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**Impact of Targeted Mental Health Intervention on Children and Adolescents  
(aged 11 – 13 years old)**

**Kimberley Walker**

**A thesis submitted to the University of Huddersfield in fulfilment of the requirements for  
the degree of Masters by Research in Psychology**

**Supervisor – Dr Steve Hemingway**

**Co Supervisor – Dr Susanna Kola-Palmer**

**February 2021**

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## Abstract

### Background

With the continued discussion within society of mental health issues, it has been suggested that stigmas and stereotypes surrounding mental health impact not only the understanding that people have about specific issues but also the perceived acceptability to discuss this topic. This in turn has the potential to affect self-management and acceptance of mental health issues that may develop during adolescence and in later life. Stigma and self-stigma can be considered to be barriers to starting the conversation and lead to uncertainty about how educational interventions should be formatted. However, previous research in this area highlights the importance of providing students with an education about mental health issues. Therefore, this research focused on improving knowledge and understanding of mental health issues in order to encourage open communication on this topic.

### Aim

This research aimed to improve awareness of mental health issues, while reducing stigmas and stereotypes surrounding mental illness in school-aged children (aged 11 – 13 years old). Through a targeted intervention programme delivered via the Personal, Social and Health Education programme (PSHE), students were encouraged to discuss and investigate mental health in order to improve their understanding of the cause and treatment, support systems available and societal attitudes towards people who experience these issues.

### Method

After a systematic review of the impact of previous mental health interventions and different pedagogical approaches was completed, an intervention programme was designed to improve knowledge and understanding of mental health issues in children. Throughout six sessions, which took place during weekly Social, Moral, Spiritual and Cultural education (SMSC), participants had the opportunity to gain an insight into mental health, their own wellbeing and consider how they could manage mental health issues that may arise. Signposting was highlighted throughout to ensure that students were aware of the avenues of support that they could access, should they feel that they would like someone to talk to. Data was collected through a pre- and post- intervention questionnaire design that generated quantitative data, the impact of these sessions was assessed using Exploratory Factors Analysis (EFA) and statistical analysis via a mixed ANOVA (Analysis of Variance) was completed.

### Results

This research generated mixed results, with some factors identified as yielding statistically significant results at the  $p = 0.05$  level. It was found that these interventions had the most impact on male participants, with statistical significance being established in understanding of mental health support ( $p = .025$ ) and social inclusion ( $p = .042$ ). This research was also found to have a significant impact for year 7 participants, particularly in the topic of knowledge of mental health ( $p = .050$ ).

### Implications

Throughout this research a previously untested measure was used which could impact the reliability and validity of the results. However, it was found to support the belief that mental health education is multi-dimensional and therefore this research could be considered a pilot study, which would provide the opportunity to conduct further testing of both the intervention and the measure. This was highlighted in through the EFA results and the discussion of individual factors identified and therefore needs to be considered in all future intervention programmes.

This research supports previous research in this area that states that mental health intervention, regardless of the format, is beneficial in raising awareness of mental health issues and addressing stigma and stereotypes in children and adolescents, and should therefore be used to inform PSHE curriculum planning. This has become particularly relevant in the last months of this research, during the Covid-19 pandemic, where the mental health of children and adolescents has been impacted by lockdowns and local restrictions. Future research in this area could assess the impact of this (or a modified) intervention programme in the development of understanding of individual wellbeing and understanding of signposting available during this time.

Future research could also explore the impact of targeted interventions on younger students, for example, primary school aged participants as well as monitoring long-term impacts, including self-management of mental health issues. Further investigation may choose to also look at the impact of interventions in different educational contexts, such as selective educational facilities and city-based institutions.



## Chapter 1: Introduction

Mental Health has become a focus within today's society especially when considering the stigma that people who are struggling can experience. This can impact their self-acceptance of the issues that they experience, their ability to discuss their feelings with those around them and their completion of everyday tasks. This is no different for children and young adults who struggle with mental health issues. One of the main barriers in recruiting participants to take part in mental health research has been identified as stigma surrounding the subject topic (Woodall et al, 2010). However, it has been identified that there is a gap in research focusing on the mental health of children and adolescents which has meant that they are often unaware of mental health issues, the symptoms and the treatment options available to them and this has reinforced the silence surrounding mental health and therefore the taboo nature of the topic (The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). This research aimed to improve the understanding of mental health for adolescents and reducing the stigmas and stereotypes surrounding mental ill health through a targeted intervention where open conversations surrounding the topic can be encouraged.

### 1.1 Definition of Mental Health

In order to discuss mental health and mental ill health, it must first be established what is meant by these terms. The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and mental health as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (World Health Organisation, 2018, p2). These definitions of health have developed through the influence of the biomedical model of health, but this recent definition is relatively unique in that it considers not only an individual's physical wellbeing but also their psychological and mental health. However, these definitions could be subjective as different interpretations could impact the way in which mental health and mental ill health is viewed within a society. For example, what one person considers a useful contribution to a community could be through charity or volunteer work while another may be supporting and contributing to the local economy. If a person was unable volunteer due to work or school obligations, could that person be experiencing mental health issues? Regardless of how health and poor health is viewed, these definitions impact how children and adolescents are educated about healthy living. Therefore, using this definition as a starting point, the focus of this research was whether stigmas and stereotypes surrounding mental health could be addressed through intervention. In addition, whether these interventions increased knowledge and understanding about mental health issues and where to access support and following treatment plans as required (Sickel et al, 2016).

### 1.2 Statistics

It has been found that one in six people within society suffer from mental health issues (Mental Health Foundation, 2016) but in spite of this it has been found that less than 4% of research between 1995 and 2003 focused on child and adolescent mental health (Link et al. 2004). Between the ages of 5 and 16, 10% of children within any classroom have a diagnosable mental health issue with 63% stating that stress has affected their daily lives and 77% saying that they fear failing (Aronin and Smith. 2016). In 2017, 6123 deaths in the UK were registered as being suicide, 7 identified as children between the ages of 10 and 14 (Samaritans, 2018). NHS England has estimated that mental health issues have an economic and social cost of £105 billion per year and that the Government is currently estimating that it spends £34 billion each year (Mental Health Taskforce, 2016). More recent information has shown that one in ten

children aged between 10 and 15 feels that they have no one to talk to in school if they feel worried or sad (Mental Health Foundation, 2018). In a YouGov study of 1,323 school children found that four in ten said that these mental health issues had caused them difficulties sleeping, 27% said that it had caused them to get into fights; one in four said that it caused them issues with their homework and 27% said that they isolated themselves from others. Following an investigation into the mental health of children and their confidence in seeking support, Kousoulis (2018) found that there is a growing crisis in the mental health of children, which is partially due to the number of children who feel they have no one to speak to in school when they struggle. These statistics provide an approximate snapshot into the current issues facing not only mental health provisions within the United Kingdom but also the health and wellbeing of children and adolescents and inform interventions needed in order to promote healthy living. However, it is worth noting that these statistics are likely to be incomplete as many of the surveys rely on a self-report data collection technique, which requires honesty from participants about their own mental health. Due to stigmas and stereotypes, which will be explored below, children and adolescents may not feel able to or ready to admit that they are struggling with their mental health meaning that the above statistics may be inaccurate. As it is estimated that the average age for the development of anxiety disorders and impulse control disorders is 11, this coincides with the transition from primary to secondary school, potential changes in friendship groups and a the pressure of focus on examinations (for example year 7 Cognitive Abilities Tests (CATS)), it could be considered as essential that negative opinions and stigmas surrounding mental health be addressed at an early age (Mental Health Foundation. 2016).

One of the key issues surrounding the reporting of child and adolescent mental health is that prevalence statistics are often out of date or underestimated which impacts Government policy and proposed interventions. Through a self-report Strengths and Difficulties Questionnaire focusing on Years 7 and 9 (11- 14-year-olds), Deighton et al (2019) found that 2 in 5 children experience emotional problems, conduct problems or hyperactivity issues. This is significantly higher than the 1 in 10 suggested by Arnon and Smith (2016) and the Mental Health Foundation (2018). Risk factors for mental health issues in children were also identified as deprivation and Free School Meals (FSM) eligibility, Child In Need status (whether children require additional external support to maintain standards of health and development) and age. Deighton et al (2019) highlight the necessity for additional resources and funding for child and adolescent mental health to be available to schools as well as creating solutions to tackle the risk factors mentioned above. Though this study does not explicitly refer to stigma, it does mention the need for prevention and early intervention concerning the mental health of children. These results have been supported by the work of Pitchforth et al (2017) who investigated the prevalence of self-reported mental health issues in children and young adults between the ages of 4 and 24 years old. It was found that over nineteen years, participants who reported experiencing mental health issues increased by an average of approximately 3%, which was considered by the researchers to be a significant increase between 1995 and 2014. Though the accuracy of this increase could be questioned as it uses a self-report method rather than official diagnostic figures, it does highlight that children and young people consider themselves to be struggling more with their mental health and wellbeing than they felt they were over a decade before. Ford and McManus (2020) commented that they disagreed with the reported underestimation of mental health issues in children and adolescents, as reported by Deighton et al (2019) and supported by Pitchforth et al (2017). As well as highlighting some of the limitations of the research methodology, it is stated that there is ambiguity in the definition of poor mental health of children. Due to this, the validity of the findings can be questioned as it can be argued that participants did not report that they had been formally diagnosed with mental health issues and could be reporting low mood or anxiety. In spite of the issues highlighted, the current research

will use statistics provided by the mental health charities of Mind and YoungMinds to inform the intervention programme.

### 1.3 Stigmas and Stereotypes

The stigmas and stereotypes surrounding mental ill health can impact a person's ability to accept their situation and the help and support required to support them, aiding self-management of issues. This thesis used three key definitions, outlined by Corrigan and Watson (2002), throughout the research process; stigma, stereotypes and self-stigma;

- Stigma is the perceived shame experienced by a person due to their current or previous situation or personal traits.
- Stereotypes are defined as negative opinions or views about a group of people which can influence the way in which an individual acts and reacts towards the group,
- Self-stigma is the negative views of self, due to perceived and real issues that they may experience.

Traditionally, there has been a history of stigma and stereotypes surrounding mental health which have included the use of derogatory terms such as 'mental' and 'psycho,' as well as the belief that people who experience mental health issues can be volatile, unpredictable, dangerous or criminal. This has continued despite recent UK Government initiatives including Time to Change, which focused on reducing the stereotypes surrounding mental health for both adults and adolescents. Caruso (2018) believed that as a direct result of the negative stigma surrounding mental health that still exists, people do not actively seek help when they start to experience issues, as they do not want to be considered weak or lacking will power. This could potentially further reinforce this negativity creating a cycle that may be difficult to break.

The above-mentioned stigmas and stereotypes are still being reinforced within today's society. Generally public stigma regarding mental illness, Corrigan and Watson (2002) suggested is culture bound in that mental health issues are more common, or people are more likely to be diagnosed with mental health issues, in Western countries than they are within Asian and African cultures and suggested that in some cases, and therefore self-stigma can result in anger which can encourage people to become more active in their mental health care and contribute to their treatment plans. Yanos (2018) pointed out that there are current examples of people, who may be considered role models by adolescents, being labelled as 'nutjobs and insane' after public meltdowns, such as Amanda Bynes and Britney Spears. This leads to, he claims, a universal belief that people who experience mental health issues are in fact insane further reinforcing the stigma. Films such as "One Flew Over the Cuckoo's Nest" represent people with mental health issues as homicidal maniacs and prone to authoritarianism and therefore provoke feelings of fear in audiences. This could also reinforce the belief that people with mental health issues are more likely to commit murder and be obedient to an extreme, which could be considered a dangerous combination. This was reinforced by Mares and Kretz (2015) when they discussed the General Learning Model, stating that media influences personal schema (the information that they have about a specific group of people) and therefore their behaviour towards them which explains the creation and maintenance of stigmas. With the access that children and adolescents have to media, including social media, it would be understandable to assume that their opinions of mental health would be influenced by what is shared on these platforms.

Corrigan et al (2001) continued to develop these theories by identifying three key strategies for addressing the stigma surrounding mental health via a random allocation to one of four experimental conditions and recall of sessions testing. They argued that education had the biggest impact on improving attitudes towards people who experience mental health issues and

specifically when session leaders were considered to be competent in their knowledge and engaging. Content allowed participants to observe presentations by people who experienced specific mental health issues and ask questions. Corrigan et al (2001) found that this did not change the attitudes that participants had, but more personal details about the presenters were recalled. Finally, protest encouraged participants to address the morality surrounding beliefs about people who experience mental health issues. This was found to have no impact on stigmas but it was found that participants recalled more of the negative information about mental health issues. In terms of the current research, the interventions must focus on educating participants about mental health issues rather than the ethical considerations of how to treat people.

Through the development of these stigmas, it has been identified that children from the age of five years old display negative behaviours towards people who are identified as having mental health issues (Adler and Wahl, 1998) primarily due to lack of positive examples of people who experience mental ill health. In a study of 104 students in year 3 (7 to 8 years old) and using a combination of direct questioning and the story book method, it was found that participants associated the label of mental illness with being crazy or mad. When comparing people with physical disabilities and mental health issues, the children responded more negatively towards mental health and described sufferers with more negative characteristics and attributes. The cause of these views were not investigated but this research shows that even from a young age, children establish negative associations with mental health leading to the development of stigmas and stereotypes. This research highlights that the formation of negative opinions can occur at a young age and it is therefore essential that this needs to be addressed and this research will seek to establish whether the start of secondary school is an appropriate time for these discussions to take place.

This research was conducted in a school in Lincolnshire and it has been highlighted that rural areas are very often left without access to the already stretched urban services. Benn (2007) stated that children experiencing common mental health issues (he references Attention Deficit Hyperactivity Disorder specifically) have little support either from the public or private healthcare sectors causing a reliance on strong and potentially addictive medications such as tranquilisers or anti-depressants. It is also mentioned that little attention is paid to children in legislations and Acts that are proposed, and they are unable to put pressure on politicians to advocate for them and so little changes. This is evident in the area of focus for this research as waiting lists for services are often in excess of six weeks and distance travel is often required to attend appointments, affecting both family finances and the child's education. However, there are currently no provisions addressing travel or costs to families to attend appointments, leaving them out of pocket for essential health care. Due to budgeting, schools are unable to support families with this or provide transport, though they can offer to host meetings. In addition, schools are also under increasing pressure to maintain attendance levels, which are affected by students being out of school for appointments, and therefore Educational Welfare Officers are often brought in to work with, and sometimes fine, families with children not attending school. This can seem unsupportive and therefore parents and children can disengage with the process, causing later issues.

#### 1.4 Structure of the Thesis

This research included a review of current provision and intervention and used a self-report pre- and post-intervention questionnaire, which data being subjected to appropriate statistical analysis to establish significance.

Chapter two outlines the history of mental health including legislation that informed current interventions, focusing on the reduction of stigma and stereotypes surrounding mental health and the now compulsory education in schools, which aimed to raise awareness of these issues. This chapter also provides a literature review of previous research regarding the minimisation of mental health stigmas and stereotypes, including the personal impacts that this can have, and investigations of effective pedagogy for teaching mental ill health.

Chapter three focuses on the method of research and includes details of the ethical considerations that were made throughout this study, hypotheses, research questions and details about the measure used.

Chapter four discusses the results, both in terms of the pre- and post-intervention average scores and then subjecting this data to an Exploratory Factors Analysis (EFA) and mixed ANOVA.

Chapter five focuses on the conclusions and discussions that can be generated through the results of this research. It also considered the implications and possible future research, which could further develop the understanding of interventions required to reduce the stigmas and stereotypes surrounding mental health in adolescents.

Following the above research, this research focused on addressing common stigmas and stereotypes on adolescents through in-school interventions with the aim of improving understanding and increasing awareness of mental health issues. This in turn aimed to raise awareness of essential signposting, which can aid the later self-management of issues.

## Chapter 2 - Background and Literature Review

This background outlines the history of mental health as well as the interventions that have previously been put in place. It is important to consider these aspects as the way in which society has viewed people who experience mental health issues has directly influenced the creation of the current stigmas and stereotypes that this research will be focusing on.

### 2.1 History of Mental Health

At the beginning of the 19<sup>th</sup> Century, the Mental Deficiency Act 1913 was introduced and proposed provision for the “feeble-minded and other Mentally Defective Persons,” and defined defectives as idiots, imbeciles and immoral imbeciles (Education England 1913, p.137). It also stated that people with mental health issues could be put in a prison, an asylum for the criminally lunatic, an industrial, reformatory school or a place of detention. Children and young adults who suffered from mental health issues were treated in a similar way to adults, with no special provisions being put in place to care for them. This meant that they were often housed with adult patients and would have witnessed first-hand different mental health issues that were not receiving appropriate support and the treatment, and trauma that was experienced, potentially providing them with an insight into their future. An example of this was the case of William Giles who was sent to Broadmoor Hospital in 1885 at the age of 10, after he was found guilty of arson while being considered unfit to plead (Stevens, 2011). New evidence suggests that William was suffering from psychosis or schizophrenia though he was described as a ‘congenital imbecile,’ (a person with low intelligence) and in spite of obvious mental health issues, he was given little to no support or rehabilitation. As a result, William remained in an institution until his death in Broadmoor in 1962 at the age of 87. The Mental Deficiency Act was one of the first examples of legislation being used to legalise the segregation of the mentally ill from society and resulted in over 40,000 people being detained for being considered to be feebleminded or morally defective (Brignell, 2010). This did not include children being born and raised in asylums, who remained in the institution until another relative collected them or until their parents were released. At this time, the impact of prolonged institutionalisation for children was unknown, though developmental delays and an increased risk of mental health issues are now found to be a possible consequence, (Van IZendoorn et al, 2011).

Into the late 19<sup>th</sup> century, the previously set standard that people who are different should be hidden from public view, potentially considering them someone else’s problem continued. Conditions within these asylums were described as torturous, with regular punishments given for lack of compliancy and resistance to treatments. These included being tied to chairs in dark rooms for hours on end, being denied a change of clothes and having their food withheld from them. Treatment of people with mental health issues has continued into modern society, with the continued institutionalisation of people who experience issues such as publicised cases of people with a diagnosis of Schizophrenia being injured or dying whilst in police custody. This has also been found to extend to children who suffer from mental health issues and learning difficulties, as highlighted in a recent report where Anne Longfield has been quoted as saying that during hospital stays for their mental health, children have been restrained to the point of limb numbness and been housed in empty and cold rooms for extended periods of time (Children’s Commissioner, 2019). One story discusses an incident where a child with autism was transported to hospital in a cage and was handcuffed at the ankles and wrists for the entirety of their weekend hospital stay. Another recently reported case states that a child with severe learning difficulties and mental health issues were segregated during a custodial sentence for seventy-six days (Crook, 2020). These reported incidents highlight the segregation

of the mentally ill still happens in modern society and it therefore could be argued that this also reinforces negative associations surrounding mental ill health.

## 2.2 History of the Diagnosis of Mental Health Issues

Before the introduction of formal diagnostic criteria, people could be diagnosed with mental health issues and/or placed in asylums for various reasons (Charleston, 2019). For example, Drapetomania was defined as a type of mania that caused slaves to wander away from or run away from their slave masters during the 19<sup>th</sup> Century. During Victorian England, women could be placed in institutions by their husbands or families for several reasons, including epilepsy and adultery. Socioeconomic status had an impact on admission to asylums; Hide (2014) found that during the 19<sup>th</sup> century, paupers were more than six times more likely to be diagnosed as being of unsound mind than people of higher class. This inequality has continued into the 21<sup>st</sup> century, with children who experience adversity (including low socioeconomic status and abuse) accounting for a third of mental health issues within the UK (Mental Health Foundation, 2018), and has been reflected in statistics outlined by Arnon and Smith (2016) and the Mental Health Foundation (2018).

As the definitions and understanding of mental health issues have developed, so too has the requirement for accurate and universal means of diagnoses. The Diagnostic and Statistical Manual of Mental Disorders (DSM) was first published by the American Psychiatric Association (APA) in 1952 and aimed to classify mental disorders. It was developed through the identification and treatment of American soldiers and veterans during and after the Second World War to accurately account for the causes of issues and allow suitable diagnosis from a trained psychiatrist (Blashfield et al, 2014). In order to gather information, questionnaires were sent to 520 members of an Army and Veterans Committee asking for suggestion revisions and opinions about the diagnostic criteria and discussions involving clinicians before the final publication of the first edition in 1952. The current version of the DSM V, published in 2013, contains diagnostic criteria for approximately 297 mental health illnesses. It could be argued, however that the DSM has paid attention to attitudes within society when considering its amendments. Due to the background of the creation of the DSM, there has been issues with using these formal criteria to diagnose children, which can cause a delay in treatment. In order to address this, the APA has worked with parents and clinicians to include the experiences and symptoms of children to aid accurate diagnosis, (American Psychiatric Association, 2013).

The ability to diagnose children and young people as having mental health issues has an obvious positive impact of being able to treat and manage symptoms. However, Scheff (1999) believed that being labelled caused people to conform to the expected behaviours associated with being mentally ill. Charities such as the Mental Health Foundation (2018) have reported that nine out of ten people who have been diagnosed as having a mental health issue have experienced a negative stigma or discrimination, and that these include (but are not limited to) difficulties finding work, maintain relationships and socialising within mainstream society. Despite the evolution of society and the improved understanding of the cause and treatment of mental health issues, it is concerning that people still experience negative attitudes when seeking help and support and shows that continued education, or targeted intervention in the case of this research, is still required to raise awareness of and address stigmas and stereotypes surrounding mental health. It could be argued that this education, as in this current research, take place in a school setting as students are required to study mental health throughout the PSHE curriculum while in a safe environment. This is reinforced through the guidance released by the Department of Education (2020).

However, it could be argued that ultimately it does not matter how the issues surrounding mental health are diagnosed and treated if the cause of the issue is not addressed. The Regent Group (2018) suggested that schools and specifically examination pressure has a detrimental impact on student's mental health. This has been evidenced by Childline and NSPCC reported that students raising concerns about examination stress increased by 200% in 2015. One potential strength of school being the cause is that school is in a prime position to put into place early interventions and allow children and young adults to understand their diagnoses in a safe environment, reducing potential stigmas and stereotypes from developing.

### 2.3 Factors Impacting Current Intervention

The history of mental health outlined above has informed current legislation and policies within the United Kingdom and informed the work undertaken by mental health charities.

As established in section 1.2 (page 9), the number of mental health issues that are being diagnosed within the United Kingdom is increasing, especially for conditions such as Anxiety, Depression, Obsessive Compulsive Disorder and Phobias, (Stansfeld et al, 2016). Current statistics suggest that 1 in 4 people have suffered from a mental health issue within the last week (Mind, 2020) and this accounts for 21.2% of the world's disabilities. It is estimated that 20% of children experience mental health problems per year, and that this increases to 60% if the child is looked after (LAC). These include nearly 80,000 young people suffering from severe depression (10% under 10 years old) and 725,000 suffer from eating disorders which results in the death of 1 in 5 of this number (Royal College of Nursing, 2017). With these statistics in mind, the Department of Health (2011) has acknowledged that stigma impacts not only a person's ability to seek help, but also impacts their motivation and ability to recover from mental health issues and that people who do experience discrimination are at risk of developing further issues and may stop them from receiving the care that they need. People who are elderly, of black or ethnic minority, are transgender or male are more likely to experience stereotypes or discrimination due to mental health issues (Department of Health, 2011). A Government Report: No Health without Mental Health (2011) has outlined an Equality Action Plan, which aimed to reduce the stigmas that people, specifically the groups mentioned above experience with the overall goal to increase access and attendance to services and improve outcomes. Working with other agencies to create a multidisciplinary team, such as the Care Quality Commission (CQC) and the National Health Service (NHS), attitudes were monitored, and legislative frameworks reviewed to ensure that the correct support is in place. Charities such as Time to Change have also worked towards raising awareness of mental health issues and through their website, it is possible to access blogs, videos and advertisements for promotional events to discuss the effects of stigma on sufferers (Davey, 2013). YoungMinds, a mental health charity focusing on 0 to 25-year olds, have released a manifesto, which asks the Government to prioritise the health and wellbeing of children with mental health issues. It has been created by using the views, opinions and concerns of children. In this document, they outline ten key points, including the development of whole school approaches to the promotion of mental health awareness, the implementation of self-management techniques for children, a reduction in support waiting times and increased support resources and provisions, (YoungMinds, 2018).

### 2.4 Review of Government Legislation

(For detailed review table, see appendix 7.1)

In recent years, the Government have made several pledges to reform the mental health policies within the UK with the aim to improve access to appropriate help, increase local services and identify potential illnesses earlier. Publications such as the Future in Mind (2015), Five Years Forward Plan (Mental Health Taskforce, 2016) and the Fair Funding for Mental Health report (Quilter-Pinner and Reader, 2018) all highlight the importance of providing early



intervention and appropriate support for people with mental health issues, especially in the case of children and adolescents. All reports also call for nationwide consistency to improve awareness of mental ill health in order to reduce the associated stigmas and stereotypes that people may experience. In recent years, multiple initiatives have been put forward by the Government but all have lacked specific recommendations as to how the mental health of children can be address and each have highlighted a lack of funding as the key issue that prevents the introduction of required training and interventions. Whittaker (2018) commented on the Government's proposed reforms saying that for a serious attempt at tackling stigmas and stereotypes surrounding mental health, funding specifically for this cause and to support those in need must be found. This further reinforces comments above that there is a significant lack of funding provided for the child and adolescent mental health services, and with funding only being made available to a small number of areas, this issue is not being remedied. Whittaker (2018) also commented that the Government continues to fail students and letting them down when they are in need, even in light of these new suggested interventions. Where additional funding has been allocated to the implementation of legislations, there has been no specific guidance or training provided no additional support for schools to implement this whole school approach and no indication about how this consistency should be achieved. In order for this to take place, a clear and practical plan should be formulated for this intervention to have a significant positive impact within schools, rather than simply pointing out what needs to be done.

In terms of the current research, one of the most influential pieces of legislation is the Transforming Children and Young People's Mental Health Provision: a Green Paper (Department of Health and Department for Education, 2017) as it is responsible for the introduction of Designated Senior Leads (DSLs) for Mental Health and Mental Health Champions (MHCs) for schools. The DSLs and MHCs roles are to work within the school community to promote awareness and wellbeing, while encouraging students to consider the mental health of not only themselves but also those around them. This green paper also encourages accessing external support agencies such as educational psychologists, school counsellors, nurses and Child and Adolescent Mental Health Services (CAMHS), with the aim of reducing service waiting times and improve outcomes for students. In order to improve understanding of mental health issues within the school community, the Impact Assessment for this provision aimed to improve the understanding of support pathways for DSLs and increase the understanding of all staff through both internal and external training. This training aimed to improve the knowledge and understanding of mental health issues for teachers and improve the pastoral teams in identifying and signposting students who begin to struggle. This is supported by the work of Jorm et al (2010), (further discussed in chapter 2.6).

However, the Government firing their chosen MHC Natasha Devon in 2016 undermined the introduction of MHCs (Demianyk, 2016). This was interpreted by some as an attempt to prevent the education system being blamed for the current mental health crisis within school which followed Devon's criticism of increased testing in schools - arguing it was 'not a coincidence' that anxiety is the fastest growing mental health illness in under 21s (Demianyk, 2016). In response to the publication of the above green paper, the House of Commons Education Select Committee have criticised the plans as lacking ambition, lacking commitment, adding additional pressure to teachers and pointed out that the Mental Health Lead within a school does not have to be a mental health professional (Staufenberg, 2018). It was planned that this provision would be initially available for 20% to 25% of areas within England, and the Government have been accused of ignoring the needs of thousands of children until it is decided whether this program is suitable for nationwide introduction. The Government disagreed with this stating that this gradual rollout will benefit students considered most at risk of developing issues. Concerns have

also been raised by Offord (2018) who highlighted that the provisions were targeted specifically at schools rather than all educational facilitators, such as colleges and apprenticeships.

The above implies that the responsibility for the mental health of children and young adults is exclusive to mainstream schools which could once again add to the workload of teachers and mean that students leaving to go onto further education providers may miss essential interventions which could cause later issues in terms of compliance to treatment options and further future self-management. This is highlighted by the non-specific learning criteria/curriculum and lack of resources that are being provided and the lack of recognition for schools that already have these or similar schemes in place. In association with Mental Health First Aid (MHFA), new teachers should receive advice on dealing with issues, specifically anxiety and depression, which as mentioned above are two of the most diagnosed mental health issues in young people (Whittaker, 2017 and PSHE Association, 2019). This aims to help students access early support and for teachers to gain confidence in signposting students to external agencies where required, and has been attempted in the school (in Lincolnshire) where this research has taken place with little effect – time constraints of teaching staff can limit how long they can spend talking to students, referrals to services such as Healthy Minds and CAMHS require parental consent, which is not always provided and when it is waiting times to access services can be as long as four to six months. There has also been the added issue of where there are behavioural concerns for the student and BOSS (the Behavioural Outreach Support Service), CAMHS or Healthy Minds cannot be accessed until the behavioural interventions have been closed, meaning that either behaviour can be address or emotional and mental health issues but not both at the same time (Lincolnshire County Council, 2018). This has caused difficulties for staff dealing with students with complex needs, as some are not being met and may be reinforcing the belief that mental health issues are less important than other issues.

### 2.5 Current Interventions

As awareness of the importance of child and adolescent mental health continues to remain a focus, additional guidance has been released by the Government to support schools in embedding the culture of open communication about wellbeing, understanding the link between mental health and behaviour and providing support and collaborative working with other agencies (Department for Education, 2018). Mental health and behaviour in schools: November 2018 provided support and recommendations for identifying risk factors that could contribute the development of mental health issues as well as introducing protective factors that could minimise the risk. It quotes data from a longitudinal study, which identified that boys who exhibit five or more of the identified risk factors are eleven times more likely to develop conduct disorders and girls with five or more factors are nineteen times more likely to develop a disorder (Department for Education, 2018). The report also states that in order to promote positive mental health within schools, they must encourage resilience to problems and challenges. This has been supported by Henderson et al (2012, discussed in section 3.1) who found that children are scared to discuss their problems and would not know who they could talk to within school, and further highlights the importance of the aims of both the Future in Mind plan (2015) and Five Year Forward Plan (2014) in tackling stigma and stereotypes surrounding mental health in school aged children. This also provides a justification for the focus of this research with adolescents.

The charity YoungMinds introduced the #hellyellow campaign on World Mental Health Day 2018 and 2019, which focused on working within schools and colleges to raise awareness of mental health issues in children and young adults. This campaign focused predominately on social media and asked people to attend events raising awareness and money to support

children with mental health issues. It was found by Sampogna et al (2017) that campaigns surrounding mental health which are released on Social Media, specifically Facebook and Twitter have a significant positive influence on raising awareness, improving tolerance and support for people who suffer from mental health issues and effectively challenges stigma. This research supports the YoungMinds campaign in effectiveness, but it does also comment that further research is needed to look at other social media platforms and with a wider range of participants. However, the prevalence of campaigns using social media has increased which may lead to over exposure and therefore leave mental health as 'one of many' adverts that people see on a daily basis. Finding the right balance is essential to make the most of this form of awareness if used during the course of this research. Woo, Lam and Kung (2018), when reviewing the work of McLean et al (2017) looked at using YouTube as a way to reduce mental health stigma, specifically in relation to Generalised Anxiety Disorder, rather than using other social media platforms. This included both general videos that covered mental health issues, as well as personal stories about the content creators' lives. It was noted that the majority of the videos analysed had received a minimum of 50,000 views, which shows that they are reaching an audience though it is impossible to identify who is being reached and what impact it is realistically having. Also, there is a concern that as the average video length was approximately six minutes, which highlights a limited attention span, not just on videos about mental health, but online content in general which shows that it is ideal to have short, sharp and to the point content. As a recent survey has shown that nine in ten young people aged between 12 and 19 access or have YouTube accounts (Youthwork Practice, 2019), it shows that this was of providing information and educating young people has the potential to be effective if done in the correct way.

The Time to Change (2019) campaign has announced the introduction of eighteen local 'hubs' which aim to tackle the stigma and stereotypes surrounding mental health at a local level. Some hubs would be funded exclusively by charities, including Mind and Rethink Mental Illness and would run anti-stigma events and activities in the local area, which allow events to be specifically tailored to the local demographic. The overall aim would be to establish hubs nationally across the county and this is hoped to be within the next three years. Though taking a different format, this expands on the work of other charities such as YoungMinds but in a more interactive way, which may both appeal and help people in a way that had not been tried before. As this initiative has only recently been announced, there is no evidence or research yet establishing the effectiveness of this new approach, but it is something that will need to be monitored in the future. If successful, similar techniques could be used within a classroom environment as part of the targeted intervention to support this goal.

The policies discussed above all have similar messages and aims and require both national and local engagement. Some County Councils have used information from these policies, conducted local research into mental health services in their area and introduced their own bespoke schemes, which aim to raise awareness and encourage mental health to become a more open conversation. Essex County Council, Southend-on-Sea Council and Thurrock Council (2016) worked together to understand the views of young people in their area. They found that:

- There is a lack of understanding by young people about mental health, and there is an issue with stigma surrounding mental health issues.
- Young people don't know how or where to access support locally
- Waiting lists are too long for young people to receive help, especially in cases of self-harm and eating disorders.

As a result of these findings, this County Council Partnership introduced the "Open Up, Reach Out" initiative. This plan is based on six main principles, which includes; early intervention, reducing judgement and stigma, a holistic approach to support and empowerment for individuals

seeking help. This programme has been supported using £3.3 million of additional funding and findings analysing the impact of the plan will be released in 2020. (However, due to the current COVID-19 pandemic, this has been delayed). Another example of this is The Health Schools Cornwall (2018) who have been working with Cornwall schools to promote whole school interventions to target mental health stigmas and looks to challenge language, stereotypes and promote understanding of mental health problems. It trains and supports staff in delivering and discussing mental health issues and signposting students to appropriate help. Due to a lack of funding, they have been unable to conduct any formal research as to the success of the scheme but have recommended that these interventions continue across the county. Similarly, Suffolk County Council (2017) have been working on a Transformation Plan which aimed to simplify the referrals process, provide access to the support required in a timely manner and increase access to early help services. By 2021, this plan aims to help an additional 700 young people access appropriate services to support them and their families. Additional information has been published via an online portal, the Suffolk Emotional Wellbeing Gateway. A possible implication of this more technological approach could be the introduction of a portal that students can access but it must first be looked at in terms of cost-effectiveness; will it be financially viable for a single school to implement this, or would it be better for a group of schools to work as a whole to fund this scheme? This is something that would need to be further explored depending on the outcome of this research.

Previous in school interventions have been outlined in qualitative case studies released by the Government, (Department of Education, 2017). The majority of the interventions mentioned as part of this report discuss support strategies, such as in school counselling, meditation and relaxation techniques, specified 'quiet areas' and buddy schemes. However this is often already in place within schools, particularly within the Special Education Needs Department (SEND) which may create misconceptions about these interventions. Provision also discussed the requirement for training and a whole school approach being essential for this to be effective. However, in terms of funding it has been highlighted that there is no additional provision for mental health support within schools, unlike pupil premium and students with special educational needs. Schools therefore are reliant on charity donations and reallocation of funding from other sources potentially causing additional deficits elsewhere, (Department for Education, 2017). This has once again meant that free services such as CAMHS and Healthy Minds are the only viable option for seeking additional support for mental health issues. Courses, such as the Mental Health First Aid are available for teachers and support staff at an expense that have to come from already stretched school budgets.

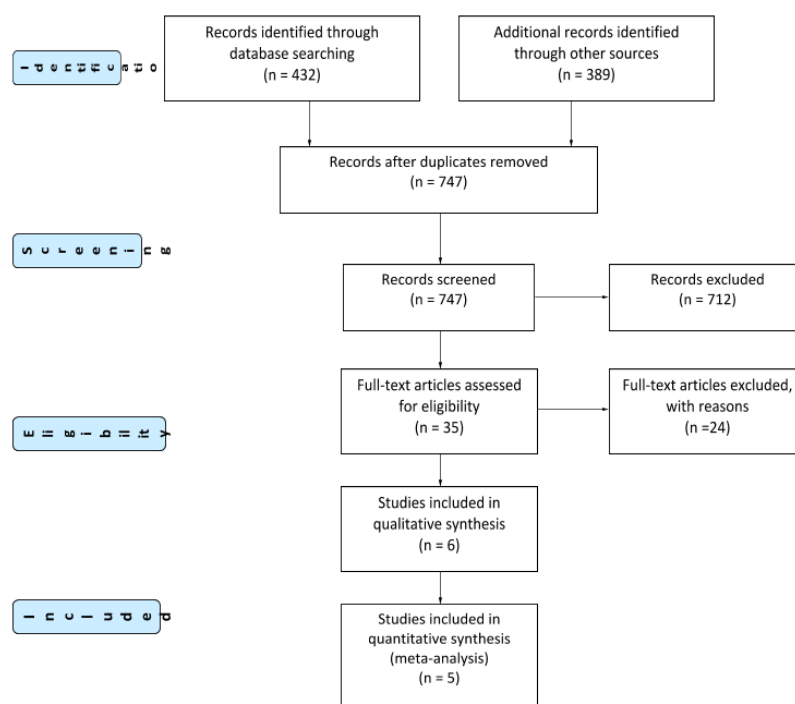
However, it is worth noting that Rogers (1999) looked at the impact of a lack of intervention for children and adolescents in the United States, regarding any mental health issues that they may experience. According to this report, a lack of adequate support with issues could lead to substance abuse, criminality, poor school performance and suicide as well as highlighting the potential costs to society, which could include the cost of emergency treatments. It is also showing the benefits of using in-school interventions; reduced waiting times, links to education and improved outcomes. To support this, four schemes have been referenced in Dallas, Baltimore, Washington DC and Denver where schools have hired trained mental health professionals to support students through their education with any concerns and issues that arise. In all settings, students reported feeling happy that they were able to access support when it was needed in the familiar school environment and that it allowed them a designated person that they could talk to at any time. It is also worth noting that though this research could be considered to be outdated, it still stated that funding for this program was an issue – some funding was received locally but the rest had to be provided or raised by the school. This is a

continuing theme throughout previous research and shows that, even in other countries mental health services are underfunded even when they are proven effective.

## 2.6 Previous Research

Before conducting this research, a review of previous studies in this area was undertaken in order to identify conclusions and applications, which may be relevant to the current investigation. It also allowed the opportunity to learn from previous research in terms of methodological approaches, specifically with children as participants. This review was also supported by a Boolean search, using the initial search operators of ("mental health" OR "mental illness") AND (stigma\* OR stereotype OR attitude\* OR prejudic\*) AND (child\* OR adolescen\*) AND (promot\* OR interven\*), (see appendix 7.2).

Diagram 2.1: A PRISMA diagram showing how literature was refined toward the included studies in the review.



(Moher et al, 2009)

As shown above, the initial search yielded 747 results, which through refinement was reduced to 5. These studies formed the basis for this thesis literature review. Papers were excluded based on duplication and refinement of the search parameters used in the Boolean search to include specific age ranges and secondary school settings. It also focused on quantitative data rather than qualitative data to support this research. Previous research was not excluded based on country conducted as it allowed comparison with issues established in England.

In order to effectively discuss stigma and stereotypes, it is first essential to establish what is meant when using this terminology. Corrigan and Watson (2002) investigated mental health stigma in relation to stereotypes and prejudice, and the issues that people with mental health issues may experience. This paper provides definitions of the key terms for investigation, outlining some of the areas for development through research. Stigma it is suggested, is made of three components; stereotypes, prejudice and discrimination. Stereotypes, being the negative view or belief that someone has about a group, are formed quickly and place certain

expectations on an individual. These stereotypes can lead to a negative emotional response, such as the belief that people can be violent, scary or criminal, which have led to prejudicial attitudes where severe mental illness has been compared to and associated with drug addiction, prostitution and criminality leading to discriminatory practices. These cases of stereotyping, prejudice and/or discrimination result in public stigma and self-stigma. However, and most importantly for the current research, it was concluded that stigma surrounding mental health is multi-dimensional and therefore any interventions addressing this must take a multi-dimensional format. Though specific recommendations for this were not discussed, this supported the varied nature of the interventions that the students completed. As with most research into this area, it has focused on adult participants rather than the focus age group for this study. However, this research can be used to identify current specific stereotypes that exist within society and starts to look at the question of how they are formed and therefore how children and young adults could learn them.

Corrigan and Rao (2012) further expanded on the research of Corrigan and Watson (2002) and developed The Stage Model of Self Stigma, which involves awareness, agreement, application and harm. Awareness begins with the public's perception of mental illness and the understanding that the majority of people are aware of specific stereotypes surrounding mental health and through these, they are able to make assumptions and have negative expectations of people who have specific issues. This includes people who are diagnosed with such conditions and makes them susceptible to self-stigma (agreement). The internalisation of stereotypes by an individual (application) can lead to self-discrimination, which could involve not only negative opinions, but also self-imposed isolation, lowered self-esteem and self-efficacy (harm). This negative view of self can lead to the development of a Why Try Effect; where self-stigma has reached a point that they feel they aren't worthy of opportunities that they are offered, and life goals become perceived as unachievable.

The challenging of self-stigma, considered by Corrigan and Rao (2012), has been identified as the most important first step to empowerment and several suggestions are made to start this process. Through empowerment, individuals with mental health issues can be encouraged to believe that they can achieve their goals and instil a sense of optimism. However, until people are able to admit to others and accept their issues, they will continue to feel the negative self-stigma described above. Both research papers identified the key to empowerment as increased awareness, understanding and knowledge of mental ill health. Though the research conducted by Corrigan and Watson (2002) and Corrigan and Rao (2012) established definitions of stigma and stereotypes and began to investigate the impact that negative opinions have on mental health self-management, there are some issues with the validity and reliability of these theories. In all cases, the research was conducted in America with the conclusions being generalised to people in other cultures, meaning that there is an imposed etic in these findings. This impacts the reliability of the results outside of America as the research has not been conducted in other parts of the world. Until this is the case, it will not possible to establish whether all people, including children and adolescent, would experience the 'Why Try Effect' and Self Stigmatisation when they suffer from mental health issues.

Sartorius (2007) noted that several people must be involved for a stigma to develop, be reinforced and addressed. These can include health workers, medical professionals, psychiatrists and even the Government as they have a stake in removing the stereotypes and taboo nature of discussions surround mental health issues. However, the author argues the terminology used to generalise groups of people with the same or similar mental health issues and the way in which patients can be spoken down to affects not only self-labelling but also could encourage others to refer to sufferers in similar ways. Discussions with service users and

family members, the introduction of schemes to directly combat stigma in both the public domain and also within the media, as well as the negative consequences that can result from stigma have been monitored for effectiveness, which will in turn go on to inform policy and procedures in a practical way. This further highlights the importance of addressing stigmas and a younger age with the aim to address and reduce the stereotypes acquired through socialisation.

Henderson et al (2012) conducted research focusing mental health stigma and the extent to which social desirability can and has impacted the results. Using a sample of 196 participants aged between 25 and 45, it was found that people are less likely to admit that they know someone or that they themselves are struggling with mental health issues in a face-to-face interview than when they completed the online self-report. In terms of social desirability, it was found that participants were more likely to answer questions in what they considered a more socially acceptable way when they were having a face-to-face interview. This shows either a lack of knowledge or a sense of embarrassment from participants in the interview condition. The researchers concluded that in order to make sure that people are more honest in a self-report, the method of data collection is essential and that participants must feel anonymous in their answers (to reduce social desirability impacting the results), and will therefore impact the method of data collection in this current research. This does raise questions regarding the positive impact of Time to Change (2015) – it would be hoped that if stigmas surrounding mental health were truly being addressed then people would feel able to be honest about their own mental health even in a face-to-face setting. As only a small sample was used (and there is no mention of the gender split of participants), this research cannot be generalised to a wider audience and therefore more research is required to determine the true impact of campaigns. This does also provide suggestions for how this research could be conducted, due to the social sensitivity of the focus topics.

Chisholm et al (2012) assessed the impact of a 'SchoolSpace' intervention, aimed at reducing stigma surrounding mental health and improving understanding of mental health issues in secondary school students. Interventions were developed and delivered by the NHS mental health workers in association with in school teaching staff and used a pre- and post-intervention questionnaire data collection method. It was found that following two sessions, the intervention had a positive impact in addressing stigmas that students had regarding mental health. It also established a link between reducing stigma and increased understanding of mental ill health, which highlights the importance of educating students and encouraging conversations about mental health, which reinforces the justification for this research.

Jorm et al (2010) investigated the impact of improving teachers of mental health issues through the Mental Health First Aid training course. This course included increasing awareness of departmental policies, specific mental health issues through formal lessons, case studies and factsheets. Though this study focused on the attitudes of staff, it was reported that an inadvertent outcome was that students felt that they received additional support regarding mental health issues. This highlights the requirement to improve knowledge and understanding of mental health issues for all members of the school community, as this has a positive impact on attitudes towards mental ill health.

There have been several international studies that have focused on improving the attitudes of children and adolescents towards mental health. Ke et al (2013) used an hour-long intervention to address stigma in secondary school students, aged 14 – 17 years old, in British Columbia, Canada. A pre- and post-intervention questionnaire was used to assess participants' attitudes in which participants could respond "yes," "no" or "unsure." The interventions used a combination of presenter-led presentation, videos and diagrams. Ke et al (2013) found that participants

experienced a reduction in negative beliefs about mental health, which continued for over a month after the intervention. However, there was no significant difference found in the stereotypes that participants had about people who experience mental health issues. Researchers reported issues in accurately assessing the sustainability of the improved attitudes due to participant dropout rates, which meant that not all completed the third questionnaire. In addition, the limited nature of the responses meant that participants could not express the degree to which they agreed or disagreed to statements, which affects the accuracy in the reflection of attitudes. This highlights the restrictions of a limited-response questionnaire and the short time period in which the interventions took place as longer interventions allow more details surrounding mental health to be explored and discussed. This could also affect later self-management of any mental health issues that may develop.

In order to support school age children with their mental health, there have been discussions about the implementation of compulsory mindfulness classes. Kuyken et al (2018) compared the effectiveness of a mindfulness intervention in twelve secondary schools with a control group who undertook the usual school curriculum, which did not include these specialist lessons. Through a pre- and post-intervention method, it was found that participants in the intervention group were found to experience fewer symptoms associated with depression and stress as well as improved self-esteem and wellbeing. However, Kuyken et al (2013) point out that the further implementation of this method of support must take into account teachers and their workload. The Department for Education are currently undertaking surveys into the workload of teachers and this may add additional pressure to teachers and support staff within the school environment. These surveys that are supported by UK teaching unions will aim to look at changing legislations and requirements of staff that schools impose to combat the amount of work teachers are required to take on, which will have a knock-on impact on recruitment and retention within the education sector (National Foundation Educational Research, 2019). This could also impact any work focusing on mental health due to both time and staffing constraints.

Sakellari et al (2014) completed another international study focusing on the impact of mental health interventions on school-aged children. Through this research, data was collected using pre- and post- intervention interviews using fifty-nine participants from 2 Greek schools. The interventions completed by the students focused on definitions of mental health, the identification of different mental health conditions, symptoms and mental health promotion, including signposting to local services. Following these sessions, it was found that participants were able to give more detailed explanations of what mental health is following the interventions as well as an increased understanding of the management of specific mental health issues. Though this research cannot be generalised to the current research due to the difference in mental health signposting between Greek and British schools, it does highlight that interventions can be a successful method in addressing stigmas and misconceptions surrounding mental illness. However, Sakellari et al (2014) comment that some participants repeated responses in both the pre-intervention and post-intervention interviews. This may be due to social desirability or a recall bias occurring, impacting the reliability of these findings. In addition, due to the age of the participants, there is a lack of ecological validity in the interview methodology, which may cause embarrassment, awkwardness or anxiety in the participants. In terms of the current research, it highlights a weakness in using an interview methodology for pre- and post-intervention analysis, particularly within the focus age group.

Previous research has been weighted towards adults rather than children and adolescents, though as highlighted above recent research is addressing this imbalance. This has continued through the media creating programmes focusing on the mental health of children and adolescents within the United Kingdom, which highlight the lack of support provided to them. Acre (2018) in *Dispatches: Young, British and Depressed* found that only 57% of



destigmatisation campaigns (interventions aimed at reducing stigma) were considered to be successful which might be because there is a cultural fear of the emotions surrounding mental health, which prevent the issues from being fully understood. It was also pointed out that the lack of holistic support for mental ill health means that it becomes medicalised which leads to conversations about whether children and adolescents should be prescribed anti-depressants due to concerns about addiction. Though the aim of this programme was to raise awareness of mental health issues in children and young adults, it must be acknowledged that the research and therefore content was bias towards this aim and is unlikely to have shown contradicting information. There was also an element of ethnocentrism and the possibility (to some extent) of social desirability, which must also be taken into account when considering the validity of these findings. This highlights the confusion that people could experience when discussing mental health but also shows that current campaigns are not as effective as they could be. Therefore, more research is required to identify the most effective method of raising awareness of mental ill health.

In order to establish research aims, it was considered essential to summarise the findings of all research discussed in a data extraction format table. This was used to inform the current study as it highlighted different methods of conducting research with similar aims and highlighting relevant findings, which could be further explored.

Table 2.1 A data extraction table summarising research discussed throughout the literature review.

<b>Authors</b>	<b>Year</b>	<b>Location and Focus of Study</b>	<b>Study Design and Sample</b>	<b>Sample</b>	<b>Summary of Relevant Findings</b>	<b>Study Limitations</b>
Corrigan and Watson	2002	Chicago, USA.  Focused on current stigma and stereotypes surrounding mental ill health and the subsequent risk of self-stigma	Meta-analysis of 64 previous pieces of research in this area	N/A	Identified and defined three key terms in the field of mental health.  Concluded that mental health stigma is multidimensional and therefore intervention must be as well.	Ethnocentric research.  Adult participants used and therefore cannot be generalised to current research.
Corrigan and Rao	2012	Chicago, USA  Extension of the research by Corrigan and Watson (2002) and focused on how self-stigma develops in individuals.	Article	N/A	Found that self-stigma can be caused by the public's negative perception of mental ill health, which can lead to self-discrimination.  Concluded that targeted group interventions to address negative stigmas can be beneficial	No practical research cited to support the theory.

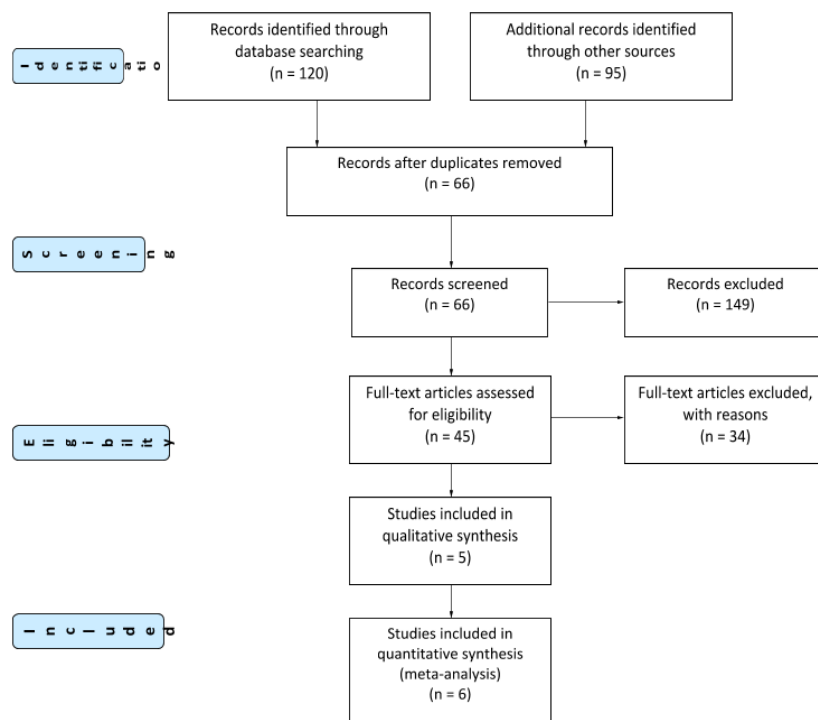
Sartorius	2007	Geneva, Switzerland  Focused on the creation of mental health stigma and how it can be reinforced.	Interviews with mental health service users and professionals	Unknown	Found that the way that people with mental health issues are spoken to, and the language used can reinforce stigma.	Interviewed mental health professionals, which were unavailable during this research.
Henderson, Evans-Lacko, Flach and Thornicroft	2012	UK  The impact of social desirability and the self-report of mental health issues.	Self-Report questionnaires and interviews	196 participants between the ages of 25 and 45 years old.	Participants were more likely to answer questions in a socially desirable way during face-to-face interviews than through a questionnaire	Due to the age of the participants, findings cannot be generalised to the current study.
Chisholm, Patterson, Torgerson, Turner and Birchwood	2012	Birmingham, UK  Assessed the impact of the "SchoolSpace" intervention program on stigmas that children had regarding mental health issues.	Pre- and post-intervention questionnaire methodology	769 participants between the ages of 12 and 13 years old.	Following two sessions, it was found that the stigmas that participants had were reduced.  Secondary outcomes found improvements in mental health stigmas	Limited number of session's undertaken, therefore long-term impact cannot be accurately analysed.
Jorm, Kitchener, Sawyer, Scales and Cvetkovski	2010	South Australia  Assessed the impact of improving the knowledge of mental health for teachers through a Mental Health First Aid course (MHFA)	Pre- and post-intervention questionnaire methodology	Teachers at 7 schools in Australia	By improving teachers understanding of mental health issues, students reported feeling more supported when experiencing issues themselves.	Focus of the research was on teachers rather than interventions for students, therefore inferences about impact cannot be accurately assessed.
Kuyken, Weare, Ukoumunne, Vicary, Motton, Burnett and Huppert	2013	UK  Assessed the impact of mindfulness interventions in schools	Pre- and post-intervention questionnaire methodology	Students in 12 secondary schools	Found that students experienced less symptoms associated with stress and depression and had improved self-esteem.	Additional training needed, which could require funding which might be unavailable.
Ke, Lai, Sun, Yang, Wang and Austin	2013	British Columbia, Canada  The impact of targeted intervention on	Pre- and post-intervention questionnaires	Students between the ages of 14 and 17 years old from 3 secondary	Found a short-term improvement in the stigma surrounding mental health	Limited responses available mean that extent of agreement or disagreement

		the understanding of mental health issues for students.		schools in Canada.	issues in students.	cannot be assessed.
Sakellari, Sourander, Kalokerinou-Anagnostopoulou, and Leino-Kilpi,	2014	Greece  Assessed the impact of mental health intervention on students	Pre- and post-intervention questionnaires	59 participants from 2 schools	Found that participants understanding of mental health issues improved following interventions.	Ethnocentric research, therefore results cannot be generalised to students in UK schools.

## 2.7 Pedagogy

As mentioned in section 2.6, before this research was conducted, a review of previous research focusing on pedagogy for teaching mental health to children and adolescents was completed, as shown in the below PRISMA diagram. Boolean search operators used in the initial search for this thesis were ("mental health" OR "mental illness") AND (teach\* OR pedago\*) AND (child\* OR school OR adolesc\*).

Diagram 2.2: A PRISMA diagram showing how literature was refined toward the included studies in the review.



Moher et al (2009)

As shown above, the initial search for pedagogical approaches yielded 66 results, which were refined to 6 studies referenced in this thesis. Once again, research was excluded based on duplication and refined based on pedagogical methods, target age range and quantitative results.

The way in which subject matter is taught (pedagogy) can have an impact on the way that it is understood; therefore, this section will focus on potential teaching methods that have been researched as being potentially effective when educating people about mental health. As previously discussed, the responsibility for education children about mental health has fallen primarily in schools through the Personal, Social and Health Education (PSHE) and Social, Moral, Spiritual and Cultural (SMSC) education curriculums. Public Health England (2015) released guidance for school, which encourages a whole school approach to teaching mental health as part of the PSHE curriculum through eight key principles.

Diagram 2.3 – Methods for encouraging a whole school approach towards mental health (Public Health England, 2015, p6)



By developing an inclusive environment, where discussions are encouraged, a safe environment is created which benefits students in learning about difficult topics, such as mental health. This whole school approach also encourages working with external agencies, such as CAMHS, parents and other teachers to identify issues in understanding and where additional support is required. Learning, it is suggested, can take place through a variety of methods including practical application and ensuring that the knowledge can be applied to students' everyday lives. Signposting is also recommended to ensure that students and teachers are confident in the routes of accessing support and resources that can help with learning. However, though guidance has been given provided ensuring that students are taught about it once again does not make recommendations about the format of sessions, which can lead to inconsistencies between schools.

Dewees and Lax (2008) commented that educators often find it difficult to address concerns and issues around mental health but that the potential long-term benefits in term of addressing stigmas, stereotypes and methods of self-management outweigh these difficulties. In their research the authors trial three methods for use in the classroom; Diagnosis in Context, Theory and Standpoint. Diagnosis in context requires students to focus on matching symptoms in a scenario to Diagnostics and Statistics Manual (DSM) criteria, with a potential extension task of adding people's interpersonal and social situations to the diagnosis. Critical application of theory involves the creation of a case study in the participant's area of practice and the requirement to explain the appropriate diagnostic steps and assessment options before identifying a contrasting approach and explaining how it could be used in practice. Finally, the Standpoint

requires participants to diagnose people from a differing standpoint or opinion to allow an alternate perspective to be seen. The research that identified these potential strategies for teaching mental health focused on student nurses, and therefore is not applicable to the focus ages of the participants within this study, but there may be an opportunity to incorporate some of these ideas into the planned interventions, such as using celebrity case studies within the sessions.

Innocent (2015) investigated the impact of storytelling as a way of reducing stigma in children between the ages of 11 and 14. A pre-and post-test methodology was used to establish whether this pedagogical approach has a significant impact on the way in which children describe and discuss people who experience mental health issues. In the post-test questionnaire, it was found that the negative responses and words used to describe people who experience mental ill health had reduced, showing that for this age group the storybook method of teaching is effective. This was also supported in a literature review completed by Nurser (2017) where six mental health storytelling interventions were reviewed. It was found that there is a positive link between storytelling and mental health recovery. Using a method to improve understanding in children that is successful in treating some aspects of mental health could help students to understand the impact of what they are learning and therefore improve relatability to the material. However, this approach is time consuming and required more one to one intervention than was possible in this research.

A recent study looked at different ways in which mental health stigmas could be reduced during tutorial time. Graves et al (2018) assigned 130 students to two groups and asked to watch parts of a documentary about celebrities who had been diagnosed with mental health issues and then viewed a presentation, which contained detailed statistics regarding mental health. Finally, participants were encouraged to access a website designed to support medical students with mental health concerns. In order to assess the effectiveness of the intervention, pre and post intervention questionnaires were completed. It was found that there was no significant difference in the stigmas presented before the study started and upon completion of the interventions; however, certain questions were highlighted as finding significant results however, on-going surveys are being used to assess whether this research has had a long-term impact on the participants. The aim of this study was to introduce the concept of mental health role models, which the participants could relate to and therefore understand. Though this study is on going, it does appear that this aim has been unsuccessful. As mentioned earlier, this may be because the participants were of university age and therefore their opinions are well formed and engrained. The results may have been affected by the fact that the majority of students were reading medicine and therefore cannot be generalised to a non-medical public.

Thornicroft et al (2016) conducted a systematic review of interventions, which targeted adults that had taken place with the aim of reducing stigma and stereotypes surrounding mental health. Their primary finding was that an increase in knowledge showed the most benefit in tackling stigma. However, the research does not explicitly explain how this knowledge increase should take place but that it must include social context and first-person narratives from people suffering from mental health issues. This study also found that opinions surrounding mental health required immediate change, though a way to ensure a long-term change and encourage effective self-management is essential. It was also stated that students who took part in interventions showed short-term attitude changes, which may indicate that the interventions occurred too late to make a significant impact. It was also highlighted that attitude changes lasted longer in high-income countries than low-income countries, which reinforces that funding is required in order to make impactful steps in combating stigmas and stereotypes.

Pinfold et al (2003) investigated the impact of targeted intervention on secondary school students in terms of challenging stereotypes and improving understanding of mental health issues. Using a combination method of external speakers; a person who works within the mental health profession and another that has suffered from mental health issues, videos and discussions, students were given the opportunity to build their knowledge and understanding of mental health issues through question and answer sessions and also to begin to understand how mental ill health can impact sufferers and those around them. Through pre- and post-intervention questionnaires, it was found that 73% of participants considered themselves to be more positive towards people with mental health conditions than before the research took place and 61% of participants reported this view continuing six months after the research took place. There were also found to be several factors that influenced the results, including gender (female participants were more likely to have a positive view on people suffering with mental health issues than male participants), attending a grammar school and having personal contact with people suffering from mental health issues. Though this research took place with year 10 students (ages 14 – 15 years old), its structure is similar to that of this research and will therefore influence the hypotheses in this thesis.

Eisenstein et al (2019) investigated the impact of peer-led interventions that develop students' knowledge and understanding of mental health and ways that resilience in their own wellbeing can be supported. Five sessions were run by sixth form peer-trainers for year 7 participants, which focused on mental health awareness, misconceptions and support systems and techniques. It was found that using a pre- and post-intervention questionnaire, participants found that learning from a peer was more beneficial than learning from a member of staff or adult and an increase in knowledge of stigma and discrimination was reported in the results. However, this research highlighted that causality could not be established between the increase of mental health issues and peer-led sessions. Though peer-led sessions can encourage open conversations and prevent participants feeling self-conscious during discussions, safeguarding disclosures could cause potential issues especially if they are not recorded and reported in the appropriate way, which could cause further issues with participants and peer-trainers mental health and wellbeing. Eisenstein et al (2019) conclude that mental health interventions can be used to reduce mental health stigma in schools. In terms of the current study, following conversations with the Senior Leadership Team, it was considered inappropriate for sixth form peer-trainers to be used to run the sessions due to the increased risk of safeguarding issues.

In terms of focusing on the target age group, both the Government and the PSHE Association have released toolkits to aid teachers in structuring the sessions with recommendations being made for specific age groups. These include introducing ground rules to ensure that all students remain emotionally safe throughout discussions and interventions surrounding mental health. These rules could include not continuing conversations outside of the classroom, deciding acceptable and unacceptable language and discussing the level of openness to avoid any safeguarding disclosures in a public forum. It also highlights the importance of signposting possible areas for support and advising that schools have a public display of this. Finally, the PSHE Association (2019) also provides resources to help teach mental health in a safe and productive way while also attempting to minimise teacher workload, which as stated above has continued to be a concern.

Some schools have expanded on the teaching of mental health issues to have the responsibility on the students. A school in London has encouraged students to raise awareness and attempt to reduce stigma and stereotypes by asking them to organise events that people their age would respond to. This led to the creation of a school based mental health “Stamp Out Stigma” conference, which invites other local schools and mental health services such as CAMHS and

aims to spread awareness of local mental health issues and interventions, the development of a support app which all students are encouraged to download and written journal articles in conjunction with a university, (Lee-Potter, 2019). In order to run these events students are encouraged to hold fundraising occasions in order to support these activities. However, no research has been published highlighting the impact of this student-led intervention, the engagement from other local schools and services has shown that this scheme as a tool to reduce stigma and stereotypes is effective. This has further been reflected in research conducted in Denmark by Nielsen et al (2014). Interventions took place using the Up scheme, which focuses on promoting mental health in school age children within the school support system. It requires a whole school approach focusing on four specific areas; education and activities, development of staff skills, engagement from parents and embedding it into everyday life within school. Though this research took place in a school, it must be noted that there is an ethnocentric element to these findings, which make it difficult to generalise these techniques to a school in England – different systems of education may have an impact on the results were not assessed in this research.

Schools in France, for example, have been found to focus less on mental health than other European schools (Patalay et al, 2017) and therefore this research may not be as useful in their setting. This holistic approach develops an understanding of both the self and others about both mental health and wellbeing. Similarly, to this research, pre and post intervention questionnaires were conducted in order to evaluate improvement of understanding of mental health and coping strategies put in place and encouraged. It was found that one third of participants were classified as having a high degree of social and emotional competence before this research took place this rose to 40.8% in the post intervention condition, though it is recommended that further research is completed to assess long term impact. This shows that although this research was not considered to yield a statistically significant improvement, a varied and consistent intervention programme can improve understanding and knowledge of mental health in school-age children.

In order to establish research aims, it was considered essential to summarise the findings of all research focusing on mental health pedagogy in a data extraction format table. This previous research was used to inform the pedagogical methods that the interventions took, included a case study (story-telling) technique, which has been found to be successful in addressing mental health.

Table 2.2 A data extraction table summarising pedagogical research discussed throughout the literature review.

<b>Author(s)</b>	<b>Year</b>	<b>Location and Focus of Study</b>	<b>Study Design and Analysis</b>	<b>Sample</b>	<b>Summary of Relevant Findings</b>	<b>Study Limitations</b>
Deweese and Lax	2008	Canada.  Focused on the development of different pedagogical approaches to teaching mental health	Article	N/A	Identified different pedagogical designs including case studies, standpoint and critical application.	Focused on teaching methods for student nurses and therefore cannot be generalised to current research.

Nurser	2017	England	Systematic literature review of six mental health storytelling interventions	12 papers	Found a link between storytelling and mental health recovery.	Commented that this method is time-consuming and more beneficial one-to-one.
Innocent	2015	Canada	Pre- and post-intervention questionnaire methodology	11-14 year old students	Found a reduction in negative terminology used to describe people with mental health issues.	Time consuming methodology, cannot be generalised to research in the UK.
Graves, Shaheed and McDonald	2018	Australia	Pre- and post-intervention questionnaire methodology.	127 students	No significant difference was found in stigmas prior to the interventions.	Participants were university students, therefore results cannot be generalised.
Thornicroft, Mehta, Clement, Evans-Lacko, Doherty, Rose, Koschorke, Shidhaye, O'Reilly and Henderson	2016	England	Systematic review	8 Systematic reviews and 8143 quantitative studies	Found increasing knowledge of mental health to be the most beneficial method.  Commented that opinions surrounding mental ill health required immediate change.	Short-term changes identified, further research required for long-term impact.
Pinfold, Toulmin, Thornicroft, Huxley, Farmer and Graham	2003	England	Pre- and post-intervention questionnaire methodology	472 students aged 14 and 15 years old	Found an improvement in attitudes towards people who suffer from mental health issues, which continued after a 6-month period.	Participants were older than the participants in this study, therefore results cannot be generalised.
Eisenstein, Zamperoni, Humphrey,	2019	England	Pre- and post-intervention	45 trained sixth form and 455	There was a significant improvement in	Peer-led interventions can cause



Deighton, Wolpert, Rosan, Bohan, Kousoulis, Promberger and Edbrooke-Childs		Investigated the viability of student-led mental health interventions.	questionnaire methodology	students aged 11 and 12 years old	the understanding of mental health issues in both the mentors and the students.	potential safeguarding issues in case of disclosures.
Neilsen, Meilstrup, Nelausen, Koushede and Holstein	2014	Denmark  Investigated the impact of promoting mental health to school aged children	Pre- and post-intervention questionnaire methodology	532 students aged 11-15 years old	Found that whole school engagement is essential for mental health interventions to be a success.	Ethnocentric research therefore cannot generalise results.
Patalay, Gondek, Moltrecht, Giese, Curtin, Stankovic, Savka	2017	France  Reviewed mental health education in European schools	Cross-Country Survey	1446 schools across 10 countries within Europe	Found that schools offered whole school rather than targeted intervention and the focus was on children already experiencing issues rather than prevention.	Ethnocentric research therefore cannot generalise results.

As shown above previous research, such as studies completed by Sartorius (2007) and Corrigan and Rao (2012), in this area has focused on the formation of stereotypes and stigma, and suggested strategies for reduction in adults who have been diagnosed as having mental health illnesses rather than in children and adolescents. Within the current PSHE curriculum, it is a requirement that students be made aware of health and wellbeing, which includes a mention of mental health issues, which formed the basis of the intervention that was developed as part of this research. However, influence for these interventions was also drawn from previous pedagogical approaches, such as those suggested by Innocent (2015), Pinfold et al (2003) and Henderson et al (2012). Due to highlighted limitations in the above previous research, this will provide the current research with a broad structure for the interventions, but a combination of approaches will be required in order to maintain interest in the topic while ensuring the accuracy of information. Sessions will therefore include teacher- and student-led methods as well as case studies, videos and the opportunity for independent work and research.

Current knowledge has focused on specific types of mental health intervention, such as the story-telling technique or with students up to the age of 16. This research focused on a varied pedagogical approach for students between the ages of 11 and 12 years old, which included a focus on specific mental health issues and a goal of contributing to the understanding of the school community. This is particularly significant as the research took place in a rural area, where mental health services can be a significant distance away and therefore signposting and understanding through this intervention could have a critical impact on children's self-management of any issues.

## 2.8 Research Aims and Objectives

This research aimed to investigate the stigmas and stereotypes those young adolescents about mental health and whether negative opinions can be addressed through targeted short-term intervention and will focus on the following question; can targeted intervention improve knowledge and understanding, and therefore address the stigma and stereotypes surrounding mental health?

It also focused on extending this to focus on stereotypes in adolescents and whether, using targeted interventions as part of the Personal, Social and Health Education (PSHE) curriculum, an increase in knowledge and understanding would reduce negative opinions about mental health illnesses.

This research was developed with a wide range of practical applications in mind. By reducing the negative associations with mental health illnesses, self-acceptance and management of issues could be encouraged at a younger age, reducing the number of cases of self-harm and suicide attempts in teenagers. This could also positively affect attendance to school, concentration in lessons, academic achievement and examination outcomes. By encouraging open discussions about issues and increasing awareness of issues, there could be a reduction in emergency referrals to services such as CAMHS and Healthy Minds and reduce waiting list times.

As part of this pre- and post-intervention questionnaire methodology, objectives for this research include:

- 1) Evaluation of the impact of targeted mental health intervention on students aged between 11 and 12 years old.
- 2) To analyse the extent to which the intervention impacts male and female participants
- 3) To analyse the extent to which the intervention impacts year 7 and year 8 participants.

Throughout this background, it has been highlighted on several occasions that the main issue in dealing with and educating children and young adults about mental health issues is the lack of available funding. This research is unfunded, therefore has experienced the same issues, and this has impacted planned interventions, resources available and staff training. However, by developing a school based targeted intervention, designed to increase understanding of mental health and addressing stigma and stereotypes, provides a practical way to educate students about mental ill health, as well as encouraging students to think about their own wellbeing and the factors that can impact it. The current study also fulfils the Government PSHE and SMSC requirements of the national curriculum.

## Chapter 3 - Method

### 3.1 Methodology

It has been identified that previous research focusing on mental health has primarily employed qualitative and mixed methods of data collection, (Palinkas, 2014), which is designed to provide descriptive accounts of the issues. However, a quantitative methodology was chosen for data collection in the current research over a qualitative methodology. In part, this was due to the time-constraints in terms of the availability of the pupils during the school day and the age of the participants of this study, but also due to the questionnaire format of data collection. However, further consideration was required to justify this approach.

Quantitative methods are derived from positivism, meaning that research takes place primarily through data collection and is therefore deductive through analysis, in approach when explaining behaviour. It also allows the researcher to remain objective throughout the study, which is especially important given the potentially sensitive subject matter (mental health) being addressed (Given, 2008). This also led to a consideration about the language that would be used as part of the data collection (rhetoric). Quantitative data also often uses larger sample sizes, which is more representative of a population and this can improve the reliability of the results and subsequent analysis (Zamboni, 2020), which in the case of this research involves two year groups within the subject school. In order to ensure that participants did not feel that they were being encouraged to discuss their own mental health, it was essential that there was a de-personalisation and impersonal voice in the questions asked, reducing ambiguity in the questions asked (Atieno, 2009). This allowed participants to express their own opinions and thoughts in a safe way with the attempt to ensure the honesty of the responses, (Drew et al, 2008). From an ontological perspective, there is a subjective-collective belief that attitudes exist as a stable and enduring concept existing within individuals, (Howarth, 2006). This can lead to the conclusion that attitudes about a particular topic can be measured quantitatively.

Quantitative methods can be helpful for measuring the change in these attitudes and deduce the specific aspects of people's attitudes that may change following interventions, (Holden and Lynch, 2004). Previous research in the area of attitudes towards mental health have focused on a pre- and post-intervention format have used quantitative methods of data collection, (Kassam and Patten, 2007). Most importantly, this research aims to establish a cause and effect relationship between the mental health interventions and the improvement of stigmas and stereotypes, which requires a quantitative data method of collection, (Sukamolson, 1996).

On the other hand, qualitative data can be considered subjective. In the case of this research, it could mean that the researcher's opinions could impact the interpretation and analysis of the results, (Ratner, 2002). Woodgate et al (2017) found that there were ethical issues in using interviews and focus groups when discussing sensitive issues, including wellbeing and mental health, with children and adolescents. This can include the disclosure of personal or sensitive issues (including risk-taking behaviours), discomfort for the participant in talking about controversial topics to a stranger and participants feeling an increased need to give socially sensitive answers. Qualitative research methods can also be subject to experimenter effects and demand characteristics in a way that quantitative methods are not, (Punch 2002). Another key issue identified by Punch (2002), when using qualitative methods with children is that the analysis of interviews or focus groups with children is undertaken by an adult. This means that there is a higher risk of a researcher imposing their own views or beliefs on the dialogue leading to a misinterpretation of results. In addition to the above limitations of an interview methodology, time was a considerable issue within the current research, as data collection took place during standard school days. Collecting the data required would have required participants to be absent from lessons for a significant period, which could impact their educational progress and cause disruption to the class as a whole when participants joined and left their lessons.

### 3.2 Research Context

Michael and Jameson (2017) commented that Government policy often has not taken into account the specific needs of rural areas, including service availability and delivery and the stereotype that people living there do not experience mental health issues. They also highlighted that it was essential that any offering of mental health services must reflect the identity of the local area, including socio-economic status and education. This belief has been echoed by Smalley et al (2012) who said that the impact of mental health issues is higher than in non-rural areas, primarily due to shortages in the availability of services but also due to stigmas associated with seeking help and a lack of local understanding of mental health issues. As this research aimed to increase knowledge of mental health in a rural school, an understanding of the local context was essential.

In 2015, it was estimated that 8,800 children within Lincolnshire had been diagnosed or experienced mental health issues, which included 3,400 emotional disorders, 5,300 conduct disorders and 1,400 hyperkinetic disorders. In 2017, there were 99 child or adolescent hospital admissions for urgent mental health care and 237 admissions because of self-harm (Lincolnshire County Council, 2018). In order to consider national policies and to address the figures above, Lincolnshire has commissioned several reports and introduced initiatives to help children and young adults in the area. Lincolnshire County Council (2017) outlined both current strategies and required changes that would improve access to services available to young people in the area. This includes supporting the Time to Change movement to address stigma and discrimination that people might experience as well as setting up a local charity that provides support to young people who are working with CAMHS. Lost Luggage (2018) aimed to raise local awareness of the work of CAMHS while providing feedback on the services that are being provided with the aim of constant improvement. It also encouraged attendance to support groups for young adults who were experiencing similar issues as an additional form of support, while aiming to reduce stigma and stereotypes within the local area through in-school training for students and staff as well as raise awareness of the services available to people who are struggling. As a result of reduced funding and the reduction in on-site school nurses, Healthy Minds Lincolnshire was introduced in 2017 with the aim to provide emotional wellbeing support through a combination of cognitive behavioural therapies and toolkits during a bespoke six-session program. Referrals can be made directly by schools or by a local General Practitioner (Lincolnshire Partnership NHS Foundation Trust, 2018). If Healthy Minds Lincolnshire is unable to help the child or young person, a request for CAMHS interventions could be requested, where a specialist team which include psychologists, social workers, nurses and psychiatrists all work together to support the young person through both diagnosis and treatment. It has been estimated that 269,425 children have been in contact with mental health services, such as Healthy Minds Lincolnshire or CAMHS. Since the introduction of the Healthy Minds Service in October 2017 and March 2018, there 1,174 referrals made for children and young adults in Lincolnshire, which results in 5,101 sessions taking place (Local Government Association, 2018).

However, the waiting lists for access of these services have been increasing, especially by the start of 2019 and some referrals that have been made from the school in this research can take between 4 to 6 months to be acted upon. In an attempted to relieve some of the pressure on these services, Healthy Minds have introduced group sessions, which focus on coping strategies specifically for anxiety and low mood. While this has proved successful for some students, others have expressed concerns about private conversations, which take place during these sessions becoming gossip around the school or may cause them additional anxiety, which means that they are re-referred to the waiting list for one to one treatment. In 2018, an Interim Paper was published by the Education Endowment Foundation, which assessed the Healthy

Minds service in terms of health-related quality of life outcomes (Lordan and McGuire, 2018). It was found in the first two years since the introduction of the service that client self-assessment evaluations were generally positive except when looking at measures of internal emotions. When looking specifically at children who suffer from anxiety related disorders, it was found that there was a significant increase in life satisfaction scores in the post intervention condition. However, it also shows that the Healthy Minds scheme works best with reinforcement from staff and tutors, which requires external at a non-funded additional cost per session. This highlights that interventions can be used to improve self-awareness of mental health issues, though it is worth noting that Healthy Minds is an external agency and these sessions do not take place in a classroom environment.

The rural nature of Lincolnshire also has been found to have an impact on the available of mental health services. A review conducted by Rhodes (2018) found that due to the size of the county and the availability of resources, high numbers of service users (including children and adolescents) were required to seek support from outside of the county. This highlights that there are unique issues experienced by mental health patients in this context that have not been resolved by current Government approaches. A lack of signposting and information about mental health was also commented on as being an area of concern, as this enhanced the confusion about the type of services available and how to access them. Finally, Rhodes (2018, p.6) commented that local provisions are “doing their best despite finite resources,” but also makes clear that there is a lack of funding available to support mental health provisions in such a wide spread area. This further reinforces the commentary that regardless of location, schools have the ability to provide support that may be lacking due to location.

### 3.3 Hypotheses

The hypotheses for this study were:

Non-Directional Hypothesis: Through targeted intervention, attitudes of young adolescents towards mental health will significantly change impacting stigma, stereotypes and misconceptions that they have.

Null: There will be no significant difference in the attitudes of young adolescents regarding mental health in pre- and post-intervention

### 3.4 Design

This research used a repeated measure design as all participants were asked to complete the pre-intervention and post-intervention Likert Scale questionnaire.

As the data for this research was subjected to a Mixed ANOVA, the independent variables were the age of the participants (year group) and gender. The within-in participants variable and dependant variable for this research were the total pre- and post-intervention scores for each participant.

Previous research in this area has used established assessment questionnaires or scales (Chisholm et al, 2012). However due to the age of the participants, it was considered essential that the questionnaire was appropriate for the age and reading ages of the participants to ensure that the statements were understood (Kenny et al, 2018).

The Strengths and Difficulties Questionnaire (SDQ) has often been used as a self-report method for children and adolescents, though it was not used in this study. Black et al (2020) conducted a review of the effectiveness of the SDQ when asking children aged between 11 and

15 to measure their own mental health and wellbeing and was assessed in terms of readability and item quality. It was found that on some of the assessment subscales, the reading age of some of the statements was over 12 and 15 years old meaning that they were potentially too difficult for the participants involved in this study. This could lead to misunderstandings or a lack of understanding of what the statement is asking and therefore impacts the reliability of the answers provided. In terms of the item quality, Black et al (2020) found that of the 25 items assessed, 14 were found to include multiple statements and therefore look at several different factors, which can lead to confusion that again could impact the reliability of the answer provided. Overall, this study concluded that the SDQ was an inappropriate measure for children and adolescents, especially where there are concerns about mental ill health or low participant reading ages. For this reason, Black et al (2020) recommended that the SDQ needed to be updated to include more simplified language to make it more accessible for the intended participant ages.

The Student Resilience Survey (SRS) has been previously used to assess family, school and community connection, participation in school and community life, support systems and self-esteem in students. Lereya et al (2016) found that though the internal consistency for this measure was good, some of the subscales had very few statements assessing them and there are overlaps between some of the statements. It was also found that specific participants groups, such as students with additional needs and students with English as an additional language, were more likely to answer in specific ways indicating a bias in some of the scales. In addition to the above limitations of the SRS, Lereya et al (2016) did not subject this measure to test-retest reliability as part of their research, the reliability and validity of the data produced by this method could be questioned.

Therefore, the questionnaire used to collect data in the current research was created by Cornwall NHS Partnership Trust (see appendix 7.3) in a programme designed to raise awareness of mental health issues and has been used with their consent via email (see appendix 7.4).

Due to the requirements of the SMSC curriculum, as set out in the National Curriculum, it was agreed with SLT that interventions would take place across six sessions and the questionnaires would be completed during morning registration (form time). There used a combination of PowerPoint presentations, videos and case studies and took the following format:

Intervention 1 – A focus on establishing ground rules for discussion in future sessions, in order to ensure a safe environment for the investigation of mental health issues. This encouraged honesty from all participants especially when asking questions to clarify their own understanding and to dispel any misconceptions or to challenge the stigmas. In this session, previous knowledge about the definitions of stigma and stereotypes was established as this set a baseline on which can be developed during the future sessions. This session supported the recommendations of The Regent Group (2018) and Public Health England (2015) in establishing a safe environment for discussing potentially sensitive and controversial topics such as mental health. It also allowed the tutor to set the expectations of the students, so that they were all aware of the requirements.

Intervention 2 – Following the establishment of the ground rules in the previous session discussions took place about certain celebrities that have openly discussed their diagnoses of mental health issues; Demi Lovato, David Beckham, Brittany Snow, Robin Williams, Adam Levine, Dwayne Johnson, Ryan Reynolds and Pete Wentz. A mix and match activity which aimed to match celebrities to the issue that they suffer from and which hopefully will encourage discussion about specific issues. The aim of this was to help students realise that any can

experience mental health problems regardless of fame and money. Students were then asked to rate certain statements linked to common misconceptions and stigmas on a scale of true to false. This was done in a practical kinaesthetic activity, which could involve students moving around set points in the room, before explaining why they placed themselves where they did. As a plenary, students were asked to write one statement that they were surprised was not true and why. This session supported the case study work of Dewees and Lax (2008) and the storytelling pedagogy recommended by Innocent (2015) and Nurser (2017) who found that improving the relatability of people suffering from mental health issues increased the impact of the subject.

Intervention 3 - This session began with students identifying what can positively and negatively impact their own wellbeing by listing things that make them happy and things that make them less happy. Tutors were encouraged not to openly discuss the participant's answers to this, as it is an individual activity that may have made people feel uncomfortable. These lists served as a reminder for students that activities can impact them and that if they do start to struggle they have the reinforcement of the Make Me Happy list, which hopefully will help them. Students were then given two fictional case studies; Chris and Emma, who are year 11 (15 – 16 years old) students who were coping with everyday life, hobbies, navigating friendships as well as their upcoming examinations. Discussions then took place about things that can positively and negatively impact their wellbeing and a comparison can be made to the students own lists. The aim was to show that people can experience issues regardless of age and that they can be similar to their own. Kuyken et al (2013) highlighted the importance of mindfulness training for children and by raising awareness of the factors that impact their own mental health and wellbeing, resilience skills and coping strategies were developed.

Intervention 4 – Students focused on specific issues that people can experience by watching videos about Bi-Polar Disorder, Anxiety and Clinical Depression. These videos were released by the NHS and involve real life stories from people that have been diagnosed as having these illnesses. This gave participants a real life understanding of the way that people can be impacted by their mental health rather than relying exclusively on case studies. During these videos, students were asked to answer the following questions about each disorder;

- Who can experience the mental health problem?
- How can family and friends help?
- What sorts of help and support can people get?
- What signs and symptoms might people experience with the mental health problem?
- Did you find out any data about the problem?

A discussion was then encouraged about what they had expected and what they had not expected with the aim to alleviate misconceptions. This session supported the work of Chisholm et al (2012) who had previously completed the SchoolSpace program, which reduced stigmas in participants by increasing their knowledge of mental health issues.

Intervention 5 – Students watched current mental health campaigns published by Lloyds Bank, Reading University Students Union and Time to Change. These looked at different issues including depression, stress and anxiety. Discussions took place after each video looking at who the target audience is, what are the key messages and how do they appeal to young people. A plenary asked how awareness could be raised about young people's mental health, which students were asked to make notes on, as this will help to set the theme for the next session. This session aimed to raise awareness of signposting available to both adolescents and adults and show that non-medical services were available if support was needed, with the goal of reducing the stigma surrounding help seeking behaviour.

Intervention 6 – The final intervention session started by looking at statistics from YoungMinds which looked specifically at how many young people experience mental health issues, the barriers that they experience and figures regarding CAMHS referrals, including assessment and

waiting times. In order to consolidate the knowledge that they have learnt throughout all of these sessions, students were asked to create a campaign; leaflet, video, discussion, about how awareness of mental health issues can be improved for their age groups. Previous in-school interventions have used statistics to highlight the prevalence of mental health issues in the target age range, to reinforce the understanding that anyone can experience mental health issues and reduce the stereotype that only certain people can experience difficulties.

In the current research, the Likert scale questionnaire used was produced by the Cornwall NHS Partnership trust as part of their Stop Stigma campaign (see appendix 7.3). A traditional scale was used with 1 being strongly disagree and 5 being strongly agree. These questionnaires generated a potential range of scores from 23 (with all questions being answered with a strongly disagree response) and 115 (with all questions being answered with a strongly agree response). The higher the overall score implies that the participant has a high knowledge of mental health issues and the stigmas surrounding the topic. The authors of this questionnaire were contacted and gave their consent for this questionnaire to be used (see appendix 7.4). For the current sample, Cronbach’s Alpha was .51 at baseline (Time 1) and .53 at post-intervention (Time 2). This shows that the internal reliability of this as a measure is low (see appendix 7.5). Due to lack of funding, formal research was not produced using this questionnaire, so its authors have not commented on this. Though this could impact the reliability of the results, this questionnaire was chosen due to the relatable language used when considering the age of the participants.

### 3.5 Participants

Initially, an opportunity sample of 372 were approached to take part in this research used to collect data for this research; however, 242 (65%) parents and guardians gave consent for their children to take part in this study. Participants in this study were aged between 11 and 13 (academic years 7 and 8) and were enrolled in a rural Secondary Modern school in Lincolnshire.

Table 3.1: A table to show the number of participants in each condition.

Year Group	Gender		Total Number of Students
	Male	Female	
7	48	52	100
8	65	77	142
	113	129	242

Of the total number of potential participants 28.2% are on the Special Educational Needs register, 26.9% are classed as EAL (to have English as an Additional Language) and 27.4% are Pupil Premium. 242 parents gave consent for their children to take part in this study and their children agreed to complete the questionnaires; 113 male and 129 female.

### 3.6 Procedure

In order to collect pre-intervention data, a set of questionnaires were completed by all participants before any of the sessions took place during the school’s weekly half hour SMSC time (during afternoon registration). Each student was assigned a unique identification number, which was given to the form tutors, allowing anonymity to be maintained throughout this research. The same identification number was used in completion of the post-intervention questionnaire, which allowed participants data to be matched to the original questionnaires completed.

Following the completion of the pre-intervention questionnaire, participants completed six interventions (as outlined in section 3.4). These sessions were delivered by the students form tutors, following discussions with the Senior Leadership Team (SLT) to reduce investigator



effects and demand characteristics in the research. Following the intervention, the same identification number was used in completion of the post-intervention questionnaire, which allowed participants data to be matched to the original questionnaires completed.

### 3.7 Ethical Considerations

The School Research Ethics Panel (SREP) approved the study and British Psychological Society's ethical guidelines were followed throughout this research (see appendix 7.6).

As the participants are aged 13 and under, informed consent had been gained from parents via a letter home, which has been approved by the schools Headmaster, Governors and University of Huddersfield School Research Ethics Panel team. As Mental Health education is currently a compulsory part of the Government's PSHE curriculum, all students were required to complete the interventions, but they were not required to complete the pre- or post-intervention questionnaires. In order to ensure patient anonymity, a random number generated was used to assign each student their unique identification number – this means that participants are unable to guess each other's identification number which may impact the answers given which was considered to be more ethical than using sequential numbering (Riecken and Boruch, 1974). If a participant wished to withdraw their data from this research, this unique number was quoted to identify their data, which would be deleted and destroyed appropriately.

All parents and students were given an information sheet explaining the purpose of the experiment as well as details of withdrawal, data protection and includes signposting to the researcher and supervisor as well as charities and organisations that can help with mental health issues if required (see appendices 7.7 and 7.8). If a parent, guardian or a participant wished to withdraw from this piece of research, they could contact the researcher/data controller at any time with either their child's name or unique identification number. Should this happen all data was deleted and paperwork destroyed. The school and parents received a summary of the findings in relation to the research question but were not be told individual students results showing whether attitudes to mental health have changed throughout this intervention. It was been arranged that the intervention be conducted by form tutors, as this is the standard practice within the SMSC programme and should reduce experimenter effects while maintaining ecological validity. They were be in a better position to identify any problems or issues that occur and referring them to the researcher and the year team as required. Additional support has been arranged in case of issues, including Healthy Mind referrals and support from the SLT as needed.

There was no deception within this research as both parents and students were provided with information sheets which provided full details of what is required and the how the data will be used.

#### 3.7.1 Safeguarding Disclosure

Before the start of the research, a risk assessment to assess any harm that may be caused by the research (see appendix 7.9). This looked at the following areas and assessed the possible level of risk and possible ways of minimising this.

Though the previous research by the Cornwall Partnership did not highlight any issues, there is a risk of students making a disclosure about either their own mental health or the mental health of those around them. The topic of the interventions may be extremely personal to them and may bring to light underlying feelings or concerns that they may have. This could have resulted in disengagement from the program, behavioural issues or concerns about their safety. The SLT line managers for lower school and Safeguarding were both aware of this research. If any

students cause concern to their form tutor or other members of staff, they were removed from the study immediately and a safeguarding referral was made. Though this was dealt with by the individual year teams, it could be the case that an external agency was requested to support the student. Parents were contacted as required through the safeguarding policy. Signposting was also made available to all staff and students that are involved in this research just in case it is needed.

### 3.7.2 Confidentiality

Confidentiality could have been an issue especially during class discussions, which were required throughout this intervention. A student may have expressed opinions that differ from other students and may cause problems (for safeguarding disclosures see above). All students were assigned a unique identification number by the experimenter who was the only person with this information. Any issues that arose throughout the interventions were dealt with directly by the form tutor and year team, as it would be considered a behavioural issue. If a concern was raised that may affect the research, the student's information was withdrawn from the study.

### 3.7.3 Protection from harm

There was a possibility that students become distressed by the information/stories that they may have seen and this may have caused them some distress. Again, if there were any concerns about students, they were spoken to by a member of their year team, as they are more familiar with the students than the researcher is. If concerns warranted it, they were removed from the interventions, their data destroyed and the appropriate external agency referral was made.

### 3.7.4 Differing Opinions

This research could have exposed students to opinions or information that they have not experienced, or that differ from the ones expressed at home. This had the potential to cause conflict both within the child and at home. Information was presented in a nonbiased way and included facts, statistics and other relevant information such as case studies.

In order to effectively debrief the participants of this research, the researcher conducted an assembly with each year group summarising the results – there was also an opportunity to meet with students regarding any questions that they may have had. Parents were also sent a summary of the findings to show whether there was a difference in the views of the students involved.

## 3.8 General Data Protection Regulation

In order to adhere to the new General Data Protection Regulation (GDPR) all information regarding to this study was stored on a password protected USB drive. Once all raw data was collected, it was then transferred to the University of Huddersfield secure server. Upon completion of result and data analysis, all paperwork associated with participants was destroyed. The only person who had access to both the electronic and paper data was the researcher (data controller). In terms of data processing, again this was the role of the researcher and the research supervisor, as clarified and discussed through the School Research Ethics Panel (SREP) process.

The method of data collection - a questionnaire - ensured anonymity of the participants as they were all assigned a unique number to identify them to the researcher only. This ensured that the pre-intervention and the post-intervention questionnaires could be matched for analysis. Post completion of analysis, the link between the participant and their assigned identification was

destroyed. All raw data that might lead to identification of the participants was password protected at all times and stored on the University of Huddersfield secure servers.

### 3.9 Statistical Analysis

Descriptive statistics for this data included the range to establish the span of scores and the mean was used as the measure of central tendency.

#### 3.9.1 Exploratory Factor Analysis

When considering the appropriate statistical test for this research, it was found that the pre- and post-intervention questionnaires yielded low Cronbach's Alpha scores, which impacted the internal consistency of this measure. When subjecting this measure to Exploratory Factor Analysis (EFA) which improved the Cronbach's Alpha scores. As the questionnaire was found to be a complex measure (as is the case with mental health), it could be argued that each question be classed as individual variables. The use of EFA allowed the number of variables in the gathered data to be reduced in order to allow effective analysis to take place. It also allowed the multi-dimensional nature of mental health research, discussed by Corrigan and Watson (2002), to be addressed. It also allowed individual themes, identified through the EFA to be analysed to assess the impact of the interventions on individual topics.

Through the EFA, five subscales were identified and subjected to further analysis (outlined in section 4.2). Each factor was named based on the similar theme of the questions within each loading, which included a combination of opinions, views and understanding (Field, 2005).

#### 3.9.2 Mixed ANOVA

A series of mixed ANOVAs were then run on the subscales as this data fulfils the following assumptions:

- This research was conducted by using two related groups, meaning that all participants were involved in both conditions.
- The data produced from the attitude Likert scale was a quasi-interval data, as the intervals on the scale cannot be classed as equal for all questions, (Coolican, 2013).
- Though there has been discussion about the appropriateness of parametric tests for Likert scale data, Norman (2010) suggested that though normal distribution is not likely, it could be argued that using an ANOVA statistical test is still the appropriate measure to use. To support this, the work of Pearson (1931) has been cited to support that the ANOVA is a robust measure in non-normal distributions as well as normal distributions. Therefore, a Mixed ANOVA was used for analysis in this research.

The independent variables analysed were the gender of the participants and the age (year group) of the participants. The dependant variable was the difference in the pre-intervention (T1) and post-intervention (T2) questionnaires.

This allowed the variance of scores between the pre- and post-intervention conditions to be established and identify statistical significance at the 0.05 level. Analysis generated quantitative (numerical), quasi-interval data (Likert scale) and was used to identify direction of and allow statistical interpretation of the results. The data was not subjected to a three-way ANOVA due to the difference in participant group sizes, which would create variations in the analysis.

## Chapter 4 - Results

This chapter will focus on the results for this research, both the raw data and the analysis including the discussion of statistical significance at the <0.05 level.

### 4.1 Response Rates

Throughout the course of this research, there was a dropout rate of 35.2%. This was as a result of absence on questionnaire completion dates, students leaving mid-way through the intervention and mid-year admissions who had not had the opportunity to complete the pre-intervention questionnaire.

### 4.2 Exploratory Factor Analysis

As mentioned in section 3.8 (page 40), the questionnaire used was subjected to Exploratory Factor Analysis, which identified five subscales for analysis.

Table 4.1: A table to show the factor loadings generated from Exploratory Factor Analysis

Question Number	Loadings				
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1		-.43		<b>.59</b>	
2					-.58
3				.72	
4					
5	.77				
6	<b>.43</b>			.32	
7		.74			
8		.71			
9	-.35		.33	<b>.50</b>	
10	.47			<b>-.58</b>	
11	<b>.46</b>			-.32	
12	.39	<b>.56</b>			
13	<b>.47</b>		-.42	-.41	
14			.78		
15					
16			<b>.74</b>	.33	
17					.68
18		.43			.45
19			-.52		
20		<b>.38</b>	-.34		
21					.71
22		.44			
23	.63				
Eigenvalue	5.09	2.10	1.60	1.48	1.25
Percentage of Total Variance	22.11	9.13	6.95	6.44	5.41

\* Where multiple loadings have been established, scores in bold indicate the highest and therefore most appropriate loading for that question

Within Exploratory Factor Analysis, eigenvalues establish the amount of variance in data and therefore the higher the eigenvalue, the stronger the factor, (Malik, 2019). Osbourne et al (2008) determined that ideal and therefore recommended factor loading exceed 0.4. In the case of this research, where this was not possible, the highest loading determined where the question loaded.

The first factor identified was robust, generating an eigenvalue of 5.09 and a total variance of 22.11%. Factor 2 accounted for 9.13% of the total variance and generated an eigenvalue of 2.10 while factor 3 had a total variance of 6.95% and an eigenvalue of 1.60. The eigenvalues for factor 4 was 1.48 and factor 5 was 1.25 with total variances of 6.44% and 5.41% respectively. Where multiple factors were identified, questions were allocated to the highest loading (highlighted in bold). Question 4 did not load with any of the factors through EFA and was therefore placed into factor two due to it being a similar theme to the other questions in this factor. This shows that the strongest factor established in this measure was factor 1 (identified as Social Distance).

Each subscale was subjected to a Cronbach's Alpha test to establish internal consistency.

Factor 1: Social Distance – this focused on the change in beliefs that participants had about the social aspect of mental health issues. This factor focused on questions:

- 5) People with mental health problems are likely to be violent.
- 6) It's easy to spot someone with a mental health problem.
- 11) Anyone with a history of mental health problems should be excluded from public office (e.g. from being Prime Minister or in the Government).
- 13) If I thought a friend had a mental health problem, I would stay away from them.
- 23) It's more important to spend National Health Service (NHS) money on treating physical conditions rather than mental health problems.

Cronbach's Alpha established that T1 = .70, T2 = .58 showing that the internal consistency was acceptable for the pre-intervention questionnaire but poor for the post-intervention questionnaire.

Factor 2: Knowledge of Mental Health – this focused on the change in knowledge about mental health issues, including biomedical diagnosis and treatment and misconceptions that participants showed in the pre- and post-intervention condition and focuses on questions:

- 4) Mental health problems are not real illnesses in the same way that physical illnesses are; people with mental health problems should just 'pull themselves together'.
- 7) Once you have a mental health problem you have it for life.
- 8) Medication is the only treatment for mental health problems.
- 12) As soon as a person shows signs of a mental health problem, they should be put into hospital.
- 20) Mental health problems only affect adults, not children and young people.
- 22) Only certain kinds of people develop mental health problems.

Cronbach's Alpha established that T1 = .70, T2 = .63 which shows that the internal consistency was acceptable for the pre-intervention questionnaire and questionable for the post-intervention questionnaire.

Factor 3: Mental Health Support – this looked at the increased understanding of support available to people who struggle with mental health issues, which concentrates on the following questions:

- 14) It is important for a person with a mental health problem to be part of a supportive community that includes family and friends.

- 16) If I thought a friend had a mental health problem, I would want to help them.
  - 19) Using words like 'nutter', 'psycho', 'loony' is just a bit of fun. No one gets hurt.
- (Reverse scored)*

Cronbach's Alpha established that T1 = .63, T2 = .53 which shows that the internal consistency was questionable for the pre-intervention questionnaire and poor for the post-intervention questionnaire.

Factor 4: Social Inclusion – this concentrated on beliefs about how people with mental health issues should be treated by society and looks at questions:

- 1) Anyone can have a mental health problem.
  - 3) I would be happy to have someone with a mental health problem at my school or place of work.
  - 9) Someone with a mental health problem should have the same right to a job as anyone else.
  - 10) I would not want to live next door to someone with a mental health problem.
- (Reverse scored)*

Cronbach's Alpha established that T1 = .66, T2 = .66 showing that the internal consistency was questionable for both the pre- and post-intervention questionnaire.

Factor 5: Self-Stigma: this focused on the feelings that people have about themselves if/when they begin to experience mental ill health, which was addressed in questions:

- 2) I would be too embarrassed to tell anyone that I had a mental health problem.
- (Reverse scored)*
- 17) If I thought that I had a mental health problem I would talk to someone.
  - 21) If I thought that I had a mental health problem I would know how to get help.

Cronbach's Alpha established that T1 = .48, T2 = .42 showing that internal consistency was poor in both the pre- and post-intervention questionnaires.

#### 4.3 Statistical Analysis for Impact on Gender

Table 4.2 A table to show the mean (SDs) for each point of the variables broken down by gender and time point.

	Males		Females	
	T1	T2	T1	T2
Social Distance	11.58 (3.64)	10.28 (2.76)	10.53 (3.02)	10.47 (3.20)
Knowledge of Mental Health	13.51 (4.41)	12.32 (3.78)	12.76 (3.33)	12.75 (3.58)
Mental Health Support	12.02 (2.46)	12.95 (2.00)	12.82 (2.28)	12.70 (2.23)
Social Inclusion	15.87 (3.21)	16.92 (2.79)	16.93 (2.40)	16.78 (2.96)
Self-Stigma	9.94 (2.36)	10.35 (2.34)	9.75 (2.31)	10.35 (2.12)

The table above shows that the mean scores for the pre-intervention (T1) and the post-intervention (T2) questionnaires did change, indicating that the interventions had an impact on each of the subscales. Each factor was subjected to a mixed ANOVA with the intention of establishing whether the interventions had a greater impact on male or female participants.

#### 4.3.1 Factor 1: Social Distance

Through analysis, it was found that there is a significant effect for time; Wilks' Lambda =  $F(1, 206) = 4.45$ ,  $p = .036$ , partial  $\eta^2 = .021$ . This shows that irrespective of gender, social distance scores decreased between T1 (mean = 11.03; SD = 3.36) and T2 (mean = 10.38; SD = 2.99). There was no significant main effect for gender;  $F(1, 206) = 2.06$ ,  $p = .153$ . It was also found that there was no significant interaction between time and gender; Wilks' Lambda =  $F(1, 206) = 3.75$ ,  $p = .054$ , partial  $\eta^2 = .018$ , showing that there was no difference in social distance travelled between T1 and T2 for male and female participants.

#### 4.3.2 Factor 2: Knowledge of Mental Health

Following analysis of the ANOVA focusing on knowledge of mental health change between T1 and T2, it was found that the interventions had no main effect for time; Wilks' Lambda =  $F(1, 206) = 2.68$ ,  $p = .103$ , partial  $\eta^2 = .013$  showing that there was no significant difference between the pre- and post-intervention scores. There was also found to be no significant main effect for gender;  $F(1, 206) = .18$ ,  $p = .671$ . It was also found that there was no interaction between gender and time in this subscale; Wilks' Lambda =  $F(1, 206) = 2.60$ ,  $p = .108$ , partial  $\eta^2 = .012$ , showing that there was no difference in knowledge of mental health between T1 and T2 for male and female participants.

#### 4.3.3 Factor 3: Mental Health Support

As a result of the ANOVA analysis focusing on understanding of mental health support, there was no statistically significant main effect for time; Wilks' Lambda =  $F(1, 206) = 3.04$ ,  $p = .083$ , partial  $\eta^2 = .015$ , showing that there was no difference in the pre- and post-intervention scores. There was also found to be no significant main effect for gender for this factor;  $F(1, 206) = 1.31$ ,  $p = .254$ . However, there is a significant interaction between gender and time; Wilks' Lambda =  $F(1, 206) = 5.08$ ,  $p = .025$ , partial  $\eta^2 = .024$  showing that a difference was found in understanding of mental health support between T1 and T2 for male and female participants.

Graph 4.1: A graph to show the interaction between Time and Gender for Factor 3: Mental Health Support



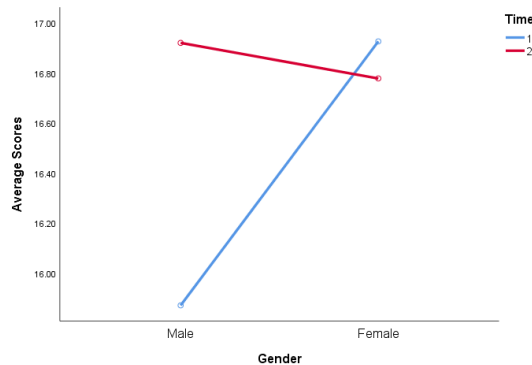
This interaction graph indicates that knowledge of mental health support increased for male participants after intervention (T2), while it decreased for female participants in T2.

#### 4.3.4 Factor 4: Social Inclusion

Through analysis, it was possible to establish that there was no statistically significant effect of time on the understanding of social inclusion; Wilks' Lambda =  $F(1, 206) = 2.36$ ,  $p = .126$ , partial

ETA = .011, showing that there was no difference found in the pre- and post-intervention questionnaire scores. It was also found that there was no significant main effect for gender;  $F = (1,206) = 2.97, p = .086$ . However, it was established that there was a significant interaction between time and gender in terms of this factor; Wilks' Lambda =  $F(1,206) = 4.17, p = .042$ , partial ETA = .020, showing that there was a difference in social inclusion between T1 and T2 for male and female participants.

Graph 4.2: A graph to show the interaction between Time and Gender for Factor 4: Social Inclusion



This interaction graph highlights the increase in social inclusion in male participants in the T2 condition, but this was not shown for female participants.

#### 4.3.5 Factor 5: Self Stigma

Following analysis of this subscale, it was possible to establish that there was a main effect for time when looking at self-stigma; Wilks' Lambda =  $F(1, 206) = 533, p = .022$ , partial ETA = .025, showing that regardless of gender there was a significant difference between T1 (mean = 9.84, SD = 2.33) and T2 (mean = 10.35 and SD = 2.22) questionnaire scores. However, there was found to be no significant main effect for gender;  $F = (1,206) = .17, p = .682$  and no interaction between gender and time in this group of questions; Wilks' Lambda =  $F(1, 206) = .19, p = .662$ , partial ETA = .001, showing that there was no difference in self-stigma scores between T1 and T2 for male and female participants.



#### 4.4 Statistical Analysis for Year of Study

Table 4.3: A table to show the mean (SDs) for each point of the variables broken down by year of study (age) and time point.

Variable	Year 7		Year 8	
	T1	T2	T1	T2
Social Distance	11.42 (3.49)	10.56 (2.76)	10.77 (3.25)	10.25 (3.14)
Knowledge of Mental Health	14.06 (3.85)	12.39 (3.00)	12.76 (3.78)	12.65 (4.08)
Mental Health Support	12.40 (2.29)	12.50 (2.30)	12.50 (2.30)	13.02 (2.10)
Social Inclusion	15.84 (3.11)	16.82 (2.70)	16.81 (2.63)	16.86 (2.99)
Self-Stigma	10.17 (1.90)	10.25 (2.21)	9.62 (2.57)	10.42 (2.24)

Each factor was subjected to a mixed ANOVA with the intention of establishing whether the interventions had a main effect for the year of study.

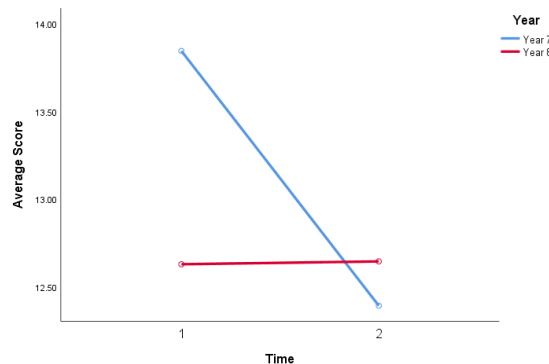
##### 4.4.1 Factor 1: Social Distance

When considering the social distance travelled, it was found that there was a significant main effect for time; Wilks' Lambda =  $F(1, 206) = 4.33$ ,  $p = .039$ , partial ETA = .021, showing that regardless of year of study, there was a difference in the T1 (mean = 11.03; SD = 3.36) and T2 (mean = 10.38; SD = 2.99) questionnaire scores. However, a significant main effect for year of study could not be established;  $F = (1, 206)$ , 2.40,  $p = .123$  and no interaction was found between time and age of the participant; Wilks' Lambda =  $F(1, 206) = .267$ ,  $p = .61$ , partial ETA = .001, showing that there was no difference in social difference between T1 and T2 for year 7 and year 8 students..

##### 4.4.2 Factor 2: Knowledge of Mental Health

Following analysis of this subscale, it was possible to establish that there was a main effect for time in knowledge of mental health; Wilks' Lambda =  $F(1, 206) = 3.733$ ,  $p = .055$ , partial ETA = .018, showing that there was no significant difference in the pre- and post-intervention questionnaire scores. There was no main effect for year of study;  $F(1, 206) = 1.59$ ,  $p = 2.09$ . However, there was also an interaction between time and age of the participant; Wilks' Lambda =  $F(1, 206) = 3.90$ ,  $p = .050$ , partial ETA showing that there was a difference in knowledge of mental health understanding between T1 and T2 for year 7 and year 8 participants.

Graph 4.3: A graph to show the interaction between year of study and time for Factor 2: Knowledge of Mental Health



This interaction graph shows that the year 7 participants' knowledge of mental health decreased following the interventions, though there was little impact for the year 8 participants.

#### 4.4.3 Factor 3: Mental Health Support

When analysing awareness of mental health support, it was found that there was no main effect for time; Wilks' Lambda =  $F(1, 206) = 2.06$ ,  $p = .153$ , partial  $\eta^2 = .010$ , showing that there was no difference in understanding of mental health support between the pre- and post-intervention questionnaire scores. No main effect for year of study could be established for this factor;  $F(1, 206) = 1.31$ ,  $p = .254$ . It was also found that there was no interaction between time and age of participant; Wilks' Lambda =  $F(1, 206) = .82$ ,  $p = .367$ , partial  $\eta^2 = .004$ , showing that there was no difference in the mental health support subscale questionnaires between T1 and T2 for year 7 and year 8 participants.

#### 4.4.4 Factor 4: Social Inclusion

Through analysis, it was possible to establish that there was no significant main effect from time in this subscale; Wilks' Lambda =  $F(1, 206) = 2.96$ ,  $p = .087$ , partial  $\eta^2 = .014$ , showing that there was no significant difference in the social inclusion scores between the pre- and post-intervention questionnaires. There was also no significant main effect for year of study;  $F(1, 206) = 3.46$ ,  $p = .064$ , and no interaction found between time and age of the participant; Wilks' Lambda =  $F(1, 206) = 2.35$ ,  $p = .127$ , partial  $\eta^2 = .011$ , showing that there was no difference in social inclusion scores between T1 and T2 for year 7 and year 8 participants.

#### 4.4.5 Factor 5: Self Stigma

In this final subscale, it was found that there was a significant effect for time when focusing on self-stigma; Wilks' Lambda =  $F(1, 206) = 3.95$ ,  $p = .048$ , partial  $\eta^2 = .019$ , showing that regardless of year of study, there was a difference in the self-stigma scores between T1 (mean = 9.84; SD = 2.33) and T2 (mean = 10.35; SD = 2.22). However, there was no main effect for year of study;  $F(1, 206) = .17$ ,  $p = .682$ , and no interaction between time and age of the participant; Wilks' Lambda =  $F(1, 206) = 2.60$ ,  $p = .109$ , partial  $\eta^2 = .012$ , showing that there was no difference in the self-stigma scores between T1 and T2 for year 7 and year 8 participants.

## Chapter 5 - Discussion

As shown above, the data generated was subjected to Exploratory Factor Analysis and in some cases yielded statistical significance showing that the intervention was effective for some of the outcomes. Overall, it was found that irrespective of gender a significant difference in social distance, understanding of social support and social inclusion surrounding mental health issues in the T2 condition was observed. Male participants displayed more awareness surrounding self-stigma when considering their own mental health and wellbeing following the interventions with the mean score increasing from 9.94 (T1) to 10.35 (T2). The biggest change in the mean scores for male participants was in knowledge of mental health (T1 = 13.51, T2 = 12.32), showing that their understanding decreased following the intervention. This may have been due to misconceptions that they had surrounding this topic before the interventions took place and could be addressed in subsequent research through an interview before and after the interventions. Female participants showed little change in their knowledge of mental health issues and this was reflected in their average scores; T1 = 12.76 and T2 = 12.75. However again, the biggest change in mean scores was in self-stigma scores, showing that the intervention encouraged them to consider their understanding of their own mental health and wellbeing; T1 = 9.75; T2 = 10.35. Overall, when considering the difference in average scores in the T1 and T2 conditions, it has been found that the interventions had more of an impact on male participants than female participants.

It was found that irrespective of year of study, significant difference was observed in social distance and self-stigma following the interventions. Year 7 participants knowledge of mental health decreased between T1 (mean = 14.06) and T2 (mean = 12.39), echoing the results found for male participants and again this could be due to misconceptions that they had before the interventions took place. This could once again be investigated through future research including interviews. Social inclusion scores increased in the T1 (mean = 15.84) and T2 (mean = 16.82) conditions, showing that year 7 participants were more aware of the societal issues surrounding mental health after the interventions took place. Overall, the interventions had less of an impact on year 8 participants, as shown in their knowledge of mental health; T1 = 12.76 and T2 = 12.65. This may have been because of receiving a year of SMSC education, which had some focus on mental health, though not as targeted as in this study. Once again, an increase in scores was found in self-stigma scores in T1 (mean = 9.62) and T2 (mean = 10.42). Again, this shows that there was an increase in understanding of their own mental health and wellbeing following the completion of this research. Overall, it was found that the interventions had more of an impact on year 7 participants than on year 8 participants.

Regardless of experimental condition, it was found that the self-stigma scores increased throughout this research. Corrigan and Watson (2002) concluded that mental health stigma is multidimensional and therefore the interventions must be as well. Improving understanding and knowledge of mental health issues and awareness of their own wellbeing while addressing stigmas and stereotypes has the potential to encourage open and non-judgemental conversations. This could be the focus for future research in the form of a longitudinal study, which would focus on the development of participants' mental health and where issues arise, their willingness to seek and accept appropriate help and support.

Concerning factors 1 (social distance), factor 3 (mental health support) and factor 4 (social inclusion), it is possible to therefore reject the null hypothesis; "there will be no significant difference in the attitudes of young adolescents regarding mental health in pre- and post-intervention." This shows that the intervention was successful to an extent, though it is worth noting that this is irrespective of gender and year of study. However in the remaining factors;

factor 2 (knowledge of mental health) and factor 5 (self-stigma), the null hypothesis failed to be rejected due to a lack of statistical significance being established.

Overall, this research has shown that it is possible to address some common stereotypes surrounding mental health through targeted intervention, which included a combination of discussion, case study and personal study methodology. It has also reinforced the belief that mental health is multi-dimensional (Corrigan and Rao, 2012), and that it is essential that intervention and its subsequent analysis must also be multi-dimensional in format. Though there has been no specific request for feedback from the Cornwall Partnership Trust, they were notified about the completion of this research and results will be passed on if required.

### 5.1 Implications

Through the literature review, it was found that interventions that aimed to improve the understanding of mental health issues were successful in addressing negative stigmas and stereotypes that participants had. However, the extent of this improvement on individual factors and the long-term impact on self-management was unknown.

Though no analysis took place focusing specifically on the language used to describe mental health (Sartorius, 2007), negative associations were addressed in order to begin the conversations about issues in an appropriate and empathetic way. Terms such as 'nutter' and 'psycho,' as well as the link between mental health and criminality, the improvement of the mean scores in factor 4; social inclusion showed that these interventions change the way that people suffering from mental health are discussed within society. This implication shows that educational intervention can be used to improve individuals' self-stigma and future self-management of issues and make students aware of the way in which society may understand and in turn treat people who do struggle.

When considering the statistical significance established for male participants when focusing on social distance, understanding of social support, social inclusion and self-stigma, it is clear that there is a gender difference in opinions surrounding mental health. This was also highlighted in the analysis of average scores in the different participant groups, supporting the findings of Salaheddin and Mason (2016) who identified differences in gender and perceived cause of mental health issue, as well as confidence in accessing sources of support. It could therefore be concluded that some of the misconceptions surrounding mental health stem from not knowing who they can talk to or how they can access help, particularly in the case of male participants. Though this current study did not identify the cause of the gender differences found in this research, it does add to an understanding of the engagement and internalisation of mental health beliefs that male participants experience throughout these interventions.

Year 7 participants were found to benefit from the interventions in terms of social distance, knowledge of mental health issues and understanding of stigma more than the older year 8 participants did. This may have been due to the removal of barriers that young people may experience when seeking support for their own mental health issues as well as ensuring that "safe" rules were established and maintained throughout the interventions (Salaheddin and Mason, 2016). However, this may have been due to the limited nature of mental health education in primary schools, meaning that in the pre-intervention condition their schools were lower. This reinforces the belief that any form of mental health intervention is better than no intervention, especially when taken in context of the increase in the diagnosis of child and adolescent mental health issues.

Overall, this research supports the findings of Henderson et al (2012), Chisholm et al (2012 and Ke et al (2013) in improving the stigmas and stereotypes surrounding mental health, which once again supports the idea that mental health education improves understanding of issues and therefore well researched and designed interventions are an essential part of the curriculum. However due to the design of this research, it was not possible to establish long-term benefit of increasing knowledge and understanding of mental health issues, particularly in the case of self-stigma and management of mental health issues (Rogers, 1999). Therefore, this research provides a strong foundation particularly for male participants and year 7 participants, with which additional learning could take place. Previous research cited in the literature review did not identify a specific age at which intervention is most beneficial, though this research has highlighted that younger students benefit more from targeted mental health education. This should therefore be considered in the planning of PSHE and SMSC lessons.

As mentioned above, rural areas such as Lincolnshire have limited resources and provisions available to them due to the size of the counties and the availability of services. This research has highlighted that schools are in a unique and essential position whereby increasing awareness of not only mental health issues but also signposting available provisions could support already stretched and underfunded services. This sentiment was supported by Rhodes (2018) who identified schools as being vital in the prevention and early intervention of mental health issues, as well as improving mental health knowledge and developing coping strategies for dealing with feelings. However, it is worth noting that this research was not replicated in an urban school and therefore it has not been possible to establish how significant the impact has been based on local context.

In the final months of this research, the Covid-19 pandemic impacted the school which this research took place in. Throughout this time, students were educated from home and there was an increase in mental health referrals of children and adolescents during this time (Mental Health Foundation, 2020). This further highlights the importance of research focusing on mental health in children and the ways in which this education takes place. Though adaptation would be required for distance learning, this intervention could be used to ensure the Government mandated PSHE curriculum be taught, while encouraging students to explore their own mental health and wellbeing and help to aid the open and honest conversations with the people around them.

## 5.2 Pedagogy

Several pedagogical approaches influenced the development of the interventions that were undertaken through this research, though as highlighted in the pedagogy review, most used a pre- and post-intervention questionnaire methodology.

The interventions that participants completed throughout this research used several pedagogical methods discussed in the literature review, specifically Dewees and Lax (2008). It was found that using case studies as a diagnostic tool aided participant understanding of mental health issues. Though participants in this research were not asked to diagnose Sam and Chris, they were asked to identify factors that may influence their wellbeing and therefore would affect their mental health. This gave students the opportunity to discuss issues impacting individuals that they can relate to but that they were assured were fictional characters and therefore limits the possible harm or offence that could be caused to others taking part in the sessions. It also allowed participants the opportunity to look at their own lives and identify factors that may positively or negatively impact their wellbeing. Tutors reported that there were often differing opinions surrounding the outcomes of the case studies, with several students wishing to know what happened to the characters following their issues. This reinforced the benefits outlined by

Innocent (2015) and Nurser (2017) who advocated the story-telling method of mental health education. Providing students with characters that can be discussed without imposing personal details allowed participants to discuss mental health issues as an abstract concept, which can be safely explored through this method. This can inform future planning of the mental health module of the PSHE curriculum.

The method of intervention delivery in this research included discussions about celebrities who experience mental health issues as well as looking at up-to-date statistics about young people who experience mental ill health as recommended in the research by Graves et al (2018). Both pieces of research allowed participants to discuss the symptoms and impact of issues for famous people as well as introducing them as possible role models for people functioning with a mental health illness. Though Graves et al (2018) used older participants than those being focused on during this research and this was not the focus in this research, it could be concluded that regardless of age introducing the idea that people who are admired and looked up to struggling it could make it more acceptable for 'ordinary' people to struggle too. This was particularly highlighted in the establishment of statistical significance for year 7 students in social distance travelled following the sessions being completed ( $p = .039$ ) and impacted self-stigma scores ( $p = .048$ ).

Looking at the points raised by Thornicroft et al (2016) who investigated possible ways that mental health interventions could take place, there were several comparisons that could be made between previous research and the current study can be made. It was found to be beneficial that opinions regarding mental health be challenged throughout interventions. This research challenged the opinions and common misconceptions that participants have through the stigma and stereotypes but also by viewing first-hand accounts by people who have been diagnosed with mental health issues and it was found that some opinions have been successfully challenged (Innocent (2015) and Nurser (2017)). Through the current research, it was not possible to generalise interventions to other societal groups, as highlighted through the difference in results between both male and female participants as well as year 7 and year 8 participants which shows that that the interventions had different impacts but also that participants were more receptive to different topics within the sessions. Overall, this study supports the research of Thornicroft et al (2016) who stated that further research is essential to establish long-term benefits. There is a global lack of research focusing on opinion change of people suffering from mental health illnesses – this research is only a small part of this statement but has shown that interventions focussing specifically mental health do have an impact on participants regardless of age.

Throughout this research, it has been established that male and female participants have engaged differently with the intervention and male participants in particular have benefited from the sessions. This mirrors the work of Pinfold et al (2003) who found that gender had an impact on the stigma and stereotypes that participants had about people experiencing mental health issues. However, Pinfold et al (2003) completed their research in various schools and this may have had an impact on their results; this may be a point that could be raised in future research. This allowed a variety of different backgrounds, contexts and educational levels to be assessed, including the religious denomination of the school, single-sex institutions, selective schools (grammar schools) and special educational needs (SEN) schools. By expanding this study in future research, it may be possible to analyse the impact of different educational facilities impact understanding and perception of mental health issues, (discussed in section 5.6).

### 5.3 Factors that may affect the results

With the Mental Health Awareness Day (10th October) and the Suicide Prevention Day (10th September) campaigns, it is likely that students were aware of mental health issues and the work that is currently being done to tackle negative attitudes. This was also been addressed through compulsory assemblies by the Senior Leadership Team and in-school campaigns by students of the Psychology Department. This has included in form presentations and arranging a school disco in order to raise money for a local hospital's mental health unit. This may gone some way to improve pupil's prior knowledge of mental health, which in turn affected the results of the pre-intervention questionnaire. The school has also worked to raise awareness through informational boards prepared by the A-Level Psychology students, which are regularly updated to inform the whole school community. However, as it is the difference that was being assessed the effect on the results should be minimal.

Prior personal experiences with mental health issues may had an impact on results for this research. This may include previous assemblies, SMSC work as well as parents or guardians suffering from mental health issues, as well as concerns about participants own mental health issues (Corrigan and Rao, 2012). This confounding variable was difficult to control in terms of previous understanding of mental health issues and preconceived opinions of people who experience mental ill health. This potentially impacted the pre-intervention (T1) questionnaire results as these opinions would have influenced the answers provided. However, in the post-intervention questionnaire (T2), participants may have shown a greater social distance travelled, in terms of participants understanding of the consequences of experiencing mental health issue, due to the increase in knowledge and understanding of specific mental health issues and the challenges that sufferers may face.

Children are very susceptible to the opinions of their parents and guardians, and this may therefore have an impact on their views of mental health, (Corrigan and Watson 2002). There was no way to prevent this from affecting the pre-intervention results, though again this could have had an impact on the social distance travelled indicated in the post-intervention questionnaire. It may also have addressed misconceptions or misunderstanding showing an increase in both knowledge of mental health issues and understanding of social support.

Finally, there may be an issue with social desirability in this research, as mental health can be considered a socially sensitive or taboo subject. This may mean that students answer questions in the way that they feel expected to answer the questions, rather than in honest, potentially controversial feelings about the statements. However, this was not controlled for though it is hoped that with the measures that have been taken to ensure anonymity the risk of this will be reduced. Following on from this public and personal stigma may have impacted the results of this research, as discussed by Henderson et al (2012) and Pedersen and Paves (2014). Conversations may have been hindered by the opinions of others especially if other students disagreed with their own views or if they are concerned that they could have been treated differently after expressing themselves. This in turn may have impacted the results of the questionnaire, but this was minimised by the confidentiality ensured by the unique identification numbers. In addition, students were encouraged to make notes in their books, which would remain confidential from the classmates with the aim to allow students an opportunity to express their thoughts about the focus topics while giving tutors an opportunity to monitor students for any concerns that would need to be referred to the safeguarding team as appropriate.

### 5.4 Limitations of the Research

Following the completion of interventions, some tutors reported that they lacked confidence in their own knowledge of specific mental health issues being discussed within their form groups.

This may have led to an increase in misconceptions surrounding specific aspects of illnesses or a reluctance to discuss particular issues that they were unfamiliar with discussing. The potential effect of this could be confusion for students or an unconscious reinforcement of the silence surrounding issues, undermining the goal of reducing stigma. If this research were to be repeated it would be hoped that the Government Scheme requiring all teachers to have a basic understanding of mental health would have been implemented which would improve their knowledge and understanding before delivering the interventions. In addition, in terms of confidentiality, the researcher remained unaware of any issues that the tutors themselves were struggling with which may have had an impact on the interventions and therefore the results (Devon, 2018).

It is impossible to analyse the impact of having tutors deliver the intervention rather than a neutral external party. This would have required additional funding to put into place, which was not possible during this research, but this is something that could be investigated as part of future research. This could allow participants to discuss any questions that they may have without fear that the discussions may be followed up later by the tutors or any offence be remembered. It could also be an opportunity to bring in people who deal with mental health issues as part as their occupations and would therefore have more understanding than the tutors would.

Due to the unique context of the school, it would be difficult to generalise these findings to alternate educational institutions such as single-sex or selective schools. Therefore, future research should expand on this current research to include both different types of schools but also schools in different locations, for example to compare the impact of the interventions in rural and inner city schools. This could be used to identify any modifications required for the intervention to be effective in multiple settings.

Another issue regarding this research was it was a short-term study looking at a six-week intervention programme and the impact of this on the understanding of mental health by participants. This will therefore not show the long-term impact of this intervention. Further research could also move this study to a longitudinal design, where these students or a sample of these students could be assessed at key points to adulthood to see if their attitudes change as they develop. It would also look at whether they were more likely to access support for any mental health issues that they may develop later in life and how long it takes them to initially seek or engage in the support.

Throughout data collection, there was the continued concern of social desirability in the participants answers as a self-report method was used and because mental health has become a topic that is not often openly discussed. Students were assured that the results of the questionnaires would remain anonymous through the unique identification numbers but there may have still been a worry that there were wrong answers to the statements. This was impossible to control for as it may have occurred in interviews or any other method of data collection.

As discussed before the research took place, it was impossible to consider previous knowledge about mental health especially through the Time to Change Campaigns as well as Mental Health Awareness Day and Week and Suicide Awareness Day. During the interventions, a school assembly and disco was arranged by two Sixth Form students at the school with the aim of raising awareness of the work done by the mental health ward at the local hospital but also to raise money for them. As part of this assembly, a psychiatrist completed a talk, which informed students about the work that they did, the issues that they faced, as well as experiences of



dealing with specific mental health issues. Though this could not be identified through the post-intervention questionnaires this could have had an impact on the results.

Though no whole school schemes were introduced throughout the research (Lee-Potter, 2019 and Nielsen et al, 2014) due to the time constraints of this research, some aspects of their findings were implemented throughout this research. This research focused on a holistic approach to mental health, which looked at in terms of own and others mental health and the factors that could affect wellbeing. Through the case studies students identified what was impacting others mental health, which included friendship issues, examination pressures and self-esteem highlighting both social and emotional, pressures which affect mental health.

Throughout this research, it was impossible to control for was students leaving the school mid-way through the intervention. This meant that some participants might have completed the intervention but not taken part in the post-intervention questionnaire resulting in an imbalance of participants in the two conditions. Some students were also mid-term admissions meaning that they joined the school part way through the sessions and therefore would not have completed the pre-intervention questionnaire so there was no baseline for them in terms of their results. In addition, staff leaving may have affected the teaching styles and attitudes to teaching the students about mental health, which may have had a subconscious, impact on the attitudes of the participants in the study and therefore may have affected the results. As it was impossible to predict students and staff leaving, there is no way to minimise the impact that this had on the research.

As a result of the multiple analyses on each factor that took place, it was possible that Type 1 errors occurred throughout the course of this research, which would involve rejecting the null hypothesis when it should be retained. There was no attempt to control for the family-wise error rate, which states that subjecting data to similar statistical tests increases the likelihood of establishing statistical significance (Ranganathan et al, 2016). This could be addressed in future research by having multiple methods of data collection that would use alternative statistical tests for example interviews which would use thematic and/or content analysis.

Finally, a previously untested questionnaire was used to gather data in this research. As a result, content and construct validity of the measure could not be assured and therefore there was no psychometric evidence ensuring that this questionnaire investigated the factors it appeared to and whether all aims would be addressed through its completion. This has potential consequences for this research being replicated, as a standardised measure may be preferable. However, using the Exploratory Factor Analysis to establish subscales improved the internal consistency of this measure, as evidenced by the Cronbach's Alpha Scores highlighted in section 4.2 (page 42). In order to improve the internal reliability of the results generated, testing this intervention through a previously established measure, such as Strengths and Difficulties Questionnaire (SDQ) or the Student Resilience Survey (SRS) may ensure test-retest reliability. Alternatively it could be argued that this study by considered as a pilot study, especially when taking into account the small sample, ethnocentric nature and the untested measure. In order to address this, further research would need to be conducted to continue to test the questionnaire's reliability and validity, a larger sample and in multiple schools.

### 5.5 Feedback from Tutors

Tutors reported that not only did the students enjoy the sessions, but it also became a topic that they were keen to explore further both in subsequent tutor times but also during their free social times, such as break and lunch. This was one of the main underlying aims of this research - that mental health become a topic, which is openly discussed by students of all ages. Students also

created resources aimed at improving the awareness of mental health issues for their age groups (see appendix 8.8). Several students asked for additional time to complete these and have asked for additional time to complete them or to be allowed to display them around the school. This enthusiasm has created the conversation, which it is hoped will continue now the interventions and research has been completed.

As recommended by the PSHE Association (2019) rules should be established while discussing sensitive topics such as mental health. This was completed during intervention session 1 and tutors reported that the most common rules that were made were that hands must be raised to speak, that there was to be no talking over each other and that no personal experiences would be discussed publicly but could be talked about confidentially with tutors at a later time. This aimed to guarantee students with a safe environment to investigate this topic and reduce the fear of being made to feel awkward or the fear of being mocked about comments that were made, as this is the most productive setting for the learning to take place.

Students reported that they enjoyed the multiple methods of presentation, which included videos, case studies and discussions as well as the required written tasks, which supported the research of Innocent (2015), Nurser (2017) and Pinfold et al (2003). They found this engaging and interesting, as they were concerned that this topic would be primarily teacher led. Following taking part in this research, some students have chosen to study Psychology as part of their General Certificate of Secondary Education (GCSE) option subjects in order to continue their investigation of mental health issues.

#### 5.6 Recommendations

This research provided a snapshot into attitudes of mental health at one rural school in Lincolnshire. In order for the impact to be accurately assessed, this research would need to be replicated both at other schools within the county and outside of the county. It would also need to be undertaken in a range of schools including Selective Grammar Schools, Alternative Provision Facilities, Special Educational Needs Centres and Pupil Referral Units. It could also be extended into single sex education facilities to establish a further difference in the gender differences in attitudes and opinions. This research could also be tested in an urban setting, to identify whether the interventions have a similar impact as they do in a rural school. Modifications may need to be made in relation to the presentation of the intervention through alternative pedagogical methods, which could be identified prior to the research taking place.

As recommended by Sartorius (2007) it is essential that several people be involved in the creation or development of stigma and stereotypes of mental health. Therefore, it could be concluded that other people must be involved in work to change and challenge the opinions that people have – for example, external parties could be invited to speak to participants to reinforce the learning in the sessions. It will also give students an opportunity to ask any questions that they might have, reinforcing their understanding of mental health.

Throughout this thesis, there has been a continued discussion regarding the most appropriate age for students to receive interventions on the subject of mental health. As indicated by the findings of this research, opinions have already been formed about mental health issues by years 7 and 8 (ages 11 to 13), and therefore future research should focus specifically on primary school students. However, ethically this may be an issue due to gaining informed consent and attempting to minimise the impact of psychological harm caused by the mental health issues that would be focused on during sessions. Modifications could be made to the interventions to make them more age appropriate as well as introducing additional support for

both teachers and students, with the potential of engaging external agencies to help with delivering sessions.

It could also be suggested that adapting this research to a longitudinal design, to include extending periods of interventions and long-term monitoring of the impact would allow students to explore mental health in more detail, as well as potentially looking at more illnesses as this may improve their overall understanding of this topic. This would also allow researchers the opportunity to assess the impact on self-management of mental health issues that may develop later in life, though the ethical implications of monitoring would need to be considered. However, this would once again need to be sensitive to the demands placed on schools concerning the PSHE curriculum and content required to be covered each year.

This research also raised an interesting question and potential confounding variable – can teachers struggling with their own mental health effectively teach students how to deal with mental health issues? When the Government’s own mental health champion has expressed a concern that the biggest contributor to poor mental health in children and adolescents is the fact that the adults around them, such as parents, other family members and teachers, are struggling with their own mental health. This means that they cannot help others until they are able to help themselves, (Devon, 2018). There has been a focus recently on the mental health and wellness of teachers, with external agencies offering “wellness days” as part of Continued Professional Development (CPD) but there is not yet a compulsory buy-in from all schools. Therefore, future research could focus on the mental health of teachers who are asked to deliver sessions about mental health and the impact that this could have on learners.

Finally, it would be possible to extend this research to take into account different pedagogical approaches, such as the storybook method (Innocent, 2015 and Nurser, 2017) or a peer mentor strategy (Eisenstein et al, 2019). Both of these methods would support primary school participants, as they are more age appropriate teaching methods than some of the case study designs and videos included in this research.

Overall, this research yielded some statistically significant results, which aimed to address the stigmas and stereotypes surrounding mental health and has highlighted that a varied intervention programme does begin the necessary conversations and investigations into mental health. It also shows that interventions introduced at a younger age has more impact than at an older age and that male participants can benefit from open and honest conversations on this topic. Therefore, the final and potentially most critical recommendation for future research is to begin interventions at a younger age to try to challenge stigmas, stereotypes and misconceptions before they become firmly established.

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## Appendices

### 7.1 – Summary of Legislations in the United Kingdom

<p>Report on Children, Young People and Family Engagement. YoungMinds 2014</p>	<p>Summary</p>	<ul style="list-style-type: none"> <li>● Investigated the engagement of children, young people and families to mental health services.</li> <li>● Found that secondary school age children felt that mental health is a taboo subject and that there was little information provided at school.</li> <li>● Parents were concerned that children and young people with mental health needs are stigmatised to a distressing level and that they have been described as dangerous, not able to be trusted, not stable, and at risk of causing physical or emotional harm to others, (YoungMinds, 2014).</li> <li>● Concluded that children and young people must be encouraged to understand good mental health and wellbeing and to promote acceptance both for themselves and those around them as well as raising awareness of signposted points of contact that they can discuss concerns or issues with.</li> <li>● Highlights the requirement for interventions within schools and that both students and parents are open to these taking place.</li> </ul>
<p>Future in Mind Plan (2015)</p>	<p>Summary</p>	<ul style="list-style-type: none"> <li>● Outlined both national and local plans to acquire additional funding, improved access to effective mental health support, multiagency approaches to treatment and improved care for vulnerable children and young adults.</li> <li>● Identified that on a national level there is a need to improve public awareness and understanding of mental health issues, particularly those that affect children and young adults, and to reduce stigma and discrimination that young people seeking help might experience.</li> <li>● Aimed to encourage schools to develop whole school approaches to mental health and ensure consistency across the country, as well as requesting a survey of the prevalence of mental health issues in children and young adults.</li> </ul>
<p>Future in Mind Plan (2016), published by NHS England</p>	<p>Summary</p>	<ul style="list-style-type: none"> <li>● Stated that an additional £1.25 billion would be used to improve the mental health care system for children and young adults.</li> <li>● Intends on improving perinatal care and the responsiveness of services for children suffering from eating disorders.</li> <li>● Aims to address this through three priority actions; increase availability of services, introducing a holistic approach to mental health and promoting positive health.</li> </ul>

		<ul style="list-style-type: none"> <li>● Raising awareness and improving services for children and young adults and aims to allow at least 70,000 children to have access to high-quality mental health services.</li> <li>● Focuses must be on vulnerable children, such as looked after children and victims of abuse or exploitation, as they are at a significantly higher risk of developing mental health illnesses.</li> </ul>
The Five Year Forward View for Mental Health: One Year On (2017)	Summary	<ul style="list-style-type: none"> <li>● Stated that at least 120,000 additional people had accessed mental health services between 2016 and when the report was published in 2017, including an additional 21,000 children and young people.</li> <li>● Developed plans to set clear treatment pathways and which will consider holistic methods, with separate pathways being put in place specifically for children suffering from eating disorders.</li> <li>● Confirmed that additional funding was directed by the Government to mental health services at a local level and can be accessed through an application process as set out in the Five Year Forward View for Mental Health</li> <li>● Confirmed that change and consistency is required to continue the positive change being implemented.</li> </ul>
Transforming Children and Young People's Mental Health Provision: a Green Paper	Summary	<ul style="list-style-type: none"> <li>● Recommended specific interventions for vulnerable groups including those with special educational needs, young offenders and children in need.</li> <li>● Introduced an incentive for those schools that identify and train a Designated Senior Lead (DSL) for Mental Health who will be the main point of contact for both internal concerns and external agencies.</li> <li>● Introduced Mental Health Champions (MHC) who would work with senior management to raise awareness of mental health within the school community.</li> <li>● Encouraged DSLs and MHCs to complete a Mental Health First Aid course, with the objective of normalising society's attitudes and behaviours around mental health, by developing the skills we need to look after our own and others' wellbeing, (MHFA England, 2019).</li> </ul>
The Fair Funding for Mental Health report (2018)	Summary	<ul style="list-style-type: none"> <li>● Announced that additional funding has been allocated to mental health services via the NHS (Gilbert, 2018).</li> <li>● Included plans for the introduction of new children and young people's crisis teams and mental health support teams in schools.</li> </ul>
Transforming Children and	Summary	<ul style="list-style-type: none"> <li>● States priorities for issues surrounding mental health as including maintaining monitoring</li> </ul>

Young People's Mental Health Provision: A Green Paper (2018)		<p>methods, additional funding for perinatal mental health and increased access to services including early interventions</p> <ul style="list-style-type: none"><li>● Recommends changes within the education system to include compulsory training for teachers and support staff to raise awareness of mental health issues in students.</li><li>● Focuses on the potential impacts of social media on mental health and calls for additional education as part of the PSHE curriculum about online safety and mental health.</li></ul>
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## 7.2 – Boolean Search Terms

Key Terms	Database	Inclusion/Exclusion Criteria	Number of Results Found
("mental health" OR "mental illness") AND (stigma* OR stereotype OR attitude* OR prejudic*) AND (child* OR adolescen*) AND (promot* OR interven*)	PsycInfo	2010-2029  Adolescence (13-17 yrs) OR Childhood (birth-12 yrs) OR School Age (6-12 yrs)	5,363
("mental health" OR "mental illness") AND (stigma* OR stereotype OR attitude) AND (child* OR adolescen*) AND (intervention*)	PsycInfo	2010-2029  Adolescence (13-17 yrs) OR Childhood (birth-12 yrs) OR School Age (6-12 yrs)	2,377
("mental health" OR "mental illness" OR "mental ill health") AND (stigma* OR stereotype OR attitude* OR prejudic* OR opinion*) AND (child* OR adolescen*)	PsychArticles	Scholarly Journals  2010-2029 > 2010-2020  Journal adolescent OR mental health OR child OR adolescent attitudes OR health knowledge, attitudes, practice OR stigma OR student attitudes  Adolescence (13-17 yrs) OR Childhood (birth-12 yrs) OR School Age (6-12 yrs)  Quantitative Study OR Qualitative Study  English	3,115
("mental health" OR "mental illness" OR "mental ill health") AND (stigma* OR stereotype OR attitude OR	PsychArticles	Scholarly Journals  2010-2029  Journal	217

<p>opinion*) AND (child* OR adolescen*) AND (intervention*)</p>		<p>child AND (adolescent OR students) NOT (adult AND parents AND parenting) Adolescence (13-17 yrs) OR Childhood (birth-12 yrs) OR School Age (6-12 yrs)</p> <p>Human</p> <p>English</p>	
<p>("mental health" OR "mental illness") AND (teach* OR pedago*) AND (child* OR school OR adolesc*)</p>	<p>PsychArticles</p>	<p>2010-2029</p> <p>(Childhood (birth-12 yrs) OR Adolescence (13-17 yrs) OR School Age (6-12 yrs)) NOT (Adulthood (18 yrs &amp; older) AND Young Adulthood (18-29 yrs) AND Thirties (30-39 yrs) AND Middle Age (40-64 yrs) AND Aged (65 yrs &amp; older) AND Preschool Age (2-5 yrs) AND Infancy (2- 23 mo) AND Very Old (85 yrs &amp; older) AND Neonatal (birth-1 mo))</p> <p>Human</p> <p>English</p>	<p>1,241</p>
<p>("mental health" OR "mental illness" OR "mental ill health") AND (stigma* OR stereotype OR attitude OR opinion*) AND (child* OR adolescen*) AND (intervention*)</p>	<p>PsychInfo</p>	<p>Scholarly Journals</p> <p>2010-2029</p> <p>(Adolescence (13-17 yrs) OR Childhood (birth-12 yrs) OR School Age (6-12 yrs)) NOT (Adulthood (18 yrs &amp; older) AND Young Adulthood (18- 29 yrs) AND Thirties (30-39 yrs) AND Middle Age (40-64 yrs) AND Aged (65 yrs &amp; older) AND Preschool Age (2-5 yrs) AND Infancy (2-</p>	<p>628</p>

		23 mo) AND Very Old (85 yrs & older) AND Neonatal (birth-1 mo))	
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### 7.3 – Cornwall NHS Partnership Trust Questionnaire about Mental Health

ID: \_\_\_\_\_ Male / Female Date: \_\_\_\_\_

This is an anonymous and confidential survey about what you know / think about Mental Health. It is being used at the beginning and end of the work you are going to do in school during SMSC. The survey will help us evaluate the project. No-one will see your individual answers. We have only asked for class / gender information so that we can compare groups of results when we repeat the survey at the end of the project. Please read the statements below and tick one of the boxes labelled 1 to 5. Please answer as truthfully as possible. There are no 'right' or 'wrong' answers and this is not a test.

		1 - Stro ngly Disa gree	2 - Disa gree	3 - Neith er Agree or Disag ree	4 - Agre e	5 - Stro ngly Agre e
1	Anyone can have a mental health problem.					
2	I would be too embarrassed to tell anyone that I had a mental health problem.					
3	I would be happy to have someone with a mental health problem at my school or place of work.					
4	Mental health problems are not real illnesses in the same way that physical illnesses are; people with mental health problems should just 'pull themselves together'.					
5	People with mental health problems are likely to be violent.					
6	It's easy to spot someone with a mental health problem.					
7	Once you have a mental health problem you have it for life.					
8	Medication is the only treatment for mental health problems.					
9	Someone with a mental health problem should have the same right to a job as anyone else.					
10	I would not want to live next door to someone with a mental health problem.					

		1 - Stro ngly Disa gree	2 - Disa gree	3 - Neith er Agree or Disag ree	4 - Agre e	5 - Stro ngly Agre e
11	Anyone with a history of mental health problems should be excluded from public office (e.g. from being Prime Minister or in the Government).					
12	As soon as a person shows signs of a mental health problem they should be put into hospital.					
13	If I thought a friend had a mental health problem I would stay away from them.					
14	It is important for a person with a mental health problem to be part of a supportive community that includes family and friends.					
15	I have heard a person I know call someone names like 'nutter', 'psycho', 'loony'.					
16	If I thought a friend had a mental health problem I would want to help them.					
17	If I thought that I had a mental health problem I would talk to someone.					
18	People are born with mental health problems.					
19	Using words like 'nutter', 'psycho', 'loony' is just a bit of fun. No-one gets hurt.					
20	Mental health problems only affect adults, not children and young people.					
21	If I thought that I had a mental health problem I would know how to get help.					
22	Only certain kinds of people develop mental health problems.					
23	It's more important to spend National Health Service (NHS) money on treating physical conditions rather than mental health problems.					

## 7.4 – Confirmation of Consent from Cornwall NHS Partnership

RE: Cornwall Healthy Schools - query

Ellwood Cheryl <cellwood@cornwall.gov.uk>  
Wed 23/05/2018, 13:05  
Kimberley Walker (Researcher) ✉

Kim – I'm so sorry! I *had* heard from my manager, but I have totally forgotten to get back to you. He is completely happy for you to use STOP Stigma.

Huge apologies for my failure, I'm so glad that you were on the ball and did get back to me.

Good luck with your research.  
Cheryl

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**From:** Kimberley Walker (Researcher) [mailto:Kimberley.Walker@hud.ac.uk]  
**Sent:** 23 May 2018 10:03  
**To:** Ellwood Cheryl  
**Subject:** Re: Cornwall Healthy Schools - query

Hi Cheryl,

I was wondering if you had heard back from your manager about the possibility of using the questionnaire for my research at all?

Thanks  
Kim

## 7.5 – Cronbach's Alpha Statistical Test

### 7.5.1 Pre-Intervention Results

**Reliability Statistics**

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.510	.528	23

### 7.5.2 Post-Intervention Results

**Reliability Statistics**

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.528	.528	23

## 7.6 - School Research Ethics Panel (SREP)

### SREP Application - Kimberley Walker (MSc by Res) - Self-Management of Mental Health Issues (SREP/2018/112)









March 29, 2019 at 4:37 PM 

From [SHUM Research Ethics](#) >

[Hide](#)

To "Kimberley Walker (Researcher)" >

Cc [Stephen Hemingway](#) > ['Kim Walker'](#) >

 [image001.png](#) 1.77 KB,  [image002.png](#) 1.82 KB,  [image003.gif](#) 1.64 KB,  [image004.gif](#) 1.68 KB,  [image005.gif](#) 1.73 KB,  [image006.png](#) 1.77 KB,  [Parents In...P comments.docx](#) 120.6 KB,  [Student Pa...P comments.docx](#) 118.74 KB

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Dear Kim,

The reviewers of your SREP Application have confirmed that your SREP Application has been approved subject to the minor amendments contained on the attached documents.

There is no need for you to submit your amended documents to SREP.

With best wishes for the success of your research project.

Regards,

Kirsty

(on behalf of SREP)

**Kirsty Thomson**  
Research Administrator

 01484 471156

 [hhs-re@hud.ac.uk](mailto:hhs-re@hud.ac.uk)

 [www.hud.ac.uk](http://www.hud.ac.uk)

School of Human and Health Sciences R&E Office - R1/17  
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

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7.7 – Parent Information Sheet and Information Sheet

Dear Parent/Guardian,

As part of the Government's Personal, Social and Health Education (PSHE) and Giles Academy's Social, Moral, Spiritual and Cultural (SMSC) curriculum, students are required to learn about mental health. This will include understanding different mental health issues, treatment options and stigmas and stereotypes that people with mental health issues may experience.

Students will be asked to complete a pre- and post-questionnaire to analyse how their understanding of mental health has developed throughout this work, and the results will be used as part of their lessons and as part of research into challenging stereotypes of mental health. All results will remain anonymous throughout all aspects of the research and no personal details will be collected other than age and gender of the students. Please be aware that the results of this research may be published.

Before agreeing that your child can participate, please read the attached information sheet, and complete the form below to confirm that you are happy for your child/children to take part in this study. If you have any questions, please contact Miss K Walker on 01205 870693 or by email on [kiwalker@gilesacademy.co.uk](mailto:kiwalker@gilesacademy.co.uk).

Kind Regards,



K Walker  
Acting Head of Year 10



E Smith  
Head of Year 7



T Chenery  
Head of Year 8

.....  
I am happy / not happy\* for my child to take part in research regarding mental health stigma and stereotypes

Pupil's Name : \_\_\_\_\_ Form : \_\_\_\_\_

I have read and understood the parental information sheet, including the GDPR information regarding data storage.

Parent /Guardian Signature: \_\_\_\_\_

(\* delete as applicable)



**Title of Project:** Self-Management of Mental Health Issues

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### **INFORMATION SHEET**

Your son/daughter has been invited to take part in a study about their thoughts, opinions and experiences regarding mental health. Before you decide whether your child/children are able to take part it is important that you understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is unclear or if you would like more information.

#### **What is the study about?**

The purpose of this research is to determine whether targeted intervention through your child/children's SMSC curriculum can improve understanding and knowledge of mental health issues, as well as reducing the associated stigma and stereotypes.

#### **Why has my child/children been approached?**

Your son/daughter has been approached as this intervention is targeted at students aged between 11 and 13. It is hoped that the intervention will have a significant impact on participants of this age.

#### **Do they have to take part?**

It is your decision whether or not your son/daughter takes part. If you decide that your child/children can take part you will be asked to sign a consent form, and will be free to withdraw at any time without giving a reason.

#### **What will I need to do?**

If you agree for your son/daughter to take part in the research they will be asked to complete a pre-intervention questionnaire to establish a baseline to compare later results to. Following this, your child will take part in a terms worth of intervention about mental health and specific mental health issues. After your son/daughter has completed the intervention, they will be asked to complete a post-intervention questionnaire, aimed at identifying the impact of the sessions that they have undertaken.

#### **Will their identity be disclosed?**

All information disclosed within the study will remain confidential, unless your child indicates that you or anyone else is at risk of serious harm. Please note the findings of this research may be published.

#### **What will happen to the information?**

All information collected during this research will be stored securely. Any identifying material will be removed in order to ensure anonymity. It is anticipated that the research may, at some point,

be published in a journal or report. However, should this happen, your child/children's anonymity will be ensured.

Information shared by participants in this research will be held confidentially by the University of Huddersfield in accordance with the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

All information collected from your son/daughter during this research will be kept securely and accessed only by the research team. Any identifying material will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published as thesis or reports to the University, journal articles and/or presented at conferences. Material from the study may also be used for teaching purposes, at seminars or workshops. However, should this happen, your child's anonymity will be ensured.

All data will be kept on a secure system at the University of Huddersfield for ten years beyond the end of the study.

The University of Huddersfield is the 'data controller' and will be responsible for the secure management of the information you provide. The researcher or research team is 'the data processor'. If you wish to complain about the management of your child's data, you should contact the University of Huddersfield Solicitor (Protection Officer) by emailing [legal@hud.ac.uk](mailto:legal@hud.ac.uk). If you are not satisfied, you may take your complaint to the Information Commissioner's Office (ICO).

Who can I contact for further information?

If you require any further information about the research, please contact me on:

Please note:

Name: Kimberley Walker

E-mail: [kiwalker@gilesacademy.co.uk](mailto:kiwalker@gilesacademy.co.uk)

Telephone: 01205 870693

Supervisor Contact Details:

Name: Stephen Hemingway

Email: [s.j.hemingway@hud.ac.uk](mailto:s.j.hemingway@hud.ac.uk)

Telephone: 01484 471859



**Title of Project:** Self-Management of Mental Health Issues

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### **INFORMATION SHEET**

You have been invited to take part in a piece of research about opinions and views about mental health. Before you take part in this research, please read the information below and please ask questions if you have any.

#### **What is the study about?**

The research is looking at whether SMSC sessions focusing specifically on mental health can develop your understanding of issues and the possible causes and consequences of having poor mental health.

#### **Why I have been approached?**

This research is focusing on students between the ages of 11 – 13.

#### **Do I have to take part?**

You do not have to take part in this research – your parents have been notified about your involvement in the study and have given permission for you to be asked. You will need to complete the SMSC sessions, but you would not have to complete the questionnaires. If you complete the questionnaire and then decide that you no longer wish to be part of the study, please contact the researcher on the below email address.

#### **What will I need to do?**

If you agree to take part in this research, you will need to complete two questionnaires – 1 before the lessons and 1 after the lessons.

#### **Will my identity be disclosed?**

All the results from this research will remain confidential.

#### **What will happen to the information?**

All the information will be kept on a secure USB drive that no one else will have access to. Once all of the data for this experiment has been collected, it will be transferred onto the University of Huddersfield secure servers, that once again only the researcher and the research supervisor will have access to.

#### **Who can I contact for further information?**

If you have any concerns or questions regarding this research, you can contact me by email at [kiwalker@gilesacademy.co.uk](mailto:kiwalker@gilesacademy.co.uk)

If you are concerned about your own mental health, and would like advise or support, you can contact any of the following agencies:

Kooth: <https://www.kooth.com/>

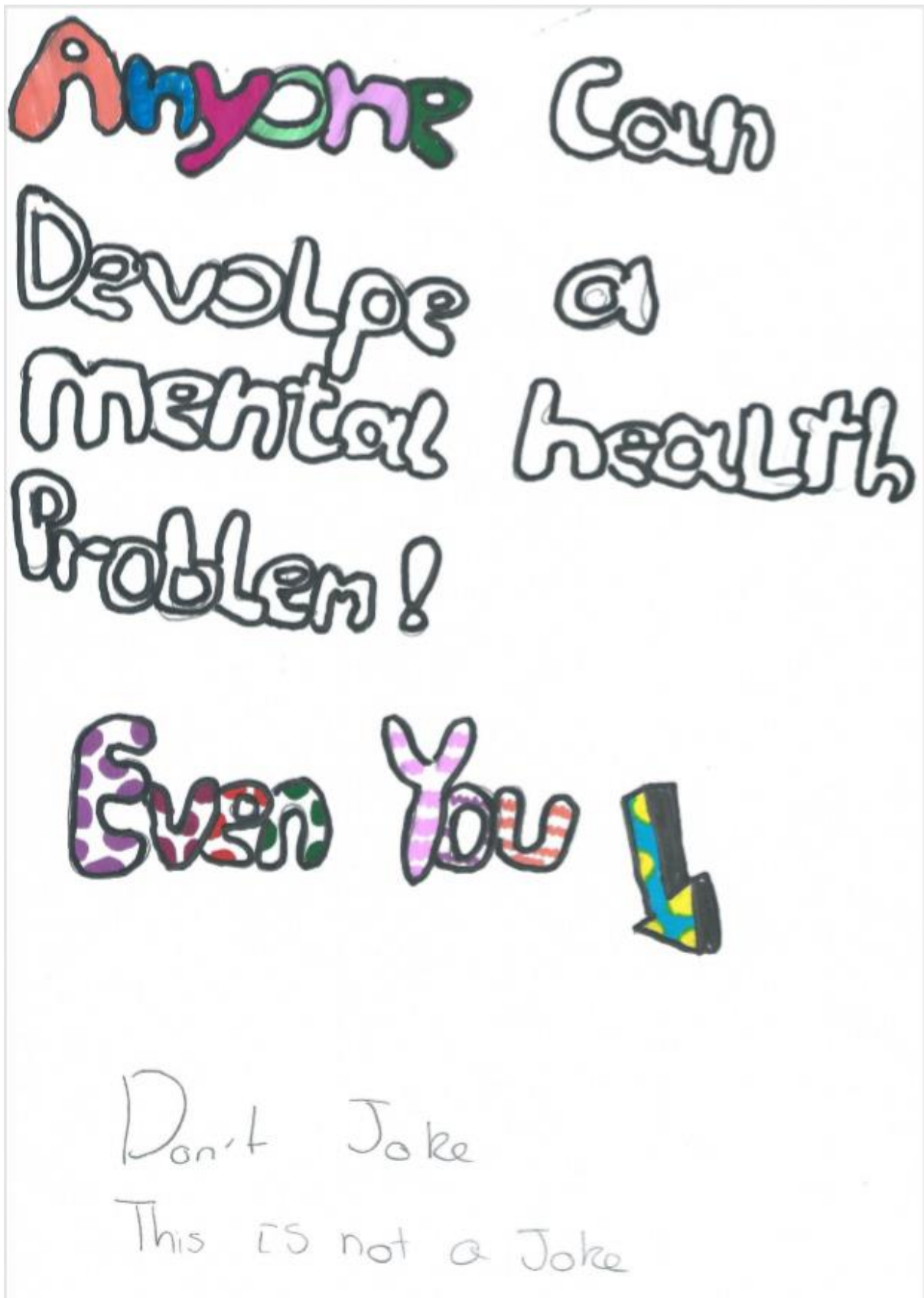
Childline: 0800 1111

## 7.9 – Risk Assessment

Concern	Likelihood	Potential Impact/Outcome	Counter Measures
Identify risks/hazards present	High/Medium/Low	Who might be harmed and how?	Evaluate the risks and decide on precautions
<p><u>Safeguarding disclosure</u> Though the previous research by the Cornwall Partnership did not highlight any issues, there is a risk of students making a disclosure either about their own mental health or the mental health of those around them. The topic of the interventions may be extremely personal to them, and may bring to light underlying feelings or concerns that they may have. This could result in disengagement from the program, behavioural issues or concerns about their safety.</p>	High	<ul style="list-style-type: none"> <li>• Students who make the disclosure</li> <li>• Family members of those that have been affected by the issue</li> <li>• Staff who deal with the safeguarding concern</li> </ul>	<p>The SLT linemangers for lower school and Safeguarding are both aware of these pieces of research. If any students cause concern to their form tutor or other members of staff, they will be removed from the study immediately and a safeguarding referral will be made. Though this will be dealt with by the individual year teams, it could be the case that an external agency is requested to support the student. Parents will be contacted as required through the safeguarding policy. Signposting will also be made available to all staff that are involved in this research, just in case it is needed.</p>
<p><u>Confidentiality</u> Confidentiality may be an issue especially during class discussions which will be a required part of this intervention. A student may express opinions that differ from other students and may cause problems (for safeguarding disclosures see above).</p>	Medium	<ul style="list-style-type: none"> <li>• Students</li> </ul>	<p>All students will be assigned a letter/number by the experimenter who will be the only person with this information. Should any issues arise, it will be dealt with directly by the form tutor and year team, as it would be considered a behavioural issue. If it were to affect the research, then students information may be</p>

			withdrawn and/or they are withdrawn from the interventions.
<p><u>Protection from harm</u> Students may become distressed by the information/stories that they are seeing, and this may cause them some distress. (see safeguarding)</p>	Low/Medium	<ul style="list-style-type: none"> <li>• Students</li> </ul>	<p>Again, if there are any concerns about students, they will be spoken to by a member of their year team, as they are more familiar with the students than the researcher is. If concerns warrant it, they will be removed from the interventions and their data destroyed and the appropriate a external agency referral will be made.</p>
<p><u>Differing Opinions</u> This research may expose students to opinions or information that they have not experienced, or that differ from the ones expressed at home. This has the potential to cause conflict both within the child and at home.</p>	Medium	<ul style="list-style-type: none"> <li>• Distress for students</li> <li>• Concerns for members of staff as to how to resolve any conflicts.</li> </ul>	<p>Information will be presented in a nonbiased way and will include fact, statistics and other relevant information such as case studies. Information will be presented as an opinion, with the exception of where statistics support what is being said.</p>

7.10 – Examples of booklets created by students through the interventions



# Mental Health



Do you want to cause that!

ON ÷

Laugh!

Suicide is the biggest killer in the UK

Hundreds of millions & maybe billions of people suffer with mental illnesses.

16,000,000 people from UK alone experience a mental health issue!

Don't make fun of people

Don't imitate!

10% of school children have mental illnesses



# Mental Health

Some mental Health problems are:

- Depression
- Anxiety
- Anorexia
- OCD
- Bi-polar
- Split personality Syndrome.

Who can get mental Health issues?  
anyone can

mental health problems are just as important as physical illnesses.

get mental health problems?

Did you Know?

- 16 million people have mental health issues
- 3 in 4 people's mental illness start in kids
- Suicide is the biggest <sup>death due to</sup> mental health problems in young adults or children.

# Mental health



Get  
some  
help

# MENTAL

# HEALTH

There are multiple different kinds of mental illnesses but this doesn't mean if someone has it, they are still normal there no different to any other human being.



→ Anyone can get it!

↓  
It doesn't matter who you are.

What is mental health?

Mental health is where you suffer with depression, anxiety, eating Disorders, Bipolar, obsessive compulsive Disorders

What will happen if i talk to someone?

they can help you through it and give you someone to talk to about it they also can calm you down

What if i dont want to talk to someone about that i dont know?

then talk to a friend and a family member and they will talk to us about it and we will tell them what to do to help you out.

Contact us now if you need us!

Do  
You need  
to talk  
to someone  
about  
it?

Do  
you  
suffer  
with  
mental  
health?