-reliant attitudes and the philosophy for young people to simply ‘get on with it’ when struggling. The potential for acknowledging the social organisation of help-seeking behaviour and the role of the community in improving mental health is discussed in the future directions section.

7.3.4.4 Self-reliance and individualistic identity

As reported in *Paper Three*, students placed emphasis on the importance of self-reliance, which can be viewed as a positive quality for adolescents. However, if a mental illness is severe or acute, self-reliant coping strategies may not be considered adequate. *Paper Two* discussed how the scepticism about mental illness conveyed by young people, and in particular, the blame they expressed towards others (e.g. a 17-year-old girl spoke about peers disclosing mental illness stating “*they’re saying they have all these terrible issues but they’re not willing to do anything about it and I’m like “well is that a mental illness or is that you just not being motivated?”*”) could be theorised to reflect the influence of dominant ideologies on young people’s beliefs about mental health. For example, Western society emphasises a strong ideal of self-fulfillment and heightened concern for the self, which in turn weakens the willingness for individuals to take responsibility for other people, and to accept and defend collective interests (Nafstad et al., 2009). As proposed by Timimi (2010), children in Western countries are socialised into a value system that creates an ethos of ‘winners and losers’, inimical to values of compassion and

social harmony. Similarly, the tendency for young people to be suspicious of others, and at times assume their peers to be ‘faking’ mental illness for selfish reasons (*Paper Two*) may reflect broader cultural values, such as individualistic identity.

7.4 Strengths and limitations

This research represents a valuable step in knowledge about youth perspectives and serves to question some of the assumptions of current approaches to the measurement and promotion of youth mental health. Nevertheless, findings must be considered in the context of several limitations. This section presents strengths and limitations underlying this research thesis as a whole.

7.4.1 Methodology

A key strength of this thesis lies in its efforts to investigate a previously under-researched population of a general, non-clinical sample of young people (thereby representing a range of participant mental health states) in order to gain their perspectives on important and pressing topics in mental health. The mixed-methods research approach also represented a considerable strength of the current thesis. The key advantage of a mixed-methods approach is that combining qualitative and quantitative approaches enables researchers to utilise the respective strengths of each method, while evading their respective weaknesses (Lund, 2012; Teddlie & Tashakkori, 2009). In addition, mixed methods designs allow researchers to gain a deeper understanding of the phenomenon of interest through collection and interpretation of both forms of data. However, the cross-sectional nature of the research studies included in this thesis represent a limitation to interpreting findings, as no casual relationships can be inferred. Nevertheless, the current findings draw attention to the need for future longitudinal studies to investigate the topic,

in order to better understand the mechanisms of knowledge, attitudes and help-seeking among young people.

7.4.2 Measures

A further limitation of the quantitative studies was that assessment of mental health and other constructs was limited to self-report survey instruments and did not include a clinical diagnostic interview. Some items used for analysis, in particular the intention to seek help measure in *Paper Four* have significant limitations. This item measured intention to seek help, rather than actual help-seeking behaviour, for which there are currently no psychometric validated measures (Wei, McGrath, Hayden, & Kutcher, 2015). Further, it was noted that the wording of this single item in the r-AQ referred to parental involvement and therefore may not have reflected an accurate estimation of intention to help-seek among young people but rather to involve parents in the help-seeking process. However, at present, there are significant gaps in the available scales for measuring mental health literacy (including knowledge, stigma and help-seeking), particularly among youth (Wei et al., 2015), pointing to a need for further development and standardisation of measures to improve the quality of future research in the area. The additional analysis utilising this single-item measure (Item 9 of the r-AQ) was conducted due to the findings of this item reflecting the most stigmatising attitudes among adolescents. It was noted retrospectively that this item reflected intention to engage in *personal* help-seeking behaviour in contrast to *attitudes towards others* with mental illness, and thus it was deemed important to consider this item separately with implications for educational interventions with a focus on individual capacity for students to actively promote their own mental health.

The Knowledge Test utilised in Paper Four consists of 13 true or false items (with the option of choosing “not sure”) related to mental health knowledge and literacy, including causes, treatment and recovery from mental illness. The measure may limit the findings, as forced-choice measures have been criticized for testing surface-level knowledge – students may be able to guess some answers correctly without possessing knowledge that relates to real-world situations (Labouliere, Tarquini, Totura, Kutash, & Karver, 2015). While the ‘not sure’ response option was included for the purpose of decreasing the likelihood of students guessing items they did not know the answer to (Watson et al., 2004), future research could include free-recall questions to comprehensively evaluate levels of knowledge about mental health among youth. Finally, it should also be considered that the Knowledge Test measure reflects a biomedical explanation of mental disorder, which has been criticised in the literature for neglecting environmental, social and behavioural factors, and it has been argued that scientists have yet to identify a psychological experience that can be fully attributed to biology (Deacon, 2013). For example, Kemp, Lickel and Deacon (2014) reported that a chemical imbalance explanation for depression elicited worse prognostic pessimism and negative mood regulation expectancies among depressed individuals, and resulted in participants viewing pharmacology as more credible and effective than psychotherapy. Thus, findings based on the Knowledge Test in the current thesis should be considered in the context of the controversy surrounding the belief that mental illness is due to physical causes. Further, the potential iatrogenic effects of biomedical attributions of mental disorder emerging in the literature should be considered in future studies of mental health literacy as well as program content development.

Both quantitative papers (*Paper One* and *Paper Four*) were limited by reliance on individual self-report instruments and predetermined cut-off scores for the dual continua model. However, given that cut-off scores utilised were based on frequently employed methods of converting scores from continuous to categorical data, the findings also highlight potential flaws of current approaches, including a system of using cut-off scores when assessing mental health and illness factors.

7.4.3 Sampling

Another strength of the current research was the inclusion of a wide age range across the three studies (and four papers), with participants ranging in age from children (age 12), adolescents (13-18) and emerging adults (19-27). This allowed for a broader and more comprehensive examination of youth mental health than studies that focused entirely on a narrower age range or a single developmental stage. Mental health initiatives increasingly are being designed to target youths ranging across these approximate adolescent/emerging adult ages (e.g. *headspace*, *The National Youth Mental Health Foundation* services target young people aged 12-25), due to serious problems documented in transitioning from child to adult mental health systems based on legal adulthood (18 years in Australia) (Malla et al., 2016). Thus, the current research reflected this emerging model of youth mental health, based on the understanding that many of the challenges and issues faced by young people under 18 are still relevant to emerging adults until they reach their mid-twenties (Youth Affairs Council of South Australia, 2015).

Klein, Shepperd, Suls, Rothman, and Croyle (2015) argue for the value of conducting studies with complementary strengths and weaknesses, proposing that a small set of studies with strategic variation in participant samples, methods and measures may prove

to be more compelling than a large set of studies conducted on the same population that utilises the same methods and measures. However, the varied experiences and characteristics of samples also represent a caveat of the current research, due to limited generalisability of findings. Further exploration of the similarities and differences in group perspectives is required to establish the links and boundaries between mental health beliefs, attitudes and behaviours that are prominent among young people in different developmental stages (i.e. child, adolescent, emerging adult). A further sampling bias is noted through the voluntary nature of participation across all three studies, whether utilising survey methodology or individual interviews. Potential characteristics of the self-selected sample must be considered, as it is possible that those who self-selected to participate reflected a group of young people skewed towards those with more optimal mental health, social support and personal resources. Further, while both males and females were represented in *Paper One*, *Paper Two* and *Paper Three*, *Paper Four* utilised a female only sample from a single school, thereby limiting generalisability to the broader youth population. Gender is known to be one of the most consistent predictors of help-seeking behaviour: women generally hold much more positive attitudes than men regarding seeking professional help for mental health (Vogel et al., 2007) and rates of help-seeking have been reported to increase with age for adolescent females and decrease for adolescent males (Marius, Merry, Robinson, & Watson, 2011). In light of recognised gender differences, further research is needed to examine the relationship between knowledge about mental illness and stigmatising attitudes in young males in addition to female.

7.5 *Future directions*

Findings of the current research thesis add valuable contributions to the body of literature and outline some important future directions for subsequent research to address.

7.5.1 Exploration of predictive quality/power of mental health states when adopting a comprehensive dual continua model

This research suggests that there is good reason to utilise dual continua measures and conceptualisations when examining the mental health of young people. As argued by Owens, Magyar-Moe, and Lopez (2015), adopting a Complete State Model of Mental Health as a conceptualisation demonstrates that “*there is much more to life than just feeling neutral or functioning at baseline*” (p. 652). However, due to the cross-sectional nature of this research, the predictive quality and longitudinal effects of dual continua mental health states were beyond the scope of the current thesis to explore. For example, if as reported in *Paper Four* the attitudes about mental illness held by individuals in moderate and optimal mental health categories are not significantly associated with knowledge, then further research should look at the specific influence of provision of mental health information on subsequent attitudes and behaviours of young people in different mental health groups. From there, it should be explored whether whole-school programs actually best serve the needs of youth across mental health states, or whether targeted interventions would represent a better distribution of resources. Findings also suggest a potential for future research to explore screening approaches and allocating young people to different ‘streams’ of mental health programs depending on the specific needs of individuals rather than a universal approach.

7.5.2 Further consideration of aspects of current practice in school-based mental health promotion

The results of thesis findings shine a light on several aspects of current school-based programs that are worthy of further exploration and consideration. Regardless of approach, the costs of implementing any youth mental health intervention should always be weighed up against potential benefits. Concerns pertaining to universal programs, individual psychological approaches applied to populations and positive thinking are discussed below, as well as potential suggestions for future exploration. These ideas, as well as suggested future directions in implementation science and acceptance-based treatments are somewhat speculative extensions of the findings of the current thesis, but are raised here in an attempt to prompt discussion and extend the platform for future research to further develop evidence-based approaches to youth mental health.

7.5.2.1 Universal programs

As discussed in *Paper Four* there has been research to suggest a lack of effect, or modest effects, of education-based and universal interventions. An Australian study of a large-scale three-year universal school-based intervention designed to reduce depressive symptoms among adolescents reported that over a five-year period, compared to adolescents who did not receive the intervention, there were no significant effects in improving risk factors or reducing levels of depressive symptoms, and no evidence that the intervention enhanced individual protective factors including optimistic thinking, interpersonal competence, problem solving/coping style or social support (Sawyer et al., 2010). Reavley et al. (2014) employed a cluster randomised trial to examine the effects of a mental health literacy intervention to facilitate help-seeking and reduce psychological

distress and alcohol misuse among university students in Australia. They reported no effects of the intervention on psychological distress or alcohol use, concluding that although education and awareness may have an influence on knowledge and mental health literacy, to achieve changes in psychological distress, more intensive and personalised interventions would be necessary.

The idea that more personalized or targeted interventions may be necessary leads to a theoretical questioning of the investment in resource-intensive universal programs. Stice, Shaw, Bohon, Marti, and Rohde (2009) conducted a meta-analytic review of depression prevention programs for children and adolescents, specifically exploring factors that predicted magnitude of intervention effects. Authors reported that selective programs delivered to high-risk youth produced larger intervention effects than universal interventions at post-test and follow-up. It was noted that the distress that characterised high-risk individuals may act as a motivating factor to engage in the program, and thus results may be related to ceiling-effects of psychologically healthy individuals in the universal program samples (Stice et al., 2009). Nevertheless, effect sizes do draw attention to the importance of considering allocation of resources to universal programs and the need for future studies to evaluate positive outcomes and longer term maintenance of such outcomes following programs. Further, it appears that it may be of benefit to consider and explore whether universal interventions favour specific subgroups of young people. For example, Kranke et al. (2010) reported that if there was a negative perception towards mental health within the family, young people displayed more shame in relation to their mental illness, suggesting that without supportive family environments as well as school environments, mental health promotions may struggle to create substantial changes for the young person. Alternatively, perhaps young people lacking

emotional resources would benefit more from potential buffering effects of school mental health promotion programs, with possible ceiling effects for young people that already have good social or family support. Such proposals should be explored to aid evaluation of the effectiveness of universal programs, particularly in regards to the assumption that they will provide benefit to the entire school population.

7.5.2.2 *Individual psychological approaches applied to populations*

So far, the majority of universal school mental health programs have been based on principles of Beck's cognitive-behavioural therapy (Garmy et al., 2015). While such principles delivered through school interventions tend to emphasise individual control and personal responsibility for one's mental health, there is concern that generalising individual cognitive-behavioural approaches that were originally designed as a specific treatment for a mental illness rather than a universal prevention strategy may be inappropriate, ineffective or even detrimental for healthy populations (Lindholm & Nelson, 2015; Mrazek & Haggerty, 1994). Adapting individual models of psychotherapy to school-wide programs is common in school-based mental health promotion, but benefits are often reported to be relatively short-term and weak (Merry et al., 2011). Hayes and Ciarrochi (2015) argue that individual-based mental health interventions focus on what's "wrong" with young people or attempt to instil "good" thinking in them, while ignoring the wider social environment. This concern is greater when such techniques focusing on individual self-regulation are taken as a potentially problematic message (i.e. *good coping skills will prevent mental illness*), while neglecting the broader social and structural determinants of health (Ayo, 2012). The current findings highlight the importance of exercising caution when teaching individual principles (e.g. CBT) to a universal population and helping students to develop the skills to differentiate between

situations where reframing of negative thoughts may be helpful and appropriate, and more complex concerns when active problem-solving strategies or further help-seeking is necessary to address the situation. Future research should endeavour to establish a strong evidence base for clearer comparison of different approaches to youth mental health promotion.

7.5.2.3 *Positive thinking and experiential avoidance*

Following on from the above point about individual approaches applied to populations, *Paper Three* brought to light some interesting discussions of positive thinking specifically, as students interviewed reflected a strong emphasis on being optimistic while ignoring negative thoughts to deal with their problems. While optimistic thinking styles have been reported to improve depressive symptoms among young people (Sawyer et al., 2009) and make students feel happier and more alert (Garmy et al., 2015), concern was raised about students perceiving the strategy to provide an alternative to other forms of help-seeking even if their situation was “really bad”, with some students expressing that they would respond to circumstances such as bully victimisation by simply “thinking of the good stuff”. Of further concern was that students conveyed that experiencing negative thoughts would result in their situation worsening (e.g. a 13-year-old male participant stated “*don’t think bad thoughts otherwise you’re gonna get worse*”). While teaching positive thinking may have some positive outcomes for students (Patton et al., 2011), the emphasis on optimism as broad solve-all approach also raises some concern, especially as students in the current study conveyed a sense of fear that allowing themselves to experience negative thoughts would result in their external situation getting worse. There may be important consequences for a developing young person’s self-esteem and sense of self-efficacy if they are faced with a serious mental health condition or event which they

were unable to resolve by simply thinking happy thoughts, especially when they believe that they should be able to always ‘think themselves better’.

There is a growing body of evidence to suggest that attempts to suppress and control thoughts may be counterproductive, because the act of thought avoidance often results in the increased experience of those very thoughts (Bardeen & Fergus, 2016; Biglan et al., 2015; Ciarrochi, Kashdan, Leeson, Heaven, & Jordan, 2011; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance is a term used to describe the common attempts to control or change the form or frequency of undesired private experiences as a result of high levels of unwanted thoughts and emotions (Luoma, Hayes, & Walser, 2007). Experiential avoidance has been reported to be associated with a wide range of psychological and behavioural problems among adults, and efforts to control thoughts or emotions may continue even when they have negative consequences, such as problematic substance use (Biglan et al., 2015). Acceptance-based treatments, such as Acceptance and Commitment Therapy (ACT), aim to alter the struggle with, and impact of, unpleasant emotions and cognitions rather than focus on avoidance of them altogether (Hayes et al., 1996). While such approaches do not abandon the aim of psychological interventions to effect change, they do so in a way that targets arguably more readily changeable domains such as behaviour and life situation, rather than automatic thoughts or feelings (Hayes et al., 1996). While there is a dearth of research in experiential avoidance during adolescence to date, some emerging evidence has reported that experiential avoidance is associated with higher levels of youth depression (Biglan et al., 2015), and that emotional awareness and experiential *acceptance* are linked to prosocial tendencies and predictions in wellbeing among youth populations (Ciarrochi et al., 2011). Thus, ‘third-wave’

acceptance-based approaches may warrant further investigation in the research and development of youth mental health interventions.

7.5.2.4 *Implementation science*

In light of some of the above concerns, steps can be taken to encourage more rigorous fidelity testing and evaluation of programs within the context of a school environment, in order to reduce gaps between research and practice, and target the needs of the population in the most effective and efficient ways possible. The scientific study of methods to promote the systemic uptake of research findings and evidence-based practices into professional practice and public policy has been termed '*implementation science*' (Forman et al., 2013). Implementation science is described as the knowledge base to optimally embed and sustain effective interventions within clinical and community systems (Betancourt & Chambers, 2016). Unfortunately, it has been reported that the utilisation of Evidence-Based Interventions (EBIs) in schools (referring to research-based interventions with a strong empirical basis that have demonstrated clear positive outcomes) is relatively low (Ennett et al., 2003; Forman et al., 2013). Previous studies have demonstrated how the unique organisational structure of the school may influence implementation through a number of key barriers and facilitators for school-based programs (Forman et al., 2013). Facilitators include teacher support, principal and administrative support, quality training and technical assistance, integration of the intervention with other programs or the curriculum, and engaging the school in planning. Meanwhile, barriers reported include finances, policies, lack of time in the school day, negative beliefs held by school staff about the intervention, and competing priorities of the school (Forman, Olin, Hoagwood, Crowe, & Saka, 2009).

Forman et al. (2013) argued that the significant efforts of researchers, as well as financial resources to support intervention research for children and adolescents, will ultimately be wasted unless interventions are ‘implemented, and implemented well’ in schools.

Implementation science in school mental health programs requires enhanced communication and partnerships between researchers and practitioners, to identify core intervention components and improve intervention fidelity and relevance to diverse client populations and settings, in order to enhance the capacity for research to provide real benefit for students, staff and school communities. Theoretical foundations and models of implementation science include systems theory (Berrin, 1968) which views society as a set of social systems that are interrelated and interdependent, and social learning theory (Bandura, 1977) which emphasises individual learning and behaviour as influenced by factors outside of the individual (such as observation of, and communication with, others). The implementation of a school-based program occurs within a school organization, which is in turn influenced by external systems including the local community, state education departments and the federal government, and thus all systems must be considered in understanding how to design and implement interventions.

Implementation science provides an opportunity for future research to consider the important context-determined aspects of effective interventions, including how to transfer core components of the intervention and adapt to the local context, enhance readiness for successful implementation and address the culture and climate within the school or community (Forman et al., 2013). Thus, it is recommended that future research in the area of school-based mental health promotion adopt an implementation science model to coordinate a more comprehensive approach to interventions.

7.5.3 Reshaping the role of education in mental health promotion

7.5.3.1 Aspects of confusion in youth understanding to address through education

While findings of this thesis suggest that the role of education in mental health promotion needs to be reshaped, it is not the author's intention to imply that mental health education is at fault in a general sense, but rather to highlight there may be specific content conveyed through educational programs that can be misconstrued or transformed into unhelpful ideas for young people. Certain findings of the current thesis represent potential new areas for mental health program content to cover in depth, and directs future research to measure potential effects (such as influence on student attitudes and behaviours) of programs that target such topics. Some aspects of confusion in youth understanding identified in the current thesis findings that may be useful to address through future mental health education are explored below. *Paper Two* suggested that there is a need to further incorporate young people's views into the design of mental health promotion initiatives, due to the complex concerns expressed by students in relation to maintaining or supporting their own mental health and that of their peers. Students expressed considerable confusion regarding the ambiguity of visible indicators of mental health, and some struggled with the contradictory nature of ideas related to mental health (e.g. 'act normal' but also offer extra support for someone with a mental illness). Regardless of whether it is actually common for young people to 'fake' mental illness or not, the very belief that others may do so (mentioned by students across both government and private schools, and across gender and age) may present a significant barrier or deterrent to help-seeking behaviours which could potentially be addressed through education. Future research and practice can explore possibilities for addressing the issues and confusion surrounding lack of visibility of psychological distress, and helping young people

understand that this should not be a deterrent to talking about and seeking help for mental health problems. Findings also demonstrated that young people experienced considerable uncertainty about how to behave towards someone with a mental illness, with a heavy focus on the fear of ‘triggering’ someone - suggesting that a general perception of mentally ill people being in a perpetual state of high reactivity and sensitivity may exist among youth. This uncertainty and confusion further highlights the need to provide practical information, clarity and advice on this topic, and demonstrates a considerable gap in our understanding for further research to explore, in order to target and reduce such confusion more effectively through school mental health programs.

Another aspect that may be useful to address through education is the strong theme of self-reliance reported in *Paper Three*. Labouliere, Kleinman, et al. (2015) reported that extreme self-reliance was associated with reduced help-seeking, and the maintenance of clinical symptoms such as depressive symptoms and serious suicidal ideation among adolescents, as well as a predictor of suicidal ideation and depressive symptoms at follow-up two years later. Similarly, there are potential issues associated with young people believing that they should always be able to maintain mental health (e.g. through personal coping strategies), as Yap, Wright, and Jorm (2011) reported that attributing a mental disorder to a personal weakness was associated with less intention to seek help, and less positive beliefs about professional help sources. Thus, it may be beneficial for school-based mental health programs such as *MindMatters* to educate students about the wide range of mental health problems and differing severity levels, in order to promote the skill and understanding among young people to help them differentiate between problems they can solve on their own, when to reach out to friends and family for support, and when to seek professional help.

7.5.3.2 *Limits of educational interventions*

While the role of education in improving mental health is clear, this thesis also suggests limitations of provision of information alone. It should also be recognised that with the ever-increasing use of the Internet, knowledge and information about mental disorders is more readily available to the public than ever (Giedd, 2012). Online resources targeting youth mental health knowledge and aiming to change attitudes and increase coping strategies and/or help-seeking are prevalent as well in Australia (e.g. *eheadspace*, *youth beyondblue* and *reachout Australia*). With abundant information about more concrete aspects of mental health knowledge (e.g. symptoms, treatment and coping strategies), perhaps future studies could explore whether some of the more challenging and complex aspects of understanding mental health (as mentioned above) including associated importance of self-reflection and compassion for others, should instead be the focus of mental health programs.

Changing young people's attitudes about mental illness is complex, and stigmatising attitudes impact their behaviour such as help-seeking (Watson et al., 2004). Previous research has suggested that when education does influence beliefs and attitudes about mental health, this change is often short-term and likely to fade (Pinfold et al., 2003). For example, as reported in *Paper Two*, despite their participation in the *MindMatters* program, students still expressed a strong fear of 'triggering' someone with a mental illness, reflecting stigmatising attitudes about mentally ill people being reactive and/or dangerous. Similarly, Pinfold et al. (2003) reported that despite efforts to reduce stigma and discrimination through a mental health training intervention for police officers, the stereotype linking mentally ill people with violent behaviour was overall found not to be successfully challenged. Bulanda et al. (2014) suggested that the influence that youths

have on each other may be more long-standing than the influence that educators can exert. In light of these potential limitations of educators and facilitators, Corrigan et al. (2007) proposed peers as a potentially preferred source for effecting stigma change, because their cognitive styles of communication would align with their audience. Thus, it is suggested that implementation and evaluation of interventions with a heavier youth-led component may represent a meaningful goal for future research and practice to explore. As proposed by Bulanda et al. (2014), current research regarding youth-led mental health promotion is scarce, yet it would be useful for future studies to examine whether youth peers have as meaningful an effect as (or a more meaningful effect than) adult presenters on mental health learning and associated attitude and behavioural change.

7.5.4 Broadening focus beyond individual approaches to include socioecological model in mental health promotion

7.5.4.1 Social and cultural determinants of mental health

The current thesis findings overall suggested the need to broaden our focus beyond individual approaches, to include a socioecological model of mental health promotion among young people. First, a number of broader social and cultural determinants of mental health must be considered that are relevant to Australian youth (as well as young people in many other developed countries). While it can be difficult to disentangle the role of specific sociocultural determinants of mental health, and the mechanisms by which these relationships exist, one only has to consider demographic and descriptive data to note the clear disadvantage certain groups suffer to their mental health and related outcomes. Special populations of young people such as those that reside in rural areas, lesbian, gay, bisexual, transgender and/or intersex (LGBTI) youths, minority groups such as refugees or Indigenous Australians and disabled young people experience increased

vulnerability to mental health problems (Allen & McKenzie, 2015). Socio-economic status (SES) is positively associated with mental health, and a bi-directional relationship exists between these variables where low SES can trigger or exacerbate mental health problems, and vice versa, mental illness can lead to a decrease in SES (Allen & McKenzie, 2015). Family and home environments must also be considered, with interpersonal stressors and family conflict as well as exposure to violence and traumatic experiences representing further risk factors for a range of psychological problems (Farahmand et al., 2012). It is relevant to note that the majority of social determinants of mental health such as income, socioeconomic status, education and employment, remain outside the scope of mental health services, and even of health services more broadly (Scanlon, 2002). Thus, greater collaboration between disciplines is needed, and in particular the relevance of social sciences in the development of health promotion interventions must be more broadly acknowledged in order to learn to better understand and respond to the needs of individuals, social groups and whole communities (Kottke, 2011).

7.5.4.2 Socioecological models

Socioecological models, such as Bronfenbrenner's ecological systems theory of development (Bronfenbrenner, 1979), view the young person within their environmental context and consider the evolving interactions between the two. Bronfenbrenner (1979) therefore defined development as lasting change in the way in which a person perceives and deals with his or her environment. As proposed by Spence and Shortt (2007) in examining ways to effectively prevent depression in young people, we must draw more upon socioecological models and consider ways of influencing the environment surrounding the young person (by increasing protective factors and reducing risk factors),

rather than an exclusive focus on the individual. Advantages of using ecological frameworks when considering youth mental health lie in the potential to examine how society and social conditions influence a person, and demonstrate the need for youth mental health to be promoted on a range of interacting levels. Nafstad et al. (2009) argue that we must be attentive to broader economic, political, cultural and social discourses, due to the enormous influence they have in shaping individual belief systems about mental health, and how to navigate and integrate individual needs with the happiness and wellbeing of others in society. *Paper Three* reported the preference for adolescents to cope with their problems alone, noting complex interrelated barriers to help-seeking on broader social and institutional levels that served to reinforce this preference. Further emphasising social influences on mental health related behaviours, Kranke et al. (2010) reported the tendency for young people with mental illness to be preoccupied by the behaviours of their peers and teachers, and when such behaviours were perceived as stigmatising or discriminatory, they became more secretive and withdrew from social interactions. As such, in moving beyond individual responsibility, mental health promotion programs hold potential to reduce self-stigmatising attitudes and challenge cultures that are detrimental to mental health.

Schools represent only one, albeit important, aspect of a young person's life. Investment in the school setting for mental health promotion is wise, given the opportunities the school provides to reach young people. However, the current research suggested that in order to be effective, we need to look outside the individual, and outside even the school environment in order to improve mental health of young people on a broader scale and in more sustainable ways. Wyn, Cahill, Holdsworth, Rowling, and Carson (2000) highlight the need to acknowledge public and social dimensions of individual wellbeing in addition

to the school organisation. Similarly, Aston (2014) described the need to consider broader factors that influence the success of school programs (such as level of government participation and commitment, knowledge and action concerning mental health promotion, and policy development) and advocated not only for schools to promote positive environments for mental health, but for society and wider communities to provide active listening cultures and an inclusive ethos to embrace mental health promotion, and for adults to possess knowledge of child and adolescent development, identity and the importance of relationships. Klein et al. (2015) argue that successful behaviour change does not occur merely through the provision of information, but rather by “*understanding and targeting the constellation of motives, emotions, cognitions, interpersonal processes, and situations that drive behaviour*” (p. 77). While the school setting is well recognised as an optimal setting for the implementation of mental health promotion, it should be acknowledged that school based mental health programs may fail to reach some of the most vulnerable young people in society. For example, Lamb and Rice (2008) found that young people with complex problems are less likely to engage successfully with their school curriculum and more likely to leave school early. The authors further reported that early school leavers demonstrated higher levels of depression, isolation, unemployment and poorer physical and mental health. These findings hold relevance for ‘whole-school’ approaches, and the need for approaches beyond the school if such programs are indeed unable to account for youth that are most in need of support.

7.5.4.3 *Community and interconnectedness*

Previous research suggests that youth interventions that focus on fostering positive environments by helping young people to build cooperation skills and develop a sense of

belonging are effective interventions (Biglan, 2015). A meta-analysis of mental health programs for low-income urban youth reported that intervention effects were highest for programs that were environmentally-based, reporting overall non-significant effects for ‘person-only’ programs that did not target the environment. Rather than focusing purely on individual behaviour, previous studies have acknowledged the importance of communities taking responsibility and acknowledging the social organisation of help-seeking behaviour in young people (Gilchrist & Sullivan, 2006). *Paper Two* and *Paper Three* provided adolescent perspectives reflecting the need for independence, autonomy and self-reliance, related to fears of burdening others and concerns that the world had much bigger problems to deal with than their own. However, it is useful to question the value of emphasising self-reliance and potential effects for youth mental health.

Settersten and Ray (2010) propose that “*perhaps the best model for young people as they embark on the path to adulthood is no longer one of independence, but of interdependence. Going it alone may have worked in the past, but in today’s highly competitive, highly interconnected, increasingly unequal, and longer life, it behoves young people to forge connections at every step of the way*” (p. 201). Psychology is based on a traditionally individualistic approach to mental health, and as a result, individual therapeutic approaches have been applied on a broader scale for population-based mental health promotion (Garmy et al., 2015). However, considering the potential limitations of individual-focused interventions discussed in the current thesis, future research should explore the potential for youth mental health interventions that move beyond individual motivational and behaviour and foster community involvement, connectedness and strong social and family ties.

7.5.5 Youth participation in development of mental health initiatives

Finally, it was considered that through involving young people in the conversation about how to improve the mental health of the youth population, important new insights and understandings can be uncovered. The definition and importance of youth participation is mentioned throughout the initial literature review (*Chapter One*), considered in thesis methodology and design (*Chapter Two*) and discussed in the individual papers presented, and thus represents a consistent thread that intertwines throughout the current thesis. In particular, *Paper Two* demonstrated interesting insight into ideas about mental health from a young person's perspective, with the theme of 'faking' mental illness presenting a theory that contrasts with the well-established body of literature regarding mental health stigma (Jorm & Griffiths, 2008). Although further research is needed to learn more about the presence of these ideas among other youth populations, the results demonstrate how youth perspectives are desperately needed to assist us to better understand such concepts and their meaning to young people in order to strive for the development and improvement of mental health programs that are engaging, appropriate and relevant to young people. The findings of *Paper Three* further highlighted complex and interrelated personal, social and institutional influences on help-seeking held by a non-clinical sample of adolescents, pointing to the need for ongoing youth participation and collaboration to better understand youth perspectives.

As stated by Siegel (2013) "*adolescents have so much to offer our world, with their drive and ingenuity to find new solutions to these important global problems. But to do this, younger people need the support of elders; they need to be honoured for their emerging minds' drive to push back and find creative explorations that may just open our minds to*

new ways of dealing with these challenging times” (p. 302). Children and young people themselves identify their minority group status, and thus the onus is on adults to strive for youth voices to be heard and responded to (Mayall, 1999). Researchers, practitioners and policy makers are encouraged to utilise ongoing youth engagement, collaboration and participation approaches when investigating and improving current approaches to youth mental health promotion.

7.6 Final comments

The series of studies presented in this thesis add to understandings of youth mental health knowledge, attitudes and behaviour. Practical implications include the usefulness of a conceptualisation that includes both positive and negative aspects of mental health, the need to consider adolescent mental health within the broader sociocultural context, the potential for a knowledge-behaviour gap related to mental health among young people and insights about mental health in the context of Millennials (and subsequent generations) as “digital natives”. The results draw attention to several key areas of focus for future research, policy and practice to explore, including exploration of the predictive power of mental health states, further consideration of universal programs and individual approaches applied to populations, reshaping the role of education in mental health promotion and broadening focus to include a socioecological model of mental health while prioritising youth participatory approaches. Taken together, the four papers that make up this PhD thesis draw attention to the complexity of youth mental health, including aspects that are salient to young people, within a developmental and social context. Youth mental health continues to be a particular challenge to address on a global level, and thus the findings reported in the present thesis hold relevance, by contributing to the knowledge base and pointing towards new directions for future research. This

thesis establishes that among the current generation of young people, concerns and issues related to their mental health remain unaddressed by current policy and practice. Thus, instead of looking for a quick fix, or a blanket solution, to improving the wellbeing of a generation, perhaps the time has come to embrace the complexity of the task at hand. If youth mental health is considered an investment in our future, then the process of exploring, evaluating and improving our approaches to youth mental health measurement and promotion represents an ongoing pursuit that is worthy of our time, efforts and resources to get right.

CHAPTER EIGHT: REFERENCES

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 179-211.
- Allen, K. A., & McKenzie, V. L. (2015). Adolescent mental health in an Australian context and future interventions. *International Journal of Mental Health*, 44, 80-93. doi:10.1080/00207411.2015.1009780
- Allom, V., Mullan, B., & Sebastian, J. (2013). Closing the intention–behaviour gap for sunscreen use and sun protection behaviours. *Psychology & Health*, 28, 477-494. doi:10.1080/08870446.2012.745935
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*, Washington, DC: American Psychiatric Publishing.
- Annells, M., Allen, J., Nunn, R., Lang, L., Petrie, E., Clark, E., & Robins, A. (2010). An evaluation of mental health screening and referral pathway for community nursing care: nurses' and general practitioners' perspectives. *Journal of Clinical Nursing*, 20, 214-226. doi:10.1111/j.1365-2702.2010.03275.x
- Antaramian, S. P., Scott Huebner, E., Hills, K. J., & Valois, R. F. (2010). A dual-factor model of mental health: Toward a more comprehensive understanding of youth functioning. *American Journal Of Orthopsychiatry*, 80, 462-472. doi:10.1111/j.1939-0025.2010.01049.x
- Armstrong, C., Hill, M., & Secker, J. (2000). Young people's perceptions of mental health. *Children & Society*, 14, 60-72. doi:10.1111/j.1099-0860.2000.tb00151.x

- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*, 469-480.
- Askell-Williams, H., & Cefai, C. (2014). Australian and Maltese teachers' perspectives about their capabilities for mental health promotion in school settings. *Teacher and Teacher Education*, *40*, 61-72. doi:10.1016/j.tate.2014.02.003
- Aston, H. J. (2014). An ecological model of mental health promotion for school communities: Adolescent views about mental health promotion in secondary schools in the UK. *International Journal of Mental Health Promotion*, *16*, 289-307.
- Australian Bureau of Statistics. (2007). *Mental Health of Young People*. (cat. no. 4840.0.55.001). Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4840.0.55.001>
- Australian Bureau of Statistics. (2014). *Schools, Australia, 2014*. (cat. no. 4221.0). Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4221.0Main+Features12014?OpenDocument>
- Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health*, *22*, 99-105.
- Baksheev, G. N., Robinson, J., Cosgrave, E. M., Baker, K., & Yung, A. R. (2011). Validity of the 12-item General Health Questionnaire (GHQ-12) in detecting depressive and anxiety disorders among high school students. *Psychiatry Research*, *187*, 291-296. doi:<http://dx.doi.org/10.1016/j.psychres.2010.10.010>

- Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bardeen, J. R., & Fergus, T. A. (2016). The interactive effect of cognitive fusion and experiential avoidance on anxiety, depression, stress and posttraumatic stress symptoms. *Journal of Contextual Behavioral Science*, 5, 1-6.
doi:<http://dx.doi.org/10.1016/j.jcbs.2016.02.002>
- Barker, G. (2007). *Adolescents, social support and help-seeking behaviour: An international literature review and programme consultation with recommendations for action*. World Health Organization. Retrieved from
http://apps.who.int/iris/bitstream/10665/43778/1/9789241595711_eng.pdf
- Barry, M. M. (2007). Researching the implementation of community mental health promotion programs. *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals*, 18, 240-246.
- Barry, M. M., Doherty, A., Hope, A., Sixsmith, J., & Kelleher, C. (2000). A community needs assessment for rural mental health promotion. *Health Education Research*, 15, 293-304.
- Bartley, M. (2006). Capability and resilience: Beating the odds. Retrieved from
<http://www.ucl.ac.uk/capabilityandresilience/beatingtheoddsbook.pdf>
- Bassett, A. M., & Baker, C. (2015). Normal or abnormal? 'Normative uncertainty' in psychiatric practice. *Journal of Medical Humanities*, 36, 89-111.
doi:10.1007/s10912-014-9324-2

- Bastiaansen, D., Koot, H. M., & Ferdinand, R. F. (2005). Psychopathology in children: Improvement of quality of life without psychiatric symptom reduction? *European Child & Adolescent Psychiatry, 14*, 354-370.
- Becker, A. E., Burwell, R. A., Gilman, S. E., Herzog, D. B., & Hamburg, P. (2002). Disordered eating behaviors and attitudes follow prolonged exposure to television among ethnic Fijian adolescent girls. *British Journal of Psychiatry, 180*, 509-514.
- Benigeri, M., & Pluye, P. (2003). Shortcomings of health-related information on the Internet. *Health Promotion International, 18*, 381-387. doi:10.1093/heapro/dag409
- Benson, J., Al Haris, T., & Saaid, B. (2010). The meaning and the story: Reflecting on a refugee's experiences of mental health services in Australia. *Mental Health in Family Medicine, 7*, 3-8.
- Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*, 219-234.
doi:10.1177/1468794112468475
- Berrin, F. K. (1968). *General And Social Systems*. New Brunswick, NJ: Rutgers University Press.
- Betancourt, T. S., & Chambers, D. A. (2016). Optimizing an era of global mental health implementation science. *JAMA Psychiatry, 73*, 99-100.
doi:10.1001/jamapsychiatry.2015.2705
- Biglan, A. (2015). *The Nurture Effect: How The Science of Human Behavior Can Improve Our Lives And Our World*. Oakland, CA: New Harbinger.

- Biglan, A., Gau, J. M., Jones, L. B., Hinds, E., Rusby, J. C., Cody, C., & Sprague, J. (2015). The role of experiential avoidance in the relationship between family conflict and depression among early adolescents. *Journal of Contextual Behavioral Science*, 4, 30-36. doi:<http://dx.doi.org/10.1016/j.jcbs.2014.12.001>
- Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., Kaufman, J., Dahl, R. E., . . . Nelson, B. (1996). Childhood and adolescent depression: A review of the past 10 years. Part 1. *Journal of The American Academy of Child and Adolescent Psychiatry*, 35, 1427-1435.
- Black, R., Walsh, L., & Taylor, F. (2011). Young people on the margins: What works in youth participation. *Youth Studies Australia*, 30, 42-48.
- Block, A. M., & Greeno, C. G. (2011). Examining outpatient treatment dropout in adolescents: A literature review. *Child and Adolescent Social Work Journal*, 28, 393-420. doi:10.1007/s10560-011-0237-x
- Block, A. M., Gjesfjeld, C. D., & Greeno, C. G. (2013). Adolescent perspectives of outpatient mental health treatment. *Best Practices in Mental Health*, 9, 22-38.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. doi:10.1191/1478088706qp063oa
- Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.
- Broughton, W. (1991). Qualitative methods in program evaluation. *American Journal of Health Promotion*, 5, 461-465. doi:10.4278/0890-1171-5.6.461

- Bulanda, J. J., Bruhn, C., Byro-Johnson, T., & Zentmyer, M. (2014). Addressing mental health stigma among young adolescents: Evaluation of a youth-led approach. *Health & Social Work, 39*, 73-80. doi:10.1093/hsw/hlu008
- Burns, J., & Birrell, E. (2014). Enhancing early engagement with mental health services by young people. *Psychology Research and Behavior Management, 7*, 303-312. doi:10.2147/PRBM.S49151
- Camara, M., Bacigalupe, G., & Padilla, P. (2014). The role of social support in adolescents: Are you helping me or stressing me out? *International Journal of Adolescence and Youth, 2014*, 1-14.
- Cappelli, M., Gray, C., Zemek, R., Cloutier, P., Kennedy, A., Glennie, E., . . . Lyons, J. (2012). The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department *Paediatrics, 130*, 321-327.
- Charland, L. (2004). A madness for identity: Psychiatric labels, consumer autonomy, and the perils of the Internet. *Philosophy, Psychiatry & Psychology, 11*, 335-349.
- Charman, D., Harms, C., & Myles-Pallister, J. (2010). Help and e-help - young people's perspectives of mental healthcare. *Australian family physician, 39*, 663-665.
- Ciarrochi, J., Kashdan, T. B., Leeson, P., Heaven, P., & Jordan, C. (2011). On being aware and accepting: A one-year longitudinal study into adolescent well-being. *Journal of Adolescence, 34*, 695-703. doi:10.1016/j.adolescence.2010.09.003

- Clarke, A. M., Kuosmanen, T., & Barry, M. M. (2015). A Systematic Review of Online Youth Mental Health Promotion and Prevention Interventions. *Journal of Youth and Adolescence, 44*, 90-113. doi:10.1007/s10964-014-0165-0
- Coates, D., & Howe, D. (2016). Integrating a youth participation model in a youth mental health service: Challenges and lessons learned. *Child & Youth Services, 37*, 287-300. doi:10.1080/0145935X.2015.1119652
- Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.
- Cokkinides, V. E., Bandi, P., Weinstock, M. A., & Ward, E. (2010). Use of sunless tanning products among US adolescents aged 11 to 18 years. *Archives of Dermatology, 146*, 987-922. doi:10.1001/archdermatol.2010.220
- Collin, P. J., Metcalf, A. T., Stephens-Reicher, J. C., Blanchard, M. E., Herrman, H. E., Rahilly, K., & Burns, J. M. (2011). ReachOut.com: The role of an online service for promoting help-seeking in young people. *Advances in Mental Health, 10*, 39-51. doi:10.5172/jamh.2011.10.1.39
- Compton, W. C., Smith, M. L., Cornish, K. A., & Qualls, D. L. (1996). Factor structure of mental health measures. *Journal of Personality and Social Psychology, 71*, 406-413. doi:10.1037/0022-3514.71.2.406
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614-625.

- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*, 37-70. doi:10.1177/1529100614531398
- Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., . . . Kubiak, M. A. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin, 28*, 293-309.
- Corrigan, P. W., Watson, A. C., Otey, E., Westbrook, A. L., Gardner, A. L., Lamb, T. A., & Fenton, W. S. (2007). How do children stigmatize people with mental illness? *Journal of Applied Social Psychology, 37*, 1405-1417. doi:10.1111/j.1559-1816.2007.00218.x
- Corrigan, P., & Kleinlein, P. (2005). The impact of mental illness stigma In P. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change*. Washington DC: American Psychological Association.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*, 124-130.
- Creswell, J., Plano Clark, V., Gutmann, M., & Hanson, W. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209–240). CA: Sage Thousand Oaks.

- Cruwys, T., & Gunaseelan, S. (2016). "Depression is who I am": Mental illness identity, stigma and wellbeing. *Journal of Affective Disorders, 189*, 36-42.
doi:<http://dx.doi.org/10.1016/j.jad.2015.09.012>
- Curtis, C. (2010). Youth perceptions of suicide and help-seeking: 'They'd think I was weak or "mental"'. *Journal of Youth Studies, 13*, 699-715.
doi:10.1080/13676261003801747
- Cutcliffe, J. R., & McKenna, H. P. (2004). Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing, 45*, 126-133. doi:10.1046/j.1365-2648.2003.02874.x
- Czyz, E., Horwitz, A., Eisenberg, D., Kramer, A., & King, C. (2013). Self-reported barriers to professional help seeking among college students at elevated risk for suicide. *Journal of American College Health, 61*, 398-406.
- Davis, K. (2012). Friendship 2.0: Adolescents' experiences of belonging and self-disclosure online. *Journal of Adolescence, 35*, 1527-1536.
doi:10.1016/j.adolescence.2012.02.013
- Deacon, B. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*, 846-861.
- Dehar, M., Casswell, S., & Duignan, P. (1993). Formative and process evaluation of health promotion and disease prevention programs. *Evaluation Review, 17*, 204-220. doi:10.1177/0193841x9301700205

- DeLeo, D., & Heller, T. S. (2004). Who are the kids who self-harm? An Australian self-report school survey. . *Medical Journal of Australia*, *181*, 140-144.
- Dengate, J. (2011). Flourishing in life: An empirical test of the dual continua model of mental health and mental illness among Canadian university students. *The International Journal of Mental Health Promotion*, *13*, 13-22.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of personality assessment*, *49*, 71-75.
doi:10.1207/s15327752jpa4901_13
- DoHA. (2004). *Responding to the Mental Health Needs of Young People in Australia: Discussion Paper: Principles and Strategies*. Canberra: Australian Department of Health and Aging.
- Donath, S. (2001). The validity of the 12-item General Health Questionnaire in Australia: a comparison between three scoring methods. *Australian and New Zealand Journal of Psychiatry*, *35*, 231-235. doi:doi:10.1046/j.1440-1614.2001.00869.x
- Dray, J., Bowman, J., Wolfenden, L., Campbell, E., Freund, M., Hodder, R., & Wiggers, J. (2015). Systematic review of universal resilience interventions targeting child and adolescent mental health in the school setting: Review protocol. *Systematic Reviews*, *4*, 1-8. doi:10.1186/s13643-015-0172-6
- Eisenberg, D., Hunt, J., Speer, N., & Zivin, K. (2011). Mental health service utilization among college students in the United States. *Journal of Nervous and Mental Disease*, *199*, 301-308.

- Eley, T. C., Sugden, K., Corsico, A., Gregory, A. M., Sham, P., McGuffin, P., . . . Craig, I. W. (2004). Gene–environment interaction analysis of serotonin system markers with adolescent depression. *Molecular Psychiatry*, *9*, 908–915.
doi:10.1038/sj.mp.4001546
- Ennett, S. T., Ringwalt, C. L., Thorne, J., Rohrbach, L. A., Vincus, A., Simons-Rudolph, A., & Jones, S. (2003). A comparison of current practice in school-based substance use prevention programs with meta-analysis findings. *Prevention Science*, *4*, 1-14.
doi:10.1023/a:1021777109369
- Erikson, E. (1968). *Identity: Youth and Crisis*. New York: Norton.
- Evans, S. W., Mullett, E., Weist, M. D., & Franz, K. (2005). Feasibility of the MindMatters school mental health promotion program in American schools. *Journal of Youth and Adolescence*, *34*, 51-58. doi:10.1007/s10964-005-1336-9
- Farahmand, F. K., Duffy, S. N., Tailor, M. A., Dubois, D. L., Lyon, A. L., Grant, K. E., . . . Nathanson, A. M. (2012). Community - based mental health and behavioral programs for low - income urban youth: A meta - analytic review. *19*, 195-215.
doi:10.1111/j.1468-2850.2012.01283.x
- Farthing, R. (2012). Why youth participation? Some justifications and critiques of youth participation using New Labour's youth policies as a case study. *Youth and Policy*, *109*, 71-97.

- Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: a framework for understanding healthy development in the face of risk. *Annual Review of Public Health, 26*, 399-419. doi:10.1146/annurev.publhealth.26.021304.144357
- Fernandes, H. M., & Vasconcelos-Raposo, J. (2013). Factorial validity and invariance of the GHQ-12 among clinical and nonclinical samples. *Assessment, 20*, 219-229. doi:10.1177/1073191112465768
- First world problem (2016). In *Oxford Dictionaries Online*. Retrieved from https://en.oxforddictionaries.com/definition/First_World_problem
- Fleming, T. M., Robyn, S. D., & Merry, S. N. (2012). 'It's mean!' The views of young people alienated from mainstream education on depression, help seeking and computerised therapy. *Advances in Mental Health, 10*, 195-203. doi:10.5172/jamh.2011.10.2.195
- Fombonne, E., Wostear, G., Cooper, V., Harrington, R., & Rutter, M. (2001). The Maudsley long-term follow-up of child and adolescent depression: 1. Psychiatric outcomes in adulthood. *British Journal of Psychiatry, 179*, 210-217.
- Forman, S. G., Shapiro, E. S., Coddling, R. S., Gonzales, J. E., Reddy, L. A., Rosenfield, S. A., . . . Stoiber, K. C. (2013). Implementation science and school psychology. *School Psychology Quarterly, 28*, 77-100. doi:10.1037/spq0000019
- Forman, S., Olin, S., Hoagwood, K., Crowe, M., & Saka, N. (2009). Evidence-based interventions in schools: Developers' views of implementation barriers and

- facilitators. *School Mental Health: A Multidisciplinary Research and Practice Journal*, 1, 26-36. doi:10.1007/s12310-008-9002-5
- French, R., Reardon, M., & Smith, P. (2003). Engaging with a mental health service: Perspectives of at-risk youth. *Child and Adolescent Social Work Journal*, 20, 529-548.
- Frisch, M. B., Cornell, J., Villanueva, M., & Retzlaff, P. J. (1992). Clinical validation of the Quality of Life Inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment*, 4, 92-101.
doi:10.1037/1040-3590.4.1.92
- Frydenberg, E., Care, E., Freeman, E., & Chan, E. (2009). Interrelationships between coping, school connectedness and wellbeing. *Australian Journal of Education*, 53, 261-276. doi:10.1177/000494410905300305
- Galambos, N. L., Barker, E. T., & Krahn, H. J. (2006). Depression, self-esteem, and anger in emerging adulthood: Seven-year trajectories. *Developmental Psychology*, 42, 350-365. doi:10.1037/0012-1649.42.2.350
- Ganley, B. J., & Rosario, D. I. (2013). The smoking attitudes, knowledge, intent, and behaviors of adolescents and young adults: Implications for nursing practice. *Journal of Nursing Education and Practice*, 3, 40-50.
- Garland, A., Lau, A., Yeh, M., McCabe, K., Hough, R., & Landsverk, J. (2005). Racial and ethnic differences in utilisation of mental health services among high-risk youths. *American Journal of Psychiatry*, 162, 1336-1343.

- Garmy, P., Berg, A., & Clausson, E. K. (2015). A qualitative study exploring adolescents' experiences with a school-based mental health program. *BMC public health, 15*, 1-9. doi:10.1186/s12889-015-2368-z
- Generation Opportunity. (2016). *2016 State of Millennial Report: A Review of the Challenges and Opportunities for Young Americans*. Retrieved from https://generationopportunity.org/wp-content/uploads/2016/01/State_of_the_Millennial_2016.pdf
- Giedd, J. (2012). The digital revolution and the adolescent brain evolution. *Journal of Adolescent Health, 51*, 101-105. doi:10.1016/j.jadohealth.2012.06.002
- Giedd, J., Blumenthal, J., Jeffries, N., Castellanos, F., Liu, H., Zijdenbos, A., . . . Rapoport, J. (1999). Brain development during childhood and adolescence: a longitudinal MRI study. *Nature Neuroscience, 2*, 861-863.
- Gilchrist, H., & Sullivan, G. (2006). Barriers to help-seeking in young people: community beliefs about youth suicide. *Australian Social Work, 59*, 73 - 85. doi:10.1080/03124070500449796
- Giles, D., & Newbold, J. (2011). Self- and other-diagnosis in user-led mental health online communities. *Qualitative Health Research, 21*, 419-428. doi:10.1177/1049732310381388
- Goldberg, D. P. (1978). *Manual of the general health questionnaire / [by] David Goldberg*. Windsor: Windsor : NFER.

- Goldberg, D. P., Gater, R., Sartorius, N., Ustun, T. B., Piccinelli, M., Gurejeo, O., & Rutter, C. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine*, *27*, 191-197.
doi:doi:null
- Goldney, R. D., Fisher, L. J., & Wilson, D. H. (2001). Mental health literacy: an impediment to the optimum treatment of major depression in the community. *Journal of Affective Disorders*, *64*, 277-284.
- Gordon, R. S. (1983). An operational classification of disease prevention. *Public Health Reports*, *98*, 107-109.
- Green, J., & Thorogood, N. (2010). *Qualitative Methods for Health Research*. London: SAGE Publications.
- Greening, L., & Stoppelbein, L. (2002). Religiosity, attributional style, and social support as psychosocial buffers for African American and White adolescents' perceived risk for suicide. *Suicide and Life-Threatening Behavior*, *32*, 404-417.
- Greenspoon, P. J., & Saklofske, D. H. (2001). Toward an intergration of subjective well-being and psychopathology. *Social Indicators Research*, *54*, 81-108.
- Griffiths, K. M., Crisp, D. A., Barney, L., & Reid, R. (2011). Seeking help for depression from family and friends: A qualitative analysis of perceived advantages and disadvantages. *BMC Psychiatry*, *11*, 196. doi:10.1186/1471-244X-11-196
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability *Field Methods*, *18*, 59-82.

- Gulliver, A., Griffiths, K. M., & Brewer, J. L. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry, 12*, 12-23. doi:10.1186/1471-244X-12-81
- Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10*, 113. doi:10.1186/1471-244X-10-113
- Han, S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*, 665-679. doi:10.1007/s10802-005-7646-2
- Hanson, W. E., Creswell, J. W., Clark, V. L., Petska, K. S., & David, C. (2005). Mixed Methods Research Designs in Counseling Psychology. *Journal of Counseling Psychology, 52*, 224–235.
- Hart, R. (1992). *Children's participation: From tokenism to citizenship*. Retrieved from https://www.unicef-irc.org/publications/pdf/childrens_participation.pdf
- Hayes, L., & Ciarrochi, J. (2015). *The Thriving Adolescent : Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection*. Oakland, CA: New Harbinger Publications.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152-1168. doi:10.1037/0022-006X.64.6.1152

- Hazell, T., Vincent, K., Waring, T., & Lewin, T. (2002). The challenges of evaluating national mental health promotion programs in schools: A case study using the evaluation of MindMatters. *The International Journal of Mental Health Promotion*, 4, 21-21.
- Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health*, 103, 777-780. doi:10.2102/AJPH.2012.301056
- Henry, J. D., & Crawford, J. R. (2005). The short-form of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, 44, 227-239.
- Herrman, H., & Jané-Llopis, E. (2005). Mental health promotion in public health. *Promotion & Education*, 2005, 42-47.
- Holen, S., Waaktaar, T., Lervåg, A., & Ystgaard, M. (2012). The effectiveness of a universal school-based programme on coping and mental health: a randomised, controlled study of Zippy's Friends. *Educational Psychology*, 32, 657-677.
- Hom, M., Stanley, I., & Joiner, T. (2015). Evaluating factors and interventions that influence help-seeking and mental health service utilisation among suicidal individuals: A review of the literature. *Clinical Psychology Review*, 40, 28-39.
- Howe, N., & Strauss, W. (2000). *Millenials Rising: The Next Great Generation*. New York: Vintage Books.

- Howell, A. (2009). Flourishing: Achievement-related correlates of students' well-being. *Journal of Positive Psychology, 4*, 1-13. doi:10.1080/17439760802043459
- Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health, 46*, 3-10. doi:10.1016/j.jadohealth.2009.08.008
- Husky, M. M., Sheridan, M., McGuire, L., & Olfson, M. (2011). Mental health screening and follow-up care in public high schools. *Journal of The American Academy of Child and Adolescent Psychiatry, 50*, 881-891. doi:10.1016/j.jaac.2011.05.013
- James, A. M. (2007). Principles of youth participation in mental health services. *The Medical journal of Australia, 187*, S57-60.
- Jané-Llopis, E. (2005). From evidence to practice: Mental health promotion effectiveness. *Promotion & Education, 5*, 5-15.
- Jané-Llopis, E., & Barry, M. M. (2005). What makes mental health promotion effective? *Global Health Promotion, 12*, 47-54
- Johnson, J., Wood, A. M., Gooding, P., Taylor, P. J., & Tarrier, N. (2011). Resilience to suicidality: The buffering hypothesis. *Clinical Psychology Review, 31*, 563-591. doi:10.1016/j.cpr.2010.12.007
- Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry, 177*, 396-401. doi:10.1192/bjp.177.5.396

- Jorm, A. F. (2015). How effective are 'headspace' youth mental health services?
Australian and New Zealand Journal of Psychiatry, 49, 861-862.
doi:10.1177/0004867415608003
- Jorm, A. F., & Griffiths, K. (2008). The public's stigmatizing attitudes towards people with mental disorders: How important are biomedical conceptualizations?
Psychiatria Scandinavica, 118, 315-321. doi:10.1111/j.1600-0447.2008.01251.x
- Jorm, A. F., & Reavley, N. J. (2012). Public confusion caused by differing understandings of the term 'mental illness'. 46, 397-399.
doi:10.1177/0004867412444109
- Jorm, A. F., Bourchier, S. J., Cvetkovski, S., & Stewart, G. (2012). Mental health of Indigenous Australians: A review of findings from community surveys. *Medical Journal of Australia*, 196, 118-121.
- Kauer, S. D., Mangan, C., & Sancu, L. (2014). Do online mental health services improve help-seeking for young people? A systematic review. *Journal of Medical Internet Research*, 16, e66.
- Kemp, J., Lickel, J., & Deacon, B. (2014). Effects of a chemical imbalance causal explanation on individuals' perceptions of their depressive symptoms. *Behaviour Research and Therapy*, 56, 47-52.
- Keyes, C. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behavior*, 43, 207-222.

- Keyes, C. (2003). Complete mental health: An agenda for the 21st century *CLM Keyes & J Jaidt (Eds) Flourishing: Positive psychology and the life well-lived*. Washington, DC: American Psychological Association
- Keyes, C. (2006). Mental health in adolescence: Is America's youth flourishing? *American Journal Of Orthopsychiatry*, 76, 395-402. doi:10.1037/0002-9432.76.3.395
- Keyes, C. L. M. (1998). Social well-being. *Social Psychology Quarterly*, 61, 121-140.
- Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the Complete State Model of Health. *Journal of Consulting and Clinical Psychology*.
- Keyes, C. L. M., & Lopez, S. J. (2002). Toward a science of mental health: Positive directions in diagnosis and interventions. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.
- Keyes, C., Dhingra, S., & Simoes, E. (2010). Change in level of positive mental health as a predictor of future risk of mental illness. *American Journal of Public Health*, 100, 2366-2371. doi:10.2105/ajph.2010.192245
- Keyes, C., Wissing, M., Potgieter, J., Temane, M., Kruger, A., & Van Rooy, S. (2008). Evaluation of the mental health continuum-short form (MHC-SF) in Setswana - speaking South Africans. *Clinical Psychology & Psychotherapy*, 15, 181-192. doi:10.1002/cpp.572
- Kiuru, N., Burk, W., Laursen, B., Nurmi, J., & Salmela-Aro, K. (2012). Is depression contagious? A test of alternative peer socialization mechanisms of depression

- symptoms in adolescent peer networks. *Journal of Adolescent Health, 50*, 250-255.
doi:10.1016/j.jadohealth.2011.06.013
- Klein, W. M. P., Shepperd, J. A., Suls, J., Rothman, A. J., & Croyle, R. T. (2015).
Realizing the promise of social psychology in improving public health. *Personality
and Social Psychology Review, 19*, 77-92. doi:10.1177/1088868314539852
- Kobau, R., P, Peterson, C., Diener, E., Zack, M. M., Chapman, D., & Thompson, W.
(2011). Mental health promotion in public health: Perspectives and strategies from
positive psychology. *American Journal of Public Health, 101*, e1-9.
doi:10.2105/ajph.2010.300083
- Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of
college students' attitudes toward seeking psychological help. *Journal of
Counseling Psychology, 47*, 138-143.
- Kottke, T. E. (2011). Medicine is a social science in its very bone and marrow. *Mayo
Clinic Proceedings, 86*, 930-932. doi:10.4065/mcp.2011.0444
- Kranke, D., Floersch, J., Townsend, L., & Munson, M. (2010). Stigma experience among
adolescents taking psychiatric medication. *Children and Youth Services Review, 32*,
496-505. doi:10.1016/j.chilyouth.2009.11.002
- Kurki, M., Koivunen, M., Anttila, M., Hatonen, H., & Valimaki, M. (2011). Usefulness of
Internet in adolescent mental health outpatient care. *Journal of Psychiatric and
Mental Health Nursing, 18*, 265-273. doi:10.1111/j.1365-2850.2010.01661.x

- Kutash, K., Duchnowski, A., & Green, A. (2011). School-based mental health programs for students who have emotional disturbances: Academic and social-emotional outcomes. *School Mental Health, 3*, 191-208. doi:10.1007/s12310-011-9062-9
- Labouliere, C. D., Kleinman, M., & Gould, M. S. (2015). When self-reliance is not safe: Associations between reduced help-seeking and subsequent mental health symptoms in suicidal adolescents. *International Journal of Environmental Research and Public Health, 12*, 3741-3755.
- Labouliere, C. D., Tarquini, S. J., Totura, C. M. W., Kutash, K., & Karver, M. S. (2015). Revisiting the concept of knowledge: How much is learned by students participating in suicide prevention gatekeeper training? *Crisis, 36*, 274-280. doi:10.1027/0227-5910/a000323
- LaFrance, M. (2007). A bitter pill: A discursive analysis of women's medicalized accounts of depression. *Journal of Health Psychology, 12*, 127-140.
- Lamb, S., & Rice, S. (2008). Effective strategies to increase school completion. *Effective Strategies Commissioned Report*. Retrieved from <https://www.eduweb.vic.gov.au/edulibrary/public/postcomp/effectivestrategiesreportprint.pdf>
- Lamers, S. M. A., Westerhof, G. J., Bohlmeijer, E. T., Ten Klooster, P. M., & Keyes, C. L. M. (2011). Evaluating the psychometric properties of the Mental Health Continuum-Short Form (MHC-SF). *Journal of Clinical Psychology, 67*, 99. doi:10.1002/jclp.20741

- Larson, R. W. (2000). Toward a psychology of positive youth development. *American Psychologist, 55*, 170-183. doi:10.1037/0003-066x.55.1.170
- Leavey, G., Rothi, D., & Paul, R. (2011). Trust, autonomy and relationships: The help-seeking preferences of young people in secondary level schools in London (UK). *Journal of Adolescence, 34*, 685-693. doi:10.1016/j.adolescence.2010.09.004
- Letamo, G. (2011). Does correct knowledge about HIV and AIDS lead to sexual behaviour? The case of young people in Botswana. *African Population Studies, 25*, 44-62.
- Lightfoot, J., Wright, S., & Sloper, P. (1999). Supporting pupils in mainstream school with an illness or disability: young people's views. *Child: Care, Health and Development, 25*, 267-283. doi:10.1046/j.1365-2214.1999.00112.x
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Newbury Park: Sage.
- Lindholm, S. K., & Nelson, K. Z. (2015). "Apparently I've got low self - esteem" : Schoolgirls' perspectives on a school - based public health intervention. *Children & Society, 29*, 473-483.
- Logan, D. E., & King, C. A. (2001). Parent facilitation of adolescent mental health service utilisation: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8*, 319-333.
- Logan, D. E., & King, C. A. (2002). Parental identification of depression and mental health service use among depressed adolescents. *Journal of American Academy of*

- Child and Adolescent Psychiatry*, 41, 296-304. doi:10.1097/00004583-200203000-00009
- Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, Australia: Psychology Foundation.
- Lund, T. (2012). Combining qualitative and quantitative approaches: Some arguments for mixed methods research. *Scandinavian Journal of Educational Research*, 56, 155-165. doi:10.1080/00313831.2011.568674
- Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy Skills-Training Manual for Therapists*. Oakland, CA: New Harbinger Publications.
- Malla, A., Iyer, S., McGorry, P., Cannon, M., Coughlan, H., Singh, S., . . . Joobor, R. (2016). From early intervention in psychosis to youth mental health reform: a review of the evolution and transformation of mental health services for young people. *Social Psychiatry and Psychiatric Epidemiology*, 51, 319-326. doi:10.1007/s00127-015-1165-4
- Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *The Lancet*, 358, 483-488. doi:http://dx.doi.org/10.1016/S0140-6736(01)05627-6
- Mariu, K., Merry, S., Robinson, E., & Watson, P. (2011). Seeking professional help for mental health problems among New Zealand secondary school students. *Clinical Child Psychology and Psychiatry*, 17, 284-297.

- Marques, S., Pais-Ribeiro, J., & Lopez, S. (2011). The role of positive psychology constructs in predicting mental health and academic achievement in children and adolescents: a two-year longitudinal study. *Journal of Happiness Studies, 12*, 1049-1062. doi:10.1007/s10902-010-9244-4
- Martínez-Hernández, A., DiGiacomo, S. M., Carceller-Maicas, N., Correa-Urquiza, M., & Martorell-Poveda, M. A. (2014). Non-professional-help-seeking among young people with depression: a qualitative study. *BMC Psychiatry, 14*, 124-134. doi:10.1186/1471-244x-14-124
- Mason, J., & Hood, S. (2011). Exploring issues of children as actors in social research. *Children and Youth Services Review, 33*, 490-495. doi:http://dx.doi.org/10.1016/j.childyouth.2010.05.011
- Massé, R., Poulin, C., Dassa, C., Lambert, J., Bélair, S., & Battaglini, A. (1998). The structure of mental health: Higher-order confirmatory factor analyses of psychological distress and well-being measures. *An International and Interdisciplinary Journal for Quality-of-Life Measurement, 45*, 475-504. doi:10.1023/A:1006992032387
- Matthews, R. R., Hall, W. D., Vos, T., Patton, G. C., & Degenhardt, L. (2011). What are the major drivers of prevalent disability burden in young Australians? *Medical Journal of Australia, 194*, 232-235.
- Mayall, B. (1999). Children and childhood. In B. M. S. Hood, S. Oliver (Ed.), *Critical issues in social research: Power and prejudice*. Buckingham: Open University Press.

- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, *311*, 109-112.
- McPherson, M., Smith-Lovin, L., & Brashears, M. E. (2006). Social isolation in America: Changes in core discussion networks over two decades. *American Sociological Review*, *71*, 353-375. doi:<http://dx.doi.org/10.1177/000312240807300610>
- Merry, S. N., Hetrick, S. E., Cox, G. R., Brudevold-Iversen, T., Bir, J. J., & McDowell, H. (2012). Cochrane Review: Psychological and educational interventions for preventing depression in children and adolescents. *Evidence-Based Child Health: A Cochrane Review Journal*, *7*, 1409-1685.
- Merry, S. N., Hetrick, S. E., Cox, G. R., Brudevold-Iverson, T., Bir, J. J., & McDowell, H. (2011). Psychological and educational interventions for preventing depression in children and adolescents (Review). *Cochrane Database of Systematic Reviews*, *12*, 1-207. doi:10.1002/ebch.1867
- Merton, R. K. (1975). Thematic analysis in science: Notes on Holton's concept. *Science as Culture*, *188*, 335-338.
- Michelmores, L. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide & Life-Threatening Behavior*, *42*, 507-524. doi:10.1111/j.1943-278X.2012.00108.x
- MindMatters. (2012). *Whole School Matters - Draft 2012*. ACT: Commonwealth of Australia.

- Mizen, P. (2002). Putting the politics back into youth studies: Keynesianism, monetarism and the changing state of youth. *Journal of Youth Studies*, 5, 5-20.
doi:10.1080/13676260120111733
- Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington: National Academies Press.
- Muehlenkamp, J., Claes, L., Havertape, L., & Plener, P. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6, 1-9. doi:10.1186/1753-2000-6-10
- Muir, K., Powell, A., & McDermott, S. (2012). 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation. *Health & Social Care in the Community*, 20, 181-189. doi:10.1111/j.1365-2524.2011.01029.x
- Myers, D. (2000). The funds, friends, and faith of happy people. *American Psychologist*, 55, 56-67.
- Nafstad, H. E., Blakar, R. M., Botchway, A., & Rand-Hendriksen, K. (2009). Globalization, ideologies and well-being: A study of a West African and a North European society. *The Journal of Positive Psychology*, 4, 305-315.
doi:10.1080/17439760902933773
- Ng, E. S. W., Schweitzer, L., & Lyons, S. T. (2010). New generation, great expectations: A field study of the millennial generation. *Journal of Business and Psychology*, 25, 281-292. doi:10.1007/s10869-010-9159-4

- Norrish, J. M., & Vella-Brodrick, D. A. (2009). Positive psychology and adolescents: Where are we now? Where to from here? *Australian Psychologist, 44*, 270-278. doi:10.1080/00050060902914103
- O'Connor, P. J., Martin, B., Weeks, C. S., & Ong, L. (2014). Factors that influence young people's mental health help - seeking behaviour: a study based on the Health Belief Model. *Journal of Advanced Nursing, 70*, 2577-2587.
- Ojanen, T., Sijtsema, J., & Rambaran, A. (2013). Social goals and adolescent friendships: Social selection, deselection, and influence. *Journal of Research on Adolescence, 23*, 550-562. doi:10.1111/jora.12043
- Owen, J., & Rodolfa, E. (2009). Prevention through connection: Creating a campus climate of care. *Planning for Higher Education, 37*, 26-33.
- Owens, R. L., Magyar-Moe, J. L., & Lopez, S. J. (2015). Finding balance via positive psychological assessment and conceptualization: Recommendations for practice. *The Counseling Psychologist, 43*, 634-670. doi:10.1177/0011000015584956
- Palinkas, L. A. (2014). Qualitative and Mixed Methods in Mental Health Services and Implementation Research. *Journal of Clinical Child & Adolescent Psychology, 43*, 851-861. doi:10.1080/15374416.2014.910791
- Park, N. (2004). The role of subjective well-being in positive youth development. *The Annals of the American Academy of Political and Social Science, 591*, 25-39. doi:10.1177/0002716203260078

- Patel, V., & Goodman, A. (2007). Researching protective and promotive factors in mental health. *International Journal of Epidemiology*, *36*, 703-707.
doi:10.1093/ije/dym147
- Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*, 1302-1313.
doi:10.1016/s0140-6736(07)60368-7
- Paternite, C. (2005). School-based mental health programs and services: overview and introduction to the special issue. *Journal of Abnormal Child Psychology*, *33*, 657-663. doi:10.1007/s10802-005-7645-3
- Patton, G., Tollit, M., Romaniuk, H., Spence, S., Sheffield, J., & Shawyer, M. (2011). A prospective study of the effects of optimism on adolescent health risks. *Pediatrics*, *127*, 308-316. doi:10.1542/peds.2010-0748
- Pavot, W., & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment*, *2*, 164-172.
- Peter, T., Roberts, L., & Dengate, J. (2011). Flourishing in life: An empirical test of the dual continua model of mental health and mental illness among Canadian university students. *International Journal of Mental Health Promotion*, *13*, 13-22.
doi:10.1080/14623730.2011.9715646
- Peterson, C. (2004). Positive social science. *The Annals of the American Academy of Political and Social Science*, *591*, 187-201.

- Pharo, H., Sim, C., Graham, M., Gross, J., & Hayne, H. (2011). Risky business: Executive function, personality, and reckless behaviour during adolescence and emerging adulthood. *Behavioral Neuroscience, 125*, 970-978.
- Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H., & Graham, T. (2003). Reducing psychiatric stigma and discrimination. *Social Psychiatry and Psychiatric Epidemiology, 38*, 337-344. doi:10.1007/s00127-003-0641-4
- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet, 370*, 859-877. doi:10.1016/s0140-6736(07)61238-0
- Räikkönen, E., Kokko, K., & Rantanen, J. (2011). Timing of adult transitions: Antecedents and implications for psychological functioning. *European Psychologist, 16*, 314-323. doi:10.1027/1016-9040/a000050
- Raviv, A., Sills, R., Raviv, A., & Wilansky, P. (2000). Adolescents' help-seeking behaviour: the difference between self-and other-referral. *Journal of Adolescence, 23*, 721-740.
- Reavley, N., McCann, T., Cvetkovski, S., & Jorm, A. (2014). A multifaceted intervention to improve mental health literacy in students of a multicampus university: A cluster randomised trial. *Social Psychiatry and Psychiatric Epidemiology, 49*, 1655-1666. doi:10.1007/s00127-014-0880-6

- Rickwood, D., Deane, F., & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *The Medical Journal of Australia*, *187*, S35-S39.
- Roberts, R. E. L., & Bengston, V. L. (1993). Relationships with parents, self-esteem, and psychological well-being in young adulthood. *Social Psychology Quarterly*, *56*, 263-277.
- Ronk, F., Korman, J., Hooke, G., & Page, A. (2013). Assessing clinical significance of treatment outcomes using the DASS-21. *Psychological Assessment*, *25*, 1103-1110.
- Roose, G. A., & John, A. M. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. *Child: Care, Health and Development*, *29*, 545-550. doi:10.1046/j.1365-2214.2003.00374.x
- Rose, G. (2001). Sick individuals and sick populations. *International Journal of Epidemiology*, *30*, 427-432. doi:10.1093/ije/30.3.427
- Rowe, S. L., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian & New Zealand Journal of Psychiatry*, *48*, 1083-1095. doi:10.1111/j.1943-278X.2012.00108.x
- Rowling, L. (2007). School mental health promotion: MindMatters as an example of mental health reform. *Health promotion journal of Australia : official journal of Australian Association of Health Promotion Professionals*, *18*, 229-235.

- Rowling, L., & Martin, G. (2002). Mental health promotion and young people: The next 10 years. In L. Rowling, G. Martin, & L. Walker (Eds.), *Mental Health Promotion and Young People: Concepts and Practice* (pp. 259-266). Australia: McGraw-Hill Australia.
- Rüsch, N., Evans-Lacko, S., & Thornicroft, G. (2012). What is a mental illness? Public views and their effects on attitudes and disclosure. *The Australian and New Zealand journal of psychiatry*, *46*, 641.
- Rüsch, N., Heekeren, K., Theodoridou, A., Dvorkshy, D., Müller, M., Paust, T., . . . Rössler, W. (2013). Attitudes towards help-seeking and stigma among young people at risk for psychosis. *Psychiatry Research*, *210*, 1313-1315.
doi:10.1016/j.psychres.2013.08.028
- Russell-Mayhew, S. (2006). Key concepts from health promotion evaluations: What psychology needs to know. *International Journal for the Advancement of Counselling*, *28*, 167-182. doi:10.1007/s10447-005-9011-0
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*, 1069-1081. doi:10.1037/0022-3514.57.6.1069
- Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*, 719-727.
doi:10.1037/0022-3514.69.4.719

- Sanders, M. R., & Morawska, A. (2010). Prevention: The Role of Early Universal and Targeted Interventions (pp. 435-454). New York, NY: Springer New York.
- Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., . . . Raphael, B. (2001). The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry*, *35*, 806-814.
- Sawyer, M. G., Sawyer, A. C. P., & La Greca, A. M. (2012). Help-seeking by young people with depressive disorders. *The Prevention Researcher*, *19*, 11-14.
- Sawyer, M., Borojevic, N., Ettridge, K., Spence, S., Sheffield, J., & Lynch, J. (2012). Do help-seeking intentions during early adolescence vary for adolescents experiencing different levels of depressive symptoms? *Journal of Adolescent Health*, *50*, 236-242. doi:<http://dx.doi.org/10.1016/j.jadohealth.2011.06.009>
- Sawyer, M., G , Pfeiffer, S., & Spence, S. H. (2009). Life events, coping and depressive symptoms among young adolescents: A one-year prospective study. *Journal of Affective Disorders*, *117*, 48-54. doi:<http://dx.doi.org/10.1016/j.jad.2008.12.013>
- Sawyer, M., Harchak, T., Spence, S., Bond, L., Graetz, B., Kay, D., . . . Sheffield, J. (2010). School-based prevention of depression: A 2-Year follow-up of a randomized controlled trial of the beyondblue schools research initiative. *Journal of Adolescent Health*, *47*, 297-304. doi:[10.1016/j.jadohealth.2010.02.007](http://dx.doi.org/10.1016/j.jadohealth.2010.02.007)

- Sawyer, S., Afifi, R., Bearinger, L., Blakemore, S., Dick, B., Ezeh, A., & Patton, G. (2012). Adolescence: a foundation for future health. *The Lancet*, *379*, 1630-1640. doi:10.1016/S0140-6736(12)60072-5
- Scanlon, K. (2002). A population health approach: Building the infrastructure to promote mental health in young people. In L. Rowling, G. Martin, & L. Walker (Eds.), *Mental Health Promotion and Young People: Concepts and Practice*. Australia: McGraw-Hill Australia.
- Schelbe, L., Chanmugam, A., Moses, T., Saltzburg, S., Williams, L. R., & Letendre, J. (2015). Youth participation in qualitative research: Challenges and possibilities. *Qualitative Social Work*, *14*, 504-521. doi:10.1177/1473325014556792
- Secker, J., Armstrong, C., & Hill, M. (1999). Young people's understanding of mental illness. *Health Education Research*, *14*, 729-739.
- Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*, 5-14.
- Settersten, R., & Ray, B. E. (2010). *Not Quite Adults*. United States of America: Bantam Books.
- Shochet, I. M., Dadds, M. R., Holland, D., Whitefield, K., Harnett, P. H., & Osgarby, S. M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. *Journal of Clinical Child Psychology*, *30*, 303-315.
- Siegel, D. (2013). *Brainstorm: The power and purpose of the teenage brain*. United States: Penguin.

- Silva, J. M. (2014). Slight expectations: Making sense of the "me me me" generation. *Sociology Compass*, 8, 1388-1397. doi:10.1111/soc4.12227
- Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research*, 34, 1101-1118.
- Spence, S. H., & Shortt, A. L. (2007). Research Review: Can we justify the widespread dissemination of universal, school-based interventions for the prevention of depression among children and adolescents? *Journal of Child Psychology and Psychiatry*, 48, 526-542. doi:10.1111/j.1469-7610.2007.01738.x
- St Leger, L. (1998). Australian teachers' understanding of the health promoting school concept and the implications for the development of school health. *Health Promotion International*, 13, 223-234.
- Stein, J. (2013, May 20). Millennials: The Me Me Me Generation. *TIME Magazine*.
- Steinberg, L. (1985). *Adolescence*. New York, NY: Knopf.
- Stice, E., Shaw, H., Bohon, C., Marti, C. N., & Rohde, P. (2009). A meta-analytic review of depression prevention programs for children and adolescents: Factors that predict magnitude of intervention effects. *Journal of Consulting and Clinical Psychology*, 77, 486-503. doi:10.1037/a0015168
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 10, 282-298.

- Suldo, S. M., & Huebner, E. S. (2004). Does life satisfaction moderate the effects of stressful life events on psychopathological behavior during adolescence? *School Psychology Quarterly, 19*, 93-105. doi:10.1521/scpq.19.2.93.33313
- Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. *School Psychology Review, 37*, 52-68.
- Suldo, S., & Huebner, S. (2006). Is extremely high life satisfaction during adolescence advantageous? *Social Indicators Research, 78*, 179-203. doi:10.1007/s11205-005-8208-2
- Suldo, S., McMahan, M., Chappel, A., & Loker, T. (2012). Relationships between perceived school climate and adolescent mental health across genders. *School Mental Health, 4*, 69-80. doi:10.1007/s12310-012-9073-1
- Sussman, S., & Arnett, J. J. (2014). Emerging adulthood: Developmental period facilitative of the addictions. *Research in Emergng Adulthood and Risky Behaviour, 37*, 147-155. doi:10.1177/0163278714521812
- Tannenbaum, C., Lexchin, J., Tamblyn, R., & Romans, S. (2009). Indicators for measuring mental health: towards better surveillance. *Healthcare Policy, 5*, 178-186.
- Taylor-Rodgers, E., & Batterham, P. J. (2014). Evaluation of an online psychoeducation intervention to promote mental health help seeking attitudes and interntions among young adults: Randomised controlled trial. *Journal of Affective Disorders, 168*, 65-71. doi:10.1016/j.jad.2014.06.047

- Teddlie, C., & Tashakkori, A. (2009). *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences* (Vol. 23-67). Thousand Oaks: CA: SAGE Publications.
- Teng, E., Venning, A., Winefield, H., & Crabb, S. (2015). Half full or half empty: The measurement of mental health and mental illness in emerging Australian adults. *Social Inquiry into Well-Being, 1*, 1-12. doi:10.13165/SIIW-15-1-1-01
- Timimi, S. (2010). The McDonaldization of childhood: Children's mental health in neo-liberal market cultures. *Transcultural Psychiatry, 47*, 686-706.
doi:10.1177/1363461510381158
- Tiwari, S., & Wang, J. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry and Psychiatric Epidemiology, 43*, 866-871.
- Tjia, J., Givens, J., & Shea, J. (2005). Factors associated with undertreatment of medical student depression. *Journal of American College Health, 53*, 219-224.
doi:10.3200/JACH.53.5.219-224
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry, 16*, 837-851.
- Trevor, H., Karen, V., Trevor, W., & Lewin, T. (2002). The challenges of evaluating national mental health promotion programs in schools: A case study using the evaluation of MindMatters. *The International Journal of Mental Health Promotion, 4*, 21-21. doi:10.1080/14623730.2002.9721885

- Tucci, J., Mitchell, J., & Goddard, C. (2007). Children's fears, hopes and heroes - Modern childhood in Australia. Retrieved from <http://apo.org.au/?q=node/8255>
- Turkle, S. (2011). *Alone Together: Why We Expect More From Technology and Less From Each Other*. New York: Basic Books.
- Turkle, S. (2015). *Reclaiming Conversation: The Power of Talk in a Digital Age*. New York: Penguin Press.
- Valde, G. (1996). Identity closure: A fifth identity status. *The Journal of Genetic Psychology, 157*, 245-254. doi:10.1080/00221325.1996.9914862
- Van Zalk, M., Kerr, M., Branje, S., Stattin, H., & Meeus, W. (2010). It takes three: Selection, influence and de-selection processes of depression in adolescent friendship networks. *Developmental Psychology, 46*, 927-938. doi:10.1037/a0019661
- Venning, A., Kettler, L., Redpath, P., Orlowski, S., Elliott, J., & Wilson, A. (2016). Cognitive Behavioural Therapy. In R. J. Levesque (Ed.), *Encyclopaedia of Adolescence (2nd Ed)* New York: Springer.
- Venning, A., Wilson, A., Kettler, L., & Elliott, J. (2013). Mental health among youth in South Australia: A survey of flourishing, languishing, struggling, and floundering. *Australian Psychologist, 48*, 299-310. doi:10.1111/j.1742-9544.2012.00068.x
- Verhulp, E. E., Stevens, G. W. J. M., Van De Schoot, R., & Vollebergh, W. A. M. (2013). Understanding ethnic differences in mental health service use for adolescents'

- internalizing problems: the role of emotional problem identification. *European Child & Adolescent Psychiatry*, 22, 413-421.
- Vogel, D. L., Wade, N. G., Wester, S. R., Larson, L., & Hackler, A. H. (2007). Seeking help from a mental health professional: The influence of one's social network. *Journal of Clinical Psychology*, 63, 233-245. doi:10.1002/jclp.20345
- Vogl, G., Ratnaike, D., Ivancic, L., Rowley, A., & Chandy, V. (2016). One click away? Insights into mental health digital self-help by young Australians. Retrieved from http://about.au.reachout.com/wp-content/uploads/2016/09/RO0001_EY4_OneClickAway_v10_WEB.pdf
- Wahl, O., Susin, J., Kaplan, L., Lax, A., & Zatina, D. (2011). Changing knowledge and attitudes with a middle school mental health education curriculum. *Stigma Research and Action*, 1, 44-53. doi:10.5463/sra.v1i1.17
- Wahlin, T., & Deane, F. (2012). Discrepancies between parent- and adolescent-perceived problem severity and influences on help seeking from mental health services. *Australian & New Zealand Journal of Psychiatry*, 46, 553-560. doi:10.1007/s00127-011-0399-z
- Walker, L., & Rowling, L. (2007). Mental health takes central role in health promotion activities. *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals*, 18, 171-172.
- Waterman, A. (1982). Identity development from adolescence to adulthood: An extension of theory and a review of research. *Developmental Psychology*, 18, 341-358.

- Waterman, A., Schwartz, S., Zamboanga, B., Ravert, R., Williams, M., Agocha, B., . . .
Donnellan, M. (2010). The questionnaire for eudaimonic well-being: Psychometric properties, demographic comparisons, and evidence of validity. *The Journal of Positive Psychology, 5*, 41-61.
- Watson, A. C., Otey, E., Westbrook, A. L., Gardner, A. L., Lamb, T. A., Corrigan, P. W., & Fenton, W. S. (2004). Changing middle schoolers' attitudes about mental illness through education. *Schizophrenia Bulletin, 30*, 563-572.
- Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International, 26*, i29-i69.
doi:10.1093/heapro/dar075
- Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: a scoping review. *BMC Psychiatry, 15*, 1-20. doi:10.1186/s12888-015-0681-9
- Weist, M. (2001). Toward a public mental health promotion and intervention system for youth. *The Journal of School Health, 71*, 101-104. doi:10.1111/j.1746-1561.2001.tb07301.x
- Weist, M. (2005). Fulfilling the promise of school-based mental health: Moving toward a public mental health promotion approach. *Journal of Abnormal Child Psychology, 33*, 735-741. doi:10.1007/s10802-005-7651-5

- Weist, M., Nabors, L., Myers, C. P., & Paul, A. (2000). Evaluation of expanded school mental health programs. *Community Mental Health Journal, 36*, 395-411.
doi:10.1023/a:1001960929126
- Weist, M., Sander, M., Walrath, C., Link, B., Nabors, L., Adelsheim, S., . . . Carrillo, K. (2005). Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*, 7-13. doi:10.1007/s10964-005-1331-1
- Wells, J., Barlow, J., & Stewart-Brown, S. (2003). A systematic review of universal approaches to mental health promotion in schools. *Health Education, 103*, 197-220.
doi:10.1108/09654280310485546
- Westerhof, G. J. (2013). The complete mental health model: The social distribution of mental health and mental illness in the Dutch population. In C. L. M. Keyes (Ed.), *Mental Well-Being: International Contributions to the Study of Positive Mental Health* (pp. 51-70). USA: Springer.
- Westerhof, G., & Keyes, C. (2010). Mental illness and mental health: The two continua model across the lifespan. *Journal of Adult Development, 17*, 110-119.
doi:10.1007/s10804-009-9082-y
- Whitbourne, S. K., & Tesch, S. A. (1985). A comparison of identity and intimacy statuses in college students and alumni. *Developmental Psychology, 21*, 1039-1044.
- White, R. W., & Horvitz, E. (2009). Cyberchondria: Studies of the escalation of medical concerns in web search. *ACM Transactions on Information Systems, 27*, 23-37.

- WHO. (2001). *The Second Decade: Improving Adolescent Health and Development*. Geneva World Health Organisation
- WHO. (2013). *Mental Health Action Plan 2013-2030*. Geneva: World Health Organisation.
- Wickrama, K. A. S., Merten, M. J., & Elder, J., Glen H. (2005). Community influence on precocious transitions to adulthood: Racial differences and mental health consequences *Journal of Community Psychology*, 33, 639-653.
- Wiedemann, A. U., Schüz, B., Sniehotta, F., Scholz, U., & Schwarzer, R. (2009). Disentangling the relation between intentions, planning, and behaviour: A moderated mediation analysis. *Psychology & Health*, 24, 67-79.
doi:10.1080/08870440801958214
- Wilkinson, R., & Walford, W. (1998). The measurement of adolescent psychological health: One or two dimensions? *Journal of Youth and Adolescence*, 27, 443-455.
doi:10.1023/a:1022848001938
- Williams, P. G., Holmbeck, G. N., & Greenley, R. N. (2002). Adolescent health psychology. *Journal of Consulting and Clinical Psychology*, 70, 828-842.
doi:10.1037/0022-006x.70.3.828
- Winefield, H. R., Gill, T. K., Taylor, A. W., & Pilkington, R. M. (2012). Psychological well-being and psychological distress: Is it necessary to measure both? *Psychology of Well-Being: Theory, Research and Practice*, 2, 1-14.

- Winzer, R., Lindblad, F., Sorjonen, K., & Lindberg, L. (2014). Positive versus negative mental health in emerging adulthood: A national cross-sectional survey. *BMC public health, 14*, 1-10. doi:10.1186/1471-2458-14-1238
- Wu, P., Hoven, C. W., Bird, H. R., Moore, R. E., Cohen, P., Alegria, M., . . . Roper, M. T. (1999). Depressive and disruptive disorders and mental health service utilization in children and adolescents. *Journal of The American Academy of Child and Adolescent Psychiatry, 38*, 1081-1092. doi:10.1097/00004583-199909000-00010
- Wyn, J., & Woodman, D. (2006). Generation, youth and social change in Australia. *Journal of Youth Studies, 9*, 495-514. doi:10.1080/13676260600805713
- Wyn, J., Cahill, H., Holdsworth, R., Rowling, L., & Carson, S. (2000). MindMatters, a whole-school approach promoting mental health and wellbeing. *Australian & New Zealand Journal of Psychiatry, 34*, 594-601.
- Yap, M. B. H., Reavley, N., & Jorm, A. (2013). Associations between stigma and help-seeking intentions and beliefs: Findings from an Australian national survey of young people. *Psychiatry Research, 210*, 1154-1160.
doi:10.1016/j.psychres.2013.08.029
- Yap, M. B. H., Wright, A., & Jorm, A. F. (2011). The influence of stigma on young people's help-seeking intentions and beliefs about the helpfulness of various sources of help. *Social Psychiatry and Psychiatric Epidemiology, 46*, 1257-1265.
doi:10.1007/s00127-010-0300-5

- Youth Affairs Council of South Australia, G. o. S. A. (2015). *Better Together: A Practical Guide to Effective Engagement With Young People*. Retrieved from http://www.officeforyouth.sa.gov.au/__data/assets/pdf_file/0008/39680/Final-Better-Together-Youth-Engagement-Guide-V3-2016-02-09.pdf
- Zimmerman, M., Chelminski, I., Young, D., & Dalrymple, K. (2011). Using outcome measures to promote better outcomes. *Clinical Neuropsychiatry: Journal of Treatments Evaluation*, 8, 28-36.

CHAPTER NINE: APPENDICES

Appendix 1. Study information sheet and consent form for *Paper One*



YOU ARE INVITED

TO PARTICIPATE IN AN EXCITING NEW STUDY ON

WELLBEING IN YOUNG ADULTS

As part of a research study aimed at understanding **positive mental health** in young South Australians, we would like to ask you a few questions about your current levels of psychological, social and emotional wellbeing.

As a valued participant in UniSA's Longitudinal Investigation of School-Leavers, **you have the opportunity to offer additional insight** into how your current state of mental health may be connected to factors in your adolescence.



The attached questionnaire should take no longer than **10 minutes to complete.**

Participation is voluntary. If you are interested, please complete the attached questionnaire and return it in the postage paid envelope. You can also provide an email address so that we can send you feedback with the overall results of the study.

If you would prefer to complete this questionnaire **online**, please visit:
www.surveymonkey.com/s/completementalhealth

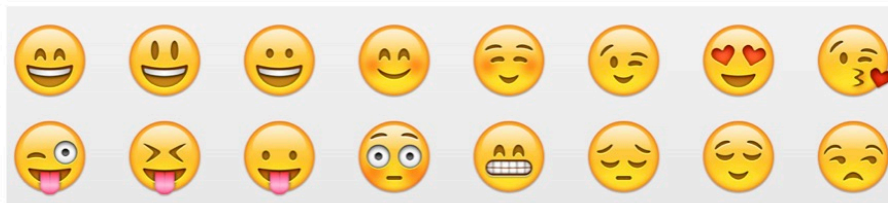
If you would like **more information** about this study, please contact:
 Emmelin Teng, PhD Candidate, University of Adelaide, on:
 Ph: (08) 8313 0057 Email: emmelin.teng@adelaide.edu.au

This project has been approved by the University of South Australia Human Research Ethics Committee and the University of Adelaide Human Research Ethics Committee.

Appendix 2. Information sheet and assent form (students), consent form (parents) and information sheet (school staff) for qualitative study (*Paper Two & Paper Three*)



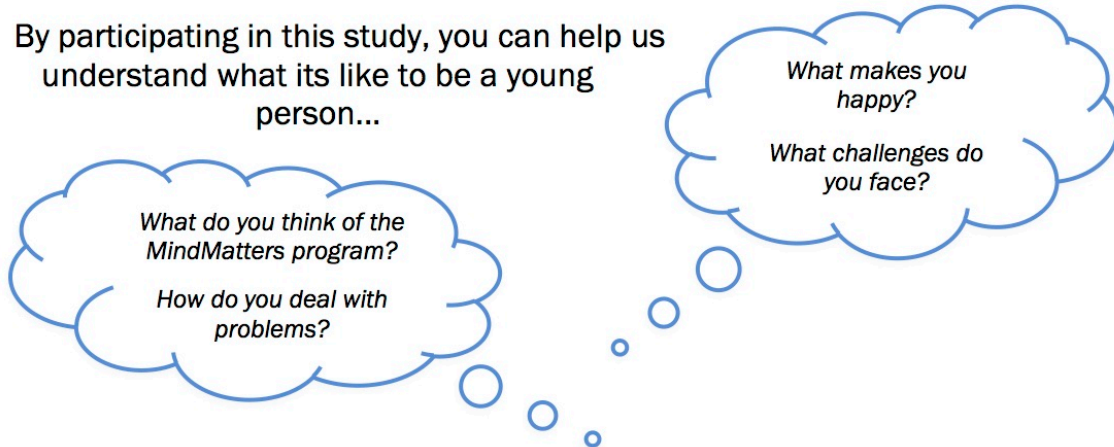
Which one describes you today?



You are invited to participate in a study on
WELLBEING IN YOUNG PEOPLE

As part of a research study aimed at understanding *mental health and wellbeing* in *young people like YOU*, we would like to interview you and ask you some questions about your thoughts, ideas and experiences.

By participating in this study, you can help us understand what its like to be a young person...



You can tell us what it's like to be YOU.

Participation is completely voluntary. If you would like to be a part of the study, you will need to complete the attached form, and also ask a parent or caregiver to read the study information sheet and sign the consent form.

If you would like more info about this study, please contact:

Emmi Teng
PhD Candidate, University of Adelaide
Phone: (08) 8313 0057
Email: emmelin.teng@adelaide.edu.au

STUDENT ASSENT FORM

We are doing a research study about mental health from the perspectives of young people. We are asking students who are involved in the MindMatters program at their schools to participate in this study. If you decide that you want to be part of this study, you will be asked to participate in a face-to-face interview asking you about your ideas and perspectives about mental health and wellbeing.

There are some things about this study you should know. The topics covered relate to mental health and wellbeing. You do NOT have to share any personal experiences or talk about anything that makes you uncomfortable.

When we are finished with this study we will write a report about what was learned, but this report will NOT include your name or that you were in the study.

You do not have to be in this study if you do not want to be. It is okay if you decide to stop after we begin an interview as well. You can withdraw from the study at any time.

If you decide you want to be in this study, please write and sign your name below.

1. I, _____, want to be in this research study.

(Sign your name here)

2. Please indicate your permission to audio record the interview by signing your name below.

This is for research purposes only, and you will not be identified for participating in the study in any way.

(Sign your name here)

___/___/___

(Date)



SCHOOL OF PSYCHOLOGY
FACULTY OF HEALTH SCIENCES

THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA

TELEPHONE +61 8 8313 5693
FACSIMILE +61 8 8313 3770

31st October 2013

Dear Parents/Caregivers,

Re: Research study: *Mental health conceptualisation and qualitative evaluation of the MindMatters program: perspectives of South Australian students*

Purpose: Your child has been invited to take part in a research study looking at young people's perspectives of mental health concepts, and their experiences of the MindMatters mental health promotion program. The study is conducted by Emmi Teng, Psychology PhD/Masters student from the University of Adelaide, in collaboration with MindMatters and Principals Australia. The purpose of this study is to gain a stronger understanding of what mental health means to young people themselves. You have received this form because your child is involved in the MindMatters program, and fits into the required age range of 12-17 years for the study.

Study Procedure: If your child is interested in participating in the study, and you give your consent to your child being involved, they will be asked to take part in an interview with myself (Emmi Teng) as the researcher, asking about what they think of the MindMatters program and how they would describe mental health terms such as 'wellbeing'. The interview can be conducted face-to-face on school grounds, and will take no longer than 45 minutes to complete. **Your child's participation is voluntary and they may withdraw from the study at any time without any penalty.**

Benefits/Risks: By participating in this study, your child may not directly benefit; however, information from this study may increase our understanding of experiences of young people relating to mental health. This information has implications for the development of mental health programs implemented through the school that will be most useful and appropriate to young people. The proposed project can be aligned with the first outcome of the DECD Strategic Plan for 2012-2016 of *Every child achieves their potential*, which amongst other aims, endeavours to provide safe, healthy and happy care and learning environments and to promote development of resilience in young people. There are no costs or perceived risks to your child for participation in this study.

Ethical Considerations: Your child's privacy and confidentiality will be ensured, as no names or personal information will be recorded. Demographic information of a general nature (age and gender) is collected for statistical purposes only. Any information provided will be used



SCHOOL OF PSYCHOLOGY
FACULTY OF HEALTH SCIENCES

THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA

TELEPHONE +61 8 8313 5693
FACSIMILE +61 8 8313 3770

only for research purposes. Please note that for confidentiality reasons, we will be unable to provide individualised feedback. However, if interested, a summary of results can be obtained by contacting me (email below).

Contact Information: Should you have any questions or queries or if you would like to further discuss the study, please do not hesitate to contact me on the email address or phone number provided below. This study has been approved by the *University of Adelaide Human Research Ethics Committee* and the *Department of Education and Child Development*. If you have any complaints or reservations regarding the ethical conduct of this study, please contact the convener of the Subcommittee for Human Research in the School of Psychology, Dr. Paul Delfabbro (08 8313 4936). Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Thank you for taking the time to read this information sheet and considering your consent to participate in this study. Your child's participation will be greatly appreciated.

Yours sincerely,

Emmi Teng,
PhD/Masters (Clinical Psychology) Candidate
The University of Adelaide
Phone: (08) 8313 0057 or 0430034949
Email: emmelin.teng@adelaide.edu.au



SCHOOL OF PSYCHOLOGY
FACULTY OF HEALTH SCIENCES

THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA

TELEPHONE +61 8 8313 5693
FACSIMILE +61 8 8313 3770

PARENT CONSENT FORM

I (name) _____

hereby consent to my child, _____'s involvement in the research project entitled:

Mental health conceptualisation and qualitative evaluation of the MindMatters program: perspectives of South Australian students

Principal Researcher: Emmi Teng
Ph: 0430034949
Email: Emmelin.teng@adelaide.edu.au

I have read and understood the Information Sheet on the above project and understand that my child is being asked to share their opinions and perspectives on the MindMatters program and their understanding of mental health and wellbeing.

I understand that my child may not directly benefit by taking part in this research.

I understand that while information gained in the study may be published, my child will not be identified; all individual information will remain confidential.

I understand that my child's participation in this research project is voluntary; a decision not to participate will in no way affect their academic standing or relationship with the school and they are free to withdraw their participation at any time.

I understand that there will be no payment for my child taking part in this study.

I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

I consent to my child being involved in this project.

Signed: _____

Relationship to child: _____

Date: _____



Dear Principals and School Staff,

This is an invitation for secondary students attending your school to participate in a research project conducted by Emmi Teng, PhD/Masters student from the University of Adelaide, working in collaboration with MindMatters and Principals Australia. The project is entitled *Mental health conceptualisation and qualitative evaluation of the MindMatters program: perspectives of South Australian students*. I write to seek your approval and assistance to conduct qualitative research by allowing me to seek to recruit participants during student involvement with the MindMatters workshops.

The purpose of the research is to gain an understanding of mental health concepts from the perspectives of young people. In addition, the research aims to evaluate the MindMatters program from a qualitative approach examining student views, in order to identify strengths and challenges of the program to those who are directly involved in it.

Approval is sought to hand out information forms to your students (ages 12-16 years old), highlighting the details of the study. The involvement of the students would require them to give their parents the information sheet and attached consent forms. If students are interested in participating, a returned consent form from parent or caregiver will be required before scheduling of an interview during MindMatters workshop times.

The findings of this research will be of particular relevance towards understanding perspectives and conceptualisation of mental health concepts among young people, as well as identifying key strengths and barriers of mental health programs implemented within schools. An advantage of this study is that it will allow important insights into the *perspectives of young people themselves* on mental health topics, which represent a largely under-researched area that is of significance for the ways that we approach mental health initiatives aimed at youth.

This study has been **approved** by the *University of Adelaide Human Research Ethics Committee* and the *Department for Education and Child Development*.

Thank you for taking the time to read this information sheet and considering the consent of your students and school to be involved in the recruitment process of this study. Your participation will be greatly appreciated. Should you require any further information please do not hesitate to contact myself on the details below.

Yours sincerely,

Emmi Teng
University of Adelaide
Phone: 8313 0057 or 0430034949
Email Emmelin.teng@adelaide.edu.au

Appendix 3. Interview protocol for qualitative study (*Paper Two & Paper Three*)

Part A - Student perspectives of mental health concepts and related attitudes and behaviours

1. What does the term 'mental health' mean to you?
Prompts: Can you think of any examples of someone being 'mentally healthy?' What does it look like? What might be important parts of mental health?
2. What does the term 'mental illness' mean to you?
Prompts: Can you think of any examples of someone being 'mentally ill?' What does it look like? What might be some important parts of mental illness? Can you get better when you're mentally ill?
3. What does the term 'wellbeing' mean to you?
Prompts: Can you think of any examples of someone having good wellbeing? What does it look like? What might be important parts of wellbeing?
4. How important is mental health in your opinion?
Prompts: Why? What makes you think this?
5. How should you act around someone with a mental illness?
Prompts: If one of your friends told you they had depression /anxiety/panic disorder/schizophrenia/eating disorder, what might you do or say?
6. What are some things that might affect someone's mental health?
Prompts: Can you think of anything that has had a good or bad effect on your mental health in the past?
7. Is there anything someone can do to look after their own mental health?
Prompts: What do you think keeps you mentally healthy? What suggestions might you give to younger kids in the MindMatters program? How do you think these things help?
8. In your life, how is your own mental health?
Prompts: Can you try to describe your mental health in your own words? What things in your life do you think contribute to this?
9. What would you do if you were feeling down, stressed or overwhelmed?
Prompts: How would you handle it? What if this went on for a long time? Would you speak to someone about it? If so, who? If not, why not?
10. What do you think might stop you or others from talking to someone about it?
Prompts: Is there anything that would make it less likely for you to tell your parents, or approach a teacher or counsellor? What about speaking to someone like a psychologist or psychiatrist?

Part B: - Student Perspectives on the MindMatters Program

11. What do you think of the MindMatters program?
Prompts: Do you think it has a positive or negative impact overall? Why?
12. What do you think the program is trying to do?
Prompts: How well do you think these goals are achieved?
13. What do you like about the program?
14. Are there any things you would change about the program?
15. Tell me about what you have learnt so far from the program.
Prompts: Can you think of anything you have learnt that has changed the way you do things or think about things?
16. Do you think it is useful to learn about mental health?
Prompts: Why/why not?
17. Do you think that knowing more about mental health influences how treat others?
Prompts: For example, would it change how you act around a friend dealing with some problems?
18. Do you think knowing more about mental health might improve your own wellbeing? How?
19. Is there anything else you want to tell me about what we've spoken about today?

Appendix 4. Audit trail sheet for qualitative study (*Paper Two & Paper Three*)

Audit Trail	Interviewer: Emmelin Teng
Date: __ / __ / __	
Participant:	
School:	
Year level/Age: M <input type="checkbox"/> F <input type="checkbox"/>	
Length of Interview: __ mins	
<i>Interview observations</i>	
<ul style="list-style-type: none"> ➤ In general, how did the interview go? ➤ Was the interview interrupted? ➤ What were the strengths of the interview? ➤ What were the difficulties? ➤ How do you think the interviewee felt during the interview? ➤ Body language, speech/tone observations, facial expressions ➤ Did the patient appear uncomfortable? ➤ Was there anything that stood out or was of concern? 	
<i>Reflexivity</i>	
<ul style="list-style-type: none"> ➤ Was a rapport established with the interviewee? ➤ What were the similarities between myself and the interviewee? ➤ How did the interviewee make me feel? ➤ Any personal characteristics which may have influenced the interview process? (e.g. gender, social status) ➤ Did the interviewee appear uncomfortable with aspects of my personal characteristics? ➤ Did the interviewee make me feel uncomfortable? ➤ Did the interviewee appear uncomfortable with any aspect of my personal characteristics? 	

Appendix 5. Participant information sheet (name of school removed to maintain confidentiality) and consent form (*Paper Four*)

Parent Information Sheet



The effect of Gratitude on the relationship between Bullying and Well-Being in adolescent girls: Information for Participants

My name is Eleni Grigoriadis and I am currently undertaking my Honours year in Psychology at the University of Adelaide. Thank you for taking the time to read this Information Statement. This Information Statement and Consent Form is 3 pages long. Please make sure you have all pages.

Your child is invited to participate in the research to be conducted by the School of Psychology, The University of Adelaide, in conjunction with _____ (explained below). Please read this Information Sheet carefully. Once you have understood what the research is about, if you would like your child to take part please sign the attached consent form Sheet.

1. What is the research project about?

This research is focused on investigating an adolescents well-being, the character strengths that contribute to it, an individual's level of knowledge about well-being, and if gratitude buffers against the adverse effects of bullying. Research suggests that bullying may result in numerous physical, emotional, and social problems (e.g., lower self-concept, motivation, and possible suicide ideation), and has hence become an increasingly important issue for youth due to the negative effects it has on well-being. This research will therefore focus on the presence, or absence, of personal strengths and the buffering effect this may have on the relationship between bullying and well-being.

2. Who are the researchers?

The project will be completed to fulfil part of the requirements of my honours degree in Psychology at The University of Adelaide. My supervisor is Dr Anthony Venning, Lecturer in the School of Psychology at the University of Adelaide and information on wellbeing literacy shared with and used by Emmelin Teng, a PhD student of Dr Venning.

3. What do you need to do for your child to take part in this research project?

If you choose to be part of our research, you will need to complete the attached consent form. Staff at _____ will then organise for your child to complete two on-line questionnaires that each take approximately 15 minutes to complete. Your child will complete these questionnaires during class hours over a two-week period and will be supervised by the teachers of the school.

4. What are the possible benefits?

It is anticipated that the results of this study will not only provide an overview of the state of wellbeing within the _____ student body, but also provide some insights into bullying and how it can be prevented. This study has the opportunity to provide information to the larger community, and your school, about how the effects of bullying may be minimised by strengthening an individuals positive personal resources.

5. What are the possible risks, side effects and/or discomforts?

We do not expect there to be any risks or side effects from your child's participation in the study. Students may experience some levels of discomfort when recalling low levels of well-being or bully-victim events, but this is not expected to be too distressing. Students and their teachers will be provided with information for further help should they be experiencing distress, and this information is also provided at the end of this Information Sheet.

6. Do I have to take part in this research project?

You have the right to decline from allowing your child to participate. Your child also has the right to withdraw from active participation in this project at any time without any repercussions.

7. How will I be informed of the final results of this research project?

A complete summary of results will be forwarded to _____ at the completion of this project and a summary will be able to be obtained from here. However, if you would like to be sent an overview of results individually you may contact myself after October 2013 at eleni.grigoriadis@student.adelaide.edu.au

How will the information collected be stored?

No personal or identifiable information will be collected from participants, and while a complete summary of results will be provided _____ data will only be accessed by the researchers. In accordance with the regulatory guidelines, the data collected in this study will be kept for at least 5 years, after which time it will be destroyed. All information will be kept at the School of Psychology, University of Adelaide and will be the responsibility of the researchers involved.

If you would like more information about the project or wish to speak to a member of the research team please contact the principal investigator as below:

Dr Anthony Venning
School of Psychology
Level 8, Hughes Building
The University of Adelaide SA 5005
Telephone: (08) 8313 6785
E-mail: b

If you have any concerns or queries about the project that the investigator has not been able to answer to your satisfaction, you may contact:

Associate Professor Paul Delfabbro
Chair of the School of Psychology Human Ethics
Subcommittee
School of Psychology
Level 4, Hughes Building
The University of Adelaide SA 5005
Telephone: (08) 8303 4936
E-mail: paul.defabbro@adelaide.edu.au

This is a guide to some resources that might help you deal with concerns about your child's behaviour, health, and emotional well-being, or worries that your child may be having. These South Australian organisations have internet websites that will also provide you with access to further related websites.

Kids Help Line
Phone: 1800 551 800
www.kidshelpline.com

Child & Youth Health
Parent Help Line: 1300 364 100
Youth Help Line: 1300 131 719
www.cyh.sa.gov

Appendix 6. Ethics approval (all papers) and data licence agreement (Paper One)



School of Psychology
The University of Adelaide
Adelaide, South Australia, 5005
Telephone + 61 8 8303 5693
FAX: + 61 8 8303 3770

Human Research Ethics Subcommittee

Approval sheet

Date: 7/6/12

Dear Heidi

The members of the subcommittee have considered your application:

Code Number: 12/49 [MENTAL HEALTH IN YOUNG ADULTS]

With [Student Name, if applicable]: EMELINE TENG

I am writing to confirm that approval has been granted for this project to proceed.

Dr. Paul Delfabbro
Acting Convener of the Human Research Ethics Subcommittee
School of Psychology
Ph. 8 303 ~~5734~~ 4936
Paul.delfabbro@~~psychology~~ adelaide.edu.au

DATA LICENSE AGREEMENT

Between **The University of South Australia** (ABN: 37 191 313 308) a body corporate pursuant to the University of South Australia Act 1990 (SA) as amended, of North Terrace, Adelaide South Australia 5000 (**'UniSA'**)

And **The University of Adelaide** (ABN: 61 249 878 937), a body corporate established pursuant to the provisions of the *University of Adelaide Act 1971* (SA) and having its principle office at North Terrace, Adelaide, SA 5005 (**'UA'**)

(each a **'Party'** and collectively referred to as **'the Parties'**)

RECITALS

- A. UniSA possess certain research Data, described in the Schedule, which UA wishes to utilise in a student research project.
- B. The Parties agree that the Data shall be licensed to UA subject to the pre-conditions and terms and conditions set out in this Agreement.

OPERATIVE PART

1. Definitions and Interpretation

1.1 In this Agreement:

'Agreement' means this Agreement, including its Schedule.

'Data' means the data collected from the Original Participants which is further itemized and described in Item 1 of the Schedule.

'Original Participants' means the human participants in the original UniSA research project who provided the Data.

'Purpose' means the UA PhD student research project further described in the Schedule.

1.2 In this agreement, unless the context otherwise requires, a word or expression:

1.2.1 importing the singular includes the plural and vice versa;

1.2.2 importing a gender includes the other genders;

1.2.3 denoting individuals includes corporations, firms, authorities, unincorporated bodies and instrumentalities;

1.2.4 referring to a party includes that party's legal personal representative, successor or permitted assign;

1.2.5 given a defined meaning in this agreement, has a corresponding meaning for any other part of speech or grammatical form.

1.2.6 headings in this Agreement are for convenience only and do not form part of the Agreement.

2. License to use Data

2.1 Subject to the other provisions of this Agreement, UniSA grants to UA a fee-free, royalty-free, limited, non-transferable, non-exclusive licence to use the Data, but solely for the Purpose.

3. Licence Pre-conditions

3.1 The Licence set out in clause 3 is conditional on the following:

3.1.1 UniSA's Human Research Ethics Committee must grant approval for the Original Participants to be contacted by UA and invited to participate for the Purpose;

3.1.2 UA must comply with all conditions or requirements imposed by UniSA's Human Research Ethics Committee in granting approval for the Purpose;

3.1.3 At least 200 of the Original Participants must respond to UA's invitation and provide written consent for their Data to be used for the Purpose, and written evidence of such response must be provided to UniSA within three months of this Agreement being signed;

3.2 UniSA is only obliged to release the Data into UA's possession if the pre-conditions set out in clause 3.1 are met.

3.3 If any of the preconditions set out in clause 3.1 are not met, or are breached, the licence in clause 2.1 will be null and void and this agreement will automatically terminate.

4. Licence Conditions

4.1 Any Data proved to UA pursuant to this Agreement must be stored and dealt with in accordance with:

4.1.1 UA's internal policies and guidelines relating to the use and storage of data;

4.1.2 the *Australian Code for the Responsible Conduct of Research*;

4.1.3 the terms of the *Privacy Act 1988* (Cth) and any other applicable laws.

5. Warranties and Indemnities

5.1 UA agrees that it will use the Data at its own risk and releases and indemnifies UniSA and its personnel against any claim, judgment or award, including a claim, judgment or award in favour of a third party, which arises as a result of:

5.1.1 UA’s use of the Data; or

5.1.2 UA’s breach of this Agreement.

5.2 UA acknowledges and agrees that the Data is provided ‘as is’ and without any warranties of any kind.

6. Ownership and Publication

6.1 UniSA owns all rights, title and interest in the Data.

6.2 UA must ensure that all publications arising from the use of the Data acknowledge UniSA. All publications must be consistent with the *Australian Code for the Responsible Conduct of Research*.

7. Miscellaneous

7.1 Governing Law. This Agreement shall be governed by the laws of the State of South Australia.

7.2 Survival. All provisions relating to liability and use of the Data survive termination of the Agreement.

7.3 Waiver/Severability. Any waiver, in whole or in part, of any provision of this Agreement shall not be considered to be a waiver of any other provision. If any term of this Agreement is found to be unenforceable or invalid for any reason, all other terms shall remain in full force and effect.

7.4 Entire Agreement. This Agreement, as to its subject matter, exclusively and completely states the rights, duties and obligations of the Parties and supersedes all prior and contemporaneous representations, letters, proposals, discussions and understandings by or between the Parties. This Agreement may only be amended in a writing signed by both Parties.

7.5 Counterparts. The Parties may execute this Agreement in any number of counterparts. All counterparts constitute one and the same instrument, and each constitutes an original of this Agreement.

**UNIVERSITY OF
SOUTH AUSTRALIA (SIGNED IN ACCORDANCE
WITH THE VICE CHANCELLORS AUTHORISATIONS)**

UNIVERSITY OF ADELAIDE

By _____

By _____

Print Name _____

Print Name _____

Title _____

Title _____

Date _____

Date _____

SCHEDULE

TO THE DATA LICENSE AGREEMENT BETWEEN
THE UNIVERSITY OF SOUTH AUSTRALIA AND THE UNIVERSITY OF ADELADE

1. Data to be licenced under this Agreement:

Only that portion of the original data arising from the '*longitudinal investigation of school leavers*' study which the Original Participants give consent to be used for the Purpose. At least 200 Original Participants must grant such consent, and written evidence of each consent must be provided to UniSA within three months of this Agreement being signed before Data will be released. The Data will be provided to UA in de-identified form.

2. Purpose

For use by Emmelin Hsien-Leen Teng in her UA PhD student research project.



Government of South Australia
Department for Education and
Child Development

Strategy and Performance

Level 8
31 Flinders Street
Adelaide SA 5000
GPO Box 1152
Adelaide SA 5001
DX 541

Tel: 8226 4108
Fax: 8226 1605

DECD CS/13/193-2.4

14 August 2013

Ms Emmelin Teng
University of Adelaide School of Psychology
North Terrace Campus
Level 4 Hughes Building, The University of Adelaide
SA 5005

Dear Ms Teng

Your project titled "Mental health conceptualisation and qualitative evaluation of the MindMatters program: perspectives of South Australian students" has now been reviewed by a senior Department for Education and Child Development (DECD) consultant with respect to protection from harm, informed consent, confidentiality and suitability of arrangements. Accordingly, I am pleased to advise you that your project has been **approved**.

The DECD Reviewer of this project is Dr Susanne Owen. Dr Owen has asked that the consent forms for the focus groups must include separate signatures for participation and for the audiotaping/digital taping.

If you wish to clarify or discuss further please feel free to contact her on Ph: 8226 3677.

Please contact Ms Allison Cook, Project Officer - Research and Innovation on (08) 8226 4108 for any other matters you may wish to discuss regarding the general review/approval process.

Please supply the department with an electronic copy of the final report which will be circulated to interested staff and then made available to DECD educators for future reference.

I wish you well with your project.

Ben Temperly
HEAD OF STRATEGY AND PERFORMANCE



Catholic Education Centre

116 George Street Thebarton SA 5031
PO Box 179 Torrensville Plaza South Australia 5031
Telephone: (08) 8301 6600
Facsimile: (08) 8301 6611
ISD: 61 8 8301 6600
Email: director@cesa.catholic.edu.au
www.cesa.catholic.edu.au

Ms Emmelin Teng
PhD/Masters Candidate
School of Psychology
Room 715, Hughes Building
University of Adelaide
ADELAIDE 5005

Dear Emmelin

RE: RESEARCH PROJECT REQUEST – MENTAL HEALTH

Thank you for your email of 30 August 2013 in which you seek permission to study secondary student perceptions of mental health. I understand the research will involve secondary students participating in the MindMatters program and you will be interviewing students who register their interest in the study. You will seek feedback in interviews with these students and will be audiotaping the interviews.

In the normal course, permission of the Principal of the school in which you wish to conduct research is required. Research in Catholic schools is granted on the basis that individual students, schools and the Catholic sector itself is not specifically identified in published research data and conclusions.

Approval is also contingent upon the following conditions, i.e. that:

- a copy of the interview questions have been provided to the Principal
- the permission of parents have been obtained
- the research complies with the ethics proposal of the University of South Australia.
- the research complies with any provisions under the Privacy Act that may require adherence by you as researcher in gathering and reporting data
- no comparison between schooling sectors is made
- the researcher will be carrying out the research within view of the class teacher or authorised school observer
- sector requirements relating to child protection and police checks are met by researchers:
 - where researchers obtain information in relation to a student which suggests or indicates abuse, this information must be immediately conveyed to the Director of Catholic Education SA
 - all researchers and assistants, who in the course of the research interact in any way with students, are required to provide evidence of an acceptable police clearance direct to the school.

Further information can be obtained direct from the Police Check Unit (08) 8210 9383 or via email at receptionpcu@adelaide.catholic.org.au.

Please accept my very best wishes for the research process.

Yours sincerely

HELEN O'BRIEN
DEPUTY DIRECTOR

11 September 2013



THE UNIVERSITY
OF ADELAIDE
AUSTRALIA

School of Psychology

The University of Adelaide
Adelaide, South Australia, 5005
Telephone + 61 8 8313 5693
FAX: + 61 8 8313 3770

School Human Research Ethics Subcommittee

Approval sheet

Date: 19/8/13

Dear Heron

The members of the subcommittee have considered your application:

Title: MINDMATTER project

Code Number: 13/83

With [Student Name, if applicable]: EMILY TONG

I am writing to confirm that approval has been granted for this project to proceed. Approval is granted to 12 months from the date specified above.

Dr. Paul Delfabbro
Convener of the Human Research Ethics Subcommittee
School of Psychology
Paul.delfabbro@adelaide.edu.au
8313 4936

Appendix 7. Conference poster and oral presentations from the current PhD

- Teng, E. (2016). Crying Wolf? Australian adolescents' perceptions of the ambiguity of visible indicators of mental health and authenticity of mental illness. Oral presentation at the 11th International Conference on Child and Adolescent Psychopathology (ICCAP 2016) at Roehampton University. 17-19 July 2016. London, United Kingdom.
- Teng, E. (2014). "Good or bad?": A qualitative investigation of adolescent perspectives on mental health concepts. Oral presentation at the 28th International Congress of Applied Psychology (ACAP). 8-13 July 2014. Paris, France.
- Teng, E. (2013). Complete mental health in young people. Key note presentation at the MindMatters Twilight Professional Development Series for Educators: Looking beyond the absence of mental illness, 30 October 2013. Australian Institute of Management, Adelaide, South Australia.
- Teng, E. (2013). Half full or half empty? The measurement of mental health and mental illness in young people. Poster presentation at the University of Adelaide Faculty Postgraduate Research Conference. 29 August 2013. Adelaide, South Australia.
- Teng, E. (2013). Half full or half empty? The measurement of mental health and mental illness in young people. Poster presentation at the International Association for Adolescent Health (IAAH) 10th World Congress: Bridging Clinical and Public Health Perspectives to Promote Adolescent Health. June 11-13 2013. Istanbul, Turkey.

MindMatters - Youth Evaluation 2016

Report prepared by:

Emmelin Teng

with the assistance of:

Helen Winefield

Anthony Venning

& Shona Crabb

The University of Adelaide, 2016

Suggested citation

Teng, E. (2016). *Youth Perspectives on Mental Health and the MindMatters Program*.

The University of Adelaide. Adelaide.

For further information:

Emmelin Teng

Psychologist & PhD Candidate

Room 247 Hughes Building

The University of Adelaide

North Terrace 5005

emmelin.teng@adelaide.edu.au

MindMatters - Youth Evaluation 2016

Youth perspectives on mental health and the MindMatters program	1
About this study	4
Why did we do it?	5
Youth participation	5
The MindMatters program	6
What does 'mental illness' mean to adolescents?	7
What does 'wellbeing' mean to adolescents?	8
What does 'mental health' mean to adolescents?	9
What did students perceive to be the goals of the MindMatters program?	11
What did students like about the program?	12
What did students think made the program challenging?	14
Student suggestions for program improvement	16
What did students gain from the program?	18
Summary	20
Acknowledgements	20
References	21

MindMatters - Youth Evaluation 2016

About this study

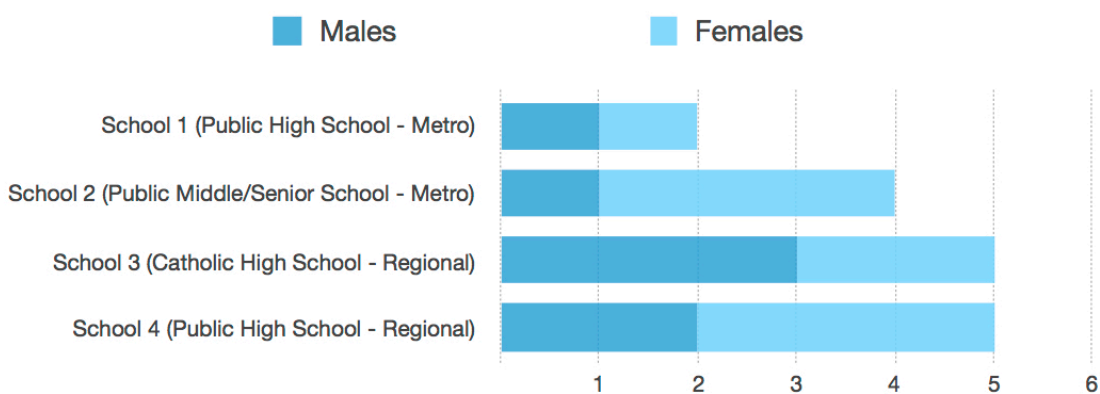
The purpose of this report is to share the voices of youth participants of the MindMatters program on mental health topics, and to provide feedback to schools and stakeholders to assist in further development of school-based mental health programs.

Participants involved in this research were 16 middle and secondary school students aged 12 to 18 years. Students were recruited through involvement with the MindMatters program being implemented at their schools. The sample consisted of 56% female students and 44% male from four South Australian schools.

***“If I ever face problems... I’ve got the knowledge of how to help myself and overcome it”
- Male, 18 years***

This study employed one-on-one interviews with young people to gain insight into ideas and issues related to mental health and the MindMatters program which are important to Australian adolescents and to identify barriers, challenges and issues to engaging young people in mental health programs and services. Data collection for this report commenced in August 2013, and analysis formed part of the author’s PhD research project examining current approaches to the measurement and promotion of youth mental health at the University of Adelaide, in collaboration with Principals Australia and MindMatters Australia.

The below chart demonstrates the spread of male and female students across the four different schools that participated in this study:



MindMatters - Youth Evaluation 2016

Why did we do it?

Young people with mental health problems represent a vulnerable group in our society. In addition to mental disorders being one of the largest contributors to disability among young Australians¹, young people are particularly resistant to seeking help for their mental health problems². Positive outcomes of mental health promotion programs are difficult to define, and can vary widely between programs. Some of these outcomes for school mental health programs include increased understanding of topics, decreased symptoms of anxiety and depression, improvements in social problem-solving, reductions in school bullying reports, reduced antisocial behaviour, improved peer relationships and behaviour, better stress management or improved awareness of mental health issues amongst families and friends³. Evaluations of mental health promotion program efficacy have focused on a diverse range of health, social and economic outcomes⁴. Since concepts like 'wellbeing' are subjective experiences, it is important to look at what mental health means to young people themselves, reflecting their own ideas and experiences.

Youth participation

A youth participation research model was employed, with the view of making the interviews empowering for young people and respectful of their needs and wishes. Youth participation is defined as *"a process where young people, as active citizens take part in, express views on, and have decision-making power about issues that affect them"* (p. 73)⁵. Involving young people in the development of mental health and wellbeing services for young people is a critical element in creating engaging, appropriate and relevant services, and youth participation models are being embraced by both government and not-for-profit sectors as a strategy to improve social inclusion, community connectedness and intergenerational dialogue in Australia⁶. Youth participation is built on a respectful relationship between service providers and young people, with a genuine interest in the opinions and views of young people translating to improving their visibility to communities, stakeholders and policy makers and ensuring the relevance of interventions to this diverse group⁷. Young people's views are not necessarily represented by those of researchers and practitioners, and so young people should be at the centre of policy and program development that concerns their own mental health⁸.

MindMatters - Youth Evaluation 2016

The MindMatters program

The Australian MindMatters program is a universal school-based mental health promotion, prevention and early intervention program. It is a mental health initiative for secondary schools that aims to improve the mental health and wellbeing of young people. The approach aims to target the entire school population, with the overall goal of enhancing strengths in order to reduce the risk of later problem outcomes and increase protective factors for wellbeing and resilience⁹.

The MindMatters framework provides structure, guidance and support to schools to build their own mental health strategy. MindMatters provides school staff with blended professional learning that includes online resources, 'Spotlights' on topics relevant to schools, face-to-face events, webinars and support. All content has been informed by strong evidence in the area of school mental health and wellbeing. The use of MindMatters' comprehensive resources has mental health benefits for the entire school community – including students, families and school staff. Students interviewed were participants in the Youth Empowerment Process (YEP), which aims to support young people in exploring issues which have an impact on their mental health and wellbeing.

The program provides resources and materials to schools in order to address areas such as curriculum and learning, school organisation, ethos and environment and partnerships and services. However, the level of choice and variation in implementation of the program afforded to school leadership also represents a challenge to program evaluation³.



MindMatters participation in Australia in 2016

What does 'mental health' mean to adolescents?

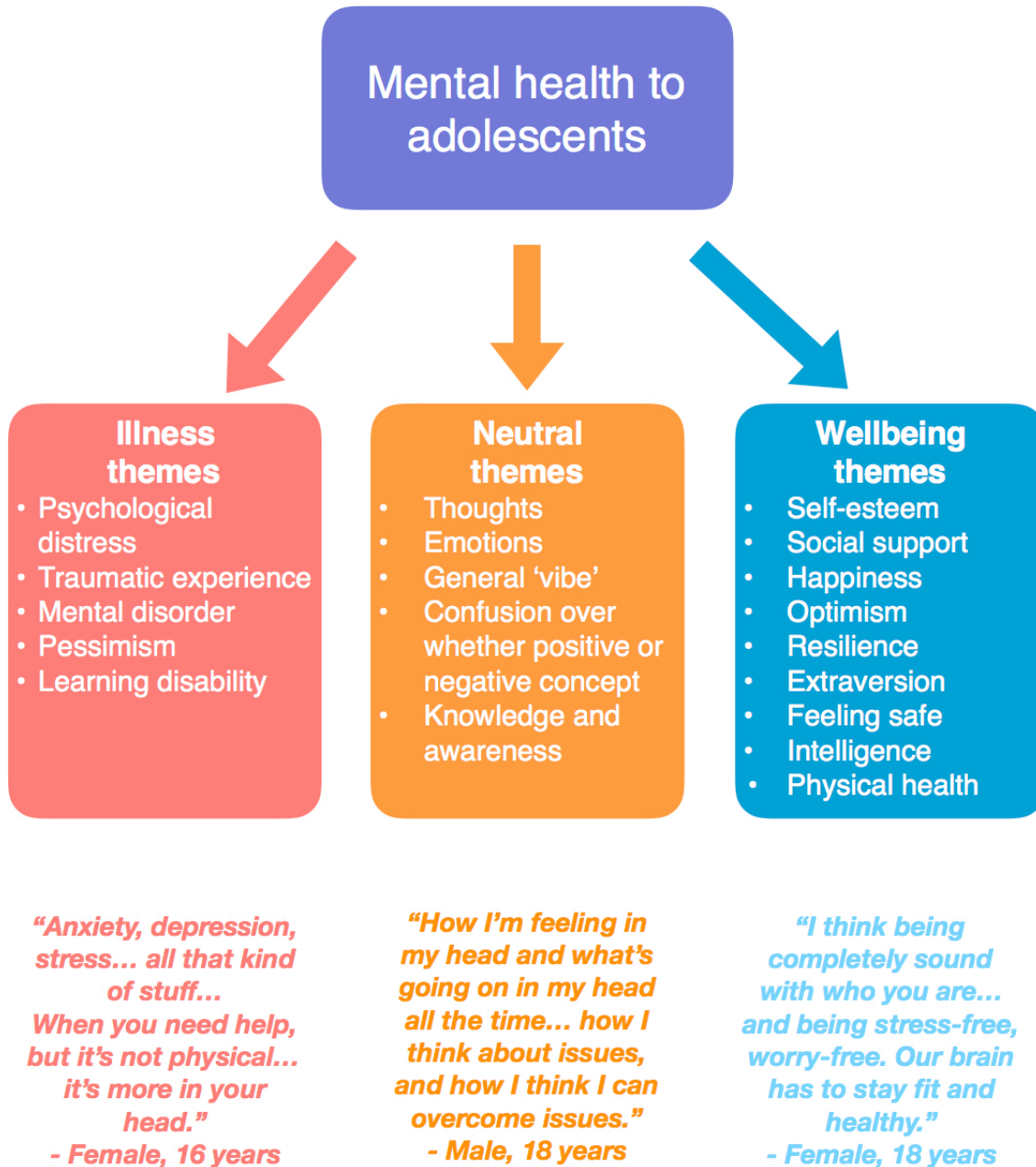
The term mental health is often used to describe the more comprehensive or complete concept of mental state, compared to mental illness which tends to evoke negative connotations or wellbeing which may focus more on positive aspects of mental state. When students were asked about what the term 'mental health' meant to them, responses could be categorised into three distinct categories: illness themes, neutral themes and wellbeing themes.

Some responses focused purely on illness themes of mental health, such as psychological distress, traumatic experience or mental disorder. Others tended to focus on wellbeing themes such as self-esteem, happiness and resilience. Some responses also included some traits such as extraversion and intelligence, which were perceived by some adolescents to be linked to good mental health. Finally, there were some themes that fell into a 'neutral' category, including 'thoughts and emotions' with no indication as to whether they referred to good or bad thoughts or emotions. Additionally, some interesting neutral themes that were explored were confusion over whether mental health was a positive or negative concept and interpreting mental health to refer to knowledge and awareness. Participant quotes are provided to support the themes presented, accompanied by the gender and the age of participant to ensure confidentiality.

The diagram on the next page demonstrates the interpretations of adolescents interviewed regarding the term 'mental health', and the three categories of responses: illness themes, neutral themes and wellbeing themes.

MindMatters - Youth Evaluation 2016

Adolescent interpretations of the term ‘mental health’



MindMatters - Youth Evaluation 2016

What did students perceive to be the goals of the MindMatters program?

Goals	Example Quotes
To provide information about mental health	<i>"I guess it really is a source of information... really important information"</i> - Male, 16 years
To promote mental health	<i>"Promote mental health in a positive manner... like the happy medium of helping yourself, helping people"</i> - Female, 17 years
To promote understanding	<i>"Stepping out of my own shoes and into other people's shoes"</i> - Female, 17 years
To build resilience	<i>"Trying to help people bounce back from mental health issues"</i> - Male, 13 years
To foster optimism	<i>"It just aims to create an optimistic society"</i> - Male, 16 years
To help students develop confidence	<i>"To try and help people be more confident to stand up to people who are bullying them"</i> - Female, 12 years
To foster student empowerment	<i>"To make sure that they know - that the kids know - that they do have a voice and that's really good because at school you don't really think like that."</i> - Male, 14 years
To develop problem-solving skills	<i>"Everyone in their life is likely to have some type of issues that they will need help through... helping them prepare towards that."</i> - Female, 16 years
To develop communication skills	<i>"It might be easier for people to express themselves"</i> - Male, 16 years
To encourage acceptance and inclusion	<i>"Show that everyone is different in their own ways, you can't exclude people from groups"</i> - Female, 17 years

MindMatters - Youth Evaluation 2016

What did students like about the program?

Strengths	Example Quotes
Youth-led program	<i>"I think it's really good that it's run by young people, like the young facilitators, because I think it brings that connection through" - Female, 17 years</i>
Wellbeing/positive focus	<i>"I think it's good that it's focused on wellbeing and positivity" - Female, 17 years</i>
Working together, teamwork	<i>"We really got to work together, building teamwork" - Male, 14 years</i>
Builds support	<p><i>"Everyone's friends now and they all help each other out" - Male, 14 years</i></p> <p><i>"Even if you didn't learn anything about mental health, you'd still have a new support network" - Female, 15 years</i></p> <p><i>"Especially some people who may not have that many friends, get to come as a group and talk and have fun and just be themselves" - Male, 16 years</i></p>
Engaging and interactive activities	<p><i>"It's not like being lectured and it's interactive" - Female, 16 years</i></p> <p><i>"You're engaged in everything... games and stuff, which helps" - Male, 16 years</i></p> <p><i>"They make it more fun I guess, compared to some places where they'll just make you sit there and talk, and listen to them" - Female, 16 years</i></p>
Raises awareness of mental health problems, allows opportunity to pass on knowledge	<i>"Once you've learnt about it, you can push it onto other people and let them learn, so then they pass it on and then it becomes a widely spread thing and then everyone can help." - Male, 14 years</i>
Changes student attitudes	<i>"It gives you a better understanding... thinking 'if that happened to me, I would want someone to be there for me'." - Female, 17 years</i>

MindMatters - Youth Evaluation 2016

Strengths	Example Quotes
Teaches about mental health and understanding emotions	<i>"It's just a really good idea to inform people about this stuff 'cause I guess it's kind of putting meaning to how they're feeling... And they're like 'okay, now I know what to do about it 'cause you just told me what it is'." - Male, 16 years</i>
Encourages communication and support between year levels	<i>"It's also really good to inform high school kids so they can pass on the knowledge to the next generation" - Male, 13 years</i>
Allows students to have a say in activities	<i>"Letting the students who are running it sort of decide the activities they wanna do and stuff" - Male, 16 years</i>
Organisation and planning	<i>"I think the programs very well set-up and planned, so I don't think it needs any improvement." - Male, 14 years</i>
The opportunity to help other students	<i>"I like knowing that people are gonna be helped by what I've done" - Male, 13 years</i>
Relevance of program content for broad range of students	<i>"It helps everyone, and not just certain people and it helps all ages as well" - Female, 16 years</i>

MindMatters - Youth Evaluation 2016

What did students think made the program challenging?

Challenges	Example Quotes
Stigma surrounding mental health and the program, lack of peer acceptance	<p>"Kids still judge" - Female, 17 years</p> <p>"[Other students] are like 'that's stupid. why are you doing it?', because they don't know anything about it and they just think it's some stupid club" - Male, 16 years</p> <p>"[Other students] can't be bothered... they don't see the importance of it" - Male, 14 years</p>
Considerations about program facilitators	<p>"I think some facilitators don't take it seriously" - Female, 17 years</p> <p>"There was a bit of an issue our school had with a couple of the mentors there... kind of spoilt the mood" - Male, 18 years</p>
School climate indicates intolerant attitudes or lack of concern towards peers displaying emotions	<p>"I find these days everyone's a bit... they see someone crying at lunchtime or upset, then they're just like 'oh yeah, they're crying - whatever'... it's not a big deal anymore." - Female, 15 years</p>
Difficulty balancing commitments for student leaders	<p>"Year 10 is the last year I'm gonna do it, 'cause year 11 and 12 I'm focusing on school" - Male, 16 years</p>
Generation gaps between adults and young people	<p>"I think adults need to be a lot kinder to teenagers because I find that the whole stigma about it is like... 'teenagers are just moody'... but the thing is if you're nice to us, we'll be nice back to you" - Female, 15 years</p>
Student leaders may not be motivated by goals of the program	<p>"This year I'm pretty sure there are a few people that are in it because their friends are in it... they're not actually taking part as much" - Female, 16 years</p> <p>"Some of [the student leaders] weren't really dedicated, so that did create an issue" - Male, 18 years</p>

MindMatters - Youth Evaluation 2016

Challenges	Example Quotes
Difficulty encouraging broader school participation	<i>"I think a lot of the things that we've done... they're only for the people that want to be a part of it. Whereas if you want to share the information with bigger audiences... I think a lot of people lose focus because they don't really want to be there. It's hard to reach other people who don't want to be there". - Female, 16 years</i>
Recruitment of student leaders	<i>"When we started there were only a few of us" - Male, 16 years</i>
Lack of agreement between student leaders	<i>"Some of [the student leaders] didn't like each other I suppose... but just personality clashes, that did create a sort of disunity amongst the group" - Male, 18 years</i>

MindMatters - Youth Evaluation 2016

Student suggestions for program improvement

Suggestions	Example Quote
Increase accessibility, promote the program more broadly within the school	<p><i>"Get kids to come more... 'cause all the kids there - they don't really have problems, they're just learning about it. So maybe get kids who are the ones who do suffer from depression and anxiety and actually get them to come to these things" - Female, 14 years</i></p> <p><i>"I think that some people that didn't know about [the program], if they were referred to it, they could be seriously helped" - Male, 14 years</i></p>
Make the program part of the curriculum (compulsory)	<i>"I know at other schools they have the Youth Empowerment Process as an actual lesson, and I think that would benefit us here as well" - Female, 15 years</i>
More student control over program processes	<i>"Letting the students who are running it decide the activities they wanna do" - Male, 16 years</i>
Smaller group sizes	<i>"The amount of people in the class [during workshops] because people have short attention spans and when someone's getting distracted they distract someone else. If it's a smaller conversation, you get to know the people really well" - Female, 16 years</i>
Selection considerations for student leaders to improve cohesion	<i>"[Recruit student leaders] that work best together... because kids can see the tension between all of us" - Female, 16 years</i>
More guidance and support for student leaders	<p><i>"I think with the help of a mentor it would have been better - from MindMatters - just to help and get anything that we missed" - Male, 14 years</i></p> <p><i>"If you have a good leader, I think that can help things amongst students... someone to look up to, otherwise there's just too many people and you get personality clashes" - Male, 18 years</i></p>

MindMatters - Youth Evaluation 2016

Suggestions	Example Quote
Modify program content for different year levels	<i>"Change some of the activities around, because I find they're really childish.. when you're trying to teach a heap of teenagers about this sort of thing, they don't all want to play with balloons and stuff" - Female, 15 years</i>
More frequent workshops and events	<i>"It should be a thing at school like maybe once a month... it's only happened once or twice this year." - Female, 13 years</i>
Balance fun activities with discussion	<i>"It is a bit of fun when you do the activities, and everyone laughs about it and stuff, but I think if they're laughing about it too much and just mucking around while doing it, then the message isn't really going through" - Female, 15 years</i>
More time for debriefing and discussion	<i>"Debriefing at the end [of a YEP workshop] was kind of quick - we thought we were gonna share ideas... we didn't do any of that" - Male, 14 years</i>

MindMatters - Youth Evaluation 2016

What did students gain from the program?

Knowledge	Example Quote
General knowledge about mental illness and health	<i>"The main thing I've learnt is the actual seriousness of mental illness, that it's not just a problem that someone can get over" - Male, 14 years</i>
Awareness of the influence of your own behaviour on others	<i>"It's teaching you that you're hurting others by what you say". - Male, 14 years</i> <i>"Now you have that knowledge that some things are good to say and some things are bad to say, and when to say them" - Male, 16 years</i>
Understanding the relevance of mental health topics and help-seeking, increased awareness	<i>"Just making people aware... what's out there, what information there is to help them if they are in need" - Male, 16 years</i>
Skills	Example Quote
How to help themselves (e.g. coping strategies, stress management, self-talk, self-care, how to seek help)	<i>"I know not to be afraid to ask because there are people out there that will help you" - Female, 16 years</i> <i>"Confidence, definitely. I have less problems with anxiety" - Female, 16 years</i> <i>"I've definitely learnt how to deal with it more if I have a breakdown again" - Female, 13 years</i> <i>"I get all stressed and upset but I know how to calm myself down which [the program] taught me" - Female, 13 years</i> <i>"Especially this year, with Year 12, how to cope with stress" - Male, 18 years</i>

MindMatters - Youth Evaluation 2016

Skills	Example Quote
How to support others (e.g. recognising symptoms, direct towards help)	<p><i>"Now I'm more assertive, and I try my hardest to help people now. Before I didn't know what to say to someone who said 'I'm having this problem' and now I can sort of think of strategies they can use. Help them get their mind off it now."</i> - Male, 16 years</p> <p><i>"Me and my friends... if one's down, like feeling sad, we will always help them and ask them what's wrong"</i> - Female, 13 years</p>
Problem-solving	<p><i>"They would show us how to get through tough situations and stuff"</i> - Female, 12 years</p>
Attitudes	Example Quote
Respect	<p><i>"Respect everyone, treat each other equally as best you can"</i> - Female, 17 years</p>
Tolerance	<p><i>"I reckon it improves peoples' attitudes because if everyone knows about mental health and someone comes up to you and says 'I've got this problem', ... your attitude towards it would be better"</i> - Male, 16 years</p>
Understanding	<p><i>"I think it's just made me a bit more caring and understanding I guess"</i> - Female, 15 years</p> <p><i>"There's different ways to deal with mental health... but it's just their way of dealing with it compared to others"</i> - Male, 16 years</p>

MindMatters - Youth Evaluation 2016

Summary

Young people with mental health problems represent a vulnerable group in our society. In addition to mental disorders being one of the largest contributors to disability among young Australians, young people are particularly resistant to seeking help for their mental health problems. Young people's views are not necessarily represented by those of researchers and practitioners, and so young people should be at the centre of policy and program development that concerns their own mental health. Participants involved in this research were 16 middle and secondary school students aged 12 to 18 years, recruited through involvement with the MindMatters program being implemented at their schools. One-on-one interviews with young people were utilised to gain insight into ideas and issues related to mental health and the MindMatters program which are important to Australian adolescents and to identify barriers, challenges and issues to engaging young people in mental health programs and services. The purpose of this evaluation report was to share the voices of youth participants of the MindMatters program on mental health topics, and to provide feedback to schools and stakeholders to assist in further development of school-based mental health programs.

Acknowledgements

We would like to thank the students interviewed for sharing their experiences and perspectives. We would also like to acknowledge the school staff, Cheree Taylor, Annette Bulling, Cathy Venning, Principals Australia and MindMatters Australia for assistance with data collection and support of this research project.

MindMatters - Youth Evaluation 2016

References

- ¹ Matthews, R. R., Hall, W. D., Vos, T., Patton, G. C., & Degenhardt, L. (2011). What are the major drivers of prevalent disability burden in young Australians? *Medical Journal of Australia*, *194*, 232-235.
- ² O'Connor, P. J., Martin, B., Weeks, C. S., & Ong, L. (2014). Factors that influence young people's mental health help-seeking behaviour: A study based on the Health Belief Model. *Journal of Advanced Nursing*, *70*, 2577-2587.
- ³ Hazell, T., Vincent, K., Waring, T., & Lewin, T. (2002). The challenges of evaluating national mental health promotion programs in schools: A case study using the evaluation of MindMatters. *International Journal of Mental Health Promotion*, *4*, 21-27.
- ⁴ Jané-Llopis, E., & Barry, M. M. (2005). What makes mental health promotion effective? *Global Health Promotion*, *12*, 47-54
- ⁵ Farthing, R. (2012). Why youth participation? Some justifications and critiques of youth participation using New Labour's youth policies as a case study. *Youth and Policy*, *109*, 71-97.
- ⁶ Burns, J., & Birrell, E. (2014). Enhancing early engagement with mental health services by young people. *Psychology Research and Behavior Management*, *7*, 303-312.
- ⁷ Sawyer, S., Afifi, R., Bearinger, L., Blakemore, S., Dick, B., Ezeh, A., & Patton, G. (2012). Adolescence: A foundation for future health. *The Lancet*, *379*, 1630-1640.
- ⁸ Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*, 1302-1313.
- ⁹ MindMatters. (2012). *Whole School Matters - Draft 2012*. ACT: Commonwealth of Australia.