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THE USE OF GUIDED SELF-HELP

TO PROMOTE EMOTIONAL WELLBEING IN HIGH SCHOOL STUDENTS

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy
in the Faculty of Medical and Human Sciences

YEAR OF SUBMISSION 2009

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Abstract

Background: The prevalence of mental disorder in children and young people in the UK is estimated at 10-20%. The World Health Organisation advocates urgent preventive measures to reduce the impact of a predicted steep rise in global rates of depression. The mental health of young people is therefore a public health issue, nationally and globally.
The UK children's policy agenda proposes that promoting emotional wellbeing is a shared responsibility between children's agencies at the Tier 1 level of Child and Adolescent Mental Health Services, but further research is required to develop low intensity, evidence based interventions to promote emotional and mental health. Schools have a remit to address emotional problems in students and evidence exists to support school based interventions to promote emotional wellbeing. However young people encounter barriers to help-seeking in primary care, which need to be understood in order to deliver appropriate support. There is an emerging evidence base for using guided self-help (GSH) to deliver cognitive behaviour therapy-based interventions to adults in primary mental health care. It is not known whether using GSH in high schools to deliver emotional wellbeing interventions to young people would be feasible or acceptable.

Aims: To develop an emotional wellbeing intervention for high schools using GSH, and evaluate it for feasibility and acceptability.

Methods: The Medical Research Council (MRC) Framework for complex interventions (MRC 2000) provided the conceptual structure of the research. There were three stages: Consultation, Development and Implementation. In the Consultation stage 54 young people aged 11-15 were consulted in 6 focus groups in 3 inner city high schools in the UK. The outcomes supported the development of a GSH intervention, named the 'Change Project', which was the focus of the Development Stage. Pastoral and Special Educational Needs staff in schools were trained and supported to deliver the intervention. In the Implementation Stage the Change Project was piloted in the same 3 high schools. It was evaluated for acceptability and feasibility using qualitative interview methods and a survey of students. The Rosenberg Self Esteem Scale was used as an outcome measure

Results: Eight Project workers delivered the Change Project and 21 students used it. They were aged 11-17 years and included male, female, white and non-white students. Self reported personal outcomes for students were generally positive. Nine sets of baseline and post-intervention RSES scores were collected. There was a general trend for improvement in scores. Presenting difficulties included potentially clinical disorders which were successfully addressed with support from school nurses. Interviews were conducted with 23 students and 27 school staff and questionnaire data were collected from 140 students. Project worker reports of the Change Project's acceptability and feasibility were mixed, though also generally positive. The acceptability and feasibility of the RSES is discussed. The ethos of pastoral care, support of senior figures and other contextual factors affected implementation quality in each school. Help-seeking in the young people was driven by peer norms of hiding signs of vulnerability.

Conclusions: Acceptability and feasibility of the Change Project were interdependent. The intervention has potential for further development. Implementation is enhanced by understanding school context. Understanding barriers and facilitators of help-seeking in young people may encourage use of emotional support in school.

Declaration

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Dedication

Finally, I dedicate this thesis to Andrew, Charlotte and Francis -whether they want it or not- for their unfailing love and support and for still being there at the end.

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The Author

I completed an arts degree in 1982 and then for several years was a member of a workers' cooperative, before training as a mental health nurse at Cheadle Royal Hospital in Cheshire. After qualifying as an RMN in 1991, I worked in central Manchester in an acute psychiatric day unit, a community mental health team, and a specialist self harm team. During this period I completed a Masters in Health Science (Public Health and Health Promotion) in the Faculty of Medicine at Manchester University.

In my last job before beginning a PhD I managed a primary care mental health service in North Manchester PCT, where I developed a mental health service based around a stepped care philosophy, using a Guided Self-help (GSH) model to deliver mental health services to adults.

The model of GSH was developed and evaluated in the School of Nursing, Midwifery and Social Work at Manchester University. During the evaluation process, I saw the potential to develop the model in other contexts. With support from Professor Karina Lovell, I won a Florence Nightingale travel award and visited a health management organisation in Seattle, USA, which provided the confidence to challenge traditional delivery modes.

My personal interest in the issues stems from my involvement with teenagers in my personal life. I have observed tremendous optimism, resourcefulness and resilience in young people just negotiating every day obstacles without drama. From my professional experience of nursing adults with mental health problems I had developed an awareness of the heavy burden that long term illness, treatments, and contact with health services can impose on an individual and people around them. The inspiration for the present research was derived from my awareness of the need to keep people out of the mental health system, and my belief that GSH could be used to deliver preventive interventions in various contexts.

My research experience consists of a Masters' dissertation, a 6 month period spent as a research assistant on secondment from the NHS, and the research described in this thesis.

List of abbreviations

Throughout this document, the author is referred to as 'the researcher'. The research described in this thesis is referred to as 'the present study', or 'the present research'.

CAMHS   Child and Adolescent Mental Health Service/s

CBT   Cognitive Behaviour Therapy

DCSF   Department for Children, Schools and Families

DfES   Department for Education and Skills

DH   Department of Health

ECM   Every Child Matters: the umbrella term for policies in the National Service Framework for children and young people

GP   General Practitioner

GSH   Guided self-help

KS3   Key Stage 3 (in UK high schools, comprises Years 7-9, of students aged 11-14 years)

KS4   Key Stage 4 (in UK high schools, comprises Years 10-11, of students aged 14-16 years)

MRC   Medical Research Council

NSF   National Service Framework

SEN   Special Educational Needs

SENCO   Special Educational Needs Coordinator (coordinates services in an educational establishment, for people with special educational needs).

SMT   Senior Management Team (in UK high schools, comprises the Head Teacher, assistant Head Teachers, and other senior managers such as Deputy Head Teachers and Heads of Year)

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Stage I: Orientation and Consultation

1 Introduction: the context of the study

1.1   Background to the study

This thesis presents a research study that aimed to explore the feasibility and acceptability of a guided self-help (GSH) intervention to promote emotional wellbeing in high school students. Young people involved in the research named the intervention 'The Change Project'. The study was set in the UK, in a large city in the north of England, and the research participants were staff and students in 3, inner city, high schools. The following section sets out the background to the research.

The mental health of young people in the UK is a cause of public concern. The current Office for National Statistics (ONS) prevalence figures for clinically recognisable mental disorders are 12.6% for boys and 10.3% for girls in the 11-16 age group (ONS 2005) but it is often unrecognised and may be as high as 20% (Macdonald 2000, Department of Health (DH) 2002). The long term impact on the emotional, social, physical, cognitive and educational development of children and young people is well established in the literature, (e.g. Gowers 2006, Merry et al. 2004, Stein et al. 2006). Policy guidelines such as the National Service Framework for Mental Health (DH 1999) and the Every Child Matters agenda (H.M.Government 2004) indicate that better services are needed to support the mental health of young people, but as yet there is little consensus on how to balance demand and supply.

Media interest in young people has ranged over education, health, welfare and law and order, with much attention given to stories about anti social behaviour, murder, suicide, and ruined lives (Marlow 2008). This indicates public interest in the causes and consequences of mental health problems in young people and contributes to the rationale for developing strategies to promote emotional mental wellbeing in this age group.

Research interest in this topic has been demonstrated in a Cochrane review of educational and/or psychological preventive interventions for depression in children and young people (Merry et al. 2004). The results of the review indicated that psychological interventions were more likely to be effective if they had a cognitive behaviour therapy (CBT) component. The review found little evidence of the effectiveness of educational

programmes and as will be discussed in this review, children and young people's mental health services are structured in a way that excludes specialist treatments, such as CBT, from the sphere of preventive and mental health promoting interventions.

Furthermore, some of the responsibility for delivering early intervention for mental health difficulties has been placed with schools, yet the evidence base for this approach is weak (Merry et al. 2004) and indeed, wider concerns have been raised about the quality of the evaluation of educational programmes in schools and educational research in general (Torgerson and Torgerson 2001). Research studies are required which explore the feasibility and acceptability of mental health interventions in educational settings, before the evaluation of effectiveness can be undertaken.

A number of policy drivers in the last 10 years have promoted child-focused services and emphasised the need for all children's' services to accept responsibility for mental health (Audit Commission 1999, Department for Children, Schools and Families (DCSF) 2006, DCSF 2008a, DCSF 2008b, Department for Education and Skills (DfES) 2004, DH 2004b, DH 2005, DH 2007b, DH and DfES 2004). Nevertheless, at present, mental health resources for young people are concentrated in specialist Child and Adolescent Mental Health services (CAMHS) and there has been little emphasis on the provision of early or preventive interventions. This can create difficulties, since the knowledge and skills of specialist practitioners may then be unavailable to young people unless they have high levels of clinical need. For example, national guidelines on the treatment of depression in young people recommend psychological therapies as a first line treatment (National Institute for Clinical Excellence (NICE) 2005) but these treatments are not normally available outside specialist mental health services.

Policy and research agendas appear to be converging to support initiatives in the field of preventive mental health interventions for young people. The present study was developed with the principles and guidelines of current children's policy in mind and so may make a relevant contribution. This research study contributes to the evidence base by addressing this important health issue through the development and exploration of an intervention to promote emotional wellbeing in high school students.

1.2   The CAMHS 4 Tier Framework

The recent report on the implementation of the Mental Health Standard of the National Service Framework (NSF) for Children, Young People and Maternity Services stated that, having addressed the initial priorities of improving provision for emergency care, learning disabilities and 16-17 year olds, a great deal of change in early intervention and primary care services is now needed (Appleby et al. 2006).

To orientate the present study in the context of current CAMHS provision, it is relevant at this point to consider the structure of child and adolescent mental health services in the UK.

In the UK, NHS provision for children and young people's mental health services is organised in 4 tiers (DH 2004a). The structure of the services is illustrated in Figure 1, showing that mental health specialists are clustered in Tier 4, at the more severe end of the spectrum of mental illness. Tier 4 services are often regional specialities and here the most serious problems are treated, for example in eating disorders units, adolescent forensic mental health units and by neuro-psychiatric teams (DH 2004). Tier 3 is usually provided by a multi-disciplinary team and is likely to include more specialised services for people with severe, persistent and complex disorders. Tier 2 practitioners are usually CAMHS specialists working individually in primary care and may offer early interventions and outreach services.

Tier 1 CAMHS mental health service providers may not have mental health training. They include GPs, school nurses, teachers and voluntary agencies and provide general advice, health promotion, early assessment and referral. For schools, this role specifically includes promoting emotional wellbeing, which is one of 4 key targets of the Healthy Schools Programme, a government initiative which encourages schools to promote health and wellbeing. Emotional wellbeing is often promoted through the pastoral provision in school, which can combine form tutors, school nurses, and senior managers as well as dedicated pastoral staff. The intention of the present study was to develop an intervention located within Tier 1.

1.3   Conclusion

From personal and public perspectives, there is a pressing need to address the mental health status of young people, accompanied by a need for research to increase the evidence base of suitable strategies to achieve this. The development of alternative strategies could contribute to the evidence base for preventive interventions to support emotional wellbeing of young people in school.

This introduction has summarised the main arguments to support the development of a preventive intervention to deliver psychological therapies to young people in school. The arguments will be expanded in the following section to provide a substantial rationale for a study aiming to explore whether this could be a feasible and acceptable approach, with which young people would engage.

Figure 1: The 4 tier framework for the delivery of CAMHS in the UK. Adapted from DH and DfES (2004) and Mental Health Network (2007)
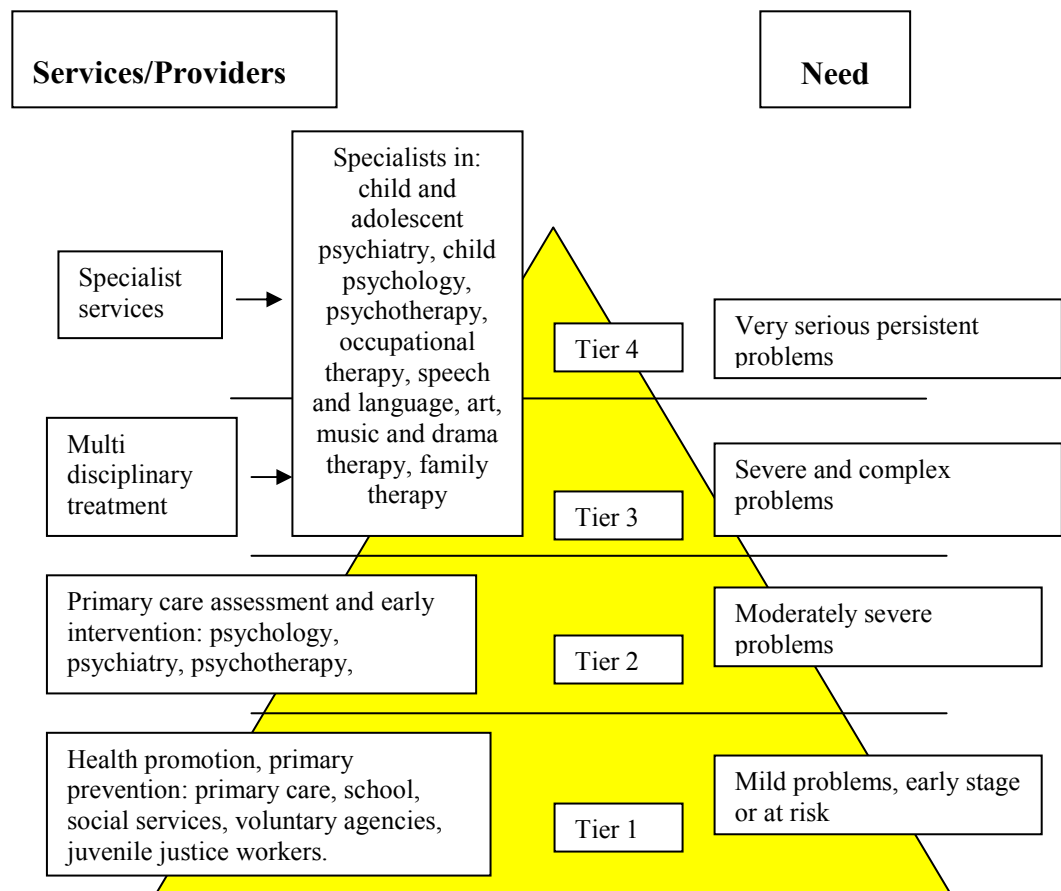
1.4 The structure of the thesis

The thesis is structured in 3 Stages which reflect the research process for this study i.e. consultation, development and implementation of the intervention. Each will be described in turn. Stage I aims to orientate the reader to the research study. It reports a Consultation process, incorporating a review of the literature followed by a discussion of the methodological principles underpinning the study. It then describes the processes involved in gathering contextual information from the proposed research setting, prior to the development of an intervention. In this stage focus groups of young people were consulted on their views about a proposed, school-based, GSH intervention.

Stage II describes the processes involved in the development of the intervention and the preparations that were made to implement and evaluate it in schools. This included securing access to research sites, defining the components of the intervention, designing materials, training Project workers to deliver the intervention, and planning for data collection and analysis.

Stage III describes the implementation of the intervention, the methods used to collect and analyse data, and the results of the analysis. All three stages are drawn together in a substantive discussion at the end of Stage III, followed by reflections on the study and recommendations for further research and practice.

The MRC framework for complex interventions to improve health (MRC 2000) was used to inform the development and evaluation of the intervention described in the 3 Stages of the thesis. This framework locates the research in the 'continuum of increasing evidence' (MRC 2000), that is, it provides guidelines to facilitate the process of clarifying research questions, and hence direction for the development of a research design appropriate for the existing knowledge base. The MRC framework is described in more detail in the methodology chapter.

1.5   Explanation of terms

There is a wide range of precise definitions of young people applied in legal, social, clinical and developmental contexts (DH 2008). In the present study, the terms 'young person' and 'young people' are used to indicate individuals in a wide age range from puberty to young adulthood.

The term 'student' is used in this study to indicate an individual attending one of the three high schools that participated in the research or in reference to other research with school or university students. Usually, in UK high schools, Key Stage 3 (KS3) students are aged 11 to 14 and Key Stage 4 (KS4) students are aged 14 to 16 years. Key Stage 5 (KS5) students are sixth formers and are aged 16-18 years. The students who participated in the present study were aged 11-17 years.

The World Health Organization (WHO) uses the term 'emotional wellbeing' to indicate the precursor of mental wellbeing, or positive mental health (WHO Europe 2005). The term is distinct from mental health, which has a specific clinical application. Currently, emotional wellbeing is a term familiar in educational contexts and appropriate to non-health settings.

1.6   Aims of the research

1.6.1   Principal aim:

- To explore the acceptability and feasibility of a GSH intervention to promote emotional wellbeing in young people in high school

1.6.2   Secondary aims:

- To develop an intervention to promote emotional wellbeing in high school students

- To explore individual components of the intervention, particularly what it would consist of, how it would be delivered, and how it would be evaluated.

- To explore the contribution the MRC framework makes to the development of the intervention

- To explore the contribution that the MRC framework makes to the development of the research study.

- To consider the potential contribution of the findings to research and practice.

2 Review of the Literature

2.1   The search strategy

Chapter 1 summarised the background to support the proposed intervention, and pointed to gaps in knowledge, which the present research study aims to address. In the following section the search strategy is described, followed by an explanation of key topics that have been explored.

A review of relevant literature was undertaken in order to ascertain existing knowledge about the potential of GSH to deliver an intervention to promote emotional wellbeing in high school students. The aim of the literature review was to establish what was known about the research area and identify gaps in knowledge. The review focused on several areas: prevalence, impact and policy relevant to the emotional wellbeing of young people; developmental considerations; the evidence for health behaviour of young people; the potential of psychological and school-based interventions for addressing emotional wellbeing in young people need in this population; and the evidence base for GSH.

Supplementary detail about the search process is provided in Appendix A.

2.2   Approach to review of the literature

As the areas of interest were wide ranging, the strategy taken in the review was to include a range of topics and study designs, to achieve 'in-depth and broad results' (Arksey and O'Malley 2005) (p.22). Details of search parameters, terms and results are included in Appendix A in order provide a transparent and replicable record of the literature search. Initial searches and search terms were refined throughout the period of research. The research process was iterative and reflexive and led to clarification of the topic areas.

2.2.1   Scope of search for relevant studies/identification of relevant studies

The search strategy was designed to locate relevant, high quality information on the topic areas. Electronic databases from health, education and social sciences were interrogated to identify relevant scientific publications, and unpublished and locally published reports, for example from charities such as Young Minds and government bodies such as the

Department of Health and the Department for Children, Schools and Families. Studies were also identified through hand searching relevant journals, conference proceedings, consulting experts and following up reference lists. Meetings with expert practitioners from psychology, psychiatry and children's services, identified further relevant topics and literature to include in the scope of the review.

Search terms included MeSH headings and other terms from the field. Searches were refined using Boolean operators and truncations ('?' '*' '$') with word stems such as child_ or psych_. A bibliography specifically for the thesis was developed using Endnote X software and this was extended over the period of time that the thesis was written.

2.2.2   Parameters of literature search

Searches were conducted from October 2005 to December 2008. The intention was to read around topics relating to young people's mental health needs in the UK, including public health perspectives, policy, health behaviour, and approaches to improving mental health in this population. Policy searches initially focused on the previous ten years to encompass significant policy changes in the areas of children's and mental health services enshrined in National Service Frameworks for mental health (DH 1999) and children and young people (DH 2004b).

Recent research was favoured over older publications if they developed the original topic, though papers of any age were included if particularly relevant. The search interrogated a wide range of texts and resources including scientific papers, grey literature, websites, reference texts, and practice literature and opinion pieces. Evidence for prevalence was established through the interrogation of public health data sources including the Office for National Statistics and the World Health Organization. Only texts written in English were retrieved. There was a wide range of methodological approaches and the quality of the literature was examined in order to assess its potential contribution to the present study (Arksey and O'Malley 2005).

2.2.3   Search Process

All papers retrieved from database searches were examined by title. Abstracts of papers were selected from the titles and these were examined further and complete papers

retrieved if relevant. Literature sourced elsewhere was scanned first for relevance and perused in full if considered relevant. Finally selected papers were examined in full. The results of the review were organised into themes which are presented in the following section.

2.3   Findings of the literature review

2.3.1   The scale of the problem

Worldwide, 4% of young people aged 12- to 17-years suffer from depression (World Health Organization Europe 2005), compared to at least 10% of 11-16 year olds in the UK (Office for National Statistics 2005). These figures are significant because the World Bank and the World Health Organization have calculated that depression is the most important cause of the global burden of disease in high income countries including the UK, the third most important cause worldwide (measured in Disability Adjusted Life Years) and predicted to rise to the most important cause worldwide by 2030 (WHO). WHO has acknowledged the importance of early intervention for mental health difficulties (Herrman et al. 2005). It may be possible that improving the mental health status of young people now could reduce the prevalence of depression in adults in the future.

Localised studies in the UK add detail to this picture. For example, the Relachs study obtained 2790 questionnaires from young people in Years 7 (11-12 years) and 9 (13-14 years) in East London schools. This method generated some insights into predictive factors for mental health difficulties in young people, which included loss and trauma (e.g. bereavement and break up of families), high stress (e.g. bullying and exams), illness, poverty and social factors, learning difficulties, and conduct disorders. Year 9 female teenagers and Year 7 male teenagers were more at risk of depression. It also exposed increased risk taking behaviour (smoking tobacco, use of paan[1] and use of alcohol) in Year 9 girls compared with Year 9 boys and Year 7 students, and drew an association between risk taking, ill health, and social and economic factors. Good mental health and wellbeing were linked with improved resilience to emotional distress, which in turn had a positive

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[1] chewing tobacco usually mixed with areca nut and betel leaf

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effect on health outcomes. The findings of the Relachs study suggested that improving mental wellbeing in a young person may impact positively on other areas of life and therefore contribute to the case for developing preventive interventions (Institute of Community Health Sciences (ICHS) at Barts and the London Queen Mary's School of Medicine and Dentistry 2003).

2.3.2 The impact of mental health difficulties in young people

The adverse, wide ranging, health and social outcomes associated with mental illness are acknowledged in the Every Child Matters agenda in the UK, through the adoption of wide-ranging health and social targets (Davidson 2008).

Census data and public health data have associated poor mental health in young people with increased risk taking, including substance abuse and suicidal behaviour. Suicide is a particular concern because it is the third leading cause of death for 15-24 year olds and the sixth leading cause of death for 5-14 year olds (DH, 2002). National Institute for Clinical Excellence (NICE) guidelines recognise the association between suicide and self-harm and a number of psychological factors including psychosocial stress, depressive illness, substance abuse, and poor coping (NICE 2003). The guidelines illustrate a direct link between research evidence and health policy.

2.3.2.1 Associated health concerns

Associations between psychological distress and physical presentations have been made in empirical studies: For example, questionnaire data from a UK primary care study of 276 adolescents aged 13-16 who visited their GPs, found that low mood correlated significantly with impairment from physical health problems and health risks such as exposure to cannabis and other drugs (Yates et al 2004). The data were obtained from a consecutive sample of 276 adolescents (67% of those who agreed to participate) and 237 parents (57% of those who agreed to participate). Participants completed robust, standardised measures including the Moods and Feelings Questionnaire (adolescents), and the Child Behaviour Checklist and the General Health Questionnaire (parents), and GPs supplied clinical data from each consultation. Participants were recruited from inner city and suburban backgrounds to achieve a diverse sample, but the generalisability of the

results was compromised by the absence of data from adolescents with mood disorders who did not attend their GP.

This finding was consistent with an earlier study in which demographic and clinical data were collected from interviews with over 130 young people attending general practice, supplemented by information provided by their GPs. The results of the earlier study demonstrated a strong positive association between mental health problems and the number and impact of physical health problems (Kramer and Garralda 1998).

2.3.2.2   Long term effects

Childhood depression and anxiety have been identified in both victims and perpetrators of bullying. In a survey in the UK, validated questionnaires exploring aspects of bullying, moods and feelings, anxiety and self esteem were collected from 904 students in 2 coeducational secondary schools to investigate associations between bullying and mental health problems. One school was in an area of socio-economic disadvantage and the other was in a relatively economically privileged area. The questionnaires were completed anonymously and subject to logistic regression analysis. The results suggested that being bullied was more prevalent with younger children, in whom it was associated with anxiety, while being a bully seemed to be associated with depression (Salmon et al 1998). Despite the large sample, lack of information about methods of sampling and analysis limit the rigour of this study, though the findings were consistent with the findings of a systematic review of primary research into barriers to health care for adolescents in primary care, which confirmed links between bullying and poor mental health (Gleeson et al. 2002).

Perspectives from developmental psychology suggest that long term mental health difficulties in young people can prevent an individual from developing positive coping strategies. This can make it hard for them to manage employment, relationships, and other achievements (Herbert 2005). Cognitive theories of depression suggest that negative thinking styles are the result of childhood adversity; therefore, negative ways of thinking can be both the cause and effect of depression, and intensify mild depression in vulnerable individuals. This evidence fits with developmental theory that as an individual matures they develop the ability to experience and report depression (Verduyn 2000). The developmental implications for an intervention to promote emotional wellbeing are that the

cognitive development of a young person affects their ability to distinguish between feelings and thoughts and consequently influences how they interpret and manage emotional difficulties.

2.3.2.3   Problems with the identification of mental health difficulties

In young people it can be difficult to differentiate between normal development and mental distress. Health workers need to distinguish between a clinical presentation requiring treatment and a transient state of distress attributable to a developmental stage, which should not be medicalised. Psychosomatic presentations (in which psychological problems are expressed through physical symptoms) were found in 47% of the 128 children 7-12 years who participated in a study of somatisation, incorporating clinical data from paediatricians, and interviews and self-report data from parents. These findings indicate the possible prevalence with which young people may present to general practice with physical symptoms caused by psychological problems and compounds the difficulty in assessment and diagnosis (Garralda and Bailey 1990). In the study no data were collected directly from the children and therefore any discussion of the children's perspectives on their symptoms were omitted. The potential significance of discrepancies in parent and child reporting is discussed below.

2.3.3   Legislation and policy

The need for change in young people's mental health services was highlighted in the NHS plan (DH 2000) following 'Children in Mind', a report from the Audit Commission which reported that weak CAMHS were contributing to the long-term impact of emotional disorders on the emotional, social, physical, cognitive and educational development of children and young people (Audit Commission 1999). Lack of systematic data collection outside hospital services meant that the picture was unclear at this time and in 1999, the first national survey of child and adolescent mental health in Great Britain was published. This instigated the ongoing development of a data set mapping statutory children's health and local authority services (DH 2007a). The exercise has demonstrated that in current CAMHS provision, marked local and regional differences affect access and availability (DH 2007a).

The publication of the NSF for mental health placed a new emphasis on the role and responsibilities of primary care services for adults and set standards for improving access to effective and appropriate interventions (DH 1999). The National Service Framework for Children and Young People followed in 2004 with the passing of The Children Act, which provided a legal framework for the various health and social care initiatives within the Every Child Matters Agenda and included a CAMHS standard underpinned by principles expressed in Children in Mind, (Audit Commission 1999). A recent CAMHS review commissioned by the DCSF has recommended a fresh emphasis on shared responsibility for protecting children and young people, strategies to improve inclusion and accessibility in services for young people, and better training and information for the children's workforce, including parents (Davidson 2008).

This agenda has overseen change in children's and young people's services (DH 2004a). In 2004 the central tenets of the Children's NSF were coordinated, child centred, children's services across health, social care and other providers. A key theme was child protection. It emphasised the importance of service mapping, improving access to quality services, offering a range of settings, raising skill levels, interagency working, and balanced and flexible services (DH 2004b). The current government agenda for young people promotes their engagement as partners and influencers of the research agenda (e.g. Badham and Wade 2008), suggesting that the development of services for young people should be informed by consultation with them.

2.3.4   Barriers to help-seeking in young people

Unmet psychological need in young people has been identified as a problem worthy of further investigation. Influences on help-seeking in young people can be grouped into contextual factors (aspects of their social, organisational and environmental context) and internal factors (psychological and emotional processes) These will now be considered.

2.3.4.1   Contextual factors affecting help-seeking

A questionnaire survey of 1074 15-16 year olds' attitudes to contraceptive services in primary care demonstrated that poor interpersonal skills on the part of general practitioners (GPs) made consultation difficult (Donovan et al. 1997), though the report did not discuss whether this had an impact on consultation rates. The participants were drawn from schools outside major conurbations, and therefore young people from schools in inner city areas were not consulted. However conditions for completion of the questionnaire were carefully managed, to eliminate concerns about confidentiality, and the response rate was relatively high (overall 14% absent from school on day of survey), which enhanced the validity of the responses.

A series of focus groups was conducted with 215 young people in the USA to explore what they wanted from health providers. Analysis of the findings indicated that, while the young people valued evidence of qualifications and hygienic practice in the health care provider, anticipation of judgemental or unfriendly attitudes from health practitioners and receptionists were particularly powerful barriers to help-seeking (Ginsburg et al. 1997). This seems to suggest that an individual young person may be discouraged from using a service if they judge that, on their terms, it is unsuitable.

In contrast, a study in primary care in the UK matched postal questionnaire data with consultation data in 678 young people attending primary care, and concluded that some factors identified by young people as barriers to consultation with a GP, such as difficulties getting an appointment, were not associated with reduced consultation rates (Churchill et al. 2000. With the exception of this study and an Australian study of help-seeking which is described below (Rickwood et al. 2005), there appear to be few studies which have examined the relationship between expressed preferences for care and consultation rates,

though the investigation of discrepancies in parent-child reporting in primary care (Kramer et al. 2004), discussed below, also touches on the question of the accuracy of self report measures in clinical contexts.

Poor availability of services appears to inhibit access to health care. The results of a postal survey of 883 UK GPs on the availability to them of CAMHS suggested that only a small minority of GPs had access to CAMHS for milder disorders, although the findings were compromised by a poor response rate (45.5%), indicating the possibility of bias (Bower et al 2003). This study demonstrated the difficulty of obtaining accurate data about children and young people's health care, which was also noted by (Gleeson et al. 2002).

2.3.4.2 Internal factors affecting help-seeking

Social cognitive theories of health behaviour explain the relationship between a topic's sensitivity and an individual's help-seeking by analysing the factors acting on an individual in their social environment. Health expectations, such as the expectation of privacy and personalised care, assessment of self efficacy (i.e. the judgement made by an individual about their ability to adopt a proposed behaviour) and perceived severity are central tenets of health psychology theories (Conner and Norman 1996a), suggesting that a young person who anticipates that they will benefit from help offered will be more likely to consider seeking help. This theory was supported by the findings of a systematic review of young people's use of primary care, which highlighted practical and attitudinal barriers to access, including rapport with the health practitioner, developmental considerations, competence, cost and location (Gleeson et al, 2002). Therefore understanding mediators of help-seeking has potential to inform the design of accessible interventions.

2.3.4.3 Problem construction

Low referral rates to CAMHS may also reflect difficulties in detection of mental health problems in young people attending primary care, and indeed the problem of poor detection rates was noted in a Department of Health report (Bower et al. 2002). Mental health training needs have been identified in GPs (Gask et al 2004); however psychological difficulties in young people can be obscured by the way they are presented.

The importance of individual construction of an issue has been demonstrated in clinical research. A study in the USA used parallel self administered questionnaires from 258 young person-parent pairs to examine discrepancy between reports to clinicians of functional impairment in the young person, from the perspectives of both parties. Statistical analysis of the data demonstrated that only 3%-12% of young people agreed with their parents' reports of friendship difficulties, with only 11%-45% of parents agreeing with their young people's reports of friendship difficulties. Parents appeared to be more sensitive to problems affecting social relationships, whereas young people were more likely to report difficulties relating to school or with antisocial behaviour (Kramer et al. 2004). This suggests that the two groups defined problems differently, possibly reflecting different priorities. It further indicates how the presentation of a problem to a clinician could depend on who is describing it.

As it can be expected that young people gradually assume personal responsibility for their health and wellbeing as part of the transition to adulthood, a young person's construction of their health issues, compared with their parents', may become increasingly important. Therefore, it seems that it is appropriate to empower young people to recognise, understand and communicate emotional difficulties they may be experiencing.

2.3.4.4   Ease of access

The cost implications of help-seeking in health contexts form a potential barrier. In the UK, although NHS treatment is largely free at the point of delivery, there are associated costs in travel, contacting health centres and hospitals, and in some cases, prescription charges. In a selective review of the evidence on systemic barriers to addiction treatments in the USA, it was found that obstacles for teenagers included insurance status, doubts about confidentiality, poor services and lack of information (McLellan and Meyers 2004).

A health resource that is perceived as easier to access may have higher uptake. A review of medical notes at a USA school-based health centre found that it was providing a useful service for a hard to reach population (Pastore 2001), and a large retrospective study of case notes from consultations with 3818 students using school based health centres in the USA found that uptake was higher than the national consultation rate for young people (Anglin et al. 1996). Though only 3 sites were used, the large sample size in the latter

study suggests the results could have relevance for understanding healthcare uptake in this age group in other settings. Hence there may be potential to reduce some practical barriers to help-seeking by placing services in schools and potentially, further exploratory research could explore the mechanisms affecting uptake of health care in this context.

2.3.4.5   Peer influences

Reference group theory suggests that peer influence and the desire to belong to a social group has a strong impact on social behaviour (Pawson 2008). Reference group theory has not generally been applied in the context of barriers to help-seeking for health concerns, but it may be viewed as supporting notions of the impact of peer values on health behaviour. According to this theory, a young person experiencing a health problem which they perceive to be outside the normal experience of their peer group may resist addressing or asking for help in case it becomes known to the peer group and jeopardises their membership of the group. This connects with the importance of embarrassment as a mediator of health behaviour, and also explains why peer groups may be cited as a preferred source of help, and a source of encouragement to access formal help, and a barrier to help-seeking (Freedenthal and Stiffman 2007).

Help-seeking from family and friends can be counter-productive, maintaining unhelpful health behaviour such as inappropriate self medication, somatisation and poor coping strategies (Garralda and Bailey 1990). The connection between identity, peer values, stigma and embarrassment and health behaviour appears to be strong, and suggests that there is potential for the peer group to be part of the problem. However it is not known how these factors may impact on help-seeking from an emotional wellbeing intervention in young people in the UK.

Peer group behaviour may be affected by demographic factors. For example a multiple regression analysis of factors associated with bullying, in self report questionnaires from 830 Scottish children and young people aged 9-14 years, found that compared with boys, girls were more likely to seek help, more likely to believe that seeking support for bullying would be effective, and less likely to be victimised. In addition, the findings suggested that the likelihood of experiencing aggression decreased with increasing age (Hunter et al. 2004). This supports the notion of age and gender as mediators of help-seeking in young

people, though as the self report questionnaire was developed specifically for the study, further research would be required to establish the applicability of the findings to other populations.

2.3.5 Shame and embarrassment

A UK systematic review of barriers to primary health care found embarrassment to be a key barrier to help-seeking in young people (Gleeson et al. 2002), while interviews with 101 young American Indians who had attempted suicide in the previous 12 months suggested that stigma, shame and embarrassment were strong factors preventing help-seeking (Freedenthal and Stiffman 2007).

The importance of embarrassment demonstrates the relevance of the relationship with the health care provider. Consistent reports that young people are encouraged to ask for help if they anticipate a good reaction from a health care provider suggest that the sensitivity of an issue may not be a barrier if other conditions are favourable. For example, focus groups with 92 young people in the USA on sex education about HIV and AIDS, found that how the topic was presented affected how they engaged with the material (Hoppe et al. 2004), suggesting that whether or not certain topics are felt to be embarrassing, in the right conditions a young person will be prepared to discuss them.

The impact of sensitivity of health issues on help-seeking has been noted elsewhere. In a study of London teenagers conducted in the 1980s (Epstein 1989; cited in Gleeson, 2002), adolescents identified acne, contraception, illness in the family, menstruation, and arguments with parents as topics too embarrassing to bring to a general health consultation, despite these being common experiences. There are therefore inconsistencies in the literature and further research into this topic could help to clarify current trends in help-seeking in young people, including the impact of the rapport with the health practitioner on the presentation of sensitive topics.

2.3.6 The range of health concerns among young people

Attempts to identify the issues that most concern young people have been reported in the health literature from the UK and elsewhere, with some consistency. For example, a database of information collected from school students in the UK between 1991 and

2003 indicated that appearance and health were primary concerns in 12-15 year olds (School Health in Education Unit (SHEU) 2004). Gray et al. (2005) cited a North American survey of 1209 young people aged 15-24, which found that sexual and mental health, weight, and information on major diseases were particular concerns. This was consistent with findings from a review of consultations with teenagers attending 3 high school-based health centres in the USA (Anglin et al. 1996).

In the UK, a study was undertaken in primary care in which 678 GP practice records of consultations with young people were matched with questionnaires they had completed about their health behaviours, attitudes and concerns. The results suggested that respiratory, dermatological and musculoskeletal conditions were the most common reasons for consultations (Churchill et al 2000).

These studies do not provide data to interpret whether the reasons for consultation were representative of the range of health concerns in the study populations. The differences between results may be related to the study contexts- such as the focus of the studies or the age or provenance of the research subjects. Somatisation and embarrassment (Jacobson et al 2002) and study bias are all potential influences on the findings. Alternatively, the differences may support a tentative argument that help-seeking in primary care for young people is associated with health concerns which directly impact on social behaviour, such as acne, sexuality, anxiety, and physical competence

2.3.7   The significance of autonomy in help-seeking

One effect of autonomous help-seeking in young people may be a greater capacity to present with somatic symptoms of mental distress, in order to legitimise their problem. This possibility was raised in a discussion paper of primary care for adolescents with mental health problems (Jacobson et al. 2002). Although somatisation may contribute to the levels of unmet need discussed earlier, it can also be seen to reflect a conscious or unconscious coping strategy designed to reduce potential embarrassment, and therefore as a positive act of self care.

Where teenagers are dependent on families and carers for funds and permission, it can be harder for them to get health care without other people knowing. Approaches to providing health services that young people can access independently are seen in some internet

based services. For instance a qualitative study of adolescent internet use for health information, consisting of focus groups with 157 high school students aged 11-19 years in the UK and the USA, found that young people like this method, though they were restricted by barriers of poor literacy and doubts about the trustworthiness of websites (Gray et al. 2005). These studies suggest that alternative health care delivery modes may have potential to improve access to care.

2.3.8 Developmental theories of adolescence

Developmental theories concerning young people appear to influence approaches to the design and delivery of services for this population and can assist in identifying interventions appropriate to the ability of the individual.

In primary care, a bio-psycho-social model has been proposed as suitable for the treatment of adolescents, because the interactions between physical, psychological and social factors in young people are perceived as significant to their health care (Christie and Wilson 2005, Jacobson et al. 2002).

Some approaches to psychological treatment of young people see problems as systemic within a family and therefore good practice is to involve other family members in treatment (Herbert 2005, Verduyn 2000). However, studies of health behaviour in young people have indicated that lack of privacy and confidentiality is a barrier to help-seeking. The family systems approach to treatment of young people could potentially engender a tension between access and effectiveness, because anxiety about information sharing with parents could prevent young people from communicating their difficulties, as studies have indicated (Churchill et al. 2000, Donovan et al. 1997, Farrand et al. 2006, Ginsburg et al. 1997, Gleeson et al. 2002, Gray et al. 2005, Rickwood et al. 2005). This suggests that there is a need for alternative approaches that do not include other family members.

Adolescence has been propitiated as a historical and social construct. In an historical account of the antecedents of modern adolescent culture it was suggested that the practice of encouraging teenagers to conduct their social life in peer groups, away from adults, was one result of economic changes in the USA, in which industrialised farming methods broke up family traditions and dispossessed or dislocated farming families ceased to be functional economic units (Demos and Demos 1969). Therefore it is argued that the

origin of teenage culture, with attendant social behaviours, is external to individual young people. The historical perspective challenges the perception of adolescence as a series of internally driven health and social problems and can be seen to challenge problem-focused models of care and point to contextual factors affecting people's experiences.

The problem oriented view of young people is encapsulated by the influential 'Sturm und Drang' theory (Hall 1904), which proposes that normal adolescence is a stormy and stressful time for young people. While advocating a sympathetic and empathic attitude, this position is, arguably, potentially harmful to young people because it normalises distress. Some of the repercussions of the model could be low expectations of young people's mental and emotional health, leading to a failure to recognise treatable problems and high tolerance of misery in young people, on the part of clinicians, carers and young people themselves.

As previously discussed, unrecognised emotional disorders in young people may account for higher prevalence rates than appear in official statistics (DH 2002, Macdonald 2000), and there are discrepancies between parents' and young people's thresholds for help-seeking for emotional problems in the young person (Kramer et al. 2004, Bernard et al. 2004). Thus it is feasible that a belief that emotional distress is normal in young people may be a formidable barrier to help-seeking.

Some cognitive theories argue that development varies with the individual and has a cultural context. For example, it has been proposed that growing independence of thought is a sign of maturity in cultures that value individualism; in contrast, definitions of adult behaviour may not accord with independent thinking in cultures with collective thinking and collective decision-making, so conforming to the collective culture would be a sign of maturity (Herbert 2005). Such anthropological perspectives can be overlooked, but are arguably a reminder of the importance of context in the development and evaluation of health interventions.

An influential theory in developmental psychology suggests that the formation of identity is a central process of transition from childhood to adulthood and a key task for young people (Erikson 1950). On this basis, it could be argued that it is potentially damaging to communicate to a young person that their problems require help from a specialist. The self-perception of being a person who needs help for a mental health problem, could become

entangled with a young person's growing sense of identity and foster low self esteem and dependence. This would be an undesirable consequence of health care and arguably as significant as an adverse reaction to pharmacological treatment.

Theories of adolescence may reflect how young people are seen by adults. It has been proposed that much of the anxiety focusing on teenagers may be on the part of parents who are coping with their own issues of ageing and loss (Herbert 2005). A focus on problems experienced or caused by adolescents can be stigmatising and ignore the positive qualities in individuals as argued by Ginsburg (2003). Equally unhelpful are theories which assume that problems must be a normal part of a healthy adolescence, because this may discourage adults from offering support when it is needed. Both views have potential to lower the personal expectations of a young person. A more helpful approach to providing support may be to prioritise the perspectives and concerns of the young people themselves.

2.3.9 The role of emotional competence

Presentation and symptoms of emotional distress vary according to the developmental age of the individual. Developmental psychology theory proposes that with increasing emotional vocabulary a child is more able to distinguish between emotions, such as sadness and anger, and depressive cognitions become possible. Emotional vocabulary does not mature until a child's self-awareness and self-consciousness have developed, typically in the years approaching puberty (Herbert 2005). The absence of emotional literacy may contribute to difficulties communicating and detecting mental health problems in young people.

Competence in conceptualising and articulating emotional experience, also termed emotional literacy, was found to be an important mediating factor in help-seeking for mental health problems, in a large Australian programme of research involving 19 separate studies. In total, 2721 young people aged 16-24 provided data via self-report questionnaires, which were supported by focus groups with young people and adults in key roles in the community. Two questionnaires were used: the General Helpseeking Questionnaire, which was developed for the research programme in order to assess both intentions and experience of help-seeking; and the Actual Helpseeking Questionnaire, which was an adaptation of a previously validated measure and intended to assess recent

help-seeking behaviour. Emotional competence, self awareness and willingness to disclose sensitive material were identified as mediators of help-seeking, and therefore in this sample the barriers and facilitators of help-seeking stemmed from these factors. For example, help-seeking was associated with being able to recognise and explain a difficulty and having support from other people (Rickwood et al. 2005). The research produced a detailed analysis of help-seeking in young people in Eastern Australia, but does not support direct comparison with help-seeking in other populations because of the limited external validity of the measures used.

A broader concept of competence was one factor associated with mental health service use in 16 year olds, though not younger age groups, in a Finnish cohort study to investigate predictors of mental health referrals. Pairs of well validated measures were used in a sample of 857 children and young people: the Rutter parent and teacher scales and the Child Depression Inventory at 8 years of age, and the Child Behaviour Checklist and Youth Self Report at 16 years (Sourander 2001). Other associated factors were the composition of the individual's family and the way the family processed problems. The study findings suggested that both emotional and practical competence can affect health behaviour, conclusions which are strengthened by the large cohort and the external validity of the measures.

2.3.10   Conclusion

Barriers to help-seeking in young people appear to be multi-factorial and there is potential to influence help-seeking through the design and delivery of services. In young people there is a danger of undermining intrinsic coping strategies by intervening too much or too early. Therefore approaches to emotional wellbeing interventions for young people must aim to offer support without undermining self reliance, so that young people can recognise and develop their coping strategies. If they are supported to communicate their perspectives on their difficulties, help may be more relevant and ultimately more useful and effective.

There are policy drivers to address psychological needs of young people and the statutory responsibility is shared amongst children's services. Barriers to help-seeking are wide-ranging, and doubts about the feasibility of removing social and cognitive barriers to

help-seeking may be construed as an argument that self care and self reliance may be an attractive health strategy for young people. For example, help-seeking could be facilitated by delivering services at times and locations, and through pathways, that are convenient and acceptable to the young people.

Hence self-help approaches may offer a strategy for the development of acceptable interventions for the prevention of mental illness and promotion of emotional wellbeing in young people.

2.3.11   Summary

- Public health data indicates that the prevalence of mental and emotional disorders in young people in the UK is at least 10%

- Mental health difficulties in young people may not be recognised. They are associated with other health and social problems.

- The Every Child Matters agenda is to improve the delivery and effectiveness of all children's services.

- Young people's health behaviour is influenced by problem construction and perceptions of confidentiality.

- Theoretical approaches to understanding health behaviour in young people may be social, cognitive, developmental, or family oriented.

- Flexible approaches to service delivery, such as self-help, may have potential to enhance acceptability and therefore improve the accessibility of suitable interventions.

The next section of the literature review discusses approaches to improving emotional wellbeing in young people.

2.4 The potential of guided self-help (GSH) to improve the delivery of psychological interventions to young people

This section introduces the argument that using guided self-help (GSH) to deliver CBT based interventions could address key barriers to help-seeking identified from research with young people.

Evidence exists to support a range of psychological interventions to promote emotional wellbeing in young people, such as interpersonal therapy and group therapies (Hazell 2005); however this discussion focuses on the potential contribution of CBT based interventions because they have a strong evidence base, are advocated in policy documents, and appear to have the potential to be adapted to suit the context of emotional wellbeing promotion in young people. Preventive and emotional wellbeing-promoting CBT based interventions are increasingly the focus of research interest, particularly in educational settings, as will be demonstrated.

2.4.1 The evidence for CBT based interventions

For children and young people, the evidence in favour of both formal CBT and interventions with a CBT component has been established in reviews of its effectiveness in depression (e.g. (Hazell 2005, Harrington et al. 1998a, Bostic et al. 2005). Reviews of the evidence by NICE have led to recommendations to use CBT and interventions based on CBT principles with children, young people, adults and older adults and a wide range of emotional and mental health problems. (National Collaborating Centre for Mental Health 2005, NICE 2005, NICE 2006, NICE 2008).

CBT is frequently cited as the preferred psychological therapy because of the weight of evidence for its effectiveness in a wide range of psychological difficulties in adults, young people and children, but the absence of evidence for other therapies may result in overstatement of the strength of the evidence for computerised CBT (Kaltenhaler et al. 2002). Therefore the case for the superiority of CBT may be flawed, but nevertheless this therapy has a strong enough evidence base to have been endorsed in policy.

2.4.2   Application of CBT with young people

Formal CBT is a psychological therapy that attempts to improve mental state by challenging negative automatic thoughts (such as habitual self criticism) and encouraging behaviour to promote self confidence and self esteem. CBT typically involves 6-8 hours of contact with a specialist therapist who has had many years of training (Richards et al. 2003). The therapist's role is to encourage the clients to think for themselves and maintain a collaborative style so that they are actively involved in the therapy (Grazebrook et al. 2005), which can enhance empowerment of the client in the therapeutic relationship .

CBT with children and young people needs to be flexibly applied to accommodate differences in social and cognitive processing. When thinking shifts from concrete to abstract and conceptual thought, at around ten or twelve years, it is accompanied by increasingly sophisticated reasoning powers, social awareness and a more complex sense of morality (Herbert 2005). With increasing cognitive development, the individual is able to think conceptually and cognitive approaches may be appropriate. If language restrictions or developmental stage reduces the usefulness of cognitive approaches in a CBT treatment, the focus may be on behavioural approaches (Verduyn 2000). CBT therefore is a flexible approach with potential to be useful in different contexts.

Family involvement in CBT treatments for children and young people is recognised as good practice which enhances outcomes, parental involvement being particularly helpful (Verduyn 1998). However as discussed in the previous section, health behaviour in young people may be compromised by a lack of privacy. Therefore access to help may be enhanced through approaches that acknowledge these barriers.

2.4.3   Self-help approaches using CBT interventions

There is a lack of consensus concerning the most active ingredients of CBT. Opinions as to the key components include the technical approach (Lovell 2000), the therapist input (Blackwood 2006), homework (Marks 1992, Marks 1997, Gega et al. 2004) and collaboration with families (in the case of children and young people) (Christie and Wilson 2005).

The development of self-help approaches based on CBT supposes that therapist

involvement may be optional. However it has been argued that the role of the therapist is a key active ingredient (Blackwood 2006). A meta-analytic review of CBT interventions for anxiety and depression in children found that it was equivalent to other bona fide treatments (e.g. interpersonal therapy and behavioural problem solving), compared with non bona fide treatments (e.g. relaxation or educational support) (Spielmans et al. 2007). This suggests that the effectiveness of CBT may depend on the therapeutic relationship and belief in the treatment rather than the specifics of the technology.

The use of CBT techniques can be seen in self-help programmes and materials that are readily available to the public, in bookshops and libraries and through recommendation by professionals involved in healthcare, health promotion and personal growth. With the addition of endorsed and recommended computerised CBT packages (NICE 2006) the question of whether the traditional approach of intensive input from a highly trained CBT professional is necessary has been raised, stimulating interest in examining self-help approaches without specialist input for less intensive and preventive interventions (Richards et al. 2003).

2.4.4 The use of self-help approaches to improve access to effective interventions

The messages from the literature discussed above suggest empirical study findings are consistent with theoretical perspectives in identifying a wide range of factors affecting attitudes to help-seeking and health behaviour in young people. At the preventive level, the availability of specialist psychological services for young people is limited by the structure of child and adolescent mental health services: Much mental health care for psychological difficulties is delivered by generic practitioners, but recognition, management and referral pathways may not be effective for reasons of organisational arrangements or clinical skill.

The acceptability of those services which are available may be poor. Although the evidence for the relationship between acceptability and uptake is not well established, it is clear that complex combinations of social and cognitive factors create psychological barriers to help-seeking which may affect decisions to use available health care.

Low expectations of confidentiality or empathy, interpretation and communication of problems, shame, and peer influences are powerful barriers. Potentially, some of these

barriers could be reduced by flexible delivery mechanisms which improve acceptability.

It has been argued that development of self-help approaches could improve access to effective psychological treatments and there is a growing base of primary research (Mead et al. 2005, Ackerson et al. 1998, Lovell et al. 2006, Lovell et al. 2003) and reviews (Bower et al. 2001b, den Boer et al. 2004, Lewis et al. 2003) (den Boer et al. 2004) (Bower et al. 2001a) (Lewis et al. 2003) to support this opinion, which is also expressed in NICE guidelines (National Collaborating Centre for Mental Health 2005).

2.4.5   The evidence base for self-help

In its simplest form self-help is a treatment undertaken independently, using cognitive and behavioural strategies described in books, computer programmes and other media (Richards et al. 2003). Self-help groups are an alternative form of self-help. They have been defined as consisting of lay people, brought together organically or mindfully with the objective of mutual support, and distinct from groups facilitated by a health professional (den Boer et al. 2004).

Much of the evidence for self-help is derived from research with adult populations, which limits its relevance for the present context. There is also a lack of evidence of effectiveness, many studies having concentrated on acceptability or showing inconclusive or insignificant effect. For example, in a controlled study of a self-help manual which was conducted with a sample of 30 patients on a waiting list for psychological treatment, acceptability was judged to be good, but there was no clinical improvement (Fletcher et al. 2005).

A meta analysis of simple self-help treatments for emotional disorders in adults found a mean effect size of 0.84 (0.76 for follow up) for bibliotherapy based strategies, though the evidence of effectiveness of self-help groups was limited (den Boer et al. 2004). Because the eligibility criteria excluded other forms of self-help, the results do not provide insights into the effectiveness of more complex self-help approaches. Further limitations stem from lack of detail about which disorders were eligible for the study, which is potentially attributable to the paucity of high quality studies in this field, as noted by the authors. In addition, there was low consistency in the use of measures in the included studies: each

study used a different combination of measures, and the measures addressed a range of conditions such as depression, anxiety, phobias, fears, distress and avoidance.

However self-help is potentially a complex intervention because of the factors impacting on its implementation. For example the ability of the recipient to engage with the process may be out of the control of the clinician or researcher, and hard to identify and evaluate (MRC 2000). More complicated models of self-help incorporate minimal interventions to support the individual. These range from a single initial assessment to ongoing brief contacts, and have the function of addressing low skills or motivation on the part of the user (Mead et al. 2005).

One example of a study exploring what young people find acceptable in self-help was conducted in the UK, based around a questionnaire completed by 968 (response rate 97%) students in years 9 and 11 in 4 high schools in Devon. The majority of respondents reported they would use a hypothetical self-help resource for low intensity psychological difficulties with preferences expressed for basing it at home, rather than school. Preferred levels of anonymity varied, with some students expressing that they would prefer to work through self-help materials without support, and others stating they would like support from an appropriate individual in school (Farrand et al. 2006). Preferred help-seeking styles varied and were influenced by age and gender, as well as the particular problem and the perception of the individual who was offering the help (Farrand et al. 2007). For example, males, females, Year 9 and Year 11 students were approximately equally likely to state they would seek help from a professional if unfairly treated by a teacher; but where the problem concerned persistent arguments with parents, boys and Year 9 students were the most likely to seek help in this way. These messages are consistent with the evidence about acceptability which has been discussed above and could be incorporated into other self-help interventions to maximise acceptability.

Self-help approaches may offer a useful alternative to CBT for young people because they aim to equip and empower individuals to protect and promote their own health, and so control their health care. Philosophically, they have the advantages of being empowering and building on existing coping strategies. Self-help strategies have been used in health interventions with young people.

2.4.6 Delivery of interventions by practitioners with brief, focused training

There is some evidence to support attempts to improve access to services through skill sharing between healthcare professionals or allocating carefully defined, specific, clinical tasks to less experienced workers in order to make better use of specialist skills within the team.

In the past decade, a new role of graduate primary care worker, trained in GSH techniques for mild to moderate mental health problems, was introduced into the mental health workforce. Graduate workers are trained to deliver a narrow range of CBT based interventions. Evaluation of this initiative through a case study found that despite their lack of clinical experience and training the graduate workers seem to have benefited mental health services (Bower et al, 2004, Harkness and Bower 2006) and endorses the utilisation of paraprofessionals to deliver closely defined interventions appropriate to their skills and experience.

This approach has caused controversy but appears to have potential to improve access to specialist skills for young people at the Tier 1 level.

2.4.7 The application of GSH

GSH has been described as a model of self-help in which the focus is on the use of written materials and the role of the therapist is to teach the recipient how to use them (Mead et al. 2005, Richards et al. 2003). This definition implies an emphasis on the cognitive processing of self-help information. There is growing evidence to support a GSH model to deliver psychological therapies to adults for mild to moderate mental health problems (Richards et al, 2003; NICE 2004). The model is theoretically consistent with CBT and utilises self-help literature. However it requires much less face-to-face contact than traditional CBT or other psychological therapies and is therefore potentially less expensive and more accessible.

GSH has demonstrated effectiveness in a range of psychological disorders in adults, but its impact on younger populations has not been explored. For example, an intervention combining a self-help manual with brief appointments with a junior doctor had equivalent outcomes and greater long term effect than formal CBT in 81 young women (mean age

23.3; SD 4.1) with eating disorders (Bailer et al. 2004).

A GSH model was piloted in primary care in a deprived urban area in the North of England, where the educational levels of the population were low and written materials potentially less acceptable or feasible. Patients with mild to moderate mental health problems received assessment, advice, motivation and support to use validated self-help materials from practitioners during 15 minute contact sessions. Evaluation of effectiveness with clinical data from 430 patients and qualitative interviews with 21 stakeholders demonstrated high acceptability among service users and providers, suggesting that the model was flexible enough to accommodate low literacy. Statistically significant improvements were identified in wellbeing, psychological health, daily functioning, risk, all non-risk items and all items, using a validated self report questionnaire (CORE-OM) (p<0.001) but there was limited evidence of clinically significant improvement using clinical/non clinical cut off scores (Lovell et al. 2006).

The service encountered a number of challenges that might also present in a model for high schools such as general unfamiliarity with the model, and practitioner's concerns about the adequacy of GSH to address typical presenting problems in the client group. The findings of the evaluation demonstrated that the model could be delivered by individuals without CBT training and be a helpful intervention for a wide range of difficulties in adults with high levels of need, low literacy, and difficult lifestyles. The model therefore had features of flexibility and acceptability and effectiveness which could be useful to a high school-based intervention.

2.4.8   Conclusion

In the context of depression and anxiety in young people, the importance of early intervention to improve prognosis and reduce impact is well established in the scientific literature (Harrington and Dubicka 2002, Harrington et al. 1998b, Hazell 2005, Merry et al. 2004). Better preventive interventions for young people could raise mental health status in this age group and potentially reduce the demand on CAMHS. The challenge for CAMHS may be to find ways of improving access to CBT for children and young people who do not have the most serious psychological difficulties.

Because GSH promotes empowerment and active engagement, its principles are congruent with theoretical perspectives on emotional health interventions with young people. Emerging evidence for GSH is informed by CBT principles and indications that it is potentially empowering, cost-effective and more accessible than formal CBT. Exploring the feasibility and acceptability of GSH in young people is a logical next step in the development of interventions to promote and protect their emotional health.

2.4.9   Summary

- Psychological treatments with a cognitive behaviour therapy component are supported by research evidence and NICE guidelines for young people.

- The active ingredients of CBT are unclear.

- Access to CBT could be improved through alternative delivery mechanisms

- Psychological interventions have previously been delivered by unqualified practitioners (graduate workers) in mental health services.

- Self-help approaches may offer a further means of improving access, but much of the existing evidence concerns adult populations and there is less from research with young people.

- GSH is a flexible and empowering approach which may be feasible and acceptable in schools.

2.5 Promoting emotional wellbeing in schools

Evidence has been presented to suggest that GSH could be a feasible and acceptable way to deliver effective psychological interventions to young people. However little is yet known about the potential for GSH to deliver an emotional wellbeing intervention, with a non-clinical population, of young people, in a school context. This section will consider the case for using a school setting to deliver an emotional wellbeing intervention through GSH. Research evidence exists to support a number of curriculum interventions for a range of sensitive topics, including emotional wellbeing (e.g.Dalle Grave 2003, Stallard et al. 2007).

Initiatives in education are broadening the scope of the mental health work carried out by schools. The National Healthy Schools Programme assumes emotional health and wellbeing to be part of overall health promotion in schools, and emphasises the importance of interagency collaboration (Department for Children Schools and Families, 2006).

Schools are used as settings to deliver emotional wellbeing interventions within and outside the UK. In an evaluation of a UK, school-based lunchtime drop in clinic run by a school nurse, which analysed data from 28 school nurses in 4 focus groups and 6 individual interviews, it was reported that the drop in was used for many reasons including family conflict, sexual health advice, and mental and emotional health concerns (Allen 2007). This is consistent with primary care studies discussed earlier and suggests that school can be a helpful context to address difficult or sensitive health issues.

2.5.1 Example of a school-based emotional wellbeing intervention

'FRIENDS' is a universal, preventive, CBT based, emotional health programme in primary schools (Stallard et al. 2007, Stallard et al. 2008). It was evaluated in research study conducted in 3 primary schools in the UK, in which it was delivered through the school curriculum by school nurses who had received 2 days of training. In 10 sessions programme supported by a manual, they taught practical skills of relaxation, anxiety management, and problem solving to primary school aged children, in a classroom setting.

Analysis of self report measures of anxiety (Spence children's anxiety scale) and self esteem (Culture free self–esteem questionnaire) from 63 children out of an initial sample of 106 showed sustained statistically significant improvement in both anxiety and self esteem at 12 month follow up; (P<0.001). Indications of a preventive effect were obtained through analysis of the number of children classified as high risk at baseline and follow up. Tentative implications of this study were that the intervention was potentially feasible, acceptable and effective in primary schools (Stallard et al. 2007, Stallard et al. 2008). As yet its potential value in high schools has not been reported.

Much of the evidence concerning emotional wellbeing interventions in schools is derived from large research programmes like the FRIENDS study. This programme had the influential backing of the World Health Organization. The work of the FRIENDS programme in primary schools (Stallard et al. 2007, Stallard et al. 2005, Stallard et al. 2008), suggests that there may be potential to develop appropriate interventions which do not have to be delivered by mental health practitioners. Potentially, a large and influential research programme may have better access to curriculum time and school staff and students than small exploratory studies. Nevertheless it may be more vulnerable to political change.

Further, while a curriculum intervention can promote emotional resilience and coping and is non-stigmatising compared with targeted interventions (Stallard et al. 2007), it is not appropriate for the delivery of individualised support or the discussion of personal issues. The challenge may be to develop small, targeted non- stigmatising interventions. The use of self-referral to identify a population to receive a targeted intervention may be a suitable resolution (Dalle Grave 2003). There is little evidence to support the introduction of small exploratory studies to promote emotional wellbeing in schools, though some of the factors affecting the implementation of school programmes are addressed later in this literature review.

2.5.2   UK policy for the promotion of emotional wellbeing in schools

In the UK, mental health promotion in schools is part of the Healthy Schools initiative and may be delivered through the curriculum as Social and Emotional Learning or Personal, Social and Health Education (DES 2007, DfES 2008)

This is often delivered by teachers who may not have received additional training (Ofsted 2005). The NICE guidance for schools published recommendations about how to promote social and emotional wellbeing, which suggest an extensive role for teachers in promoting, assessing, identifying and managing the emotional needs of students (National Institute for Health and Clinical Excellence 2008). However Stallard et al reflected that many teachers know little about mental health issues and therefore may not be a suitable choice (Stallard et al. 2007), and indeed in the UK the training of classroom teachers for this role appears to be a neglected area (Ofsted 2005).

Pastoral care in schools involves emotional support for students, aimed at helping them to achieve their potential in school. This work requires interpersonal skills including active listening, motivating and facilitation (Department for Education and Skills 2000). Mainstream schools in the UK normally have a Special Educational Needs Coordinator (SENCO), who manages Special Educational Needs (SEN) staff and coordinates SEN work in school. This focuses on helping students with SEN to cope with academic work (Careers Advice Service 2008). These students have different levels and types of learning needs. Supporting them required many of the same skills that are used in pastoral care (Care Services Improvement Partnership (CSIP) 2006).

2.5.3   Role of learning mentors in schools

Learning mentors are salaried school staff from a wide range of backgrounds and experience. As a minimum, they receive a 5-day accredited training course, once in post (Department for Children, Schools and Families 2006). The DCSF has supported the recruitment of learning mentors in high schools in urban areas and the scheme is expected to expand to more areas of the country as the role matures.

One of their specific roles is developing supportive relationships with pupils who are underachieving, to help 'overcome social emotional and behavioural problems which act as

barriers to learning' (Department for Education and Skills, 2008). They carry caseloads, working to bridge the gap between educational and pastoral objectives though their role is focused on learning rather than emotional wellbeing.

They often work outside the curriculum, and like school nurses could potentially support an emotional wellbeing intervention in schools. The location of learning mentors in many urban schools presents an opportunity to design an emotional wellbeing intervention that they could be trained to deliver, and study its acceptability and feasibility, but little is known about the likely effect of expanding their professional role in this way.

In the context of health interventions, primary care graduate workers successfully perform a similar role in mental health care (National Institute for Mental Health in England 2004). Paraprofessional roles, in which unqualified individuals carry out professional functions under supervision of qualified professionals, have developed in other professions including teaching (Directgov 2008) the police force (The Home Office 2008), the ambulance service (NHS 2008), and law (Institute of Paralegals 2003).

Therefore the expansion of the roles of unqualified staff to improve the delivery of services is familiar in a range of professions. The concept of using people who are not mental health specialists to deliver psychological therapies could be developed further in schools. It is consistent with the tradition of mental health care delivered by paraprofessionals such as graduate mental health workers, and resonates with the delivery of mental health treatment in primary care and CAMHS tier 1 by primary care practitioners including GPs (Jacobson et al. 2002), and school nurses (Wilson et al. 2008).

2.6 Factors affecting the implementation and evaluation of school programmes

Implementation studies in educational research have contributed to an evidence base about barriers and facilitators to consider in the design and planning of a school-based emotional wellbeing intervention. Research studies exploring the implementation of new programmes in schools have consistently found that the implementation process is often enhanced if the whole school is engaged in the initiative, suggesting that school based research projects may require considerable investment in building relationships with key individuals.

For example, in educational practice literature, it has been proposed that the main barriers to programme delivery are 'attitudinal roadblocks' from educators, parents and administrators (Elias et al 1997, p.2), and 'logistical roadblocks' related to curriculum planning, funding, and training needs (Elias et al 1997 p4). This suggests a need for a cohesive approach to programme implementation.

The authors argued that to overcome these blocks requires a long term perspective of 7 to 10 years. It involves persistent and coordinated strategic planning across educational districts and within individual schools; approaching potential funders; training teachers to be skilful in SEL, and being mindful of the benefits to students if the programme is implemented and the loss to them if it is not (Elias et al. 1997).

In academic papers, conclusions from evaluations of UK school behavioural improvement Projects have suggested that integrated, coordinated and targeted approaches are successful ways to address school improvement (Hallam 2007, Hallam et al. 2005). On the basis of telephone interview data from 10 schools in 18 local authorities, and qualitative interviews with stakeholders in schools which were examples of good practice, it was concluded that successful implementation depended on clear aims and strong management, physical capacity in schools, training needs, and the provision of support within schools. These findings were compromised by the absence of qualitative data from schools which were not identified as examples of good practice; therefore although the facilitators of implementation were consistent with other implementation literature, barriers to implementation were not clarified.

Understanding the barriers may enhance understanding of the processes involved in implementation. Whole school projects require a scale of commitment from a school which may not be available to small exploratory research studies (Stallard et al. 2007, Stallard et al. 2008, Bond et al. 2007, Patton et al. 2003, Hallam 2007, Hallam et al. 2005). Yet however desirable whole school approaches are to the implementation of programmes, they may not be feasible.

A report on health promotion initiatives in Scottish schools reported that organisational support was an important factor for successful implementation, but also indicated some of the pitfalls of implementing a programme where the project has not engaged the full support of the school (Inchley et al. 2007). For unfamiliar, untried, or untrusted

interventions, implementation may have to go ahead without the wholehearted support of the school. It has been noted that there are a large number of projects available for schools to choose from (Paton et al 2002), and schools may be inclined towards established programmes endorsed by public funding. This may limit the potential of small, single handed doctoral research projects to engage the interest of school managers

Contextual factors such as the school population can affect school processes and achievements and the implementation of school programmes therefore have an important impact on implementation. In a review of the literature reviewing the links between school context and performance, it has been argued that the school's popularity compared to other schools, the characteristics of the area, and the local authority policy affect pupil intake- and hence often funding, leadership, teaching quality and academic achievement. For example, improvements made by schools in social and emotional learning or engaging reluctant students may not gain recognition because they are not necessarily reflected in public examinations Thrupp and Lupton (2006). Therefore implementation of a school based research project may be subject to influences out of the control of the researcher.

2.6.1 Influence of school leadership on programme implementation in schools

School leaders appear to exert considerable influence on the implementation of school programmes. The impact of the Head Teacher has consistently been identified as a key factor affecting the implementation of school programmes to promote social and emotional learning (Elias et al. 1997, Inchley et al. 2007, Greenberg et al. 2003, Patton et al. 2000, Kam et al. 2003).

The support of the school principals had a significant effect on the implementation in 3 schools in Pennsylvania, USA of a programme to prevent delinquency (Kam et al 2003). An exploration of pastoral care in 4 secondary schools in England and New Zealand reported that each Head Teacher had their own ideas about what pastoral care was for and how it should be delivered (Galloway 1983). Head Teachers made various interpretations of the pastoral responsibility of the school. In one case, it was aimed at mitigating obstacles to learning, such as hostile behaviour at school or lack of opportunities to complete homework at home. Elsewhere, it was aimed at promoting social adjustment by maintaining a stable and supportive environment in the school. A third Head Teacher's

interpretation of pastoral care was to focus on making education inclusive, by removing ability streams and setting realistic educational goals for each pupil. This report omitted detail about methods, and therefore its main contribution is in the subjective discussion of the role of Head Teachers in the 4 schools; however it is one of few studies which address this issue directly.

2.6.2   Impact of school leadership on pastoral care delivered by teachers

The form tutor's pastoral role could be undermined by school policy and organisational factors shaped by the Head Teacher, such as insufficient time, training, and recompense for the role (Galloway 1983). Head Teachers' strong personal influence on the development of systems of pastoral care was emphasised in a narrative literature review (Muijs et al. 2004). There was a tendency in some schools to confuse pastoral care and discipline, suggesting a link with higher levels of disruptive behaviour in those schools. Class teachers often carried a lot of disciplinary and pastoral responsibility, without being sufficiently well informed about a pupil's circumstances to gauge the most appropriate response to a problem occurring in the classroom. However, the practice of referring issues to more senior staff, often heads of year, to deal with, both frustrated the heads of year and tended to escalate the problems. More satisfactory approaches were seen in cases where the form tutor role incorporated formal pastoral responsibilities. This meant that teachers could consult with staff who knew the pupils well instead of raising problems through the managerial hierarchy.

The attitude of teachers to pastoral roles may be a factor affecting pastoral care. It has been speculated that asking for help might be seen as an admission of failure rather than a process of professional development even for inexperienced teachers, and further that this attitude underpinned a tendency for some teachers to exonerate themselves, and possibly their lack of skills, by attributing problems to the individual pupil or their family (Galloway 1983). Therefore it is argued that an ethos among the staff in which they do not admit to needing help could compromise the quality of pastoral care and could have a negative effect on pupils. Such an ethos could develop organically or be a mechanism by which the Head Teachers influence the operation of pastoral care.

The individual Head Teacher seems to have the power to make a personal decision about

their school's approach to pastoral care. Galloway argued that the location of this power in an individual may not be an obstacle to effective school management, provided that staff felt they had been consulted, although pastoral care appeared to depend on consistent leadership and a supportive and collaborative school culture (Galloway 1983). In conclusion, there is some evidence to suggest that how pastoral care is delivered will have a major impact on the whole school.

2.6.3   Evaluation of pastoral care in school

Though the work reported above enhances understanding of how pastoral care operates in high schools, more systematic approaches to evaluating pastoral care may contribute a better understanding of effectiveness. A review of educational interventions found that they may not be implemented as planned, suggesting that it is essential to understand the implementation process (O'Donnell 2008).

Pastoral interventions in school tend to be complex, involving many contextual factors that impact on their delivery. In health contexts, the MRC framework for the evaluation of complex interventions has been noted as a valuable tool to support complex interventions outside health contexts (Campbell et al. 2000).

2.6.4   Discussion: the potential of GSH to promote emotional wellbeing in high school

CBT is often unavailable to young people outside specialist services in the current Child and Adolescent Mental Health service structure. In a recent postal survey of CAMH services, only half the CAMHS organisations reported routinely offering CBT (Ross and Brannigan 2008). Therefore its availability as an early or preventive intervention is also limited.

The development of CBT based interventions to promote emotional wellbeing in schools appears to have an emerging evidence base for acceptability, feasibility and effectiveness (Stallard et al. 2005). Cognitive behaviour therapy (CBT) principles are central to many of the educational materials that have been developed to promote emotional wellbeing in schools, such as the SEALS social and emotional learning programme in the UK (Department for Children Schools and Families 2008). Hence the use of school contexts

to deliver CBT based emotional wellbeing interventions may be a timely and feasible means of protecting young people's mental health and promoting emotional wellbeing.

GSH requires the active engagement of the individual and involves them learning how to recognise and manage their mental and emotional state (Mead et al. 2005, Richards et al. 2003) Some sociological perspectives on self-help have suggested that health care deliverers need to strike a balance between providing health support when it is needed without fostering dependence unnecessarily (Bury 2006). Because the role of the helper is minimal, prominence is given to inherent coping. GSH could avoid pitfalls of more intensive intervention, such as over-medicalising experiences, and undermining self reliance by creating a demand for 'expert' help (Bury 2006). This is particularly pertinent to young people and emotional problems, because both are associated with issues of identity and increased suggestibility.

The evidence from the literature that has been presented suggests that self-help may have the flexibility and effectiveness to be a suitable means of delivering psychological therapies for young people in school.

2.7   Conclusion to the review of the literature

The literature demonstrates the potential of a school-based, GSH intervention to promote emotional wellbeing in young people. There is a need to improve the emotional wellbeing of young people, and up to this point, there has been little discussion of the feasibility and acceptability of combining these components in an intervention. The logical next step is to investigate this further. The present research aimed to develop an exploratory study to evaluate the feasibility and acceptability of such an intervention.

The prevalence of mental health problems in children and young people is at least 10% and may be as high as 20%. This indicates a need to develop preventive interventions to promote emotional wellbeing in high school students.

There is growing evidence that adding minimal therapist contact to CBT-based self-help treatments improves acceptability and effectiveness, but it is not known whether this GSH approach would work for teenagers in high schools. It is possible that non-mental health specialists in schools could successfully deliver a GSH model for mild to moderate emotional and psychological difficulties without intensive mental health training. There

is a gap in the evidence base concerning the feasibility and acceptability of using a GSH intervention in schools.

Help-seeking in young people depends on complex personal and environmental factors. A self-referral system and collaborative goal setting approach could help the young person to keep control over the support they received. There is potential for promoting lasting improvements in emotional wellbeing because coping skills for self management re learnt. School staff who have received training to deliver the intervention may feel more confident mental health role and the experience of being involved in delivering the intervention may form the basis for a sustainable scheme. Therefore a study was conducted to start the process of developing a feasible and acceptable intervention to promote and protect emotional wellbeing, delivered through GSH to 11-16 year olds in high school.

2.8   Relevance of this research

A profile of the local area in which the study was based shows why the new knowledge generated by this research project is needed. The city where the research was based has high levels of social deprivation, with associated high youth unemployment, high levels of teenage pregnancy and high male suicide rates in the 15-34 age group. These features are associated with mental illness. New knowledge will assist in the development of suitable mental health improvement strategies to raise the capacity of young people to acquire self management skills and improve their life choices in the long term.

3 Methodological principles underpinning the study

3.1 Introduction

In the previous chapter, the literature review presented the case for an emotional wellbeing intervention in high schools, delivering cognitive behavioural strategies to teenagers using a GSH model. As stated earlier, the study aims were to develop and implement a suitable GSH intervention in a high school setting, and evaluate its feasibility and acceptability. The following section discusses the methodological approach to the research study.

3.2 The Medical Research Council (MRC) Framework

The MRC framework for the development and evaluation of complex interventions to improve health was adopted as the conceptual model for the study. It was published in 2000 to provide guidance for the development of research designs and as a discussion document (MRC 2000). The framework was oriented towards the development and completion of an evaluative randomised controlled trial (RCT), to evaluate the intervention, though it was acknowledged that this might not be feasible or preferable in every study. The research process was illustrated in an influential diagram, describing a linear model in 5 sequential research phases. The phases spanned the research process from theoretical exploration to testing the feasibility of long term implementation (see Figure 2). The authors emphasised that the framework was not intended to be prescriptive, but the linear model was an influential component and appeared to become the focus of debate about approaches to complex interventions in health research.

Reflecting on the framework, Campbell et al (2000) argued that linear research models for complex interventions may not be the most appropriate, since iterative approaches could lead to better health and research outcomes. For example, where there are doubts about feasibility, an iterative approach facilitates the review of intervention components. Campbell et al (2000) proposed an alternative, cyclical model representing the iterative aspects of a research study which occur when observational, exploratory, explanatory and pragmatic phases inform each other to add to knowledge and understanding (see Figure 3).

In the context of nurse led interventions in intensive care, Blackwood reported that the first 3 phases of the linear model constituted a useful tool in the research design, though

noted that the development of an RCT was not an obvious next step and the evaluation of long term effectiveness had potentially prohibitive funding implications (Blackwood 2006). The contribution of the framework to nursing research was described by Sturt and Whitlock (2006), who observed that many nursing interventions are complex and used the linear model to frame a preliminary, quantitative investigation in a diabetes self management study. These examples illustrate the potential of the linear model to support health research.

In anticipation of a planned major revision, the framework was critiqued by Campbell et al (2007), in a paper which challenged some core tenets. It was argued that major parts of the research process could be, and often were, conducted concurrently. In addition, the assumption that a complex intervention to improve health must be evaluated in an RCT was questioned. It was proposed that it is acceptable, and may be desirable, to implement interventions without such a trial, if they are supported by sufficient evidence to remove doubt about their value (Campbell et al. 2007).

These arguments were incorporated into a revised version of the framework, following a major consultation (MRC 2008). In its current form, the framework describes the iterative development of 4 key elements (development, piloting, evaluation and implementation), using carefully planned and systematic strategies. The focus on RCTs has been replaced by an acknowledgement that other forms of evaluation may be more appropriate, depending on the context- for example with qualitative studies. The possibility that the framework may be appropriate for research outside health settings has been mooted, and the importance of adapting the framework to the specific context has been emphasised (Craig et al. 2008).

As the interpretation of health needs and service demands are continually evolving, the framework may well be subject to further review. In its present form the latest version of the MRC framework for complex interventions to improve health appears to be an iterative, flexible and potentially generic research model.

3.1   Application of the MRC framework to the study

The MRC Framework defines complex interventions as packages of components of care. Therefore any school-based self-help intervention can be conceptualised as a complex

intervention, since it is composed of several elements, including the school setting, modes of access, content of therapeutic sessions, and preparation of practitioners.

3.2   Description of the MRC framework

The MRC Framework maps out the research process in 5 phases: Theory, Modelling, Exploratory Trial, Definitive RCT and Longer Term Implementation. Figure 2 below describes the linear interpretation. The linear process sets out the phases distinctly, demonstrating how new knowledge builds on existing knowledge, and is particularly helpful with planning and design.

However as a piece of research develops, iteration is often required as early theories are revisited and revised. Figure 3 below illustrates the iterative relationship between observing, exploring, explaining and pragmatic phases of intervention development.

Figure 2: Linear interpretation of the MRC Framework for Complex Interventions to Improve Health (MRC 2000)
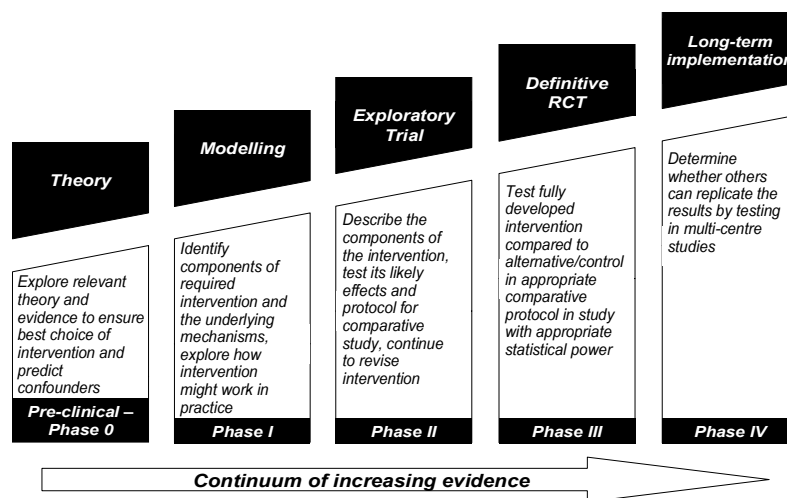
Figure 3: Iterative Representation of the MRC Framework for Complex Interventions to Improve Health (BMJ. 2000)
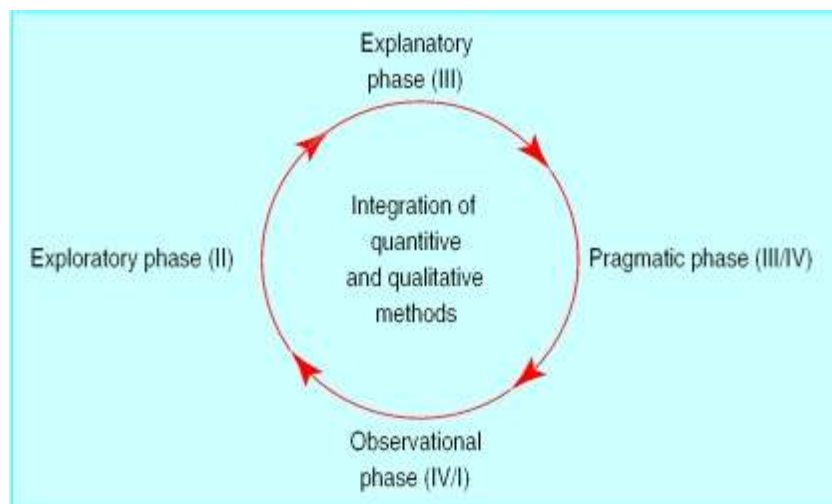
These models are retrospective perspectives on the research process, which may be more complicated in reality. The linear version of the MRC Framework was the most helpful model for the present study because it suggested the incremental growth of knowledge about the intervention. It was adopted as the main guide of the study design. Further explanation of the MRC Framework in relation to the linear model in Figure 2 is set out below.

3.2.1   MRC Framework: Theory Phase (Phase 0)

In the Theory phase, evidence is gathered from the literature and empirical experience, which initiates a preliminary research question. Underlying assumptions can be examined through an exploration of theories about the components of the intervention.

The objective is to "explore relevant theory to ensure the best choice of intervention and hypothesis and to predict major confounders and strategic design issues" (MRC 2000, p.3). At this stage, a piece of research was envisaged that would address the clinical problem of low level psychological difficulties in young people, to reduce immediate and long term impact of these needs.

3.2.2   MRC Framework: Modelling Phase (Phase I)

Phase I proposes that a theory is modelled, informed by the literature review. The theory is

refined gradually as the research question becomes more focussed. The modelling phase may also employ qualitative techniques such as focus groups to find out more about the mechanisms of an intervention in the context of the research study, before examining them in an exploratory trial.

The objectives are to:

identify the components of the intervention, and the underlying mechanisms by which they will influence outcomes to provide evidence that you can predict how they will relate to each other.

(MRC 2000, p.3).

Working out these relationships in the modelling phase may be achieved through further theoretical exploration or by applying a preliminary version of the intervention in a pilot study, as described by (Blackwood 2006). For the present study, a theoretical model was developed, driven by research evidence and the health policy framework in the UK, and built from 3 main components: help-seeking in young people, psychological interventions delivered through GSH, and school settings. Figure 4 illustrates the relationship in the present study between the development of the research design and the intervention using the MRC Framework, showing how the research design leads to the intervention development, and both stem from the Framework.

Figure 4: relationship of the MRC Framework to the structure of the research

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│  ┌────────────────────────┐          ┌──────────────────────────┐    │
│  │ Research question:     │   ───►    │ MRC framework Phases 0-1 │    │
│  │ feasibility and        │          │   • Theory               │    │
│  │ acceptability of       │          │   • Modelling            │    │
│  │ proposed intervention  │          └──────────────────────────┘    │
│  └────────────────────────┘                                          │
│              │                                    │                   │
│              ▼                                    ▼                   │
│  ┌─────────────────────────────────────────────────────────────┐    │
│  │              Research design                                 │    │
│  │                                                              │    │
│  │         Theory + Modelling + Evaluation-                     │    │
│  └─────────────────────────────────────────────────────────────┘    │
│                               │                                      │
│                               ▼                                      │
│  ┌─────────────────────────────────────────────────────────────┐    │
│  │                     Stage I                                  │    │
│  │ Literature Review + Orientation + Informal consultation with │    │
│  │ stakeholders + Focus groups with young people                │    │
│  │                                                              │    │
│  │                     Stage II                                 │    │
│  │ Development of intervention + training for Project workers +  │    │
│  │ design of acceptability and implementation questionnaire for │    │
│  │ general student population + selection of outcome measure     │    │
│  │                                                              │    │
│  │                     Stage III                                │    │
│  │ Implementation of intervention                               │    │
│  │ Evaluation through:                                          │    │
│  │     • questionnaire                                          │    │
│  │     • outcome measure (Rosenberg Self Esteem Scale)          │    │
│  │     • semi-structured interviews with staff and students     │    │
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3.2.3 Exploratory Phase (Phase II)

Whereas the modelling phase helps to improve understanding and refine theory, in the exploratory phase a trial is conducted, in which information is gathered to make decisions about the feasibility of a main, larger trial, possibly an RCT. This may be in the form of an implementation study where the intervention can be examined in various forms, thus helping to clarify the active ingredients and their possible effects on outcomes.

3.2.4 Definitive RCT and Long Term Implementation (Phases III and IV)

A definitive RCT involves the comparison of a well defined and understood intervention with a control in a study which can predict and minimise confounding factors.

Long term intervention concerns the replicability of the intervention, and requires sufficient understanding of the processes in the intervention to apply it in the long term in uncontrolled settings and anticipate the results. These last two phases are achievable only after the theory, modelling and exploratory phases have been completed. They were beyond the scope of this study and therefore have not been addressed here, though as stated above, the findings of the exploratory phase would underpin the development of a protocol for an RCT.

3.3 Ethical considerations

There is potential for conflicting value systems between health research and school cultures and therefore negotiations with schools should include a discussion of the ethical issues pertaining to research participants' freedom to opt in or out, confidentiality inclusion, and consent/assent (Hennessy and Heary 2005). A reciprocal arrangement with schools would acknowledge the contribution they make to the research study (Lewis 2004) and for example could include training for staff, to increase their knowledge or skills and enhance the potential of an intervention to be continued after the research process has ended. This could be part of an exit strategy aimed at minimising disruption to the school community caused by the research.

3.4 Conclusion

The MRC Framework (Medical Research Council 2000) is a useful conceptual tool that assists with the formulation of a research design. It sets out a pathway to explain how research aims should drive research methods, describing the stages that will clarify components, define the evolving research question, and model the mechanisms of the intervention.

 In the early stages of the process, the objectives are to define and focus the research questions. For such exploratory purposes, qualitative methods may be more appropriate. As the active components of an intervention are clarified, the measurement of efficacy and

effectiveness becomes feasible. Therefore the MRC framework was at the heart of the research design and the development of the intervention.

By emphasising that the research aims drive the methods, the Framework echoes the work of qualitative theorists such as Popay et al (1998), who argued that congruence between aims and methods is a benchmark for qualitative work.

This section has presented the methodological principles underpinning the approaches taken in the research. The following section orientates the reader in the research context by describing the 3 schools that participated in the research.

3.5   Description of schools participating in the study

3.5.1   Demographic profile

Public health data were available to provide a statistical picture of deprivation levels in the local areas around the schools. The research was set in 3 high schools in one city. In the table below, details have been summarised to preserve the anonymity of the schools.

The local area had an ethnically and economically diverse population which was reflected in the demographic profiles of the students. All 3 schools were in wards which are classified as being among the most deprived wards in England (Association of Public Health Observatories 2008) (detailed reference suppressed).

Descriptive pseudonyms Girlschool, Sportschool, and Faithschool were assigned to the schools to protect their anonymity in this thesis. Girlschool was an all girls school. Faithschool had a religious ethos, a member of the clergy on the staff, and close links with the local faith community. Sportschool had a special focus on sports.

3.5.2   Faithschool

Faithschool was an inner city mixed school. Though it was state funded, it also had support from the local faith community and had admission criteria additional to those stipulated by the local authority. It was an oversubscribed school with high academic achievement and good academic results for students from ethnic minorities, particularly black boys.

Faithschool was located in an area with a large black population, in an electoral ward that was in the top 5% of the most deprived wards in England. Based on the Income Deprivation Affecting Children Index (IDACI), it was in the most deprived area, compared with the other 2 schools (Association of Public Health Observatories, 2006 (detailed reference suppressed)). Faithschool served the local community as well as families living over a wider area, who sought it out because of its academic and religious status. Some students travelled long distances to Faithschool from other parts of the city.

School inspections had reported that there were low incidences of bullying but acknowledged that this might be due to underreporting.

3.5.3   Girlschool

Girlschool was also positioned in a community with high levels of poverty which incorporated both poorer and wealthier families and ranked 826/8414 in the indices of multiple deprivation (Association of Public Health Observatories, 2006). The high proportion of students with Pakistani, Indian and African ethnic identity partly reflected the local community. The two other state girls' schools in the city were both over 5 miles away and this school was heavily oversubscribed. Its admissions were controlled by the local authority.

3.5.4   Sportschool

This was an inner city mixed school located in a deprived area with mainly white residents and a ranking of 240/8414 in the indices of multiple deprivation (Association of Public Health Observatories, 2006). The students reflected the local community, as they were likely to live locally. There were two other mixed gender state schools within a two-mile radius of the school and it was undersubscribed.

Sportschool had a large proportion of students who had learning and behavioural difficulties. However, a recent Ofsted inspection had praised the social environment of the school and students' progress. The school had Sports College Specialist Status (DfES 2009), which was perceived by the school management to enhance morale and learning opportunities for the students.

3.5.5 Demographic detail

Table 1 below illustrates some key differences between the schools. The MINI scores in the table suggested a high level of mental health need in all 3 communities, based on population estimates and deprivation data. In Sportschool's local area the MINI was double the national average. The proportions of students entitled to free school meals at Sportschool and Girlschool suggested equivalent poverty levels.

The IDACI score suggests that these wards had high proportions of children living in deprived households and that Faithschool's local community was the most deprived of the 3. However although all 3 schools were located in areas of high deprivation, the Sportschool students were the most likely to live in the same electoral ward as the school.

The level of available detail about the ethnicity of student populations varied between schools. Girlschool and Sportschool provided the size and range of different ethnic groups represented in the school, and further information was accessible through Ofsted reports, which are in the public domain. Girlschool records had also made a distinction between ethnic groups within Pakistan, since this was relevant to the school population. Regarding Faithschool, information from a senior manager and a recent Ofsted report revealed the proportion of African-Caribbean students but without further detail.

The 3 schools are located within a large city with a history of cultural diversity, in which many ethnic groups are represented, including non-British white people. In this context, ethnic identity alone has limited value as a predictor of emotional wellbeing, health behaviour, personal history, social status, values or aspirations. These will also depend on factors such as how long a student has been in the UK, whether they are a refugee, and whether they or their family are English speaking.

Table 1: Key demographic features of the school populations

Name	Girlschool	Faithschool	Sportschool
Gender mix (students)	females	males/females	males /females
Approx Number of pupils 11-18 yrs	1700	1200	600
Ethnic mix	Many minority ethnic backgrounds - largest group South Asian	Over half African-Caribbean backgrounds	Vast majority white British
Majority ethnic group	Pakistani	African-Caribbean	White British
English as a second language	60%	15%	<1%
Free school meals entitlement	Almost 3 times higher than national average	Close to national average	Almost 3 times higher than national average
Pupils with learning difficulties and/or disabilities	Half national average	Below national average	Higher than national average
Deprivation	In top 20% of most deprived wards in England	In top 5% of most deprived wards in England	In top 10% of most deprived wards in England
MINI[2] National average score =1.	MINI 2000: 1.59	MINI 2000: 1.99	MINI 2000: 2.01
IDACI[3]: Score	0.35	0.64	0.45
Rank	25/32	4/32	21/32

Some key demographic features of the schools have been described. In the following section, the structure of the research study will be summarised.

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[2] Income Deprivation Affecting Children Index (IDACI). The regional score is 0.25. A higher score or higher ranking indicates higher poverty levels. IDACI ranking for this city is for 32 wards, e.g. a ranking of 4/32 indicates this ward is the 4th most deprived in the city.

[3] Mental Health Needs Index (MINI). The MINI model is based on ward level population estimates and deprivation data produced for the Indices of Multiple Deprivation (IMD) 2000 (source: city council. Accessed 16.08.06). A score >1 indicates higher psychiatric admission rates than the national average.

3.6 The structure of the research design

The thesis structure corresponds to the research study structure, being organised in 3 Stages:

- Stage I: Consultation, in which information and knowledge were gathered from theory and context

- Stage II: Development, in which an intervention and its components were defined and developed

- Stage III: Implementation, in which the intervention was piloted and evaluated.

Stages consisted of methods and processes indicated in Phases 0-1 of the MRC framework (MRC 2000). According to the MRC Framework, preliminary steps in a research inquiry involve gathering information about relevant theory to steer the design of an intervention. The literature review findings supported the principle of developing a school based GSH intervention to deliver low key psychological interventions to young people. This provided theoretical knowledge but without local context.

Context is significant to research design because it affects acceptability and feasibility, as indicated in Popay et al (1998) and recent discussions on the MRC Framework (Campbell et al. 2007, Craig et al. 2008). The consultation therefore incorporated meetings with experts (children's mental health commissioning team, school nurses, child psychologists, educational psychologists, teachers and young people) and discussions with an advisory group of academics including the dissertation supervisors, other academics, clinicians and young people. Subsequently, young people were consulted in a series of focus groups.

Findings from the focus groups were synthesised with theoretical principles and contextual insights in the development stage. In the implementation stage, the intervention was piloted in high schools. Collecting and analysing a range of qualitative and quantitative data addressed questions of feasibility and acceptability and helped to clarify the active ingredients of the intervention.

In conclusion, the contextual understanding gained in the consultation study set the stage for the development and implementation of an acceptable and feasible intervention.

3.7 The context of the research

The literature review revealed a dearth of evidence concerning the use of GSH methods to deliver emotional support to young people in high school. A case was made for developing and exploring a high school-based, GSH intervention to promote emotional wellbeing. This section reports the consultation that took place to gain insights to inform the development of an intervention that would be acceptable and feasible in a high school context.

In order to generate a comprehensive understanding of lay knowledge (Popay et al 1998), preparatory research activity involved familiarisation with the study context. Personal and professional contacts were used to help with implementation. The principle research activity was a series of focus groups with young people to explore their views on the proposed intervention. These exploratory aims located the study in the Theory Phase of the MRC framework (MRC 2000). The methodological approach was also influenced by the principles of attention to lay knowledge, interpretation of subjective meaning, and understanding of context, which were set out by (Popay et al. 1998) as standards for qualitative research.

3.8 Stakeholder meetings

Following the literature review, the broad aim of the consultation was to explore with young people and other stakeholders in high schools and elsewhere on a proposal for a school-based emotional wellbeing intervention. Familiarisation with the context was achieved by informal and formal discussions with a wide range of experts in education and children's mental health. Meetings took place with key individuals in local high schools. This clarified suitable approaches to gaining access to school communities to conduct the research study and generated an understanding of context.

3.9 Establishment of an advisory panel

An advisory panel was established of experts who understood the context of the research, following Popay et al (1998). This consisted of young people, a school nurse, university academics, some with relevant clinical backgrounds, a pastoral manager/teacher, a CAMHS nurse, and an educational psychologist (see Appendix A). Communication was

through face-to-face meetings and email. Following a meeting of the advisory group, the intervention was named 'the Change Project'.

3.10   Identification of Project workers to deliver the Project

The mental health work of school nurses is well documented in the literature and supported by their professional bodies (Mental Health Network 2007, Wilson et al. 2008). However local school nurse teams did not have the spare capacity required to contribute to the intervention. Accordingly, school staff from pastoral and Special Educational Needs teams were identified as potential Project workers. Advantages to this were that there were larger numbers of potentially suitable staff, and as the staff were closely integrated with main school activity, there was a possibility that the skills learned from delivering the Project might be imparted to other staff, thus making the research project more reciprocal (Duffy 1985, Oakley 1989).

3.11   Conclusion

Familiarisation with the study context was essential to facilitating the rest of the process. Informal rapport building and inquiry paved the way for formal requests for support with the research and clarified key principles to be incorporated into the application for ethical approval.

Having explored the local context and clarified preliminary steps to gain access to school sites and a potential source of Project workers, students were consulted on their views about the intervention. The following sections describe the processes involved in the focus group study, beginning with a description of the methodological principles underpinning the study.

4 Methodological approach to the consultation with young people

4.1   Aims of the consultation

- To consult young people on their views about a potential school-based intervention to promote emotional wellbeing.

- To identify potential components and mechanisms of a theoretical intervention

- To identify potential barriers and facilitators to using the intervention

- To identify relevant indicators of outcomes

Specific objectives were to explore the range of emotional wellbeing issues that concern young people, to identify those which would be likely to be presented by young people in school; to consult on preferences for delivery of a self-help emotional wellbeing intervention in school; and to gain insights into young people's views on relevant outcomes.

4.2   Rationale for choice of focus group method

The views of young people were accessed through focus groups, an interview method that can generate rich data (Krueger 1997), with potential for sensitivity, inclusiveness and empowerment, which are relevant advantages for working with young people (Hennessy and Heary 2005).

Although the participation of young people in research is encouraged in policy, expressed in the publication of 'Hear by Right' (Badham and Wade 2008), strategies are required to facilitate meaningful involvement (Kirby et al. 2003, Kirby 2004) as power may be imposed in

...ingrained and subtle ways of talking and being with young people which can be hard to overcome yet can have very negative effects. This includes using unintelligible or patronising language, using inappropriate body language, using physical space in a particular way (e.g. seating arrangements), using adult – preferred structures (e.g. formal meetings) not giving age-appropriate information and feedback, and by giving adult concerns priority

(Kirby 2004, p.14).

In school, specific power imbalances may relate to young people's experience of their status in school, the perceived role, knowledge and experience of the researcher, and coercive behavioural norms of the school setting, where adults are in charge. Focus group methods offer an opportunity to establish a culture within the groups that would counteract normal social hierarchies in school (Morgan and Krueger 1993). Facilitation can be directed towards group ownership and verification of the data, to reduce the facilitator's influence on the tone and content of discussions and privilege the value systems of the participants.

With effective facilitation, members who are more confident can be supported to encourage more timid members to contribute. Promoting the engagement of all group members enhances the trustworthiness of the findings. In addition, the opinions of group members are open to challenge and modification by the group, which reflects processes in natural settings and further promotes the trustworthiness of the data.

Focus groups can access group interactions and nuances in perspectives on sensitive topics or with vulnerable groups (MRC 2000). For example, a focus group method was found to be an effective means of consulting young patients on their preferences for end of life care (Lyon et al. 2004) and Ginsburg et al (1997) facilitated focus group members to talk energetically amongst themselves, and thereby captured some of their anxieties and frustrations about health care.

Theoretical limitations of focus groups include the lack of consensus on how they should be conducted, particularly with regard to the optimum size (McLafferty 2004). Ethical problems have also been noted, such as a tendency, particularly in health service research, for an organisation to conduct a consultation through focus groups, so creating the

impression that it intends to act on the outcomes of the discussions (Duffy 1985).

Research with young people must be developmentally appropriate. Limitations to inclusion in a school-based focus group include the potential for some voices to be drowned out by others, the reliance on students who attend school, and the disadvantage to participants with verbal communication difficulties. Inclusion can be encouraged by considering potential difficulties with language, literacy, sensory impairment, mobility and other obstacles at the design stage. Individuals may have preferences for verbal or written data collection methods. This suggests that using a range of methods may be an effective way to access the views of a population.

Reciprocity in research implies that the researcher will give something in exchange for the assistance of the research participants (Lewis 2004). Passing on skills or information to research participants can have a beneficial and empowering effect without challenging the ethical boundaries. Focus groups can help to reciprocate the contribution of the participants through information sharing, particularly on sensitive topics. For example in a focus group consultation exploring what young people knew about HIV and AIDS it was possible to communicate health messages about safe sex which had not apparently already been heard by the group members (Boyle et al. 1989).

4.2.1   Conclusion

Focus groups have potential to reduce the impact of power imbalances between interviewer and interviewees and access views on sensitive topics. Views expressed by participants in groups may be less influenced by the research setting. In schools, focus groups may resonate with other group activities and seem congruent with the setting, though they may also have the potential to empower individual participants, and reveal social processes.

A potential limitation on focus group data is the impact of group dynamics. Social cultures among adolescents can be a strong influence on behaviour (Anderson 1999), so group dynamics can potentially restrict contributions from certain individuals, while providing a platform for the views of more articulate individuals. The impact of such dynamics could be reduced by sampling generally homogeneous groups who would tend to have common experiences with each other (Hennessy and Heary 2005), though this could also

reinforce social hierarchies. Effective facilitation can enhance the inclusiveness of the groups.

The methodological case for the use of focus groups has been presented above. The following sections will present the methods.

4.3   Methods used in the focus group consultation

4.3.1   Approach to access and sampling

Approximately 6 months was invested in building a rapport with senior managers, school nurses, pastoral and SEN teams and other key staff on each site, prior to facilitating the groups.

Eligibility criteria for schools were that they should all be in the same local authority, state funded, and inner city, in order to allow comparisons between schools while retaining the benefits of learning from participants' shared experiences (Miller 1998).

Practical requirements were that the Head Teacher should be amenable to hosting the research. After gaining ethical approval, a list of 11 eligible schools was reduced to the 6 believed to be most likely to support the research. Concurrent meetings with school nurses from other parts of the city stimulated interest in the research amongst health and educational professionals. The clinical and local knowledge of the researcher appeared to add credibility to the research.

Formal approaches to the 6 Head Teachers by telephone and letter were followed up with an email, containing a summary of the research proposal and likely benefit to the schools. Finally, a very brief letter on a single side of paper was posted. Girlschool, Sportschool and Faithschool responded to this, all agreeing to support 2 focus groups, one each with KS3 and KS4. The schools were described earlier.

Letters were distributed to students via the Deputy Head Teachers, with information about the study, explaining the research aims, what would happen in the groups, and assurances about confidentiality (see Appendix A). The Deputy Head Teachers stipulated that the

focus group discussions should focus on general views about emotional wellbeing and not have a therapeutic purpose. The mental health nursing background of the researcher was helpful in reducing anxieties about the welfare of the participants.

4.3.2 Ethical approval

Ethical approval for the focus group consultation was granted by the University of Manchester Research Ethics Committee in March 2006 (Reference 06/1001/NMSW). The Committee agreed that the participation in focus groups was a school activity that did not require consent from carers.

Strategies to protect the welfare of the participants included a co-facilitator in each group. All the facilitators had clinical backgrounds and were skilled in group work, so if any serious personal issues were to arise within the groups, they could be addressed appropriately and in line with school protocols.

4.3.2.1 Obtaining a focus group sample

A purposive sample of students was sought, which was appropriate for the exploratory aims, and feasible and acceptable in the school contexts. This included students from each school, each gender and each Key Stage (KS). Deputy Head Teachers helped to recruit students by balancing timetabling considerations and benefit to students. The sampling plan is shown in Table 2 below:

Table 2: Theoretical sampling for focus group consultation (anticipated sample)

No. groups conducted, by school	KS 3 (11-14 yrs)	KS4 (14-16 years)	Total
Faithschool	1	1	2
Girlschool	1	1	2
Sportschool	1	1	2
Total number of groups	3	3	6

4.3.2.2   Eligibility

Any student in KS3 or KS4 in the 3 schools was eligible for the focus groups. Sampling guidelines provided to the Deputy Head Teachers were: 2 groups of 8 students in each school, one group from each Key Stage. Each school chose to exclude students from Year 11 (15-16 years) because of their heavy study commitments.

4.3.2.3   Assent and consent

Information about the research aims, what assenting involved, and participants' ongoing right to opt out at any time was communicated to the participants at a developmentally appropriate level (Morrow and Richards 1996), verbally and in writing, during recruitment and at the start of each group. Participants were asked to keep group discussions confidential within the groups and assured that their contributions would be anonymised, unless any concerns arose that should be shared with the pastoral team. They indicated assent by signing a form (see Appendix A).They were explicitly informed that they could choose to leave at any point during the session. They signed separately if they permitted the group to be audio taped, for which the agreement of all members was required.

4.3.3   Approach to data collection

Data from the focus groups in the Consultation stage were collected during March and April 2006.

A topic guide informed by literature about emotional wellbeing issues for young people was used to stimulate discussion in an open conversation where participants were encouraged to identify issues of importance to their peer group (see Appendix A). The presence of the researcher in each group ensured a consistent facilitation style. Having two facilitators simplified the processes of obtaining written assent, dealing with latecomers and other interruptions, managing group dynamics and recording data on audio-cassette and in written notes. The two facilitators were able to inject energy into each group to maintain a brisk pace. Simple vignettes were used to stimulate discussion of potentially personal and difficult issues without exposing individuals (see Figure 5).

Figure 5: Sample vignette for focus groups

> **Someone your age has moved from another town and is coming to join your school. Things at home are difficult for them at the moment.**

4.3.3.1   Strategies to encourage engagement of participants

It was anticipated that some strategies might be necessary to encourage participation (Hennessy and Heary 2005). Refreshments were provided to act as an icebreaker and improve concentration and mark a difference between the focus groups and normal classroom activity.

Other strategies were adopted to encourage engagement of the participants. To accommodate different styles of engagement among individuals, a variety of activities were planned which included moving around, talking, writing, drawing, and group and individual tasks. To accommodate differences in cognitive ability (Herbert 2003) objects were used to aid discussion about options for accessing help and advice, including a mobile phone, a compact disk, a book, and a cassette tape.

Facilitators made contemporaneous notes during the groups and ensured that key discussion points were recorded on flipcharts by group members, so that they could be verified or challenged by the participants. To enhance the audit trail, flipcharts were recorded by digital photographs (for example, see Appendix A). Immediately following conclusion of each focus group, the facilitators discussed their impressions and further notes were made.

4.3.4   Summary

- Access to schools depended on obtaining the approval of Head Teachers and a persistent approach was required.

- The acceptability of the research project was supported by the researcher's clinical background.

- Strategies were developed to enhance data collection including co-facilitation, a range of activities and the introduction of objects to promote discussion.

This section has described data collection methods. The next section will report the approach to analysis of the focus group data.

4.4 Approach to data analysis

After data were collected, a thematic content analysis of the data was conducted, supported and verified by a co-facilitator. This was based on the principles described in Miles and Huberman (1994), which involve processes of data reduction, data display, and conclusion drawing. Within these principles previously published strategies can be adopted or adapted, and new ones developed.

Some procedures from the Framework approach (Ritchie and Spencer 1995) were adopted, specifically the use of matrices using Microsoft Excel (Swallow et al. 2003). The topic guide was adapted during the course of the groups in response to emerging themes. For example, it became apparent early on that there were privacy issues relating to mobile phones, and subsequently the ambiguous attitude of the participants towards mobile phones was explored.

4.4.1 Familiarisation with the data and data reduction

Familiarisation with the data involves working closely with raw data to arrive at a deep knowledge of content and context (Ritchie and Spencer 1995). It is one of the prescribed stages of the Framework approach (Swallow et al. 2003). Miles and Huberman (1994) warn against getting lost in detail. To remain orientated with the data, extensive use was made of text notes, lists and charts to develop a system of collating the data in a form that was convenient to use.

Promptly following the groups, the recordings were listened to, which enhanced an understanding of the interviewees' views. Notes made during the interviews were consulted and reflected upon at the same time. Audiotapes were transcribed verbatim and the transcriptions checked line by line against memory and the original recordings. Transcripts were compared with the corresponding flipcharts and found to be similar in tone, content and emphasis, and all data were included in the analysis. Contributions and comments were pooled so that all the ideas generated in each group were assumed to have equal value. Raw data were kept close to hand so that the context of each statement, however brief, was understood.

These processes allowed the researcher to gain detailed knowledge of the data to assist

with coding and further analysis.

4.4.2   **Coding with data display**

Coding was conducted manually. This was appropriate for the small number of groups (Krueger 1997) and a useful means of increasing the novice researcher's understanding of analysis processes (Pope et al. 2000). Familiarity with the raw data was central to the approach to coding, since most of the data could be traced back to the original source from memory. The data were allocated codes which linked them to the source. By this strategy the analysis was grounded in the raw data, thus enhancing rigour (Ritchie and Spencer 1995). The strategy assisted with data management, and facilitated further analysis at a later stage.

Each individual comment recorded in focus group flipcharts, facilitator notes and transcripts, was recorded on large pieces of paper using a colour code to trace them back to the original group. Data display incorporated 6 different colours, which facilitated the recognition of patterns in responses between age groups and schools. displaying the whole of the data together allowed patterns of response to be identified and suggested 3 main descriptive codes which related to the topic guides: typical worries and difficulties identified by the participants, how they could tell when someone was feeling better, and what they thought about asking for help from a resource in school outcomes. Comments were then allocated to one or more sub-categories of the broad descriptive codes, and copied onto a Microsoft Excel sheet (Swallow et al. 2003). Colour coded raw data were referred to throughout, to enable constant checking of context.

Data processing at this stage included decisions about whether the number of comments on an issue reflected the level of interest in a topic, and how to categorise comments that were made in writing but appeared to be unrelated to the group discussion. For example the Girlschool KS3 data included a large number of written suggestions about how to live a moral life, although this topic had not been discussed in the group. These issues were resolved through discussion with a co-facilitator and academic supervisors.

4.4.3 Conclusion drawing and verification

Next, conceptual themes were identified. According to Miles and Huberman (1994) the qualitative researcher begins data collection and analysis with a tentative sense of what the messages in the data may be, and through the processes of analysis becomes aware that conclusions are becoming more explicit and grounded. The analysis involved constant reflection and iteration between raw data and conceptual ideas, in order to ensure that the conceptual ideas were grounded in the data and to minimise researcher bias. Working with one of the group co-facilitators, these categories were merged and subdivided until key conceptual themes were agreed upon. Headings were reviewed, refined, merged and subdivided according to growing understanding of the data, using a manual cut and paste technique (Pope et al. 2000). Links between raw data and descriptive codes are displayed below.

Further refinements of the processed data were conducted using Microsoft Excel (Swallow et al. 2003) to display links between the themes that had emerged and the raw data sources (see table). This method was adapted from Framework analysis (Ritchie and Spencer 1995) to facilitate coding and cross checking. A sample Microsoft Excel data sheet showing part of the analysis process is attached in Appendix A.

4.4.4 Identification of conceptual headings

The Framework approach was devised to achieve rapid analysis of data for health policy development (Ritchie and Spencer 1995). The usefulness of the approach for the present study was limited because the nature of the inquiry was exploratory. It was found that the charting process enhanced management of the data. However in Framework the data are organised into conceptual headings, which, although they are derived from the data, are not responsive to new insights.

Because this was a piece of doctoral research there were opportunities for reflection on the data which might not be available in health services research conducted within a short period of time. Iterative processing of the data took place until a stable group of conceptual themes was identified. The charting technique was used to manage and display the data, while emerging themes were added and refined during through a process of comparison,

checking and reflection over a prolonged period.

4.4.5 Conclusion

Sampling, data collection and analysis were characterised by attention to context. Sampling was organized around educational key stages in each school. Data collection involved the development of strategies to promote engagement and inclusion, and protecting the welfare of the participants. Data analysis used a manual technique suited to the quantity of data and the experience of the researcher. The principle of adapting to context was consistent with principles in the MRC Framework (MRC 2000), Popay et al (1998) and (Miles and Huberman 1994), so is supported by theory and practice.

This section has described the processes involved in a thematic analysis of the focus group data. In the following section, the methodological messages will be discussed together with a discussion of the themes that were identified in the data.

5 Findings from the focus group consultation

Having described the methods used, this chapter will now present the findings of the focus group consultation.

5.1   Description of the Sample

Six focus groups were conducted with 2 age groups on each site, a total of 54 participants. Group size was between 6 and 16, and both the key stages and genders were represented. The age range was 11-15 years. To enhance confidence in the anonymity of the research process, the only personal information collected from participants was their age and gender, the distribution of which in each group was consistent with the school population. Table 3 shows the size and context of the groups. This will be discussed below.

Table 3: Focus group sample, consultation study

Location	Group	Key Stage (KS)	Age (yrs)	Girls	Boys	Total
School foyer	Faithschool	KS4	14-15	6	5	11
School canteen (thoroughfare)	Faithschool	KS3	12-14	9	7	16
Meeting room (access to photocopier)	Girlschool	KS4	14-15	8	0	8
Meeting room (access to photocopier)	Girlschool	KS3	11-13	6	0	6
Large classroom (shared space)	Sportschool	KS4	14-15	2	4	6
Large classroom (shared space)	Sportschool	KS3	13-14	3	4	7
Overall			**11-15**	**34**	**20**	**54**

5.2   Data collection: adaptations made

The Deputy Head Teachers organised recruitment to the focus groups and assembled groups with a size range of 6-16 (see Table 3). The facilitators adapted promptly to the group dynamics presented by larger groups, by working together to rearrange the space, and devising large and small group activities which maintained the interest of the participants.

The physical space provided for the focus groups was not always suitable for confidential discussions and the facilitation therefore also had to adapt to interruptions and observation from other students and staff. This has been noted as a limitation of conducting research in schools (Blackwood 2006). In the table above, it can be seen that the locations provided for the groups were not private, and this may have influenced the content of discussions (France et al 2000, Hallam 2007).

A flexible approach. to focus group methods were planned into the research design to suit the context (Hennessy et al. 2008, Popay et al. 1998). For example a period of 60 minutes was planned for each focus group but the duration ranged from 20-60 minutes, requiring appropriate adaptations such as prioritising key discussions and encouraging the group to summarise key points.

Data were audio taped except in Sportschool where groups refused permission to make audiotapes and in Girlschool due to technical problems. Poor acoustics spoilt the sound quality of one tape in Faithschool. Field notes were recorded on paper.

5.3   Comparison of responses

5.3.1   Age group

Reported issues varied with age group. The older groups (KS4) seemed to have a stronger tendency to conceive a problem in terms of a task to do, such as *'Making new friends'* (Sportschool (SS) KS4), rather than merely describe it, as in '*Will they make any friends'* (SS KS3). They also contributed more examples of internally defined emotional wellbeing, such as '*Positive attitude' (*Girlschool (GS) KS4) and *"More confidence"* (SS KS4), whereas younger groups used more concrete and behavioural examples, consistent with

development theory discussed in the literature review in this thesis: *'They would be playing around with their friends more'* (Faithschool (FS) KS3). However these differences were less striking than the consistencies across the group data.

5.3.2   School

Although there was an overall impression of consistency in the data from the 6 groups, some differences between schools were identified. Sportschool groups were more likely to identify bullying as a main problem, and appeared to have higher expectations that telling school staff would help with the problem. Racism was highlighted in Faithschool (FS) and Girlschool (GS), both of which had an ethnically diverse population. In contrast with Sportschool, Faithschool students tended to have a low opinion of school support systems. In Girlschool, the largest of the 3 and the only single sex school, worries about orientation and feelings of alienation were dominant themes.

5.4   Young people's views on the proposed GSH intervention to promote emotional wellbeing

5.4.1   Introduction

This section presents findings of three main themes about the design of a school-based emotional wellbeing intervention. Overall, the findings were broadly similar across the groups. There was a shared understanding of emotional wellbeing, which was understood to be about feeling optimistic and self confident and proactively engaging peers in a social setting.

Key themes were: identified problems, desirable qualities in a helper, and relevant outcomes. The importance of choice was identified as a common theme running through these 3 topics. In the data quoted below, the sources were audiotapes, flip charts and session notes.

5.4.2   Range of difficulties likely to be encountered

Table 4 summarises the problems named by the participants as suitable to bring to a

school-based support system. They were organised into 4 categories:

- feelings,

- peer relations,

- school pressures, and

- family problems.

Older students said that they felt intensely personal matters such as boyfriend/girlfriend problems were inappropriate for a school-based support system, and explanations for this view suggested that they were concerned about trust. Because of the possibility of discrepancy between self reports and behaviour (Bekaert, 2003), it was possible that a wider range of problems might present at the intervention than predicted by the focus groups.

Problems that related in some way to school were more likely to be considered appropriate for a school-based support system. Peer relations were a concern, including managing friendships, peer pressure and bullying. Students stressed the importance of fitting in, having friends, being socially active, and negotiating with peers. School pressures included academic work, relationships with teachers, and navigating around school life. Home concerns revolved around family arguments and coping with conflicting messages from home and school (see Table 4).

5.4.3   Qualities valued in a helper

Helpers did not need to be specifically trained in mental health. Table 5 provides detail to show how friendliness and trustworthiness in the help-giver were seen as most important, followed by their practical skills. Participants stated that a potential confidante would need to validate their experiences by listening empathically. If they could do this then the young person might be willing to accept guidance from them. This sequence was compatible with recent findings about the role of therapeutic alliance in self-help treatments (Blackwood 2006) and discussions by Ginsburg on the benefits of setting the stage for future help-seeking (Ginsburg 2001).

5.4.4 Outcomes relevant to young people

Table 6 shows detail and examples of relevant outcomes, illustrating different perspectives on subjective wellbeing and external indicators of wellbeing. A good outcome was perceived as a combination of social behaviour and subjective wellbeing. Friendly and social behaviour would usually imply feelings of happiness, confidence and optimism. However it was acknowledged that an observer could misinterpret the meaning of behaviour and a distressed individual might deliberately mask their true feelings.

Getting into trouble at school would often be interpreted by teachers as a sign of feeling stressed or unhappy, but the groups agreed that conforming to school rules was context-specific and had limited intrinsic meaning:

"It depends what you're in trouble for, say you go round battering people, then as you're being helped, I think it would be likely that you would stop, beating people up, but if it was for maybe talking in class or rudeness to teachers it might not, that might just be how you are." (CS KS4)

Despite the potential for misinterpretation of social behaviour, it was identified as an important outcome. However, the young people linked the appearance of feeling better with subjective wellbeing. As one participant, who appeared to be frustrated with the discussion on how to identify outcomes, suggested

'Ask them if they're feeling better' (SS KS4).

5.4.5 Importance of choice

The fourth theme running through the data was choice. This was identified in the analysis and was not explicitly expressed by the participants, who expressed their personal preferences rather than a model for an intervention. That is, the amount of choice and available would be irrelevant if it could not accommodate what an individual needed.

The diversity of preferences on modes of communication is illustrated in Table 7 below. On some points, the comments directly contradicted each other. For example, mobile phones represented privacy to some and risk of exposure to others. Similar views were expressed about computer-based contact. Private access to technology may depend on

economic resources and social norms of school, home and peer groups.

In addition to the dissent on technology, there was no instant consensus on the profession, age or familiarity of an ideal help-giver. Some participants said that peer mentoring systems were unreliable because the mentor would either fail to turn up, not know how to help, or not respect confidentiality. They suggested that adults had the advantage of being more skilled and generally more trustworthy, though they were likely to dominate the agenda and might share information with colleagues. As referred to above, the group discussions processed some of the ideas of participants. However, the overall message from the data concerning an ideal help-giver was that they would somehow combine the qualities of a best friend, a mentor, and a benign outsider.

These two areas of dissent support the argument that the young people wanted some choice about help-seeking. With choice, they would be able to maintain some autonomy over what happened to personal information. Therefore, even when choice of helper or technology was limited, the ability to decide whether, when and how to access help was valued by the participants.

Table 4: Examples of difficulties likely to be encountered by young people

Category	Type	Examples
Would disclose if appropriate support available in school	Peer relations Friendships Fitting in	*How to make friends or approach people* (GS KS4) *...worried that the older pupils will make them do things they don't want to do* (SS KS3) *I think I am different from everyone else. I feel strange.* (GS KS3) *Racial comments* (CS KS3)
	Social aspects of school	*How the attitude of new people - students and teachers - might be* (CS KS3)
	Bullying	*Bullying and loneliness* (CS KS3) *Adapting to the way her new school is run* (GS KS4) *They might not get along with any teach- like angriness, sadness, lonlynes* (sic) (SS KS3)
	Home and family	*Ask parents for new equipment/parents might shout* (CS KS3) *People finding out about home* (SS KS4)
Would not disclose	Very private or personal matters	*1)Express how you feel but don't explain the root of your problem. 2) See how well they understand your 1st problem and feel confident to open up.* (CS KS4) *You wouldn't go to the counsellor regarding very personal problems like your boyfriend* (GS KS4)

Table 5: Qualities valued in a helper

Category	Type	Examples
Attitude of help-giver	Friendly, accepting	*People that you talk to are people that you trust and people that you see as friends, so the counsellor needs to be a friend to them and someone that they see as an equal* *(CS KS4)* *...the counsellor needs to ...accept whatever comes* *(CS KS4)*
Type of help	Practical and emotional support	*It's not just going to be about sorting the problems, it's going to be about making you feel better as well* *(CS KS4)* *Teach you how to ... adapt to people"* *(GS KS4)*
Confidentiality	Trustworthy	*Buddy system: not used, embarrassing to tell somebody else your business* *(GS KS3)*
Attributes of help-giver	Empathy Equality Age Familiarity	*Kind... Understanding... adult* *(SS KS3)* *Not dominate conversation* *... like you know when they like say something and they're going on too much ... you can just stop them* *(CS KS3)* *Not a teacher* *(CS KS4)* *Friend- need to be able to relate to/be equal to* *(CS KS4)* *Buddy system: not used, embarrassing* *(GS KS3)* *Not want to speak to someone in school (pupil) as people can spread rumours* *(GS KS4)* *Not a complete stranger but not someone you know well* *(CS KS3)*

Table 6:Outcomes relevant to young people

Category	Type	Examples
Feeling better	Sense of optimism, and a positive outlook	*It's not just going to be about sorting out the problem, it's going to be about making you feel better about it as well* (CS KS4)
		Feeling more positive (SS KS4)
		Able to relax (GS KS4)
		Not being scared (SS KS3)
		Confidence not behaviour (GS KS4)
		Ask one of their friends what they're like because sometimes they aren't actually better (CSKS3)
Looking better	Happier and more confident	*They wouldn't have an angry face* (GS KS3)
		They would just be a lot more confident in themselves like, when they were walking about school (CS KS4)
		Sense of humour (GS KS4)
		Not snapping at small things (GS KS4)
Proactive social behaviour	Interacting more Getting more involved socially	*Talk more* (SS KS4)
		They wouldn't just sit in the corner or something they would go out and do something (CS KS3)
		Making a new good friends in school (sic) (GS KS3)

Table 7: Importance of choice in modes of communication

Category	Type	Examples
Mode of communication	Face to face Remote Anonymous	*Doesn't have to be secret* (SS KS3)
		Telephone more private (SS KS4)
		Phones no good because somebody could just go through your messages (GSKS3)
		Help lines need to be free (SS KS4)
		Texting- can put what you mean (GS KS4)
		Writing easier than talking (SS KS4)
		Problem could be deeper, so could expand if face to face (GS KS4)

5.4.6 Summary

- Three main themes and a secondary theme were identified in the data

- Problems identified by the participants were related to subjective feelings, peer relationships, school stresses, and family problems.

- Attitudes to help-seeking diverged on some issues such as familiarity of the helper but agreed on the high value placed on trustworthiness and friendliness.

- Relevant outcomes were subjective wellbeing and social behaviour and the link between these was acknowledged.

- The young people also seemed to value having choices about help-seeking.

The next section will discuss the challenges of taking health research into schools and the implications for the development of the proposed school intervention.

5.5 Discussion: the challenges of conducting health research in high schools

5.5.1 Introduction

In the previous section, findings from a focus group consultation were presented.

The messages from the groups were clear and provided a framework for the development of the intervention. The context of the focus groups raised methodological issues which were incorporated into the interpretation of the data. This discussion reflects on these issues before considering the implications of messages from the data, about how to develop the intervention.

5.5.2 The relevance of context

The consultation demonstrated that young people's views about emotional wellbeing and the development of interventions in school can be obtained from school-based focus groups. As suggested by the literature, the focus group methodology required adaptation to suit the population and adapt to the limitations of the school physical and social environment, for example in approaches to sampling, facilitation, data collection and interpretation of the data.

It appeared that the school context presented a challenge to the expectation of confidential research, as the groups were conducted in spaces in which they could be seen and overheard. Schools may favour visible activity over confidential activity, in order to follow good practice in child protection (Appleby et al. 2006).

This was consistent with epistemological perspectives expressed in the MRC framework (MRC 2000) and Popay et al (1998), which emphasised the importance of understanding the context of the research in order to interpret the data. By referring to the MRC framework, the study data could be recognised as exploratory, derived from a specific context, and not generalisable. The guidance offered by Popay et al (1998) highlighted the impact of the context on the data as well as the significance of the lay perspective to understanding the meanings in the data.

By using a range of media, there was potential for confusion in the analysis process. For example some very brief written comments contrasted with more lengthy statements on the audio-tapes. However a systematic approach to data management and analysis addressed the potential for privileging more lengthy contributions. The validity of the data was enhanced through strategies to engage the participants and by using a method that was congruent with the research context.

The research setting influenced the choice of sampling strategy. Firstly, the Deputy Head Teachers had limited time to assemble participants and more complex sampling demands would have carried the risk of alienating the deputies from the Project, which would have foundered without their support. Secondly, they were able to use their knowledge of the students to assemble groups of students who were familiar with each other, in order to encourage discussion. Thirdly, asking the deputies to contact participants removed the researcher's personal bias from the process. Using Deputy Head Teachers as gatekeepers limited control over recruitment.

It was possible to purposively sample young people from both key stages and genders in each school (except Girlschool, because it was a single sex school), though the sampling method excluded the viewpoints of certain participants, a potential limitation of qualitative sampling methods which has been encountered in a study of alcohol usage in adolescents (Hill 2005). Future research could consult alternative methods of accessing this age group.

The use of mixed media appeared to have encouraged responses from more reticent individuals by demonstrating that written, spoken and drawn contributions were equally welcome. In the images in Appendix A, the collections of sticky notes represent a conversation that was being conducted at the same time as a verbal exchange. Differences between the responses of different age groups were apparent: for example, in Girlschool the older students were more vocal and wrote less, while the younger students said little and wrote copiously, as can be seen in the images in Appendix A. Physical objects and activities and the use of vignettes appeared to enhance focus, and was consistent with the strategies suggested by (France et al. 2000). Responses to the vignette included in Figure 5, included a number of poignant comments without any individual identifying personal experience, for example:

Might be scared to go home because of family problems

(FS KS3)

Not wanting to do bad things, what her so called friends are doing

(GS KS3).

Maintaining a light tone within the group facilitated engagement and protected individuals from emotionally difficult conversation, consistent with focus group literature (Kitzinger 1994).

There was little suitable space available for running the groups and groups were not held in private spaces, which was consistent with another report of research in schools (France et al. 2000). This compromised privacy and indicated the apparent value placed on the visibility of activities within schools, which conflicted with the value placed on privacy in the research. However it had the benefit of drawing attention to the research and introducing it into the school culture.

5.5.3   Development of ideas through group interaction

The quotation below in Figure 6 demonstrates the way in which group themes developed during conversations between participants. In the passage, the participants are discussing what they feel is important in a person offering emotional health support in school. They are referred to as a 'counsellor' in this example. It can be seen from the text that the young people value qualities such as age, experience and attitude. The passage demonstrates how their ideas are drawing together to give a picture of an individual who is more experienced and skilled than the recipient, but relates to them in a friendly and empathic way. Some of the problems mentioned are associated with asking busy teachers for support, or using a peer support system which can be unreliable. As a group, they set out some of the advantages and disadvantages of support provided in school and pointed out where helpers can go wrong by allowing their agenda to dominate an encounter. This example shows how a focus group can draw attention to the way that ideas evolve, as described by (Kitzinger 1994).

Awareness of group interactions informed the interpretation of the data. For example, the group above were generally articulate and well informed about emotional health issues and

members contributed fairly evenly. This contrasted with other groups. It therefore suggested that the participants had previously discussed emotional wellbeing, and suggested that the group might have been composed of individuals who would be very likely to engage in a sophisticated discussion. This generated an impression that Faithschool might be particularly supportive of emotional wellbeing promotion, and provided context for developing subsequent phases of the research.

Figure 6: Illustration of group interaction: Passage from Key Stage 4 Focus group conversation about qualities required in a helper (Y denotes young person)

Y5: When they feel they can open up the whole truth to the counsellor then, that's the time they should choose to do it not when the counsellor feels that they need to know what's going on.

Y6: I sort of agree (with what) she was saying ... with a teacher there's always this element that they've got to sort out a problem ..but (you need) someone who you can go and talk to (and they're) going to take much more time…

Y3: It would have to be a trained counsellor, it would have to be someone who was erm, yeah, who was able to talk to (children),

Y5: They could talk to the counsellors yeah, but I think they also could talk to someone who's older than them, not a lot older than they were,

Y2: (when) she said that it needs to be someone who's, trained I think that does, that does count a lot because, (they need) to be able to be patient and listen

Y4: someone who can relate to you as well

Y6: I think that we need to build on what we have as well as the buddy scheme, which is something that a couple of us are involved in,

Y7: ... I think it would be better to actually go to someone who has been in that situation because ...they could be telling you what they think is right (instead of) what they know is right.

Y5: …You know like the buddy scheme that she was talking about I think it's a good idea but it's not that easy for year tens to do that…because of the pressure of GCSEs

Y4: I don't think year 9s would be like mature enough to understand what they're feeling.

Y1: I think yeah there needs to be like, there needs to be a certain age gap I reckon.

Y3: There needs to be a counsellor who is paid to do it because, who hasn't got other pressures.

5.5.4   Implications for the next step of the research

The consultation identified emotional health issues considered important by young people – peer, family and school concerns; internal and external confidence - and their preferences for the design of school-based interventions - friendly and empathic support; choice. The findings have relevance particularly in the areas of selecting and training staff, organising access, and measuring outcomes.

According to the focus group data, for the intervention to be acceptable, the following points should be considered.

- The delivery of the intervention should be by individuals who were able to behave in a friendly, empathic and trustworthy manner.

- The intervention should be able to address issues personal issues which young people said they would not disclose in a school-based intervention.

- Alternative routes to the intervention should be explored to increase choice, and the potential of using technologies such as mobile phones or computers to widen access should also be considered.

- Pastoral school staff could contribute to interventions because of their understanding of emotional health, slight distance from the school mainstream and non-authoritative school role which have a good fit for the personal attributes of the helper outlined in the groups.

- Concerns about discretion need to be addressed for example by ensuring appointments take place outside lesson time and away from classroom areas.

- Young people should be in control of any contact with the interventions, suggesting the need for methods of self-referral, and providing access for young people without their parents and carers knowing.

5.6　　Conclusion of Consultation Stage

The previous discussion suggested some ways in which the study context could influence messages from the research. The students identified and reported on three main topics that they thought were important to an emotional wellbeing intervention based in school- the range of likely presenting problems, the nature of the help offered, and outcomes they thought were relevant. They also expressed a diversity of views on some topics, suggesting a need to be able to make choices about help-seeking.

There was remarkable consistency between the data generated from the groups, the only demographic influence discernible being the ages of the participants. As indicated, the young people identified the range of difficulties they might ask for help with in school, provided some insights into attitudes to help-seeking, and made suggestions of what would be meaningful outcomes from their perspectives. It was apparent that there were coercive influences in the recruitment process, restrictions on privacy and confidentiality, and social and cognitive influences potentially acting on how group discussions developed.

However, the messages were clear and their trustworthiness was enhanced by the approaches taken. For example, since the participants could develop their ideas as a group, the findings were collectively agreed upon. In addition, the impact of the context was a primary consideration in processing and understanding the data. Therefore the data were considered to be sufficiently trustworthy to be used to inform the next step of the research: the development of an intervention.

The data provide new information to guide the development of emotional wellbeing interventions for this population. They are broadly consistent with what is known about adolescent help-seeking behaviour (Donovan et al. 1997, Farrand et al. 2007, Freedenthal and Stiffman 2007, Ginsburg and Slap 1995; Gleeson et al. 2002; Jacobson et al 2002; Rickwood et al 2005) but add detail into how best to provide practical and effective emotional support.

High schools are potentially helpful settings for preventive and early interventions to promote emotional health in young people. In appropriately adapted GSH models, there may be public health and personal wellbeing benefits for young people at a key developmental stage. It is important that such interventions are developed in consultation

with potential users and take account of potential barriers and facilitators inherent in the context of high schools.

Flexible methodologies are required. For example, the focus groups in the present study were conducted in less than ideal conditions where space, time and privacy were compromised- an insight into high school cultures. However this study demonstrates that school-based focus groups with young people can report on their emotional health needs and identify features of accessible and acceptable interventions perceived to be of value by young people. Further, the young people in the study appeared to welcome the idea of introducing an emotional health intervention in their high school.

Focus group methods can be adapted to enable a wide range of young people to participate and to discuss sensitive topics. Skilled facilitation can support the safe discussion of sensitive topics in focus groups. Young people were able to name and discuss general or common emotional concerns, and identify barriers and facilitators to help-seeking.

Sources of problems were named as home, school and friends. They said that they would be less likely to bring very personal problems to formal support in school. The interpersonal skills of helpers appeared to be more important to the young people than specific clinical techniques, suggesting that interventions using school-based staff would be acceptable.

Problems and desirable outcomes were generally seen in terms of subjective wellbeing and social functioning. Diverse personal preferences were expressed with regard to modes of delivery, indicating the importance of building flexibility into interventions. The findings of this consultation contribute relevant knowledge for the development of a high school-based intervention to promote young people's emotional wellbeing.

Stage II: Development

6 The development of an implementation study

6.1   Introduction

Stage II of the research was informed by the consultation process in Stage I. This section of the thesis describes Stage II, in which an intervention was developed together with an evaluation strategy.

Stage II was concurrent with analysis of the focus group data and took place over a period of approximately 6 months following the completion of the focus groups and the introduction of the Change Project into schools.

The intervention was named the 'Change Project'

6.2   Aims and objectives

Aims

- To develop a school-based, GSH intervention for the delivery of emotional wellbeing interventions to young people in high school.

- To develop an evaluation strategy for the intervention.

Objectives

- Develop intervention protocols

- Identify appropriate self-help resources

- Design and deliver a training programme for Project workers

- Develop strategies for evaluation of feasibility and acceptability of the intervention

6.3　　　　Principles informing the Development Stage

6.3.1　　　Relevance of the MRC Framework to the study aims

The Development Stage was an intermediate stage between the Consultation and the Implementation of the Change Project. In this stage, exploratory findings from the Consultation were reflected upon and incorporated into the research design, corresponding to processes in the theoretical and modelling phases of the MRC framework (Medical Research Council 2000).

6.3.2　　　Combining findings from the literature review and consultation with stakeholders.

The data from focus groups with young people generated insights into their views on what would contribute to the acceptability of the proposed intervention. They expressed a view that school, home, and subjective wellbeing were the main problems they would seek help for from support based in school.　They said that the best kind of help would be friendly, empathic and effective, while relevant outcomes would be subjective wellbeing and social behaviour. These ideas were incorporated into the development of the model along with theoretical and contextual knowledge gathered during the Consultation Stage.

Contributions from other stakeholders including school nurses, teachers and school planners pointed to factors which would enhance acceptability and feasibility. School staff confirmed the need to provide additional emotional support for students but highlighted the demands already made on schools to achieve wide-ranging targets with limited resources.

6.3.3　　　Reprise of findings from literature review

As previously explained, young people can be perceived as vulnerable to many problems emanating from their rapid physical, emotional, social and cognitive development. Alternatively, the notion of troublesome adolescence has been seen as exaggerated, rooted in economic history (Demos and Demos 1969) or critiqued as a social construction, propitiated by adults who are uncomfortable with their own loss of youth (Herbert 2003, Herbert 2005) and maintained by a pessimistic literature which concentrates on problems

and does not recognise strengths (Ginsburg 2003).

Conflicting perspectives on supporting adolescent emotional wellbeing include the idea that low intensity support, through self-help approaches, is helpful (Richards et al. 2003, den Boer et al. 2004, Lovell et al. 2006, Richardson and Richards 2006, Khan et al. 2007, National Institute for Clinical Excellence 2006) or that it may be undermining and problematising (Bury 2006). Equally, school-based health care has been promoted as supporting learning (Eber and Nelson 1997, Dalle Grave, Rones and Hoagwood 2000), and suspected of interfering with learning (Warwick et al. 2005, Elias et al 1997).

Therefore there were many perspectives to consider in the development of the intervention. Table 8 presents a summary of perspectives generated from the literature review and the focus groups in Stage I, linking them with the concepts which underpinned the intervention. These messages emphasised the importance of subjective meaning, social context and lay knowledge (Popay et al. 1998).

Table 8:Literature review and focus group findings leading to concepts underpinning the development of the intervention

Category	Focus groups findings	Findings from literature review	Concepts to underpin the intervention
Rationale for an emotional wellbeing intervention	Emotional support can be useful.	Too much help can define experience as problematic and promote dependence.	Focus should be on promoting effective independent coping.
Scope	Most likely presenting difficulties: problems occurring in school e.g. bullying, friendships, and schoolwork.	Family, and physical and sexual health, are also be common sources of concern in young people.	Intervention strategies should be able to address issues identified by the focus groups and literature.
Helper	Helpers should be friendly, non-judgemental, knowledgeable, understanding, with the time to listen	Appropriately skilled non mental health specialists have delivered effective emotional and mental health interventions.	A helper should have appropriate professional and interpersonal skills.
Help	Practical and emotional support both valued. Face to face and indirect contact both valued Young person should set agenda	A variety of delivery modes have been applied in health interventions for young people. A young person's construction of a problem may differ from adult views.	Problem solving and emotional support both required. Choice and empowerment promotes engagement. Privilege voice of young person
Outcomes	Social behaviour and subjective wellbeing were identified as the most relevant outcomes to the young people.	Outcome measurement must fit the population and the aims of the intervention	Social behaviour and subjective wellbeing are valid outcome measures

6.3.4 Summary

- The Development Stage combined theoretical and contextual knowledge to identify the concepts underpinning the intervention

- The Development Stage corresponded to processes in the theoretical and modelling phases of the MRC framework.

- Findings from literature and the Consultation Stage suggested concepts to support the development of the intervention and evaluation strategies.

6.4 Methodological principles informing the development of the Change Project

6.4.1 Respecting cultural differences

In preliminary discussions with school staff it appeared that some were uncomfortable with language associated with mental illness. Although the Change Project had been conceived as a health intervention, semantic adjustments were made to make the Project acceptable and in a school. Everyday language or language from educational practice literature was more acceptable. Consequently the phrase 'emotional wellbeing' replaced 'mental health', although the scope of the Project was not altered. The terms 'anxiety' and 'depression' were replaced by 'worries', 'feeling upset', and other non-clinical words. This language has been retained in the thesis.

As confidentiality was an important facilitator of help-seeking in young people, there was a potential clash of interests, which was addressed by agreeing confidentiality protocols with the Deputy Head Teachers, school nurses and Project workers.

6.4.2 Principles underlying recruitment and training of pastoral and SEN staff to be Project workers

Both pastoral and SEN staff were experienced in delivering support directly to high school students who were experiencing a range of difficulties. They were familiar with the population, setting, and scope of issues that might emerge from an emotional wellbeing intervention, and therefore well matched to the needs of the Project.

As Project workers would be working with an unfamiliar emotional wellbeing intervention they were potentially vulnerable to personal and professional anxiety (Cleave et al. 1997). Tight operating protocols were required to contain the amount of exposure and responsibility they encountered. Their relationships with their colleagues had to be taken into consideration to avoid tensions caused by time spent on the Project. To be feasible and acceptable, Change Project training and supervision had to be presented sensitively, perceived as useful, and arranged at their convenience.

6.4.3 Principles underlying risk protocol

As the Project workers were not clinicians, a risk assessment and management protocol was required that did not rely on clinical judgement. The protocol also had to fit seamlessly with the established child protection protocols in the schools, to avoid any confusion. The tool had to be suitable for completion by individuals without clinical training and brief enough to fit into the framework of the 30 minute assessment process.

6.4.4 Preparation of documentation

The administrative aspects to the Project were a possible obstacle, since they represented extra paperwork for Project workers, who were already managing heavy administrative workloads. In order to encourage completion of forms, the documentation was prepared to be visually engaging and easy to complete. Adjustments were made following pilot work with young people and educational practitioners.

Principles of readability were applied to the text and layout. Guidelines from the Plain English campaign and the Dyslexia Association suggested the adoption of short sentences, simple sentence construction without passive phrases or conditional verbs, carefully spaced layout, a font without serif (such as Tahoma or Arial), and the use of shaded boxes and bullet points (The British Dyslexia Association 2008, Plain English Campaign 2006). These details needed to be incorporated into documents that were brief enough to encourage perusal. The principles were applied to every document that was created for the Project and ongoing adjustments were made, where possible, in response to feedback.

6.4.5 Keeping control of the health agenda

Pastoral activities within schools aim to support a student to engage with school life and academic tasks. For example, anger management can help prevent conflicts that lead to suspension and interfere with opportunities for education. This contrasts with the aims of health interventions in schools, which are to improve health status, and naturally prioritise health outcomes over academic improvements.

Therefore, in asking pastoral and SEN staff to deliver a health orientated intervention, there was potential for role conflict. Prioritising emotional health instead of educational or

behavioural goals required a shift in emphasis which could be supported by incorporating appropriate materials in the Project.

For example, during consultation with school nurses and education psychologists one published educational resource, 'Retracking' (Bates 1996) was suggested for inclusion because the strategies it contained were primarily concerned with emotional competence. In contrast, materials available from a government website to support social and emotional aspects of learning (SEALS) (Davidson 2008) were not included because they focused on classroom behaviour - a different emphasis (Butler and Gasson 2005). To illustrate the difference, a sample from each document has been reproduced below in Figures 7 and 8.

Figure 7: Sample from 'Retracking' (Bates, 1996) showing emphasis on broad context of self esteem

I AM GOOD AT .....

CIRCLE THE THINGS THAT YOU ARE GOOD AT.

staying calm

listening to people

asking questions

making others laugh

controlling my temper

saying thanks

talking to new people   saying sorry   helping others

being sympathetic

resisting pressures / saying NO

talking about myself

showing I like people

talking to the opposite sex

giving compliments

sharing / giving

taking turns / being fair

talking to my parents

talking to my teachers

———— PAGE A 1 4 ————

Figure 8: Sample from SEALS Year 7 resource pack (Department for Education and Skills 2007) showing emphasis on school context

Social and emotional aspects of learning: Learning about me!

Resource sheet

Resource sheet 4.2 Liam's morning/feelings line

Liam's morning

8.00 a.m. Liam has got up late for school this morning – his mum has overslept and getting ready for school was a real rush and a muddle, and to make it worse they have run out of milk so there is no cereal, just toast and orange juice. On the good side his dad phones to say the job he was doing in the Far East will be over quicker than he thought and he will be home at the weekend.

9.00 a.m. Liam runs all the way to school and gets there just on time – too late he realises he has left his French homework on the kitchen table. He sees his good friend Ahmed and they walk together to their classroom, stepping aside to avoid some of the older boys who are running and shouting – one of them pulls off Liam's glasses and he has to run after him to get them back. They pass the English teacher who asks Liam whether he liked the Terry Pratchett book she recommended – he did – and they talk for a minute or two about it.

10.00 a.m. PSHE – they fill in a sheet on 'My social and emotional skills'. The teacher invites them to 'find one person you know and trust to talk about what you have written in'. He looks around but Ahmed has paired with someone else and the only person left is Tim, the class joker who likes to tease him for wearing glasses and being 'Professor Know All'. Liam feels he has no choice but to work with Tim, but he wishes now he had not ticked 'very like me' in his answers to questions like 'I get upset if I do badly at something' and 'I am easily hurt by what others say about me' as he thinks Tim will tease him later.

10.45 a.m. Break, spent with Ahmed – Tim nowhere in sight.

11.00 a.m. French – the teacher asks him where his homework is – Liam explains about the kitchen table. The teacher looks doubtful but trusts him and gives him the chance to bring it in tomorrow.

12.00. Lunchtime – rehearsal of the school play – 'Oliver'. Liam is really pleased to have landed the title role which is quite a stretch for him but he is working hard at it and knows all his lines so in the rehearsal he is word perfect and not many other people are – the teacher directing tells him that is great. One of the girls in the play, who Liam has been hoping to talk to for a long time, but was too shy invites everyone to a party after the performance next week. Liam wonders if he will have the courage to go. After the rehearsal she comes up to him and tells him she is especially hoping he can come.

Draw a line to represent Liam's morning, from when he got up to after the rehearsal. Your line needs to show how he has been feeling today. Make it go up and down according to whether his feelings are positive or difficult. Label it with some of the feelings he has.

Now do one for your day so far (only write on it things you think you can share with other people).

2

6.4.6   Ethical principles

The ethical principles of reciprocity, working with young people in school, the welfare of participants, and minimising disruption, discussed in Stage I, were applied to the intervention design via the focus on training existing school staff to deliver the Change Project, so that new skills could be retained within the schools and the intervention could be sustained.

6.4.7   Summary

- Potential tensions arising from the introduction of emotional wellbeing research into a school environment were taken into consideration in the design of the intervention.

- Training for Project workers was influenced by awareness of their existing pastoral/SEN skills and roles in school.

- The principles of clear written English were applied to written materials to enhance accessibility.

- The health related purpose of the intervention was promoted through the selection of appropriate materials.

- The intervention was designed to be sustainable after the research study ended.

6.5   Methods used in the development of the Change Project

6.5.1   Development of Project documents

Advisory panel members together with SEN and pastoral staff helped with the design of developmentally appropriate documentation to enhance accessibility and inclusion for individuals with low levels of literacy.

6.5.2   Development of a set of self-help materials

Criteria for selection of published materials or development of new materials were:

- Focus on emotional wellbeing rather than learning outcomes

- Addressing an emotional wellbeing issue identified as relevant by the focus groups, other stakeholders, or in the literature

- Freely available, easily reproducible, and affordable within the Project budget

- Appropriate language and visual appeal.

Self-help books and activity sheets were developed specifically for the Project (see Appendix B). The books closely followed the content and structure of a series of published self-help materials used in clinical settings (Newcastle North Tyneside and Northumberland Mental Health NHS Trust 2003), but were adapted to suit young people aged 11-16. The adapted books were approved by the authors of the original publications, school staff and an educational psychologist and one was piloted with a young person who provided encouraging feedback. They covered the topics of panic, anger and depression. The activity sheets described techniques including thought challenging, goal setting, and mood monitoring.

Self-help worksheets with an emotional wellbeing theme were picked out from Educational Psychology publications. Mental health resources included sections from 'SHADE' (Lovell 2000) which is a GSH manual for anxiety and depression, and CD-roms

and an associated website from NHS Scotland (Richards et al. 2005, Richards et al. 2006). Other websites were examined for relevance, quality and suitability in consultation with members of the advisory panel and a number were adopted for the Project (see Appendix B).

The appropriateness of the materials was judged on the basis of the clinical experience of the researcher and consultation with members of the advisory panel, clinical and educational psychologists, young people, and school nurses, who recommended certain publications for consideration. They were selected to address the predicted scope of need in the young people and suit the skill set of the Project workers.

6.5.3   Development of a risk assessment protocol

The school nurse in each of the 3 schools agreed in principle to support the Project by accepting referrals from Project workers subject to completion of a validated assessment tool. After considering alternatives, the PHQ-2 (Kroenke et al. 2003) was included in the assessment protocol.

The PHQ-2 is a brief, 2 item screening tool. It was developed for use in primary care in adult services to indicate whether to screen for depression, and is endorsed for this purpose in the UK by the Department of Health. The links between depression and other psychological difficulties in young people is well established (Ruchkin et al. 2006, McCrone et al. 2005 , Sareen et al., Turgay 2005, Parker and Roy 2001, Perkins et al. 2007, Waters et al. 2001) and therefore depression screening acts as a proxy for broader screening.

The practice recommendation for application of this tool in primary care in the UK is to refer an individual who scores positively for an assessment from a qualified clinician (Care Services Improvement Partnership (CSIP) 2006). In the Change Project, a protocol for a referral to the school nurses for a clinical assessment was worked out in consultation with the nurse on each site, meeting the needs of the Project and congruent with school child protection procedures.

The PHQ-2 is shown in Figure 9 below to illustrate the brevity and apparent simplicity of the questions, and their potential to stimulate further investigation into an individual's

mental state.

Figure 9: The PHQ-2 (Kroenke et al 2003)

> *Over the past two weeks, how often have you been bothered by any of the following problems?*
>
> *Little interest or pleasure in doing things*
>
> *Feeling down, depressed, or hopeless*

A dialogue was conducted with the author of the PHQ-2 instrument and clinical colleagues. The outcome was a decision to use the instrument for risk assessment in the Change Project, without adaptations for the intended audience of 11-16 year olds. The rationale was that the language was simple and any clarification that might be required would aid the assessment process.

6.5.4   Negotiating access to schools

To ensure a robust and relevant research design, methods of access, sampling, data collection and data analysis were considered from a methodological viewpoint and interpreted for the study. Each site required different adaptations and close consultation with the schools underpinned the process.

In each school the development of rapport with key individuals was necessary to obtain permission and support for the research. Apart from granting permission to proceed with the research, Head Teachers were inaccessible throughout the research study. Communications were initially difficult on each site. Through a combination of letters, telephone calls, email and personal visits from the researcher, a dialogue was eventually established with a Deputy Head Teacher in each school, who became a champion for the Project.

The perception that the schools would benefit from the research was important and indeed Sportschool requested some consultation work, unrelated to the research, concerning a problem with some students. Once trust was established, communications and meetings

became easier to arrange.

All 3 Deputy Head Teachers were cautious in allocating staff time to the Project. Many schools in the local authority, including the research sites, were already participating in externally-driven Projects of various kinds, initiated for example by school improvement, health, community or business agendas. Therefore the Change Project was competing for space and time in the schools.

Relevant government policy such as the National Healthy Schools standard (DH 2005) and Standard 9 of the National Service Framework for Children Young People and Maternity Services (DfES 2004) was presented to promote the Project. These policies emphasised the importance of emotional wellbeing in young people and the responsibility of schools to find ways to promote it. It was explained that the Change Project was intended to address a recognised student need with minimum disruption to the school. In addition there was the prospect of direct benefits to staff, since some would receive training and supervision from an experienced mental health professional (the researcher) and this could potentially help them to broaden their skills and manage their pastoral responsibilities more effectively.

The access strategy appeared to help to engage the commitment of the Deputy Head Teachers to the Project.

6.5.5 Negotiating access to young people using the Change Project

A self referral system of access to the Change Project was developed, consistent with Consultation stage findings that help-seeking in young people may be encouraged if they have some control over the process. The link between the Change Project intervention and the research study was made explicit and therefore young people who used the Project assented to be part of the research and formed a consecutive sample of Project users. All students were eligible to self refer for an initial appointment, regardless of other factors.

On the suggestion of the schools, carer consent would be assumed unless a carer had contacted the school to indicate otherwise. This approach was customary in each school.

6.5.6   Negotiating access to Project workers from Pastoral and SEN teams

In each school, Deputy Head Teachers agreed that a small group of SEN teaching assistants and pastoral staff whom they judged to have an interest in emotional wellbeing, capacity to take on the role, and good interpersonal skills could be trained to deliver the Change Project.

In Sportschool and Girlschool an inclusive approach was taken to the recruitment of Project workers to prevent the development of tensions between Project workers and pastoral staff not directly involved with the Project.

In Sportschool and Girlschool a general invitation was put out to SEN and pastoral staff to become involved. School managers preferred this approach because it was inclusive and less likely to cause tensions between staff. It was agreed that suitable individuals would self select when they knew what the role involved, so Change Project training was offered to every pastoral and support worker in these two schools. Following training, which is discussed below, a group from each school agreed to join the Project.

In contrast, in Faithschool 2 pastoral workers were approached by the Deputy Head Teacher and invited to be Project workers.

Further detail about the background of the Project workers is provided in Appendix B.

6.5.7   Development of Project worker training manual and training programme

A manual was prepared to support Project worker training (see Appendix B), informed by empirical knowledge from clinical practice, the research literature, policy documents, the schools focus groups, and familiarity with the culture of each school.

The first part of the manual covered the background and theoretical underpinnings of the intervention; the proposed Project worker role, the rationale for self-referral and facilitating control of the agenda by the young person. The second part focused on how to conduct an appointment, including self-referral, length and structure of appointments, and administrative aspects such as record keeping and data collection. It included an explanation of the self-help materials which were incorporated in the intervention, together with the procedures for data collection as well as referral, appointments, screening, and

referral to the school nurse when necessary.

The training programme consisted of working through the manual, followed by role play and a discussion about specific aspects of implementation in a particular school, including timing, venue, anonymising data, data storage, supervision arrangements, and advertising.

6.5.8   Summary

- Self-help materials were accessible and focused on emotional wellbeing.

- Access to school was negotiated through sustained communication.

- Access to research participants (young people) was through self referral to the intervention.

- Access to Project workers was negotiated with pastoral and SEN teams.

- A training programme for Project workers was developed.

6.6 Outcomes from intervention development: components of the Change Project intervention

6.6.1 Introduction

This section describes the outcomes of the development processes relating to the Change Project intervention. Supplementary materials are attached in Appendix B.

6.6.2 Self-help materials

Copies of the self-help materials which had been identified as suitable for the Change Project were provided for each Project worker to use in interventions.

6.6.3 Delivery of Project worker training

Pastoral and SEN staff were trained in the intervention by the researcher, an appropriately qualified and experienced mental health practitioner, who was in clinical practice and receiving clinical supervision during this period.

Access to the schools and initial contact with the pastoral managers and SENCOs have been discussed above. Following an initial meeting on each site with potential Project workers, training was conducted at Girlschool and Sportschool in the autumn term of 2006. Faithschool staff were trained in February 2007. After the training, 3 teams of Project workers were established from individuals who volunteered, as illustrated in Table 4 below.

The training was conducted separately in each school. In Girlschool, 5 individual school support staff who was considering becoming involved in the Project attended. In Faithschool 4 pastoral staff attended training. In Sportschool, 10 SEN staff were present and in addition the school nurse and the educational welfare officer attended as observers, not intending to deliver the Project but supportive of it. Due to timetabling difficulties in Sportschool, the Project worker training took place after school and therefore staff were paid to attend.

The intended 2 day training course was negotiated down to 6 hours by Deputy Head

Teachers who indicated that longer training was not feasible, but later reduced further because of timetable restrictions. The training was adjusted to accommodate the reduced time, which is shown in Table 4. Additional training was delivered during ongoing weekly supervision sessions.

Table 9: Staff attending Project worker training

	Girlschool	Sportschool	Faithschool	Total
Number trained	5	12 (including two observers)	4	**21**
Time allocated for classroom training	2 hours	4 hours	1 hour	-
Number who took on Project worker role	**3**	**7**	**2**	**12**

It was agreed that a minimum of 2 Project workers would be required on each site, sufficient to run the Project in school, allowing for sickness and absence. In total, 21 staff were trained, of whom 12 subsequently took on the role. In Girlschool, a new member of staff joined the Project at a later date and was trained by her colleagues.

Facilitated discussion time was used by Project workers to explore the rationale for minimal interventions, short appointments, the reason for keeping it confidential from parents and teachers; the need to prioritise the concerns of the young person as they presented it; and strategies to encourage completion of the paperwork necessary for data analysis.

In addition to training, Project workers agreed to attend weekly supervision, for 30 minutes, at a set time at the end of a working day. This was set up and continued throughout the run of the Change Project.

6.6.4   Feedback from Project workers concerning Change Project training

Following the training, the Project workers agreed to implement the model, suggesting that they found it acceptable and feasible. The Project workers also said they understood the reasons behind the design of the model and that it was not necessary to spend any time talking about this. There was no particular interest in hearing about the background or justification for the Project, for using GSH, or the evidence base for the intervention- the main interest was in pragmatic aspects. Feedback suggested that they perceived the Project

worker role as a logical extension of their existing roles.

Some concerns were raised by Project workers about the short appointment times and what was possible within the time, but as a group they did not raise other concerns about the Project, suggesting they supported it and felt it was possible for them to deliver it. They also appreciated that because of their training, the schools could maintain the Project after the research input had ended.

6.6.5 Format of appointments

The Project worker role was to help the Project user to clarify their difficulty on their terms and set appropriate goals. The Project worker provided guidance for the use of self-help materials in paper or electronic form.

Project sessions were delivered within school buildings, outside lesson time. Sessions were 1-1 and face to face. The initial session lasted 30 minutes, and follow up sessions were 15 - 30 minutes. The Project worker and Project user evaluated whether the intervention was helping and whether to continue with appointments. Follow up appointments– as many as mutually agreed-were possible unless there were concerns about risk or the intervention was unhelpful or inappropriate for the needs of a particular individual.

6.6.6 Access

All students were eligible for an initial appointment. Access routes were designed to maximise simplicity and inclusivity as far as possible within the setting. Access was principally via self-referral, through a choice of access routes including verbal, email, mobile phone texting, or application form. The access route was designed to make the Project available to students who would not normally be referred to specialist services but would still like some help. In addition, the process of self-referral encouraged reflection and motivation from the participant. Third party referrals were acceptable if the young person agreed to accept help, but in general they were encouraged to ask for an appointment for themselves.

6.6.7 Confidentiality

Privacy was a strong facilitator of help-seeking, so personal information was confidential within the Project unless there was a child protection issue. In this case they would seek advice from an appropriate person such as the Project supervisor, or the school child protection officer, though they would discuss this with the young person first. This meant that teachers, form tutors, parents and other carers were not normally informed about young people using the Project. The Project protocol included making sure that the Project user understood the limits of the confidentiality offered.

6.6.8 Safety protocol

The safety protocol included:

- Screening for depression at the initial and subsequent appointments, using the PHQ-2 tool (Kroenke et al. 2003)

- A referral pathway from the Change Project to school nurses, following a positive screening

- Activating child protection protocols in school when indicated, and clarity about the limits of the confidentiality policy

- Supervision for Project workers through weekly meetings and telephone contact as required.

6.6.9 Summary: Change Project components

- During the Development Stage, the components of the intervention were clarified.

- The intervention was guided self help, delivered in brief appointments.

- Twenty one pastoral staff participated in Project worker training, of whom 12 became Project workers.

- Training was compromised by shortage of time.

- Risk protocols were incorporated into the intervention.

- Supporting self-help materials were paper and internet based.

6.7 Methodological principles underpinning the development of an evaluation strategy

6.7.1 Overview

The aim of the evaluation strategy was to explore the acceptability and feasibility of the intervention. It combined qualitative interviews, an outcome measure (the RSES) and a questionnaire.

6.7.2 Rationale for use of qualitative interviews

A qualitative method was planned, using semi structured interviews with a sample of students and staff to explore the views of individuals in the school communities, following the implementation of the Change Project. Qualitative interviews in research can provide detailed insights into the complexities of social context and natural settings (Miles and Huberman 1994, Ritchie and Lewis 2003) and were therefore appropriate for the evaluation of feasibility and acceptability of the intervention.

6.7.3 Rationale for use of an instrument to measure emotional wellbeing outcomes

The rationale for using an outcome measure in an exploratory study was considered. The components, active ingredients and possible confounding factors of the intervention lacked sufficient clarity for a comparative study. Potentially, the experience of using the Project would be more significant to the young people than any measurable outcome, thus reducing its value as an indicator of therapeutic success. However future developments of the present research study may require the use of outcome measures. Therefore the aim was to investigate the feasibility and acceptability of using an instrument to measure young people's emotional wellbeing in the present context. Following a review of other potentially appropriate instruments, as summarised below, the Rosenberg Self Esteem Scale (RSES) (Rosenberg 1965) was adopted as an outcome measure.

6.7.4   Criteria for selection of an outcome measure

The focus groups in the Consultation stage confirmed that subjective wellbeing was the most important indicator of wellbeing, with both feelings and social behaviour deemed relevant. Criteria for selecting an outcome measure were that it should measure emotional wellbeing in a non clinical population of young people, be suitable for self report in the context of a brief intervention in a school setting, have UK norms, and be freely available. Many validated outcome measures met some, but not all of these criteria.

There are a number of instruments potentially suitable for measuring emotional wellbeing in a community sample of teenagers but apparently little consensus in the literature on the approach to take. For example, the National Healthy Schools Programme in the UK recommends measuring emotional wellbeing outcomes through a focus on bullying reports (The National Healthy Schools Programme 2007).

To enhance returns, a major consideration was the length of instrument and how easy it would be to complete, because of the potentially prohibitive administrative load associated with the delivery and evaluation of the Change Project, much of which would be the responsibility of Project workers. Another criterion was that it would have to be valid as a stand alone measure, because triangulation with responses from teachers or parents was contrary to the ethos of the Project. Thirdly, it had to be sensitive to nuances in a community sample. Emotional wellbeing implies a mental status that is not clinical, since at a clinical level the diagnostic terminology of anxiety and depression are employed. Clinically orientated measures may not detect low-level emotional difficulties.

The instrument also needed to have demonstrated adequate internal and external validity and reliability as a self report measure. Self report measures from young people are often combined with reports from significant adults such as teachers, parents or clinicians, to improve validity. For instance, the Child Behavior Checklist is a well validated instrument specifically designed for multiple respondents (Achenbach and Ruffle 2000).

In contrast, discrepancies between parent and child reporting in primary care and mental health services have been reported (Kramer et al. 2004, Bagley et al. 2001) and the case has been made for self reported outcome measures with older children based on the results of validation studies. Finally, it would be helpful to adopt an instrument with UK norms, to

allow comparisons to be made with other UK studies.

Population screening tools can lack sensitivity and this has been highlighted as a limitation of some widely used scales for normal populations such as the Strengths and Difficulties Questionnaire (SDQ) (Goodman et al. 2000, Rønning et al. 2004). Likewise, it has been suggested that clinically oriented scales are insufficiently sensitive to detect slight changes in a normal population (Trowell et al. 2003) and consequently instruments including the Children's Schizoid-affective Diagnostic Schedule (K-SADS) (Puig-Antich and Chambers, 1976), the Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers et al. 2000), and the Moods and Feelings Questionnaire (Costello and Angold 1988)were rejected for the present study.

The RSES was selected because it is a short and simple validated self report instrument that measures self-esteem in a non–clinical population of adolescents.

6.7.5   Principles informing development of a questionnaire to explore acceptability

In order to elicit the views of students who might have little or no interest in the Change Project, a questionnaire aimed at the general population of students was designed. This was potentially a group with different attitudes to help-seeking from those who showed an interest in the Project. It was intended that the questionnaire sample would comprise two complete forms in each school, one from KS3 and one from KS4. A form is a discreet pastoral unit of students, usually in the same age group, which stays together during the years in school, unlike subject classes, which depend on academic criteria.

The questionnaire was designed to be visually appealing to the respondents, to enhance return rates. The design drew on the advice of the focus groups in the Consultation study on how to make paper products appealing as well as questionnaires from the Relachs Study (Institute of Community Health Sciences (ICHS) at Barts and the London Queen Mary's School of Medicine and Dentistry 2003) and the KINDL measure (Ravens-Sieberer and Bullinger 2000) whose visual style was congruent with the young people's expressed views.

6.7.6 Ethical principles informing the research

Issues relevant to research with young people, included assent, coercion, vulnerability, inclusion and child protection. They were addressed through the development of research protocols to ensure clear information and explanation and mechanisms for identifying and referring young people felt to be in need of further support.

6.8 Methods used in evaluation development

6.8.1 Qualitative interviews

The feasibility of conducting post intervention qualitative interviews was approved by key school staff during the development process.

6.8.2 The concept of self esteem

Self esteem was adopted as a key measurable concept for evaluation of the intervention. The contribution of the concept of self esteem to major psychological theory is seen in its central role in influential models. It forms part of the esteem needs in Maslow's hierarchy of needs (Maslow 1943), and in Rogerian person-centred counselling theory, positive self esteem is seen as contributing to the development of self acceptance and as a desirable outcome in itself (Rogers 1995). In self efficacy theory, which has influenced perspectives in management and educational philosophy, individual motivation is understood to be partly driven by the need to maintain self esteem (Bandura 1986).

The relevance of self esteem to depression was demonstrated in a series of papers from a longitudinal study in the 1980s, of approximately 400 women from mainly working class homes in London. The study produced data suggesting that adequate self esteem had a protective function against depression, and in distressed individuals, low self esteem increased their vulnerability to clinical depression (Brown et al. 1990a, Brown et al. 1990b, Brown et al. 1985). This body of work has become increasingly influential on understanding of the social aetiology and socio-economic aspects of mental health, particularly depression.

With regard to children and young people, Butler and Gasson (2005) noted that academic

achievement has been attributed to high self esteem, while low self esteem has been suggested as contributing to social and health problems including depression, teenage pregnancy, crime, and abuse of self or others. In non-clinical populations of young people, self esteem has been identified as a suitable measure of vulnerability to mental health problems (Bagley and Mallick 2001).

Therefore self esteem may be perceived as underpinning emotions, cognitions and behaviour, and moderating emotional resilience.

6.8.3 Rationale for choice of the RSES to measure outcomes

The RSES met the criteria specified for an outcome measure suitable for the Change Project. As a self esteem measure, it appeared closely relevant to the subjective wellbeing outcomes prioritised by young people in the Consultation stage focus groups. The RSES is used in a wide range of studies. For example it demonstrated strong cross-cultural appropriateness in a survey of self esteem in nearly 17 thousand adolescents in 53 nations (Schmitt and Allik 2005). The scale of this research, which was conducted as part of a large project on international sexuality, suggests the broad applicability and robustness of the measure. Other studies using this instrument include a survey of the self esteem of 550 Canadian adolescents, in which the impact on self esteem of age, gender, and social and cultural environment were considered (Khanlou 2004). Analysis suggested that males had significantly higher self esteem. The RSES was used in conjunction with another self esteem measure (Current Self Esteem), and the results indicated that the RSES tended to identify higher self esteem than the Current Self Esteem measure, which was used in conjunction. This indicates the potential limitations of using a single measure in a research study. A selective review of self esteem measurement in African American women (Hatcher 2007) compared 3 robust self esteem measures, and found support for internal consistency but less support for validity, suggesting that cultural dimensions may be relevant to the measurement of self esteem.

The RSES was developed in the 1960s with a sample of over 5000 adolescents in US high schools. In his work with young people, Rosenberg (1965) defined self esteem as a person's judgement of their self worth and argued that it underpins their emotional wellbeing. More recently, a brief cohort study conducted in Australia with 163 university

students identified a link between poor emotional competence (understanding and managing emotional problems) and reduced subjective wellbeing (Ciarrochi and Scott 2006). The authors concluded that self-esteem is partly rooted in emotional competence and both are related to emotional wellbeing. In a review of self esteem scales for use with young people, it was argued that self esteem was an appropriate measure of subjective wellbeing in a non-clinical population (Butler and Gasson 2005).

The RSES has been produced in both Likert and Guttman formats, the former being more frequently employed (Bagley and Mallick 2001). It has been translated and used widely in a variety of age groups and cultures in many studies. It is a 10-item unidimensional measure of global self-esteem, with first person statements to which the respondent chooses one of 4 levels of agreement. Of the 10 items, 5 are worded negatively and 5 positively: the higher the score, the higher the self esteem.

Various studies have reported construct and external validity, reliability and consistency in the RSES. For example a coefficient alpha measure of 0.76 to 0.87, indicating good internal consistency was reported from the use of the scale in a study of cancer patients, (Curbow and Somerfield 1991).

A further advantage of the RSES is the reporting of UK norms by Bagley and Mallick (Bagley and Mallick 2001). This facilitated a comparison with self esteem scores from Project users in the present study. UK norms for the RSES were produced by Bagley and Mallick from a sample of 1330 students aged 12-19 years but lack of detail in the published report undermined the strength of the paper. However, the authors asserted that the UK norms were similar to those produced from a study of 2108 Canadian teenagers, which was reported in more detail (Bagley et al. 1997).

In these two studies, the RSES was presented as a Likert scale, with each of the ten items scoring 1, 2, 3 or 4, with a maximum score of 40. For the 12-19 age group, in the Canadian paper the reported scale means were: males 31.36 (SD 5.13); females 28.32 (SD5.49). Similar mean scores of 31.26 (SD 5.40) for males and 28.31 (SD 5.35) for females were reported from the UK study.

In these studies a cut off point of <21 was used to indicate clinically defined 'devastated self esteem'. Among the Canadian teenagers, 2.7% of males and 7.5% of females had

scores <21 (Bagley et al. 1997); in the UK study, 4.3% of males and 6.0% of females had scores <21(Bagley and Mallick 2001) Comparison of the scores from these studies with scores from the present research study would provide background information about the relative self esteem of the study participants. For clarity, these figures are summarised in Table 10 below.

Table 10: Comparison of RSES norms

	Males with devastated self esteem	Females with devastated self esteem	Male scale means 12-19 yrs	Female scale means 12-19 yrs
British Study (Bagley and Mallick 2001)	4.3%	6.0%	31.26 (SD 5.40)	28.31 (SD 5.35)
Canadian Study (Bagley et al. 1997)	2.7%	7.5%	31.36 (SD 5.13)	28.32 (SD 5.49)

The RSES was selected because it has important properties of brevity and simple language, making it widely accessible. Cost implications are low because it is freely available (subject to acknowledgement), and the scoring system is simple. It also had advantages of brevity, simplicity, and validity that did not depend on co-reports, suggesting that it would be feasible and acceptable in the context of the Change Project, potentially enhancing return rates.

Some difficulties with the negative wording were noted by Sarkova et al (2005), who used the scale with Eastern European adolescents and found that interpretation of negative sentences could be problematic. It was felt that slight adjustments to language would make the scale more accessible to the young people. Consequently, the abbreviations SA/ A/ D /SD were replaced with words written in full, and the text was laid out in table form so it would be easier to read, following guidelines from the British Dyslexia Association (The British Dyslexia Association 2008) (see Appendix B).

6.8.4   Construction of Change Project questionnaire

A questionnaire was developed with the following objectives:

- To investigate whether the Project was perceived as acceptable and accessible by

the wider community of students;

- To investigate the impact of the way the Project was promoted;

- To investigate views on seeking help from the Project

- To identify patterns of response across gender, key stage and ethnic group.

The questions were derived from themes emerging from the research analysis, and focused on barriers and facilitators of help-seeking in the target population. Preliminary drafts of the survey were tested in an academic research group and with young people from the advisory panel. This led to amendments in emphasis and format of the questions. For example, an option of 'maybe' was added to the options for some question responses, to encourage the engagement of young people, might feel uncomfortable with making emphatic statements.

A section on the demographic profile of the respondent was included, to investigate demographic explanations of the acceptability of the Change Project. This was based on census questions about age and ethnicity. The ethnic group classification system of the Department for Education and Skills (DfES (2007) was adopted because it was both brief and comprehensive, reflecting the wide range of black ethnic groups in two of the schools, compared with the short classification system from the national census office

Principles of readability and plain English were applied to the text and layout (The British Dyslexia Association 2008) (Plain English Campaign 2006). Microsoft Word readability function test revealed a Flesch Reading Ease of 90.7 and Flesch-Kincaid Grade Level of 2.5. These figures indicated that the text was accessible to individuals with Grade 4 reading ability (9-10 years old) (Education Otherwise 2008).

6.8.5   Research study documentation

Written information for parents, teachers and young people; advertising materials; protocols, consent forms and other supporting documents were designed using principles of readability as above (see Appendix B).

6.8.6 Submission to University Ethics Committee

The University of Manchester Ethics Committee approved the Project subject to minor amendments, i.e. a written consent from the Head Teacher of each school and the insertion of a health and safety section from the school protocol. After amendments, the Project was approved in October 2006 (Reference TPCS/ethics/06166). Approval was granted to use an opt-out system, in which all students were eligible for the Project unless their carers communicated a refusal.

6.9 Outcomes from evaluation development

6.9.1 Selection of an instrument to measure outcomes

The Rosenberg Self Esteem Scale (RSES) (Rosenberg 1965) was selected as an emotional wellbeing outcome measure for the Implementation stage (Stage III of the present research).

6.9.2 Change Project questionnaire

The questionnaire consisted of 12 questions relating to implementation, acceptability, and the demographic profile of the respondent. A copy is attached in Appendix B.

6.10 Discussion

Using insights gained from the Consultation, a narrow set of simple cognitive and behavioural interventions was identified for the intervention, suitable for the predicted needs of the Project users, the skill set of the Project workers and the time available for Change Project sessions. Paper and electronic self-help resources were developed or selected from the literature to support delivery.

6.10.1 Implications of outcomes of Project worker training

Recruitment and training of Project workers from pastoral and SEN teams appeared to be acceptable and feasible, since a team of Project workers was created in each school. Though the anticipated 6 hour training time was not achieved, it was agreed with Project

workers to address additional training needs through frequent supervision.

The strategy adopted in Sportschool, to train the staff outside of school time and pay them for their attendance, may have attracted a larger group of individuals to the training sessions in that school.

The Project workers were familiar with delivering emotional support and did not express any concerns about the strategies incorporated into the Change Project. This contrasted with training mental health practitioners in a similar model, as recounted by Lovell et al (2006). Lovell noted how experienced practitioners initially found the model difficult to conceptualise and trust, and counterintuitive to their clinical practice and experience.

Some issues relevant to the delivery of the Project were not addressed in the training because of the need to prioritise topics to fit the time available, including the principles of self-referral, the reasons for highly structured appointments, and what to include in brief written records. Training did include role play with group feedback, but there was little opportunity to practice each strategy incorporated into the model. This could potentially threaten the quality and fidelity of the intervention and questions the feasibility and acceptability of delivering training to pastoral and SEN staff without adequately protected time.

6.10.2   Ethical concerns

An ethical concern had been raised during the consultation period that young people might feel pressurised into using the Project because it was part of the school culture. Therefore care was taken to communicate the empowerment promoting ethos of the Project.

It was not feasible to incorporate all the design features favoured by the focus groups, such as instant access, out of hours support, choice of Project worker or delivery of interventions by texting, computer messaging, or telephone conversation. Restrictions of time, money and equipment meant that the use of phones and email was only workable for making appointments, so all the sessions were face to face. Further, Project worker timetables meant that it was not feasible to offer contact out of school hours, except immediately after school. Finally, although there was likely to be some choice of Project worker, this depended on other commitments and was not always offered.

Potentially, the Project could disrupt existing pastoral pathways in school and it needed to be compatible with routines and pastoral care already established on each site.

The process of self-referral encouraged the individual to reflect on the issue of concern before receiving support. Although it was possible that some young people would not be able to use a self-referral system due to lack of skill or confidence, this process had potential to encourage reflection and motivation from the participant, and therefore enhance the development of personal coping skills.

6.10.3   The evaluation strategy

The evaluation strategy combined methods, which had potential to provide complementary data that could generate an understanding of complex processes involved in the intervention. The shortened training time may have suggested that there would be further difficulties associated with lack of time, requiring adaptation to the research design. For example, data collection of RSES scores from Project users relied on the Project workers. In addition, the lack of concern among Project workers regarding the curtailed training may have indicated either a high level of relevant skill, or a low level of awareness of training needs. These issues were open to exploration in the analysis of data from the Implementation stage.

6.11   Conclusion

The development processes discussed here moved the research from theory to practice, informed by theoretical and contextual knowledge. The movement corresponded to the movement from first to the second phase of the MRC framework (MRC 2000).

The development of a complex intervention must consider how the intervention will work in context. In the development stage, the available knowledge informed the intervention design, with attention to the research aims and the needs and preferences of the individuals and organisations concerned.

These process clarified the components of the intervention and enabled the next steps to be planned: the implementation of the intervention and collection of data for analysis.These processes are described in the following Stage.

6.12　Summary

- Theoretical and contextual information obtained in the consultation stage informed the methods used in the intervention development.

- The components of the intervention were established and supporting self-help materials were selected or developed. Principles of feasibility, acceptability and readability were considered in the preparation of documents.

- Risk management protocols were established in consultation with school staff.

- A training programme was delivered to Project workers. Training and supervision were feasible, within the time available.

- A team of Project workers was established in each school

- The evaluation strategy included the use of qualitative interviews, a self-esteem outcome measure, and a classroom questionnaire.

These developments were aimed at enhancing the feasibility and acceptability of the intervention: the 'Change Project'.

Stage III: Implementation

7 Methods used in the Implementation of the Change Project

7.1 Methodological principles

The conceptual design for the Implementation was indicated by the 'modelling' and 'exploratory trial' phases of the MRC framework. In any complex intervention there may be a lack of clarity about the active ingredients and the framework offered a step-wise approach to clarifying the research questions on the basis of existing knowledge.

7.2 Aims of the Implementation Stage

The principal aims of the Implementation Stage were to clarify how the components of the intervention related to each other and to explore its feasibility and acceptability in the school settings. Secondary aims were to explore the implementation processes, and the feasibility, acceptability and relevance of using the Rosenberg Self Esteem Scale (RSES) (Rosenberg, 1965) as an outcome measure.

7.3 Access and sampling

The approach to obtaining a sample of Project users was based on the idea that the intervention would be accessed by self-referral, facilitated by strong advertising and information outlining the purpose and procedures of the Project. All Project users were asked by their Project worker to agree for the researcher to contact them after they had finished contact with the Project, in order to invite them to be interviewed.

All Project workers were directly invited to be interviewed. The Project workers and other contacts in the schools assisted with access to other staff and young people for interview.

7.4 Implementation strategies

The implementation of the Change Project generated data for evaluation and a range of strategies were employed to enhance this process.

As described in Stage II of the thesis, further approaches were made to schools during the

Development Stage. By the end of the summer term 2006, Girlschool, Sportschool and Faithschool had agreed to support the implementation of the intervention as a Project for two school terms, starting in the autumn of 2006. After gaining ethical approval in October 2006, a team of Project workers was trained in each school, information leaflets were distributed, and the Project was launched in the schools. In Girl school and Sportschool the launch took place in October and November 2007. In Faithschool it took place in January 2008, which reduced the opportunity for the Project to become established in the school culture.

7.4.1 Timing

The time scale of the various tasks involved in implementing the Change Project is provided in Appendix B.

7.4.2 Advertising the Change Project

Promotional material was developed carefully using a range of media. Samples are in Appendix C. Information letters were sent to all students, carers and school personnel including non teaching staff. They had a simple design which was suitable for printing in large quantities. A more complex design with photographic illustration was developed for distribution to young people who expressed an interest in the Project.

Launching the Project was achieved through a combination of letters sent home, posters and flyers around school, public announcements in assembly, internal newsletters, in-house television, and staff briefing.

To enhance communication about the Project, a Change Project website was set up which could be accessed via a link on Faithschool and Girlschool intranets. In Sportschool, which did not have a school website, the web address was published on the printed materials around school. An email address and mobile phone numbers for requesting appointments were advertised on posters, flyers and the website. Other advertising routes were agreed with the Deputy Head Teachers and pastoral/SEN teams, including school newsletters, in-house radio and TV, parents' evenings and open evenings.

This activity was possible through extensive negotiations conducted in school throughout

the duration of the whole research study. The development of a rapport with school staff was instrumental in reducing the impact of any cultural clashes. School based research in has potential to highlight the differences between institutional norms of each culture, with respect to timing, communication routes, confidentiality, privacy, visibility, coercion, free will, collective and individual identities. A dialogue maintained with key individuals helped to retain their interest in the Project and raise its profile in the schools.

7.5 Data collection strategies

The intervention was delivered on school premises, during the school day but outside lesson time. Data were collected for analysis and reporting from case notes, the RSES outcome measure, the Change Project questionnaire, interviews and observations, to produce a rounded understanding of the acceptability and feasibility of the Project from perspectives of Project users, Project workers and the wider school community.

The following section focuses on the collection of interview data. A descriptive analysis of case data, the outcome measure and the classroom survey are presented in Chapter 8.

7.5.1 Background information

Some background information about the schools and their social environments was presented above in section 3.6.

7.5.2 Approach to interview sampling

Interview data were collected from students who had used the Project, students who had not used the Project, Project workers, senior managers and other school staff.

The sampling approach was purposive in order to maximise the variation in the sample. Age, and gender were represented in each category. Forty-two interviews with individuals were required to ensure that key groups in the school community were represented, in respect of school, gender, role and key stage (for students). The sampling matrix is set out in Table 11 below.

Table 11: Individual Interviews required ensuring key group representation

	Number of options				
Category	3 Schools: FS/GS/SS*	2 Genders M/F*	2 Key Stages KS3/KS4*	Proposed sample size	
Project user	3	2	2	12	
Other student	3	2	2	12	
Project worker	3	2	N/A	6	
Senior manager	3	2	N/A	6	
Other school staff	3	2	N/A	6	
Total required				42	

The venue and timing of each interview was decided between the researcher and the interviewee. A topic guide including questions about feasibility, acceptability and accessibility was designed to provide prompts in the interviews, appropriate to the interviewee. Interviews were tape recorded when the interviewee agreed, otherwise the researcher made brief notes during the interview and added detail immediately afterwards.

As themes emerged from the data, lines of inquiry were identified and followed up in subsequent interviews. Different topics were emphasised, depending on the interviewee. For example, Project users and Project workers were asked about their experience of the intervention, whereas other interviewees were asked about help-seeking in more general terms. The topic guide evolved during the months in which the interviews were conducted and in response to emerging insights. Samples of topic guides are in Appendix C.

7.5.3   Summary

- Implementation strategies included managing the timing of the Project launch, promoting the Project, and supporting the Project workers.

- Data collection strategies included collecting background information, qualitative interviews, a self esteem outcome measure and a classroom questionnaire.

- The promotion of the Change Project was influenced by the support of key individuals in the schools and the timing within the school year,

- A range of advertising and promotional strategies were used.

8 Descriptive analysis of the Change Project

8.1   Introduction

This chapter presents and discusses methods and findings from case data from young people who used the Change Project, the use of the Rosenberg Self Esteem Scale (RSES), and the Change Project questionnaire, which was distributed to a sample of students in KS3 and KS4 independently of other Change Project activities. Statistical data were explored using SPSS 15.0. It provides contextual information to support interpretation of the interview findings which are reported next.

8.2   Project user case data

8.2.1   Description of sample

Project user case data from the 21 Project users, consisting of demographic information and details of the interventions, were anonymised, coded and recorded in the notes kept by the Project workers. Case data were examined for insights into the delivery and impact of the intervention. This section presents the case data which are most relevant to understanding the impact of the intervention.

Each year group was represented in the sample of Project users. Most project users were in years 8 and 10, i.e. 12-13 or 14-15 years (see Table 12).

Table 12: Distribution of ages in project users

Age in years (Key Stage)	Year Group	Frequency
11-12 (3)	7	2
12-13 (3)	8	9
13-14 (3)	9	1
14-15 (4)	10	5
15-16 (4)	11	3
16-17 (5)	12	1
Total	-	**21**

8.2.2 Description of case data

In total, 53 appointments were made by project users, of which 49 were attended, a mean of 2.3 appointments each. The number attended per individual ranged from 1-8. Project users were encouraged to consider how many appointments they wanted and there was no prescribed upper or lower limit to the number of appointments. Nine project users attended 1 appointment, 6 project users attended 2 appointments and 3 attended 4 or more appointments. Duration of contact lasted between 1 and 65 days, with 6 project users having contacts over more than 40 days (see Appendix C).

Data about access routes were obtained for 10 project users, of whom 3 self referred using a post box system set up in each school, 1 used the dedicated mobile phone number published with the Project information, 3 approached the Project worker directly, and 3 were referred with the help of a third party (parent or form tutor). Email addresses set up to make appointments with the Project were not used.

Figure 10 indicates the range of presenting problems with the project. The most common presenting difficulties were schoolwork and relationships (5 instances each), followed by anger (3) and bullying (3). Other presenting difficulties related to self esteem, transition, panic, sexuality and self harm. The last 3 of these were not predicted by the focus groups as likely to be brought to a school based intervention.

Figure 10: Distribution of presenting difficulty among Change Project users
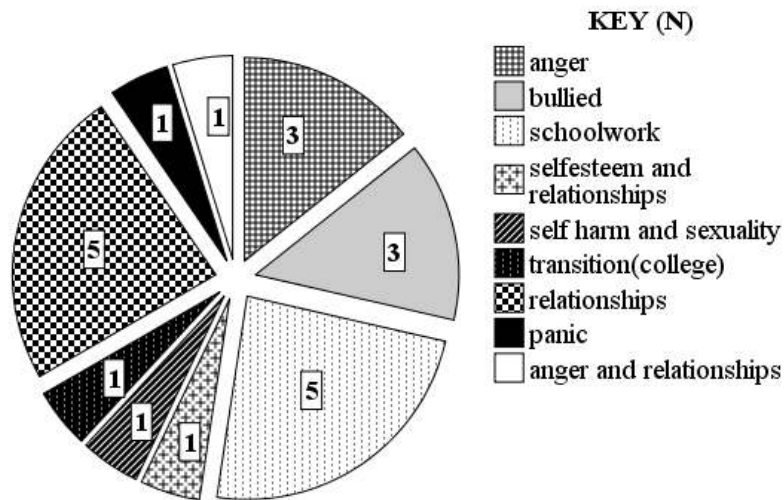
8.3 Measurement of self esteem in Change Project participants

The RSES was included in the Change Project protocol in order to explore the feasibility and acceptability of using an instrument to evaluate effectiveness. Project workers were asked to request that Project users complete an RSES as part of the initial assessment (pre), at the end of the intervention (post) and at 4 weeks follow up (follow up). Completed measures were subjected to analysis using descriptive statistics. Inferential analysis was not planned and would not be appropriate considering the small sample size.The original scoring system was used, in which each item can score from 0-3 (maximum potential score: 10 x 3 = 30) (Rosenberg, 1965). A higher score indicates higher self-esteem. The scoring system was adjusted by adding 1 for each question to facilitate comparison with published UK norms, based on a sample of 665 males and 665 females aged 12-19 years in British high schools (Bagley and Mallick 2001), in which a scale of 1-4 for each question was used (maximum potential score: 10 x 4 =40).

8.3.1 Description of the RSES sample

Twenty one young people participated in the Project, of whom 19 returned a total of 34 measures, a response rate of 54% (total possible measures N=63). Project users who

returned RSES scores were in the age range 11-17 years[4]. Follow up RSES scores were collected at between 30 and 99 days post intervention.

No baseline scores were obtained from males. For females, the overall mean baseline score was 24.6 (SD 3.8; range 20 –33; 95% confidence interval 22.1-27.0). The mean baseline score reported by Bagley and Mallick (2001) for females in a slightly older age group (12-19 years) was 28.3 (SD 5.4; confidence interval unreported). Therefore the mean score for females in the present study was 3.7 points lower at baseline, though still above the cut off score of <21 used by Bagley and Mallick (2001) to indicate very low self esteem.

RSES score summaries are displayed in Table 13 below. To obtain score summaries, the Project user sample was divided into 3 categories, depending on whether the individuals had submitted 1, 2 or 3 RSES scores. Categories are represented in the first column in the table. Two project users submitted no scores, 6 submitted 1 score each, 11 submitted 2 scores each and 2 submitted 3 scores each. The mean RSES score increased by 1.2 between baseline and follow up.

Table 13: RSES score summaries

RSES scores collected		Pre	Post	Follow up	Total N
0 RSES returned (2 x PU)	N	0	0	0	0
1 RSES returned (6 x PU)	N	3	0	3	6
	Mean	25.3	-	23.8	
	SD	3.1	-	3.4	
2 RSES returned (11 x PU)	N	7	10	5	22
	Mean	24.6	28.3	28.3	
	SD	4.4	3.1	4.5	
3 RSES returned (2 x PU)	N	2	2	2	6
	Mean	23.0	19.5	22.5	
	SD	4.2	4.9	3.5	
Total RSES returned	N	12	12	10	34
	Mean	24.6	26.8	25.8	
	SD	3.8	4.7	4.5	
(SD=Standard Deviation; PU= Project User)					

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[4] The Change Project was targeted at KS3 and KS4 (11-16 years) but open to any student in the three schools. It was accessed by 3 sixth form students, who were from Girlschool.

8.3.2   Discussion

The self esteem score was higher in post than pre-measures (mean score increase = 1.2). While the results should be interpreted with caution because of the limitations of the response rate, this suggests that the RSES can detect an effect of the interventions and that there is some indication of positive effect of the intervention. This implies that it may have characteristics which are suitable for the Change Project intervention and therefore may have value in future studies in this field.

Recruitment to the Project was associated with low self esteem in comparison to national norms, suggesting that lower self esteem is not a barrier to participation and may be a motivator. This would be consistent with the role of severity of problem as an incentive to seek help, which has been proposed in health psychology theory (Conner and Norman 1996b).

Strategies used to enhance collection of RSES scores included: explaining the potential therapeutic value of self assessment in Project worker training; altering the layout of the measure to improve readability and visual appeal; incorporating completion of the baseline measure into the initial appointment; anonymising forms; providing checklists and spare forms for Project workers and prompting them to pursue missing measures; and providing spare forms with an explanatory note from the researcher and a stamped addressed envelope, for the Project workers to distribute to project users via the internal school post.

Despite these attempts to improve the response rate, the collection of scores was difficult. Project workers reported that collecting follow up scores was inconvenient because they were no longer seeing the project users regularly and therefore had to send messages to them or try to locate them during the busy school day. Project workers reported that they tended to feel that appointments were rushed, and therefore one cause of missing RSES scores may have been that they were reluctant to use appointment time for completion of the measure. A further, tentative, explanation, based on general observations made by the researcher when spending time at the schools during the research, is that the evaluation of student's progress using structured instruments was not usually a feature of pastoral care. This may resonate with a discussion paper which argued that a more rigorous approach is

needed to properly evaluate educational programmes in schools (Torgerson and Torgerson 2001).

In addition, some young people from KS3 pointed out a number of potential problems with the instrument, saying it was boring, intrusive, and too long. Finally, as young people repeatedly emphasised the need to hide their vulnerabilities from others, they may have been unwilling to complete the forms if they thought other people might see them. A high response rate (86%), from a study in which young people completed questionnaires on a sensitive topic in confidential conditions (Donovan et al 1997), supports this suggestion.

The use of the measure appeared to be compromised by factors within individuals and the organisational culture. There may be potential to improve response rates by consultation with young people on how to engage their interest in measuring their self esteem. For instance, electronic versions of the RSES may be more visually appealing and promise greater anonymity. Project worker training could include a greater emphasis on the use of outcome measures, and in future developments of the research it may be helpful if measures are collected independently by researchers. In conclusion, the RSES is potentially useful as a measure of outcome, provided that factors adversely affecting response rates can be addressed.

Case data suggested a wider range of presenting difficulty than predicted by the focus group consultation. As it included very personal issues such as sexuality and self harm it was consistent with the emotional and mental health difficulties reported in primary care studies (e.g. Gleeson et al. 2002, Jacobson et al. 2002). The range of presenting difficulties suggests that young people may benefit from comprehensive emotional support provided in school settings, while the reasons for variation in duration of contact with the Change Project require further investigation, being potentially attributable to factors such as the complexity of the presenting difficulty, or the extent to which a young person was helped or not helped by the intervention.

The use of most of the available access routes (all except email) suggests that it was helpful to offer multiple methods of referral, to suit different individuals. Tentative explanations for the larger numbers of Project users from years groups 8 and 10 include

factors within the schools, such as how the Project was promoted and delivered, and developmental reasons such as differing attitudes to help-seeking among different age groups. These possibilities could be the focus of further study.

8.4 The Change Project questionnaire

The questionnaire was incorporated into the research design at the Development stage for the purpose of providing insights into the views of students who did not use the Change Project, particularly barriers to help-seeking. The questionnaire is attached in Appendix B.

8.4.1 Methods

To obtain a sample of students to complete the questionnaire, KS3 and KS4 form tutors in each school who had expressed an interest in the Project were identified by Pastoral staff . They were subsequently approached by the researcher, to ask for permission to bring the questionnaire to the students during form time. Students who were present in the classroom at the time were eligible to participate.

The aims of the research and the questionnaire were explained to the students by the form tutor and researcher together, except in a KS4 form in Faithschool, where the form tutor did not want the researcher present. Students were informed that their participation was optional. Help with reading or clarifying questions was given where indicated by students or form tutors. The surveys were completed in a classroom environment, and therefore there were opportunities for collaboration between respondents. Questionnaire data were entered into SPSS 15.0 for analysis.

8.4.2 Results

Seven forms participated: 3 from KS4 and 4 from KS3, including an extra KS3 form in Sportschool that requested to participate. Questionnaires were distributed to 156 students and completed and returned by 140 (response rate 89.7%), constituting 4.1% of the population of students in the 3 schools (N= 3409).

Approximately 1/3 of returned questionnaires came from each school. The sample of KS3 Year 7 and Yr 8 students (N= 80) was larger than the sample of KS4 students (N=60), who were all in Yr 10. Response rates by school and Key Stage are provided in Table 14.

Table 14: Change Project Questionnaire: response rates

School	KS	Missing	Returned (Response rate)	Total N
Faithschool	KS3	2	26 (92.9%)	
	KS4	12	18 (60%)	44
Girlschool	KS3	0	17 (100%)	
	KS4	2	28 (93.3%)	45
Sportschool	KS3	0	37 (19+18)* (100%)	
	KS4	0	14 (100%)	51
Total N	-	**16**	**140 (89.7%)**	**140**

* The sample consisted of 19 students from one form and 18 from another.

The mean age of the sample was 13.3 years (SD 2.2). Fifty one percent of the participants identified their ethnic group as white. The majority of the white respondents were in Sportschool. The ratio of male to female respondents was approximately 1:1 in Faithschool and 2:3 in Sportschool. The greater proportion of respondents (69.3%) was female, which reflected the inclusion of Girlschool in the sample.

Over 2/3 of the male respondents were ethnically white. There were almost equal proportions of white to non white females (see Table 15).

Table 15: Comparison of questionnaire sample and school population by ethnic group and gender

		Sample N (% of school sample)	School population N (% of school population)
Ethnically white*	Faithschool	19 (43.2**)	558* (47.0)
	Girlschool	6 (13.3)	45 (16.3)
	Sportschool	46 (90.1)	518 (91.0)
	All	**71 (50.1)**	**1346 (39.0)**
Female*	Faithschool	21 (47.7)	****
	Girlschool	45 (100.0)	1700 (100.0)
	Sportschool	31 (60.8)	****
	All	**97 (69.2)**	****

*   Eleven respondents did not state their ethnic identity. See Appendix C for further detail of the ethnic profile of the respondents.

**   Figure extrapolated from school records

***   Three respondents did not state their gender.

****   Information unavailable

8.4.3 Analysis of postcodes

Analysis of postcodes was conducted to explore whether the students lived in the community where the schools were located. Ninety respondents reported a postcode or partial postcode on the survey. The results suggested that the Sportschool respondents were most likely to live close to the school, whereas Faithschool and Girlschool students lived in a wide range of postcodes within the city. Only 1 Faithschool respondent lived in the same postcode as the school, compared with 22 Sportschool and 11 Girlschool respondents (see Appendix C). This suggests that the Sportschool respondents were most likely to be drawn from and potentially reflect the local community.

8.4.4 Analysis of questionnaire responses

The following section presents a summary of the survey responses to questions about the promotion and acceptability of the project. Each question has been considered in turn and

the responses have been considered with reference to school, key stage, gender and ethnic group.

8.4.4.1   Implementation of the project

Question 1 focused on the effectiveness of the various advertising routes used. Seventy four respondents (52.9%) stated that they did not previously know about the Project. This included over two thirds of respondents in Faithschool and nearly half in both Girlschool and Sportschool. Detail is provided in Appendix C.

- Impact of advertising routes

Sixty six respondents (47.1%) indicated that they did previously know about the project. The most effective advertising routes appeared to be: assemblies in Girlschool (16/28 =57% of identified routes), posters and leaflets in Faithschool (9/19 =47.4% of identified routes), and assemblies (7/32), posters and leaflets (10/32) and form tutors (8/32) in Sportschool (in total = 78% of identified routes).

- Access to the project

The data were explored to identify patterns in school, key stage, year group, gender and ethnicity relating to respondents' knowledge about accessing the Project. In Question 2: 'Do you know how to get an appointment with the project?', almost 3/4 of students across the schools (N= 103, 74%) ticked 'Maybe', suggesting there was some confusion about access routes.

Sportschool respondents and ethnically white respondents were most likely to say they knew how to make an appointment. There was little difference between Key Stages or gender (see Appendix C).

- Understanding the purpose of the Change Project

Respondents were invited to indicate what they thought was the purpose of the Project, by placing ticks against a list of options: 'Information, Advice, Support, Help, Something else, Don't know'.

'Don't know' was considered to be a negative option and the other options were considered to be positive. An assumption was made that more positive ticks implied that more of the project functions were acknowledged. On this basis, there was little difference

between schools or Key Stage, but females appeared to be more aware of the range of functions of the Project than males. The most frequently cited purpose of the project was to offer support (see Appendix C for further detail).

8.4.4.2   Acceptability

Responses to the question, 'Do you know someone who has used the project?' were explored by school, Key Stage, gender and ethnicity. An assumption was made that if project users had told others about using the project, this would indicate lower stigma and therefore higher acceptability. The respondents least likely to state they knew someone who had used the project were male, in Key Stage 4, or in Faithschool. There was little difference between ethnic groups.

Question 4: 'Would you consider using it if you had any worries?' also looked at the acceptability of the project. Answers to this question were more varied between subgroups than with the other questions. Two thirds of Girlschool respondents indicated a positive response, compared with just under half of Sportschool and approximately one third of Faithschool. Between the schools, Key Stage 3, non-white students and female students were most likely to be willing to consider using the Project (see Appendix C).

Acceptability was also addressed via respondents' perceptions of its potential to be useful. Over half of the respondents in each school said they thought the project sounded useful. Key Stage 3 students and white students were more to say that the project sounded useful. There was very little difference by school or gender (see Appendix C).

8.4.4.3   Free text answers

Two hundred and four free text answers were submitted on the questionnaires. Faithschool respondents were most likely to submit free text answers, suggesting an interest in the topic and the value of providing free space on the questionnaire.
The free text comments were subjected to a thematic analysis. The results are presented below.

- Reasons not to use project

These included not having any problems, having a pre-existing support network: *"I would sort them out with my mum''*, and valuing self reliance: *"it is my problem to face"* (Faithschool KS3 students). Talking to strangers was unappealing to a number of respondents, who said they did not like *"talking to people I don't know about my worries"* (Girlschool KS4) and lack of trust was a theme raised by two individuals in Sportschool KS3, who each wrote *"I don't trust them"*.

- Reasons to use project

Reasons to use the project had similar themes with a different perspective. The young people wrote about the importance of confidentiality and learning how to help themselves *"it seems to help you solve your own problems"* (Faithschool KS3). They appeared to value having someone to talk to and accessing help, advice and support for problems including bullying and family worries. The project seemed to fit into existing notions of support, for example one person said, *"because if I couldn't talk to my parents I'll have to tell someone els(e))* (Sportschool KS3). Several expressed optimism that it would be helpful in phrases like *"mabey (sic) it could make things better* (Girlschool KS3).

There were no dominant themes across age groups or schools, though a tendency to place more value on self reliance was detectable in the Faithschool KS3 responses. Here, there were a number of comments on why not to use the project, such as *"it's my life"; "they are my problems"; "it is my problem to face"* (Faithschool KS3).

- Suggested improvements and comments

These free text questions generated comments on improvements to the project. The strongest message was that there was a low level of knowledge about the project, its purpose and how to access it. A level of frustration was communicated in some comments. One student who wrote, *'what is it!!!'* (Faithschool KS4) was expressing the point made by many. This theme was expressed most often by Faithschool KS4.

Others made specific suggestions about the way the project was organised, ranging from publicity ideas- mainly posters and assembly- to establishing a dedicated venue for appointments. A small number of comments were made about Project workers, suggesting that they should be young, and perhaps with personal experience of having problems. Specific problems mentioned were bullying, homophobia, racism, and behaviour in

schools, and lack of confidence.

8.5   Discussion

As the questionnaire was completed by 89% of students in the forms where it was distributed, the response rate was good overall. The Faithschool Key Stage 4 response rate was 60%, which was lower than the rate in other schools and Key Stages. A potentially important factor in the collection of these data was the classroom environment and presence of the form tutor, though the lack of privacy in the context may have influenced the responses given.

Overall, questionnaire data suggest that the Project seemed to be more acceptable in Girlschool and less acceptable in Faithschool, It was viewed more favourably by Key Stage 3 and females, with a slight indication of higher acceptability among non white respondents (56.4% willing to consider using the Project, compared with 49.2% of white respondents). This finding is consistent with the pattern of uptake by Project users as indicated by case data.

The advertising for the Change Project appeared to have had the least impact in Faithschool, where 68.2% of respondents said they had not previously heard of the Project. Nearly 2/3 of Faithschool students were previously unaware of the Project, compared with just under half of Girlschool and Faithschool. There was little difference according to gender and ethnic group, but older students were slightly more likely to say they did not previously know about the Project (see Appendix C).

Overall in the schools, the most effective advertising routes seemed to involve minimal written information, and the greatest impact seemed to be obtained through posters and verbal announcements. More routes were acknowledged in Sportschool. Possible contributory factors could be low reading levels in Sportschool and Girlschool, compared with Faithschool.

The information that was sent home had little impact across the schools, and there was little indication of word of mouth advertising through friends. Overall therefore, verbal messages received through official routes were effective means of communication; and posters and flyers, which had little written information, were also relatively successful. There may be potential to enhance advertising of the Project by prioritising media that do not rely on written messages. This principle could also be applied to information about how to access the Project and what its purpose is. In a future study it may be useful to

implement the questionnaire prior to introducing the intervention in order to gather information about need and raise awareness amongst potential users.

It is possible that the Project did not have sufficient time to become established in the schools as its duration was less than a school year. The degree of management support may be a further confounding factor. Each school has a distinctive ethnic, academic and socio-economic profile- for example, Girlschool has a single gender but a high number of ethnic groups, both of which could affect the way the Change Project was perceived by the students.

In conclusion, these results seemed to suggest differences in the acceptability and profile of the Project, potentially associated with the school, age, gender and ethnicity of the population. To interpret these results in more detail, further exploration of potential confounding factors is required.

9 Implementation Stage Findings

9.1 Qualitative interview data

The total interview sample is presented in Table 16 below, prior to a detailed presentation of findings in which the interviews with young people are presented first, followed by interviews with adults.

The sampling of interviews was driven by a theoretical approach in which analysis was started during data collection, and emergent themes and ideas could be pursued with new interviewees. For example, the theme of hiding emotions was identified in some interviews with the younger adolescents in one school; it was explored further by purposefully accessing older adolescents, or younger ones in the other schools.

Fifty people were interviewed in the Implementation Stage. All the interviews were conducted face to face by the researcher. There were two home interviews. All the others took place on school premises after school, or during a lunch break or free period. Interviews took place between March and July 2007 except for one Project user's, which was delayed until October 2007. The range of schools and roles was represented. Thirty five interviewees were female and 14 were male. Twenty seven were school staff and 23 were students at one of the schools. Table 16 shows the range of people interviewed.

Table 16: Interviews sample

	Faithschool	Girlschool	Sportschool	Total
Project user	2	3	4	9
Other student	8	1	5	14
Project worker	2	3	3	8
Other pastoral (including SEN staff)	3	1	2	6
School nurse	1	1	1	3
Senior manager	3	1	1	5
Teaching staff	2	1	2	5
Total	21	11	18	50
Male	12	1	2	15
Female	9	10	16	35

9.2 Findings from interviews with young people

9.2.1 Missed appointments

Analysis of the initial Project records revealed a difference between requested (N=29) and attended (N=21) appointments, i.e., 27.5% of initial appointments were missed.

9.2.2 Description of interview sample

Table 18 describes the sample of young people who participated in interviews. A total of 23 young people were interviewed, 9 who had used the Project and 12 who had not. Eighteen were interviewed individually. Five who chose to be interviewed together formed a focus group.

Fourteen were female, 16 were ethnically white, and 15 were in Key Stage 3. Nine had used the Change Project and 14 had not. Ten were from Faithschool, 9 were from Sportschool and 4 were from Girlschool. Pseudonyms were allocated to protect the identity of the individuals, as shown in the table.

Some interviewees talked about the difficulties which had brought them to the Change Project. These included problems with anger, aggression and fighting, friendships, school work, bullying and panic attacks.

Table 17: Young people: interview sample.

N.B. Data have been aggregated and names have been changed to protect the identity of individuals

School	Interview type	Used the Change Project	Did not use Change Project	Male	Female	White	Non-white	KS3	KS4	Total
Girlschool	**Individual interviews**	3 *(Lily, Louise, Nina)*	1 *(Shannon)*	0	4	1	3	2	2	**4**
Sportschool	**Individual interviews**	4 *(Hannah, Amy, Jack, Tanya)*	0	1	3	3	1	2	2	**4**
	Focus group	0	5 *(Jessica, Chloe, Katy, Courtney, Lara)*	0	5	5	0	5	0	**5**
Faithschool	**Individual interviews**	2 *(Chris, Simone)*	8 *(Alex, Toby, Patrick, Savannah, Danielle, Isaac, Greg, Tom)*	7	3	6	4	6	4	**10**
	Total interviewees	**9**	**14**	**8**	**15**	**15**	**8**	**15**	**8**	**23**

9.2.3 Project user sample

All the young people who had used the Project (N=21) were invited to consent to being approached about an interview. Fourteen agreed, and 9 were interviewed. All schools were represented in the interviews. Figure 11 shows attrition which occurred between the potential Project user interview samples and the actual sample.

Figure 11: Process of accessing Project user interview sample showing attrition
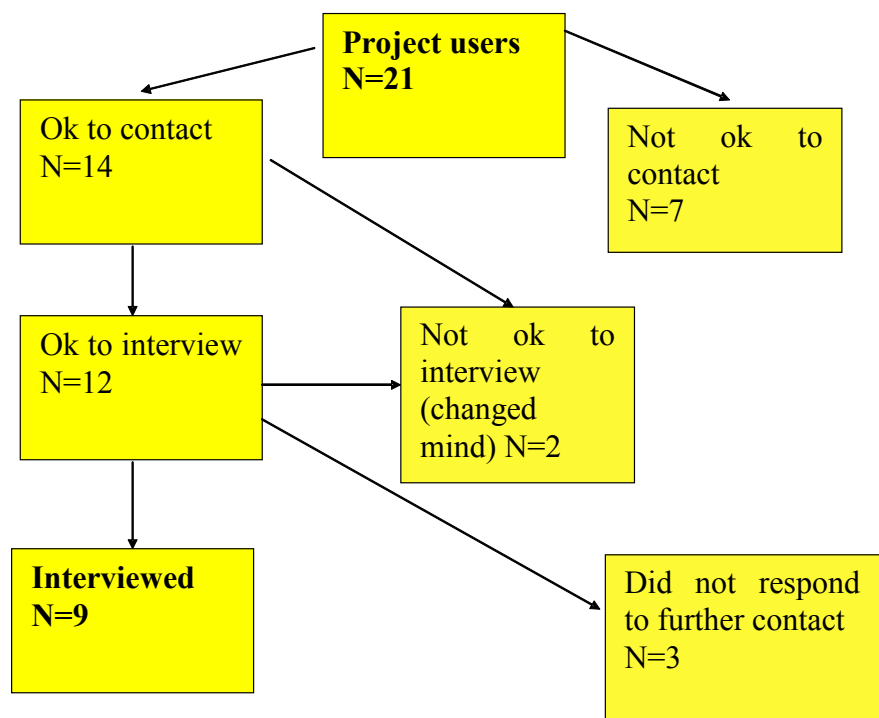
9.2.4 Non Project user sample

The criteria for eligibility were that the interviewee was a student in one of the schools, who had not used the Project and had agreed to the interview. Most of the interviewees were approached by pastoral staff and invited to take part in an interview. The Sportschool group were accessed via a form tutor and 2 Faithschool students were accessed via contact with their carers. Sixteen students were approached and 2 declined (see figure 12).

Figure 12: Sample of students who did not use the Change Project, showing attrition
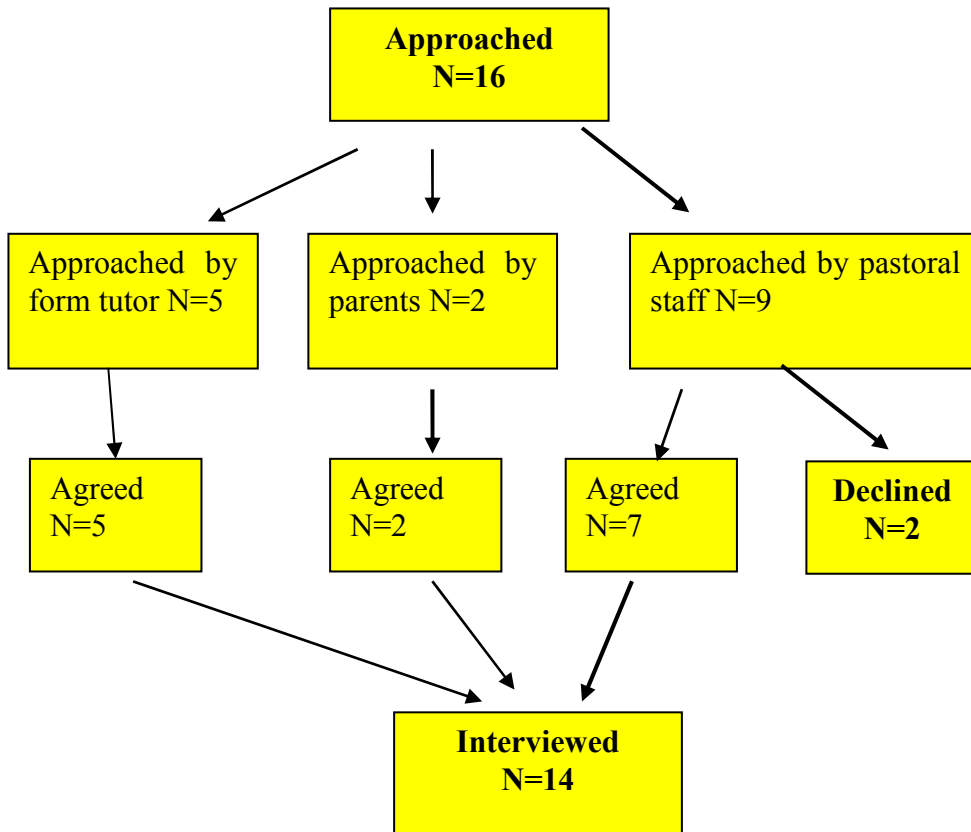
9.2.5   Description of interviews

All the interviews were conducted face to face by the researcher. Interviewees were invited to choose whether they wanted to be interviewed at home, at school, at another mutually agreed venue, or by telephone. Alex's and Tom's interviews took place at home and the other students were interviewed at school. The school-based interviews took place during breaks or free periods, except for one (Tanya's) where the interviewee was excused from a lesson to participate. Four of the Faithschool interviews were conducted in spaces open to people passing by. Most of the interviews took place in school and lasted around 35 minutes. The young people's interviews tended to be shorter than the adult interviews. The shortest was 10 minutes, because of an interruption, but the others ranged from 20 to 70 minutes.

Interviews were semi structured and a topic guide was used. The topic guide evolved in response to the themes generated from the interviews.

9.2.6   Assent

Young people signed assent forms before the interview. Verbal explanations were prepared to supplement the written materials, which emphasised the purpose of the Project, confidentiality, and freedom to withdraw at any stage without incurring any disadvantage.

9.3   Approach to analysis of interview data.

9.3.1   Introduction

A thematic analysis of the interview data was conducted. The method of analysis drew on the procedures from Framework (Ritchie and Lewis 2003). NVIVO 7 software was used for data management.

Qualitative methods were used to analyse interview data. The analysis was informed by insights into the individual school environments, which had been acquired by the researcher through prolonged contact on each site .

9.3.2   Analysis method

After each interview, the researcher listened to the audiotape and made notes. Four tapes were transcribed by the researcher. The others were professionally transcribed and each transcript was checked by the researcher against the tape before being accepted as accurate and imported into an NVIVO 7 software file. Two interviews were not recorded on cassette and written notes were imported into NVIVO instead.

NVIVO 7 is a software package for qualitative data analysis. It is flexible, allowing for coding frameworks to be rapidly applied, tested, altered or removed, and therefore suitable for iterative coding approaches. For example, using the software it was possible to set up hyperlinks between raw data and developing ideas; generate tables of evolving coding frameworks; and manipulate case data to explore themes in different contexts.

As the researcher had conducted all the interviews and created or revised each transcript, much of the interview content was retained in memory, which facilitated creative thinking firmly rooted in the raw data.

The cut and paste technique used in the Consultation Study was repeated electronically using the software. When data display was required beyond what could be shown at one time on a computer screen, charts were drawn on large sheets of paper using coloured marker pens, sticky notes, and scissors to revise categories and move from descriptive codes to conceptual themes. Additional charts were created in Excel documents (Swallow et al. 2003) to summarise themes, while retaining visible links with the data. At a later stage data analysis moved away from the software and themes were displayed on large wall surfaces for revision, and these stages were also captured in digital photographs for reference .

The Framework approach to data management provided a systematic method of working with the data, moving from descriptive (i.e describing the content) to conceptual (i.e. interpreting the content) coding in logical stages. Framework involves becoming very familiar with the data, developing a coding system, checking it, summarising salient points, and creating charts to display cases and themes so that more abstract ideas can be explored without losing sight of the content of the data.(Ritchie and Spencer 1995).This method was particularly helpful because there was a large amount of qualitative data, which could not be displayed together without using summaries and charts.

Throughout the research study, digital photographs helped to create an audit trail of raw and organised data, which enhances rigour in qualitative analysis.

Three anonymised scripts were coded independently by colleagues and young people, who provided comments to aid the analysis and in certain cases challenge interpretation. .

The data analysis method was therefore a synthesis of approaches, combined to suit the data, the research question and the skills of the researcher, and incorporating strategies to enhance rigour

9.4   Summary

- A purposive sample of 23 young people was interviewed, consisting of representation of genders (except in Girlschool), Key Stages 3 and 4, Project users and non Project users in each school.

- Due to the recruitment methods, the non Project users were likely to have experience or interest in pastoral care but they did not generally know about the Change Project.

- The approach to analysis of the interview data was underpinned by principles of Framework analysis. NVIVO 7 software was used to manage the interview data.

10 Pathways to help-seeking: findings from interviews with young people

10.1 Introduction

The following section is a descriptive account of the findings from the individual interviews and focus groups in the implementation stage, which were analysed together. Eighteen young people were interviewed individually and 5 were interviewed together. Because there was a strong consensus in the messages from the group, the group data are treated in the same way as the individual interviews.

The key messages from the interviews concerned facilitators and barriers to help-seeking. These were discussed in general terms and in the context of the Change Project.

Barriers to help-seeking were a core theme. Within this, the importance of hiding vulnerability seemed to be driving health behaviour in all the young people and was the explanation for self protecting strategies including distraction, tolerance, masking true feelings, aggression and tolerance of distress. The consequences of being perceived as vulnerable were believed to be social isolation and reduced subjective wellbeing, which were apparently closely connected.

Facilitators of help-seeking were aspects of the help which did not threaten to expose or increase vulnerability, such as trustworthiness and discretion, or appeared to be so promising that the individual would take a risk. Some interviewees appeared to have higher tolerance of being exposed, and be more likely to seek help.

The model in Figure 13 describes how the data are presented in this chapter, starting with young people's views on the range of problems they might encounter, moving on to decision making processes about help-seeking, and finally what they thought about the Change Project.

In the presentation and discussion of findings, the young people are referred to by their pseudonyms, and the researcher conducting the interviews is referred to as SK.

Figure 13: Interviews with young people: how the presentation of findings is structured

```
┌─────────────────────────────────────────────┐
│      Problems experienced by young people    │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│      Facilitators and barriers to help-seeking- │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│      Young people's views about the Change Project │
└─────────────────────────────────────────────┘
```
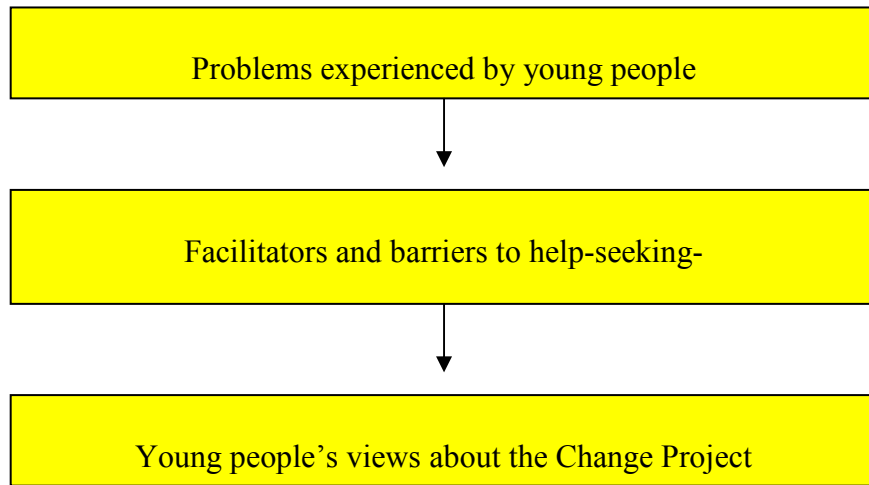
10.2   Problems and difficulties identified by participants

Problems and difficulties were often interdependent. They could be broadly classified as relating to home, school and the outside world (see Figure 14).

Figure 14: The context of problems encountered by young people

```
                ┌──────────────────────┐
                │   Context of problem  │
                └──────────────────────┘
              ╱           │           ╲
             ▼            ▼            ▼
    ┌──────────┐   ┌──────────┐   ┌────────────────┐
    │   Home   │◄─►│  School  │◄─►│  Outside world │
    └──────────┘   └──────────┘   └────────────────┘
         ╲                              ╱
          ◄────────────────────────────►
```
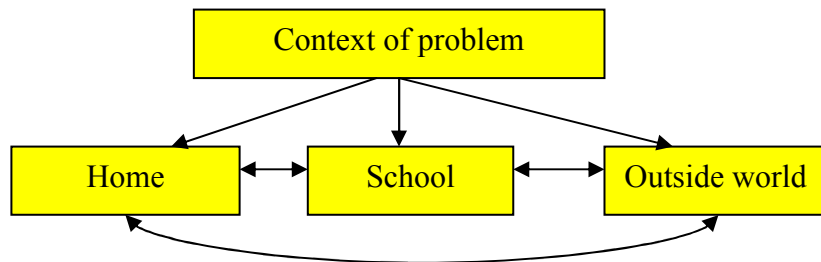
10.2.1   Problems and difficulties at home

The most commonly raised home problems were family life and trying to manage the dual demands of home and school.

10.2.1.1   Family life

Problems linked with home environments included loss Three of the young people referred to bereavement suggesting that it might be quite a common experience for this age group, and consistent with public health figures which indicate a standardised mortality rate of 120 in this city (where the rate for England is 100), (Local authority public health data, detail suppressed). For example, when Alex was asked to say something about the sorts of problems that people his age tended to have, his immediate reply was,

Like if someone's died in the family.

Conflict such as arguments between or with parents were described by the Sportschool focus group:

Jessica: If your mum and dad fall out

Katy: You could have a problem at home

Chloe: What if your mum and dad are hitting you or something?

10.2.1.2   Conflicting messages from home and school

Mixed messages could also be stressful, because they might create a situation where the young person was caught between different ideas about priorities, such as struggling at home to find an opportunity to study, as described by Patrick:

Like school work or homework, like if they don't get any time to revise or anything or do their homework they'll get in trouble then…Sometimes that happens quite a lot with some of my mates.

Physical wellbeing was another potential worry that spanned home and school, and young people might not know who to turn to. Shannon suggested that some people have

...health problems...like not knowing what to do when they start their periods ... and they don't talk to the school nurse or their parents or whatever.

10.2.2 Difficulties at school

This was another category of difficulty, and particularly informative to the research aims, because interviewees said this was the type of problem they would be most likely to approach someone in school to get help for, which was consistent with the focus group findings.

10.2.2.1 Problems in school caused by anger and aggression

Anger and aggression seemed to be common in school, and interfered with school work and relationships with teachers. Greg explained that he put distance between himself and school to avoid conflict,

I've not been in school recently...quicker I'm out of here the better probably... ...been in and out of school since year 10... not that I don't want to come to school, (but) there's people within this school that make it bad for you and I'm staying away from it because I know one day I'll say too much and I'll just flip and I'll come off worse

For others, being suspended had kept them away. Tanya said she was often suspended from school because she had

'A bit of a temper... I was in a fight every day. ;

Similarly, Amy said she felt angry a lot of the time at school and this got her into trouble there because it affected her behaviour:

SK: So when you feel angry ...what do other people see?

Amy: Um, like me getting mad at them, sometimes...I'm always shouting,

As well as stresses caused by conflict between the demands of home and school keeping up with schoolwork could be a worry.

Before I came (to this country) I couldn't really speak English. I had a problem with self-confidence ...I'm in set 2[5]... I was a bit negative about things.

(Lily)

There seemed to be a lot of potential for clashes with teachers, because students found it hard if they felt they were not being treated fairly.

You could have like issues with teachers when you don't think it's fair that they've given you detention for something you didn't do, and sometimes teachers don't listen to you... Because it's sometimes hard when you're a student and teachers don't want to listen to you.

(Toby)

Yesterday I was dead mad and everything, because all the teachers, I just felt like they were all on at me, and they always are, every single day.

(Amy)

10.2.3   Relationships with peers

Difficulties with friends and peer groups were a common theme. Not having enough friends or trustworthy friends could be a cause of low self confidence or low self esteem. The ramifications of this were that it could be harder to create or maintain friendships, and feelings of anger or low mood could develop. Therefore, relationship problems could be both cause and effect of another problem.

10.2.3.1   Effect of anger on friendships

Feelings of anger and frustration could have a bad effect on relationships and make it hard to be friendly. Chris talked about trying to learn new ways of handling general difficulties with making friends and coping with the social world of school.

---

[5] The top academic stream in Girlschool is Set 1, and she felt she had failed by being in Set 2.

I overreact so and then I have (to) not react…I'm aggressive… to people sometimes,
so I'm trying to turn that into a positive way to talk to people instead of shouting at
them, and stuff, try to do it a nice way.

(Chris)

Even feeling irritated could affect friendships, and be enough of a worry to ask for help, as in the case of Simone, who explained she had accessed the Change Project because:

I don't get on very well with people when they annoy me.

In Amy's case, frustration with teachers had a direct affect on how she behaved with her friends:

Amy: *I tried to be good and everything… I was good and everything, but (the*
             teacher) still kept going on at me…and I just ignored her, but it was dead
             hard to ignore her, but I tried not to react to her,

SK: *Did you manage it?*

Amy: *Yeah in the end…. but it's, it was just on me mind and I just wanted to*
             stress at someone…and I ended up snapping at my mates.

It was important to protect friendships because when they went wrong, a person could quickly become a victim of someone else's anger, as Louise explained:

(My friend) was getting stressed, because she'd fallen out with her friend, and she
started bullying her, and picking on her, and all this, and they'd actually got the
police involved.

(Louise)

10.2.3.2   Experiences of being mocked or bullied

Name calling, ridicule and other verbal bullying was taken seriously across the age groups. If a person was mocked for not being clever in lessons this could affect their mood. This included older students, like Isaac, who was in Year 10.

People may be called names like stupid- if you're in a lower set or something like that people just naturally think your stupid 'cause you're in a lower set and little things like that just get people down.

This was a common problem, as illustrated in the following examples:

Say like in the mornings when like people's names are read out to go and see (pastoral staff). People will laugh and stuff like that.

(Toby)

You see like on the corridors like name calling and everything... and ... in my class there's some people get picked on in there...Like calling them (names), they might think it's a joke but to the victim they might, they could think it's upsetting.

(Patrick)

The Sportschool group gave a clear example of what it was like to be hurt with words:

Katy: *Like with bullying people say sticks and stones will break your bones but names will never hurt you. But if someone said where's your brother gone and they know that he's dead or something like that*

Jessica: *My brother's dead.*

Katy: *And it would really hurt you inside*

For Hannah, verbal and physical bullying went together.

You get bullied, called names, all that... (get) hit down the stairs

On the other hand, one Sportschool interviewee thought there was less bullying in school than she had expected:

I was worried because people said people get bullied here but since I've been here no one's really got bullied.

(Lara)

10.2.3.3   Managing tensions

Savannah described learning to cope with tensions within a volatile friendship group:

> *Savannah:* *Like my two friends who are in the form, they've changed, they've really changed. It's really weird, I don't understand it...*
>
> *SK:* *And do you still hang around with them?*
>
> *Savannah:* *Off and on. Off and on...It depends. Like these two girls, I've had trouble with them ages ago. And like it's like a pattern like, I'll be friends with them and then we won't be speaking and we won't be friends and it'll go like that. Going round and round and round.*

Tensions between social groups were a potential obstacle to developing a wider peer group, as illustrated in Tom's explanation of how he felt relationships worked between ethnic groups in Faithschool:

> *I mean within, within like black groups of people you'll have Africans, and Afro-Caribbeans, and they'll split off as many ways as it is possible...it's a very big divide...and if anyone kind of... gave disrespect to anyone else, the whole group would turn against their whole group, and then there's kind of a big thing.*
>
> *(Tom)*

10.2.3.4   Embarrassment

Embarrassment seemed to be a very difficult emotion, potentially linked with shame and humiliation. The young people tried hard to avoid it. For example, Shannon said that

> *People don't want other people to notice what they're doing, they don't like it.*

Some individuals had personal experience of being embarrassed by teachers, perhaps in the course of carrying out pastoral duties. This was a particularly strong theme in Faithschool.

> *SK:* *When teachers know about your personal business, do you think that's okay or not okay?*

> Simone: (shakes head)…they might interfere a lot, and ask you like a lot of questions in front of other people… like your friends that you don't want them to know about…(you) might feel a bit upset and like embarrassed

Savannah described this as being 'confronted', perhaps because she felt it was an aggressive approach.

> (A teacher might) come and confront you about (a problem) …and they're like putting you on the spot really so you don't really know how to explain yourself about the situation.
> (Savannah)

Embarrassment appeared to be an important consideration in decisions about seeking help. Patrick felt that if it was known that a person was getting help from the Change Project they would be laughed at, and this would make them angry and agitated.

> Some people probably would laugh at them…like, they get mad and then start a fight or something like that, or name calling…you'd get worked up.
> (Patrick)

10.2.3.5   Worry

Worrying was a familiar feeling that most of the interviewees had experienced to some degree. Two interviewees reported personal experience of serious anxiety problems.

> Personally, within the school, I had some issues with anxiety, health anxiety
> (Tom)

> I suffer with panic attacks… I was having them really regular, when I went through a really bad time… I had it when I was younger, but then it stopped, and then when my friend died…things started going wrong, and that's when it started swelling up again
> (Nina)

However most of the time anxiety seemed to be attendant on other problems rather than being central to them. Worry was something that changed the way a person looked and what they did as well as how they felt:

(People) keep it inside them sometimes, which makes them like get eaten away, because they've not got anybody to tell…you'd just be by yourself, hunched up and lonely.

(Shannon)

10.2.4 Threats from the outside world: Crime and risk taking

For some interviewees the outside world was seen as a dangerous place. Although none gave specific examples of threats affecting them directly, they talked about things they knew about through other routes.

SK: *Have you heard about other sorts of things that stress young people out?*

Jack: *…Smashing cars up, other people's cars up…playing on the train track…*

Savannah described how attractive images of gang culture and problems in the local community impact on people in school:

Savannah: *Um like where I live there's like different types of like dangers right…and like my generation now, it's like we just we want to be 'it', like they want to be like that idol that they see (on TV) so … when they're out on the street they'll… like try and be bad like some rappers… And like there's all gun crime, drug taking and all that and I just see it all the time.*

SK: *And do those problems come into school?*

Savannah: *Sometimes they do. Very rarely but I've seen it in the past.*

Some interviewees pointed to a connection they saw between having a problem and acting in a certain way:

A whole generation (have) probably got a problem, but can't sort out anything, the only thing to turn to is drink or whatever

(Shannon)

People outside of school who've got problems...who's out fighting with gangs and that...whatever they're doing, there could always be someone for 'em to talk to, like help units and that for 'em if they need help and that, for someone to talk to

(Jack)

10.3   Summary: The network of difficulties

At home, school and in the outside world, young people might be facing a range of pressures and problems involving loss, conflict, school work, peer relationships, crime and risk taking. The main impact of this appeared to be emotional, which might lead to external difficulties, such as complications caused by certain behaviours. Figure 15 is a representation of how these factors interacted, according to the interviewees. There was a complex network around these problems, which were unlikely to be isolated. Uncomfortable feelings resulting from the problems could make a situation worse for an individual if people noticed they were upset.

Figure 15: The network of difficulties described by young people
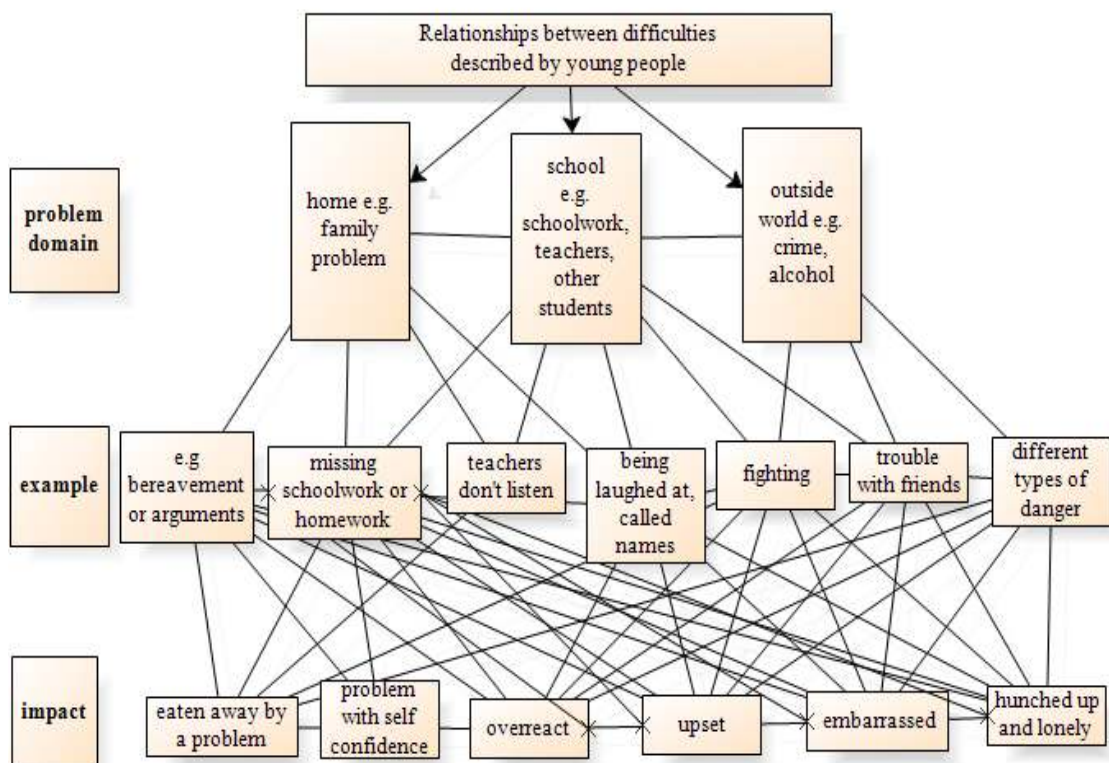
The figure demonstrates the lesser impact of the outside world in this network, which has been represented with fewer connecting lines to other problems. This may reflect the

young age of the participants. Being of school age they may have had little experience of or interest in life outside school, home and social networks.

As well as explaining their potential problems, the young people also described the emotional impact of problems and how they saw themselves reacting to them. What they said about this is presented in the following section.

10.4   Coping with difficulties: conditions for help-seeking

Besides the emotional response, a person who recognised a problem and could not deal with it alone might make a series of decisions about what to do about a problem. Their decisions would make sense to them but might not help them to feel better. Both helpful and unhelpful responses were described. Most of the interviewees thought that in principle, talking to someone about a problem would probably be helpful, firstly because the individual would feel better, and secondly, because they would gain a clearer idea about how to alleviate the problem. However, they did not always feel they could do this.

Peers and adults were both potential confidantes. There were many risks attached to sharing a problem with someone and a young person would make judgements about the level of risk before taking this step. These judgements clustered around personal, social and environmental conditions. The importance of the conditions to the decision to seek help varied between individuals.

10.4.1   Personal conditions: competence confidence, and courage

According to the interviewees, personal qualities of courage (willingness to take a risk), competence (lifeskills, emotional competence, ability to judge the risks involved in disclosure, communication skills) and confidence (self confidence, high expectations of the help offered, motivation) were needed if independent help-seeking was to be a feasible option.

10.4.1.1   Competence to make decisions

Self awareness appeared to be a prerequisite of help-seeking, although Tom explained that younger people might not have self awareness, nor want it.

> Tom: *... a lot of people won't realise, even for a long time ...you get people at the age of 30 that still don't realise that they have these problems... One of the main stages of ...getting over something like anxiety ...is ... accepting that you have it, ...I think it's not so much maturity as it is life experience ...Even (at the age of 10 or 11) just to distract yourself from problems, you'd watch TV, or you'd look outside, or you'd read a book, or you'd go and play football, you know,*
>
> SK: *So if somebody said to you, you know, have you got a problem...*
>
> Tom: *you'd be like, 'please go away!'*

The ability to make judgements about risks and benefits of asking for help was one of the personal qualities that the interviewees associated with help-seeking. The balance of risk and benefit is demonstrated in the quote below from a Project user describing his decision to refer himself to the Change Project.

> I just said, I just give it a shot, nothing can happen, nobody going to kill me for that
>
> (Chris)

This contrasts with the more guarded response from a young person who did not use the Project:

> *I would say that most people either wouldn't want to tell people or wouldn't think it would work...*
>
> *(Toby)*

There were judgements to be made about whether a problem was small enough to manage without help or serious enough to need help from another person, such as an adult. For example, falling out with a friend might be minor, and bullying might be serious.

> Chloe: *If I was being bullied I would tell people about it like get teachers to help, but if like something happened with me and my friends... I'd sort it out for myself*
>
> Courtney: *Because it's to do with friends, because it's to do with, like it's my problem*

> *Katy:*   *Because it's extreme, like, bullying is worse than falling out with your friends*

> *Say if my friend now got bullied, … if she told me, I wouldn't go back and say nothing unless it's repeatedly happening,… I'd just like say right, if the person comes back to you or says something or hits you or something then it's got to be taken seriously you need to tell someone else.*

> *(Savannah)*

Another part of deciding to talk about a problem was feeling able to ask for help and explain the situation. Lily described a series of steps that she went through in order to make an appointment. This points to a possible source of bias in the interview data in that Project users, such as Lily who is quoted below, had the resources or skills to access the Change Project, whereas others might have been put off.

> *I saw on the wall, a (Change Project) poster I think. It said Miss X was doing it. I asked my teacher how to find Miss X. I didn't know who she was. I went to see her and she gave me an appointment….I expected Miss X to talk to me. It was like what I expected.*

> *(Lily)*

A further condition was that the individual would need to know what help was available and how to access it. Some demonstrated that they were poorly informed about a number of resources supposedly available to them.

> *I didn't know about (the Change Project) 'til today.*

> *(Toby)*

> *The school nurse is not somebody that everybody goes to, because they don't really know her that well, she's only in like once a week or something like that[6].*

> *(Shannon)*

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[6] Girlschool had a dedicated school nurse who was present in her office on most week days and many students approached her for a range of emotional and physical health issues.

10.4.1.2 Courage to ask for help

Asking for help was a big step and required courage to acknowledge a problem, trust oneself to be able to explain it, and entrust another person with personal information.

> *You have to be kind of brave and that and like confront yourself and believe in yourself that you can talk about how you're feeling and that in confidence.*
>
> *(Savannah)*

A student in the younger age group (KS3) talked about her positive attitude to help-seeking in Girlschool:

> *I didn't think it at first, but when you actually tell people (about going to the Change Project) they accept it… and they sort of go yeah, if you need help, get help…well maybe some people would start picking on them or something, going hah, hah, you're doing the Change Project, but at the end of the day, it's like you're the one who wins, you're the one who gets better, and you're the one who can live life better.*
>
> *(Louise)*

Help-seeking was seen by Greg as a matter of personal preference.

> *Like it's all down to their personal opinion, whether they use (the Change Project) or not, isn't it? If they want help, they'll get the help. If they don't want the help, so much, they won't get it.*
>
> *(Greg)*

10.4.1.3 Confidence

One form of confidence was the belief in the intervention. Appearing tough and not showing weakness had important social advantages of improving or maintaining social status. This raised the issue of trustworthiness and confidentiality as there was a risk that other people could find out about an individual asking for help.

- Confidence in the helper

If the young person could choose who to talk to, and was comfortable that a confidante was trustworthy, they would be more likely to confide in them. Jack said he had a history with his Project worker, a member of the SEN (Special Educational Needs) team, and felt comfortable with her.

> *SK:* *Have you had help from the SEN room all the way through school?*
>
> *Jack:* *Yeah. I've been here since year 8 and they've always been there for me, to help me out.*

They also felt more comfortable if they could control what happened to information they disclosed. There was a general idea that teachers would not keep information confidential. They were thought to gossip in the staffroom about the private lives of the students, and they were known to approach students publicly to ask personal questions, which students found difficult and embarrassing. Therefore trusting a teacher carried a considerable risk that a person would be exposed among the school community as vulnerable and weak.

> *Some like teachers in the school, not all of them, but some of them would just go and tell all the other teachers when they're in the staffroom. Some of them have big mouths*
>
> *(Chloe)*

- Self confidence

A second type of confidence identified by the interviews as a facilitator of help-seeking was self confidence, since a personal who felt comfortable in their peer groups might be willing to risk being exposed. Self confidence provided protection from the judgements of other people.

It was important in school to look tough; phrases like *'showing off'* (Simone), *'looking big and hard'* (Katy), and being *'cool and upright'* (Louise) were used in this context. Hiding emotions was one way of looking tough. Keeping a problem to oneself was common, but not felt to be a comfortable option, and the effect was described graphically:

It's sort of difficult if you keep it to yourself. It gets all up inside you and then right if anyone talks to you about something you kind of feel like how come I can't do that.

(Savannah)

People don't talk about what they're going through. They just keep it inside, but (I) think there are people who may need (to talk), who start putting themselves down but they just keep it inside.

(Isaac)

10.4.2   Reasons not to ask for help

The reasons not to ask for help were generally the inverse of facilitators of help-seeking, relating strongly with the social impact of being exposed.

10.4.2.1   Other people might find out

A major risk involved with telling was that personal information might be spread around school. If that happened, a person might have to have embarrassing conversations about their problem, or be laughed at, or just know that their private life was public. The risk was there both with friends and with school staff.

There's nothing worse than trusting someone, telling them your business, and then it going round the whole school…if it's something so private and confidential that you do not want anyone to know …you take a big risk telling that person. Because you have to think, will they go and phone the other friend and tell them, will they blurt it out when they're in an argument.

(Nina)

10.4.2.2   Privacy and embarrassment

As the young people seemed sensitive to being exposed as vulnerable, it followed that they would prefer to keep private any personal information that was potentially embarrassing. The previous section presented a finding that embarrassment was not only the possible negative consequence of exposure, but also a discrete problem with its own

consequences, such as aggressive behaviour. Being able to avoid embarrassment was one of the conditions that might facilitate help-seeking. Therefore it seemed that if a young person believed that help-seeking would be kept private, they would be more likely to consider it. This could be achieved by facilitating discrete access and private consultations:

I read the (Change Project) posters and I, it's private so no one would know about it

(Chris)

Just somewhere you know you can go without, say if your parents, you don't want them to find out, just somewhere like that, that'd help, cos you'd be at ease a lot more.

(Greg)

In Girlschool in particular, coping with potential embarrassment seemed to be less of an obstacle to help-seeking:

(If you need help) I think you should definitely tell people, because then it's kind of horrible keeping secrets from people, and you shouldn't be ashamed of needing help.

(Louise)

However, for others, the threat of being embarrassed could be off-putting. The Sportschool group offered an explanation for why people might not turn up to their appointments with the Change Project, linking embarrassment with loss of confidence:

Lara: They're embarrassed

SK: So…, why would they make the appointment in the   first place...?

Lara: Because they were feeling confident and then   something's put them back down.

They could get embarrassed or something by going to (see someone about a problem) and that could upset them so yeah there is a bit, a lot of thought with going to (tell someone).

(Patrick)

Asking for help required that the person had decided they had a problem, but as explained above, being embarrassed was an upsetting problem in itself. For Shannon, the embarrassment was an obstacle to getting help with a problem, and worse in older students.

I think younger people have got more confidence than older people, to tell you the truth, because like older people like just, people I know, older people than me just keep things to themselves more than like younger people.

(Savannah)

10.4.2.3 Shame

One interviewee explained that the fact of needing help for a problem could be a cause of shame, an internally driven emotion in contrast with embarrassment which had more of a social context.

Some people can, ... kind of develop the feeling that, oh my God I'm stupid, ...you get it like, being ashamed of relying on someone else to help you...it makes them feel a bit weak.

(Tom)

10.4.2.4 Talking about problems is boring

It was thought that not everyone with a problem would take sufficient interest in it to want to talk about it. This seemed to be a developmental issue. Being bored by the prospect of talking about it was a commonly expressed idea with the younger participants. For example, when asked about the accessibility of lunchtime sessions with the Change Project, some of the younger interviewees explained that a person might not take an opportunity to talk about a problem if they other priorities.

Katy: *They don't want to waste their time talking to people when they could be playing out with their friends...*

Chloe: *They get bored with the idea of talking about their problem*

Lunchtimes and your breaks are like free time from lessons and tests and stuff

(Alex)

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10.4.2.5   You don't take the risk

The disadvantages of storing up worries were clear to the interviewees, yet there were many considerations to think about in relation to asking for help. Most of the interviewees had a lot to say about the risks of telling. Teachers seemed to be strongly identified with the risk of spreading personal information about students and this might put students off from confiding in them.

> *I told a teacher something personal a long time ago I think it was year 8 yeah and they went back and told like other teachers.*
>
> *(Savannah)*
>
> *…I think sometimes teachers can be say a little bit nosy, so sometimes if you are upset you have to kind of hide it, so you don't take the risk,…they've automatically got an opinion on you … if you were saying, oh yes things are not alright at home, they'd straight away think something was seriously going on, and …bring other people in… like the social services or things like that, and everything gets blown out of proportion, and it really wasn't anything too serious, too wound up.*
>
> *(Nina)*
>
> *Some like teachers in the school, not all of them, but some of them, would just go and tell all the other teachers when they're in the staffroom.*
>
> *(Greg)*

For example, Alex and Hannah explained the problem with telling about bullying:

> *SK:*   *What's bad about telling teachers or parents, what could go wrong if that happens?*
>
> *Alex:*   *They might just like tell everyone and then …just make you get more bullied if the bullies know about it that you've told someone.*   *Alex*
>
> *Hannah:*   *Like if you say if you get bullied, call names, all that, if you tell your mum or dad then they'll come into school.*
>
> *SK:*   *…So if a person's mum and dad come into school does that help …?*
>
> *Hannah:*   *No, because they want the best for the teachers but they don't want the best for the children. Because … the teacher thinking, 'oh this child*

won't get bullied', but from now on it could get bullied more often.
(Hannah)

Amy said that addressing the problem could make it worse even without complications caused by other people.

(They) might be too stressed to come, or, it won't help, it'll baffle their heads or something. Because that's what most people said (about)... Anger Management[7], it messes your head up, and they might think this is just the same.

(Amy)

10.4.3 Strategies to manage emotions without help- seeking

10.4.3.1 Bottling it up

'Bottling it up' was a strategy that the young people understood, in the face of the problems associated with asking for help. Both the problem itself and the feelings about it might be bottled up, despite the pressure. This appeared to be generally accepted as a practical way to deal with difficult emotions in school, although as Louise's statement below suggested, it was a strategy that carried its own risks.

Everybody (in school) seems to store stuff in a bottle, they store all their, all their anger, and all their emotions and all this, and they shove it in a bottle...and one minute I think the cap is going to slip off, and it's going to go mad.
(Louise)

---

[7] Amy had had some discussions with her form tutor about accessing anger management sessions

10.4.3.2 Convincing yourself you don't care

One method of coping with a problem that was bottled up was by fooling oneself that it wasn't important.

> *Some people feel that they don't care… but I think (that) quite deep down, (if they get into trouble for not revising or doing their homework), it makes them think that they do care, and it could change their life if they don't do good in the GSCE's or anything, so people convince themselves that they don't care.*
>
> *(Patrick)*

10.4.3.3 Wearing a mask

The idea of putting on a special face to look 'hard' in school was frequently raised by the interviewees, who understood it as a normal way to protect their feelings and image in school.

Looking hard meant not showing vulnerability- being aggressive in school was seen as a way of looking tough and attracting friends. It seemed from these interviews that everyone in school knew it was a ruse, yet went along with it, as these examples show.

> *Everybody kind of puts a mask on, as soon as they come in through the (school) gate, and they bottle up all their emotions…oh they act all cool and upright.*
>
> *(Louise)*

> *SK: When you see people going round school are … acting tough, do you think well … they're upset about things?*
>
> *Simone: Yeah and they're just trying to make people think they're fine.*
>
> *SK: …And do you think people put an act on when they come into school?*
>
> *Simone: Yeah to show off in school, and everything.*

These processes were perceived as not only obvious but also rational because they protected social status, friendships and self esteem.

Jessica: *They want to be big hard with their friends so it makes them look solid and it makes us look weak. And they just want to show off and be the centre of attention.*

Katy: *They're all in a gang at school, they go all around, they don't bully you if it's just… one on one…if there's no people there. If there's a crowd they just go, 'oh look, they're cheering for me'.*

SK: *Why do people want other people to be scared of them?...*

Jessica: *To make them look big and hard if they go into year 11…*

Courtney: *So when you go in year 11 they'll probably be popular[8]*

SK: *So to get more friends then?*

Courtney: *Yeah.*

Chloe: *Yeah. To get a reputation*

(KS3 Group)

---

[8] 'Popular' has a particular meaning with this age group in this part of the UK: it means having a lot of influence on peers, and having followers, potentially by being intimidating (definition provided by young people on the advisory panel)

10.4.3.4   Being angry

Being angry might be more tolerable than being upset. It also stopped people from asking questions because they tended to notice the anger more than the problem. Nina explained:

To be honest I think being angry ... it's almost better than being upset. ... I think everyone goes into the emotion of anger, because I think it's just so much easier. ...when my friend died ... straight away I found anger.... Forget all the upset, forget all the hurt...I think anger was just such a more easier emotion to deal with. ... It's kind of like if you're upset, 'well what are you upset about?'.... With anger ... it's like, 'all right then, just calm down...' you don't get questions... you don't get any of that. So ... if you're upset, you straight away turn it into anger (snaps fingers) ...your emotions just do it.

(Nina)

10.4.3.5   The impact of anger

Anger was a familiar emotion and several interviewees provided clear descriptions of their experience of it. In the example below, Nina described how easily a small event could cause a big emotional reaction.

Being a teenager's the actual worst part of your life, because it's just like you go through such a roller coaster... and your emotions are everywhere, it will only take the littlest thing, like you can't get chocolate, and you'll be well annoyed over the whole day.

(Nina)

The interview data suggested that anger was a complex mix of problem, solution and coping strategy. Their comments on the most important causes and effects of anger are summarised in Figure 16, which shows causes and effects of anger according to the participants.

Figure 16: Advantages and Disadvantages of Anger and Aggression
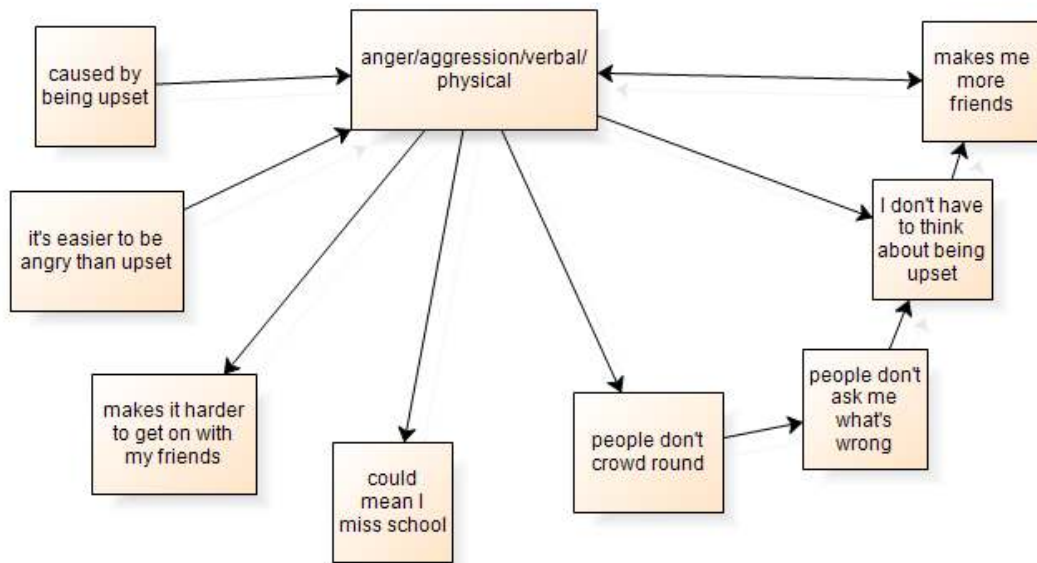
This model was built up from analysis of the interview data and subsequent consultation with young people on the advisory panel.

10.4.4   Summary

- The participants said that ideally, a good way to access help with a problem was to choose someone to confide in, though this might not be the best course of action in every situation.

- If a person was not going to tell, they would have strong feelings to cope with.

- In schools, it was normal for people to put on a tough exterior, leading to hiding of vulnerable feelings.

- Anger was functional to protect individuals from embarrassment and feeling vulnerable but also created relationship difficulties.

10.5 Feedback about the Change Project from Project users

10.5.1 Introduction

The Project users were asked about aspects of their experience of using the Change Project. No personal questions were asked and the topic guide was used to shape the interview. The topics introduced in the interviews related to the feasibility and acceptability of the Project, with a particular line of inquiry into psychological or practical barriers to using it.

10.5.2 Accessibility of the Project

One of the themes of the research inquiry was the accessibility of the Change Project. The subthemes of reasons for help-seeking, self-referral process, how the Project was promoted, and the experiences of using it were suggested by the data and the findings below have been organised accordingly.

The initial reason for accessing help was a problem the young person had not been able to resolve, and which they thought the Change Project might help with. In the quotations below, a range of difficulties and triggers are described by Project users, which motivated them to access the Project.

I asked for help at home, I did get it, but sometimes I can't just go and every time to get my parents worrying about me…(I went because of) problems, with getting on with people…

(Chris)

I had a problem with self confidence.

(Lily)

Um, well I kept like being dead nasty with everyone so often, and Miss, Miss X brought me Mum in, and then told her about it, and then me Mum's like decided about it, to like help me a little bit.

(Amy)

Well my Mum just said that it might be a good idea because I don't get on very well with people when they annoy me … I agreed.

(Simone)

SK: *What did you think would happen in the appointment?*

Hannah: *Tell about bullies.*

I do my work (in the SEN room) sometimes… (Miss) asked me if I needed any help with college forms or if I needed to talk to someone.

(Jack)

I sort of had like anger management issues, so I kind of needed to deal with it, so I said, well, I might as well give it a try.

(Louise)

No-one … understood what I went through, so I had to like kind of get professional help[9].

(Nina)

Tanya: *I got recommended by the teachers…*

SK: *What did you think about making an appointment,*

Tanya: *I don't know, I felt alright…that I could speak to people and that.*

---

[9] i.e. help from the Change Project as opposed to informally asking friends and family to help her. Nina had experienced panic attacks after a traumatic event.

10.5.3 The process of self-referral

Access to the Change Project by self-referral was perceived by Project users as straightforward, as shown in the examples below.

> *SK: So how did you make the appointment?*
>
> *Chris: I went up to (the Project worker) and asked him*
>
> *SK: Did you know him already?*
>
> *Chris: Yes*

The ease of access contrasted strongly with the findings from Project users who had not used the Project, most of whom had at best vague notions of the presence and purpose of the Project in their schools (see findings from adults interviewed).

Although straightforward, not all referrals were independent, with just over half saying they were encouraged or assisted by form tutors, teachers, or parents (see Appendix C).

> *SK: If they hadn't told you, do you think you would have gone (to the Change Project) anyway?*
>
> *Amy: No. I would have just left it, and have carried on,*

In some cases the assistance was merely drawing a student's attention to the Project and leaving them to take the next step. Knowing the Project workers was a major help in the access process.

> *Miss ... mentioned it, and I wasn't over keen on the idea at first, and then gradually I sort of, like, you know, sit there and think about it, and then get used to the idea, and then arrange it with Miss, and Miss said she'd arrange an appointment.*
>
> *(Nina)*

10.5.4 Knowing about the Project

The messages about the Project had reached Project users from posters or announcements in assembly or form time. Letters sent home or flyers distributed in school did not seem to

have had any impact, though appointment slips were freely available in the schools and this was how at least one person heard about the Project.

SK: Can you remember how you heard about it?

Hannah: In main office, the (appointment) slip.

I read the posters
(Chris)

We'd all heard about the Change Project, you know, in assembly, a couple of months back, but no-one ever like thought of that, you know what I mean, never thought of doing it, because there was nothing going on at that time.
(Nina)

10.5.5   The administration and paperwork

Although there were a number of forms to fill in at the first appointment with the Project, this did not seem to have been burdensome for the Project users.

There's a couple of sheets that you have to circle, or write down your feelings or answer some questions, that was it really, there was no really, strong like paperwork, like hassling paperwork.
(Nina)

However the paperwork could potentially alienate Project users by raising concerns about confidentiality.

SK: Did you have to fill in a lot of forms before you started?

Chris: Yes

SK: And what did you think about that?

Chris: Um, I wasn't sure that it was private and confidential then

10.5.6 Views on the Self Esteem Questionnaire

Some interviewees were invited to discuss the Rosenberg Self Esteem Questionnaire, because it was proving difficult to collect measures as planned. They offered a critique of the appearance, relevance and suitability of the instrument.

The Sportschool group were critical of the appearance of the questionnaire. They felt it was hard to read, boring, and some of the questions were intrusive:

Chloe: *People don't like to write*

Katy: *You can't even see it and it's strongly agree, agree, that's just rubbish…*

Courtney: *No one's going to really like it*

SK: *What about the questions?*

Chloe: *Hard*

Lara: *They're just too long and people can't be bothered reading them*

Jessica: *quite personal*

Chloe: *…too strong. Ten is too many*

Jessica: *You need to put colour in it…you need colours of the rainbow*

Comments from Tom, an older student, suggested that the questionnaire would not be completed honestly if there was a chance that other students would be able to see the answers, and also that accurate answers required that a person was aware of how they were feeling- which was not always the case.

I think it's quite hard to kind of judge sometimes after you've been through a session … quite hard to say, okay, well now I'm happy with myself, sometimes it's a bit hazy for a while… so some people might find it kind of hard to interpret where they're at.

(Tom)

10.5.7   Summary

- The self referral process appealed to some individuals because it was confidential but others were helped to access the Project.

- The impact of advertising about the Project appeared to be inconsistent.

- Making written records of the intervention caused concerns about confidentiality in some Project users, but they did not suggest that the administrative aspects were burdensome.

- Suggestions were made about how to improve the acceptability of the self esteem questionnaire.

- Project users did not object to the paperwork involved.

- The interviewees suggested that the intervention could be improved by having a regular venue, offering alternative communication modes, and better advertising.

10.6 Views on SEN and pastoral staff as Change Project workers

Recruiting and training SEN and pastoral staff seemed to be a successful strategy because they were viewed as credible, and approachable, as the quotations below suggest. Where students already knew them, this was another helpful factor. In each school the pastoral staff were generally felt to be trustworthy and sympathetic. However as Project workers were involved in asking individuals to be interviewed, the sample of non-Project users may be biased towards students who knew the pastoral staff.

SK: Ok, what do you think about the fact that it's the pastoral tutors doing it...?

Alex: I don't think so because they usually like help people out, and people know about them more than like all the other teachers,

With it being pastoral tutors you know you can trust them with pretty much everything, so that helps a lot.

(Greg)

A couple of teachers off the Pastoral Team are really, really good.

(Nina)

10.6.1 Interventions

The interventions that the interviewees said they had tried in the Change Project were: emotional and practical support, cognitive and behavioural strategies, and education. All of these had value. Talking and being heard provided relief for bottled up feelings.

SK: If a person comes on to this Project, what do they want actually?

Simone: Just to talk about it, and just to get it out.

:

SK: *How did it feel talking to (the Project worker) about it?*

Chris: *Um I feel like the whole heavy things like just dropped.*

SK: *How do you mean?*

Chris: *Like the whole weight just dropped, you know, in my mind.*

I didn't really know what to expect, I just, I don't know, I didn't have a clue at first like, but (the Project worker) was just talking to me, she was really nice.

(Louise)

The value of practical strategies appeared to be secondary to being able to talk to someone trustworthy, being listened to and taken seriously. However learning how to cope was also important. Nina said that talking was not enough for dealing with panic attacks- some effective techniques were also needed:

I like talking, and getting everything off your chest,…(but) you have to learn about strategies, to help you.

(Nina)

10.6.1.1   Cognitive strategies

The use of diaries was popular with the Project workers and, as shown below, this could function in several ways, helping a person to understand their feelings and providing Project workers with information they might need to make practical interventions.

The person that I was speaking to about the Change Project give me a diary where I could write it down everyday and, what happened, and just I could write me feelings down to it and everything, and she was like just sorted it out, just stuff like that, if I was feeling unhappy or I was being picked on, and she had to sort it out for me.

(Tanya)

Louise (below) described a worksheet she had used which aimed to raise self awareness.

There was one big picture, with loads of people, and there was, there was somebody crying away in a corner, and there was somebody being all happy and smiley, and giggly, and having fun with their friends.

(Louise)

Jack worked towards focussing on his own goals instead of focussing on the name calling he was subject to.

If they're calling me (names) at the back, I put my mind to it, just concentrate on the teacher and what they're saying and just not let my mind tell me to walk out the lesson and that and…let it tell me to get on with my coursework and just listen to the teacher and focus on the teacher and just let them just do what they want, but I want to pass my exams.

(Jack)

Helping a person to see something differently was another cognitive strategy that was employed in the sessions.

She gave me a paper, to say what you are good at. Different things, like making friends. Then I realised that there were things I was good at, like making friends.

(Lily)

10.6.1.2 Behavioural strategies

In Faithschool, Chris described a number of behavioural strategies he used, including joining a social skills group and practising how to talk to people without being aggressive.

(The Project worker) is doing …like, how to get on with people, how to like listen, how to make the problem like much easier to deal with it… I went to the club[10] … and they give you, how to talk to people and stuff…(so now) even if people are being wrong I try to listen to them. (Chris)

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[10] This is a social skills group based in school

Other students described working towards behavioural goals.

Go every Thursdays, talk about it, and got sets of targets to do, stay in lessons, all that… And then see can I stay in lessons for 14 days.

(Hannah)

SK: Did you sort of work out any things that you could do differently?

Tanya: …Like, I'd, instead of fighting back, just walk away….take me anger out on a punch bag and stuff like that… me brother's got a punch bag, and that's what I was using,

10.6.1.3   Educational strategies

Nina had been using a self-help manual about panic, from which the Project worker selected the most relevant sections.

(The Project worker) said, "I don't want you to feel bombarded with information, and then get stressed out"…so she picked out specific sheets that she thought would help me, … and if then there was a certain (thing) that I didn't …understand, she'd go through it…, you know, like the adrenalin, and flight, or things like that.

(Nina)

10.6.2   Impact of intervention

With the exception of Amy, the interviewed Project users said they had benefitted from the Project. Amy felt that she had not benefitted at all and the Project had been too superficial to help with her problems:

SK: So what was it like when you had your first meeting?

Amy: Didn't really know what to say, but Miss, … she talked to me about it,

SK: And what did she get you to do?

Amy: Um, write some things down, and like answer some sheets,

SK: … did that help you at all, doing that?

Amy: *Not that much, not really…she just asked me if I feel better and everything, and you just say, not that much, and that's it really.,*

10.6.2.1   Impact on home problems

There was evidence of increasing resilience to emotional upset, as Project users worked out ways to manage their feelings better.

It has helped me so much, I've learnt how to cope with issues, and like problems and everything in a whole, you know, different way, and how like there are strategies to help me when I was like completely, having like some sort of breakdown,

(Nina)

One interviewee said she had managed to avoid being referred to a psychiatrist because her parents could see the improvements:

Before I did this my parents also said they wanted to take me into a psychiatrist.

(Louise)

Self esteem had also improved in some cases. For example, Lily had been able to adjust her negative opinion of her achievements in school.

I realised I was doing well.

(Lily)

In his interview, Chris had identified self esteem as the root of a number of difficulties he had getting along with people and making friends. He said that after accessing help from the Project, he felt better about himself:

Chris   I'm no longer thinking that I'm rubbish, I think I've got some good things.

SK   How long had you been feeling rubbish for?

Chris   All of my, all those years.

10.6.2.2   Impact on school problems

Problems with school work, and school life also seemed to have eased for some of the Project users

I never used to attend my lessons, I was always wagging it…For the last couple of weeks I've just been getting to all my lessons and getting my work done and that and I'm looking to pass my exams!

(Jack)

You're allowed to talk to people on your own and tell them what you want to change in your life, all that….People listen to me about bullies, and then they talk to me…and see what can we do about it.

(Hannah)

Tanya: I've still got a bit of a temper, but before I was in a fight every day, but now I'm like in a fight every month or something like that…

SK: Right, so, things aren't perfect for you?

Tanya: No, but they're better,

For Tanya, accessing the Change Project helped her to feel better about asking for help at school:

Before all the Change Project and my work, sort of like, I didn't know who to talk to and stuff like that, but now I can come up the SEN Room, and speak to the people.
(Tanya)

10.6.3   Suggestions for improvements to the Change Project

All the interviews addressed the interviewees' ideas about how the Project could be improved.

10.6.3.1   Venue

The spaces that were used for Change Project sessions were not always satisfactory. Chris

and Simone, in Faithschool, reported they had had some of their appointments cancelled because there was no place for them to meet with the Project workers. However one Project user suggested that it was helpful to have a regular meeting place.

I kind of think it's good if it's always in one room, because then you don't sort of get distracted by things, because you, you keep seeing the same things again, and it's just a room where, you sort of get used to that room.

(Louise)

10.6.3.2   Modes of communication

Some suggestions about using phone and computer technologies to broaden modes of access were put to the interviewees. These had been raised in the focus groups in the Consultation Study but it had not been feasible to incorporate them into the Change Project. Phone contact or instant messaging were suggested to the interviewees as a possible replacement for a face to face meeting. Responses were mixed, since some people felt they needed to be able to see who they were talking to and others felt the anonymity would be helpful. Project users had all experienced face to face contact so their views were potentially strongly influenced by their experience.

Yeah, I think it's kind of nice if you just talk to someone, yeah, like MSN and things, you're talking to one person, but if you do it on like a message board or something, it, it doesn't really feel that close.

(Louise)

If you don't want to face a person, then they can talk to them on the phone and they're allowed to listen to you and give you advice.

(Hannah)

I think it's whether people, on different people's views, or if they don't mind talking over the phone or on MSN because some people don't like talking to who they can't see but some people don't mind, like I if it was me I'd just talk over the phone or something.

(Patrick)

10.6.3.3 Brief appointments

The prescribed duration of appointments was 30 minutes for an initial session and 15 minutes for subsequent sessions, with no preordained limits to the number of sessions. Some felt the sessions were too short to have a helpful discussion.

SK: *What would have helped?*

Amy: *Talk to me a bit longer, and just like, discuss better things,*

SK: *Right, you mean things that you, that are important to you, is that what you mean?*

Amy: *Um, no just like, just talk a bit better, could like get it out,*

SK: *So is that, is that the kind of thing that helps then, just getting it out,*

Amy: *Yeah, might get me stress out*

Thirty or 40 minutes would be better. 15-20 minutes is not enough to talk properly.
(Lily)

However this did not seem to be a problem for others:

SK: *What did you think about the length of the appointments…?*

Tanya: *Didn't think anything of it really, if that's the amount of time that we can have, because they've got other meetings in that room and stuff like that.*

10.6.3.4   Advertising

Interviewees were asked how best to advertise in their schools. They tended to agree that messages had to be repeated, letters were ineffective, and they would be most likely to absorb messages from posters or verbal announcements.

SK   What do you think is the best way of getting a message out in school?

Simone   Erm, just like telling some teachers to tell you, and just give you some more information about it,

SK   Written information, or, just listening, or,

Simone   Just listening....

SK   And do you think that teachers would have to talk about it more than once…?

Simone   Yeah.

SK   How often then?

Simone   Every week

I would sort of like have like people coming in like after classes or in break or, and talking to people about it and stuff like that.

(Tanya)

You could get people in assembly, people could … listen, and people who have problems, I think, would think about themselves in between ... I think announcing it in assembly would be the best idea. And then you can still need the posters.

(Isaac)

One interviewee pointed out that using a well publicised Project could draw attention and mocking.

(I don't think it should be) over advertised …, some people would like take the mick with it, obviously.   (Greg)

Literacy levels were a consideration as posters with writing on might not be accessible to all students.

> *SK:* *Have you seen (the Change Project) posters anywhere?*
>
> Jack: *In my classroom and in other classrooms, yeah, but I've not had time to read it cos I've been doing my coursework and that.*

10.7 Conclusion

This chapter has presented the findings of semi structured interviews with young people in the schools that participated in the research study. They were recruited using a purposive approach and were broadly representative of the school populations. However, the interviewees who did not use the Change Project were recruited for interview personally by the Project workers, so were likely to be more typical of students receiving support in school than other students who were not.

Some of the data suggested that being able to access help in school was a developmental issue, but other data implied a link with the schools. In each school, teachers were felt to be unreliable confidantes, and pastoral staff were felt on the whole to be trustworthy. It was important to be in control of a disclosure.

Interview data suggested that in Faithschool there seemed to be more risks involved in disclosing vulnerability to peers. In Sportschool, there was a more open culture of help-seeking, potentially attributable to the SEN team. Girlschool appeared to have a culture that was more open to discussing and acknowledging emotional difficulties and there was less shame associated with help-seeking.

Problems and difficulties clustered around home, school and the outside world. They were heavily interdependent. The way the young people talked about responding to problems suggested that they would be more inclined to seek help if personal, social and environmental conditions were met, that is, if they felt motivated and able to ask for help and were reasonably confident of a good outcome.

If a young person was not asking for help with a difficult problem, they would be likely to bottle up their feelings or take their frustrations out through aggressive behaviour. Anger and aggressive behaviour in school had several functions: it was a means of pretending not to care; it attracted a supportive peer group; it protected the privacy of the individual by deflecting personal questions; and it was easier to be angry than to be upset.

The interviewees tended to report that the Change Project was appropriate and accessible by those who used it and at least potentially acceptable by the other interviewees, though most of them knew very little about it. Self-referral was perceived as accessible by Project users and theoretically appropriate by others, as a means of preserving confidentiality. The recruitment of SEN and pastoral staff to be Project workers was strongly endorsed by the data, since they were perceived to be trustworthy and helpful, and familiar faces, consistent with the conditions suggested by the focus groups in the Consultation Stage.

Interventions were supportive, cognitive, behavioural and educational. Most Project users were very positive about having benefitted from them. The brevity of the sessions was identified as an area to reconsider because it prevented the more in-depth discussion that some Project users would have wanted.

Other ways in which the interviewees suggested that the Project could be improved included how the Project was promoted, identifying appropriate meeting rooms, and using telephone and internet technologies as an alternative to face to face contact.

The self esteem questionnaire was critiqued and suggestions were offered to enhance returns such as improving its appearance and phrasing.

In conclusion, the interviews with young people generated detailed and relevant data about the components of the intervention, including acceptability, implementation and access. The interviewees also revealed details about how the fear of emotional exposure was a major mediator of help-seeking.

10.7.1 Summary

- The view of the interviewees was that pastoral and SEN staff were suitable as Project workers.

- Most of the Project users reported benefits from receiving emotional support and using cognitive and behavioural strategies.

- Some were satisfied with the brief appointments while others felt the appointments were too short.

- The Change Project was perceived as accessible or potentially accessible and appropriate for emotional support in the students.

11 Method and Results of Interviews with school staff

11.1   Introduction

Having presented the findings from the young people's interviews, the results of interviews with staff will now be presented.

11.2   Approach to sampling

The approach to sampling was purposive as it was the intention to speak with a comprehensive range of individuals including pastoral and SEN staff involved with the Change Project, teaching staff, school nurses and senior managers. Most of the interviewees had roles that incorporated an amount of classroom teaching: in the table below their principal role is indicated. The sample included representation in key roles relating to the Change Project, but as with the sample of young people, interviewees were likely to have a prior interest in pastoral care or the Change Project Representatives of these groups were accessed and the sample profile is displayed in the table below.

It was proposed to interview a minimum of 6 Project workers, 6 school managers and 6 other staff in order to maximise the representativeness of the sample, i.e. 18 in all.

The researcher directly approached all 12 Project workers and 3 school nurses to be interviewed, of whom 4 Project workers declined, saying they felt embarrassed. Twelve other members of staff were recruited by personal contact. Four (2 from Sportschool and 2 from Faithschool) were recruited through personal letters distributed to all staff via the pigeon hole system in the staffrooms. Apart from the Project workers, no individual explained reasons for not agreeing to be interviewed. Some interviewees said they came forward because they wanted to talk with the researcher about the Project, and used the opportunity to give advice or ask for information.

Two senior managers who had been instrumental in agreeing to support the research who declined to respond to this approach were also approached by letter, email and telephone, without success. One was from Sportschool and one was from Girlschool. In total, 27 adults were interviewed (See Figure 17).

Figure 17: Sample of adult interviewees
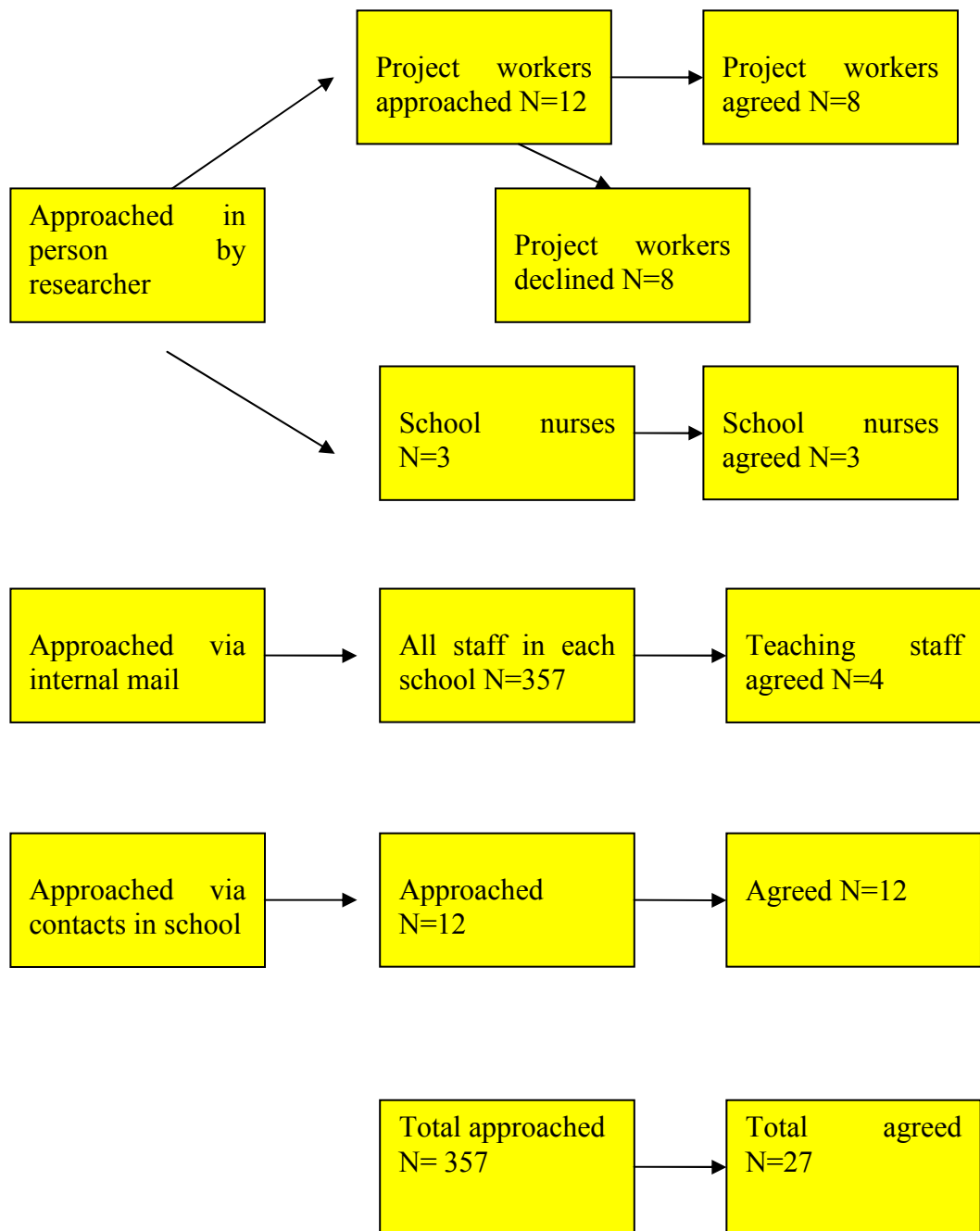
11.2.1   Approach to interviews

Interviewees chose whether to be interviewed individually or in a group. The Project workers in Sportschool and Girlschool chose to have a group interview because it was a more efficient use of their time. Where possible, the semi structured, qualitative interviews were delayed, to maximise the opportunity for the Project to settle into the school culture. All interviews took place in school and with one exception (Sylvester), were conducted in privacy, since the adults had better access to private spaces than the young people. These interviews took place concurrently with the interviews with young people and the development of the topic guide was informed by all interviews.

11.2.2   Addressing concerns about anonymity

Some interviewees expressed concerns about their comments being traced back to them. This was particularly common in Faithschool and several interviews included sections that were not recorded because the interviewee requested that the tape be turned off. Concerns about anonymity were addressed through assurances that the tapes would be labelled with codes rather than names, and identifiers would be removed from transcripts. In addition, the professional roles of individuals were pooled into groups of:

- Project workers (PW),

- Pastoral staff (including school nurses and pastoral managers) (PS),

- Teaching staff/managers (including senior managers) (TM).

Table 18 describes the sample of adult interviewees. Pseudonyms have been used.

Table 18: Interview sample (adults)

Role of interviewee	Faithschool	Girlschool	Sportschool	Total	Category
Project workers (PW)	2 *(Megan, Sylvester)*	3 *(Angela, Susan Kim)*	3 *(Harriet, Linda, Ruby)*	**8**	PW
Other pastoral staff (PS)	4 *(Owen Sally Frances, Jennifer)*	2 *(Judith, Wyn)*	3 *(Margaret, Maureen, Maurice)*	**9**	PS*
Teaching staff /managers (TM)	5 *(Daniel, Julia, Kate, Oliver, Pete)*	2 *(Derek, Jacky)*	3 *(Claire, Faye, Grace)*	**10**	TM**
Total	**11**	**7**	**9**	**27**	**-**

*PS= Project worker, pastoral staff, teaching assistant, or school nurse

**TM= Teacher and/or manager including senior manager

12 Messages from the interviews with school staff

The key messages from these interviews were perceptions of the range of difficulties encountered by young people; tension and ambivalence in the context of pastoral care; conditions for help-seeking; and the feasibility and acceptability of the Change Project. The interviewees also shared their perspectives on barriers and facilitators to help-seeking in young people.

12.1.1 Range of difficulties encountered by young people

There was a range of views on the level of problem or difficulty young people might be facing. This range of problems was similar to that identified by the young interviewees, and could be categorised in a similar way as pertaining to home, school or the outside world. Typical issues identified by the adults were: child protection concerns, bereavement, arguments at home with parents, falling out with friends, and bullying and name calling.

The brief appointments in the Change Project were felt by some to be appropriate for the age group and the type of difficulties they encountered:

I think it is actually functional to have short appointments and I think that generally, you know, the having short term and long term goals works very very well with kids this age.

(Megan)

12.1.2 Spectrum of severity

The adults' perceptions of the severity and impact of a problem differed from the young people's. Pete pointed out that many common experiences of young people were part of normal development.

I don't think there's going to be much new under the sun really. You know, the things that students are doing are the things that teenagers have always dealt with, anxiety about people liking them or not liking them because of the way they are, the way they look. It's gonna be the same… not much to do is there, it's not a smorgasbord is it, drink, smoke, have sex, I mean what else is there?

(Pete)

At the other end of the spectrum was the awareness of extreme stresses facing some young people. Serious situations at home included illness or death in the family, domestic violence, sexual or emotional abuse. Some interviewees talked in a general way about these issues and others had stories to tell with specific examples of these.

There are family issues, you know, divorce, separation bereavement, all of those things

(Julia)

It appears to me to be a high percentage of students who have, a parent's died, I mean, … people in this city die younger, …I think we have a lot of parental deaths, that's the only way of putting it.

(Jacky)

(There's) a house I visit a lot [on behalf of the school] …I was never too sure of the guy who was always in the house…and then (the mum) started having bruises… So she said, "I fell off me bike"… she looked very sheepish, and I think he was …behind the door…And within a day (she and the kids) had been lifted, (to emergency accommodation for) homeless families.

(Maureen)

Her issue was around her mum's illness, which she thought was terminal

(Wyn)

There was a very big court case not long ago in the city where (a student's) father got 14 years for rape, constantly, continually, over the years, ...of her, and other members of the family.

(Maureen)

However the interviewee quoted below described how these severe difficulties were not typical.

There's lots of girls who aren't happy with, with their shape…not girls with eating disorders, these are ordinary girls who just go, "God, none of my clothes fit", to the very serious things that are child protection issues and domestic violence and alcohol abuse, (either) the young person, or in the home. So that they're hugely wide-ranging, and I've got to say the most people that knock on the door are the very minor ones who … haven't actually got a very serious problem.

(Wyn)

12.1.3 Boundaries and cultural clashes

Boundaries were an issue that frequently caused conflict:

(This student will)kind of come and seek me out, and she just, she just chats really, she sounds off and tells me about, you know, problems that she's having with her mum, …it tends to be that they're just arguing about boundaries

(Sally)

There's a lot of, people who are having conflict with parents, there's an awful lot about that, there's even supporting some young people who've moved out of the family home.

(Margaret)

Boundaries issues could reflect a cultural clash between home and school, as described in this example.

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Culturally people have their own, you know, ideas about being respectful in society, and how, how somebody should present themselves…and a good woman would go home and stay in the house…but yet we send them to this school…all these PSHE [personal, social and health education] classes… that are challenging perceptions and feelings, and then we just send them home!…(And) then they come back in here and say, "but you said I should pursue my dream, and I should this, that and the other, but I go home and I'm not allowed to watch the telly"…(Although) it's done in a spirit of protection and love.

(Wyn)

This type of problem could become serious for young people.

In severe cases it can be, emotional abuse, that you know they are kept in the house and you know their books are censored, their TV programmes are censored.

(Wyn)

Although boundaries could cause unhappiness or conflict, lack of them could also be seen as a problem, because young people were felt to need guidance.

One of the other things is…that has an effect on them is…is parental control or lack of parental control. I think the setting of boundaries and…for instance, I mean the number of them who go to bed really, really late …

(Julia)

12.1.4   Perspectives on the impact of emotional difficulties

The young people named peer relationships as a very significant issue that coloured other experiences. The adults acknowledged this but also were aware of the transience of some of these problems.

They come in, in the morning, and they hate somebody, and by lunchtime they've got their arms round one another.,

(Jacky)

Teenage problems, okay, ...there's I mean, there's the boys, obviously, and a lot of the girls falling out with each other, a lot of it is peers actually, and Miss I don't want to work, because she's going to be in the lesson, and she said this, and she said that

(Angela)

Adults were empathic with the perspectives of young people, including the impact of apparently superficial problems and the connections with underlying difficulties.

Sometimes it will seem trivial to us, but of course it's not trivial to them at the time, is it?...You can have a big spot on the end of your nose, and that's the end, you know, that is the end, isn't it, you've got to come in and face everybody, and people are laughing, and all that kind of thing

(Jacky)

Sally: *I've got one boy who comes to see me and he said that he'd been sick early in the day, and it turned out ...the family had suffered a racial harassment and they had to move from where they were living, into homeless families accommodation,*

SK: *So are you saying that it was probably psychological why he was feeling sick?*

Sally: *Yes*

12.1.5   External social influences

It was acknowledged that some students had serious and complex problems which were often hidden. In addition to family problems, there were other, overarching influences seen to be acting on a young person's attitude to school, such as parents' experience of schools, wider social and historical influences and prejudices in the local communities, which caused conflict and bullying in school.

Gay people have a horrendous time in (the local community) ..., the children in the school, you hear them say appalling things about gay people, and you tackle them about it, and they won't even listen to you.

(Maureen)

We sometimes here in this school have angry parents, who are angry about their own experiences, and that has repercussions on the children sometimes. one kid told me the other day, 'the teachers are my enemies'.

(Frances)

12.1.6 Communication difficulties

Communication was seen as a difficulty. One student had had a health problem he was too embarrassed to consult his GP about, and had needed support to rehearse how to explain it to the doctor.

I said, just practice saying it to yourself, I said, it really is no big deal. So he went to see the doctor, and came back and said everything was fine,

(Margaret)

One interviewee described how a student's inability to explain a problem had resulted in her being excluded.

The student completely lost, lost her temper, lost the ability to communicate what she'd actually wanted to say …and ended up really abusing a Senior member of staff on the corridor… without ever actually communicating the fact that what she needed to do was talk to me because there was an issue in (the classroom). (And she) was excluded for a day.

(Judith)

One member of staff explained how communication difficulties could also potentially harm friendships For example, students who fell out with their friends might not know what to say to mend the friendship.

…falling out, feeling lonely, don't know how to say sorry, don't know how to say, you know, I wish I'd not said I wasn't your friend, because actually I do want to be your friend.

(Wyn)

Even where a young person seemed to have effective communication skills and a good relationship with a trusted adult, extreme stress might remain hidden for years. The interviewee quoted here was talking about her horror that a pupil she had supported in school for 6 years had not confided in her about being sexually abused during this time:

Where did I go wrong, you know, and I keep questioning myself, and what I could have done, I could have got her out of that misery, couldn't I? Long ago!...we think that we have got such a professional relationship with a pupil that we would be the first person they would tell; that's not necessarily so.

(Maureen)

Nonetheless, it was acknowledged that not all problems were serious. There was also a view that the impact of some problems might be exaggerated by the young people. One interviewee with teaching and pastoral responsibilities felt that help-seeking merged sometimes with attention-seeking:

We have students who, any attention is better than no attention at all ... I think they feed off any attention they get.

(Jacky)

Another talked about the way that a 'drama' can add to the status of an individual:

I sometimes think they get carried away sometimes with the drama of having this thing, you know, you, that in itself makes them quite interesting and popular for a short time, however long that might be,

(Wyn)

12.1.7 Tension and ambivalence in the context of pastoral care

Although the Change Project was fairly well received, the numbers recruited were modest compared with expectations based on preliminary discussions with pastoral staff in school. When this was explored with the interviewees, an ongoing debate about pastoral care in school was revealed. Emotional support was seen as important to learning, but there were various views on what the relationship between the two should be, and how best to deliver it.

12.1.7.1   The wrong kind of pastoral care

Some felt that pastoral care could be used when there was no real need. One form tutor said that she felt over-promotion of the Change Project could lead students to think that they were supposed to have a problem.

I have told my form and my classes about the Project, I have promoted it, but then I thought you could promote it to the point that they think they must have a problem that needs sorting out.

(Faye)

In Sportschool, The Change Project was seen as a suitable model of emotional support. One explanation was that the timing of appointments was seen to have removed their appeal as an alternative to attending classes. At Sportschool a previous resource with an open door policy was thought to have been abused by students, who would use it simply in order to get out of lessons.

There were lots of children who just saw it as a, a skiving option. … I think [in the Change Project] you've really got the genuine children who want help here, rather than those who just want to get out of a lesson for an appointment to, and so forth, so I think it's done that filtering job.

(Grace)

Ruby	*I think a lot of them went because it was…*
Harriet	*yeah, time out of lessons*
Linda	*Yeah, a lot of that was abused, an awful lot of that*
Harriet	*the ones you've got coming now (to the Change Project), they're the genuine ones, because of the time frame of it, I think*

The potential for misuse of pastoral care by students was a particular concern to some, but not all, of the staff. One felt that staff who complained about students using the mental health facility as an excuse to get out of lessons were missing the point:

(The school mental health worker) had an amazing clientele, and sometimes they were there because they were dodging the lessons, but a lot weren't… say she had 100% attendance, and it was abused by 25%, the rest…were getting a lot out of it, and they were going home feeling much better about themselves.

(Maureen)

12.1.7.2 Prevention or promotion of dependence

Another issue in the provision of pastoral care was the potential for creating dependence, which several adults were sensitive to. Again thinking about the service provided by the school mental health worker, a member of the pastoral staff at Sportschool explained,

I think there were a lot of things held onto for too long…almost like babysitting, a lot of day to day support but not enough plan of action… There was some work, but there was an awful lot of the children keep coming, and they, there was, they created a dependency on her then, which is, not what you're supposed to do. You're supposed to enable the young person to learn… and move on

(Margaret).

However, while not all problems were complex, it was generally agreed that many required a lengthy intervention which the Change Project did not offer.

Staff in the other schools were also mindful of the value of encouraging independence in the students and the dangers of not doing so.

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I mean really and truly (my) job is to make yourself, not so the students rely on, the opposite way round and we're sort of leading them to independence, we should be trying to put ourselves out of a job, that's how somebody once put it to me, and that is the way that we should do it.

(Jacky)

In the end it is the counsellee, or the mentee, who's got to pick up their bag and walk with it; it's not the mentor or the counsellor who can carry the other person's baggage

(Oliver)

12.1.7.3 Questions about the purpose and extent of pastoral care in school

- Level of support

Views about the purpose of pastoral care were somewhat divided over the question of whether it was there to support learning or to support young people. This was particularly noticeable in Faithschool. It was linked with awareness that it was impossible to address every pastoral issue. The dangers of opening up to all sorts of problems seemed to be frustratingly obvious to the interviewee quoted below.

Twenty five years ago …I had 100 and something odd students…there was no pastoral assistants …it was me, and I dealt with it. Now we've moved on a long way from there, and it's a continual process of more adults, more people being engaged, more recognition of problems, and we get fed in a lot more problems… I have to make a decision on, does the school deal with this, this could take out teachers away from doing their job of teaching, And it's that balance all the time. …we start interacting and trying to solve problems that are not actually in the classroom or the environment, environs of the school.

(Daniel)

Although many staff appeared to feel that there was no natural limit to the demand for pastoral support, a boundary could be set by positioning emotional support below teaching in the hierarchy of functions of a school.

There is a sense in which pastoral care, ...if its oversight is taken away from teachers, it just becomes the be all and end all, and I would suggest that maybe there are times when that happens, I mean I think it happens here, there's I think there's a boy who, there's too much care and not enough "get yourself in the classroom and learn", going on, you know.

(Oliver)

Alternatively, pastoral staff at Girlschool pointed out that they might stay at school until late, precisely because of the limits to social services functions.

Say it's a C.P. (Child Protection) case that I've picked up at twelve o'clock lunchtime, and we're still sort of trying to get people, social services to come out, we could still be here until 7 o'clock with that particular student.

(Judith)

Nevertheless the need for extensive support for students was keenly felt.

I just think, I mean this is very much a personal view, that schools, and I'd say this school, we don't really, we're still not acknowledging the core problems, that we're still not prepared to say, "yes, young people today need more support than we're actually offering and giving them".

(Julia)

- Measuring outcomes of pastoral care

The interview data provided some insights into the interviewees' views on how pastoral care could be evaluated. There was some agreement that it tended not to be evaluated well. Measureable outcomes included a good Ofsted report, retaining challenging students in school, or increased resources for a pastoral team.

Less tangible results were the facilitation of independence, as discussed above, or a sense of improved wellbeing in a student. This last outcome could be contentious as for some pastoral staff subjective wellbeing might be achieved by helping a young person shift from introversion to extroversion through improved self awareness and understanding of a problem; therefore a depressed student could become angry, with management repercussions for the school.

I suppose, one of the things that you look for is that something's shifted, some feeling's shifted, someone perhaps who presented as really depressed and quiet, might leave therapy more angry, and teachers might say oh, that person's much more boisterous in lessons now, we'd see that as a positive thing…But you couldn't say that what we look for is less angry, or a happier child, because it doesn't always result in that.

(Owen)

- Appropriateness of school as a location for healthcare.

Some staff felt that young people were likely to benefit from more comprehensive health services in schools, sexual health being a common theme:

I go into the SRE (Sex and Relationships) lessons…then I talk very much about, you know, the young person's clinics, where they can go, that they can go to for advice, information of contraception

(Margaret)

Angela: I did sex education with them last week…

Susan: Is that where you put the condoms on, did you do that one?

Angela: No, didn't use condoms, it was just a talk… (The school nurse) did the condoms in here and I did the talk in there

However expanding school healthcare could have its own problems:

There was a news item yesterday about a school … on 350 occasions they gave out the morning after pill…you have to ask the question, was that so health-driven, that actually, the education side of it, the learning side of it, was being neglected?…actually what are we teaching these children, you know, do these girls know how to protect themselves, how to say no, how to care for themselves?

(Oliver)

- Balance of teaching and pastoral activity in school

Some staff in Faithschool talked about conflicting views about whether school was an appropriate point of access for sexual health advice:

There is kind of two, two mindsets, definitely, within the school, those that are all for Projects and you know allowing pupils to access different services and ...I will say it's a more kind of old fashioned way of thinking ...I don't think that the, that second group kind of look at the bigger picture really of what's going on, with the young people.

(Sally)

There's this conflict of interest and the fact that you know "we've got to keep up our academic achievements!" We would be able to keep them up, you know, at the expense of the students' health and wellbeing.

(Julia)

Some interviewees said they knew teaching staff who resented their growing responsibility for pastoral care, but the majority view appeared to acknowledge that pastoral work was part of the job of anyone who worked in a school. Pastoral care was an overarching theme which was essential to teaching and learning.

I think it's really not, "we do pastoral and we do something else"...pastoral care tends to be the umbrella for lots of other things, so it wouldn't be done separate from that.

(Derek)

Teachers need to be kept in the loop so if a child has come into school after a really difficult time at home, they don't just get "why aren't you wearing your school shoes?" straight away. Schools used to be just schools, but those days are gone.

(Faye)

Setting limits to the extent of their pastoral responsibilities had practical and philosophical dimensions. As pastoral care was seen as helpful to learning, there was agreement that it should be provided, but its purpose, extent and mode of delivery were not fixed.

- How to deliver pastoral care in school

There were two principal modes of delivering pastoral care: by integrating and embedding it into the school culture or through delivery alongside the mainstream teaching and learning activity. As shown above, some thought it was not helpful to separate the two strands. Where they were viewed as separate, as by many Faithschool interviewees, the pastoral care might have lowered status within the school. It seemed that the view in Faithschool was that the management of pastoral care needed to be in the hands of a teacher, because they understood behaviour management and would maintain a learning-orientation to pastoral targets-

> *I think the person with responsibility for a year group, or a number of year groups, needs to be a teacher…I think that the pastoral system within the school needs that learning- driven leadership.*
>
> *(Oliver)*

The status of pastoral care and pastoral staff seemed to be higher in the other schools. For example in Girlschool, pastoral care was a separate faculty:

> *We are held in sort of equal status with other faculties, the Humanities faculty for example, and the English faculty and the Foreign languages faculty.*
>
> *(Judith)*

In Sportschool, the high status of pastoral care was expressed through the appointment of pastoral staff to senior management positions.

> *Two heads of year are pastoral, non teaching. We're very lucky*
>
> *(Faye)*

Attitudes to the pastoral staff seemed to reflect the status of pastoral care. All the Project workers talked about lack of time to operate as they would wish in their pastoral or support roles. Sportschool and Girlschool Project workers said they had been invited to attend emotional literacy or counselling training, while some Faithschool pastoral staff said they were in need of training that was not available.

There's a lot of pressure on us in terms of time and the amount of children we need to see, the fall outs, and the things that are disclosed to us, there doesn't seem to be any training.

(Faithschool staff[11])

There was always a tension between being available for the students and taking time out for professional development, but it seemed greater in Faithschool. As a member of staff pointed out, the pastoral care in the school relied on the availability of large numbers of pastoral staff

How effectively we're meeting their training needs I'm unsure, especially, largely because what we want them to be is here in the school with children…we've always gone for numbers… many of them I don't think are paid on the same rates as a mentor in another school would be, but we still attract people

(Faithschool staff[12])

It was generally acknowledged that pastoral care required a long term approach. This had implications for research and other Projects with a limited life span. Therefore short Projects might not achieve much and could be frustrating to staff and students.

Schools often lacked appropriate pockets of time or space to deliver pastoral care and there was a corridor culture in each of the schools, in which pressurised staff with heavy workloads and little time would quickly approach students on their way to lessons, to check how they were doing.

Susan: *But it's hard for us as well because sometimes we're rushing to lesson, we haven't got time,*

Kim: *Yeah 'cos you almost feel like sort of guilty, don't you, you want to sort of help, the person on the corridor, don't you*

Susan: *Yeah, you think, ah, I should have spoke to her*

Kim: *But then you're kind of running to help, to assist the kids at school*

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[11] Sensitive information therefore detail suppressed

[12] As above

Finally, the limitations of skills among staff caused concerns. One form tutor said there was a lot of homophobic bullying in school which the form tutors were expected to deal with, though they had not received training for it and might not have the strategies for it (detail suppressed). However even where training had been offered it was not always a success- Project workers in Sportschool and Girlschool talked about resistance to emotional health training. For example, pastoral staff in Girlschool had objected strenuously to sessions they had been asked to attend:

> *(It was) a bit of a counselling group for staff for our team…everybody was against it, … They were like, "we're not, we don't want people to know out personal business" and all that, and all it was, was getting work off your chest, worries about work…it was brilliant…emotional literacy sessions… (but) a lot of them kicked off in our office.*
>
> *(Girlschool staff)[13]*

Senior managers admitted that they needed the pastoral staff to be available for the students, and therefore the development of their skills through training or participation in the Change Project or similar initiatives could not be a priority. School nurses expressed worries that pastoral staff did not have adequate skills for the responsibilities they were given, and several staff felt that staff should have supervision to support them in their pastoral roles, as in the quotation below

Faithschool staff[14]:	*I have a lot of meetings with teachers and pastoral staff, where they'll informally come and ask for advice on how to deal with a child; I don't do any formal supervision for pastoral staff…*
SK	*Would you see a need for that?*
Faithschool staff:	*Yes, a massive, massive need… That would be a useful use of my time, I think.*

---

[13] Sensitive information therefore detail suppressed

[14] As above

12.1.8   Barriers and facilitators to help-seeking: Conditions affecting the implementation of the Change Project

There's so much going on …you see, in here, in this school, we've very, very complex phenomena… You're dealing here with very deep rooted, not just personal issues, but structural issues as well…

(Frances)

Aspects of how the Change Project had been implemented were discussed in the interviews and in the process, broader points about implementation of Projects in school were raised by the interviewees. An overarching theme was the necessity for the school to take a Project on wholeheartedly with interest and commitment at every level in the staff hierarchy.

Some of each interview addressed the interviewees' views on how the Change Project had worked in their school and this extended into broad ranging discussions about influences on help-seeking in young people.

12.1.8.1   Age and gender

The data from some interviewees suggested that there might be gender and age differences in attitudes to help-seeking: that while younger students might not have the skills to recognise and communicate a problem, older students and male students might feel more inhibited in this regard. For example, a member of pastoral staff said,

I have found the boys tend to come to see me the younger they are. Once they get into, say, if they're in Year 7,8 and 9, I would see more boys, but it's the Year 10s and 11s who, who I don't see very often.

(Sally)

However it was more common for the interviewees to identify age as a factor in attitudes to help-seeking. Self-awareness, communication skills and health information were felt to be key:

I think the younger ones need more help identifying that they've, that they've got a problem… or (realising) that you can get help, you don't have to feel like that

(Margaret)

One Project worker summarised their view of the relationship between development and feelings in young people:

Well I think, you know, in Year 7 and 8 they're sort of, they've come to High School, and most things were a joke, and most things you don't understand … what's happening to you, and you know the culture is that kids take the mick out of each other. And then the hormones kick in, and then the moods start, and decision making is changed. And sometimes it becomes a bit more irrational, and, and everything's a lot more serious. And then once you actually mature a bit more, and they come to be happier with themselves, or at least they come to a plateau where they start coping with the way that they are, their attitude changes again.

(Megan)

12.1.8.2   Peer approval

The influence of a young person's peer group was thought to be a more likely barrier than facilitator of help-seeking, since as one interviewee pointed out,

Adolescents function through peer recognition, peer approval, it probably isn't cool, is it, to ask for help, particularly for boys.

(Frances)

12.1.8.3   Familiar territory

Many adult interviewees said that as long as a new Project felt strange within the school culture, students would be wary of it. Many said that, to be properly used, the Change Project would have to keep going for long enough to become a normal part of school life.

I think the job now is to embed it into the school culture. (Grace)

In relation to how the students usually responded to initiatives in school, a sentiment expressed quite frequently was the importance of familiarity. A familiar face and a well-trodden path were considered important facilitators of help-seeking. Like other initiatives, the Change Project was

> *...the unknown, and none of us really likes the unknown, you want somebody who's sort of (trodden) on that territory, and to tell you that it's all going to be all right.*
>
> *(Jennifer)*

One of the cultural aspects of schools was the constant stream of information being distributed, so much that it could be difficult to interpret. One interviewee proposed that students might be confused about what the Change Project was, which reflected the confusion about it expressed in the questionnaire and interviews with students.

> *I think what sometimes may be a little bit disconcerting or maybe a little bit confusing maybe ... is that, you tend to get a lot of things coming from different directions and I think, you know, they need to know it's the one they should go to, it needs to be a very proven path.*
>
> *(Derek)*

12.1.8.4 Importance of a Project champion

All the adults agreed that an emotional wellbeing initiative like the Change Project needed a champion in a senior position with power and leadership qualities that could be harnessed to galvanise support for the Project. The impact of a champion was felt most strongly in Sportschool, where a senior manager had positioned themselves as a point of contact for the researcher, and at the time of the interview was already thinking of ways to link the Change Project with the curriculum:

> *(The Change Project) could go further really in a school, you know, work with the Heads of (departments), and you could do modular packages.*
>
> *(Grace)*

In Girlschool and Sportschool the enthusiasm for the Change Project was carried by a number of people in pastoral, teaching and management roles. In Faithschool the initial welcome extended to the Project by the school cooled off when a senior manager's role 238

changed. After this the manager could no longer actively champion the Change Project, and explained later, in the interview, that there had been cultural changes within the school so that the Project was perhaps no longer seen as fitting the school's new ethos.

When this Project started, I had responsibility for personal and social and health education…but I've not had that for the last while. …I just sense that there's been a shift and perhaps a worry that if you say, "oh yeah, we've got problems", that, you know, "our students have issues", they have concerns that somehow it's showing that we are in some way weak, which I think is really sad.

(Faithschool staff[15])

Another interviewee from Faithschool endorsed the view that losing the Project champion had created an obstacle for the Change Project:

I think that within the school I think you'd probably need that kind of leadership for, for Projects to, to take off to be honest.

(Faithschool Staff[16])

12.1.8.5   Inclusion of teachers in the referral process

Many interviewees felt that teachers needed to be involved in the Project to the extent that they understood what it was, how it worked, and could refer or steer students towards it where they felt it would be helpful. One of the Project workers explained why this mattered:

I was quite disappointed … about it being non-referral [i.e. third parties could not refer]. Because I thought, you know, there was loads of kids who I've thought, oh they'd benefit well from this, so well, you know…a lot of kids …they have not got them skills, to actually self refer…(they) lack basic life skills, like you know making a cup of tea…being able to write their address on a letter.

(Sylvester)

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[15] Sensitive information therefore role of interviewee not revealed

[16] As above

Sylvester's report above reflects a faithful interpretation of the Project referral protocol, though interviews with Project users indicated that in each school there were Project users who were encouraged by adults to attend the Project. Most felt that self-referral was a particularly beneficial feature which would empower young people and help them to understand their own emotional needs. Others believed that it was unrealistic to expect many students to be able to self refer because of the various developmental and cultural barriers to help-seeking. A third set of views clustered around the idea that, since the action of self-referral required a person to have already overcome those barriers, they would be:

> *...quite a long way down the road to recovery at that point...If you know you have a problem you're quite a lot better off than people who don't realise they have a problem*
>
> *(Pete)*

Several interviewees pointed to active self-referral and open referral systems in school as a good model operated by school nurses, mentors and therapists.

12.1.8.6   The importance of timing

As there were always competing demands for scarce resources in schools, a Project that met an identified need would have better support within the school. Despite the large pastoral team in Girlschool, it was widely acknowledged that the pastoral faculty was under-resourced and therefore Project was welcomed as an additional resource. The recent departure of a mental health worker from Sportschool had left a gap in emotional support for students that, it was perceived, the Change Project could fill. In contrast, in Faithschool some staff felt that the extensive pastoral system already provided an appropriate level of support, while others suggested

> *I think it'd be very useful if people are equipped with [coping strategies] for life, so ... they can manage to re-frame their thoughts. To me, I'd be interested in giving kids a package to take away with them in their relationships.*
>
> *(Frances)*

It was agreed that the timing of a Project launch would affect the impact it would have on the school culture. Starting it at the beginning of the new school year would embed it in the culture, since teachers were more receptive to new information then. The duration

of a Project was also influential because initiatives took a while to take off and short term projects were inherently frustrating because they were perceived as liable to close down just as they were beginning to be known and used.

If you were setting up a project ...you would need funding, and you would probably have to get it from the Education Department... And you may have it for a while, and then you'd be a provisional service, and then (with the LEA) cutting back on this, cutting back on that, you'd be here one day, gone the next day... And that, that's the type of situation with projects. So when one's got a crisis, of a child, leading to permanent exclusion, and you want to find them a place outside in sort of a special school type of situation, nobody knows, because the funding's been withdrawn from this one, given to that...drives me potty.

(Daniel)

12.1.8.7   Setting the stage

Several interviewees felt that it was important to prepare students for a Project like the Change Project, by working to raise both emotional literacy – self awareness and the ability to communicate feelings effectively- and the profile of the help on offer. One suggested classroom sessions could deliver a low key health education activity to raise awareness of available interventions:

People could come in (to classrooms) and do a little talk

(Kate).

12.1.8.8   Quality of help offered

The school nurses were sensitive to the need for emotional health work to be carried out by people with appropriate skills and attitudes and each one expressed their that the pastoral skills of school staff, including pastoral staff, varied considerably. However they were not mental health workers themselves and were open to the potential of GSH delivered by unqualified, but suitably trained, Project workers. As the Project workers were not trained in health care the school nurses were reassured by the screening process in the Change Project, because it directed students with a positive screening outcome to them for assessment. They worried about some of the individuals who were providing such care₂₄₁

in the schools without adequate training or supervision, since it might not benefit the students. Another implication of this point was the suitability of buddy schemes to support students. It was suggested that peers might not have the emotional maturity to fulfil the role and one individual gave an example of the potential for abuse of vulnerable peers.

One of our pupils (peer mentored) another girl, and actually it sort of came out about her, you know, being gay, and her life was virtually destroyed for months, because of how the other person used it…I think the children that are mentoring cannot be expected to carry a powerful burden

(Maureen)

12.1.8.9   Capacity of school to host emotional health work

It was generally agreed that as well as skills, emotional health work required time and space. No Project worker felt that they had had enough time to fulfil the role as they would have liked to. In Sportschool, ring-fenced time was available for the Project, but Project workers in Girlschool and Faithschool said that their pastoral colleagues had expressed concerns that this role prevented pastoral and support staff from spending time in their primary role.

We're there basically to support the students, and [the Change Project] is taking time off the students,

(Angela)

Location was important. Some of the adult interviewees felt that it was critical to provide a private environment, including the area outside an appointment space. Others felt the arguments in favour of openness were more powerful. A third group seemed not to acknowledge the significance and risk, to young people, of being seen to access emotional help.

12.1.8.10   Potential extra benefits

The Change Project was believed to have the potential to offer, not only direct benefits to students, but also benefits to staff, school culture, and for Sportschool, its reputation. Some Project workers felt that through the Change Project training and supervision they had

learned skills to enhance their pastoral role, and had gained variety in their work. Some teaching staff felt the benefit in terms of feeling they had somewhere else to direct students they were worried about. Skill deficits among teaching staff and form tutors could be addressed both by providing an extra resource and also by the opportunity for skill sharing that the Project presented. Theoretically this could influence the school culture and it was agreed that the Change Project had achieved this in Sportschool.

Finally, the school could benefit politically because the Change Project could help it to meet emotional wellbeing targets set by the Healthy Schools award scheme.

12.1.8.11   Structural factors impacting on the Change Project

Many of the school staff talked about the impact of pastoral structures, such as the individual below who communicated that there was some tension between pastoral and disciplinary functions.

> *The Head prefers to have a direct handle on excluded (students), so from, it's like the*
> *discipline side of the welfare system …that cuts me out.*
> *(Faithschool staff[17])*

Several interviewees expressed that internal politics could affect pastoral care and funding:

> *There's power things going on all the time, (one member of staff) tended to grab*
> *more resources for Year 7 than the rest of the school put together*
> *(Faithschool staff[18]).*

It was evident that some staff felt frustrated by some of the internal structures, but there were also several who seemed pleased with the school pastoral systems, particularly in Sportschool and Girlschool, where pastoral care had high status. Nevertheless, the gaps in provision for young people outside school concerned staff. In Faithschool a member of the teaching staff talked about a student who was

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[17] Sensitive information therefore role of interviewee not revealed

[18] As above

...at the school gate every day, we've excluded him, he hasn't got anywhere as far as I know

(Daniel).

Service limitations appeared to cause considerable stress and difficulty for schools and the ability of statutory services to fulfil their roles was called into question. Some school staff discussed frustrations arising from poorly funded, planned or delivered social and health services for young people. In Girlschool a senior member of staff recalled waiting at school with a student whose local authority care arrangements had broken down, until the duty social worker could attend to her.

(If) the Social Worker (says they) finish at 4.30 p.m. they (really do) finish at 4.30, (whereas) I, say it's a C.P. [child protection] case that I've picked up at 12 o'clock lunch-time, and we're sort of still trying to get people, Social Services to come out, we could still be here until 7 o'clock with that particular student.

(Judith)

12.1.9   The Adult Perspective: Summary of Chapter 12

- Developmental issues were thought to affect the ability of the students to use the Change Project.

- Tensions concerning the purpose and role of pastoral care concerned whether it had a central or supporting role in school.

- Interviewees reported that student difficulties ranged from mild, transient problems to extremely adverse personal circumstances.

- There was more ambivalence about pastoral care in Faithschool and Faithschool pastoral staff reported less training and management support compared to the other schools.

- Difficulties with the Change Project included: inaccessibility of the referral system, limits of time and space for delivery by Project workers, and brevity of appointments.

- Brief appointments were also considered appropriate for the context of young people in high school.

- Benefits of the Change Project included: the structured approach, the timing of appointments and the filtering effect of the referral system.

12.2   Conclusion

A range of individuals were consulted on issues relating to the Change Project. They included young people who had used the Project, some who had not, staff who were involved in it and staff who were not involved in it. All the interviewees had views on the processes of help-seeking in young people, and the influence of peer norms and the school context.

Young people's perspectives tended to focus on the internal and structural factors affecting help-seeking. In school contexts, there were strong social pressures within the peer group and fears about being emotionally exposed by revealing a problem, and possibly losing face in the peer group, were perceived as the central barrier to help-seeking. Therefore the acceptability of the Change Project was related to this. The Project users identified245

that being able to access the Project independently, and confidentially, encouraged them to use it.

Adults were more likely to see help-seeking behaviour in developmental terms. A specific aspect of the Change Project that some adults suggested reviewing was the self-referral system. There was a widely held view that young people lacked the competence to initiate help-seeking. Though they acknowledged peer pressure, the adults did not place as much emphasis on it as the young people.

Both young people and adults appeared to be satisfied with the involvement of the pastoral staff as Project workers. The young people tended to express that the pastoral staff, and hence the Project workers, were empathic and trustworthy. The Project workers themselves had reservations about their capacity to fulfil the role, but did not have concerns about their competence to do so.

The implementation and support for the Project varied between sites. Views on pastoral care can be summarised as seeing it in a central or a supporting role. In Girl school and Sportschool it was a central part of school life but in Faithschool there was a degree of ambiguity amongst the staff as to the proper extent of the pastoral role of the school. This appeared to have caused some confusion in the implementation of the Change Project and may have been detrimental to its successful delivery. For example, each school had a nominated Deputy Head Teacher who championed the introduction of the Change Project into the school, but in Faithschool this individual's role was changed and the Change Project was no longer in their remit, and was thus implemented without their support.

Table 19 summarises key differences between the schools, with regard to the implementation of the Project.

Table 19: Implementation of Change Project in 3 schools: summary of key differences

Factor affecting implementation	Faithschool	Girlschool	Sportschool
Attitude to contribution of the Change Project to the pastoral care in school	Mixed views on how to meet emotional needs- organic growth and driven by charisma	Shared view that pastoral care should be comprehensive- team is under resourced for the work	Perceived gap in provision which CP fills
Context of pastoral team	Pastoral team: no time, enthusiasm ++, low status? No voice, not supported, confused line of management	Enthusiasm, not time, high status (pastoral faculty), high level of need, complex interventions, under-resourced	Enthusiasm++, high moral, supported, have an hour a day, have a voice
Is pastoral care integrated into the whole school culture?	Not integrated with the other work of the school	Culture of integration: ethnic, pastoral/teaching, shared values	Pastoral and education integrated
School leadership	18 months ago new HT appointed, new ethos, focus on image.	New HT appointed during Project after period of instability	Stable leadership. School undersubscribed; due to close (will be an academy)
Support for Project from a key individual ('Project champion')	Project champion moved from PHSE post Not championed thereafter	no champion in senior management promoted by school nurse, SENCO, pastoral team	Championed at all levels
Impact on pastoral care- interviewee perspectives	No impact on pastoral system	Slightly enhanced pastoral system	Definitely enhanced pastoral system
	Materials good	Materials used	Materials excellent
	Method good	Method: mixed reception	Method good
	Not viable:	Sustainable in theory	Sustainable
	Not enough time	Not enough time	Pressure of time
	Doesn't fit school management ethos	Fits ethos	Fits ethos- healthy school award
	Doesn't fit pastoral system	Doesn't fit pastoral team's system	Adds to pastoral system
Comment	Split between party line and values of individuals	High level of complex social needs.	Small size of school and good communications

13 Methodological discussion

In this chapter the application of the MRC framework to the research study is considered, followed by a discussion on strengths and limitations of the methodology.

13.1   Application of the MRC framework

The MRC framework steered the development of an appropriate design for the each research question. The study was divided into 3 parts using the MRC framework as a reference. These were: a consultation study, a development study and an Implementation study. They corresponded to the first 2 Phases of the framework.

13.1.1   Consultation Stage

The Consultation Stage was used to explore the potential of GSH to form the basis of a school-based intervention, which was initiated from experience of using it in adult primary mental health care. The MRC Framework advocates preparing for the development of an intervention through information gathering from theory and context (MRC 2000). This was addressed in a consultation process incorporating a literature review, information gathering from professionals in the field, and a series of focus groups with young people.

The approach to a review of the literature was influenced by the breadth of the areas of interest, which included: prevalence of mental health difficulties in children and young people, health policy, education policy and children's policy in the UK, health interventions in schools, emotional wellbeing strategies with young people, psychological interventions with young people, and self-help approaches. Literature was reviewed systematically. With insights from the present study, it would be possible to identify more focused areas to explore, which could include material beyond the scope of this study such as academic papers in languages other than English.

In addition to the academics in the advisory group, many of the education and health professionals who were consulted as part of the information gathering could provide perspectives on local issues and local high schools. This facilitated the processes of understanding current concerns and gaining access to schools, but further development of

the Change Project would require a thorough knowledge of these issues from other perspectives, such as between different regions and across the UK.

Focus groups with young people were conducted in the same schools that eventually hosted the Change Project and generated knowledge to inform the development of an intervention to promote emotional wellbeing, which was suitable in those schools. A broader understanding of young people's views would be afforded by conducting focus groups in other parts of the UK, and other methodological approaches to consulting young people could also be considered.

By the end of the Consultation stage, information had been gathered to support the development of an intervention which could be piloted in high schools. The MRC Framework emphasises the relationship between the research question and the existing knowledge. At this point, it provided guidance to limit the expectations from the research study to an evaluation of feasibility and acceptability of a pilot intervention, appropriate to what was known so far about the components of the intervention.

13.1.2   Development Stage

During the Development stage the results of the consultation process were applied to development of an intervention and evaluation strategies. Complexities included principles of working with young people, the potential influence of the school setting on the research process, appropriate adaptation of GSH for use with young people, the inclusion of pastoral staff as Project workers, and developing the necessary relationships with key individuals on each site. At this point, relationships between components were starting to be identified, consistent with the MRC Framework (MRC 2000). For instance, due to lack of capacity on the part of the schools, in each school the initial training programme for the Project workers was reduced from 2 days to less than half a day and the implementation of the Project was delayed. From this example, the lesson was learned that in a future study the school would need to clarify and commit to a mutually agreed amount of time for this crucial component of the intervention.

The evaluation strategy included development of a questionnaire, aimed at students not involved in the Change Project, and focussing on aspects of the implementation process and the acceptability of the intervention. An outcome measure (the RSES) was

incorporated into the intervention to measure changes in self esteem in Project users. In-depth exploration of feasibility and acceptability was conducted using qualitative interviews.

13.1.3   Implementation stage- interviews, survey and self esteem questionnaire

The Implementation stage was an opportunity to implement and observe the impact of the Change Project as a whole and its individual components. The recruitment to the Project was lower than expected on the basis of preliminary consultation with school staff, and therefore help-seeking processes in young people were explored in the interviews. Qualitative interviews with young people and school staff, including both individuals who had used the Project and who had not, allowed these questions to be explored and generated rich data about their perspectives on the Project and barriers and facilitators to help-seeking in this age group.

13.1.4   Contribution of the MRC framework to the research

The MRC Framework (Medical Research Council 2000) has been subject to recent reviews which proposed an increased focus on the context of interventions: context acts on theoretically understood research design and intervention mechanisms; therefore context may be key to understanding the intervention's impact, whether positive or negative (Campbell et al. 2007, Craig et al. 2008). To understand the action of a complex health intervention it is necessary to explore the impact of context and research design on outcomes and this thesis has attempted to describe relationships between research context and the feasibility and acceptability of the research design and the Change Project intervention.

The iterative processes in the Framework have also been emphasised(Campbell et al. 2007, Craig et al. 2008). It has been observed that the Theory, Modelling and Exploratory phases may be conducted simultaneously (Campbell et al. 2007) and in fact are potentially more productive if approached in this way. The methodological approach used in the research was consistent with this observation. Figure 18 shows how the MRC framework was used to shape the study. Using the conceptual framework as the starting point, the design consisted of 3 Stages, corresponding to the Theory and Modelling phases of the

Framework. After each Stage, the state of knowledge was evaluated to develop the detail of the following Stage. Figure 18 illustrates the ongoing contribution of knowledge to the development of the research.

Figure 18: Development of an intervention using the MRC framework
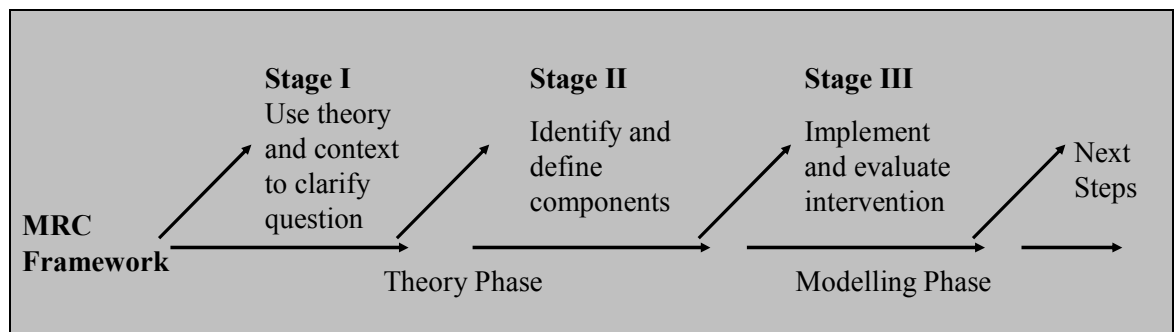
13.2   Strengths and limitations of evaluation strategies

The evaluation strategies were aimed at exploring the acceptability and feasibility of th Change Project. They combined semi structured individual interviews, focus groups, case data, a self esteem measure, and a questionnaire. The outcomes of analysis of the RSES suggested an improvement in self esteem across the Project user sample, indicating that the measure was able to detect slight changes in self esteem in a normal population of high school students, tentatively suggesting the possibility that the intervention had a positive effect on their self esteem.

The pattern of use of the Change Project by different demographic groups of students indicated a tendency for greater uptake in 12-13 and 14-15 years olds, and females. This slightly contrasted with questionnaire findings that the Change Project appeared to have a greater impact and be more acceptable with KS3 students and females. Both sets of data indicated that Faithschool students were least likely to use the Change Project or find it acceptable. These data provided context to help interpret the qualitative data, for example, resonating with the finding that there were differences between Faithschool and the other 2 schools which may have influenced attitudes to help-seeking and the implementation of the Change Project. This could be investigated further in future research.

The self-esteem questionnaire was used to measure changes in young people who had received an intervention from the Project. The brevity of the questionnaire was felt by interviewees to encourage responses. However, the low returns on the self-esteem questionnaire suggested that barriers to completing it- such as its appearance, the language used, and its perceived relevance- should also be addressed. Inferential statistics were not appropriate with the data from the RSES and the questionnaire, and insights into the difficulties involved in data collection from the present study could be used to inform future evaluation strategies.

Combining research methods is a logical outcome of a methodology driven by the research question (Popay et al. 1998). Therefore this research looking at emotional health explored the context that generated the data. The study of social processes, such as help-seeking for health problems, requires perspectives which view phenomena in their social context because social norms vary and therefore so do judgements about the definition and severity and desired resolution of an emotional problem (Hennessy and Heary 2005). Assuming this perspective in the present study enhanced understanding of links between individual perceptions and help-seeking behaviour in young people and generated potential explanations of factors affecting the feasibility and acceptability of the intervention.

13.3   Bias

Interviewees were recruited purposefully in order to obtain views, in each school, from adults in a range of roles and young people in each Key Stage, and gender in Faithschool and Sportschool. This is an appropriate method for qualitative inquiry but the sample was biased towards people who had some involvement or interest in the Project or emotional wellbeing.

The classroom survey complemented the interviews with the students by addressing sample bias. It accessed views from a second population of individuals, since the respondents were approached in classes and included students who knew nothing about the Project, generating more data on help-seeking, school settings for emotional support, and demographic information which permitted some descriptive statistical analysis of the respondents.

13.4   Observation

The use of systematic observation drew attention to patterns such as in the delivery of pastoral care in different settings. To illustrate: when comparing observational notes with interview data, a tentative association was made between the allocation of time for training the Project workers and the impact of time restrictions on the rest of the Project. In Sportschool the initial training period was longest (4 hours) and the Project workers had more time for the Project; the opposite was true in Faithschool. These 2 sources of information support the suggestion that investment in training may be an indicator of commitment to the intervention. Other influential phenomena that were anticipated from observational notes were how attached pastoral staff were to their familiar ways of working. This seemed to be influencing several aspects of the Project: no use was made of the electronic resources (CD ROMs and websites) that were provided; difficulties finding private physical space seemed to be compounded by a reluctance in some Project workers to work confidentially with young people; the appointment system of the Change Project appeared to clash with the ad hoc system of providing pastoral support in school.

The observational notes were subject to an ongoing thematic analysis. Relationships that seemed to be important to the story emerging from the data were explored. Early insights were generated to help with analysis and support the implementation of the Project.

13.5   Strategies used to enhance rigour

13.5.1   Quality standards for qualitative research

Rigour in qualitative research can be enhanced by adoption of standards for qualitative health research set out in Popay et al (1998) which proposed 3 fundamental principles: interpretation of subjective meaning, description of social context and attention to lay knowledge.

Following Popay et al (1998), qualitative methods were used in an attempt to achieve a deep understanding of the personal worlds of the participants. The knowledge gained from these processes was an essential driver in defining subsequent research questions.

The voice of the young people was privileged in data collection and analysis to reduce the

impact of the researcher's preconceptions and those of other participants.

The techniques, experience and knowledge that the researcher brought to the study, and the assumptions that underpin it, were explained in the preface, providing context which helps the reader to evaluate the researcher's conclusions about the research.

13.5.2 Reflexivity

The rigour of a research study depends on whether the text is believable or plausible. This can be achieved through reflexivity, in which the research methods are observed and reflected upon while the study is being conducted (Koch and Harrington 1998). Throughout the present study, a reflexive research journal was kept and emerging ideas were discussed with colleagues. Using this approach encouraged the researcher to think about and manage the various roles pertaining to the research inquiry and the development of the intervention, such as investigator, Project manager, trainer and supervisor. The process of reflexivity also heightened sensitivity to the influence of the researcher on the data, such as what people revealed, and how those data were used.

13.5.3 Observation

Observational notes and records that were made of impressions and developing ideas enhanced understanding of the interaction between the Project and the setting. Observation is an ethnographic method with its roots in anthropology (Ritchie and Lewis 2003). A common function of ethnography is to compare conflicting versions of the same phenomenon. It was valuable to observe and reflect on different experiences of school life, because it deepened understanding of the feasibility and acceptability of the Change Project in a real life context.

13.5.4 Credibility

Strategies to enhance credibility included providing contextual detail, staying close to the data and checking (Patton 1990). In this study detailed information about the schools has been presented. In addition a detailed audit trail was created to demonstrate the research processes, allowing a reader to track back from a study report to the raw data if necessary (Popay et al. 1998). Iterative thinking was recorded in notes from supervision sessions

and formed part of the study data. This type of record can illustrate responses to challenges in the study, such as strategies evolved in response to recruitment problems.

Triangulation of results and checking emerging theory also enhances rigour (Miller et al. 2002) and therefore participants and colleagues were involved in checking and reviewing analysis outcomes.

13.5.5   Use of technology to support analysis and audit trail

Both manual and computerised analysis methods were used in the analysis of qualitative data. NVIVO 7 software was used because it can enhance rigour by providing a means of organising and storing data and creating an electronic audit trail. It also supports iterative approaches to coding.

13.5.6   Research question-driven methodology

Qualitative research methods provide access "to the lived reality of individuals" (Boyle et al. 1989).This study used qualitative interviews to explore views of the study sample on aspects of emotional wellbeing As this was a relevant issue in schools, the methods needed to be able to identify and grasp individual constructions of how an emotional wellbeing intervention fitted into the world of school. Using qualitative interview methods to explore the perspectives of students and staff on the acceptability and feasibility of the intervention suited the research question and thus enhanced the rigour of the research.

13.6   Analysis

The development of an approach to analysis of the qualitative data in this study incorporated a number of analytical ideas. The focus groups and individual interviews in the Consultation and Implementation studies were subject to thematic analysis using an approach in which tentative theory was generated from the data, using the tools of Framework (Richards and Morse 2007). As data were collected and analysed, they were compared with what was already known, and new insights developed. For example, a picture emerged of the difficulties the Project workers were having, in making time and finding a space to see the young people. This contrasted with the outcome of planning conversations in which the Project workers were confident about their capacity to take on

the role and illustrates a tension between theoretical and actual capacity which could inform future development of the intervention.

Using a topic guide naturally requires some pre-empting of themes and it could be argued that it imposes the voice of the researcher at too early a stage in the analysis. Therefore interviews were partly structured around the idea of barriers to help-seeking from the Change Project, and an open mind was retained about how they might evolve as messages emerged from the data.

This open approach to categorising and coding the data was made easier through the use of appropriate software. NVIVO 7 supported iterative coding and complex data management, but not data analysis, which is an intellectual process (Tashakkori and Teddlie 2003).

13.7 Contextual influences on the acceptability and feasibility of the intervention

Attention to context and the lay perspective is advocated to enhance rigour and understanding the impact of context on the data is part of the analytical process (Popay et al 1998). This section summarises the key contextual influences on the acceptability and feasibility of the intervention.

13.7.1 School culture

Social and cultural aspects of the school context affected the acceptability and feasibility of the Change Project.

In Sportschool the Project was perceived as fitting very well into the aims of the school to support their students emotionally through the development of coping skills. It coincided with a period when there was no universally available emotional support service in school and the school was aiming to improve this provision, and therefore was appropriate in terms of need and timing.

In Girlschool the pastoral team had a high status within the school and the school management supported their activities with the Change Project, so although there were restrictions on the time they had to perform the Project worker role, morale was reasonably high and this appeared to support the implementation of the Project. A change of

management outlook within Faithschool had meant that although the Project was initially enthusiastically welcomed, it was not supported by the most senior staff, and the Project workers' initial enthusiasm seemed to wane during the period of implementation.

Another set of contextual factors related to the students. The classroom surveys and interviews conveyed a sense that despite the problems apparently facing the students, help-seeking was more likely to incur peer disapproval in Faithschool than in the other two schools.

13.7.2 Capacity

Lack of capacity to deliver the Project affected its feasibility initially and after a period of time also affected whether the Project workers found it acceptable.

All Project workers had difficulty making time for appointments, but also reported that the 15 minute appointment slots were uncomfortably short and they felt they were rushing the project users. The timing of the sessions was another issue, since the availability of students might not match that of the Project workers. For example in Sportschool the lunch hour was very short and therefore not a realistic option for appointments, and in Girlschool many students had to leave for home as soon as school was finished.

However, as some interviewees suggested that the Project needed more time to become established, lack of capacity in the short term may have influenced the long term acceptability of the Project.

Private physical space was in short supply in Sportschool and Faithschool. In Sportschool the appointments took place in a corner of the large SEN room which was the size of two classrooms. In Faithschool some appointments were postponed because there was nowhere for them, and on other occasions they took place in the school canteen, which was a thoroughfare.

13.7.3 Cultural perspectives on the value of confidentiality

There were conflicting interpretations of the importance of confidentiality in schools. The young people did not expect teachers to keep their information private, which was a considerable barrier to confiding in them. The ethos of the child protection legislation

emphasised the need for agencies to share information in the children's best interests. Teachers did not seem to understand or share the high value young people placed on privacy and control over their personal information. Some felt that they should be informed about the students to help them judge how to act towards them- for example, how much to penalise a student who was not in school uniform. This was supported by a culture of openness in school, which could compromise confidentiality.

Another factor at work was the desire for self reliance expressed by some of the young people, particularly in Faithschool, where the sentiment 'it's my problem to deal with' recurred in interviews and the survey.

Reflection on this set of dynamics suggested that schools may operate on a flawed family model, where certain individuals believe they have the right to know what is going on, in the best interests of other family members; yet because of the scale and complexity of communications within a large school, and the low status of students in the hierarchy, there are difficulties in controlling how information is passed around.

13.7.4   Peer group values: The importance of hiding vulnerability

For young people, managing peer relations in school required adherence to a set of social mores based around the principle of not showing vulnerability. The manifestations of this were reluctance to acknowledge and ask for help with a problem. Anger was both functional and dysfunctional: it was a protective mechanism that projectedprojected an impression of being tough, but could also damage relationships. Some of the processes involved in bullying were attributable to the need to appear aggressive. Help-seeking in school was conditional on favourable judgements about what it might do to a person's image, i.e., whether it would incur peer disapproval.

The process of help-seeking from the young people's data demonstrated the view of participants on how positive expectations can encourage help-seeking and negative expectations can discourage help-seeking.

Once a young person has acknowledged a problem, there is a process of decision making about what to do about it. If young people judge that the risks of telling another person about a problem are too high, they will keep the problem to themselves, and may resolve it

alone, tolerate it, or find that it is too much to cope with.

Close friends or family who know about the problem may offer practical or emotional support. However if the young person finds that they cannot live with or resolve the problem, they may think about asking for help from another person.

This involves a detailed assessment of the risks and benefits of confiding in someone. If they judge that the conditions are satisfactory, and potential benefits outweigh potential risks, they are likely to take this step.

A positive outcome from disclosing the problem will encourage the young person to have confidence to ask for help on a future occasion. An unhelpful outcome, such as betrayal of trust, embarrassment, or the problem not being resolved, will contribute to a lack of confidence in this route. The impact of this could be considerable. It could consolidate fears that there is no help available, and lower expectations about quality of life, the likelihood that future problems can be resolved, and the trustworthiness of other people.

The concepts in this model are developed and discussed further in the Discussion Chapter.

13.7.5 Conclusion: The relevance of the context to the feasibility and acceptability of the Change Project

The contextual factors described above demonstrate the value of the piloting process advised in the MRC Framework (MRC 2000), because they were not all anticipated from the Consultation Stage. The piloting process revealed that the social and cultural contexts of the schools affected perspectives on the feasibility and acceptability of the intervention.

13.8   Summary

- The study had consultation, development and implementation stages.

- A range of data collection methods were used. Quantitative data was limited, but complemented qualitative data.

- The analysis approach drew on Framework methods.

- Contextual factors in school affected the feasibility and acceptability of the intervention

The findings of the research in the Implementation Stage have been presented. The final chapters in the thesis contain reflections on the findings and what they mean for the feasibility and acceptability of the intervention.

14 Discussion

14.1 Introduction

The literature review presented the current state of knowledge concerning barriers and facilitators to help-seeking in young people. In the following section, this is discussed in the light of the study findings.

The aims of the research were to develop and explore the feasibility and acceptability of the intervention, but the study also generated insights into factors influencing help-seeking in young people, which are described in this chapter.

This chapter addresses factors affecting help-seeking from the Change Project, to provide context to understand how the Change Project was perceived by the young people and adults in the schools. The Change Project intervention is then discussed with reference to feasibility and acceptability .The final section reflects on the lessons learned from the study and offers some tentative recommendations.

14.2 Factors influencing help-seeking

Interviews and questionnaires revealed the components of complex decision making processes that appeared to accompany help-seeking in the peer group, including young people who had not been involved in the Change Project. The data suggested that help-seeking from the Change Project was influenced by internal factors, such as attitudes to vulnerability and help-seeking, and contextual factors, such as whether the organisational aspects of the Project suited them.

When explaining what might stop them from using the Change Project, the young people tended to focus on the internal barriers, mostly pertaining to their fear of exposure. Although some students, particularly those from Girlschool, expressed the view that a person should not feel embarrassed about asking for help with a problem, students in all 3 schools said that the social norms of their peer group strongly discouraged them from revealing vulnerabilities to others. This view appears to be central to understanding help-seeking processes in the young people in the present study, and leads to insights into the feasibility and acceptability of the Change Project intervention.

For the young people, internal factors affecting help-seeking from the Change Project included making individual judgements about the anticipated risks and benefits, based on personal attributes and social norms. These findings are partially encapsulated in a combined model of health behaviour reported by Conner and Norman (1996), but also provide further detail about decision making. The model was adapted following the present study and an amended version is represented in Figure 19, emphasising a proposed gap in knowledge about the decision making processes that may precede health behaviour. In the figure this is represented by the space between the second and third columns. In the first column, a series of 5 ovals represents themes of perceived advantages and disadvantages to help-seeking in a particular social context, incorporating cognitive and affective responses. The central column represents a combination of factors: individual (intention) and structural (environmental constraints and skills).

Figure 19: Relevance of major theorists' model of health behaviour to interpretation of findings (adapted from Conner and Norman 1996)
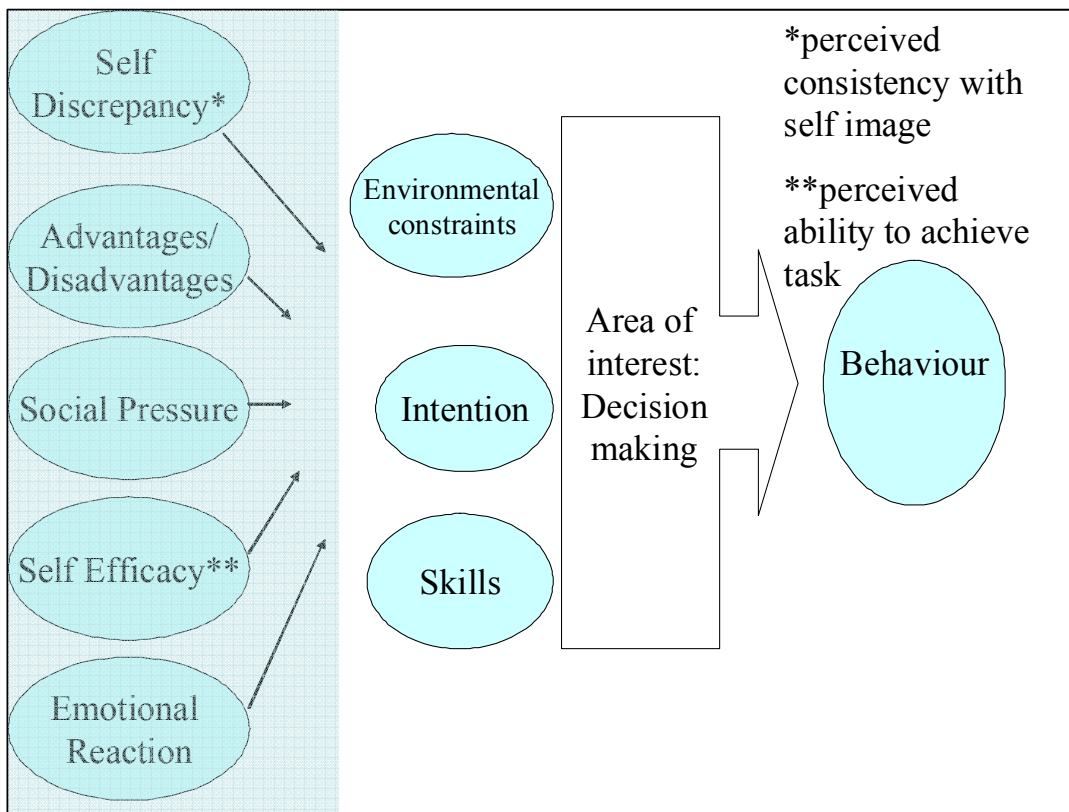
The data from the young people emphasised the impact of internal factors on help-seeking. This is broadly consistent with the focus on cognitive and affective barriers to help-seeking that was reported in Freedenthal and Stiffman (2007). Potentially, the young people's emphasis on the influence of internal factors may have been a function of their perspective; for example they may have been unaware of the planning and negotiations involved in creating confidential access to the Change Project. Further, the confidentiality of the Change Project, which the young people valued, was achieved through structures designed into the intervention including private access through self-referral, a commitment to confidentiality and the utilisation of a trusted group of staff in the role of project workers.

Other data from the young people and adults referred to contextual influences on the Project, such as how well it was promoted in each school and whether project workers had enough time to deliver it. For the young people, the principal contextual influences were the adequacy of advertising and promotion of the Project, and social context, i.e. whether

the school rhetoric, pastoral systems and peer norms supported help-seeking.

In an American Indian study, young people from a slightly higher age range reported fear of consequences, stigma, cost and availability of services as influences on help-seeking, and it was suggested that structural barriers to care might 'might emerge more prominently if internal barriers were overcome' (Freedenthal and Stiffman 2007, p.72). Young people in the present study might also have reported structural factors as a significant barrier to help-seeking if they had major experience of being obstructed by them.

The health psychology literature has identified that factors affecting health behaviour stem from internal factors, such as the psychological and emotional processes within an individual, and external factors, such as their social and environmental context (Conner and Norman 1996a). This study further develops understanding of how health behaviour and motivation to change are influenced by the relationship between an individual and their context.

The concept that behaviour and processes are influenced by factors within individuals and factors within their context has been explored elsewhere. UK educational policy recognises 'internal' (i.e. motivational and values based) and 'structural' (i.e. social and economic status) influences on the health behaviour of young people (Desforges and Abouchaar 2003). In a discussion of barriers to the implementation of educational programmes, Elias et al (1997) identified 'attitudinal' barriers in the perspectives and opinions that people might have about a programme and 'logistical' barriers as arising from factors within a school organisation, such as training, delivery or administration. The categorisation of barriers as either attitudinal or logistical appears consistent with the internal or contextual processes identified in the present study.

In the following account, these factors will be discussed.

14.3 Internal factors affecting help-seeking from the Change Project

14.3.1 Beliefs about the impact of emotional exposure

The concept of emotional exposure appeared to be at the core of help-seeking processes. There was a high level of agreement between the young people that emotional exposure should be avoided. This suggested that personal values and peer values had some degree of interdependence.

In the peer culture, looking emotionally strong was judged on the basis of being socially functional, i.e., having friends and interacting with the peer group. Emotional strength drew peer approval and attracted friends.

Conversely, if a person was perceived as socially isolated they tended to be also perceived as an emotionally vulnerable person and hence socially unattractive. Hence the crucial social function for the young people, apparently collectively agreed upon within the peer groups across the 3 schools, was to avoid emotional exposure and secure peer approval. These two cycles are illustrated in Figure 20 below.

Figure 20: Adolescent functioning through peer approval
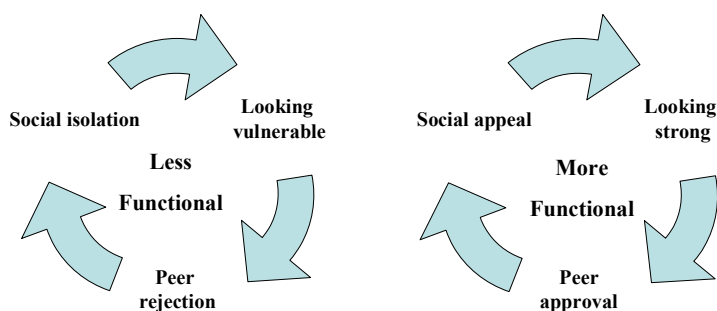
There was a sense of rank order of increasingly dangerous exposure: from being noticed, singled out, called names, laughed at or embarrassed, humiliated to being upset (i.e. crying) in public carried increasing risk. The young people described strategies they used to protect themselves, such as hiding their feelings, blending in, being aggressive, and avoiding situations. At an internal level, reduced social status damaged self esteem, which would then be compounded by self criticism emanating from having a weakness in the first place. This finding is consistent with Rosenberg's conclusion that a mismatch between ideal self and perceived self would have a detrimental effect on self esteem (Rosenberg 1965).

The outcomes as measured by the RSES suggested that the self esteem of the Project users seemed to be lower than expected from UK norms. One possible interpretation of this is that low self esteem may have been a facilitator of help-seeking from the Project, although it is not known how baseline self esteem compared with students who did not present to the project. For other students, it is possible that the Project may have been unappealing because it represented a potential threat to self esteem. This is an area for further investigation.

14.3.2 Relationship between acceptability and accessibility

Some questionnaire respondents wrote that they would not use the Change Project because they did not trust it to be confidential. Therefore doubts about confidentiality may have reduced the acceptability of the Project. Arguably, greater acceptability could counteract barriers to access such as an unfamiliar referral route or reluctance to risk exposure.

Relationships between acceptability and accessibility have been reported previously. For example from one study of attitudes to health care in young people, it emerged that they felt discouraged from using health centres because they misinterpreted the triage system and believed they were being discriminated against when other people were seen before them (Ginsburg 1997). Thus it is suggested that perceptions of inaccessibility could create potent psychological barriers to access and good access to support is an essential component of an acceptable intervention.

14.4   Summary

- The young people said that peer approval was cultivated through the appearance of emotional strength and therefore the appearance of emotional vulnerability could lead to peer rejection.

- Decision making about help-seeking from the Change Project was linked with the fear of emotional exposure.

- For the young people, the acceptability of support may be enhanced by improving access to it.

14.5   Help-seeking from the Change Project: the young person's journey

Young people described a sequential process of decision making in this context based on a core value system in which peer approval was sought by avoiding emotional exposure. In the following section, the young person's notional journey towards help-seeking is mapped out.

14.5.1   Self awareness

Acknowledging a problem was a big step which risked jeopardising self esteem, congruent with the notion that the peer group, of which the individuals were members, did not approve of emotional vulnerability. Therefore to admit a problem, particularly if it could not be resolved independently, could reduce an individual's perception of their own social worth. This process reflects the analysis of self esteem as stemming from the fit between perceived and ideal self (Rosenberg 1965), and echoes the findings from Freedenthal and Stiffman (2007) that reluctance to admit a problem was a barrier to help-seeking.

Both Project users and non-Project users were approached to explore barriers to using the Change Project. Interviewees were asked if they could say why people who had asked for appointments with the Project might fail to attend, and space for free text on the questionnaire invited comments about the acceptability of the Project. Many of the young people had views on this, suggesting it was a relevant topic.

Among the interviewees, the view that self awareness developed with age was

communicated by some of the adults and young people from Key Stage 4 (15-16 years). In a contrasting view, many of the adults expressed the view that students lacked competence to organise themselves and simply tended to run out of time or forget about appointments that had been made. Alternatively they said that problems could resolve themselves, so the motivation to access formal support would fade.

Some of the older students said that when younger, they were less likely to recognise, acknowledge, or think about any emotional difficulties they might have. This was consistent with the younger interviewees in Key Stage 3, who suggested that an individual might suddenly lose the courage they needed, decide they preferred to spend their time relaxing with their friends, or simply feel bored by the prospect of discussing a problem. Therefore there appeared to be a perception that help-seeking for emotional problems was linked with developmental maturity. This suggests that the self referral process within the Change Project may not have been suitable for all potential project users. For example, some may prefer to have support from third parties, such as carers or form tutors, to identify difficulties and access help; others may prefer drop-in arrangements not requiring appointments.

14.5.2   Coping through self reliance

Many of the young people reported in interviews and questionnaires that, once aware of a problem, the first problem response was a strategy of self reliance. This was congruent with the proposed core value of avoiding emotional exposure and appeared to be linked with the desire to protect self esteem. For example, free text questionnaire data suggested that self reliance was an expectation young people might place on themselves, because they felt they should be taking responsibility for their problems. Perhaps self reliance was a first strategy because it was an intuitive way of coping, but also possibly because it avoided exposure. There were wide variations: one individual might describe being self-reliant for a prolonged period but another might quickly involve another person to help with their problem.

Whether it was intuitive or a consciously chosen strategy, adults and young people affirmed that tolerating or addressing a problem required competence, confidence and courage. Young people suggested that both strategies required hard work and

perseverance. For example Tom, a KS4 Faithschool student, explained from his own experience that accepting a problem was a big challenge, and yet one of the main steps in getting over it.

14.5.2.1   Strategies for self reliance

Denying the existence of an emotional difficulty can be interpreted as a strategy of self reliance, since it follows that an individual will not ask for help with a problem they do not believe they have. Some perspectives on denial suggest that it has potential to be a protective defence mechanism (Cohen and Block 2004). Freedenthal and Stiffman (2007) reported that self reliance was perceived as a positive attribute by the young people in their study. However some participants in the present study, particularly in KS3, appeared to make an association between self reliance and unhelpful coping through 'bottling it up'.

Self reliance might involve hiding the problem, or disguising its emotional impact. Participants used graphic phrases such as 'keeping it all up inside you' to explain the strain involved in keeping a problem secret. Others provided examples of dealing directly with the problem or its impact. For example, one interviewee suggested that a person who was being bullied could try to ignore the bullies until they stopped through boredom. Others gave the example of using reading as a distraction or coping with uncomfortable feelings by talking with pastoral staff at school. In interviews, young people proposed self-reliance as an appropriate initial response to a problem, even though they acknowledged that keeping problems to themselves could be stressful.

14.5.2.2   Influence of context on self reliance

Interviewees also indicated that coping strategies altered in response to context. For example, when Louise (Girlschool) explained that she felt people at school wore masks to hide their feelings, she was comparing this presentation with how people were when she saw them outside school, which was much softer and more approachable.

Since coping style therefore seemed to be linked with social norms, understanding those norms may provide insights into how to support help-seeking in different groups of young people. There was a stronger tendency for Girlschool and KS3 interviewees to express

support for help-seeking, compared with other students, and these reports were reflected in the questionnaire findings that they reported being willing to consider using the Change Project. This suggests that to improve the uptake of school based emotional health services, it may be helpful to improve their acceptability with males and KS4 students. This could involve developing school-based strategies to raise the acceptability of help-seeking in these groups.

14.5.3 Uncertainties about help-seeking

Some young people communicated a sense of shame associated with needing help, because it indicated that they failed to live up to their own and their peers' expectations of being self reliant. Therefore the idea of consulting anyone, even a trusted person, was problematic.

If self reliance was unsuccessful, the next step would be to share the problem with someone else. Almost all the young people who commented in interview or through questionnaires indicated that they would prefer to turn to people they knew and trusted, often parents. People outside the close circle of confidantes would only be consulted if the former strategy failed. This is consistent with findings of Freedenthal and Stiffman (2007) that internal barriers to help-seeking seemed to be more significant to the participants than contextual barriers, and that young people appear to make a distinction between seeking help from informal sources such as friends and family, and formal sources such as health professionals or religious figures. It suggests that formal and informal resources may have distinct functions in the support of young people, both of which are valuable.

One barrier to help-seeking from the Project was the perception of difficulties involved in getting an appointment. This was not felt to be an issue for the Project users, who had overcome any access barriers they had encountered, but was a constant theme with the adults and endorsed by the high proportion of questionnaire respondents who reported that they did not understand how to access the Change Project. This idea is relevant to health behaviour theory in which action can be understood as depending a person's knowledge and their belief in their ability to act on it (Schwarzer 2001).

Young people presented a common view in interviews that an individual did not need to have had personal experience of something going wrong – such as being exposed as

vulnerable- in order to perceive a threat associated with asking for help. The idea of help-seeking being fraught with risk was so strongly held by the young people that it appeared to become part of their collective experience, independent of clear supporting evidence.

Social theoretical perspectives have added further helpful insights into the help-seeking norms in this population. The notion of self as a subjective construct of social values and theories rejects the idea that an individual reacts in relation to their world (Garcia and Mann 2003). This theory helps to explain the interdependence of individual values and peer norms in the young people in the study.

14.5.4   The importance of confidentiality

Young people expressed a view in interviews and questionnaires that low expectations of confidentiality prevented them from using both the Change Project and other school pastoral care. Therefore for some of the young people in the study, the protection afforded by a visible system, in which little activity took place in private, interfered with self care by compromising confidentiality.

Adults' reports for the most part did not emphasise peer approval as much as young people. This reflected the tendency noted in schools, to prioritise visibility over confidentiality. Given the emphasis on confidentiality and discretion evident in the young people's interviews and questionnaire responses, the preference for visibility appeared to carry risks: some young people reported that asking for help with a problem could expose them publicly, potentially resulting in humiliation and loss of self esteem.

Potential tensions around the issue of confidentiality in schools were noted in relation to child protection legislation, and appeared to influence the way the focus groups were conducted in schools. There is a parallel with concerns in primary health care about the treatment of adolescents without their parents' consent: because there is a transition from dependence to autonomy, judgements are made by carers and service providers about when and to what extent young people should be taking responsibility for their welfare. This may contribute to discrepancies between parent and child reporting of emotional difficulties, which was reported by Kramer (2004).

14.5.5   Assessing trustworthiness

If a problem could not be resolved through self reliance the individual might consider taking the risk of involving other people.

Personal perceptions of potential risks and benefits to involving another person were weighed up. The consultation focus group data suggested that essential qualities needed in a confidante were trustworthiness and loyalty. A loyal person would try to help the individual without making the problem worse by spreading gossip. Young people might approach carefully selected individuals, typically in their social or family networks. These phases were similar to informal help-seeking identified in Freedenthal and Stiffman (2007).

Alternatively they might move towards formal help from sources such as the Change Project or other pastoral provision. Four interviewees said they had previously used statutory services based outside school for emotional support whereas those in the Freedenthal and Stiffman (2007) study more often described seeking help in health settings. Participants in the present study were in a younger age range (11-16 years compared with 15-21 years) and it is possible that they were less able to access statutory care outside school independently, compared with the older group. Young people in the present study reported preferring to involve people in their social or family group first, followed by formal help based in school. Therefore age may be a determinant of attitudes to formal help-seeking. As both studies concern emotional wellbeing, it is also possible that the nature of the difficulty is a determinant of help-seeking behaviour.

14.5.6   Potential facilitators of help-seeking

Part of the weighing of risks and benefits of asking for help concerned the individual's assessment of their confidence that the outcome would be beneficial, and their willingness and competence to confront their situation. These data appear to resonate with the Health Action Process Approach because they describe processes that contributed to the shift from motivation (wishing to take action) to volition (being willing to take action) (Schwarzer 2001).

This finding is qualitatively different from those identified in a study of adult use of primary care (Calnan et al. 2006) which reported principally pragmatic reasons for consulting a GP, in which the impact of the problem was often the trigger for seeking a consultation. The contexts are different: Calnan et al's (2006) sample presented with upper limb pain, which potentially has less stigma attached than emotional difficulties. Different populations may have different motivations for accessing health advice. For example, young people may be more motivated to seek help for problems that impact on their social behaviour. This is supported by findings from primary care research suggesting that young people's use of primary care tends to be for a fairly consistent range of presenting problems concerning physical, sexual and mental health (Gleeson et al. 2002). Nevertheless, it has been suggested that with young people, minor physical problems might be used as a proxy, either to make the consultation less daunting or to legitimise a less tangible other problem (such as low mood) (Jacobson et al. 2002). There can be complicated motives behind an apparently straightforward consultation.

It is therefore argued that, whereas older people may prioritise a physical issue (such as pain relief) in a health consultation, young people may prioritise those particular health issues that could affect their social status. This principle can be applied to an interpretation of health priorities identified from a UK study of primary care consultations with young people. In descending order of frequency of consultation, these health concerns were: respiratory, dermatological, musculoskeletal, ear, nose and throat, and potentially psychiatric conditions (Churchill et al. 2000, McPherson 2005). It seems reasonable to suggest that any of these conditions could have a potentially dramatic impact on the social activities of young people by affecting their appearance or their ability to participate confidently in leisure activities and could provide motivation to access formal health care.

These suggestions indicate some of the complexities that may underlie health behaviour in young people, and partly explain why their help-seeking is difficult to interpret for health service planning. The intricacy of individual motives may also explain why the barriers and facilitators of help-seeking in these young people were not understood until after the analysis of Implementation Stage data.

14.5.7　Impact of unpleasant consequences on attitudes to help-seeking

Some young people described experiences of untrustworthy behaviour by both peers and adults, including spreading gossip, which could add humiliation, shame and embarrassment to an individual's problem. Other teenage study participants felt mistrustful based on the experience of others. Therefore the experience of some appeared to have been absorbed by the peer group, and become a collective belief that asking for help would have unpleasant consequences of emotional exposure.

The young people suggested that if the prospective Project users believed that the experience of the intervention would be unpleasant or not worth their while, they would be unlikely to risk using it. Those who participated in the Consultation Stage stated that they would not choose to access help from a person who was unfriendly, unempathic, unskilled or impatient with them. As low expectations may then be a barrier to help-seeking, this finding is consistent with perspectives in health psychology theory, that health behaviour is encouraged by expectations of a good outcome (e.g. (Conner and Norman 1996a).

14.5.8　Long term effect of favourable outcomes from help-seeking

Project users described improved subjective wellbeing after using the Project. The records kept by the Project Workers suggested that personal targets had been achieved and students felt better because they had been able to address or reduce the impact of the problem. The exception was Amy (Sportschool, KS3), who said she would have preferred to have time to ventilate her feelings at length rather than identify and work towards goals. This demonstrates a need for a range of emotional health resources to address different needs, which is philosophically consistent with the 4 Tier CAMH model, which allocates resources according to a concept of level of need (DH 2004a).

Some Project users also said that they felt able to approach Project workers in the future for help and support, so using the Change Project may have enabled them to extend their support networks in school. This endorses the argument that developing a rapport with young people encourages them to access help later (Ginsburg 2001).

Interviews with pastoral staff in the 3 schools suggested that the Project was perceived more positively overall in Girlschool and Sportschool, compared with Faithschool.

There was a widely held view amongst staff interviewed that a Project like this needed time to settle into the school culture, in which it would be aided through word of mouth recommendations. Educational practice literature has also pointed out that school based interventions need time to settle into a school culture (Elias et al. 1997).

14.5.9 The young person's journey: Summary

The pathway to help-seeking has been described above from the point of view of the young people, using the data they provided in focus groups, interviews and questionnaires. The data regarding help-seeking, feasibility, acceptability and accessibility were consistent with the focus group data from the Consultation Stage. A notable finding of the Implementation Stage was the essential importance to health behaviour of core values based in peer group norms.

Each step on the pathway was explained by the participants and has been set out accordingly in Figure 21. Starting with awareness of a problem, the individual would be likely to want to keep it to himself or herself and may find they could manage it independently. If not, they would consider asking other people, but the potential risks and benefits would have to be carefully considered, and they would vary depending on the circumstances and the confidante. The smaller the risk of exposure, the lower the barrier to help-seeking. Negative consequences would discourage future help-seeking and good outcomes would encourage future help-seeking because they would influence expectations. These processes are illustrated in Figure 21.

Figure 21: Pathways to Help-seeking
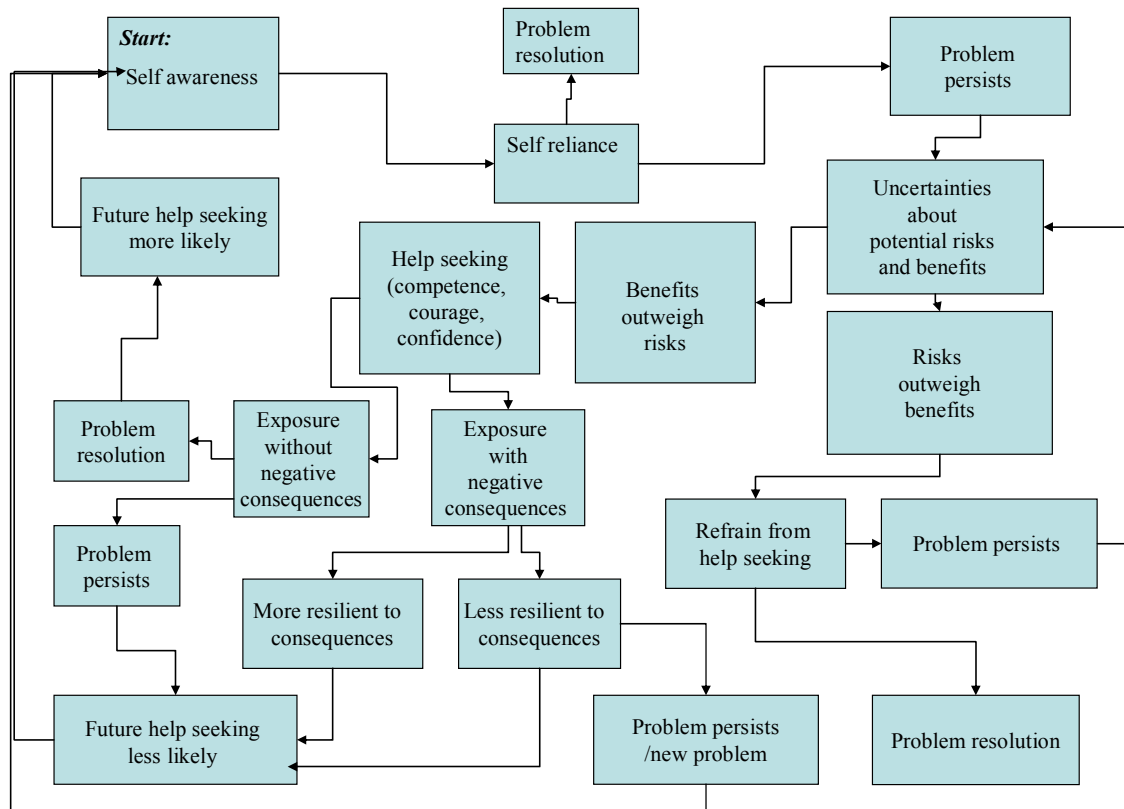
These findings resonate strongly with those from the American Indian study conducted by Freedenthal and Stiffman (2007), in relation to the importance of peer norms, the fear of exposure, shame and embarrassment; the value of self reliance, and perspectives based on own or peer group experiences. Some of the common themes from the present study and Freedenthal and Stiffman (2007) are displayed in Table 20 below. The consistency between the findings suggests that there may be common barriers to help-seeking in adolescent populations and it may be helpful to investigate this topic further in future research.

Table 20: Common themes occurring in present research study and reported in Freedenthal and Stiffman (2007)

Present study category	Present study example	Freedenthal and Stiffman 2007 (page reference)	*Freedenthal and Stiffman category*
Self reliance	"it is my problem to face" (Faithschool KS3 questionnaire respondent)	"I figured it out on my own that I should be smarter" (16 year old female explaining why she did not seek help) (p.70)	*Self reliance, should not need other people's help*
	I can't just go and every time to get my parents worrying about me (Chris, male, KS3, Faithschool)	I would feel like I am burdening them with my own problem (18 year old female) (p.70).	
Fear of consequences	I don't think they can trust people (Shannon, Girlschool, KS4) Everything gets blown out of proportion (Nina, Girlschool, KS3)	Did not want to hear what they wanted to say (18 year old female) (p.71) 'they might think I was crazy or something' (16 year old female) (p. 69)	*Fear of consequences*
Privacy and embarrassment	…ashamed of relying on someone else to help you (Tom, Faithschool, KS4) People might laugh at you.(Alex, Faithschool,KS3)	'everybody would know' (17 year old female) (p.69) 'shame' (19 year old male) , (p.69)	*Shame, Embarrassment and/or stigma*
	..prefer to keep things private or talk to family or close friends (Faithschool female KS4)	'I just talked it over with my mom' (female(age not reported)) (p.70)	*Had other support*
Emotional competence	I wouldn't get any worries [19] (Faithschool KS3 male)	It wasn't a big deal. (female(age not reported)) (p 68)[20]	*Did not perceive need for help*
Low expectations/lack of confidence	People…wouldn't think it would work Toby, Faithschool KS3 It won't work, or it'll baffle your head (Amy, Sportschool, KS3)	I didn't think (professional help) would do anything. (18 year old female) (p.70) The problems were not serious enough to anyone but me (20 year old male (p.70)	*Felt hopeless, alone*
Inconsistencies between the two studies			
Importance of avoiding emotional exposure	They could get embarrassed … and that could upset them (Sportschool focus group KS3)	Not reported	*Not reported*
Did not emerge from study findings	*Did not emerge from study findings*	'no money'; 'no medical place where I live'(p.67 (no further detail))	*Costs/no services available*

[19] The present study involved a non-clinical population, and there is no implication here that the participant had a problem that they were not aware of.

[20] Likewise, this example is interpreted by the authors to indicate that the participant was able to manage the problem without help.

14.5.10 Conclusion: emotional exposure and competence, confidence and courage

The driving principle behind the individual decision making processes was the need to avoid emotional exposure. The core internal facilitators of help-seeking in the young people in the present study have been summarised as confidence, competence and courage. This reflects the finding that for young people, help-seeking involved confronting problems, being brave and taking risks.

In this context, competence means the ability to identify an emotional problem and the resourcefulness to address it, and included the communication skills to explain a problem to someone else, and practical skills to understand and navigate a route to help or support. Confidence in the support offered was a further condition affecting help-seeking. The evidence suggested that the young people wanted to know that their privacy would be respected, the helper would be friendly and empathic, and the help itself would be effective. Self confidence was also required since without it the individual would be less likely to ask for support. Finally, courage was a crucial component. Young people said that an individual needed courage to confront their problem and talk them into taking action. Therefore complex processes appeared to accompany decisions about whether to seek help or not.

The influence of the peer group norms on help-seeking reflects theories of health behaviour that conceptualise social factors as a dominant contextual influence on individuals (e.g. Conner and Norman (1996); Rosenberg (1965)).

Having considered the individual factors affecting help-seeking, in the following section, the impact of contextual factors on the feasibility and acceptability of the Change Project are now discussed.

14.6 Contextual factors affecting the Change Project

14.6.1 Introduction

The previous section discussed the processes involved in help-seeking from the perspectives of the young people in the study. As students, they were not contractually obliged to think about the Change Project, so their engagement was likely to be more grounded in their personal value systems than the values and philosophies of their school. Contextual issues such as how pastoral care was organised in school, or where a person could access help outside school, were brought up in the interviews by the interviewer but discussed only briefly if at all by the young people. Few young people talked about the structure of the pastoral care or could give examples of where they could go to for emotional support outside school and their social and family networks.

Like the young people, the adults in this study said that factors such as competence and maturity affected help-seeking. However adult participants were more likely than the young people to draw attention to the contextual influences, including the referral process and the provision of relevant information. Their perspectives are discussed next.

14.6.2 Importance of key roles

14.6.2.1 Senior management

Some contextual influences stemmed from values embedded in the school policies, which appeared to reflect views of the Head Teachers and the senior management team enacted a value system that appeared to be defined by the Head Teachers. Right from the initial thoughts about the design of the research it was understood that, for the Change Project to be viable, it had to be acceptable to the value system embodied in the school leadership.

The direct and public support of the Head Teacher for the Change Project in Sportschool afforded it high status, which meant that staff managing conflicting priorities were more likely to promote it above other issues. In the finding that the Head Teacher could galvanise support for the Project and was potentially the key to implementation, the present study agrees with a conclusion from a finding of a North American, school based research

study conducted in 6 inner city, state funded schools. The American study found that school principals were an important influence on the quality of project implementation in the context of an educational programme. The study methods did not generate explanations for this phenomenon and the authors suggested that further research was needed to understand it (Kam et al. 2003).

In the process of analysing the study findings it became clear that the Change Project was most successfully integrated in Sportschool, where there was a dynamic senior member of staff championing it as a core service and the school appeared to be wholeheartedly committed to it.

In each school a Deputy Head Teacher championed the Change Project. The role of project champion is reported in educational practice as being important to school programme implementation (Elias et al. 1997).

Their contributions varied in the present study: for example in Sportschool the champion reported close communication with the Head Teacher on the Change Project and also promoted the Project vigorously, supporting and praising all the staff involved in delivering it, which appeared to contribute to their commitment to it. In Girlschool, the project champion had little time to act in that role although she identified herself as strongly supportive of the Project.

In Girlschool, and to a greater extent in Sportschool, the Project Workers said they felt largely supported to deliver the intervention. In contrast, in Faithschool structural reorganisation removed the champion from the Project after the school had agreed to support it but before it had been introduced. Here, Project Workers reported a lack of support, and the Project appeared to be less feasible and acceptable. Therefore it may be the case that the project champion role is key to successful implementation. This is a topic that may benefit from further exploration.

14.6.2.2   Project Workers

Conceptually, pastoral teams were positioned between the organisational ethos and a more personal perspective on the Project. This was a key role. Without their support, the Change Project could not be delivered and would not be feasible, even if it had support from the

Head Teacher. Therefore the Project needed to be feasible and acceptable at all levels of the organisation.

Four potential Project Workers, who had showed interest and attended training, dropped out before the Project was implemented. One from Faithschool and one from Girlschool cited other commitments, and one from Girlschool and one from Sportschool did not give reasons but appeared to have lost interest. Hence it is possible that the recruitment strategy of inviting pastoral staff to volunteer to be Change Project Workers was appropriate because the 12 staff who self selected and stayed with the Project throughout were interested and available.

The planned training was not perceived as feasible by the Deputy Head Teachers. The issue of training for Project Workers was highlighted as a problem in the development study, when the training programme had to be drastically curtailed to fit into abruptly changed school timetables. Thus the limited opportunity to explain and discuss the principles of the intervention may have affected treatment fidelity.

The feasibility of the Project for the school as a whole seemed to depend on how it fitted conceptually and practically into the existing pastoral systems. To a large extent this was a judgement made by the Project Workers. They said they were enthusiastic about the Project because they believed it would support the students and they were keen to be involved in some provision for students who were not targeted by the pastoral teams.

However, their final assessments of the Project's feasibility and acceptability were based in their experiences of working hard to deliver the Project to the students who accessed it, while at the same time trying to attract other, more reluctant, students to use it. They were disappointed that the numbers of students using it had been modest, as they perceived a high level of need for emotional support. Consequently, they said that its feasibility was challenged by the demands it made on a busy school day. Its acceptability, from their point of view, seemed to be determined by their perceptions of its accessibility and acceptability to young people.

If the Project was not considered acceptable by the Head Teacher, schools would not engage with it. Additionally, if it was not considered to be feasible by Project Workers, there would be a lack of support for implementation. Therefore to implement the

intervention, it had to be considered acceptable first and feasible second. There appeared to be a circular process involving the Head Teacher's perceptions of acceptability, the quality of Project implementation and perceptions of its feasibility. It is argued that while the Head Teachers ' perspectives on the value and relevance of the Project could initially support a positive attitude to the Project within a school, the Head Teacher's ongoing perceptions of acceptability and feasibility were influenced by the success of the implementation.

14.6.3   Conflict between rhetoric and culture in school

There was evidence that the official rhetoric, which was principally generated by the Head Teacher, could conflict with the school culture, i.e., what was actually happening in the school. Conflict between rhetoric and culture appeared to damage attitudes to pastoral care in the school, creating mixed messages and a stressful working environment in the pastoral teams. This in turn appeared to shape attitudes to the feasibility and acceptability of the Change Project.

There was less conflict evident in Sportschool, where students and staff both expressed a view that the staff had a caring attitude towards the students. This is exemplified in one manager's assertion that he made a point of walking around the school smiling at students, saying hello and asking how they were.

In Girlschool there were high proportions of students who were in local authority care, needed support with language and learning or lived in low income families. Through spending time with the pastoral team I learned that there was an expectation in the school that that the pastoral faculty could and should deliver extensive social support to students identified as vulnerable. This appeared to link with high workloads. For example, one member of staff was responsible for the pastoral care of a group of children in local authority care and frequently became involved in home visits, child protection concerns, and negotiations about care arrangements.

There were different issues again in Faithschool. Local authority data suggested that the levels of social problems among the students may have been high compared to national averages. However, as noted in the findings chapter, in the official school policy there was a reluctance to be open about this. The official rhetoric of the school suggested that the

pastoral care was comprehensive, but some staff and students who were interviewed said it was limited in scope and capacity. One student reported difficulties accessing the pastoral support he felt he needed, having learned from experience that it was only available to certain categories of students.

14.6.4   Image management

The findings of this study suggested that in all 3 schools, the culture was a composite of mission statements, official messages passed down via the management hierarchy, and the reality of day to day management. The reactions of the 3 schools to the Project seemed to stem in part from a need to control and manage the image of the school. Inevitably in the schools people in different roles did not necessarily share a view on how things should be done. This caused tensions among the staff and appeared to block the Change Project in some respects.

For example a member of the senior management team in Faithschool reported in an interview that the school preferred not to advertise schemes that suggested there might be students with emotional or behavioural difficulties in the school. Girlschool and Sportschool were more supportive of messages targeted at problems like sex and smoking and communicated this policy publicly, through posters on these and other more general health topics around the school. In contrast with Faithschool, the image management in these schools partly rested on acknowledgement of problems and public statements that the school was supportive to students who were having difficulties with them. Indeed in Sportschool they were part of a general drive to achieve targets in the "Healthy Schools' programme (Department for Children Schools and Families, 2006) and the Change Project was incorporated into the plan. Therefore the acceptability of the intervention was partially dependent on whether the school leadership judged that it projected the desired image of the school.

Coherence within school cultures, such as cooperation between Head Teachers and classroom teachers (Kam et al. 2003) or a coordinated, whole school approach (Leurs et al. 2005)has been identified as a facilitator of programme implementation. This finding develops understanding of the process by suggesting that image management within a school may be an obscure yet powerful force in the school agenda which affects school

programmes.

14.6.5   Special Features of Faithschool

In Faithschool, the low impact of the Change Project compared with the other schools, as revealed in the interviews and questionnaire, suggested that there may have been specific factors in Faithschool that affected the implementation of the Project. There appeared to be a trend for the findings from Faithschool to differ from those from the other 2 schools- for example the questionnaire data indicated that the students were less aware of the Project.

One possible explanation was that the structure and philosophy of the existing pastoral system in Faithschool did not support the Project. Unexpected data were obtained from Faithschool, when 3 individuals in influential roles explained that the school chose to avoid the public acknowledgement of problems in students. For example the school did not advertise the services of the school nurse with regard to smoking cessation or sexual health, and did not promote the Change Project either. The reason given was that if the faith community knew that the school was offering these services, admissions to the school would fall, and with it the school's income. This contrasted with the open attitude in the other 2 schools, suggesting that image management may have a profound effect on the potential for health education at school.

A further potential influence on the Project was that in Faithschool staff and students reported that the structure of pastoral care in the school meant that students' access to it was tightly managed and controlled.. A minority of staff said that this was appropriate, because pastoral care had potential to overwhelm the educational functions of school.

It emerged from the interviews with staff and students in Faithschool that there were indeed two conflicting sets of values within the school, attributable to a recent change of head teacher, which, according to the interviewees, dictated a less embracing attitude to pastoral care. One Project worker said it was difficult to be sure that involvement in the Change Project was legitimate. Therefore there may have been a lack of consistency between the official rhetoric and the values of individuals.

As Faithschool initially encouraged the Change Project, the obstacles presented by unfavourable attitudes towards it were not foreseen. The need for a consistent approach in school programme implementation is widely accepted e.g. (Hallam 2007).The

evidence from the present research suggests that the implementation of the Change Project may have been restricted by conflicting moral paradigms in Faithschool which led to the Project being welcomed by some staff and at the same time unsupported within the organisation of the school.

14.6.6 Conclusion

It is proposed that competence (emotional literacy and being able to navigate the system), confidence (in self and the system) and courage (to acknowledge a problem and take a risk) formed the basis of the help-seeking in this population. This was influenced by internal and contextual factors stemming from coping style, peer values, school culture, and organisational arrangements.

These factors were mediators of a central value which was to avoid exposing vulnerability, particularly within the peer group. They contributed to judgements that individuals made as to whether the support offered was acceptable. An implication is that since young people prefer to disguise their emotional difficulties, it is illogical to design support systems to which access depends on the efficiency of third parties to identify need. Nevertheless, many services for young people use third party referral systems and this may be a point of intervention.

There seemed to be a shared social structure and value system amongst the students, which was common across the 3 schools. The messages from the data were generally consistent with findings from Freedenthal and Stiffman (2007), as described in Table 20. Similar themes included shame, self-reliance, fear of the consequences of disclosure, and use of close networks before accessing formal help. There was a difference in the perceived relevance of cost, which may be attributable to contextual factors in study design and population age.

Other differences were more tonal than contrasting, such as a focus on avoiding embarrassment (present study) compared with avoiding shame (Freedenthal and Stiffman 2007). The implication, that there may be commonalities across social worlds of different populations of young people, is consistent with sociological study of street codes operating among urban American gangs (Anderson 1999). In both settings the rules of behaviour were tightly organised and rigorously applied, and young people tended to accept the

rules of the peer group and adhere to them, absorbing the values and consequently avoiding actions that exposed vulnerability.

The findings therefore imply that the intervention worked best when integrated into the school culture. These processes may occur in other adolescent populations and this is an area for further exploration. Furthermore, as these similar findings occurred in adolescent populations with different age ranges, it may be useful to explore whether interventions to encourage help-seeking in younger adolescents may prevent the development of suicidality in older groups.

14.6.7 Summary

- Implementation of the Change Project appeared to benefit from the active engagement of key figures in the schools such as the Head Teacher, a Project champion, and Project Workers.

- Perspectives on the purpose of pastoral care varied between schools.

- Schools were image conscious and Faithschool was reluctant to advertise help available for students with problems.

- There was potential for tension between rhetoric and culture, which could impede implementation.

This chapter has presented a discussion on the organisational and cultural factors in school which influenced the Change Project. In the following section, lessons learned are discussed.

14.7 Lessons learned about the intervention

This chapter reflects on the knowledge contributed by the research study and presents some tentative recommendations for future research and practice.

14.7.1 Components of the Change Project intervention

14.7.1.1 Defining confidentiality

The principle behind protecting the confidentiality of a minor seeking health advice is that lack of confidentiality is a barrier to help-seeking (Harbour 2004). Although the lack of absolute confidentiality may discourage young people from accessing the service, on the other hand it also serves to prevent collusion between the young people and the therapist, so ultimately the service may feel safer to them. Therefore the extent of the confidentiality offered in the Change Project was agreed with key school staff and carefully explained to Project users in advance of any disclosures.

14.7.1.2 Recruitment of Pastoral staff to act as Project workers

On the basis of the supervision sessions and records they kept, Project Workers appeared to have appropriate skills to deliver the intervention accurately within the tight structure of the Project. As pastoral staff or teaching support workers, they were experienced in interpersonal communication with students and their enthusiasm for the Change Project helped to make it work in the schools. They demonstrated the ability to summarise emotional problems, and used strategies to empower the Project users, such as helping them control the agenda and encouraging them to manage their own care. They collaborated with Project users to identify long and short term goals, assessed risk using a screening tool, made appropriate referrals to the school nurse, kept records, developed trust and rapport with the Project users, and maintained confidentiality. They made appropriate use of supervision with the researcher to discuss how best to address the difficulties of individual students or structural difficulties such as such as the paperwork or the appointment Therefore the utilisation of these staff as Project Workers appeared to be feasible and acceptable in principle, though dependent on the extent of the support they

received.

The time, space and training needs of the Change Project Workers appeared to impact on how they delivered the Project. The value of the intervention was judged at both organisational and personal levels by Project Workers, because they had to manage their roles to deliver the intervention. The interview data demonstrated that overall they believed that the Project was valuable, and were therefore willing to uphold it for the duration of the research, despite the effort required.

Some staff at Sportschool expressed concerns that they were not using a wide enough range of strategies, which could be addressed through training. Even with extended training, acting in a therapist role may be more demanding than delivering a curriculum based intervention, which was the task of the school nurses who participated in the FRIENDS research (Stallard 2008).

Interview data revealed that administrative tasks were unpopular with some of the Project Workers, particularly the more experienced staff. Only in Sportschool did the Project Workers have protected time for supervision and essential record keeping. In the other two schools, planned supervision sessions with the researcher were constantly being rearranged and they described taking Project paperwork home to complete it. One Faithschool project worker explained that the pastoral system in the school lacked a methodical approach to record keeping and it is possible that this was reflected in the low return rates on the self esteem questionnaire in all the schools. This suggests that planned organisational support was instrumental in supporting the Project workers.

Project Workers from Girlschool and Faithschool, who had more experience of pastoral work compared with learning support, appeared to be familiar with a broad range of emotional health work, while further Change Project training was arranged in Sportschool because the staff said they were using only a narrow range of strategies, mainly cognitive. However the Sportschool Project Workers were the most comfortable with working to a tight structure, which may reflect their principal roles in classroom learning support rather than pastoral care.

As discussed, the opportunity to train the Project Workers before launching the Change Project was limited. The training was modelled on a training programme delivered in

primary care (Lovell et al. 2006) and although it was adapted for the intervention and the school context, delivery of training was compromised by lack of time and potentially a perception that longer training was not necessary.

The impact of the training on the fidelity and effectiveness of intervention delivery is an issue which could usefully be explored in further developments of the Project.

An alternative approach would be to incorporate coping strategies into social and emotional learning curriculum. This could prepare students to use guided self-help appointments and legitimise the inclusion of Change Project training in ongoing staff development programmes. Finally, existing skill sets of Project workers could be established before the design of a training programme, in order to tailor training to individual needs.

14.7.1.3   Brief appointments

Generally, the Project Workers found the short appointments challenging. The doubts expressed by Project Workers about what could be achieved in a short time were consistent with findings in primary care, that patients tended to find brief (15 minute) appointments more acceptable, compared with clinicians in an evaluation of a Guided Self-Help model (Lovell et al. 2006).

Some of the resistance reported by Project workers in relation to brief appointments were the desire to communicate to the students a sense of having time to listen to them, lack of faith in the efficacy of the self-help strategies, poor understanding of the theoretical rationale for using brief interventions, and lack of training and practice. Potentially, the issue could be addressed if barriers to providing sufficient training and supervision could be overcome so that Project workers had the opportunity to become more familiar with the rationale and delivery of the guided self-help. This aspect of the implementation is consistent with the observation that logistical and attitudinal blocks can affect the delivery of school based programmes (Elias et al. 1997)

However, the brevity of the appointments appeared to enhance the feasibility of the intervention in the present study because they provided an opportunity for the pastoral teams to offer support to students who were not visibly in crisis were less likely to come

under their care. The pastoral staff had identified an additional need in students with less obvious problems, and they felt that the Change Project might offer support to these students.

14.7.1.4 Strategies to protect students' welfare

The safety protocols in the Change Project protected the Project users and Project Workers by providing a framework for the Project Workers. The inclusion of a depression screening tool (PHQ-2) guided Project Workers to know when to make referrals to the school nurse. In principle this seemed to be acceptable to school managers, school nurses, project workers and project users.

As a result of using the PHQ-2 to screen Project users, 4 individuals were referred to the school nurse, all of whom agreed to this following discussions with the Project workers. None were subsequently referred out of the Project, though in the case of one student who was self harming, an agreement was reached between the student and the pastoral team that she would be closely monitored and supported. One Project user had a lengthy period of contact with the Project involving 8 appointments, though the duration of contact was driven by the student's requests for reassurance rather than the Project worker's concerns about more serious difficulties. Therefore the safety protocol involving the use of the PHQ-2, and a referral pathway to the school nurse appeared to be feasible and acceptable as well as appropriate and effective.

The opt out system appeared to be equally straightforward. Anecdotal reports from the Project workers suggested that approximately 6 students had been opted out, and and no difficulties were reported to the researcher resulting from the opt-out.

14.7.1.5 The use of instruments

The classroom questionnaire had a high response rate, suggesting that useful data about the profile of a health intervention in schools can be obtained in this way.

The appropriateness of using a self esteem measure was demonstrated by the data suggesting that self esteem underpinned emotional wellbeing in the young people.

Potential reasons for low returns of this measure included data collection methods, lack of appeal to young people, and low commitment from the Project workers. Alternative approaches could include sourcing or devising other measures and reducing the responsibility of Project workers to collect data.

14.7.1.6   Supporting materials

Printed resources including the training manual and self-help books were produced for the Project. Several interviewees, both adults and students, said they liked the materials and found them helpful. Further research could evaluate how these materials were used.

14.7.1.7   Planning for sustainability

The development of an intervention has to consider sustainability, because any research intervention could be detrimental to the host organisation if it disrupts existing systems. To protect the needs of the school and the individuals, an exit strategy was developed by developing supporting materials for the Project and planting Project worker skills required within the school workforce rather than keeping them within the research Project. Thus the schools could choose to sustain the Project if they wished.

14.7.1.8   School context

There were some tensions around key components of the intervention, which seemed to relate to the introduction of health research into a school context. In future developments of interventions such as the Change Project, it may be helpful to distribute a version of the Change Project questionnaire in advance in order to gauge potential reactions to the intervention from a wider sample of the school communities, including the staff, which could then inform the implementation process.

- Visibility and confidentiality: conflict of ethics

The importance of confidentiality to young people has been discussed and the tension between visibility and confidentiality in school settings seemed to be a central theme in the study data. There were conflicting ethical positions apparent between the expectations

of health research and the expectations of schools. The tension appeared to stem partly from the need for teaching staff to be kept informed about events that might affect students' learning or behaviour in school, and the legislation to protect children.

The need for teachers to be properly informed about pupils' pastoral needs is well established in practice (Galloway 1983) and information sharing is enshrined in policy. An Every Child Matters publication, Working Together to Safeguard Children stated

> *Education staff have a crucial role to play in helping identify welfare concerns, and indicators of possible abuse or neglect, at an early stage. They should refer to those concerns to the appropriate organisation, normally LA (Local Authority children's social care" but the evidence from the present study is that teaching staff may not acknowledge how important confidentiality is to young people.*
>
> *(Appleby et al. 2006, p.67)*

This contrasted with the high value that students placed on keeping control of their personal information. Lack of available space for private meetings in school was observed throughout the research, but may not have been a priority. The problem of finding space to deliver the Project therefore seems to be an example of a cultural norm in schools of favouring visibility over confidentiality.

For the Change Project, the promise of confidentiality was qualified by a proviso that serious concerns might have to be referred to an outside agency. This did not happen in any cases, though 4 students were referred to the school nurse, with their agreement. School nurses and Project Workers said they were familiar with explaining this to students before any disclosures were made. Therefore the student had control over their information at the point of disclosure, but could lose control if the adult decided to pass the information on because of its seriousness.

- Threats to stability of the research project

There were potential risks to the research process associated with the school context. As explained earlier, many of the methodological processes of gaining access, implementation and collecting data relied on the attitudes and commitment of the staff and the effectiveness of their relationship with the researcher. Any rapport developed between the researcher and school personnel depended on the researcher having continued access to

individuals. This was potentially vulnerable to changes made in school. The significance of these conditions was suggested when the Project champion in Faithschool was moved from the Project, which subsequently lost momentum in that school.

- Tensions between pastoral worker and Project Worker roles

The philosophy behind the Change Project was to support young people to learn how to protect their own emotional wellbeing, and the intervention was based around guided self-help, with collaborative goal setting and shared responsibility. This structured approach, with a referral system, planned appointments, and target setting was delivered in   3 schools where the culture of pastoral care was characterised by crisis management.   In Girlschool and Faithschool particularly Project Workers and other pastoral staff often seemed to be experiencing suffered high levels of stress, with missed or interrupted dinner breaks, unfeasible timetables, and in some cases a lack of management support.

It was anticipated by Project workers that the structured approach might reduce their stress by managing time effectively. However in practice the Project Workers seemed uncomfortable with managing an appointment system. Therefore, Project Workers might be rushing to attend to a distressed student in one minute, while at the same time making an appointment for the next day with a prospective Project user.

Project Workers explained how it was sometimes unrealistic to make the change from crisis intervention to crisis prevention and expressed the view that it was appropriate to be available for ad hoc support for students throughout the school day.

Therefore there appeared to be a conflicting philosophy between an appointment oriented system, with its origins in health care, and a responsive system developed in schools. Although several interviewees felt that often young people could wait for help, and would benefit from learning how to tolerate some anxiety, this sense of urgency around young people's emotional wellbeing needs is a developmental consideration that would apply to the delivery of other health interventions in schools.

It may be beneficial to explore opportunities in schools for supporting pastoral staff and young people to make distinctions between occasions when an immediate response is required and when a more considered assessment of need is more appropriate. Competing demands from crisis management and planned intervention may be reconciled through

better understanding of the benefits of planned care and more confidence about alternatives to a crisis response, though this may be difficult to put into practice because of the cultural context of pastoral care in school.

This could be addressed through continued working with staff and students.

- Promotion of the Change Project

Questionnaire evidence suggested that many students had not heard of the Change Project, though over half stated that they thought it sounded useful, particularly students in Girlschool, females, and younger students[21]. Given this degree of notional support, the Project may have potential to overcome some of the barriers to help-seeking that have been presented in this thesis.

As the literature suggests that help-seeking in young people is closely bound up with their perceptions of accessibility and acceptability, a school-based emotional wellbeing intervention should be well advertised. According to interviewees in this study, the best way to publicise it would be through a consistent campaign of word of mouth, posters, and verbal announcements.

Arguably, the Project might have been better promoted if senior management had had a stronger sense of its potential value to the students. Future developments of this research could present its findings as part of a persuasive argument to school directors, to work with the vision of the Head Teacher to influence the social climate of the school (Kam et al 2003) and anchor more assertive commitment to the Project.

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[21] The proportions of survey respondents who stated they would consider using it were 71% in Girlschool, 45% in Sportschool and 36% in Faithschool, with higher figures among females (57%) and the KS3 students (58%) .

14.7.2   Summary

- The Change Project components could be reviewed, to facilitate implementation in schools and help-seeking from students.

- Confidentiality was an important facilitator of help-seeking from the Project.

- It appeared to be feasible and acceptable for unqualified pastoral and SEN staff to carry out the role of Project worker, supported by training and supervision.

- The acceptability and feasibility of brief appointments was not clearly established, though the young people appeared to be more comfortable with them than the Project workers.

- The sample of self esteem outcomes was limited, but the data which was collected appears to indicate that the intervention has potential to reduce self esteem, and insights have been gained into strategies to improve response rates.

14.7.3   Ethical considerations in research with young people in school: the potential of conflicting value systems

There is potential for a clash of values when bringing health research into schools. UK legislation to protect young people favours integrated working, which in schools may often mean information sharing (Hunter and Pierscionek 2007). As explained by the Deputy Head Teachers during negotiations about the research with the schools, there is an obligation on schools to keep carers informed. Therefore a feasible research design for schools will acknowledge and negotiate differences between the values of the research paradigm and those of the school context.

The school culture and available resources may affect how a research Project is conducted. Physical space and protected time may be difficult to access. Confidentiality and privacy may be harder to achieve if they conflict with a school culture of openness and visibility. Access to an emotional health intervention in schools may be stigmatised or affected in either direction by peers or adults.

There is potential for a clash between the expectations of ethical health research design and the practical approach required for working in a school setting. As information sharing and openness may be more highly valued than privacy, confidential data collection may be incompatible with prevailing working practices in schools and require particular attention.

14.8   Feasibility and acceptability of the Change Project intervention

The following list summarises ingredients of the intervention that appeared to contribute to its feasibility and acceptability.

- Facilitation of independent self referral

- Having a friendly and trusted helper such as Pastoral and SEN staff delivering GSH

- Interventions through in which students learn effective strategies to protect their emotional wellbeing in confidential, structured sessions.

- Respecting the privacy and confidentiality of project users;

- Scheduling appointments outside lesson time,

- Locating the intervention in school;

- Using problem formulation, goal setting, and target planning,

- Involving the school nurses in the screening protocol.

By incorporating the advice of young people into the design, the Change Project addressed some of the barriers to help-seeking identified in the data. The appropriateness of the intervention for the age of the population was enhanced by the process of self-referral, which meant it was available, but not imposed. Because young people were deciding for themselves whether they had a problem, they were able to exercise control over who learned about their personal business. Further, the Project users said they were able to define the presenting problem in their own terms and set goals collaboratively, so they were able to maintain control of the intervention.

Young people reported that the interventions were helpful, suggesting that they can be supported to self care for emotional problems outside the health system. Further studies

of effectiveness could be designed on the basis of the model developed in this study and the lessons learned.

Further developments could include the following:

- The development of a school culture which was open about emotional wellbeing, could reduce the perceived risks of help-seeking in school. This could be addressed through close working with senior managers in school, curriculum interventions, and supervision for staff.

- Advance access to key figures, including the Head Teacher, and the identification of an effective Project champion, would support the Project implementation in a school. Practical support for the Project Workers including adequate training time could be defined and agreed before they committed to delivering the Project. It may also be helpful to develop strategies to involve other school staff appropriately, in order to encourage a sense of ownership of the Project to assist its integration into the school culture.

- Open referral would improve access for less competent individuals while preserving highly valued confidentiality valued to the Project: that is, self-referral and third party referrals should both be acceptable, with the condition that the young person willingly engages.

The role of competence, confidence and courage in facilitating help-seeking for emotional difficulties in young people has been described. This knowledge can be applied to a framework of recommendations for further development of the Change Project, based on the lessons learned. The researcher's main influence is over the research and intervention designs. Widening access to the Change Project through an open referral system could improve inclusiveness for young people who lack skills to refer themselves. Ongoing support for the Project workers through training and supervision could enhance young people's confidence in the Project's trustworthiness. Evaluation strategies which engage the young people may have potential to improve their perceptions of the Project's value and encourage them to use the Project for emotional support.

Schools may be able to enhance young people's competence to recognise and seek help for emotional difficulties, through curriculum activities that promote emotional literacy

(such as the FRIENDS programme (Stallard 2008)). The confidence and courage of young people to seek help may depend on explicit and implicit messages circulating within individual schools, about the legitimacy of help-seeking for emotional difficulties. These may be susceptible to influence from school based emotional wellbeing promotion, such as that supported by the Healthy Schools Programme (DH 2004a). Improvements to support for staff in the form of training or supervision may also enhance general emotional wellbeing in schools.

Table 21 summarises potential points of intervention to improve the Change Project, based on knowledge gained from the present study. This demonstrates a process described in Phase II of the MRC Framework (MRC 2000): in an investigation of a complex intervention, some components may be seen as variables, and therefore the extent to which they may be controlled in a trial should be considered.

Table 21: Lessons learned about help-seeking in high school.

Domain	Barriers	Facilitators	Proposed strategies for the promotion of help-seeking in high school- may require considerable commitment from school management
Internal	Fear of the unknown	Courage Familiar face Encouragement	Encourage a discourse in the school (staff and students) about emotional wellbeing and help-seeking.
	Won't help (Lower expectations)	Might help (Higher expectations) outcome	Involvement of trusted and popular helpers in promoting help-seeking/delivering interventions
	Don't know where to get help	Effective information	Well designed posters, verbal information. Clear and flexible access routes.
Contextual	Risk of exposure	Control over personal information	Clear information about confidentiality; training for school staff about recognising and handling sensitive issues.
	Written information is ignored	Culturally appropriate advertising (development, setting, literacy, language)	Advertising material is appropriate for setting and target audience
	Risk of peer ridicule	Peer approval	Embed help-seeking in school culture

Specific issues about the further development of the Change Project

Safety protocol	Researcher able to access school nurses to engage them in development of protocol.
15 minute appointment length	There may be training implications. Appointment time could be extended.
Evaluation of effectiveness	Researcher able to review evaluation strategies and data collection methods. E.g data could be collected by additional researchers to improve response rates.
Referral route	Alternative access routes, including open referral systems, could be developed further.

14.9   Reflections on the study

This section summarises the achievements and limitations of the study, indicates what it has added to knowledge, some proposals for future developments of the intervention and raises questions which could be addressed in further research study.

14.9.1   Achievements of the study

- Feasibility and acceptability of the Change Project intervention was evaluated.

- Self-help resources were developed.

- Project worker training was developed

- Feasibility and acceptability of supervision for Project workers was demonstrated.

- Three high schools engaged in consultation, development and implementation stages of the study.

- Senior managers, pastoral and SEN teams, school nurses, teachers and students participated in the research.

- A range of data were collected.

- Feasibility of conducting individual confidential interviews with students in high school was demonstrated.

14.9.2   What this study adds to research knowledge

- The MRC Framework can be relevant to research outside a health setting.

- The fear of emotional exposure may be a barrier to help-seeking in young people

- Competence, confidence and courage in young people may facilitate help-seeking

- Gender, age and context may affect attitudes to help-seeking.

- Self referral is a preferred means of access to interventions for some young people.

- Unqualified pastoral and SEN staff can deliver GSH interventions in school.

- The ethos of pastoral care in school may influence the implementation of emotional wellbeing interventions.

- The PHQ-2 can be an effective screening tool for young people in a normal population.

- The RSES can be a relevant measure of changes in emotional wellbeing.

- Distribution of a questionnaire to forms in school can achieve a good response rate.

- It is potentially feasible and acceptable for unqualified pastoral and SEN staff to deliver GSH interventions in school.

14.9.3   Questions the study has raised

- Consistency with findings from other research (Freedenthal and Stiffman 2007) suggests a need for further exploration of help-seeking attitudes in young people.

- The effectiveness of the intervention is not known.

- The role of the school context in the implementation of the intervention is not clearly understood.

- The role of the school context in attitudes to help-seeking in school is not clearly understood.

14.9.4   Potential developments of the Change Project

- Improve acceptability by clarifying support preferences, and investigating marketing, and delivery modes in different genders, age groups and contexts.

- Financial incentives for pastoral and SEN staff to attend training and act as Project workers

14.10 Conclusion

The aims of this research study were to explore the feasibility and acceptability of a guided self-help intervention to promote emotional wellbeing in high school students. The research has demonstrated that young people in high school can be supported to look after their emotional wellbeing, using evidence based interventions delivered through guided self-help.

The acceptability of the Change Project to the young people in the study appeared to depend on their attitudes to help-seeking. They did not demonstrate an interest in the intervention's feasibility, though this may be because it was provided in school. Those who had used the Project tended to focus more on their experience of the intervention and those who had not used it tended to be more conscious of barriers to access, which included lack of information and opportunity, lack of trust in confidentiality, and anxiety about exposure. This suggests that addressing perceptions of accessibility is an important part of such interventions.

Interviews and questionnaires revealed the components of complex internal decision making processes which appeared to accompany help-seeking in the peer group, including young people who had not been involved in the Change Project. The young people communicated a collective value system, which rested largely on the idea that peer approval was essential for subjective wellbeing and strongly influenced their social world. They emphasised that revealing weaknesses challenged the social norms and risked loss of friends, peer group status and hence self esteem. This view appears to be central to understanding help-seeking processes in the young people in the study

Internal factors that facilitated overcoming barriers to help-seeking from the Change Project included competence at recognising and managing emotions, confidence in the help available, and courage to take the step to ask for help; these were associated with emotional and cognitive development and individual beliefs and experiences.

The influence of the school context on the acceptability and feasibility of the intervention has also been explored. Within each school, different contextual factors have been identified. The data suggested that school cultures emanated from a combination of official school policies and unofficial rules of the social world of school. Official school policies

were communicated down through the hierarchy from the Head Teacher and reflected publicly in organisational arrangements. Unofficial rules were more obscure and less accessible and were revealed through the data collected from interviews and questionnaires in the process of trying to understand barriers and facilitators to help-seeking from the Change Project. It appeared that congruence with the school policies enhanced the Project's acceptability to the school leadership, and this led to greater feasibility. Hence the support of school leadership was central to acceptability and feasibility.

In conclusion, the findings suggested that the feasibility and acceptability of the intervention were defined by a complex interplay of young people's attitudes to help-seeking and the ethos within each school. This study has added fine detail to help understand young people's attitudes to help-seeking for emotional difficulties and the impact of the school context. This new information can be used to inform further development of the Change Project and other school based emotional wellbeing interventions.

14.11   Final conclusion: contribution of the study

This thesis has discussed the rationale, development and implementation of a guided self-help intervention to promote emotional wellbeing in high school settings. The study findings showed that feasibility and acceptability of the intervention were strongly influenced by individual factors affecting help-seeking in the high school students and structural factors in the context of each school.

The study design was guided by the MRC Framework for complex interventions to improve health (Campbell et al. 2007, Craig et al. 2008, Medical Research Council 2000) The Framework was a helpful and appropriate methodological tool for a school-based research study.

A variety of data were collected from people who supported, delivered and used the Project and others who had not had any involvement with it. These data helped to understand the components and processes of the intervention. The feasibility of the intervention depended on the interest and capacity of the individual school culture and staff, while its acceptability depended on internal and structural factors affecting help-seeking in the students. Particular emphasis has been placed on the decision-making

processes that were found to be involved in help-seeking of the young people, because the young people provided rich data on this important topic.

The Change Project appeared to have potential to make a contribution to pastoral care provided in schools. At the end of the research, the Project was stopped in Faithschool and discussions were held in the other two schools to plan its continuation there, which was consistent with the success of the implementation on each site.

The research study has generated insights into help-seeking in young people, implementation of health interventions in schools, and the use of guided self-help to promote emotional wellbeing intervention in schools. These insights can now be used to develop a more feasible and acceptable intervention which can be tested for effectiveness.

References

Achenbach, T. & Ruffle, T. (2000) The Child Behaviour Checklist and Related Forms for Assessing Behavioral/Emotional Problems and Competencies. *Pediatrics in Review,* **21**(1), 265-271.

Ackerson, J., Scogin, F., McKendree-Smith, N. & Lyman, R.D. (1998) Cognitive Bibliotherapy for Mild and Moderate Adolescent Depressive Symptomatology. *Journal of Consulting & Clinical Psychology August 1998,* **66**(4), 685-690.

Allen, B. (2007) Lunchtime drop-in clinics accessible in schools *British Journal of School Nursing,* **2**(5), 205 - 211.

Anderson, E. (1999) *Code of the street: Decency, violence, and the moral life of the inner city,* W. W. Norton., New York.

Anglin, T., Naylor, K. & Kaplan, D. (1996) Comprehensive school-based health care: high school students' use of medical mental health and substance abuse services. *The American Academy of Pediatrics,* **97**(3), 318-330.

Appleby, L., Shribman, S. & Eisenstadt, N. (2006) *Promoting the Mental Health and Psychological Wellbeing of Children and Young People. Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services.* (Department of Health).

Arksey, H. & O'Malley, L. (2005) Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology,* **8**(1), 19-32.

Audit Commission (1999) *Children in Mind: Child And Adolescent Mental Health Services.* Audit Commission: Portsmouth.

Badham, B. & Wade, H. (2008) *Hear by right: Standards framework for the participation of children and young people.* Revised Edition (National Youth Agency and Local Government Association).

Bagley, C., Bertrand, L., Bolitho, F. & Mallick, K. (2001) Discrepant parent-adolescent views on family functioning: Predictors of poorer self-esteem and problems of emotion and behaviour in British and Canadian adolescents. *Journal of Comparative Family Studies,* **32**(3), 393-403.

Bagley, C., Bolitho, F. & Bertrand, L. (1997) Norms and Construct Validity of the Rosenberg Self-Esteem Scale in Canadian High School Populations: Implications for Counselling. *Canadian Research Institute for Law and the Family*, 31(1), 82-92.

Bagley, C. & Mallick, K. (2001) Normative data and mental health construct validity for the Rosenberg Self-Esteem Scale in British Adolescents. *International Journal of Adolescence and Youth,* **9**(2-3), 117-126.

Bailer, U., de Zwaan, M., Leisch F, Strnad A, Lennkh-Wolfsberg C, El-Giamal N, Hornik K & S., K. (2004) Guided self-help versus cognitive-behavioral group therapy in the treatment of bulimia nervosa. *International Journal of Eating Disorders,* **35**(4)), 522-37.

Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory.* Prentice-Hall, Inc., Eaglewood Cliffs, New Jersey.

Bates, J. (1996) *Retracking,* Devon County Council, Devon.

Bernard, D., Quine, S., Kang, M., Alperstein, G., Usherwood, T., Bennett, D. & Booth, M. (2004) Access to primary health care for Australian adolescents: how congruent are the perspectives of health service providers and young people, and does it matter? *Australian & New Zealand Journal of Public Health,* **28**(5), 487-92.

Blackwood, B. (2006) Methodological issues in evaluating complex healthcare interventions. *Journal of Advanced Nursing 2006 Jun; 54(5): 612-22.*

Bond, L., Butler, H., Thomas, L., Carlin, J., Glover, S., Bowes, G. & Patton, G. (2007) Social and School Connectedness in Early Secondary School as Predictors of Late Teenage Substance Use, Mental Health, and Academic Outcomes. *Journal of Adolescent Health,* **40**(4), 357.e9-357.e18.

Bostic, J., Rubin, D., Prince, J. & Schlozman, S. (2005) Treatment of Depression in Children and Adolescents. *Journal of Psychiatric Practice,* **11**(3), 141-154.

Bower, P., Garralda, E., Kramer, T., Harrington, R. & Sibbald, B. (2001a) The treatment of child and adolescent mental health problems in primary care: a systematic review. *Family Practice,* **18**(4), 373.

Bower, P., Jerrim, S. and Gask, L (2004) Primary care mental health workers: role expectations, conflict and ambiguity. *Health and Social Care in the Community* **12**(4) 336-45

Bower, P., Macdonald, W., Sibbald, B., Garralda, E., Kramer, T., Bradley, S. & Harrington, R. (2002) *Child and Adolescent Mental Health Services (CAMHS) in primary care. Final Report to the Department of Health.* Department of Health

Bower, P., Richards, D. & Lovell, K. (2001b) The clinical and cost-effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. *British Journal of General Practice,* **51**(471), 838-45.

Boyle, M.E., Pitts, M.K., Philips, K.C., White, D.G., Clifford, B. & Woollett, E.A. (1989) Exploring Young People's attitudes to and knowledge of AIDS- the value of focused group discussions. *Health Education Journal,* **48**(1), 21-23.

Brown, G.W., Bifulco, A. & Andrews, B. (1990a) Self-esteem and depression. Social Psychiatry and Psychiatric Epidemiology, 25(5), 235-243.

Brown, G.W., Bifulco, A. & Andrews, B. (1990b) Self-esteem and depression. *Social Psychiatry and Psychiatric Epidemiology*, 25(5), 244-249.

Brown, G.W., Craig, T.K. & Harris, T.O. (1985) Depression: distress or disease? Some epidemiological considerations. *The British Journal of Psychiatry,* 147(6), 612-622.

Bury, M. (2006) The Expert Patient: Challenges to Self Care in the NHS Dundee May 2006. In *Enhancing Self Care - The Evidence Base.* [Conference presentation] Alliance for Self Care Research and the Social Dimensions of Health Institute, West Park Conference Centre, Dundee.

Butler, R.J. & Gasson, S.L. (2005) Self Esteem/Self Concept Scales for Children and Adolescents: A Review. *Child and Adolescent Mental Health,* **10**(4), 190-201.

Calnan, M., Wainwright, D., O'Neill, C., Winterbottom, A. & Watkins, C. (2006) Making sense of aches and pains. *Fam. Pract.,* **23**(1), 91-105.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A.L., Sandercock, P., Spiegelhalter, D. & Tyrer, P. (2000) Framework for design and evaluation of complex interventions to improve health. *BMJ,* **321;**(7262), 694-696.

Campbell, N.C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., Guthrie, B., Lester, H., Wilson, P. & Kinmonth, A.L. (2007) Designing and evaluating complex interventions to improve health care. *BMJ,* **334**(7591), 455-459.

Care Services Improvement Partnership (CSIP) (2006) *Best Practice Guidance for Primary Care Staff using the Mental Health Domains in the QOF.*

Careers Advice Service (2008) *Careers Advice: Special Educational Needs Teacher* [Online] (Updated 2008) Learning and Skills Council (LSC). Available at: http://careersadvice.direct.gov.uk/ ed. [Accessed Nov 2008]

Christie, D. & Wilson, C. (2005) CBT in paediatric and adolescent health settings: A review of practice-based evidence. *Pediatric Rehabilitation,* **8**(4), 241-247.

Churchill, R., Allen, J., Denman, S., Williams, D., Fielding, K. & Fragstein, M.v. (2000) Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *Br J Gen Pract.,* **50**(461), 953-957.

Ciarrochi, J. & Scott, G. (2006) The link between emotional competence and wellbeing: A longitudinal study. *British Journal of Guidance & Counselling Vol 34(2) May 2006, 231-243.*

Cleave, H., Carey, P., Norris, P., Sloper, P., While, D. & Charlton, A. (1997) Pastoral Care in Initial Teacher Education: A Survey of Secondary Teacher Education Institutions. *Pastoral Care in Education,* **15**(2), 16-21.

Cohen, S.T. & Block, S. (2004) Issues in psychotherapy with terminally ill patients. *Palliative and Supportive Care,* **2**(181-189).

Conner, M. & Norman, P. (1996a) *Predicting health behaviour. Research and Practice with Social Cognition Models.* Open University Press, Ballmore: Buckingham.

Conner, M. & Norman, P. (1996b) Predicting Health Behaviour: A Social Cognition Approach. In *Predicting health behaviour. Research and Practice with Social Cognition Models* (Conner, M. and Norman, P. eds.) Open University Press, Ballmore: Buckingham.

Costello, E.J. & Angold, A. (1988) Scales to Assess Child and Adolescent Depression: Checklists, Screens, and Nets. *Journal of the American Academy of Child & Adolescent Psychiatry,* **27**(6), 726.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. & Petticrew, M. (2008) Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ,* **337**, a1655.

Curbow, B. & Somerfield, M. (1991) Use of the Rosenberg Self Esteem Scale with cancer patients. *Journal of Psycosocial Oncology,* **9**(2), 113-31.

Dalle Grave, R. (2003) School-based prevention programs for eating disorders: achievements and opportunities. *Disease Management & Health Outcomes. 11(9): 579-93.*

Davidson, J. (2008) *Children and young people in mind: the final report of the National CAMHS Review.* Independent review commissoned by the Department for Children, Schools and Families.

DCSF (2006) *The Standards Site:National Healthy School Standard.* [Online] (Updated 2008) Available at: http://www.standards.dfes.gov.uk/ [Accessed Dec 2008].

DCSF (2008a) *Every Child Matters: Change for Children: Child and Adolescent Mental Health Services* [Online] (Updated 2008). Available at: http://www.everychildmatters.gov.uk/health/camhs/ [Accessed 12 December 2008).

DCSF (2008b) *Social and emotional aspects of learning... improving behaviour… improving learning* [Online] (Updated 2008). Available at: http://www.standards.dfes.gov.uk/primary/publications/banda/seal [Accessed 24 November 2008].

Demos, J. & Demos, V. (1969) Adolescence in Historical Perspective. *Journal of Marriage and the Family,* **31**(4), 632-638.

den Boer, P., Wiersma, D. & Van den Bosch, R.J. (2004) Why is self-help neglected in the treatment of emotional disorders? A meta-analysis. *Psychological Medicine,* **34**(6), 959-71.

Desforges, C. & Abouchaar, A. (2003) *The Impact of Parental Involvement, Parental Support and Family Education on Pupil achievement and Adjustment: A literature review. Research Report No 433.* Department for Children, Schools and Families.

DfES (2004) *Every Child Matters: Change for Children in Schools.* Vol. DfES/1089/2004 DfES Publications.

DfES (2007) *Research & Statistics Gateway* [Online] (Updated 2007). Available at: http://www.dfes.gov.uk/rsgateway/DB/SFR/s000232/tab001b.shtml [Accessed 19 April 2007].

DfES (2009) Standards Site [Online] *What are Specialist Schools?* (Updated 2009) Available at: http://www.standards.dfes.gov.uk/specialistschools [Accessed 27 April 2009].

DH (1999) *National Service Framework for Mental Health.* London:HMSO.

DH (2000) *The mental health of children and adolescents in Great Britain: A survey carried out in 1999 by the Office for National Statistics on behalf of the Department of Health,* HMSO, London.

DH (2002) *National Child and Adolescent Mental Health Service Mapping Exercise* [Online] (Updated 2002). Available at: www.dur.ac.uk/service.mapping/CAMH/brief.php [Accessed April 2005].

DH (2004a) *National Healthy Schools Standards- a guide for schools.* Department of Health: Crown Copyright.

DH (2004b) *National Service Framework for Children, Young People and Maternity Services: The mental health and psychological wellbeing of children and young people*. Crown Copyright.

DH (2005) *National Healthy School Status: A Guide for Schools*. Department of Health: Crown Copyright.

DH (2007a) Background-the evolution of Policy.[In *Health and Social Care Topics*.Department of Health.[Online] (Updated 2008) Available at: www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices [Accessed Nov 2008]

DH (2007b) *National Service Framework for Children Young People and Maternity Services: Core Standards.* Crown Copyright.

DH (2008) *Glossary: Young Person* (Every Child Matters: Change for Children article) [Online] (Updated 11 August 2008). Available at : http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary [Accessed 25 11 08].

DH & DfES (2004) *CAMHS Standard, NSF for Children, Young People and Maternity Services.*

Directgov (2008) *Careers Advice: Teaching Assistant*. [Online] (Updated 2008) Available at: *<http://careersadvice.direct.gov.uk/helpwithyourcareer/jobprofiles/profiles/profile 180/>* [Accessed 22.09.08.]

Donovan, C., Mellanby, A.R., Jacobson, L.D., Taylor, B. & Tripp, J.H. (1997) Teenagers' views on the general practice consultation and provision of contraception. The Adolescent Working Group. *Br J Gen Pract.,* **47**(424), 715-718.

Duffy, M. (1985) A critique of research: a feminist perspective. *Health Care for Women International,* **6**(5/6), 341-352.

Eber, L. & Nelson, C.M. (1997) School-based wraparound planning: integrating services for students with emotional and behavioral needs. *Am J Orthopsychiatry,* **67**(3), 385-95.

Education Otherwise (2008) *United Kingdom and American Grades* [Online] (Updated 2008). Available at: http://www.education-otherwise.org [Accessed 3 April 2008].

Elias, M.J., Bruene-Butler, L., Blum, L. & Schuyler, T. (1997) How to launch a social and emotional learning program. *Educational Leadership,* **54** (8),15-20.

Erikson (1950) *Childhood and Society*. New York: W.W. Norton and Company, Inc.

Farrand, P., Parker, M. & Lee, C. (2007) Intention of adolescents to seek professional help for emotional and behavioural difficulties. *Health & Social Care in the Community,* **15** (5), 464.

Farrand, P., Perry, J., Lee, C. & Parker, M. (2006) Adolescents' preference towards self-help: Implications for service development. *Primary Care & Community Psychiatry,* **11**(2), 73-79.

Fletcher, J., Lovell, K., Bower, P., Campbell, M. & Dickens, C. (2005) Process and Outcome of a Non-Guided Self-Help Manual for Anxiety and Depression in Primary Care: A Pilot Study. *Behavioural and Cognitive Psychotherapy,* **33**(3), 319-331.

France, A., Bendelow, G. & Williams, S. (2000) A 'risky' business: researching the health beliefs of children and young people. In *Researching Children's Perspectives* (Lewis, A. and Lindsay, G. eds.) Open University Press, Buckingham.

Freedenthal, S. & Stiffman, A.R. (2007) "They Might Think I Was Crazy": Young American Indians' Reasons for Not Seeking Help When Suicidal. *Journal of Adolescent Research,* **22**(1), 58-77.

Galloway, D. (1983) Disruptive Pupils and Effective Pastoral Care *School leadership & management,* **3**(3), 245

Garcia, K. & Mann, T. (2003) From I Wish to I Will : Social-Cognitive Predictors of Behavioral Intentions. *J Health Psychol,* **8**(3), 347-360.

Garralda, M.E. & Bailey, D. (1990) Paediatrician identification of psychological factors associated with general paediatric consultations. *Journal of Psychosomatic Research,* **34**(3), 303-312.

Gask, L., Dowrick, C., Dixon, C., Sutton, C., Perry, R., Torgerson, D. & Usherwood, T. (2004) A pragmatic cluster randomized controlled trial of an educational intervention for GPs in the assessment and management of depression. *Psychological Medicine,* 34(1), 63-72.

Gega, L., Marks, I. & Mataix-Cols, D. (2004) Computer-aided CBT self-help for anxiety and depressive disorders: experience of a London clinic and future directions. *Journal of Clinical Psychology,* **60**(2), 147-57.

Ginsburg, K. (2001) Setting the Stage for Effective Communication with the Adolescent Patient. *CommonHealth: The Journal of the American International Health Alliance,* **9**(1), 25-27.

Ginsburg, K.R. (2003) Developing our future: seeing and expecting the best in youth. *Journal of Midwifery & Women's Health,* **48**(3), 167-9.

Ginsburg, K.R., Menapace, A.S. & Slap, G.B. (1997) Factors affecting the decision to seek health care: the voice of adolescents. *Pediatrics,* **100**(6), 922-30.

Ginsburg, K.R., Slap, G.B., Cnaan, A., Forke, C.M., Balsley, C.M. & Rouselle, D.M. (1995) Adolescents' perceptions of factors affecting their decisions to seek health care. *JAMA,* 273, 1913-1918.

Gleeson, C., Robinson, M. & Neal, R. (2002) A review of teenagers' perceived needs and access to primary health care: implications for health services. *Primary Health Care Research & Development,* **3**, 184-93.

Goodman, R., Ford, T., Simmons, H., Gatward, R. & Meltzer, H. (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *British Journal of Psychiatry,* **177** 534-539.

Gowers, S., Bailey-Rogers, S.J., Shore, A. & Levine, W. (2000) The Health of the Nation Outcome Scales for Child & Adolescent Mental Health (HoNOSCA). *Child and Adolescent Mental Health,* **5**(2), 50-56.

Gowers, S.G. (2006) Evidence Based Research in CBT with Adolescent Eating Disorders. *Child and Adolescent Mental Health,* **11**(1), 9-12.

Gray, N.J., Klein, J.D., Noyce, P.R., Sesselberg, T.S. & Cantrill, J.A. (2005) The Internet: A window on adolescent health literacy. *Journal of Adolescent Health,* **37**(3), 243.e1-243.e7.

Grazebrook, K., Garland, A. & and the Board of BABCP (2005) *What are Cognitive and/or Behavioural Psychotherapies?* Paper prepared for a UKCP/BACP mapping psychotherapy exercise.

Greenberg, M.T., Weissberg, R.P., O'Brien, M.U., Zins, J.E., Fredericks, L., Resnik, H. & Elias, M.J. (2003) Enhancing School-Based Prevention and Youth Development Through Coordinated Social, Emotional, and Academic Learning. *American Psychologist,* **58**(6-7), 466-74.

H.M.Government (2004) *Every Child Matters: Change for Children*. (Inter-departmental ed. Crown Copyright.

Hall, G.S. (1904) *Adolescence: Its psychology and its relation to physiology, anthropology, sociology, sex, crime, religion, and education* (Vols. I & II). London: Appleton and Co.

Hallam, S. (2007) Evaluation of Behavioural Management in Schools: A Review of the Behaviour Improvement Programme and the Role of Behaviour and Education Support Teams. *Child and Adolescent Mental Health,* **12**(3), 106-112.

Hallam, S., Rogers, L., Castle, F., Rhamie, J., Creech, A. & Kokotsaki, D. (2005) *Evaluation of the Behaviour Improvement Programme, Research Report 702.* (Department of Children, Schools and Families)

Harbour, A. (2004) Understanding Children and Young People's Rights to Confidentiality. *Child and Adolescent Mental Health,* **9**(4), 187-190.

Harkness, E., & Bower, P.(2006) National Evaluation of the Graduate Worker Initiative-current roles and future trends. *National Primary Care Graduate Worker Conference.* Nottingham, UK.

Harrington, R. & Dubicka, B. (2002) Adolescent depression:an evidence-based approach to intervention. *Current Opinion in Psychiatry,* **15**, 369-375.

Harrington, R., Whittaker, J. & Shoebridge, P. (1998a) Psychological treatment of depression in children and adolescents. A review of treatment research. *The British Journal of Psychiatry,* **173**(4), 291-298.

Harrington, R., Whittaker, J., Shoebridge, P. & Campbell, F. (1998b) Systematic review of efficacy of cognitive behaviour therapies in childhood and adolescent depressive disorder. *British Medical Journal,* **316**(7144), 1559.

Hatcher, J. (2007) The State of Measurement of Self-Esteem of African American Women. *J Transcult Nurs,* **18**(3), 224-232.

Hazell, P. (2005) Depression in Children and Adolescents. In *Clinical Evidence: Child Health*, Vol. /06 BMJ.

Hennessy, E. & Heary, C. (2005) Exploring Children's Views Through Focus Groups. In *Researching Children's Experience: Approaches and Methods* (Greene, S. and Hogan, D. eds.) Sage, London.

Hennessy, E., Swords, L. & Heary, C. (2008) Children's understanding of psychological problems displayed by their peers: a review of the literature. *Child: Care, Health and Development,* **34**(1), 4-9.

Herbert, M. (2003) *Typical and atypical development: from conception to adolescence,* Blackwell, Malden, Mass. ; Oxford.

Herbert, M. (2005) *Developmental problems of childhood and adolescence : prevention, treatment and training,* BPS : Blackwell Pub., Malden, Mass. ; Oxford.

Herrman, H., Saxena, S. & Moodie, R. (eds.) (2005) *Promoting mental health: concepts, emerging evidence, practice : report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne,* World Health Organization.

Hill, M. (2005) Ethical considerations in researching children's experiences. In *Researching Children's Experiences* (Greene, S. and Hogan, D. eds.) Sage, London.

Hoppe, M., Graham, L., Wilsdon, A., Wells, E., Nahom, D. & Morrison, D. (2004) Teens speak out about HIV/AIDS: focus group discussions about risk and decision-making. *Journal of Adolescent Health,* **35**(4), 345.e27-35.

Hunter, D. & Pierscionek, B.K. (2007) Children, Gillick competency and consent for involvement in research. *J Med Ethics,* **33**(11), 659-662.

Hunter, S., Boyle, J. & Warden, D. (2004) Help-seeking amongst child and adolescent victims of peer-aggression and bullying: The influence of school-stage, gender, victimisation, appraisal and emotion. *British Journal of Educational Psychology,* **74**(3), 375-390.

Inchley, J., Muldoon, J. & Currie, C. (2007) Becoming a health promoting school: Evaluating the process of effective implementation in Scotland. *Health Promotion International,* **22**(1), 65-71.

Institute of Community Health Sciences (ICHS) at Barts and the London Queen Mary's School of Medicine and Dentistry (2003) *Health of young people in east London-the Relachs Study.* HMSO London:

Institute of Paralegals (2003) *Institute of Paralegals* [Online] (Updated 2003). Available at: http://www.instituteofparalegals.org. [Accessed 22.Sep 2008]

Jacobson, L., Churchill, R., Donovan, C., Garralda, E., Fay, J. & RCGP Adolescent Working Party (2002) Tackling teenage turmoil: primary care recognition and management of mental ill health during adolescence. *Family Practice,* **19**(4), 401-9.

Kaltenhaler, E., Shackley, P., Stevens, K., Beverley, C., Parry, G. & Chilcott, J. (2002) A systematic review and economic evaluation of computerised cognitive behaviour therapy fro depression and anxiety. *Health Technology Assessment,* **6**(22).

Kam, C.-M., Greenberg, M.T. & Walls, C.T. (2003) *Examining the role of implementation quality in school-based prevention using the PATHS curriculum,* Prevention Science. Vol 4(1) Mar 2003, 55-63.

Khan, N., Bower, P. & Rogers, A. (2007) Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience. *Br J Psychiatry,* **191**(3), 206-211.

Khanlou, N. (2004) Influences on adolescent self-esteem in multicultural Canadian secondary schools. *Public Health Nursing,* **21**(5), 404-11.

Kirby, P. (2004) *A Guide to actively involving young people in research: For researchers, research commissioners, and managers.* INVOLVE Support Unit, Hampshire.

Kirby, P., Lanyon, C., Cronin, K. & Sinclair, R. (2003) *Building a Culture of Participation: Involving children and young people in policy, service planning delivery and evaluation.* Nottingham: DfES.

Kitzinger, J. (1994) The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health & Illness,* **16**(1), 103-121.

Koch, T. & Harrington, A. (1998) Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing,* **28**(4), 882-890.

Kramer, T. & Garralda, E. (1998) Psychiatric Disorders in Adolescents in Primary Care. *British Journal of Psychiatry,* **17**, 508-513.

Kramer, T.L., Phillips, S.D., Hargis, M.B., Miller, T.L., Burns, B.J. & Robbins, J.M. (2004) Disagreement between parent and adolescent reports of functional impairment. *Journal of Child Psychology and Psychiatry,* **45**(2), 248-259.

Kroenke, K., Spitzer, R. & Williams, J. (2003) The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care,* **41**(11), 1284-1292.

Krueger, R.A. (1997) *Analyzing & Reporting Focus Group Results,* Sage, Thousand Oaks.

Leurs, M.T.W., Schaalma, H.P., Jansen, M.W.J., Mur-Veeman, I.M., St. Leger, L.H. & de Vries, N. (2005) Development of a collaborative model to improve school health promotion in the Netherlands. *Health Promot. Int.,* **20**(3), 296-305.

Lewis, G., Anderson, L., Araya, R., Elgie, R., Harrison, G., Proudfoot, J., Schmidt, U., Sharp, D., Weightman, A. & Williams, C. (2003) *Self-help Interventions for Mental Health Problems.*

Lewis, J. (2004) Design Issues. In *Qualitative Research Practice* (Ritchie, J. and Lewis, J. eds.) Sage, London, pp. 47-76.

Lovell, K. (2000) *SHADE- self-help for anxiety and depression.* Unpublished practice self-help book.

Lovell, K., Bee, P., Richards, D. & Kendal, S. (2006) Self-help for common mental health problems: evaluating service provision in an urban primary care setting. *Primary Health Care Research and Development,* **7**, 211-220.

Lovell, K., Richards, D.A. & Bower, P. (2003) Improving access to primary mental health care: uncontrolled evaluation of a pilot self-help clinic *British Journal of General Practice,* **53**(487), 133-135.

Lyon, M., McCabe, M., Patel, K. & D'Angelo, L. (2004) What do adolescents want? An exploratory study regarding end-of-life decision-making. *Journal of Adolescent Health,* **35**(6), 529.e1-6.

Macdonald, W. (2000) Child and Adolescent Mental Health and primary Care: Current Status and Future Directions. *Current Opinion in Psychiatry,* **13**(4), 369-373.

Marks, I. (1992) Innovations in mental health care delivery. *British Journal of Psychiatry,* **160**, 589-97.

Marks, I. (1997) Behaviour therapy for obsessive-compulsive disorder: a decade of progress. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie,* **42**(10), 1021-7.

Marlow, A. (2008) Time to look for the good behind the hood? Media Portrayal Special Report. In *Debatable: Youth Parliament Newsletter*.

Maslow, A.H. (1943) A Theory of Human Motivation. *Psychological Review*, 50, 370-396.

McCrone, P., Knapp, M. & Fombonne, E. (2005) The Maudsley long-term follow-up of child and adolescent depression: predicting costs in adulthood. *European Child & Adolescent Psychiatry,* **14**(7), 407-13.

McLafferty, I. (2004) Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing,* **48**(2), 187-94.

McLellan, A.T. & Meyers, K. (2004) Contemporary addiction treatment: a review of systems problems for adults and adolescents.*Biological Psychiatry,* 56(10), 764-70.

McPherson, A. (2005) Adolescents in primary care. *BMJ,* **330**, 465-467.

Mead, N., MacDonald, W., Bower, P., Lovell, K., Richards, D., Roberts, C. & Bucknall, A. (2005) The clinical effectiveness of guided self-help versus waiting-list control in the management of anxiety and depression: a randomized controlled trial. *Psychological Medicine,* **35**(11), 1633-43.

Medical Research Council (2000) *Medical Research Council Framework for Complex Interventions.* Medical Research Council.

Mental Health Network (2007) *Maintaining the momentum towards excellent services for children and young people's mental health.* (The NHS Confederation) [Online] (Updated 2007) Available at: http://www.library.nhs.uk/childhealth/ViewResource.aspx?resID=275784&tabID= 290 [Accessed Jun 2008].

Merry, S., McDowell, H., Hetrick, S., Bir, J. & Muller, N. (2004) Psychological and/or educational interventions for the prevention of depression in children and adolescents. *Cochrane Database of Systematic Reviews 2004* (2).

Miles, M. & Huberman, A. (1994) *Qualitative Data Analysis: An Expanded Sourcebook 2nd ed.,* Sage Publications Thousand Oaks CA.

Miller, R.L., Acton, C., Fullerton, D.A. & Maltby, J. (2002) *SPSS for Social Scientists,* Palgrave Macmillan, Basingstoke, Hampshire, UK.

Miller, T. (1998) Shifting Layers of Professional, Lay and Personal Narratives: Longitudinal Childbirth Research. In *Feminist Dilemmas in Qualitative Research* (Ribbens, J. and Edwards, R. eds.) Sage, London.

Morgan, D. & Krueger, R. (1993) When to use focus groups and why. In *Successful focus groups: Advancing the state of the art* (Morgan, D. ed. Sage, Newbury Park, California.

Morrow, V. & Richards, M. (1996) The Ethics of Social Research with Children: An Overview (1). *Children & Society,* **10**(2), 90-105.

Muijs, D. Harris, A. Chapman, C. Stoll, L. & Russ, J. (2004) Improving Schools in Socioeconomically Disadvantaged Areas - A Review of Research Evidence. *School Effectiveness and School Improvement,* **15**(2), 149.

National Collaborating Centre for Mental Health (2005) *Management of depression in primary and secondary care (National Clinical Practice Guideline 23).* National Institute for Clinical Excellence.

National Institute for Clinical Excellence (2005) *Depression in children and young people: identification and management in primary, community and secondary care.* The British Psychological Society and the Royal College of Psychiatrists.

National Institute for Clinical Excellence (2006) *Computerised cognitive behaviour therapy for depression and anxiety: Review of Technology Appraisal 51.* National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (2008) *Social and emotional wellbeing in primary education: Quick reference guide. PG12.* National Institute for Health and Clinical Excellence.

National Institute for Mental Health in England (2004) *Primary Care Graduate Mental Health Workers.* (NIMHE North West ed). NIMHE, London.

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (2003) *Self-help Leaflets.* Vol. 2008 Newcastle North Tyneside and Northumberland Mental Health NHS Trust.

NHS (2008) NHS Careers: *Emergency care assistant.* [Online] (Updated 2008) Available at: www.nhscareers.nhs.uk [Accessed 22.Sep08]

O'Donnell, C. (2008) Defining, Conceptualizing and Measuring fidelity of Implementation and its Relationship to Outcomes in K-12 Curriculum Intervention Research *Review of Educational Research,* **78**(1), 33-84.

Oakley, A. (1989) Who's afraid of the randomised controlled trial? Some dilemmas of the scientific method and 'good' research. *Women and Health,* **15**(25).

Office for National Statistics (2005) *Child Health-Mental Health* [Online] (Updated August 2005) Available at: www.statistics.gov.uk [Accessed 25 November 08].

Ofsted (2005) *Healthy minds: Promoting emotional health and wellbeing in schools*. HMI 2457. (Ofsted ed).

Parker, G. & Roy, K. (2001) Adolescent depression: a review. *Australian and New Zealand Journal of Psychiatry,* **35**(5), 572-80

Pastore DR, Murray PJ, Juszczak L (2001) School-based health center: Position paper of the Society for Adolescent Medicine .*Journal of Adolescent Health*, **29**(6):448-50

Patton, G., Bond, L., Butler, H. & Glover, S. (2003) Changing schools, changing health? design and implementation of the Gatehouse Project. *Journal of Adolescent Health,* **33**(4), 231-239.

Patton, G.C., Glover, S., Bond, L., Butler, H., Godfrey, C., Di Pietro, G. & Bowes, G. (2000) The Gatehouse Project: a systematic approach to mental health promotion in secondary schools. *Australian & New Zealand Journal of Psychiatry,* **34**(4), 586-93.

Patton, M.Q. (1990) *Qualitative evaluation and research methods,* Sage, Newbury Park, CA.

Pawson, R. (2008) Testing programme theories: Realist synthesis. [Conference Presentation.] *3rd ESRC Research Methods Festival* St Catherine's College, Oxford University. Jun 2008

Perkins, S.J., Murphy, R., Schmidt, U. & Williams, C. (2007) Self-help and Guided Self-help for Eating Disorders. In *Cochrane Database of Systematic Reviews*.

Plain English Campaign (2005) *How to write in plain English.* [Online] (Updated 2005) Available at: //www.plainenglish.co.uk/howto.pdf [Accessed Mar 2006]

Popay, J., Rogers, A. & Williams, G. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research,* **8**(3), 341-351.

Pope, C., Ziebland, S. & Mays, N. (2000) Qualitative research in health care: Analysing qualitative data. *BMJ,* **320**(7227), 114-116.

Ravens-Sieberer & Bullinger (2000) Der KINDL[R]- Fragebogen fur Jugendliche. In *Kiddo-KindlR / Jugendversion / 12 –16 Jahre* Vol. 2008.

Richards, C., Cannon, N. & Scott, E. (2005) *Depression in Teenagers: An Interactive CD-ROM About Depression in Teenagers. Version 02.* The Young People's Unit: NHS Lothian.

Richards, C., Cogan, N., Hacker, T., Amin, M. & Beoing, L. (2006) *Stress and Anxiety in Teenagers: An interactive CD-ROM About Stress and Anxiety in Teenagers. Version 01.* The Young People's Unit: NHS Lothian.

Richards, D.A., Lovell, K. & McEvoy, P. (2003) Access and effectiveness in psychological therapies: self-help as a routine health technology. *Health and Social Care in the Community,* **11**(2), 175-82.

Richards, L. & Morse, J. (2007) *Readme First for a User's Guide to Qualitative Methods,* Sage California.

Richardson, R. & Richards, D.A. (2006) Self-Help: Towards the Next Generation. *Behavioural and Cognitive Psychotherapy,* **34**, 13–23.

Rickwood, D., Deane, F.P., Wilson, C.J. & Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *AeJAMH (Australian e-Journal for the Advancement of Mental Health) Vol 4(3) Dec 2005* (No Pagination Specified).

Ritchie, J. & Lewis, J. (eds.) (2003) *Qualitative research practice : a guide for social science students and researchers,* Sage Publications London; Thousand Oaks, Calif.

Ritchie, J. & Spencer, L. (1995) Qualitative data analysis for applied policy research. In *Analyzing Qualitative Data* (Bryman, A. & Burgess, R. (eds.)) Routledge, London.

Rogers, C.R. (1995) On Becoming a Person: A Therapist's View of Psychotherapy. With A New Introduction by Peter D Kramer M.D., Houghton Mifflin Company, New York

Rones, M. & Hoagwood, K. (2000) School-Based Mental Health Services: A Research Review. *Clinical Child and Family Psychology Review,* **3**(4), 223-241.

Rønning, J., Handegaard, B., Sourander, A. & Mørch, W.-T. (2004) The Strengths and Difficulties Self-Report Questionnaire as a screening instrument in Norwegian community samples. *European Child & Adolescent Psychiatry,* **13**(2), 73-82.

Rosenberg, M. (1965) *Rosenberg Self Esteem Scale (RSES),* Florence Slade, Princeton University Press, Princeton, NJ.

Ross, G. & Brannigan, C. (2008) Are Depressed Adolescents Routinely Offered CBT? A Brief Review of Current Practice. *Behavioural and Cognitive Psychotherapy,* **36**(01), 113-117.

Ruchkin, V., Sukhodolsky, D.G., Vermeiren, R., Koposov, R.A. & Schwab-Stone, M. (2006) Depressive symptoms and associated psychopathology in urban adolescents: a cross-cultural study of three countries. *Journal of Nervous and Mental Disease,* **194**(2), 106-13.

Salmon, G., James, A. & Smith, D.M. (1998) Bullying in schools: self reported anxiety, depression, and self esteem in secondary school children. *BMJ,* **317**(7163), 924-5.

Sareen, J., Stein, M.B., Cox, B.J. & Hassard, S.T. Understanding comorbidity of anxiety disorders with antisocial behavior: findings from two large community surveys. *Journal of Nervous and Mental Disease 2004 Mar; 192(3): 178-86.*

Schmitt, D.P. & Allik, J. (2005) Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: exploring the universal and culture-specific features of global self-esteem. *Journal of Personality & Social Psychology,* **89**(4), 623-42.

Schwarzer, R. (2001) Social-Cognitive Factors in Changing Health-Related Behaviors. *Current Directions in Psychological Science,* **10**(2), 47-51.

School Health in Education Unit (SHEU) (2004) TRENDS: Young people's worries (1991-2003). *Education and Health,* **22**(1).

Sourander, A.H., L; Ristkari, T; Ikaheimo, K; Helenius, H; Piha, J. (2001) Child and adolescent mental health service use in Finland *Social Psychiatry & Psychiatric Epidemiology* **36**(6), 294-8.

Spielmans, G.I., Pasek, L.F. & McFall, J.P. (2007) What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review,* **27**(5), 642-654.

Stallard, P. (2008) Promoting Mental Health in Schools: The Friends Cognitive Behaviour Therapy Programme In *Association of Child and Adolescent Mental Health . Yorkshire Branch, half day conference* St George's Centre, Leeds.

Stallard, P., Simpson, N., Anderson, S., Carter, T., Osborn, C. & Bush, S. (2005) An evaluation of the FRIENDS programme: a cognitive behaviour therapy intervention to promote emotional resilience. *Archives of Disease in Childhood,* **90**(10), 1016-9.

Stallard, P., Simpson, N., Anderson, S. & Goddard, M. (2008) The FRIENDS emotional health prevention programme: 12 month follow-up of a universal UK school based trial. *European Child & Adolescent Psychiatry,* **17**(5), 283-289.

Stallard, P., Simpson, N., Anderson, S., Hibbert, S. & Osborn, C. (2007) The FRIENDS Emotional Health Programme: Initial Findings from a School-Based Project. *Child and Adolescent Mental Health,* **12**(1), 32-37.

Stein, R.E.K., Zitner, L.E. & Jensen, P.S. (2006) Interventions for adolescent depression in primary care. *Pediatrics,* **118**(2), 669-82.

Sturt, J. & Whitlock, S. (2006) Complex intervention development for diabetes self-management. *Journal of Advanced Nursing*, 54(3), 293-303.]

Swallow, V., Newton, J. & Van Lottum, C. (2003) Research in brief. How to manage and display qualitative data using 'Framework' and MICROSOFT Excel. *Journal of Clinical Nursing,* **12**(4), 610-2.

Tashakkori, A. & Teddlie, C. (2003) *Handbook of mixed methods in social and behavioural research,* Sage, London.

The British Dyslexia Association (2008) *Dyslexia Style Guide* [Online] (Updated 2008). Available at: http://www.bdadyslexia.org.uk/extra352.html [Accessed 01 04 08].

The Home Office (2008) *Police.* [Online] Available at: http://police.homeoffice.gov.uk/community-policing/community-support-officers/community-cso-faq (Updated 2008) [Accessed 22.09.08.]

The National Healthy Schools Programme (2007) *Healthy Schools: Outcomes.* (Department of Health and Department for Children, Schools and Families Health) Crown Copyright.

Torgerson, C.J. & Torgerson, D.J. (2001) The Need for Randomised Controlled Trials in Educational Research. *British Journal of Educational Studies,* **49**(3), 316-328.

Trowell, J., Rhode, M., Miles, G. & Sherwood, I. (2003) Childhood Depression: Work in Progress; Individual Child Therapy and Parent Work 1. *Journal of Child Psychotherapy,* **29**(2), 147-170.

Turgay, A. (2005) Special report. Child and adolescent psychiatry: comorbidity of dysthymic disorders in children and adolescents. *Psychiatric Times,* **22**(10), 34-6.

Verduyn, C. (2000) Cognitive Behaviour Therapy in Childhood Depression. *Child Psychology and Psychiatry Review,* **5**, 176-180.

Warwick, I., Aggleton, P., Chase, E., Schagen, S., Blenkinsop, S., Schagen, I., Scott, E. & Eggers, M. (2005) Evaluating healthy schools: perceptions of impact among school-based respondents. *Health Educ. Res.,* **20**(6), 697-708.

Waters, E.B., Salmon, L.A., Wake, M., Wright, M. & Hesketh, K.D. (2001) The health and wellbeing of adolescents: a school-based population study of the self-report Child Health Questionnaire. *Journal of Adolescent Health,* **29**(2), 140-9.

Wilson, P., Furnivall, J., Barbour, R.S., Connelly, G., Bryce, G., Phin, L. & Stallard, A. (2008) The work of health visitors and school nurses with children with psychological and behavioural problems. *Journal of Advanced Nursing,* **61**(4), 445-455.

World Health Organization (2008) *The global burden of disease:* 2004 update . Annex A: Deaths and DALYs 2004 Annex tables [Online] (Updated 2008) Available at: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html [Accessed 25 11 08].

World Health Organization Europe (2005) *Mental health of children and adolescents* (WHO European Ministerial Conference on Mental Health: Briefing Doc [Online] Available at http://www.euro.who.int/document/MNH/ebrief14.pdf [Accessed 25 11 08]. Helsinki, Finland.

Yates, P., Kramer, T. & Garralda, E. (2004) Depressive symptoms amongst adolescent primary care attenders. Levels and associations. *Social Psychiatry & Psychiatric Epidemiology,* **39**(7), 588-94.

Zahner, G. & Daskalakis, C. (1997) Factors associated with mental health, general health, and school-based service use for child psychopathology. *American Journal of Public Health,* **87**(9), 1440-1448.