ADOLESCENTS' VIEWS ON MENTAL HEALTH AND SCHOOL-BASED SUPPORT

NADIA DAER

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of professional doctorate in clinical psychology

JULY 2021

Word Count: 27,852

ACKNOWLEDGEMENTS

I would like to thank the participants who took part in this study and shared their thoughts and experiences with me, and the school staff who agreed to take part and helped me facilitate the focus groups.

I would also like to thank my Director of Studies, Trishna Patel, for her direction, helpful feedback and encouragement, all of which I am very grateful for.

Thank you also to my family and friends for their love, support and patience. I have appreciated it immeasurably.

ABSTRACT

Background: Adolescence is critical period of bio-psychosocial development and mental health problems during this stage can have long lasting consequences. Growing concern about adolescent mental health has been fuelled by reports of increased prevalence of mental health problems, referrals to mental health services and perceived risk factors such as social media and, most recently, the Covid-19 pandemic. Effective strategies for addressing adolescent distress require up-to-date research on the nature and impact of these complex issues, yet chronic underfunding means that the evidence base remains limited. Research seeking the perspectives of adolescents themselves is particularly sparse, despite adolescents being a key source of information on the issues currently affecting them. At the same time, schools increasingly asked to support student wellbeing and incorporate mental health teaching into their curriculums have expressed concern about the lack of resources or guidance with which to do this.

Aims: To explore adolescents' perspectives on the issue that they identify as impacting their mental health, and to gain their views on school-based support and teaching on mental health.

Method: A critical realist approach was adopted. Three focus groups were held with adolescent pupils (n=19) at one London school. The transcripts analysed using Thematic Analysis.

Results: Two main themes were generated: 'Meeting Expectations' and 'Relationships with Teachers'.

Conclusion: The findings support the literature on adolescent identity development and the need for adolescents to gain a sense of competence, autonomy and meaningful relatedness to others. This linked to literature about the importance of the student-teacher relationship for wellbeing and connectedness at school. The findings added to the literature by identifying that providing spaces where adolescents' views are sought and listened to by adults were the single best thing that adolescents felt schools could do to improve mental health support and teaching.

Adolescents' Views on Mental Health and School-Based Support

1. INTRODUCTION

1.1. Chapter Overview

This chapter provides an overview of adolescence as it is understood in the psychological literature and explores concerns that adolescent mental health is worsening.

With a focus on the experiences of adolescents in the United Kingdom (UK), critical summaries of both the research indicating a rise in distress and of proposed government strategies for addressing it, are presented. Consideration is also given to the challenges that schools face providing mental health support to adolescents and teaching skills for mental wellbeing, in line with the latest government plans.

The chapter will end with a scoping review of the literature to highlight gaps and provide a rationale for the study aims and research questions.

1.2. Adolescence

Adolescence is the phase of development in between childhood and adulthood where one or more transitional events mark the progress from physiological immaturity and social dependency to biological maturity and the acquisition of adult roles, greater personal agency and social accountability (Curtis, 2015; Steinberg, 2019).

This process is understood differently in different cultures, but almost all mark the transition from child to adult in some way. In the West, current theory understands adolescence as a series of transitional events informed by physiological, psycho-social, cultural and historical factors, making it a dynamic construct, understood and experienced differently within and between cultures and contexts (Crockett, 1997; Curtis, 2015; Graber & Brooks-Gunn, 1996).

For this reason, the age ranges associated with adolescence also differ between sources. The World Health Organisation (WHO) suggests ages ten to nineteen years but definitions can range from ages twelve to nineteen, to nine to twenty six, and it is widely acknowledged that the age range associated with adolescence in the West have expanded by as much as twice the length of 100 years ago (World Health Organisation, n.d.). This is thought to be primarily an outcome of extended schooling and the delay in young people taking up adult roles in relation to working and starting families, and has contributed to social scientists now distinguishing between early (approximately ages 10-13), middle (approximately ages 14-17) and late (approximately ages 18-21) adolescence phases (Steinberg, 2019).

It is worth noting, therefore, that while the majority of research and literature referenced in this thesis is grounded in Western ideas of adolescence and development, these represent only some of the possible ways of viewing and understanding this subject. This study was conducted in England, and it is assumed that Western ideas largely frame the cultural context in which British adolescents are growing up (although this may not be true for all British adolescents' experiences). Given the (critical realist) epistemological position adopted for this research, it is acknowledged that there may be other understandings of adolescence that could be applied.

Despite the variation in conceptualisations of adolescence, there is a reality that adolescents in the United Kingdom do not have full rights and freedoms until their late teens and live within structures designed and imposed by adults as they are developing. It is important, therefore, that adults understand adolescents' needs and experiences so that the structures that exist around them support their wellbeing. Overlooking this responsibility can have negative implications for adolescents and long-term mental health implications for the adults they will grow up to be (Kim-Cohen et al., 2003).

1.2.1. Adolescence As A Distinct Stage

Although we were all adolescents once, and may feel we can remember our experiences well, it can be difficult to know how they compared with those of our peers, or of adolescents today. Recent experimental psychological research, along with descriptions of adolescence from historical texts, suggests that there are some core features of adolescent behaviour and experience that persist across time and between countries, cultures and even between people and other animals (Blakemore, 2018; Logue et al., 2014; Steinberg et al., 2017). For instance, Logue et al. (2014) found that reward-seeking behaviour (drinking alcohol) in mice increased when with peers for adolescent mice but not adult mice, suggesting that peer effects during adolescence are evolutionarily inbuilt across multiple species of animals. Similarly, Blakemore (2018) highlighted how, in writings from Aristotle in ancient Greece to Shakespeare in England in the 16th century through to our present day observations, descriptions of adolescence note very similar traits of sexual disinhibition, emotionally lability, lack of respect for authority and prioritising peer relationships, indicating traits that continue to manifest across centuries of cultural change (Aristotle, 350 BCE; Shakespeare, 1611). Observations of characteristics that may be inherent to the experience of adolescence can direct us to core needs for supporting and understanding adolescents themselves.

1.2.2. Self And Others

Commonly, perceptions of adolescence consider it to be a period of inherent ‘storm and stress’, whether as a result of biologically driven changes, as suggested by G. Stanley Hall (1904), or, as is currently considered, due to a number of physiological, psychological and social causes (Arnett, 1999). These include the process of relinquishing the childhood identity and building an autonomous adult identity. Humans live in complex societies and so, alongside reaching sexual maturity in a physiological sense, this requires gaining a psychological and emotional sense of oneself both as an independent person, distinct and unique from others, and as part of a community in which one is accepted and feels they matter and belong (Adams & Marshall, 1996). In achieving these goals, adolescents look around them for role

models and guiding ideas to imitate and explore, adopting skills and characteristics, and testing, relinquishing and redefining them in a gradual process of change which has been described by some as a period of ‘identity crisis’, reflecting the unique struggle that children have of curating an identity that will thrive in a competitive adult environment, at a time when they are also undergoing significant physiological changes (Erikson, 1964; Marcia, 1980).

Recent advances in neuropsychology, including fMRI scanning, has enabled researchers to observe the physical brain as these changes occur. These observations have demonstrated that identity formation and the development of the ‘social brain’ takes place alongside the continuing physical development of the brain, and particularly of the prefrontal cortex (PFC), which continues to form throughout adolescence and up until the mid-twenties (Mills et al., 2014). This provides an added challenge to adolescents trying to adapt to an adult world as they do not have access to the full adult range of brain functions. The PFC is responsible for advanced executive functioning and planning, complex social skills, self-monitoring and emotion regulation (Spear, 2013). Its state of development during adolescence is thought to be a contributing factor in associated behaviours such as ‘sensation seeking’ that are often labelled as risky or dis-regulated and which commonly form the basis for concern around adolescent mental health, particularly when substance use, failure to attendance school or petty crime are involved (Shulman et al., 2016; Steinberg et al., 2017).

Adolescents also become increasingly aware of those around them and of how they might be perceived by others, developing what Charles Horton Cooley described as the ‘looking-glass self’ (Cooley, 1992). While this trait endures into adulthood, social sensitivity appears heightened during adolescence, causing adolescents to feel embarrassment and social exclusion more acutely than either adults or children, and to be more influenced by their peers and more likely to compare themselves to others (Blakemore, 2018; Blakemore & Mills, 2013; Somerville, 2013).

1.2.3. The Role Of The Environment

While many of the apparent challenges and hurdles of adolescence could be understood as inherent to the process of physical and psychological maturation, it is widely accepted that the environment and the features of adult society also play a significant role in defining the adolescent experience. For instance, in societies where marriage is of great social and political importance, biological markers of puberty and menarche are more likely to be celebrated as signifiers of transition as they indicate readiness for marriage (Brooks-Gunn & Reiter, 1990). In these societies, adult roles may be assumed sooner that in societies where adult status is linked to employment requiring advanced education, where markers linked to educational achievements are used to denote readiness for independence, which may occur several years after puberty (Crockett, 1997). In this way, many of the boundaries and features of adolescence may differ within as well as between societies, as ethnic, geographic, class and economic subgroups have access to different resources and valued adult roles.

However, this means that it is not always easy to delineate the extent to which environmental factors might be either guiding or hindering adolescent development. Margaret Mead was a prominent anthropologist who felt that American culture stifled natural adolescent processes. She observed that in Samoan Island culture, adolescence appeared to be a smoother and less tumultuous experience than in America and noted that Samoan adolescents had more freedom and choice than American adolescents and earlier exposure to adult themes such as sex and death (Mead, 1943). More recently, systemic theorists, Carter and McGoldrick (2005) discuss adolescence as a transitional process that fundamentally involves the whole family, who must develop with the child by increasing the flexibility of family boundaries and enabling them to exercise independence and explore moving in and out of the system. They suggest that distress and dysfunction are related to the developmental momentum of the family as a whole (B. Carter & McGoldrick, 1988). Key to these theories are the transferring of control to adolescents, and this highlights the necessity for adults (who typically hold more power) to understand adolescents and their needs for freedom and independence, but also adequate support during the process.

1.2.4. Understanding And Support

The ideas discussed so far indicate that adolescents' transition to independence requires safe opportunities to explore the complex social environments in which they are developing and experiment with ways of being in them. It is important, therefore, that adults understand the ways in which adolescents' experiences and needs are distinct, recognise the potential influence of the social, cultural and environmental context on adolescent development and are careful not to unnecessarily problematise adolescent behaviour. For instance, Steinberg and Morris (2001) note how adults must be able to distinguish between patterns of adolescent behaviour that reflect relatively harmless 'experimental behaviour', transitory or 'adolescence limited' problems, behaviour that signals an underlying or emerging mental health problem and problems that are not related to adolescence at all, but that may have had their roots in earlier childhood.

Bronfenbrenner's Social Ecological Model (1986) has endured as a popular organising framework for considering the influence of a child's physical, cultural and relational environment on development. It emphasises long held beliefs about the proportional influence of relationships and environmental factors in the more immediate micro and meso systems on children and adolescents, as they typically spend more time with their families and local community (Ianni, 1764; Winnicott et al., 1986). However, it is important to recognise the extent to which families and communities are influenced by wider societal and global level factors and that these will often make themselves felt in the lives of adolescents in ways that should not be overlooked.

1.3. The 'Crisis' In Adolescent Mental Health

Concerns about the mental health of young people have increased in recent decades, and there is now a common perception in the West, if not globally, that there is a 'crisis' in adolescent mental health (Fink et al., 2015; Gunnell et al., 2018; MEDIA, 2019; O'Hara, 2018; Rutter & Smith, 1995).

In the UK, this perception has been fuelled by research reporting increased prevalence of mental distress. It is worth noting here that mental distress is conceptualised and described differently by different people, in different settings, by different disciplines and across time as understandings of mental health change and are affected by social and cultural developments and trends. This study's title refers to adolescent 'mental health' which, drawing on aspects of the World Health Organisation definition, this researcher understands broadly to refer to a person's state of psychological wellbeing and the extent to which they feel able to cope with the normal stresses of life and realise their abilities (World Health Organisation, 2018). This definition allows for the idea that mental health can be conceptualised as something like a continuum of subjective wellbeing and functioning, up and down which each person may move, reflecting their experience of life at any one time. However, throughout this chapter, literature is referenced in which mental health is spoken about and conceptualised differently, including in ways that orient more closely to the idea of distinct categories of illness and disorder. It is this researcher's belief that categorising distress in these ways is not always helpful as it tends to prioritise quantifying experience over better understanding it and can fuel negative perceptions of distress and stigma. Nevertheless, many of the studies that have shaped the perception of adolescent mental health have utilised such categories and, where these are referenced, the language used by those studies is necessarily included.

In considering prevalence of distress, one prominent study, Collishaw et al. (2004), concluded that between 1974 and 1999 there had been a substantial increase in adolescent conduct problems as well as a rise in emotional problems. In data collected in 2006, they again found increases in youth and parent reports of emotional problems in girls and increases in parent-reported rates of emotional problems in boys (2010). Similarly, in 2009, a study from Scotland found increases in General Health Questionnaire (GHQ), 'caseness' of psychological distress among female 15 year olds between 1987 and 1999 and both males and females between 1999 and 2006 (Sweeting et al., 2009). Ross et al. (2017), also used the GHQ in Great Britain and also found slight increases in mean psychological distress scores between 1991 and 2008 in females but not males.

By 2017, prevalence of distress categorised in the research as ‘mental health disorders’ in five to fifteen year olds was reported to have increased from 9.7% in 1999 to 11.2%, and one in eight young people (12.8%) aged between five and nineteen was understood to have a diagnosed mental health disorder (Sadler et al., 2017). Overall, rates of disorder appeared to increase with age throughout childhood and adolescence, although differences in data collection for different age groups may have impacted the data (Sadler et al., 2017). By 2020, rates of probable mental health disorder were reported to have risen again to one in 9 (NHS Digital, 2020a).

Rates of self-harm and suicide, key indicators of psychological distress, have also supported evidence for worsening mental health. In young people, increases in both have been reported, with data indicating that suicide rates in most western countries have increased since the 1950s and one study reporting a 68% rise in incidents of self-harm in girls aged 13-16 between 2011-2014 and an increase in girls compared to boys within the same period (Eckersley & Dear, 2002; C. Morgan et al., 2017).

In terms of life satisfaction, the UK performed poorly in the 2015 OECD global survey, with over 50% of British 15 years olds surveyed reporting being dissatisfied with their lives and female respondents over 15 percentage points less likely to rate feeling satisfied with their lives than males (OECD, 2018).

It is important to note, however, that reports that utilise standardised measures of distress and diagnosis encourage an assumption of realism about the psychological and psychiatric constructs they measure which may or may not always be helpful (Guyon et al., 2018). In the case of several studies that used the Strengths and Difficulties Questionnaire, for instance, the examination of mental ill health relies on an assumption of the objective existence of the pre-specified factors that make up the measure’s subscales, including ‘hyper-activity’, ‘emotional symptoms’ and ‘conduct problems’, as well as in the construct of mental ill health as a consequence of these factors. In this way, although they are effective at quantifying the constructs they measure, these studies provide very little meaning about adolescents’ own understanding or experiences of distress or poor mental health. However, the studies mentioned here are prominent in the literature, influential within government guidelines and are referenced in media articles read by the population, meaning that

they may have an effect on the kinds of support adolescents receive and how distress is understood in society. It is important, therefore, that consideration is given to the strengths and limitations of research into the perceived crisis in adolescent mental health. This will be discussed further in section 1.6. Complexity, Limitations And Data Gaps.

1.4. Pressure On Child And Adolescent Mental Health Services (CAMHS)

Alongside the complex picture of distress, rates of referral to mental health services have also risen, with NHS data indicating that the proportion of under 18s in contact with mental health services rose from 18.8% in September 2016 to 22.8% in September 2018 and 20.9% by July of 2020 (*NHS Digital: Mental Health Services Monthly Statistics*, 2020). Reports have seen that figure continue to rise throughout 2020 and into 2021 (Campbell, 2021).

Lengthy waiting times for CAMHS services were already proving a barrier to young people receiving help, and last year only 20% of referrals began treatment within the government's target of four weeks (The Children's Commissioner for England, 2021). Further, it is estimated that only between one in three and one in four young people who needed mental health services accessed them in 2019/20 (The Children's Commissioner for England, 2021).

Underfunding of CAMHS, including budget allocations that were not ringfenced, and poor strategies around re-designing services are felt to be part of the problem (Buchanan, 2016; Frith, 2016; Pick et al., 2018). In 2020, the Children's Commissioner noted that spending on children's mental health still varied by location by as much as £175 per child, from 26p to £176 per child depending on area, and that a gulf remains between adult and child spending, with an average difference of £133 per person and a range of £14 to £191 depending on NHS area (The Children's Commissioner for England, 2020). These findings align with other reports outlining concerns that budget allocated for children's mental health provision have not been reaching the front line (Children's Commissioner, 2017; National Audit Office, 2018).

In a 2018 survey of members of the Association of Child Psychotherapists who had front line experience with NHS child and adolescent services, over 60% reported that their service was facing downsizing, that the threshold for access had risen in the last five years, and that they had noticed negative changes in the number of clinician posts, number of sessions offered per client and the frequency of sessions (Pick et al., 2018). Over 30% described services as either mostly or completely inadequate.

Pressure on NHS resources and social distancing measures due to COVID-19 have only exacerbated the difficulties in providing support to children and adolescents as CAMHS assessments and treatments have been suspended or delayed in many services at a time when an increase in need is anticipated (Crawley et al., 2020; Lally, 2020).

As a result of these issues, deteriorating mental health service provision are, in themselves, now cited as a causal factor in the deterioration of child and adolescent mental health (Clarkson, 2019; Davies, 2018; O'Hara, 2018).

1.5. Prevention Over Cure: Identifying The Causes Of Distress

> "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in"
>
> - Bishop Desmond Tutu

While it is vital that planning around costing and delivering the services promised improves so that support reaches adolescents in distress, understanding the root causes of distress is also needed to help establish whether it is truly increasing, if so why, and how we might address the causes *before* they impact adolescents.

Academic and third sector research into adolescent mental health have been exploring these questions for several decades (Eckersley & Dear, 2002; Green et al., 2005; Rutter & Smith, 1995), and data from longitudinal studies emphasises the need to consider a wide array of factors as potentially impacting on distress (Lerner

& Castellino, 2002). Globally, a great number of possible determinates and risk factors that might confer greater chance of experiencing mental ill health are now recognised. These include, but are not limited to; factors to do with poverty and socio-economic problems, quality of home life, exposure to violence including bullying and discrimination of different kinds, chronic illnesses, intellectual disabilities, desire for greater autonomy, exploration of sexual identity and pressure to conform with peers (World Health Organisation, 2020).

However, (and as we have seen highlighted during the pandemic) the social, cultural and material environments around adolescents can change quickly and so, to help address the factors that might impact adolescent mental health, prevention work requires up to date information on which risk factors are currently operating on a national, local (community) and individual level (Social Care, Local Government and Care Partnership Directorate, London, UK, 2014). Although it is beyond the scope of this thesis to include the research on all identified risk factors thought to be impacting adolescents in the UK, the following provides a brief overview of five factors considered salient today.

1.5.1. School Pressure

The use of formal assessment in UK schools is believed to have increased over the last few decades and students in the UK have been the most extensively tested in the world (Torrance, 2003). Teachers and students have both reported that the increased focus on educational attainment and exam results has impacted mental health and wellbeing, with 80% of students in one study stating that exam pressure has significantly impacted their mental health and 82% of teachers agreeing that exam focus has superseded consideration of wellbeing (Cowburn & Blow, 2017). However, test anxiety is impacted by other school-related factors (OECD, 2018) and is neither the only source of school related stress. Other sources found to be associated with school include academic achievement targets, teacher interactions, school attendance and school/leisure conflicts (Byrne et al., 2007). Additionally, these factors may differ by, for instance, school type (private, state, academy), as

exam requirements vary along with the resources available to students and teachers (Brady & Wilson, 2021).

1.5.2. Digital And Social Media

Social media platforms have created communication and sharing networks currently used by over 80% of teens in the UK (Statista, 2020). Heavy digital use has been associated with sleep problems, bullying and harassment, depression, poor body image and low self-esteem, with heavier users found to be between 48% and 171% more likely to report unhappiness, low wellbeing and suicide risk factors such as depression, suicidal ideation and previous suicide attempts (Twenge & Campbell, 2019). However, social media can also offer access to support systems, knowledge and learning, and may well have helped mitigate the impact of social distancing during the pandemic on a population for whom peer interaction is a critical aspect of development (Widnall et al., 2020).

1.5.3. Adverse Childhood Experiences

Adverse childhood experiences, including direct harm such as abuse, neglect or loss of a parent, or factors affecting the child's environment such as exposure to violence between others or substance abuse, marriage breakdown, poverty or having a parent in prison are well evidenced mental health risk factors that have a dose responsive effect that rises steeply with each adverse experience (NHS Highland, 2018; Read et al., 2008; Shevlin et al., 2007). Surveys conducted in 2013 and 2015 in England and Wales found that 48% of adults in England and 47% of adults in Wales had experienced at least one of these types of adverse experience before the age of 18 (NHS Highland, 2018).

1.5.4. Ethnicity And Racism

Additionally, in the UK, people from minority ethnic communities are more likely to experience adverse experiences that involve race hate, poverty and unemployment,

more likely to live in substandard housing and to be in contact with the criminal justice system (Equality and Human Rights Commission, 2016).

In their study of developmental risk factors for children, including financial stress, parental depression, domestic violence, worklessness, overcrowding, and physical disability, Sabates and Dax (2012) found that, in the UK, Bangladeshi families were the least likely to be free of risk factors and the most likely to face multiple risk factors, followed by Black and Pakistani families (Sabates & Dex, 2012).

In 2020, the Black Lives Matter movement highlighted the continuing problem of discrimination and racism towards people of colour in the UK. In England and Wales, 57% of children on remand are from a black or other ethnic minority and that figure rises to nearly 90% in London, despite people from minority ethnicities accounting for only 15.5% the population according to 2016 figures (Grierson, 2020).

1.5.5. The COVID-19 Pandemic

COVID-19 has presented a wide spectrum of possible impacts and risks to adolescent mental health, from increased family time and decreased exposure to school or social stressors to fear of catching COVID-19 or losing a family member, worrying about exams or future career prospects, being trapped in an abusive home environment or losing access to adequate food or shelter (Lee, 2020; Roberts, 2020; Unicef: UK, 2020).

Some early studies have already reported back on the impact that the pandemic may be having on children's and adolescents' mental health, but the findings have, perhaps unsurprisingly, been mixed (Ford et al., 2021), with some reporting significant increases in ratings of depression during lockdown (Bignardi et al., 2020), and others finding no change in risk of depression, a decrease in anxiety and increase in wellbeing compared to pre-pandemic levels (Widnall et al., 2020).

As the pandemic has highlighted structural and health inequalities in the UK, it is expected that there will be subgroups of adolescents vulnerable to different risks or

benefits and further research in this area will be needed to track the effects (Liu et al., 2020). Overall, however, there is concern that adolescents' relative lack of control over many of the factors impacting their environments (e.g. household finances, ensuring a safe home) and their sensitivity to lack of social interaction due to their developmental stage, may put them at high risk of long lasting consequences as a result of the restrictions imposed during lockdown (Orben et al., 2020b).

1.6. Complexity, Limitations and Data Gaps

The previous sections have given an indication of the range of risk factors and determinants that may be influencing the current crisis in adolescent mental health, and the breadth of research required to identify them all. However, as well as recognising the broad scope of factors involved, this research begins to highlight the difficulties with conducting and interpreting research in this area and that add to the challenge of constructing a clear picture of adolescent distress that could guide strategies for addressing it.

1.6.1. Conflicting Data

First, not all the data indicate a clear or steady increase in distress (Sweeting et al., 2009). The *Mental Health of Children and Young People in Britain,* 2004 survey found no changes in overall prevalence of mental disorders in children between 1999 and 2004, with approximately one in ten five to fifteen year olds (from a sample of over 12,000 UK families) reported to be experiencing a mental health disorder at both time points (Green et al., 2005). With this finding sitting alongside other studies reporting increases in mental health problems over a slightly wider time frame (e.g. Collishaw et al., 2010) it is possible that repeated measures with long interims may indicate increases over time but obscure contradicting trends occurring in between (Ross et al., 2017). This indicates the need for more frequent surveys of child and adolescent mental health. However, these are still undertaken significantly less frequently than adult surveys (Ford, 2018).

Second, studies into prevalence of distress or disorder have commonly used self-report measures which may be subject to response biases, including changes in understandings of mental health concepts over time and between cultures and generations, and the extent to which people know themselves or their children/students well enough to provide accurate information about their mental state (McDonald, 2008). For instance, Ross et al. (2017) noted that studies relying on parent or teacher reports have tended to indicate stable or declining trends in distress over time compared with studies using self-report measures from adolescents, which have more often indicated increases in distress. This suggests that there are either differences between how adolescents and the adults around them perceive adolescent distress, or differences in how each group describe or conceptualise adolescent distress, or both. Additionally, several studies have acknowledged that self-report measures cannot confirm the extent to which adolescent or parent/teacher concepts of mental health disorders differ from clinical definitions or whether those conceptualisations have changed over time (Green et al., 2005; Pitchforth et al., 2019; Ross et al., 2017). These studies note that apparent increases in reported distress may be at least partly accounted for by changes in conceptualisations of distress and improved reporting of mental health problems, but they also highlight the importance of seeking, acknowledging and understanding adolescents' own perceptions and understandings of their experiences.

1.6.2. Complexity

The example of the range of possible effects of the COVID-19 pandemic on adolescent mental health highlights what we know about both mental health and adolescent development more generally: that experiences are influenced by a combination of, and interaction between genetic, biological, social, cultural, temporal and environmental factors, and that this complexity means that risk factors for mental ill health may not be experienced in the same way by everyone (Khan, 2016; Law et al., 2015; Rutter, 2013).

For instance, the *Mental Health of Children and Young People in Britain,* 2004 survey found that the prevalence of mental disorders was greater in children and

young people in single parent and reconstituted families (Green et al., 2005). This is supported by studies demonstrating the negative impact of divorce and other disruptions to family structure on childhood mental health and wellbeing (Amato, 2000; Behere et al., 2017; Rees et al., 2008). Conversely, however, for many children, wellbeing has been shown to improve following separation of parents, indicating that family dynamics may be more important than family structure and supporting the sense that risk factors do not guarantee health outcomes (Collishaw et al., 2010; Rees et al., 2008; Sweeting et al., 2010).

Similarly, Crockett (1997) pointed to concerns about adolescents working in part-time employment, as this had been found to be linked to decreased sleep and exercise, and delinquency and drug use, (Bachman & Schulenberg, 1993; Steinberg et al., 1993). Crockett noted that, while some studies described part time work as a risk factor, others had found part-time work to be associated with increased self-reliance and other positive elements of psychological adjustment (Greenberger, 1986). This highlights the mixed findings between studies and the complexity in how risk factors operate, with some factors that might be perceived as risks not only exacerbated or mitigated by other factors but leading to positive growth in different conditions. Research aiming to quantify the effects of specific risk factors is complicated, therefore, by the possible interactions and compounding effects of any number of other biological, psychological or environmental factors. Without a detailed understanding of these effects, interpretations from a small number of studies may result in unhelpful assumptions about the causes and determinants of distress and mental health.

Most conclude that this calls for further research into the mechanisms by which risk factors operate (Lerner & Castellino, 2002; Rutter, 2013; Solmi et al., 2021). While this is certainly valuable and important work, such research would require very large samples to be able to draw robust conclusions at both a national and a local level (Hatch et al., 2012). This would be both costly and time consuming and some suggest that conducting multiple studies of naturally occurring subgroups (e.g. ethnic, geographic, economic) may provide more useful insights into the factors operating within a given ‘ecological niche’ than larger studies using national level samples where mediating factors are less often explored in detail (Crockett, 1997).

1.6.3. Data Gaps

Broadly speaking, more recent approaches to mental health provision by the government, NHS and Local Authorities have promoted the collection and use of local data to inform decisions made at the local level (Social Care, Local Government and Care Partnership Directorate, London, UK, 2014). Data is supposed to be collected when people make contact with NHS services, who are encouraged to incorporate the views of young people into service development. Local Authorities also undertake Joint Strategic Needs Assessments (JSNAs) in their area to understand local health and social care needs better (NHS Digital, 2020b; Public Health England, 2017, 2019).

In practice, however, data collection and quality are not always good. A major national review of CAMHS services by the Care Quality Commission (CQC) in 2017, found significant gaps in the information collected about young people and their mental health needs and reported that what was available was often either unclear, unreliable or not shared properly (Care Quality Commission, 2018). This was felt to be particularly true for groups known to be at higher risk of mental health problems including those who identify as lesbian, gay, bisexual or transgender and those who are homeless. For these groups, data collection was found to be either insufficient or non-existent. The report identified that gaps in the data were often mirrored by gaps in availability of services, meaning that services had been unable to either identify or respond to the needs of these groups at all (Care Quality Commission, 2018).

Additionally, a 2016 review of 23 JSNAs from local authorities around London found that JSNAs were invariably disorganised and unwieldy documents in which mental health information was either absent or difficult to find and poorly referenced where it did exist (Campion et al., 2017). They found that, when mental health was mentioned in a JSNA, the data was commonly represented as figures in tables only, with no descriptive detail, and that, in relation to child and adolescent mental health, only drug misuse was mentioned in more than 50% of JSNAs surveyed. Further, less than half provided estimates for any child or adolescent mental health diagnosis and many applied national rates of prevalence rather than looking at local factors (Campion et al., 2017). For instance, none took account of local deprivation levels,

which are known to vary across the country and be associated with significantly higher odds of mental health problems (Green et al., 2005).

1.7. Lack Of Preventative Focus In Governmental Strategy

As discussed in section 1.5, while funding treatment for mental health problems is important for those experiencing psychological distress, it should not be a substitute for enabling communities to thrive in ways that prevents distress in the first place (Arango et al., 2018). This is an area in which many people feel influential government policies are failing young people, and the difficulties that CAMHS services find themselves in could be seen as just one consequence of a wider systemic problem with the way that child and adolescent mental health has been conceptualised in government policy and strategy documents over at least the last decade.

While most mental health policy or strategy reports make reference to the importance of prevention, the commitments to action demonstrate that the focus of support is heavily weighted towards treatment (funding mental health services) with little meaningful dedication to exploring or addressing causal factors (Department of Health & Social Care, 2019; Department of Health and NHS England, 2015). Indeed, in the UK, less than 5% of funding for mental health research goes towards prevention research (MQ Transforming Mental Health, 2015).

In the 2015, *Future in Mind* report, (a comparatively thorough and influential report on child and adolescent mental health), environmental factors still barely featured in the actions recommended, and helpful propositions to invest in the early years of childhood suggested achieving this through supporting children and families to "adopt and maintain behaviours that support good mental health" and by enlisting schools to support ''character building'' traits in students (Department of Health and NHS England, 2015, p. 33). This locates both the problem and solutions in individuals rather than engaging with the social and environmental causal factors that require systemic change.

There are obvious reasons why, in an age of austerity, mental health policy documents might be reluctant to examine the effects of social and environmental factors on mental health too closely. However, many people working to support adolescents feel that it is the structural and systemic social and health inequalities that lead to poverty and poor health, along with policies that are actively hostile towards minority and vulnerable groups, that undermine communities' ability to nurture resilient children (Churchill, 2018; Psychologists for Social Change, 2018).

Avoidance of these factors may be aided by the enduring influence of the framework of diagnosis and 'disorder' as the dominant model for understanding distress. Callaghan et al. (2016) point to a shift, occurring around ten years ago and visible in the language used in policy reports, away from the notion of mental health as a consequence of social and economic inequalities and towards an individualised and medicalised understanding of distress. They highlight changes from describing mental health in terms of what is needed for 'psychological wellbeing' and acknowledging 'health-inequalities' to referring to 'mental illness' and individuals with 'mental health problems', from discussing children as having potential and of childhood as precious in its own right to focusing on reduce mental illness in a general sense and referencing childhood wellbeing only inasmuch as it impacts adult mental health (Callaghan et al., 2016). In this way, child and adolescent mental health is seen primarily as an economic burden, to be addressed early in order to avoid the financial cost of adult mental health later (Department of Health and Department for Education, 2017; Department of Health and NHS England, 2015). Callaghan et al. suggest instead that "a more systemic view might offer a more complex and contextualised perspective from which to understand and promote children's mental health, enabling a non-pathologising and more contextually driven understanding of children's experiences, and particularly of children's distress within their relational contexts" (Callaghan et al., 2016, p. 17).

1.8. Schools On The Front Line

Due to the central role schools play in the lives of young people, they have long been considered part of adolescents' system of support when it comes to mental health

and wellbeing. Specifically, as somewhere that children spend a significant amount of time, they are felt to be a useful setting for providing support and links to mental health services for students and parents, and teachers are felt to be well placed to identify student distress early (Department for Education, 2018; Ford, 2018; House of Commons et al., 2017; Young Minds, n.d.).

1.8.1. Government Strategy

The government has recently increased the focus on schools' role in tackling child and adolescent mental health and, in 2017, the green paper *Transforming Children and Young People's Mental Health Provision* circulated proposals for a number of new endeavours (Department of Health and Department for Education, 2017). The paper proposed incentivising schools and colleges to train mental health leads to oversee 'whole school approaches to promoting better mental health' that would incorporate the school ethos, culture and environment as well as teaching and partnerships with parents and other organisations (Department of Health and Social Care and the Department of Education, 2018, p. 5). It also suggested funding new Mental Health Support Teams who would link schools and NHS services, provide psychological support to students experiencing mild to moderate mental health difficulties and trialling four week wait times for NHS services for children and young people. Teaching on mental wellbeing would also become a compulsory part of the curriculum under the proposals and would include lessons on how to understand emotions, how to make good decisions about physical and mental health, recognising the signs of mental illness, ensuring safety online, and more (Gov.uk, 2020). As such, schools have been positioned as key players in the prevention of adolescent distress, and in facilitating access to mental health support for those who need it.

1.8.2. Teachers' Perspectives

The government committed to all of the proposals and roll-out of the plans are intended to reach at least a fifth of schools by 2022/23 (Department of Health and Department for Education, 2017). However, while research indicates that teachers

and school staff often agree that addressing mental health is part of the school's role (Reinke et al., 2011; Rothì et al., 2008), and some reports suggest that teachers already have many or all of the skills needed to do it (Mittler, 2000), there is also broad acknowledgement of the limitations of academic staff's skills and capacities in this task, and agreement that wider system and multi-agency support from clinically trained partners is essential for mental health problems to be addressed adequately in schools (Children and Young People's Mental Health Coalition et al., n.d.; O'Reilly et al., 2018; Reinke et al., 2011). Particularly as teachers and school staff do not receive specific training in attending to mental health problems and may have only limited access to support from trained professionals (Sharpe et al., 2016). Studies of teacher perspectives indicate that they often feel they lack the knowledge, skills or confidence to either help students in distress or teach adequately on mental health issues, which can lead them to feel incompetent, frustrated and worried for their pupils, impacting their own job-satisfaction and even mental health (Andrews et al., 2014; Knightsmith et al., 2014; Rothì et al., 2008; Shelemy et al., 2019).

1.8.3. Roles And Resources

Lack of psychological knowledge can also affect how students perceived as disruptive are treated by teachers and there are related concerns about how these students, many of whom may be distressed or struggling with mental health difficulties, are supported in schools (Nash et al., 2015). For instance, Rothi et al.'s (2008) study of teacher views reported concerns about keeping control in the classroom in order to facilitate learning. They suggested that the emphasis this can place on behaviour (and what is seen as 'problem behaviour') can lead to disciplinary measures being used where mental health referrals for underlying psychological or emotional problems may have been more appropriate. This example highlights several issues regarding mental health support and understanding in schools. First, teachers' have many responsibilities to fulfil in the classroom, and those who already feel stressed may feel overburdened by additional mental health related responsibilities (Naghieh et al., 2015; National Education Union, 2019). Second, if distress is seen as 'problem behaviour' by overstretched teachers, not only will adolescents be unlikely to be offered the right support, but the

causes of the distress will remain poorly understood by school staff and perhaps parents too, and difficulties for all involved may escalate. However, even with sufficient time or resources, without specific psychologically training, understanding and attending to students' mental health needs will not always be possible for teachers due to the nature of the mental health difficulty or because school stressors are a factors in the distress (O'Reilly et al., 2018).

Increasing resourcing and/or training for teachers could help schools feel confident in delivering a whole school approach to supporting adolescent mental health. However, so far, comments from the psychological community, the charity sector and government committees have suggested that the provisions for schools lack ambition and sufficient road mapping, have been rolled out too slowly and lack focus on the causal factors of distress for young people (Children and Young People's Mental Health Coalition et al., n.d.; Education and Health and Social Care Committees, 2018; Psychologists for Social Change, 2018). Waiting for nationally developed guidance or curriculums to help teachers fulfil the aims set out may take some time. It may be more beneficial for schools and local authorities to build on what is known about adolescent mental health and wellbeing in their communities to inform ideas that are relevant to their populations.

1.9. Adolescents' Voices

Adolescents themselves are the source of information about their wellbeing and it is important that their perspectives, understandings and self-identified meanings are sufficiently visible in the literature, and that they themselves feel involved in decisions and services that are relevant to them. This was recognised by the 1989 United Nations Convention on the Rights of the Child (UNCRC) which specified that children's views should be included in all matters that affect them. Since the convention was ratified, consultation with children has become more widespread (The United Nations, 1989).

Although UK studies and reports on adolescent mental health often state that they consult with young people or ask for their views, many feel that they are still lacking

in a meaningful way (Mawn et al., 2016; Woolfson et al., 2009). To some degree, this may be because national reviews commonly use surveys to gather data from large samples and convert it to statistics, rather than qualitative methods where young people have control over the language used and the line of questioning (The Children's Society, 2020). Some reports do use mixed or qualitative methods such as focus groups or semi-structured interviews, but still ask for views about an already narrowly defined issue, such as specific mental health symptoms or, for example, the government's four point proposal for mental health provisions in schools (Green et al., 2005; Young Minds And the Department of Health, 2018).

Given the unique social and cultural features of the adolescent stage of development, however, research designed and led by adults cannot easily tap into the adolescent experience, as adults may not prioritise the same issues or ask the same questions that adolescents would (Kellett, 2005). Additionally, issues that faced adolescents twenty, ten or even five years ago may no longer be relevant, and so regular consulting with adolescents is important to stay up to date with the issues facing them. The benefit of this is that the perspectives adolescents bring provide 'clearer expression of known need and the uncovering of unmet needs' (Pinkerton, 2004, p. 121). The resulting research, interventions and decisions are then more likely to be relevant, innovative and accessible (Sawyer et al., 2012; Shaw et al., 2011). These benefits are often lost when research design limits the scope for adolescent voices to take their own form.

1.10. Summary Of The Problem

Adolescence is a critical period of human development that requires support and understanding from the systems operating around young people. Adolescent distress in the UK is an important problem but also a complex one. Recorded increases in distress and referral rates to mental health services are concerning, although it is unclear to what extent the figures represent changes in conceptions, diagnosing and reporting of distress (Pitchforth et al., 2019). However, with CAMHS struggling to manage demand, and the pandemic slowing services down further, adolescent mental health is an area that requires attention.

The UK government's strategy thus far has focused almost exclusively on funding CAMHS and promoting mental health support within schools, including building better links between schools and NHS mental health services (Parkin & Long, 2020). The approach to increase CAMHS spending concentrates support primarily at the point at which adolescents are already suffering, and data suggests that it is not proving effective in addressing difficulties even at this stage (The Children's Commissioner for England, 2021). While plans for schools to foster greater resilience in young people provide probably the best current opportunity for preventative work, the guidance and training for schools remains vague and teachers report being unclear about how to deliver what is being asked (Cowburn & Blow, 2017).

Those working with adolescents broadly agree that a preventative approach would both ease the pressure on CAMHS services and avoid adolescent suffering (Arango et al., 2018). However, understanding the mechanisms by which causal factors of distress operate is complex, as they are impacted by individual, family, community, environmental and cultural factors that differ by individual as well as by sub-population (ethnic, geographical, identity and more). Further research is required to understand these mechanisms better, but this doesn't need to involve large scale national studies alone, and in fact, research may be more effective if undertaken on at the community level (Crockett, 1997; Kellett, 2005).

Adolescents themselves are a key source of information about how to best support them, and inclusion of children and young people in matters that affect them is strongly encouraged (Kellett, 2005; Pinkerton, 2004). Qualitative approaches to gathering adolescents' voices and views are thought likely to facilitate better understanding of the both factors and mechanisms of distress and wellbeing operating in population subgroups, and of adolescents' views on what school-based support should include and how it should be delivered.

Although adolescents' perspectives on proposals or services designs are sometimes surveyed, very little evidence of inductive research exists, where adolescents' views have driven strategy decisions or service design from the outset (Atkinson et al.,

2019). Research of this kind would require less funding and resources than large scale quantitative studies as it would not require large samples and could be replicated in multiple population subgroups, offering data relevant to that subgroup which could inform locally delivered support.

1.11. Review Of The Literature

Following Booth, Sutton and Papaioannou's guide, a scoping review of the literature was conducted using the 'Who, What and How' to identify recent studies that have sought adolescents' views on self-identified mental health risk factors and on school-based support.

A database search of adolescents' views included: PSYCHINFO, PsychARTICLES, SCOPUS, Child Development & Adolescent Studies, ERIC, Education Research Complete, Education Abstracts (H.W. Wilson) and Academic Search Complete.

The search used the subject terms: (DE "Mental Health") OR (DE "Well Being") OR (DE "Quality of Life"), and the Boolean/phrases: (adolescents OR teen* OR "young adults" OR students Or Pupils) and (views OR factors OR perspectives OR perceptions OR reasons OR determinants) or ("school support" or "school-based intervention"). These terms were identified through relevant index terms and key words. Additional studies and relevant grey literature were searched using Google search and reference lists of relevant studies and reports.

The results were filtered by language (English), and hand searched for relevance and to narrow geographical location to include only UK based studies. They were also limited by date to studies published since 2015. Including only studies conducted in the UK after 2015 helped to maximise the cultural and historical relevance of the search returns. This was felt to be important as older studies, or studies conducted outside the UK would be less likely to produce data that would be relevant to UK schools, NHS mental health services or commissioning teams making decisions about how to address adolescent distress today. This was felt to be particularly true given the significant social, economic and policy events that have

taken place since 2015, including the Future in Mind (2015) report, Brexit, the black lives matter movement and Covid-19. An age filter (adolescents, 13-17 years) was also used to confine results to secondary school aged adolescents as this study is interested in mental health provision in secondary schools.

The search of academic literature returned a large number of studies related to the factors and determinants of adolescent mental health and several studies surveyed the views of adolescents. However, very few studies sought views in a qualitative or open-ended way, as opposed to with reference to particular, pre-determined mental health risk factors, school-based interventions or population sub-groups. Of the studies that did, the vast majority were conducted outside the UK, in Europe and the US. Less than five had been published in the UK within the last 5 years. The diagram, '*Figure 2. Literature Search Returns'* illustrates the process of searching and refining the reviewed literature.

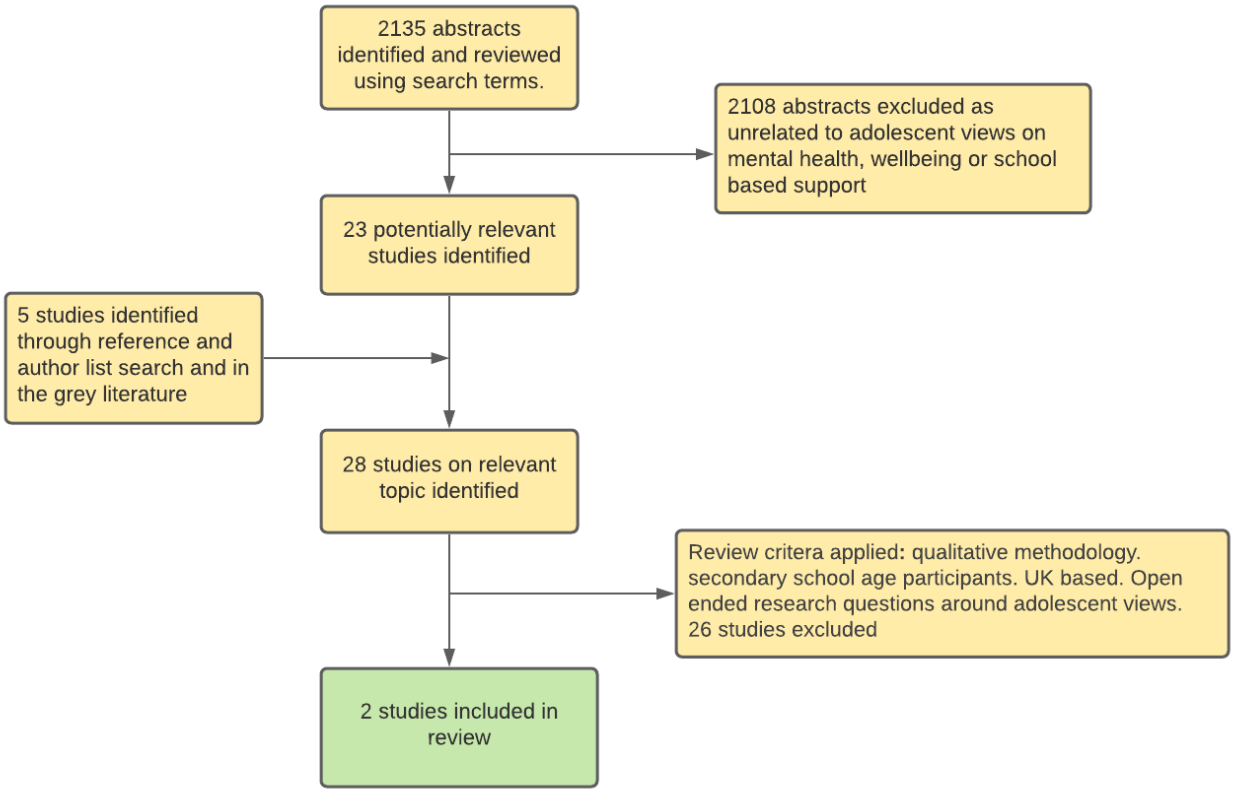

Figure 1. Literature Search Returns

Within the grey literature, third sector organisations often reference ‘what children and adolescents have said to us’ in reports and web articles exploring adolescent mental health and wellbeing. These data sources appear to draw from either research specifically undertaken or data from the organisation’s support services. While this data could certainly be relevant to this literature review, methodologies were often either not provided or contained too little detail to properly validate the data set. Additionally, grey literature data and associated methodologies are harder to search for so the researcher acknowledges that there may be relevant data in the grey material that has not been identified through Google searches or other searches of reference lists.

Two studies undertaken since 2015, looking at adolescent perspectives on mental health, wellbeing and school-based support, have been included in the final review, with one deriving from the grey literature. A summary of these studies follows.

1.11.1. Matthews, Kilgour, Christian, Mori, Hill (2015)

This mixed methods study aimed to assess subjective wellbeing of secondary school students and explore their perspectives on health and wellbeing, including risk and protective factors, from an asset-based perspective. Researchers recruited 869 students aged between 11 and 16 from a school in Wales to complete the *Personal Wellbeing Index – School Children* (PWI) measure to assess happiness with life and personal wellbeing. They then held three focus groups with students from years 7 (age 11), year 9 (age 13) and year 11 (age 15) (n=18). The focus groups explored pre-determined topics including happiness, material possessions, health, personal development and future goals, barriers to success, and relationships. The findings identified average happiness and wellbeing scores above norms for this population for both male and female participants, and the focus group data emphasised the wide variety of factors that influence wellbeing including friends, family, pets, bullying, sports injuries, having nowhere to go, lack of jobs and more (over 40 items were generated), highlighting the importance of making space for wellbeing issues in schools.

This study generated a large amount of data, including adolescents' views, that had local, practical use for decision makers in the school and the borough council. This demonstrates the value of undertaking smaller scale, locally situated research. Much of the data came from the focus groups, which covered a broad range of subjects. However, the subjects were chosen by adults (as far as can be discerned) and this is likely to have influenced, and perhaps limited, what was captured.

This study recruited participants across three different year groups and responses to both the PWI and the focus groups differed by age group, highlighting the importance of recognising developmental age and experiential differences between adolescents within research. The study recruited participants up to the age of 15. This leaves a gap in the literature for subsequent age groups of adolescents. Further, as middle adolescence (approximately ages 14-17) culminates around the time of significant life changes for many, including leaving school, applying for university or starting jobs, leaving home or even preparing for marriage, and with research suggesting that older adolescents are more likely to experience poorer mental health than younger adolescents (Sadler et al., 2017), it may be particularly important to look at the experiences of adolescents of age 16 to 21.

The study's asset-based approach was felt to be a strength as it facilitated identifying the participants as scoring more highly on measures of happiness and wellbeing than might have been expected and helped recognise those assets that could be supported in schools. The study described using this approach in response to the "shift in public health discourses which favour responsibility and capacity building over rights and dependency" (Matthews et al., 2015, p. 12). However, as described in earlier sections of this chapter, a contrasting concern is the risk posed by the degradation of structural and systemic support systems over the past decade of austerity, with many calling for more research that explores the impact of environmental factors on mental health from the perspective of adolescents (Psychologists for Social Change, 2018). In fact, the focus group data elicited responses on the determinates of wellbeing more generally (including risk factors, not just assets), and it was this data that appeared to have the most practical utility.

1.11.2. The Children's Commissioner

The Children's Commissioner undertook a mixed methods consultation with adolescents across England as part of their 2020/21 business plan. The consultation recruited 1,924 children and adolescents ages 6-17 to complete an online survey of multiple-choice questions about the things that worry them and what they think would improve their lives. It ran a second survey with 2000 8-17 years old (with 764 respondents at the time of reporting) of multiple-choice and open text answer questions about stress in particular; what causes it, how it feels and how adolescents cope with it. They then followed the surveys up with focus group discussions on the topics in the survey, speaking to 137 participants in total in groups of between 1 and 30 (modal number: 6) and collages by some participants in each age group (n=46). The focus groups spoke to different groups of children and adolescents separately including primary and secondary school students, children with special educational needs and disabilities, children with migrant backgrounds, children in the criminal justice system, and children with care experience. The report does not specify a method for analysis of the focus group data, which is discussed following the quantitative data from the surveys, organised by survey topic (e.g. mental health, social media, the environment, feeling safe) and including quotes from the participants and extracts from the collages.

This consultation also gathered a large amount of data and the focus groups provided context and meaning to the survey data. For instance, survey respondents' greatest worry was feeling sad or stressed, and the thing that they felt would most improve children's lives was having someone to talk to at school who could help them with their mental health. The focus group data provided information on the kinds of things that made participants feel sad or stressed and what was important about school mental health support (which included confidentiality and quick access). The consultation report provided a platform for adolescents' voices and transparently formed the basis the of Children's Commissioner's business plan, which included quotes from participants in research and is publicly available and aimed at informing government strategy. The sample recruited was large and drawn from across the country, enabling a greater quantity of data to be gathered and insights and recommendations to be made at the national level.

This indicates the potential utility of this kind of data. However, the size and distribution of the sample may affect the rspecific elevance of some insights at the local level. Additionally, the introduction to the business plan on the Children's Commissioner's website admits that although relevant data on risk factors for young people exists "central government (and there have been four different government administrations in my six year term of office) hasn't been interested" (Children's Commissioner for England, 2020). It is possible, therefore, that smaller scale research aimed at informing local authority, school and NHS service strategies may be more likely to be accepted and valued.

The data collected in this study was, again, based on adult identified topics, which, while numerous and broad in scope, may have influenced the responses gathered. Arguably, the age range of participants withing the focus groups was too wide. One had two participants, aged 10 and 15, and another included participants aged between 14 and 21. Focus groups should strike a balance between homogeneity and as reasonable diversity of views (Moore et al., 2015). Bearing in mind the developmental differences between adolescents with even modest age differences, this size of age gap may have impacted the quality of the conversations.

1.12. Summary Of Literature Review

The review of literature indicates that there is a paucity of up-to-date qualitative research on adolescents' views about their own mental health and wellbeing. Cultural, political, environmental and social factors likely to impact adolescents change rapidly and regular research is needed to stay abreast of potential shifts in adolescent culture and experience. This review identified only two relevant UK based studies conducted in the past five years, suggesting that there are gaps in knowledge of contemporary issues affecting adolescents.

Further, none of the UK based studies about either mental health or school-based support that qualitatively surveyed adolescents' views allowed adolescents to identify the topics discussed. This limits the involvement that adolescents have in research

conducted about them and is also likely to influence the data gathered in the studies. This suggests that there may be gaps in understanding of what is meaningful or important to adolescents, and that improvements that could be made in the involvement of young people in research and decisions made about them.

Of the two studies that surveyed adolescents' views in an open-ended way, one used a national sample and one used a local sample. It is notable that the study based on a local sample was able to draw insights that had direct relevance and application for local services. This supports the calls for more smaller scale research with subgroups of adolescents and compounds the lack of up-to-date data. It also supports the use of qualitative research of this kind for identifying insights that may be relevant to schools looking for guidance on tailoring mental health teaching or support to their student population.

1.13. Current Research

1.13.1. Study Rationale

Both the gaps in the literature and the gaps in service and support provision in schools and NHS services point to the requirement for further research in order to better understand the current experiences of adolescents with regards to mental health and wellbeing and school-based support needs.

Qualitative research with subgroups of adolescents is indicated for a number of reasons. First, exploring adolescent-identified issues, meanings and perspectives, occurring at the local (school or community) level, can offer new insights that are more likely to be relevant to local decision makers. Second, due to changing social contextual factors, regular, contemporaneous research is required in order to understand the factors affecting adolescents today (Crockett & Silbereisen, 2000). Third, meaningful inclusion of adolescents voices in research may have implications for adolescents' development, particularly their sense of personal agency at an important time of transition to autonomous functioning (Kellett, 2005).

The present study aims to give voice to the views of London based adolescents as no London-based studies were found to have been undertaken within at least the last 10 years. Additionally, as the nations' largest city, London is thought to be home to over a million 10-20 year olds (Statista, 2018), however, the number of 15 year olds reporting low life satisfaction in the capital has been reported to be significantly higher than in the rest of England.

1.13.2. Clinical Relevance

This research aims to gather insights that would assist schools with the task of building mental health into Personal, Social, Health and Economic (PSHE) lessons and adopting a whole school approach to supporting mental health. This is important both for the quality of support schools are providing to adolescents and for the wellbeing of teachers, who have reported struggling both with the lack of clarity around what is expected of them and with a lack of confidence in supporting students in managing and learning about mental health.

Additionally, the views of adolescents on the issues currently affecting them could help local councils and NHS services get a better understanding of the needs of their population and inform genuine prevention work. This approach is vital for helping adolescents thrive and avoid suffering, and also for helping tackle the demand for CAMHS in the medium to long term.

1.14. Research Questions

This research aims to elicit adolescents' perspectives on self-identified mental health and wellbeing factors and on school-based support. It will do this by asking the following research questions:

a) What do young people describe as impacting their mental health and wellbeing?
b) How do young people view their school's role in supporting their mental health and wellbeing?

2. METHOD

2.1. Overview

This section will outline the design of the study undertaken and the methodology used, starting with an explanation of the epistemological positioning of the research. The process of data collection and analysis and the ethical considerations that informed them is documented so that the study could be replicated, in the interests of transparency and to aide reflection and evaluation later in this section and in the final chapter of this document.

2.2. Epistemology

This research is built upon a critical realist epistemology. Epistemology is the study of the nature of knowledge: specifically, how we gather it and on what basis we know what we know (Burr, 2003). Epistemology is closely linked to ontology, therefore, which is concerned with the nature of things and what they must be like according to scientific and philosophical enquiry (Bhaskar, 2008). Key within these discussions is the extent to which knowledge is seen to reflect reality, with different schools of thought positioned variously along a realism - relativism continuum (Harper, 2012). Direct realists believe that there is an objective reality that can be observed and measured whereas, at the other end of the continuum, social constructionists question the extent to which we can access an unbiased view of the world, and further, to what extent objects, structures or categories of things are created by the social, cultural and historical/temporal context, and therefore can be said to exist in any real or material sense at all (Burr, 2003).

In applied psychology, epistemology plays a critical role both because there is significant variation in the perception and understanding of psychological phenomena within and between cultures and because applied psychology has the potential to impact wellbeing profoundly (Boyle, 2011). Currently, in the West, for instance, the use of a medicalised framework of diagnosis for mental health

difficulties, and the accompanying, broadly realist, assertions of distress as symptoms of illnesses, mean that people in distress are treated as suffering from an illness for which they require healing (Parker et al., 1995). This has implications for how others respond to them and the kind of support they receive, but it also has implications for the industry that has grown up around the treatment of disorders, which, arguably, relies on a realist epistemology to exist (Szas, 1961).

Critical realism, sitting somewhere near the middle of the continuum, asserts that while data can tell us something about reality, it does not represent an exact mirror of reality, with further interpretation required to understand the underlying mechanisms that drive experiences and behaviours (Bhaskar, 2008). Within this, critical realists hold differing perspectives about exactly how certain we can be of the existence of underlying structures and mechanisms, with some suggesting that interpretations are insights into reality and others maintaining that interpretations only ever refer to possibilities of reality (Willig, 2012). However, broadly speaking, a benefit of critical realism within mental health is that it can hold in mind curiosity about cultural and historical relativism whilst also supporting people's claims of distress (Bentall & Pilgrim, 1999).

Based on the gaps in the existing evidence base, the aim of this research was to better understand the experiences, meanings and priorities of adolescents living in one geographical niche, and to amplify these for potential use in the design of strategy, services and curriculum, particularly around school-based support in their area. As the aim was not primarily to explore or analyse the ontological nature of the constructs that the adolescents might talk about, or the language they might use to do that, it made most sense to take a broadly realist perspective towards the research questions, data and analysis. However, the study also aimed to acknowledge the risks and limitations of a purely realist position where adult led conceptions of wellness and distress are the only ones presented to children and adolescents in (primarily quantitative) research. This study offered instead, the opportunity to be led by adolescent voices, with the implicit understanding that this represented a perspective that critiques realism through its recognition that understandings of wellness and distress can differ between people, that this difference might impact the experience of support for adolescents and must

therefore be considered as a priority over adult assumptions about wellness or distress.

With this approach, it was recognised that the researcher's own context and position (as an adult apart among other things) would impact the collection and interpretation of the data, and that this would need to be considered and reflected on openly in the research. By taking a critical realist position, therefore, the research aimed to make possible an exploration of the issues affecting adolescents that was sensitive to the possible influences and constraints on research of this nature (social, economic, political, linguistic) whilst also accepting the issues and reflections raised by the participants (Bentall & Pilgrim, 1999).

2.3. Design

2.3.1. Qualitative Methods

The research questions and epistemological stance were interested in meaning associated with categories identified by the participants (rather than pre-existing categories), and it was therefore decided that a qualitative approach would be most suited to address this aim (Willig, 2019).

Qualitative research methodologies focus on the subjective experiences of psychological or social phenomenon and are less concerned with quantifying them with numbers (Braun & Clarke, 2013). In this way, they are more likely to uncover new insights and, through providing an opportunity for people to tell their stories and have those stories heard and taken account of, can also empower groups (Faulkner, 2012). Focus groups, rather than individual interviews, were chosen for this research for two reasons. First, as the emphasis was intended to be on adolescent led issues and meanings, it was more likely that a discussion between adolescents would elicit these through minimising the presence and power of the adult researcher and empowering the adolescents to lead the discussion, and second, the data was most relevant to the community of adolescents at the participating school and, as such,

the perspectives of this group as a community were as valuable as individual insights (O.Nyumba et al., 2018).

2.3.2. Focus Groups

Determining the size and number of focus groups required to achieve ‘saturation’ is a much-debated topic, with type of saturation, method of analysis, type of knowledge sought and the participants involved all influencing recommendations (Guest et al., 2016). To achieve “data saturation…the point in data collection and analysis when new information produces little or no change to the codebook” with a relatively homogenous group and using a semi-structured guide to interview, most suggestions recommend at least two focus groups, with research indicating that two to three are likely to be sufficient to capture 80% of themes and three to six likely to capture 90% (Guest et al., 2006, p. 65, 2016). In line with these recommendations, this research aimed for between two and four focus groups.

Deciding the composition of the groups requires balancing the need for homogeneity of characteristics with diversity of perspectives, and this may be influenced by the research topic or questions (Moore et al., 2015). Consideration of what will facilitate fruitful conversation is also important, with size of group, familiarity and difference between participants key influencing factors (D. L. Morgan, 1996). The literature advises that, while groups of ten or more people may provide the opportunity for a greater diversity of perspectives, they also risk losing depth of description if people don’t have sufficient time or space to speak (Kreuger & Casey, 2014). Groups of between four/five up to six/eight are usually advised (Guest et al., 2016; Kreuger & Casey, 2014; D. L. Morgan, 1996). Additionally, adolescents of different developmental ages are likely to think, reason and engage differently in discussion and so groups may benefit from being arranged by age (Adler et al., 2019). This research limited participants to ages 16 -18 and aimed for groups of between four and eight in size.

Online focus groups have become increasingly popular over the past decade, with some research indicating that adolescents may even prefer the convenience of

online groups compared to face to face focus groups (Zwaanswijk & van Dulmen, 2014). Online focus groups can be synchronous or asynchronous, depending on whether they involve a discussion in real-time, such as in a chat room or video conferencing space, or are conducted in a text based space such as a forum or over email (D. L. Morgan, 1996). Asynchronous groups can avoid scheduling issues, provide a slower pace, greater anonymity and suit those who might prefer to write about their experiences rather than talk about them (Williams et al., 2012). Synchronous groups are most similar to a face to face interaction, with video and audio technology allowing discussions to incorporate a greater range of vocal and visual cues (Link, 2012). After consultation with a young person in the target age group (but unrelated to the participant group), the researcher chose to use synchronous focus groups to facilitate real-time discussion, which was also considered likely to suit the participants as it was arranged for during school hours.

2.4. Consultation

An interview schedule was devised around the research aims and with consultation from another young researcher unrelated to the participant group (see Appendix C). Interview schedules benefit from testing and refining in order to ensure that questions are relevant and worded and delivered in a way that helps build rapport and elicit rich conversation (Braun & Clarke, 2013). It was important, therefore, to consult with young people on the questions to gain the 'insider' perspective that may not have been accessible to the researcher (Allam et al., 2004; Kellett, 2005). This input helped shape the final interview schedule and the use of terminology.

This research is exploratory and aimed to provide an unbiased space to talk, in order to elicit adolescents' perspectives with as little adult influence as possible. The language around mental health used was a concern therefore, as, although stigma around mental illness appears to have lessened in recent years and in younger generations, research suggests that stigma direct towards adolescents and including from other adolescents remains widespread (Kaushik et al., 2016). In order to help counteract potential stigma arising from the phrase 'mental health' that may have hindered conversation, reference was also made to 'wellbeing' in the focus group

questions. It was hoped that this would encourage discussion about factors that may cause or protect from psychological distress.

2.5. Ethical Considerations

This study was registered with the University of East London (UEL). As participants were not recruited through NHS health services, ethics approval was granted by UEL's ethics committee (see Appendix D). The research was carried out in accordance with the BPS Code of Human Ethics (2014) and the Ethics Guidelines for Internet Mediated Research (2017).

2.5.1. Informed Consent

Upon registering interest in the research, all participants were provided with a Participant Information Letter (PIL) and a consent and demographics form outlining the aims of the research and what would be involved should they choose to participate (see Appendix F, G, H). This included a reminder that participation was voluntary and that detailed the right to withdraw without consequence. It also included information about how data from the study would be used and protected, confidentiality and anonymity and remuneration for participating. Participants were recruited from the sixth form (years 12 and 13). As they were all over the age of 16 they were able to provide consent themselves, and confirmation of this was included on the consent form and reiterated verbally at the start of the focus group (British Psychological Society, 2014). The participants were also provided with contact details for the researcher and given the opportunity to ask questions before deciding to participate. However, consent is an ongoing process and so participants were reminded again, upon joining the focus group, that participation was voluntary and that they may leave without giving notice or reason and that their decisions would not be communicated to the school (Salmons, 2016).

2.5.2. Confidentiality And Data Protection

The PIL explained what data would be gathered from the participants and how it would be anonymised and stored throughout the research process and afterwards, to ensure confidentiality of personal and identifying information was maintained and that data was not unnecessarily kept (National Data Guardian, 2020).

The focus groups were conducted online using MS Teams, which was the approved platform for use by UEL due to its data security provisions. The focus group transcripts were anonymised at the transcription stage and stored in a password protected online location, separately from the consent forms, which were also stored online in a password protected folder. Participants were informed that the researcher's supervisor and examiners may read the anonymised transcripts and that the transcripts would be stored for up to three years to enable future publication but that the original recordings would be deleted following transcript checks. This was in accordance with the 2018 Data Protection Act and the Caldicott Principles (2019; National Data Guardian, 2020).

2.5.3. Potential Distress

The PIL also acknowledged that the research involved discussion of factors impacting mental health and, as such, could bring up issues that participants might find emotionally upsetting. Including this in the PIL was intended to provide participants with sufficient time and information with which to consider their participation before deciding, but again, it was reiterated during the focus groups that participants could leave or take a break as they needed. The PIL also included signposting to sources of support if participants felt they needed it following the focus groups and this included the school counsellor as well as charity and NHS services.

Due to the COVID-19 pandemic and the social distancing measures in place, the focus groups were held online, and participants were not required to have their cameras on. A good principle for hosting focus groups is to choose a space that is comfortable, easy to find and reflects the kinds of spaces that people usually talk in

(Kreuger & Casey, 2014). It was hoped, therefore, that while the researcher could not set up the physical space, the online space (MS Teams) was somewhere that the participants were comfortable and familiar with as this was also the platform that the school used for remote learning. Additionally, to help reduce any distress felt during the conversations, and to provide space to ask questions about the process, the final questions during the focus group discussions were oriented around reflecting on the experience of the focus group (Fossey et al., 2002).

2.5.4. Debrief

Following the focus groups, the participants were emailed a debrief letter (see Appendix I) with a reminder of how their data would be used, options to withdraw from the study and what resources were available if they felt any adverse effects from taking part. This included the school counsellor, charity and NHS mental health services, and the researcher and UEL contact details were also included with an invitation to contact us with concerns or follow up questions.

2.5.5. Remuneration

Remuneration for taking part in research is a debated issue, with potentially complex practical, ethical and methodological implications (Head, 2009). The primary reasons for offering it are as an incentive to participate to aide recruitment or as a show of gratitude for voluntary participation, and there are arguments for the ethics around its use either way (Head, 2009).

In this study, the participants were told that they would be entered into a prize draw to win £10 Amazon vouchers of which eight vouchers were available across the three groups of participants (enough for approximately half of participants to win). This was intended more as a recompense for the time that participants had given up (during an exceptionally stressful school year) than an incentive, and it was hoped that the ‘prize draw’ element (as opposed to guaranteed payment) would limit the sense in which participants might feel compelled to volunteer for monetary reasons

alone. The winners were chosen using assigned numbers and a random number generator and winning participants were informed by email directly.

2.6. Participants

2.6.1. Recruitment

Participants were recruited via opportunity sampling from a school. Recruiting through a school was felt to be one way of identifying a geographical subgroup of adolescents whose views might be relevant to both their own school and local authority and mental health services. A head teacher of a London school was contacted via the researcher's own network and asked if they would be willing to advertise the study within their sixth form. Written agreement (via email) was confirmed from the head of the sixth form and the study was advertised to sixth form pupils. Due to the pandemic and the perceived feasibility of running studies through schools during lockdowns, recruitment was not extended to additional schools in the area.

Focus groups bring together people who share certain characteristics (Kreuger & Casey, 2014). This research aimed to hear from adolescents living in an approximate geographical location as it was thought that they would be more likely to have shared some experiences of social, cultural and environmental factors that might impact mental health and that would be relevant for schools, local authorities and local mental health services. Recruitment started with this school, with the aim of recruiting at least two focus groups worth of participants. The school that agreed to participate was an inner London academy school of approximately 1000 students. The school's borough is densely populated, ethnically diverse (with over half of residents describing their ethnicity as other than white British) and contains a high proportion of young adults in comparison with many other London boroughs and with other local authorities across the UK. It is within the top third of most deprived boroughs in London and the top sixth most deprived local authorities in England.

A teacher for the sixth form assisted as a liaison for logistical arrangements. An e-advertisement was sent (via the liaison) to all students with details of the study (see Appendix J) and interested participants were invited to contact the researcher with questions or queries or to register interest. In practice, interested participants more often made themselves known to the liaison who informed the researcher. The PIL and consent form were emailed out as early as possible in advance of the proposed focus group date, in order for interested participants to read and consider participation fully and ask questions if they wanted. Initially this was more than a week before the focus group date, however a large number of additional participants registered interest on the day of the second planned focus group – far too many for one group and with less time available to read the PIL. This was not easy to manage at short notice and represented another example of the 'ethics in practice' that sometimes involves responding to dilemmas arising during data collection (Guillemin & Gillam, 2004). It was of ethically importance that every participant interested was offered the chance to join a focus group. However, without sufficient time to run two focus groups that day, all participants were offered the choice of a third focus group date the following week with the communication that the researcher was keen to provide everyone interested with an opportunity to partake in the research and that participants were able to choose the date that they preferred to attend. In this way, a third group was run.

2.6.2. Inclusion Criteria

In order to aid recruitment and gather a range of perspectives the research was opened to students of all genders but restricted to within the school's sixth form (years 12 and 13 - ages 16 to 18). There were no other restriction criteria.

2.7. Data Collection

2.7.1. Consent Forms

Participants were thanked by email for registering interest in participating and requested to read and return the signed consent form to confirm their participation.

Consent was obtained by e-signature or typed signature and sought again verbally at the start of the focus group. Consent forms were stored in a password protected folder located on a secure UEL server.

2.7.2. Data Collection

Three focus groups were held in total with five, ten and four participants respectively, and nineteen participants in total. All groups included a mix of genders and ethnicities. The first focus group was held just after the school's exams and just before the summer holiday, in July. Due to the challenges schools faced returning to face-to-face teaching in September (including selective quarantines and adaptations required to teaching) the second two focus groups were held in November. The timing and location of the focus groups must also be planned, with consideration of fatigue as well as school and homework commitments for school aged participants (Adler et al., 2019). The focus groups in this research were, therefore, held in the afternoons during school hours and lasted for 90 minutes as recommended in the literature (Heary & Hennessy, 2002). A drawback of holding the focus groups during school hours was that the physical location was then impacted by the change from remote to face-to-face teaching between the summer and autumn terms. During the first focus group, in July, the participants were not in the same physical location and attended from home, as schools were operating remotely at that point. The second and third focus groups, in November, were conducted with the participants together at school, in a room that the liaison had booked for them. The researcher was unable to set up the space for these groups and was the only member not physically present for them. The participant debrief letter was emailed out following the group.

2.8. Analytic Approach

2.8.1. Thematic Analysis (TA)

From among the possible qualitative analytical approaches, thematic analysis was chosen for this research based on the research questions and the intended utility of the research outcomes (Harper, 2012).

TA is a flexible analytic tool for identifying patterns and themes in data, and can be used across realist and constructionist epistemological paradigms (Braun & Clarke, 2006). In TA, themes identified in the data through a process of coding can draw on pre-existing theory (deduction) or be base in the raw data (inductive) (Joffe, 2012). In these ways, TA differs from other prominent approaches that were considered including Interpretive Phenomenological Analysis (IPA), Grounded Theory and Discourse Analysis.

IPA prioritises people's lived experiences of a phenomenon and emphasises the interpretation of those experiences through the research (Braun & Clarke, 2013). To do this it focuses on individual cases or small, homogenous samples, exploring, in detail each person's own account and understandings. Grounded Theory aims to develop new theories from data that fit the context of the data, explain social processes and have strong working capacity (Glaser et al., 1967). Grounded theory utilises close inspection of the data and is best suited to larger studies (Braun & Clarke, 2013). Discourse Analysis is situated in constructionist perspective and has, as its focus, the question of how meaning is created through language (Willig, 2019). Analysis is, therefore, heavily focused on the transcript and on the social processes that inform language and meaning.

The research questions in this study were designed to try and capture adolescents' perspectives without bias in order to gain insights into what adolescents benefit from in terms of support or nurturing. The requirement then, was for an analytic framework that could identify and prioritise shared patterns of manifest meaning (in the form of themes) but also explore those meanings further, to understand them better and enable interpretations of latent meaning that could be valuable to the research questions. Thematic analysis was best suited to achieve this, as diversity of perspectives was welcome and the aim was not to generate a theory of a social process.

2.8.2. Transcription

The focus groups were recorded using MS Teams software and transcribed orthographically following Braun and Clarke's (2012) recommendations for Thematic Analysis. As such, all words, utterances and pauses were noted, as well as typed responses in the chat function and instances where the audio quality prohibited data capture.

2.8.3. Stages of Analysis

Braun and Clarke's six stage approach to thematic analysis was followed. As such, the analysis followed the undermentioned process.

2.8.3.1. Familiarisation With The Data

The process of active immersion into the content of the data began during the transcription stage. This enables the researcher to become familiar with the data and to start to notice any patterns or meanings in it. After transcribing was complete, the transcripts were read and re-read to aide familiarisation with them. Notes were made on the researcher's initial reflections and ideas during this process, an example of which can be seen in Appendix M.

2.8.3.2. Generating Initial Codes

Once familiar with the data, initial codes were assigned to the transcripts. Codes refer to the smallest elements of the raw data that can be assessed as meaningful with regards to the research questions (Boyatzis, 1998). Through several readings, the data was coded using Nvivo 12 for Mac software to assign and collate coded extracts together from the different transcripts. These codes were primarily data driven or inductive and so all possible patterns of meaning were coded for at this stage, which meant there were several overlaps and data extracts that fitted into more than one code. See Appendix L for a list of all initial codes.

2.8.3.3. Searching For Themes

Whilst coding, thoughts about possible themes in the data and preliminarily grouping codes that appeared to fit together were noted. After initial coding was complete, the process of grouping and collapsing codes with similar meanings continued, and themes were generated in this way. Nvivo software and an online 'whiteboard' were used to collate codes and create thematic maps.

Braun and Clarke describe searching for themes as an active process in which the researcher is constructing (rather than discovering) distinct but related themes through the choices they make in grouping and refining codes (Braun & Clarke, 2012). Themes were generated with the research questions in mind, and this involved losing some codes that didn't feel relevant. However, it was also important that the themes and overall narrative was led by what the participants' prioritised in the discussions and so care was taken not to lose too many codes or themes at this stage.

Several lists of possible themes were made, and each one checked against the codes to gauge themes that meaningfully represented them. Eventually, a initial thematic map was created that contained ten themes with sub themes, eight closely related to the research question and two that fitted less well but which were coherent and interesting (see Appendix A).

2.8.3.4. Reviewing Themes

At the next stage, the themes were checked again against the original coded data extracts to ensure that they were internally coherent, meaningful and reflective of the data set (Braun & Clarke, 2006). The researcher then reflected on the themes in relation to the data set as a whole, considering how well they worked or represented the data set and looking out for any overlooked data to be coded and any recoding with reference to the themes. Braun and Clarke warn that generating themes and coding and recoding can be an endless process and care was taken not to overwork the data set (Braun & Clarke, 2006). At the beginning of this stage, the researcher

felt that there were too many themes but a fairly strong overall narrative that connected them, so work focused on collapsing some of the themes together and refining them with the aim of creating a more manageable number of themes (six) that contained as much depth of information as felt useful, relevant and possible. These six themes can be seen the second thematic map in Appendix B.

2.8.3.5. Defining And Naming Themes

From the thematic maps, the themes and sub themes were re-read to try to distil the essence of what the themes communicated about the data set and in relation to the research questions. The final theme titles were then the most concise descriptions of the researcher's key interpretations of the data as they related to the codes and sub themes.

2.8.3.6. Producing The Report

Section 3 of this thesis contains the report of the analysis including a description of the themes supported by extracts from the data. The report should provide a coherent overall narrative and the order of the discussion of themes and sub themes should support that narrative.

2.9. Researcher Reflexivity

Within qualitative research, complete objectivity as a researcher has been recognised as unrealistic, and instead it is understood that outcomes constructed by researchers are imbued with those values and privileges that the researchers possess (Harrison et al., 2001). Many feel that it is better to acknowledge those privileges and values and make them known to the readers through reflexive telling of the process of the research (Ortlipp, 2008). This helps to posit the research outcomes in an honest and transparent way. Keeping a reflective journal during the research process can help with this, enabling the researcher to notice where their attention is drawn during the coding stages and question why (see Appendix K for diary extracts).

With regards to this research, this researcher feels that the following reflections and acknowledgements of her are relevant to hold in mind.

I am a British, cis gender female in her 30s. I am of duel-ethnicity (white and Indian) and have one parent who is an immigrant to this country. I am not religious, but my Indian family are Muslim and were born in East Africa. I was born and brought up in the UK, but not in London, and I experienced a middle-class upbringing. This may have impacted the ways that I explored and related to issues in the discussions and/or the values, meanings or importance I ascribed to the data during analysis.

Additionally, I am an adult and have not been an adolescent for some time. During the analysis particularly, I noticed myself thinking back to when I was in school and trying to recall how I felt in about my relationships with my peers and with my teachers. I felt this helped me to try and keep the adolescent perspective in mind as I interpreted the data, but I was aware both that relating to my own adolescence will be hindered by the time that has elapsed since, and that my adolescence was experienced in a very different cultural and historical context from my participants'.

As a trainee psychologist, I have personal and professional thoughts about distress and how I would hope to respond it. I noticed that I had a strong reaction to the content of the first focus group and that compassion for them and their description of their experiences. Kvale notes the potential ethical risks of confusing the roles of therapist and researcher and situates this concern within a discussion about the power dynamics in interviews (Kvale, 2006). In this discussion, they also note the inherent power that the researcher has in interviews and the difficulty of claiming an 'interview-dialogue' as an egalitarian process if, ultimately, the researcher set the interview up for their own purpose. Although the aim of a focus group is for the participants to talk amongst themselves, I was conscious of my inherent power as the researcher-recruiter and the extent to which my questions and prompts, despite the intention for them to be broad and despite having consulted with an adolescent researcher in writing them, will have led or shaped the discussion, and therefore the data.

3. RESULTS

3.1. Chapter Overview

This chapter presents participant's discussion of mental health stressors and their views on the school's role in supporting mental health and wellbeing. Thematic Analysis (TA) was used to explore the research questions and a thematic map is presented to illustrate the themes and sub themes generated. The themes and sub themes are then expanded upon and extracts from the transcripts used to support and evidence my interpretations. In places, minor changes to extracts have been made to improve readability such as removal of repeated words or curtailed sentences (for example "I, I don't thin- I don't know if"). Ellipses are used where words have been removed. To ensure anonymity, participants are referred to by number (assigned by the researcher). Teachers (mentioned in quotes) have been given pseudonyms.

3.2. Sample Demographics

Nineteen participants in total took part in the research and focus groups 1, 2 and 3 were made up of 5, 10 and 4 participants, respectively. No participants withdrew consent to use data. No concerns arose as a result of the focus groups and no participants requested or required follow up. The participants were all aged between sixteen and eighteen, screened for by use of sixth form students only. Eleven participants opted to complete the demographic questions (see Appendix H) and table 1 outlines the data from these participants. Broad information is presented only, to maintain confidentiality.

Participant Demographics

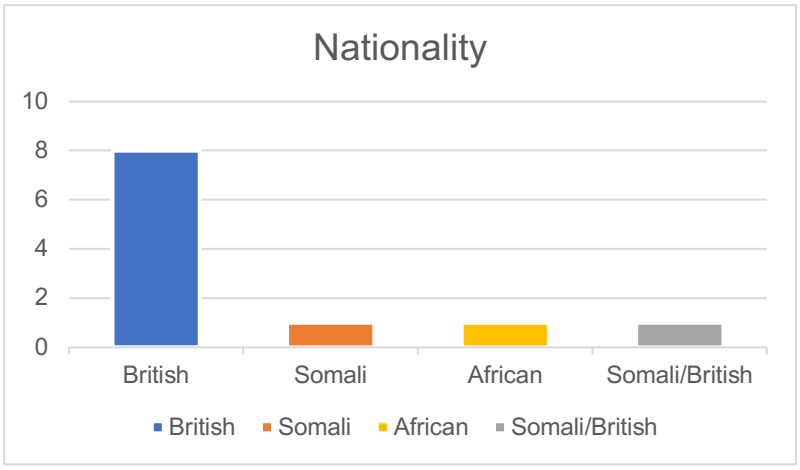

Figure 2, Nationality

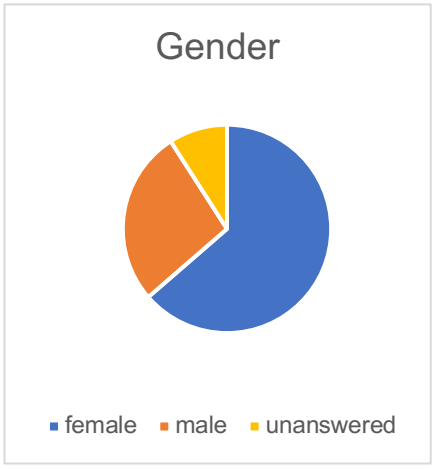

Figure 3, Gender

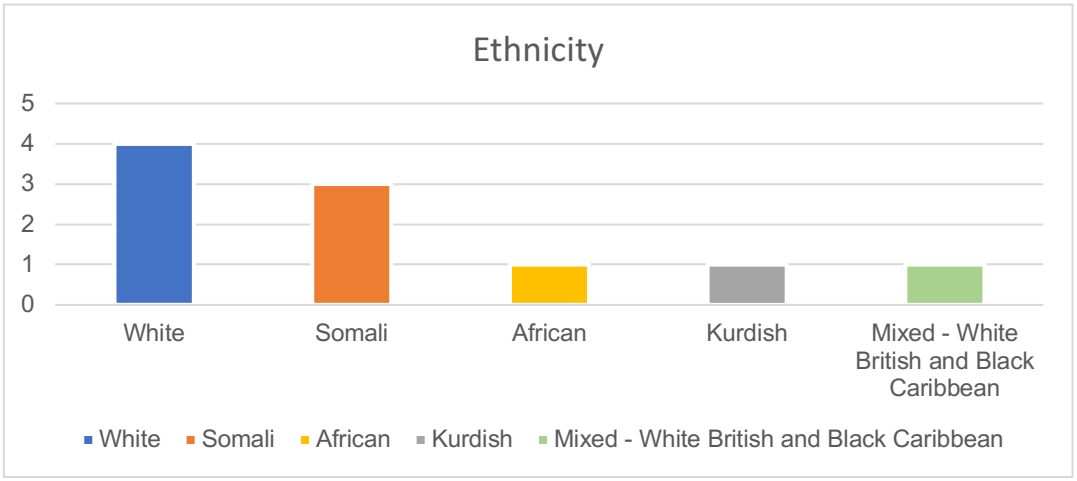

Figure 4, Ethnicity

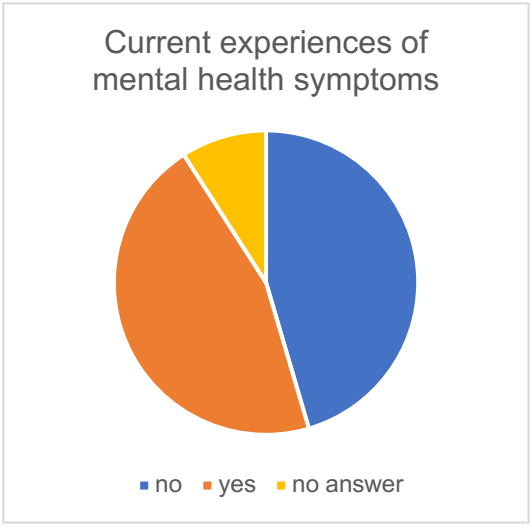

Figure 5, Current experiences of mental health

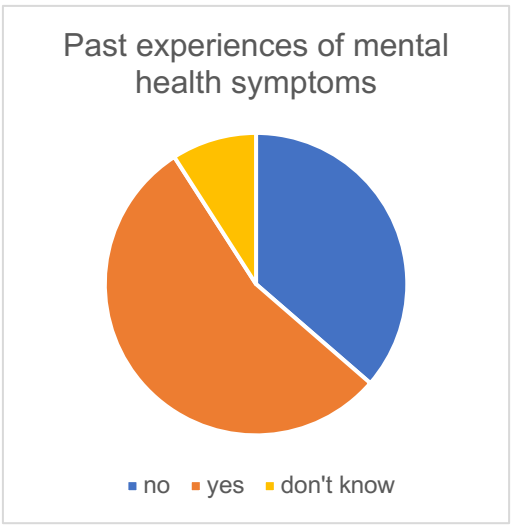

Figure 6, Past experiences of mental health

3.3. Thematic Map

Using Braun and Clarke's six stage approach to TA, thematic maps were constructed and refined to produce the final map (Figure 7, Final Thematic Map) containing two main themes, each containing three sub-themes. These themes and sub-themes were felt to best represent the data.

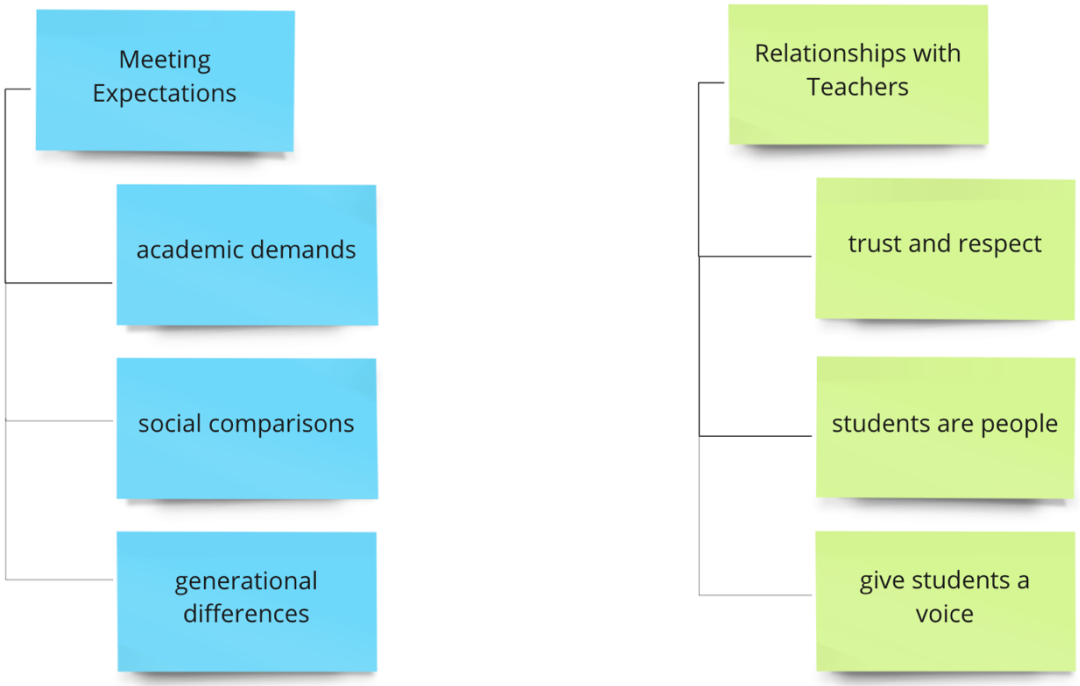

Figure 7, Final Thematic Map

3.4. Terminology And Shared Understandings

The focus groups did not aim to capture only stressors that participants felt would directly or imminently cause mental illness but hoped to include all issues that were important to adolescents' psychological wellbeing. The discussion was oriented more towards gathering reflections on stressors than exploring experiences of distress, but it was useful to gauge the participants' understanding of the term 'mental health' as the focus group questions did use it. When asked what the participants meant by 'mental health', one participant said:

> “maybe like stress or anxiety or depression or things that can be diagnosed but also things that may seem little but can lead to other things”. (Participant 1)

This response was a good indication that the participants’ perspective on mental health was sufficiently broad that they were likely to talk about a wide range of issues that they felt impacted their wellbeing. During the focus groups, in order to gauge the level of distress they caused, the participants were asked how the stressors they described impacted their mental health and wellbeing and what that impact looked like. The participants talked about feeling ‘stressed’ and, when asked what that felt like, they said:

> “I think constantly overthinking” (Participant 2)

> “I'd say mood swings” (Participant 3)

> “I'd say mental breakdowns” (Participant 4)

Some of the participants also talked about crying or wanting to cry and these descriptions helped paint the picture of the nature and severity of distress that the stressors they talked about caused them.

3.5. Theme One: Meeting Expectations

This theme reflects the participants’ reports that expectations of them, by teachers, parents, wider society and themselves, were a common stressor. As one participant said:

> “I think what impacts your mental health is … the pedestal people put you on, and you might want to live up to that and it's very hard sometimes … to please everyone, so if you're in a race to please everyone and not pleasing yourself, it gets a bit like, d’you know what I mean?” (Participant 5)

The participants talked about expectations around academic achievements as particularly stressful. They described how their teachers encouraged comparisons between peers as a way of motivating them to do well and that this often exacerbated the pressure they felt to do well. The participants also talked about their own perceptions of societal expectations of what constitutes a happy and successful person, many of which they accessed through social media, and which could, at times, invite unhelpful comparisons around beauty, happiness and success. Lastly, they described feeling that adults (mainly parents and teachers) set expectations for them based on their own priorities, which, due to generational differences, did not always align well with adolescents' experiences of themselves and which were less easy to manage.

3.5.1. Academic Demands

Academic expectations were the source of pressure most talked about as causing distress. The participants said that expectations around both the volume and the standard of work they were given by their school felt unrealistic and unhelpful. They talked about the impact that these expectations had on them and about some of the things that helped and hindered them from managing the demands of schoolwork.

Of the volume of work, the participants described how it made their days feel mundane as it took up so much of their time. One participant said:

> "You just wake up so early and there's so much work to do then you go home and it's pretty late and you have more work and it just the same every day" (Participant 6).

Here, Participant 6 also mentions having to wake up early. Adolescents' sleeping patterns shift towards being evening-oriented, peaking at around age 16-17 (Randler et al., 2017), so the requirement to get up for school earlier than might suit them may contribute further to the sense that schoolwork dominates their time and contributes to tiredness. As well as feeling mundane and dominating their time, the participants

talked about how schoolwork dominated their thoughts, and said that this could be very stressful. Participant 7 said:

> "when I finish school 4 o'clock …. I want to relax [but] ... I feel stressed 'cause the work is there, it's in my mind, it's all I think about" (Participant 7).

Participant 7 describes the struggle to balance rest and relaxation after school with the volume of work there is to do. The participants were asked how the pressure of schoolwork made them feel and participant 8 said:

> "just like, don't wanna get out of bed and really sad and just wanna cry" (Participant 8).

Another said:

> "I don't feel like my usual self" (Participant 9)

Here, Participants 8 and 9 describe feeling tearful and demotivated. Exam periods were described as particularly stressful times for students. Participant 6 said:

> "I remember, just walking around like, just seeing kids break down. Including myself" (Participant 6).

These participants describe the pressure of schoolwork leading to low mood, sadness and feelings of being unable to cope, and schoolwork appeared to limit their ability to explore other interests or take a break and unwind. When asked what helped them manage stress and what they prefer to do when they were not working, the participants talked about enjoying activities like sports and dance. Opinions on whether they had enough access to extra-curricular activities were mixed, but these non-academic activities appeared to provide an opportunity for play and exercise that the participants valued. One participant mentioned a Friday dance group;

> “It’s really funny, especially when we're with all our friends and we’re just laughing at each other and how ridiculous we look, but also just like, forgetting about all that stress and what that day has been like.” (Participant 9)

Participant 9 described them and their friends feeling happy and unselfconscious when they danced and indicated that it helped them let go of stress. Unfortunately, the design of the school was felt to limit opportunities for more regular physical activity outside, socialising and play or even eating lunch away from the learning space:

> “there isn't really the space to differentiate between work and lunch … it’s like you never really escaped from the lesson, so there's no way to like, de-stress”. (Participant 6)

The participants described how the cramped conditions of the dining area, the fact that they were often unable to sit with their friends and sometimes had to rush or even miss out on eating because of lack of space or being let out of lessons late, contributed to the sense that only academic tasks were valued by the school. More than the design of the school, however, the participants talked about how their teachers interacted with them. Participant 10 said:

> “they see students as like, these robotic organisms that will get handfuls of homework and finish it in like an hour or so … they don’t see us as having a personal life outside of school … they don't realise that we're still human at the end of the day, we're going to make mistakes” (Participant 10).

Here, Participant 10 describes a dehumanising process that expects students to perform like robots rather than people who have multifaceted lives and who are imperfect. With this, they express not only how unachievable the expectations of them feel, but of how they think they are perceived by their teachers. The relationship with teachers is explored further in a later sub theme, but several of the participants felt strongly that their teachers had a single-minded focus on academic grades that was detrimental to their wellbeing. Schools have their own accountability measures around exam results and the academic pressure the participants

described being put under by their teachers may well have been being felt by the teachers too. After hearing references made by teachers to the school's national performance, Participant 10 astutely noted this, describing the process as one of projection between teachers and students:

> "they're pushing us based on the expectations that they have on themselves and their feelings that they have for themselves, and I don't think that's fair on us". (Participant 10)

Some participants felt that their families were also heavily focused on schoolwork and had high expectations for them to do well. Participant 2 said:

> "I believe that there's a constant feeling of having to impress your family. And that obviously puts a lot of stress on individuals because they feel as though, like, they have to make sure that they don't make any mistakes, or their parents may be like, upset" (Participant 2)

Both Participant 10 and Participant 2 mentioned feeling unable to make mistakes. Again, this suggests that they felt under pressure to perform at a very high standard. Expectations from family will be also explored further in a further sub theme, however, it seemed that the academic expectations of teachers and parents connected with the participants' own expectations of their academic performance. Participant 9 said of their grades;

> "I find them important, especially if I want to achieve my dreams and goals" (Participant 9)

Academic expectations promoted by teachers and families appeared to reinforce and amplify participants' expectations of themselves. Thoughts about whether they would live happy and successful lives were mentioned by other participants at points throughout the focus groups (and will be picked up in the next sub theme) and it is possible that the challenge of meeting the high academic expectations at this stage of their lives was also impacting the confidence they had in their ability to achieve their future goals.

3.5.2. Social Comparisons

The participants described how expectations of them exacerbated, and were exacerbated by, comparisons of themselves with others (social comparisons). They discussed this with reference to comparisons of academic achievements with peers at school and comparisons of beauty, happiness, and success with people they saw on social media and YouTube. In both cases, the participants felt that social comparisons were unhelpful and could be detrimental to mental health. In school, they felt comparisons were driven by their teachers' focus on academics:

> "they always would pick the highest students. And the students who like, never got anything below like, A stars … so it was just stressful thinking that we had to be like them" (Participant 6)

The participants described feeling that their teachers invited and encouraged comparison with high achieving students. Participant 9 said:

> "They compare us a lot … and I feel like comparing students in that way can be really like, discouraging … because you might be thinking 'oh I'm not doing as well as them' and that adds on top of the stress that you're already going through" (Participant 9)

Comparing themselves and being compared with other students appeared to amplify the worry the participants already had about doing well in their studies and increasing the stress they were feeling. Participant 10 said:

> "I'm constantly comparing myself to these people that are achieving higher and higher, and I feel like it's just a huge weight on my shoulders" (Participant 10)

It seemed likely that their teachers were trying to motivate them to do well, but the participants described being aware of their limits and that being compared with much higher achieving students affected their self-confidence negatively. Some of the

participants expressed a wish to have more say in which classes they were placed in. Participant 6 said:

> “I wish the teachers would listen to you more on where we think we should be working … I was put into the highest science class, but I knew that I wouldn't be able to like, perform well there.” (Participant 6)

Outside of school, several participants reported that social media was influential in the lives of adolescents. Social media was described as a place to share information and support with people they could relate to more easily than many of the adults in their lives, but it was also felt to feed unhelpful comparisons with others. Participant 11 said;

> “social media as well, a lot of people post things, but it's like, if you aren’t this certain way, then you're like, a bad person. But it makes people feel worse than they really are”. (Participant 11)

Participant 11’s comment suggests that adolescents are thinking about their identity as people and who society expects them to be when they are looking to social media. Participant 12 added:

> “what people see on the Internet, they might wish for that to be themselves. Like, say if they see social media influencers and they wish to be like them, but they can't, it affects their mental health negatively.” (Participant 12)

Comparisons on social media were commonly related to influencers, who the participants described as aspirational figures. However, they also recognised that influencers were often promoting unrealistic if not dishonest ideals around happiness and beauty:

> “I believe that they show us what they want us to see. Like, you would maybe see a video, someone who's like, really happy, but they may not actually be happy behind closed doors.” (Participant 2)

One participant suggested that it would be more helpful if influencers were honest and would “just show me the real you” (Participant 7), but most of the participants described accepting that influencers were just doing a job. Despite knowing that their content was highly curated, the participants reported that the comparisons with influencers presenting happy and successful lives could impact their mental health. Participant 5 said:

> “You can only be so strong for so long … you might wanna be thinking to yourself, ‘yeah, this won’t impact me it’s all fake’, but it might get to you at one point”. (Participant 5)

Aspirational content was also felt to impact mental health by discouraging people from expressing their feelings:

> “a lot of young people see their favourite youtuber always happy …and they will be like … I can't show this emotional side of me or speak about my feelings that much because … my idol’s out there taking everything on the chin” (Participant 10)

Here, cultural norms around the expression of emotions are mentioned. Other participants also talked about thinking it common for people to ‘bottle things up’ rather than talk about them for fear of being judged by others. These comments suggest that adolescents feel there is an expectation to contain rather than express emotions, and that this is compounded by comparisons with social media influencers who portray themselves as consistently happy. There was a sense that age, existing mental health and how impressionable a person someone was would impact whether engaging with social media would be more beneficial or detrimental to their mental health:

> “I feel like if you have strong mental health, you’ll not get affected by things in social media and, of course there’s going to be days when your mental health is going to be weak but if you’re confident in yourself, you love yourself, then social media will [not] impact you”. (Participant 7)

The participants showed a great awareness of how emotional resilience is not static but varies, and that on days when resilience is lower, people might be more vulnerable to external factors affecting them negatively. Participant 7 talked about confidence and self-esteem being tools of resilience and protective factors against unhelpful social comparison with figures on social media. The participants felt that this kind of resilience increased with age, and Participant 13 felt that there was growth between younger adolescents at secondary school at the older ones in the sixth form. They said:

> “Like, at our age, at like,16 and over, I think it's different for like, kids in my secondary school. We’re more, like, sure of ourselves. But obviously, we still have fragile mental health but like, in general, you’re less impressionable now than you are when you're younger”. (Participant 13)

The participants spoke thoughtfully and compassionately about mental health, but almost exclusively used words such as ‘weak’ or ‘fragile’ when talking about lowered resilience or susceptibility to distress. Their broader comments were never derogatory, and this language seemed more likely a reflection of cultural norms for describing mental health. However, if so, it indicates that negative judgements about mental distress are implicit in the common language of society and reinforce expectations around presenting a ‘strong’ persona. Or, as Participant 10 succinctly put it:

> “we've been built on a society where we're told to not really show that much emotion, otherwise we’re deemed as weak” (Participant 10)

The participants recognised that this wasn’t always helpful and could prevent people from accessing support. Participant 2 said:

> “A lot of people … don't really like to express how they are feeling, so that therefore means that a lot of people don't actually know if they can relate to people, which would obviously mean that it's difficult for them to help them with what they're going through”. (Participant 2)

3.5.3. Generational Differences

The participants described how they felt the adults in their lives (namely, teachers and their families) sometimes struggled to relate to their experiences because, due to cultural and technological advances, their own cultures, backgrounds or life experiences had been so different. Participant 13 said:

> "I think more has changed in the time from our parents being our age to us, than their parents to them at that age. Because of like things social media. I don't think our parents understand some of the problems our generation has because of technology". (Participant 13)

This was felt to be particularly true for families where parents had emigrated from other countries where there was a cultural split between the generations and where experiences of migration and struggle were not shared by children growing up in the UK. The particular impact that some of the participant's felt immigrant parents' experiences had on their expectations of their children was described by Participant 7:

> "parents think that exams are the ones that will get us into uni and make us have good jobs and [if we don't do well] they will probably think we'll fail, especially a lot of immigrant parents … so they will apply more pressure on kids and they will be like 'oh, you're gonna be failures, you're gonna be like me' … and then most immigrant kids feel stressed out and have no motivation at all". (Participant 7)

Participant 7 points to immigrant parents' desires for their British born children to benefit from opportunities they didn't have as creating a potentially unhelpful dynamic. They added:

> "it's done in a way where … they pressure you and you just get, basically you think you're stupid and you're failing and you have no motivation for your work and so your mental health goes down, down, doooown!" (Participant 7)

As with Participant 10's observation of the teachers, Participant 7 appeared to be describing being on the receiving end of psychological projections by family members, whose concerns about their own success or failure appeared to be contributing to adolescents feeling worse about how they were doing at school. The participants had expressed their own aspirations to succeed academically too, so it is, perhaps, difficult to quantify distress caused by the projections of others and distress caused by their expectations of themselves (in the countertransference). However, there is a likelihood that the messages the participants received from adults were, at least, exacerbating their existing concerns.

Differences in cultural conceptions of mental health were also described as unhelpful at times and presenting a barrier to relating. Participant 14 said:

> "if you're from a culture that thinks mental health is a taboo issue, I think it can be hard for you to communicate on your feelings"

The participants reported struggling to speak to parents who had different conceptions of mental health, and who they felt didn't understand adolescents' perspectives. The cause of the disconnect was often linked to the parents' experiences of emigrating. Participant 5 said:

> "your parents might refuse to accept that you're mentally unstable because they think 'ahh, how's my daughter, how's my son going through this?' … 'They're living in a better country than I did, they have everything that I wanted, but they're still unhappy'" (Participant 5)

The participants described how their parent's experiences of coming to the UK to try to improve opportunities for their families often created expectations around their children's academic achievements and their overall happiness that prevented them from understanding or relating to their children's experiences. However, the participants expressed understanding of their parents' perspectives and appeared less distress than when they talked about their teachers' expectations. Participant 12 said:

> “most of our parents are like, immigrants so they didn't get the level of education that we have. So maybe their support makes us think twice about why they came to this country, to make us have education to make us have better lives”. (Participant 12)

Here, Participant 12 appreciates how parents’ expectations come from a place of care for their children, and Participant 7 agreed that “they have good intentions”. This understanding on the participants’ behalf may have helped mediate the pressurising experience of their parent’s expectations, but there remained a sense that a lack of shared understanding around mental health meant that adolescents didn’t feel they could rely on adults as people to talk to about their difficulties: Participant 1 said:

> “I think it's easier to talk to younger people about mental health. Maybe in the fear of being judged more by older people who might not understand it or didn't grow up with the awareness of mental health.” (Participant 1)

This also applied to understandings of phenomena specific to youth culture. Participant 5 said:

> “Although teachers understand like, the concept of knife-crime, and like, what it is, I feel like they don't truly understand the deeper meaning of it”. (Participant 5)

Participant 5 described how not all teachers had sufficient understanding of issues that affect adolescents, such as knife crime, to be able to relate to an adolescents’ perspective. This, they said, made it difficult to feel able to turn to teachers for support:

> “there's some teachers … you can talk to you and some teachers that you can't because you feel like they won't understand a word coming out of your mouth”

There is a sense, from the language Participant 5 uses here (not even one word will be understood by a teacher), that they may feel that teachers aren’t interested

enough, or haven't made enough effort to try and understand the issues that affect adolescents. Participant 12 took this further and said that they felt adolescents were often actively misunderstood in society. They said:

> "if, somebody sees groups of people wearing hoods, they think that they're gangsters. There are stereotypes going on but that's society making that assumption." (Participant 12)

Participant 12's comment shows how expectations can negatively impact adolescents in more ways than one. Here, rather than setting unrealistically high expectations for adolescents, adults misinterpreting cultural signifiers (hoodies) have led to negative societal expectations for some groups of adolescents. Participant 12 followed this by saying:

> "We need to show them that this is not us. Show them the real people that we are, yeh, level up, reveal our true colours." (Participant 12)

This comment demonstrates a wish to be understood better and not be viewed in a negative light, and a sense that adolescents want to challenge societal perceptions of them. This sense of agency and desire to be understood as the good people that they believe they are highlights the stage of psycho-social development that these adolescents are at and is a reminder of how close they are to independence. Unfortunately, it contrasts with how they described feeling they were perceived by some of their teachers and at least one participant felt that their teachers had not acknowledged their development since the start of secondary school, and that assumptions about them had become hard to shift. They said:

> "you're always saying people transform, people change, but you're not giving me that chance and you always putting the blame on me, even if it isn't me." (Participant 9)

Some of the other participants agreed with Participant 9 that teachers could hold on to negative assumptions about students, "like they carry grudges" (Participant 10).

This raises a concern about whether perceptions of particular students impact the support and investment they get at school.

Throughout all three focus groups, there was a strong sense that that poor relating with the adults in their lives caused the participants distress, and that they wanted these relationships to improve. They described struggling to engage with activities that they enjoyed and struggling to feel confident about their futures, under the weight of the expectations of them by society, teachers and their families, and the cultural messages they received about needing to present themselves as happy and successful.

3.6. Theme Two. Relationships with Teachers

This theme, closely linked to the first, further explores the impact of adolescents' relationships with adults, describing the extent to which the participants felt their teacher's ways of relating with them at school directly impacted their mental health and also impacted the quality of support and teaching on mental health that they received.

In their discussions, they described how teachers often made little effort to engage with students as people and that students' thoughts, feelings, values and priorities were neither sought nor respected in many cases. Participant 12 said:

> "Personally, I think here, like teachers, they care more about your actions and what you physically do than what's going on inside your head. Like, say if you're if you're wearing trainers to school, they're more focused on that than asking how's your day been" (Participant 12).

3.6.1. Trust And Respect

The participants described feeling that many teachers demonstrated little interested in getting to know them or considering their perspectives. They said that this impacted trust and respect in their relationships with teachers and that many

students felt uncomfortable talking to staff at school about personal or emotional difficulties because confidentiality was not adequately respected. One participant said “teachers are huge gossips” and another added:

> “sometimes if you walk past, you can hear them talking about another student or something they’ve said or something that might have happened and you just feel, what if I say something and then they start talking about me?” (Participant 9)

The participants had noticed teachers sharing students’ information between themselves and in public spaces and recognised that their information would not remain private. This was expressed as a reason that adolescents felt ambivalent about turning to school staff with difficulties or distress. Participant 8 said:

> “I don't feel confidentiality talking to teachers that much because I have had experiences in the past where I've spoken to the teacher about something and they brought it up with another teacher”. (Participant 8)

As well as not feeling confident that confidentiality would be upheld, more than one participant felt that their preferences for giving personal information were not respected either:

> “I feel they’ll put that pressure on to you to try and pry it out of you and tell them what's going on at home even though you just told them that you don't feel comfortable talking about it. … [It] makes you not wanna interact with them and feel less comfortable around them.” (Participant 10)

The difficulties they had speaking with teachers affected the participants belief that they had a safe space to take problems. While some participants said they did not want to talk about personal issues with school or even with friends, others described the value of being able to talk with a trusted person. Participant 2 said:

> “sometimes we just need someone to talk to and just feel comfortable around and hopefully things will get better over time because you feel more confident.” (Participant 2)

Participant 2 is describing the benefits of a safe space as a resource to boost or support their own resilience. By failing to provide this space, the school staff were overlooking an opportunity to help students build and utilise resilience skills against stressors that might affect their mental health. Not only did the participants describe this as a lost resource, they also described how it impacted their impression of the student-teacher relationship. Participant 10 added:

“it’s almost like the teachers are another like, body of students basically like, a like, year 13 sort of standard like. You wouldn't see them as like, actual adults in that sense.” (Participant 10)

This reflection suggests that the students did not feel contained by the adults at the school and saw them as no more reliable than other students and, in fact, often actively unreliable, both in their trustworthiness with sensitive information and in the way they responded to students. The participants also talked about teachers showing favouritism, being moody and ‘switchy’ with students, being “either really nice, or really angry, but towards certain pupils” (Participant 6). It seemed that the participants did not feel that being treated fairly or equitably by their teachers was something they could count on. Participant 6 said:

“I feel like some teachers, just genuinely don't like kids. They don’t understand how we work at all and they’re just so strict and angry all the time”. (Participant 6)

The participants appeared to be describing teachers who were often angry, unpredictable and unreliable. This may relate to the observations noted in previous sub themes, that teachers are also under stress and that this may be impacting the way they relate to students at times. This is important to consider as the participants made it clear that trust and respect in their relationships with their teachers could have a significant impact on their help seeking behaviours.

3.6.2. Students Are People

The participants described feeling that the way they were treated at school by teachers who showed little interest in them ignored who they were both as adolescents on their way to becoming adults and as people aside from academic students. Participant 10 said:

“most of the other teachers who have gossiped and spoken about other students, they don't really see us as students. As teenagers, as grown teenagers that go through different phases in life” (Participant 10)

From this comment, Participant 10 demonstrates that the adolescents themselves are aware that they are at a stage of change in their development and need a different kind of relating than they did when they were younger, but suggest that their teachers are either unaware, unwilling or unable to change the way they relate to them. Participant 8 said:

> “They see us as a number, not as a person” (Participant 8).

The participants also reported that their home lives and responsibilities outside of school were often not considered, and that this added to the pressure of school and the sense that they were not viewed as complex individuals. Participant 15 said:

> “I wish they would understand that things can happen at home that directly impact our school life, and that it doesn’t help to have a teacher demanding things from you when you already have home stress” (Participant 15)

As well as describing how the lack of acknowledgement of their personhood affected them, the participants spoke emphatically about those teachers who they felt did acknowledge, understand and respect them. From these teachers, the participants said they benefitted greatly from honest, compassionate interactions that took into account their experiences and perspectives. Participant 10 said:

> “I feel like with Mr. Watson especially, he understands the mind of a student, of the teenager … he would tell us personal stories about what has happened in the past with him, and you don't really find that a lot with other teachers. Like, other teachers, will just say, ‘Oh, I went Cambridge. I got A stars, I have been a studious student, I've been perfect’ and so and put up that perfect facade. Whereas Mr Watson will show us his flaws.” (Participant 10)

The participants described wanting guidance from their teachers, but of a sort that was honest, helpful and relevant rather than pressurising. Here, the teacher’s willingness to offer a more realistic and achievable perspective on studying showed that he was thinking about his students’ experiences and, perhaps, trying to alleviate some of the pressure they felt. The participants appreciated this. Participant 15 added:

> “He understands that school is hard and that we can't always keep up with everything we’re getting given. So, say we have like, a problem with the workload or something and you tell him, he would make an effort to reduce it and understand us and adapt it to our lives.” (Participant 15)

The participants appreciated those teachers who tried to get alongside them and engage with them as people on issues other than schoolwork. Participant 6 said:

> “he also takes like more time to know us. Maybe other teachers, they won't, like, if you're doing something they wouldn't usually join in, but sometimes he might, or he just be in the background like, like having conversations with us. So he understands us more.” (Participant 6)

The participants clearly valued this positive relating and teachers taking time to get to know them was requested explicitly when the participants were asked what the school could do differently to help alleviate stress.

3.6.3. Give Students A Voice

Actively seeking and including adolescents' perspectives was also the primary suggestion for improving mental health teaching. The participants described the current teaching, via the Personal, Social, Health and Economic (PSHE) curriculum, as helpful to an extent, but said that the lessons were too didactic, the delivery too subjective and that the teachers sometimes lacked a good understanding of issues as they related to adolescents. They described how sessions "weren't necessarily built around us" (Participant 8) and said that "teachers put too much of their own opinion on things, so you never truly felt comfortable" (Participant 6). They reported feeling that what was missing was their own perspectives. Participant 6 added:

> "sometimes the school has an idea of what they think is right and what is wrong, but sometimes issues that they like, bring up are a lot more complicated. And others might have more like, depth on the idea, but you never hear about it, and if you mention it, you're dismissed". (Participant 6)

Participant 6 felt that there was insufficient space for students to express and share their thoughts during PSHE mental health lessons. When asked what the participants would choose to cover in these lessons, Participant 9 said:

> "make it like a two-way thing, so it's not just like teachers telling us, but we can also express our opinions freely about how we think they could change things or like, what we don't like in like, what they do. And then they can like, understand our perspective as well and like, improve as well."

Participant 9 makes a specific suggestion here, that incorporating feedback for teachers on how they could improve the support they offer would feel like a valuable use of mental health sessions. This supports the idea the quality of the teacher-student relationship is important for adolescent wellbeing. Participant 9 may also have been asking for greater power and agency in the relationship with this comment. As is apparent throughout the focus group data, the participants are asking for their developmental age to be properly acknowledged, particularly in the school setting, and a 16 or 17 year old adolescent will be looking for opportunities to

practice their independence and have themselves be recognised as an individual within adult society. There is also a reality about adolescents holding a certain amount of knowledge about what support they need and want, and this is echoed by other participants. Participant 14 said:

> "I think the best thing they could do is ask how they could help" (Participant 14)

The participants requests were to be given more input in an area of the curriculum where they felt their knowledge should be prioritised. In one focus group they pointed to the focus group itself as an example of the kind of space they needed. Participant 10 said:

> "more like, sessions like this, for example, I feel like would have been a more effective that PSHE" (Participant 10)

And Participant 8 added:

> "I enjoyed this, having been able to say how we're actually feeling to someone that isn't part of the school but understands how we're feeling … you understand what we're trying to say, but without us feeling afraid to say anything" (Participant 8)

Given the extent of the input as a researcher to the focus group discussions (no information was provided on any of the topics discussed and very few comments at all were made about what they said) this reflection highlights the participants' need for a space to talk from their perspectives and, perhaps, have an adult listen without judgement. It may also be that speaking to someone outside of the teaching staff (and therefore unrelated to the stressors they experienced) worked better. When it came to mental health content, one participant felt that PSHE lessons did help destigmatise mental illness and normalise distress, but several others reported feeling that more could be covered in the sessions. Participant 4 said:

> “they feel like depression is the only sort of mental health there is and personally I feel like there's a lot more that we could learn about in these sessions” (Participant 4).

As well as teaching on issues directly related to mental health, some participants reported wanting more guidance around navigating life after school – as Participant 13 said: “things you have to do when you’re an adult”. (Participant 13). They mentioned:

> “tax, and a like, after university, like do we get a job straight away or do we have to wait for like, a year or like, what do we do?” (Participant 7)

This request reflects the participants’ goals and priorities and sits with the other themes in terms of the importance of recognising what issues are relevant for adolescents and which spaces they really have where these issues are acknowledged and understood. The participants were clearly concerned about their futures, and the pressure of school targets appeared to amplify their worry both by setting unreasonable standards and by limiting the support they felt they could access from their teachers around other issues.

4. DISCUSSION

4.1. Chapter Overview

This chapter explores the results as they relate to the research questions and with reference to existing literature. This is with the aim, ultimately, of linking the findings to their clinical utility. As part of this process, the chapter considers the strengths and weaknesses of the study and so, following a discussion of the study's findings and implications, a critical review is provided before a final summary of the study.

4.2. Findings In Relation To The Research Questions And Literature

Previous research has stressed the importance of taking a preventative approach to addressing adolescent mental health and the importance of seeking adolescents' perspectives to enrich the evidence base on which mental health strategies and services are built. This research sought the views of adolescents on the things that they identified as being important for understanding and supporting their wellbeing by speaking to a non-clinical population from one London school. The study aimed to address two research questions:

a) What do young people describe as impacting their mental health and wellbeing?
b) How do young people view their school's role in supporting their mental health and wellbeing?

These questions will be discussed with reference to the themes and sub themes generated by the analysis, and in relation to the literature.

4.2.1. What Do Young People Describe As Impacting Their Mental Health And Wellbeing?

The participants' experiences and descriptions of the factors that they felt impacted their mental health and wellbeing were reflected throughout both of the main themes,

‘Meeting Expectations’ and ‘Relationships with Teachers’. They described their own personal experiences and reflected on those of their peers in discussing the stressors in their lives. They spoke in particular detail about the pressure of academic targets, their hopes and fears for themselves and their futures in a culture that often promotes unhelpful ideals, and the ways in which they did not always feel supported by the adults in their lives. Underlying these issues appeared to be a communication about the needs of a group developing their identities and the ways in which, particularly their relationships with their families, schoolteachers and wider social groups sometimes failed to accommodate or support this process, and in doing so, was a major cause of low mood, low morale, frustration and poor self-confidence.

4.2.1.1. Meeting Expectations

The participants’ described distress stemming largely from worry about the expectations they had of themselves and that they felt other people had of them. They described this stress in relation to several different but interconnected sources within this theme. In the first sub-theme ‘academic demands’, the participants reported pressure around academic work and exams as impacting their mood and, particularly around exam times, leading to overthinking, tearfulness and feeling unable to cope. They described feeling that the expectations of them set by teachers pushed them beyond their capacity both in terms of volume of work to be completed and the standards they were expected to achieve. This supports reports by UK adolescents and teachers that worry about poor grades is a common adolescent stressor (Putwain & Daly, 2014; The Key, 2017) and research linking self-reported academic-related stress with poorer mental health including low mood and anxiety (Pascoe et al., 2020). It is perhaps notable in this regard that five participants (at least 26% of the whole sample) stated in their demographics form that they had current or past experiences of mental health symptoms such low mood and anxiety, although detailed exploration of these experiences was outside the scope of this study and so cause cannot be assumed.

The participants described how their teachers' ways of communicating the expectations often contributed to the academic pressure they felt. They found it demoralising to be compared to higher performing students and felt they received little in the way of praise, encouragement or acknowledgement of their individual strengths and capacities. It may be that comparing students to more successful peers is a technique used by teachers to motivate them to work hard, but the participants' descriptions suggested that it undermined their confidence in themselves. As mentioned in the first chapter of this study, adolescents' heightened sensitivity towards social evaluation supports the idea that they would be particularly susceptible to negative evaluations by others and it may be important for schools to bear this in mind when trying to motivate adolescents in school (Somerville, 2013).

In fact, the influence of teaching and teacher-student relating on emotional wellbeing is well documented in educational and psychological literature. e.g. (Kidger et al., 2009; Murray-Harvey & Slee, 2006), and the recent focus on resilience-building in school-based mental health strategy further stresses the importance of supporting adolescents' confidence in their abilities and potential for development (Newman, 2004; Schoon & Bartley, 2008). This is not a new insight, therefore, and yet it appeared that, in this school, the teachers felt hindered in their ability to hold positive regard for the students. The participants' own reflections on this corroborate research suggesting that the pressure that teachers themselves are under to produce good exam results for their schools can limit their capacity to attend to students' emotional worlds (Cowburn & Blow, 2017). Concerns that UK schools are incentivised to operate as 'exam factories' are well documented (Hutchings, 2015) and it appeared that this was causing teachers to project their own anxious feelings (including fear of failure) into their students, who would have had a valency for identifying with the projections due to their own desire to do well (Bion, 1961).

Some of the participants reported a similar experience in their relationships with their families. They described immigrant parents' hopes that their children would benefit from educational opportunities that they didn't have putting extra pressure on them to do well, but also of their parents' projected fears and disappointments about their own failure making it difficult to feel positive and confident about their ability to do well.

In both cases, unhelpful projections from adults were having a detrimental effect on the participants' moods, morale and self-confidence. This seems an important area to consider, therefore, particularly in schools where the professional setting is intended to support and improve adolescents' wellbeing and development. The influence of parents and teachers on adolescents' psychological and emotional states aligns with Bronfenbrenner's ecological systems framework, which suggests that the more immediate micro and meso systems are likely to have the most immediate influence on children and adolescents (Bronfenbrenner, 1986). As the framework depicts, however, the participants' reflections indicates that the pressure filtering down to them through parents and teachers in fact originated in the exo and macro systems, where cultural, political and economic factors influenced the organisation of school targets and families experiences of migration. Acknowledging this pathway may help parents and teachers process or divert the anxiety they feel before it reaches adolescents.

4.2.1.2. Social Comparisons

The participants were also drawn into negative evaluation of themselves when using social media and they recognised that a degree of resilience was needed in order not to feel undermined by influencers presenting curated content of themselves as happy, successful and good looking. As discussed in chapter 1, adolescents are looking to develop their skills and identities as adults and social comparisons are a valuable means of gathering and appraising information about themselves and the world around them (Krayer et al., 2008). Social media can be a useful resource therefore, and is likely to have been particularly useful in maintaining peer relationships during the pandemic-related lockdowns (Orben et al., 2020b). However, the participants demonstrated a sophisticated understanding of how social media content could impact mental health, and how adolescents engaging with social media should moderate their use depending on their mental health and resilience, both of which they understood could change in status over time and between people. This perhaps draws further attention to the instances when their teachers or parents

make unhelpful comparisons, for instance, in school lessons, and adolescents are unable to avoid or disengage with them.

4.2.1.2.1. Extra-curricular activities

The participants described participating in extra-curricular activities, such as playing sports and video games, listening to music and socialising with their friends, as times where they were less likely to be focusing on comparisons with others. These were activities they said they enjoyed and used to help reduce stress, although some of the participants said that they provided only temporary relief, and/or were sometimes difficult to fully enjoy because of intrusive worry about schoolwork.

Nevertheless, allowing sufficient opportunities for play and socialising are considered important aspects of a school curriculum (Newman, 2004). Research indicates positive links between physical exercise and mental state (Zhang et al., 2020), and the benefits of play are considered important for children's physical, social and emotional development even into their adolescent years (Eccles & Roeser, 2011). Although evidence for the protective effects of physical exercise on academic stress specifically is not conclusive (Gerber & Pühse, 2008; Norris et al., 1992) the participants at this school described that both time and physical space for non-academic activities were limited (the school did not appear to have sufficient outside space for sports, play or just getting away from the classroom) and that this made them feel stressed and frustrated. Adams and Marshall (1996) note that autonomy and self-determination are a key function of identity and it is possible that the self-directed nature of extra-curricular activities was an important aspect of their appeal and ability to relieve stress. Again, having such narrow focus on academic grades may have contributed here to schools overlooking children and adolescents' needs for a variety of physically, creatively and socially stimulating activities. It may be important to think about how the design of inner-city schools that have limited outside space may reinforce this mindset, as teachers as well as students are limited in their opportunities to escape the classroom.

4.2.1.3. Relationships With Teachers, Parents And Wider Society

As well as contributing to particular worries or expectations that adolescents had about themselves, the participants' accounts of positive and negative interactions with their teachers, families and with wider societal attitudes, indicated that meaningful and compassionate relating with older generations of adults (or lack of it) had a significant impact on their mood and wellbeing.

Several participants felt that the majority of their teachers showed little interest in them as people, aside from their academic performance, and said that this left them feeling unseen and misunderstood. This is supported by findings that young people see caring teachers as those who show an interest in students on a personal level (Ferreira & Bosworth, 2001) and that relationships with teachers are closely linked to happiness (life satisfaction) and sense of engagement and belonging at school (OECD, 2017; Suldo et al., 2013).

While it might not be surprising that students of caring teachers are more likely to feel happy and engaged at school, being recognised as an individual and as a valued member of a group becomes especially important during adolescence. As discussed in the introduction, the transition from child roles and identities to adult ones is a gradual process of active acquisition, adaptation and redefinition of skills and traits (Marcia, 1980) and the literature commonly stresses the importance of being individually and collectively recognised and accepted by others during this process, of mattering to others, and of being able to exercise autonomy (Adams & Marshall, 1996; Erikson, 1964). The extent to which sense of belonging and engagement have an impact on adolescent happiness and life satisfaction is likely to be very significant, therefore, as is having sufficient opportunities to direct the use of their own time and activities.

Additionally, while studies have demonstrated the influence of peer judgements on adolescent behaviour (Gardner & Steinberg, 2005) the participants' descriptions of their perception that the adults in their lives did not understand them well or held

negative attitudes towards them indicates that adolescents are not only concerned with what their peers think of them. The participants reported that it was simply easier to relate to people their own age because adults seemed not to understand their experiences. It is possible that the participants felt unable to talk about peer evaluation given the focus group setting, but the apparent importance of positive regard and feeling understood by adults is also supported by research into the links between feeling understood, self-esteem and mental health (Mann et al., 2004). This demonstrates a common thread throughout the issues that participants raised; that the process of adolescent identity formation and psychological development is significantly affected by the relationships and interactions with the adults in their lives, including teachers, and that adult support and compassionate understanding is extremely important during this stage (García-Moya et al., 2020).

More broadly, Self Determination Theory (SDT) posits that humans have a basic psychological need for a sense of their own competence, sufficient (and developmentally appropriate) choice and autonomy and meaningful relatedness with others to enable psychological development (Deci & Ryan, 2012). These needs align almost exactly with the participants' descriptions of what they felt they lacked at school and what caused them distress. While Baker et al. (2003) discuss these needs in relation to children's development and as key features that positive school environments foster, Deci & Ryan propose that they are fundamental to all people across the life span (Deci & Ryan, 2012), suggesting that it is not only adolescent specific needs that the participants' describe not being met, but fundamental human ones.

It was interesting to note the issues that the participants spoke less about in the focus groups. Whilst the pandemic will have had had a huge practical impact on the participants' lives at the time of the focus groups, they spoke very little about covid. One participant reported finding it difficult that they felt a greater obligation not to socialise with peers because their parents were more vulnerable, and some participants mentioned briefly the worry that the pandemic might affect job availability for them in the future, but comparatively little time was spent on this topic, compared with those mentioned in the themes and subthemes. Similarly, while racism was mentioned in one focus group, again in relation to job future prospects, other

prominent issues such as Brexit and climate change, that might affect young people, were not mentioned at all. It may be that repeated focus groups would touch on these topics more – an hour and a half is unlikely to be long enough to cover everything – but it also reinforces the importance of having these conversations with adolescents (and regularly) rather than making assumptions about what issues are of greatest importance for them.

4.2.2. How Do Young People View Their School's Role In Supporting Their Mental Health And Wellbeing?

The participants' views about their school's role in supporting their mental health and wellbeing were clear and consistent across the focus groups. All focus groups said that the best thing the school could do to support them was to improve the way staff related to students. This further supports the discussion about adolescent development and basic psychological needs.

4.2.2.1. Trust And Respect

The participants described holding ambivalent views about the support available at school in relation to mental health and wellbeing. Many felt that they could not trust their teachers to understand them, respect their privacy or boundaries around information sharing, or show them genuine compassion or respect, and so they did not feel able to rely on the school to support their mental health or wellbeing. For a space to feel safe to express thoughts and feelings in, and for the space to be perceived as helpful, it needs to be seen as reliably providing confidentiality, non-judgemental listening and the ability to contain emotions. The lack of these foundational aspects is incompatible with an attempt to be positioned as a resource or point of contact for adolescents struggling with mental health, and undermines a whole school approach to improving mental health and wellbeing (House of Commons et al., 2017).

Several studies emphasis the role of peer support and learning in relation to mental health and help seeking behaviours, based on the idea that adolescents are more

oriented toward their peers' opinions (Atkinson et al., 2019; Orben et al., 2020a). Again, however, this study's findings suggest that the poor quality of support and relating with adults may be another salient factor in adolescents' apparent preference for peer support.

Training teachers to provide confidential spaces for students would not be difficult. However, it might highlight a question about the extent to which teachers can be expected to hold the role of mental health support for students. Particularly as the participants identified academic targets as a key source of distress, teachers may find it hard to support adolescents with academic stress while their primary role is to be setting work for students.

More broadly, however, the issue of lack of trust and respect between students and teachers indicates a need for schools to better acknowledge and respond to the psycho-social needs of students, particularly at this developmental stage. One participant's reflection that "sometimes we just need someone to talk to and just feel comfortable around and hopefully things will get better over time because you feel more confident" demonstrates that adolescents at this stage are often aware of their own resilience and are simply looking for adults to support them in building it and feeling confident drawing on it (Fergus & Zimmerman, 2005; Schoon et al., 2004).

This supports Carter and McGoldrick's (2005) conception of adolescence as necessarily involving adults gradually loosening the boundaries around children and increasingly respecting their skills and need for autonomy. The participant's comment also suggests that the requirements for adults supporting adolescents' mental health may not, in many cases, be onerous, or require complex skills, although knowing this and how to apply skills in listening and containing can still require guidance.

4.2.2.2. Students Are People

The participants described their schools' failings with regards to positive relating as a loss, and they expressed the value they got from those teachers who they felt did

relate well with them. From these teachers, they described feeling recognised and acknowledged as people and as growing adults. It was clear how much they enjoyed positive interactions. For instance, one participant related having given a teacher a gift and that teacher showing them whenever they used it. The participant was describing feeling respected by the teacher because something they offered had mattered and been shown to be of value in an adult social setting. As already discussed, recognition by others during adolescence supports identity formation and resilience building. Feeling acceptance and approval from teachers as key adults that adolescents interact with is demonstrably important, and builds on similar research undertaken recently in which British and Spanish adolescents stressed the importance of humanising aspects of teacher-student relationships (García-Moya et al., 2020).

The participants also described valuing their teachers' honest and realistic accounts of their own goals and achievements. This could be seen to link to descriptions of identity formation as a process of curation by the individual from selected features of past and idealised future identities and drawing from aspects of leaders, peers and idols in their lives (Adams & Marshall, 1996; Erikson, 1964, 1968; Marcia, 1980). The participants appreciated realistic guidance and modelling of what they could achieve, therefore, and valued teachers who were honest and relatable. A participant's description of the teaching body as "another body of students basically, [of a] year 13 sort of standard" and that "you wouldn't see them as like, actual adults in that sense" suggests that they don't see many of their teachers as honest, relatable or aspirational, and that this was felt as a loss.

4.2.2.3. Giving Students A Voice

In line with the common thread of this study's findings, the participants reported that being included and having their perspective sought and acknowledged in lessons about mental health would improve the relevance and utility of these sessions. Some participants reported that PSHE lessons addressing mental health had been valuable in helping normalise distress and provide information on common types of psychological and emotional distress and how to access support for them. However,

other participants felt that the sessions were limited on these subjects and there was broad agreement that didactic sessions that did not seek adolescents' views often felt irrelevant and even dismissive of adolescent issues. Some participants also felt that more guidance on how to navigate aspects of post-school adult life would be of benefit. These insights provide valuable data that can be used to inform the design of teaching materials to guide schools in how to deliver the aims set out in the 2017 *Transforming Children and Young People's Mental Health Provision* green paper (Department of Health and Department for Education, 2017).

Further, they indicate core features of how to deliver a whole school approach to mental health support. Wilson and Deane (2012) discuss adolescents' increased need for autonomy as a potential barrier to mental health help seeking behaviour and, while it is true that some of the participants in this study said that they preferred not to seek help with personal issues, others highlighted the focus group itself as the kind of space that enabled them to feel seen and heard by adults. As previously mentioned, the focus group facilitation aimed not to lead or bias the participants' responses and so researcher reflections and comments were kept to an absolute minimum. Yet, one participant said of the facilitation "you understand what we're trying to say, but without us feeling afraid to say anything". By providing only enough gentle encouragement for participants to keep talking on their own terms, the facilitated space enabled them to feel that their voices were being actively listened to without judgement. They had felt that they mattered in that space, and this was what they described was missing in their relationships with most of their teachers and in their PSHE lessons.

These findings support the use of qualitative methodology in research about adolescents but also highlight a key resource to addressing the problems adolescents report. Providing open spaces for adolescents to talk and be heard would require little or no additional training for teachers, nor the development of curriculums or teaching programs. It would be a low (or no) cost way of both facilitating learning about mental health and the single most useful way of improving it, according to adolescents themselves.

4.3. Implications For Practice

4.3.1. Respecting Adolescents In School

The current strategy for preventing and supporting adolescent wellbeing encourages schools to teach emotional resilience and support adolescents' psychological wellbeing through a whole school approach to mental health. The guidelines on exactly how to do this have been vague, however, leaving schools and teachers feeling unclear and ill equipped.

The findings of this study suggest that giving students more opportunities to explore topics of their own choosing with staff who were able to facilitate such discussions would help students feel listened to and their viewpoints respected and would help them feel connected to and included in decisions made about them. The participants suggested that the focus group-style format itself (i.e. an open space for adolescents to talk about the things they identify as being important) could provide a guide for schools in how to facilitate this kind of space in PSHE lessons. If utilised, this may help address problems with mood, morale and self-confidence, possibly reducing the numbers of adolescents whose mental health deteriorates and encouraging help seeking behaviours.

4.3.2. Ensuring Safe Space To Talk

Of course, not all distress can be prevented and when adolescents are struggling, they need safe and supportive people to turn to. This study highlights the importance for school staff to respect adolescents' confidentiality and boundaries around information sharing to support help-seeking behaviour.

The study raises a question about the appropriateness of the teachers' role in supporting mental health (particularly within the context of the existing pressure on teachers) that requires further exploration. However, guidance on the how to maintain confidentiality and the links between emotional wellbeing, teaching and student-teacher relating (Kidger et al., 2009), may help teachers feel more confident

in providing safe and supportive spaces. This could be disseminated by school mental health leads as part of the strategy on how to build a whole school approach to mental health and a positive school climate.

4.3.3. Supporting Teacher Wellbeing

The findings suggested that the pressure of school targets on teachers may have contributed to the poor relating with students that was reported by the participants. This supports studies of teacher perspective that suggest that teachers often feel under-equipped to support student's emotional wellbeing. Addressing teacher stress and anxiety - likely related to lack of resources and/or performance targets (The Key, 2017) – may also be needed for teachers to feel they have the capacity for curiosity about adolescents' emotional worlds and to manage and contain adolescents' feelings (Menzies, 1960). This points to consideration of resourcing and funding of schools and to a review of the targets and methods by which schools are evaluated.

4.4. Implications For Research

This study was undertaken in one London school in a borough whose context (economic, environmental and social) does not necessarily represent all boroughs in London or all local authorities in the UK. Therefore, with regards to generalisability of findings and utility for services, local authorities and government strategists and policy makers, the sample could be considered to have been small and the generalisability limited. The study's findings suggests that research of this kind is acceptable to the participants and helped them feel heard, understood and valued. It may be useful, therefore, to repeat the study and use a wider sample (that includes more schools in the borough) in order to improve the robustness of the findings.

Research of this nature that was conducted more widely and repeated (perhaps every two or three years, or more frequently if resources allowed) as part of the strategy for tackling mental health in school settings would be likely to capture a rich and diverse range of views and perspectives. This data could provide schools, local authorities, and NHS services with up-to-date data on adolescents' needs, difficulties

and strengths that could not only inform genuinely preventative interventions, but that constitute a preventative intervention in itself.

Consideration of whether this could be undertaken by internal or external researchers highlights costs and benefits of both options. The research suggests that if teachers were to facilitate the focus groups, it might help improve teacher-student relating and disrupt unhelpful processes of projection through curious engagement with adolescents' experiences. However, undertaking the analysis, write up and work involved in organising an publishing the research would certainly be beyond the capacity of teachers who are already over worked and under resourced. Additionally, it could present an extra emotional burden for teachers if they were required contain distressed adolescents' thoughts and feelings whilst managing their own. Further still, adolescents may, in fact, prefer reflecting with someone outside of the academic staff. It may be more feasible for an existing counsellor situated in the school, the appointed mental health lead, or a member of the school's linked mental health team to undertake the research, either entirely or as part of a team including teachers so that teachers were not over-burdened with the task – certainly of analysis and dissemination, the latter of which could, perhaps, be done via a student-teacher forum following write up. This may also help build rapport and trust between adolescents and mental health teams, which could help facilitate help seeking behaviour. It may also help inform the frameworks of support that mental health teams linked to schools are in the process of building.

Greater involvement of adolescents in the research process could also reap further benefits. A Participatory, Action Research (PAR) approach may help facilitate the communication of adolescent views and the translation of them into action, supporting adolescents' need for relatedness, autonomy and sense of competence and encouraging the adults supporting them to adapt the way they relate to adolescents (Baum et al., 2006). This has been done in other studies with good results (Atkinson et al., 2019).

However, the major strength of this research appeared to be the process of allowing adolescents to talk on the topics that they chose, and for their views and opinions to be heard. As this is both scarce in the literature, and reportedly lacking in

adolescents' lives, the primary recommendation for further research is to repeat this study within communities using bigger samples to build on the existing evidence base.

4.5. Critical Review

This section offers a critical review of the study. Yardley (2017) suggests that guidance on demonstrating validity in qualitative research written in recent decades broadly agrees that the key dimensions to consider are sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. The review will follow this guidance and will end with a discussion of the study's limitations.

4.5.1. Sensitivity To Context

The research aimed to prioritise the participants' perspectives by considering their social, cultural and developmental context and adapting the research protocols accordingly wherever possible. For instance, young people were consulted at the research design stage and when devising the focus group prompts. The feedback the consultants offered guided the sampling method, where and when the focus groups were held and the kinds of questions and the language used in the focus group discussion prompts. It was hoped that these actions would also help minimise the inherent researcher-participant power difference and prize-draw remuneration for the participants' time was provided for this reason also.

Additionally, the write up of this study has aimed to be reflective and transparent about the researcher's own context and the ways in which it will have influenced the collection and interpretation of the data. The researcher kept a reflective long throughout data collection and analysis and extracts from this can be found in Appendix K. The limitations section of this review also speaks to this.

4.5.2. Commitment And Rigour

In order to ensure rigour, the study design and implementation was grounded in literature on how to conduct qualitative research and how to undertake thematic analysis (Braun & Clarke, 2006). The researcher was committed to prioritising the voices of the participants and made every effort to afford them the space and opportunity to share what was important to them. Their words were incorporated wherever possible in the analysis and descriptions of the themes.

4.5.3. Coherence And Transparency

In order to present a coherent account of the research undertaken, the methodology and results sections (chapters two and three), document the process of research design, data collection and analysis. Extracts from the researcher's reflective log, and the stages of analysis are included in the appendices for further transparency. The limitations section (following) also aims to help situate this research and guide consideration of its findings.

4.5.4. Impact And Importance

This study gathered rich insights from adolescent participants, shedding light on what issues were currently affecting them and what support they felt was most helpful from their school. The study achieved it's aims, therefore, and demonstrated that qualitative research of this kind is possible, inexpensive and that adolescents were not only amenable to taking part, but felt they benefited from the process. This information is of direct and immediate utility to those involved in supporting adolescents in schools or designing strategies to address adolescent mental health.

4.5.5. Limitations

Due to social distancing rules during the pandemic, the researcher had less control over the focus group location and space than anticipated. The groups had to be held remotely via video/audio call and, while it was hoped that the online setting might

turn out to provide a less threatening space to talk and make it easier for participants to feel able to leave at any point if they wanted to, it presented a challenge to the 'ethics in practice' as the researcher was unable to observe facial expressions and body language and respond to any distress that might have been visible but not audible (Guillemin & Gillam, 2004).

Further, as social distancing rules for schools changed over the months of 2020 (from remote teaching back to face-to-face), the location changed for each of the groups held. The first focus group was conducted when schools were operating remotely so participants were located in their own homes at this time, whereas the second and third groups were conducted when schools had returned to face-to-face teaching and so the participants were together at school while the researcher facilitated remotely (the researcher was not permitted to attend the school due to the school's social distancing policy). The researcher was less able to influence the creation of a 'safe space' to talk in, therefore, and was reliant on the quality of the technology available to the participants (including internet connection and computer microphones) to facilitate the groups well. For the researcher trying to facilitate, this felt challenging at times because there may have been things they were not picking up on in the participants' behaviour that may have influenced either the smooth running of the conversation or the perceived meaning of their responses. However, the researcher's sense of control over the space should not necessarily be the priority and the participants may not have found the set up to have been challenging. It might have been interesting and useful to have explored their experience of the group more, however.

The open discussion nature of the focus group format may have influenced the topics that the participants chose to discuss. They may not, for instance, have felt comfortable talking about the impact of peer relationships on mental health or wellbeing in front of their peers. Recruiting participants from different schools who did not know each other may have made it easier for participants to express their views but may also have hindered discussion about shared perspectives on their school's practices.

Similarly, the participants' reflected that mental health stigma can prevent adolescents feeling able to share their feelings with others. It is possible, therefore, that people with experience of more severe mental heal th symptoms may have chosen not to share their perspectives, or take part in the research at all.

4.6. Conclusion

This study explored the views of adolescents at one London school on the issues affecting their mental health, and how they perceived their school's role in supporting them. The study aimed to address the paucity of recent research exploring adolescent identified issues and ideas, to inform relevant strategy, service and curriculum design.

Two main themes were generated using TA; 'Meeting Expectations' (containing the sub themes Academic Demands, Generational Differences, Social Comparisons) and 'Relationships with Teachers', (containing the sub themes Trust and Respect, Students Are People, Give Students a Voice).

A common thread in both themes indicated that participants felt under-supported in their development of self and identity by the adults in their lives, whose ways of relating to them often undermined their confidence in themselves and hindered help-seeking behaviour. This highlights the importance of adult support in adolescent development and resilience building.

An unexpected outcome of the study was that the study itself modelled the utility of these findings, as the participants identified the experience of being asked what they think and listened to as an example of the kind of support that they would value most from their school.

Therefore, the study recommends that this kind of research is conducted regularly with school populations to better understand current issues affecting adolescents, and that the focus group structure and principles be used to inform both mental health teaching and teacher-student relating in schools.

5. REFERENCES

Adams, G., & Marshall, S. (1996). A developmental social psychology of identity: Understanding the person-in-context. *Journal of Adolescence*, *19*, 429–442.

Adler, K., Salanterä, S., & Zumstein-Shaha, M. (2019). Focus Group Interviews in Child, Youth, and Parent Research: An Integrative Literature Review. *International Journal of Qualitative Methods*, *18*, 1609406919887274. https://doi.org/10.1177/1609406919887274

Allam, S., Blyth, S., Fraser, A., Hodgson, S., Howes, J., Repper, J., & Newman, A. (2004). Our experience of collaborative research: Service users, carers and researchers work together to evaluate an assertive outreach service. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 368–373. https://doi.org/10.1111/j.1365-2850.2004.00755.x

Amato, P. R. (2000). The Consequences of Divorce for Adults and Children. *Journal of Marriage and Family*, *62*(4), 1269–1287. https://doi.org/10.1111/j.1741-3737.2000.01269.x

Andrews, A., McCabe, M., & Wideman-Johnston, T. (2014). Mental health issues in the schools: Are educators prepared? *The Journal of Mental Health Training, Education and Practice*, *9*(4), 261–272. https://doi.org/10.1108/JMHTEP-11-2013-0034

Arango, C., Díaz-Caneja, C. M., McGorry, P. D., Rapoport, J., Sommer, I. E., Vorstman, J. A., McDaid, D., Marín, O., Serrano-Drozdowskyj, E., Freedman, R., & Carpenter, W. (2018). Preventive strategies for mental health. *The Lancet Psychiatry*, *5*(7), 591–604. https://doi.org/10.1016/S2215-0366(18)30057-9

Aristotle. (350 C.E.). *Rhetoric: Book 2. Chapter 12* (J. H. Freese, Trans.). Harvard University Press; William Heinemann Ltd. http://classics.mit.edu/Aristotle/rhetoric.2.ii.html

Arnett, J. J. (1999). Adolescent Storm and Stress, Reconsidered. *American Psychologist*, 10.

Atkinson, C., Thomas, G., Goodhall, N., Barker, L., Healey, I., Wilkinson, L., & Ogunmyiwa, J. (2019). Developing a student-led school mental health strategy. *Pastoral Care in Education*, *37*(1), 3–25. https://doi.org/10.1080/02643944.2019.1570545

Bachman, J. G., & Schulenberg, J. (1993). How Part-Time Work Intensity Relates to Drug Use, Problem Behavior, Time Use, and Satisfaction among High School Seniors: Are These Consequences or Merely Correlates? *Developmental Psychology*, *29*(2), 220–235.

Baker, J., Dilly, L., Aupperlee, J., & Patil, S. (2003). The Developmental Context of School Satisfaction: Schools as Psychologically Healthy Environments. *School Psychology Quarterly*, *18*, 206–221. https://doi.org/10.1521/scpq.18.2.206.21861

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854–857. https://doi.org/10.1136/jech.2004.028662

Behere, A. P., Basnet, P., & Campbell, P. (2017). Effects of Family Structure on Mental Health of Children: A Preliminary Study. *Indian Journal of Psychological Medicine*, *39*(4), 457–463. https://doi.org/10.4103/0253-7176.211767

Bentall, R., & Pilgrim, D. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, *8*(3), 261–274. https://doi.org/10.1080/09638239917427

Bhaskar, R. (2008). *A realist theory of science*. Routledge.

Bignardi, G., Dalmaijer, E., Anwyl-Irvine, A., Smith, T. A., Siugzdaite, R., Uh, S., & Astle, D. (2020). *Longitudinal increases in childhood depression during the COVID-19 lockdown in a UK cohort*. OSF Preprints. https://doi.org/10.31219/osf.io/v7f3q

Bion, W. (1961). *Experiences in Groups and Other Papers*. Tavistock Publications Limited.

Blakemore, S.-J. (2018). *Inventing Ourselves: The Secret Life of the Teenage Brain*. Transworld.

Blakemore, S.-J., & Mills, K. (2013). Is Adolescence a Sensitive Period for Sociocultural Processing? *Annual Review of Psychology*, *65*. https://doi.org/10.1146/annurev-psych-010213-115202

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development* (1998-08155-000). Sage Publications, Inc.

Boyle, M. (2011). Making the World Go Away, and How Psychology and Psychiatry Benefit. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition* (pp. 27–43). Palgrave Macmillan UK. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=797941

Brady, J., & Wilson, E. (2021). Comparing sources of stress for state and private school teachers in England. *Improving Schools*, 13654802211024758. https://doi.org/10.1177/13654802211024758

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). *Thematic analysis.* (pp. 57–71).

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*.

British Psychological Society. (2014). *BPS Code of Human Research Ethics*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

British Psychological Society. (2017). *Ethics Guidelines for Internet-mediated Research.* www.bps.org.uk/publications/policy-and-guidelines/ research-guidelines-policy-documents/researchguidelines-policy

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, *22*(6), 723. https://doi.org/10.1037/0012-1649.22.6.723

Brooks-Gunn, J., & Reiter, E. O. (1990). The Role of Pubertal Processes. In S. S. Feldman & G. R. Elliott (Eds.), *At the Threshold: The Developing Adolescent* (pp. 16–53). Harvard University Press.

Buchanan, M. (2016, March 8). NHS child mental health money 'missing' despite investment. *BBC News*. https://www.bbc.co.uk/news/health-35747167

Burr, V. (2003). *Social Constructionism*. Routledge. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=199330

Byrne, D. G., Davenport, S. C., & Mazanov, J. (2007). Profiles of adolescent stress: The development of the adolescent stress questionnaire (ASQ). *Journal of*

Adolescence, *30*(3), 393–416. https://doi.org/10.1016/j.adolescence.2006.04.004

Callaghan, J., Fellin, L., & Warner-Gale, F. (2016). A critical analysis of Child and Adolescent Mental Health Services policy in England. *Clinical Child Psychology and Psychiatry*, *22*. https://doi.org/10.1177/1359104516640318

Campbell, D. (2021). Extent of mental health crisis in England at 'terrifying' level. *The Guardian*. http://www.theguardian.com/uk-news/2021/apr/09/extent-of-mental-health-crisis-in-england-at-terrifying-level

Campion, J., Coombes, C., & Bhaduri, N. (2017). Mental health coverage in needs assessments and associated opportunities. *Journal of Public Health*, *39*(4), 813–820. https://doi.org/10.1093/pubmed/fdw125

Care Quality Commission. (2018). *Are we listening? A review of children and young people's mental health services*. https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services

Carter, B., & McGoldrick, M. (1988). *The Changing Family Life Cycle: Framework for Farmily Therapy*. Gardner Press.

Carter, E. A., & McGoldrick, M. (Eds.). (2005). *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., classic ed). Pearson Allyn & Bacon.

Children and Young People's Mental Health Coalition, Fair Education Alliance, & Partnership for Wellbeing and Mental Health in Schools. (n.d.). *Transforming Children and Young People's Mental Health Provision; A response from the Partnership for Wellbeing and Mental Health in Schools, the Fair Education Alliance and the Children and Young People's Mental Health Coalition*.

Children's Commissioner. (2017). *Briefing: Children's Mental Healthcare in England: October 2017*. Children's Commissioner. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf

Children's Commissioner for England. (2020, April 21). *Business plan 2020-21*. Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/about-us/corporate-governance/business-plan-2020-21/

Churchill, H. (2018). How austerity has hurt children in need. *Social Policy Association*. http://www.social-policy.org.uk/50-for-50/austerity-children/

Clarkson, L. (2019). Young People's Mental Health Is Deteriorating. Here's Why It Matters To Us All. *HuffPost UK*. https://www.huffingtonpost.co.uk/entry/young-people-mental-health_uk_5d1b7903e4b03d611642cda1

Collishaw, S., Maughan, B., Goodman, R., & Pickles, A. (2004). Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry*, *45*(8), 1350–1362. https://doi.org/10.1111/j.1469-7610.2004.00335.x

Collishaw, S., Maughan, B., Natarajan, L., & Pickles, A. (2010). Trends in adolescent emotional problems in England: A comparison of two national cohorts twenty years apart. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *51*, 885–894. https://doi.org/10.1111/j.1469-7610.2010.02252.x

Cooley, C. H. (1992). *Human Nature and the Social Order*. Transaction Publishers.

Cowburn, A., & Blow, M. (2017). *Wise Up To Wellbeing In Schools*. Young Minds. https://youngminds.org.uk/media/1428/wise-up-prioritising-wellbeing-in-schools.pdf

Crawley, E., Loades, M., Feder, G., Logan, S., Redwood, S., & Macleod, J. (2020). Wider Collateral Damage to Children in the UK Because of the Social Distancing Measures Designed to Reduce the Impact of COVID-19 in Adults. *BMJ Paediatrics Open*, *4*(1). https://doi.org/10.1136/bmjpo-2020-000701

Crockett, L. (1997). Cultural, Historical, and Subcultural Contexts of Adolescence: Implications for Health and Development. *Faculty Publications, Department of Psychology*, *244*. https://digitalcommons.unl.edu/psychfacpub/244

Crockett, L., & Silbereisen, R. (2000). *Negotiating Adolescence in Times of Social Change*.

Curtis, A. C. (2015). Defining adolescence. *Journal of Adolescent and Family Health*, *7*(2), 40.

Davies, C. (2018, June 24). Mental health services for the young is NHS's 'silent catastrophe'. *The Guardian*. https://www.theguardian.com/society/2018/jun/25/mental-health-services-young-nhs-silent-catastrophe-survey-chronic-underfunding

Deci, E. L., & Ryan, R. M. (2012). Self-Determination Theory. In *Handbook of Theories of Social Psychology: Volume 1* (Vol. 1–1, pp. 416–437). SAGE Publications Ltd. https://doi.org/10.4135/9781446249215

Department for Education. (2018). *Mental health and behaviour in schools* (p. 34). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755135/Mental_health_and_behaviour_in_schools__.pdf

Department of Health & Social Care. (2019). *Advancing our Health: Prevention in the 2020s*.

Department of Health and Department for Education. (2017). *Transforming Children and Young People's Mental Health Provision: A Green Paper*.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

Department of Health and NHS England. (2015). *Future in Mind—Promoting, protecting and improving our children and young people's mental health and wellbeing*. Department of Health and NHS England.

Department of Health and Social Care and the Department of Education. (2018). *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps*. Department of Health and Social Care and the Department of Education.

Eccles, J. S., & Roeser, R. W. (2011). Schools as Developmental Contexts During Adolescence. *Journal of Research on Adolescence*, *21*(1), 225–241. https://doi.org/10.1111/j.1532-7795.2010.00725.x

Eckersley, R., & Dear, K. (2002). Cultural correlates of youth suicide. *Social Science & Medicine*, *55*(11), 1891–1904. https://doi.org/10.1016/S0277-9536(01)00319-7

Education and Health and Social Care Committees. (2018). *The Government's Green Paper on mental health: Failing a generation*. House of Commons. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/642.pdf

Equality and Human Rights Commission. (2016). *Healing a Divided Britain: The need for a comprehensive race equality strategy*. Equality and Human Rights Commission. https://www.equalityhumanrights.com/sites/default/files/healing_a_divided_britain_-_the_need_for_a_comprehensive_race_equality_strategy_final.pdf

Erikson, E. (1964). *Insight and Responsibility*.

Erikson, E. (1968). *Identity: Youth and Crisis*. W.W. Norton & Company.

Faulkner, A. (2012). Participation and Service User Involvement. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy a guide for students and practitioners* (pp. 39–55). Wiley-Blackwell.

Fergus, S., & Zimmerman, M. A. (2005). Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk. *Annual Review of Public Health*, *26*(1), 399–419. https://doi.org/10.1146/annurev.publhealth.26.021304.144357

Ferreira, M. M., & Bosworth, K. (2001). Defining caring teachers: Adolescents' perspectives. *Journal of Classroom Interaction*, *36*(1), 24–30.

Fink, E., Patalay, P., Sharpe, H., Holley, S., Deighton, J., & Wolpert, M. (2015). Mental Health Difficulties in Early Adolescence: A Comparison of Two Cross-Sectional Studies in England From 2009 to 2014. *Journal of Adolescent Health*, *56*(5), 502–507. https://doi.org/10.1016/j.jadohealth.2015.01.023

Ford, T. (2018, August 7). Does mental health awareness do more harm than good? A response from Prof Tamsin Ford to The Spectator. *ACAMH*. https://www.acamh.org/blog/mental-health-awareness-harm-good/

Ford, T., John, A., & Gunnell, D. (2021). Mental Health of Children and Young People During Pandemic. *BMJ*, *372*. https://doi.org/10.1136/bmj.n614

Fossey, E., Epstein, M., Findlay, R., Plant, G., & Harvey, C. (2002). Creating a positive experience of research for people with psychiatric disabilities by sharing feedback. *Psychiatric Rehabilitation Journal*, *25*(4), 369–378. https://doi.org/10.1037/h0095000

Frith, E. (2016). *Young People's Mental Health: Time to Deliver*. https://epi.org.uk/publications-and-research/children-young-peoples-mental-health-time-deliver/

Fuggle, P., Bevington, D., Duffy, F., & Cracknell, L. (2016). The AMBIT approach: Working with hard to reach youth. *Mental Health Review Journal*, *21*, 61–72. https://doi.org/10.1108/MHRJ-04-2015-0012

García-Moya, I., Brooks, F., & Moreno, C. (2020). Humanizing and conducive to learning: An adolescent students' perspective on the central attributes of positive relationships with teachers. *European Journal of Psychology of Education*, *35*(1), 1–20. https://doi.org/10.1007/s10212-019-00413-z

Gardner, M., & Steinberg, L. (2005). Peer influence on risk taking, risk preference, and risky decision making in adolescence and adulthood: An experimental study. *Developmental Psychology,* 625–635.

Gerber, M., & Pühse, U. (2008). "Don't crack under pressure!"—Do leisure time physical activity and self-esteem moderate the relationship between school-based stress and psychosomatic complaints? *Journal of Psychosomatic Research*, *65*(4), 363–369. https://doi.org/10.1016/j.jpsychores.2008.06.012

Glaser, B. G., Strauss, A. L., & Struzel, E. (1967). *The Discovery of Grounded Theory: Strategies For Qualitative Research.* Aldine Publishing.

Gov.uk. (2019). *Stop and search*. https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/stop-and-search/latest

Gov.uk. (2020). *Training Module: Teaching Mental Wellbeing*. https://www.gov.uk/guidance/teaching-about-mental-wellbeing

Graber, J. A., & Brooks-Gunn, J. (1996). Transitions and turning points: Navigating the passage from childhood through adolescence. *Developmental Psychology*, *32*(4), 768. https://doi.org/10.1037/0012-1649.32.4.768

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental Health of Children and Young People in Great Britain, 2004: (557702010-001)* [Data set]. American Psychological Association. https://doi.org/10.1037/e557702010-001

Greenberger, E. (1986). *When Teenagers Work: The Psychological and Social Costs of Adolescent Employment*. Basic Books.

Grierson, J. (2020, December 21). Nine out of 10 children on remand in London come from BAME background. *The Guardian*. https://www.theguardian.com/society/2020/dec/21/nine-out-of-10-children-on-remand-in-london-come-from-bame-background

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough? *Field Methods - FIELD METHOD*, *18*, 59–82. https://doi.org/10.1177/1525822X05279903

Guest, G., Namey, E., & Mckenna, K. (2016). How Many Focus Groups Are Enough? Building an Evidence Base for Nonprobability Sample Sizes. *Field Methods*, *29*. https://doi.org/10.1177/1525822X16639015

Guillemin, M., & Gillam, L. (2004). Ethics, Reflexivity, and "Ethically Important Moments" in Research. *Qualitative Inquiry*, *10*, 261–280. https://doi.org/10.1177/1077800403262360

Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *BMJ*, *361*. https://doi.org/10.1136/bmj.k2608

Guyon, H., Kop, J.-L., Juhel, J., & Falissard, B. (2018). Measurement, ontology, and epistemology: Psychology needs pragmatism-realism. *Theory & Psychology*, *28*(2), 149–171. https://doi.org/10.1177/0959354318761606

Hall, G. S. (1904). *Adolescence its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion and education,*. D. Appleton and Co.

Harper, D. (2012). Choosing a Qualitative Research Method. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy a guide for students and practitioners* (pp. 83–99). Wiley-Blackwell.

Harrison, J., MacGibbon, L., & Morton, M. (2001). Regimes of Trustworthiness in Qualitative Research: The Rigors of Reciprocity. *Qualitative Inquiry - QUAL INQ*, *7*, 323–345. https://doi.org/10.1177/107780040100700305

Hatch, S. L., Woodhead, C., Frissa, S., Fear, N. T., Verdecchia, M., Stewart, R., Reichenberg, A., Morgan, C., Bebbington, P., McManus, S., Brugha, T., Kankulu, B., Clark, J. L., Gazard, B., Medcalf, R., & Hotopf, M. (2012). Importance of thinking locally for mental health: Data from cross-sectional surveys representing South East London and England. *PLoS ONE*, *7*(12). https://doi.org/10.1371/journal.pone.0048012

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology: Theory & Practice*, *12*(4), 335–344. https://doi.org/10.1080/13645570802246724

Heary, C. M., & Hennessy, E. (2002). The Use of Focus Group Interviews in Pediatric Health Care Research. *Journal of Pediatric Psychology*, *27*(1), 47–57. https://doi.org/10.1093/jpepsy/27.1.47

House of Commons, House of Commons, Education and Health, & Committees. (2017). *Children and Young People's Mental Health—The Role of Education*. https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/849/849.pdf

Hutchings, M. (2015). *Exam Factories? The impact of accountability measures on children and young people*.

Ianni, F. A. J. (1764). *The Search for Structure: A Report on American Youth Today*. Simon and Schuster.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy a guide for students and practitioners* (pp. 209–225). Wiley-Blackwell.

Kaushik, A., Kostaki, E., & Kyriakopoulos, M. (2016). The stigma of mental illness in children and adolescents: A systematic review. *Psychiatry Research*, *243*, 469–494. https://doi.org/10.1016/j.psychres.2016.04.042

Kellett, M. (2005). *Children as active researchers: A new research paradigm for the 21st century?* ESRC National Centre for Research Methods NCRM Methods Review Papers NCRM/003. http://eprints.ncrm.ac.uk/87/1/MethodsReviewPaperNCRM-003.pdf

Khan, L. (2016). *Missed Opportunities*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/missed-opportunities

Kidger, J., Donovan, J. L., Biddle, L., Campbell, R., & Gunnell, D. (2009). Supporting adolescent emotional health in schools: A mixed methods study of student and staff views in England. *BMC Public Health*, *9*(1), 403–420. https://doi.org/10.1186/1471-2458-9-403

Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*(7), 709–717. https://doi.org/10.1001/archpsyc.60.7.709

Knightsmith, P., Treasure, J., & Schmidt, U. (2014). We don't know how to help: An online survey of school staff. *Child and Adolescent Mental Health*, *19*(3), 208–214. https://doi.org/10.1111/camh.12039

Krayer, A., Ingledew, D. K., & Iphofen, R. (2008). Social comparison and body image in adolescence: A grounded theory approach. *Health Education Research*, *23*(5), 892–903. https://doi.org/10.1093/her/cym076

Kreuger, R., & Casey, M. A. (2014). *Focus Groups: A Practical Guide for Applied Research* (5th ed.). SAGE.

Kvale, S. (2006). Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, *12*(3), 480–500. https://doi.org/10.1177/1077800406286235

Lally, C. (2020, July 14). *Child and Adolescent Mental Health During COVID-19*. UK Parliament. https://post.parliament.uk/child-and-adolescent-mental-health-during-covid-19/

Law, D., Faulconbridge, julia, & Laffan, A. (2015). *What good looks Like in Psychological Services for Children Young People and Their Families: Special Edition of the Child and Family Clinical Psychology Review*.

Lee, J. (2020). Mental health effects of school closures during COVID-19. *The Lancet Child & Adolescent Health*, *4*(6), 421. https://doi.org/10.1016/S2352-4642(20)30109-7

Lerner, R. M., & Castellino, D. R. (2002). Contemporary developmental theory and adolescence: Developmental systems and applied developmental science.

Journal of Adolescent Health, *31*(6, Supplement), 122–135. https://doi.org/10.1016/S1054-139X(02)00495-0

Link, A. (2012). From Synchronous to Asynchronous: Researching Online Focus Group Platforms. *Cultivating Change in the Academy*. https://www.academia.edu/1779184/From_Synchronous_to_Asynchronous_Researching_Online_Focus_Group_Platforms

Liu, J. J., Bao, Y., Huang, X., Shi, J., & Lu, L. (2020). Mental health considerations for children quarantined because of COVID-19. *The Lancet Child & Adolescent Health*, *4*(5), 347–349. https://doi.org/10.1016/S2352-4642(20)30096-1

Logue, S., Chein, J., Gould, T., Holliday, E., & Steinberg, L. (2014). Adolescent Mice, Unlike Adults, Consume More Alcohol in the Presence of Peers than Alone. *Developmental Science*, *17*(1). https://doi.org/10.1111/desc.12101

Mann, M. (Michelle), Hosman, C. M. H., Schaalma, H. P., & de Vries, N. K. (2004). Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research*, *19*(4), 357–372. https://doi.org/10.1093/her/cyg041

Marcia, J. E. (1980). Identity in Adolescence. In J. Adelson (Ed.), *Handbook of Adolescent Psychology*. Wiley.

Matthews, N., Kilgour, L., Christian, P., Mori, K., & Hill, D. M. (2015). Understanding, evidencing, and promoting adolescent well-being: An emerging agenda for schools. *Youth & Society*, *47*(5), 659–683. https://doi.org/10.1177/0044118X13513590

Mawn, L., Welsh, P., Kirkpatrick, L., Webster, L. A. D., & Stain, H. J. (2016). Getting it right! Enhancing youth involvement in mental health research. *Health*

Expectations: An International Journal of Public Participation in Health Care & Health Policy, *19*(4), 908–919. https://doi.org/10.1111/hex.12386

McDonald, J. (2008). Measuring Personality Constructs: The Advantages and Disadvantages of Self-Reports, Informant Reports and Behavioural Assessments. *Enquire*, 20.

Mead, M. (1943). *Coming of age in Samoa: A study of adolescence and sex in primitive societies*. Penguin.

MEDIA, A. (2019, October 7). *Origins of the Youth Mental Health Crisis*. Medium. https://medium.com/insightnetwork/origins-of-the-youth-mental-health-crisis-470a1c750e0d

Menzies, I. E. P. (1960). A Case-Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital. *Human Relations*, *13*(2), 95–121. https://doi.org/10.1177/001872676001300201

Mills, K. L., Lalonde, F., Clasen, L. S., Giedd, J. N., & Blakemore, S.-J. (2014). Developmental changes in the structure of the social brain in late childhood and adolescence. *Social Cognitive and Affective Neuroscience*, *9*(1), 123–131. https://doi.org/10.1093/scan/nss113

Mittler, P. (2000). *Working Towards Inclusive Education Social Contexts*. David Fulton Publishers.

Moore, T., McKee, K., & McCoughlin, P. (2015). Online focus groups and qualitative research in the social sciences: Their merits and limitations in a study of housing and youth. *People, Place and Policy Onlin*, *9*(1), 17–28. https://doi.org/10.3351/ppp.0009.0001.0002

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., Kapur, N., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: Cohort study in primary care. *BMJ*, *359*. https://doi.org/10.1136/bmj.j4351

Morgan, D. L. (1996). Focus Groups. *Annual Review of Sociology*, *22*(1), 129–152. https://doi.org/10.1146/annurev.soc.22.1.129

MQ Transforming Mental Health. (2015). *UK Mental Health Research Funding*. MQ Transforming Mental Health. https://b.3cdn.net/joinmq/1f731755e4183d5337_apm6b0gll.pdf

Murray-Harvey, R., & Slee, P. T. (2006). Australian and Japanese school students' experiences of school bullying and victimization: Associations with stress, support and school belonging. *International Journal on Violence in Schools*, *2*. http://www.ijvs.org/files/Revue-02/Pdf-N2/IJVS-02---December-2006---Murray-Harvey.pdf

Naghieh, A., Montgomery, P., Bonell, C. P., Thompson, M., & Aber, J. L. (2015). Organisational interventions for improving wellbeing and reducing work-related stress in teachers. *Cochrane Database of Systematic Reviews*, *4*. https://doi.org/10.1002/14651858.CD010306.pub2

Nash, P., Schlösser, A., & Scarr, T. (2015). Teachers' perceptions of disruptive behaviour in schools: A psychological perspective. *Emotional and Behavioural Difficulties*, *21*, 1–14. https://doi.org/10.1080/13632752.2015.1054670

National Audit Office. (2018). *Improving children and young people's mental health services*. https://www.nao.org.uk/wp-content/uploads/2018/10/Improving-children-and-young-peoples-mental-health-services.pdf

National Data Guardian. (2020). *The Caldicott Principles*. GOV.UK. https://www.gov.uk/government/publications/the-caldicott-principles

National Education Union. (2019). *Tackling stress*. NEU. https://neu.org.uk/advice/tackling-stress

Newman, T. (2004). *What Works in Building Resilience*. Bernardos Policy and Research Unit.

NHS Digital. (2020a). *Mental Health of Children and Young People in England, 2020*. NHS Digital. https://files.digital.nhs.uk/CB/C41981/mhcyp_2020_rep.pdf

NHS Digital. (2020b). *Mental Health Services Data Set*. NHS Digital. https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

NHS Digital: Mental Health Services Monthly Statistics. (2020). NHS Digital. https://digital.nhs.uk/search

NHS Highland. (2018). *Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity* (The Annual Report of the Director of Public Health, 2018). NHS Highland. https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf

Norris, R., Carroll, D., & Cochrane, R. (1992). The effects of physical activity and exercise training on psychological stress and well-being in an adolescent population. *Journal of Psychosomatic Research*, *36*(1), 55–65. https://doi.org/10.1016/0022-3999(92)90114-H

OECD. (2017). *PISA 2015 Results (Volume III): Students' Well-Being*. OECD. https://doi.org/10.1787/9789264273856-en

OECD. (2018). *PISA 2018 Results (Volume III): Students' life satisfaction and meaning in life* [OECD Library]. https://www.oecd-ilibrary.org/sites/c414e291-en/index.html?itemId=/content/component/c414e291-en

O'Hara, M. (2018, July 31). Young people's mental health is a 'worsening crisis'. Action is needed | Mary O'Hara. *The Guardian*. https://www.theguardian.com/society/2018/jul/31/young-people-mental-health-crisis-uk-us-suicide

O.Nyumba, T., Wilson, K., Derrick, C. J., & Mukherjee, N. (2018). The use of focus group discussion methodology: Insights from two decades of application in conservation. *Methods in Ecology and Evolution*, *9*(1), 20–32. https://doi.org/10.1111/2041-210X.12860

Orben, A., Tomova, L., & Blakemore, S.-J. (2020a). The effects of social deprivation on adolescent development and mental health. *The Lancet. Child & Adolescent Health*. https://doi.org/10.1016/S2352-4642(20)30186-3

Orben, A., Tomova, L., & Blakemore, S.-J. (2020b). The effects of social deprivation on adolescent development and mental health. *The Lancet Child & Adolescent Health*, *4*(8), 634–640. https://doi.org/10.1016/S2352-4642(20)30186-3

O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose responsibility is adolescent's mental health in the UK? Perspectives of key stakeholders. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *10*(4), 450–461.

Ortlipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *Qualitative Report*, *13*. https://doi.org/10.46743/2160-3715/2008.1579

Parker, I., Georgaca, E., Harper, David, McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology.* SAGE.

Parkin, E., & Long, R. (2020). *Support for children and young people's mental health*. House of Commons Library.

Pascoe, M. C., Hetrick, S. E., & Parker, A. G. (2020). The impact of stress on students in secondary school and higher education. *International Journal of Adolescence and Youth*, *25*(1), 104–112. https://doi.org/10.1080/02673843.2019.1596823

Pick, I., Waggett, N., & Moselhi, C. (2018). *'Silent Catastrophe' Responding to the danger signs of children and young people's mental health services in trouble*. The Association of Child Psychotherapists.

Pinkerton, J. (2004). Children's participation in the policy process: Some thoughts on policy evaluation based on the Irish National Children's Strategy. *Children & Society*, *18*(2), 119–130. https://doi.org/10.1002/chi.820

Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R. M., & Hargreaves, D. S. (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: Analysis of repeated cross-sectional national health surveys. *Psychological Medicine*, *49*(8), 1275–1285. https://doi.org/10.1017/S0033291718001757

Psychologists for Social Change. (2018). *UK Government Green paper Transforming Children and Young People's Mental Health Provision ignores the impact of childhood adversity and social deprivation*. http://www.psychchange.org/uk-government-green-paper-transforming-children-and-young-peoplersquos-mental-health-provision.html

Public Health England. (2017). Mental health: Environmental factors. In *Mental health and wellbeing: JSNA toolkit*. https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place

Public Health England. (2019). *Universal approaches to improving children and young people's mental health and wellbeing: Report of the findings of a Special Interest Group*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842176/SIG_report.pdf

Putwain, D., & Daly, A. L. (2014). Test Anxiety Prevalence and Gender Differences in a Sample of English Secondary School Students. *Educational Studies*, *40*(5), 554–570. https://doi.org/10.1080/03055698.2014.953914

Randler, C., Faßl, C., & Kalb, N. (2017). From Lark to Owl: Developmental changes in morningness-eveningness from new-borns to early adulthood. *Scientific Reports*, *7*, 1–8. https://doi.org/10.1038/srep45874

Read, J., Fink, P., Rudegeair, T., Felitti, V., & Whitfield, C. (2008). Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model. *Clinical Schizophrenia & Related Psychoses*, *2*, 235. https://doi.org/10.3371/CSRP.2.3.5

Rees, G., Bradshaw, J., Goswami, H., & Keung, A. (2008). *National Survey of Young People's Well-Being 2008*. 96.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting Children's Mental Health in Schools: Teacher Perceptions of Needs, Roles, and Barriers. *School Psychology Quarterly*, *26*(1), 1–13.

Roberts, Y. (2020, June 21). Hunger, violence, cramped housing: Lockdown life for the poorest children. *The Guardian*. http://www.theguardian.com/society/2020/jun/21/hunger-violence-cramped-housing-lockdown-life-for-the-poorest-children

Ross, A., Kelly, Y., & Sacker, A. (2017). Time trends in mental well-being: The polarisation of young people's psychological distress. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *52*(9), 1147–1158. https://doi.org/10.1007/s00127-017-1419-4

Rothì, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education*, *24*(5), 1217–1231. Scopus. https://doi.org/10.1016/j.tate.2007.09.011

Rutter, M. (2013). Developmental psychopathology: A paradigm shift or just a relabeling? *Development and Psychopathology*, *25*(4pt2), 1201–1213. https://doi.org/10.1017/S0954579413000564

Rutter, M., & Smith, D. J. (1995). *Psychosocial disorders in young people: Time trends and their causes*. Wiley.

Sabates, R., & Dex, S. (2012). *Multiple risk factors in young children's development* (p. 32). Centre for Longitudinal Studies.

Sadler, K., Vizard, T., Ford, T., Marcheselli, F., Pearce, N., Mandalia, D., Davis, J., Brodie, E., Forbes, N., Goodman, A., Goodman, R., & McManus, S. (2017). *Mental Health of Children and Young People in England, 2017: Summary of key findings*. NHS Digital. https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf

Salmons, J. (2016). *Doing qualitative research online*. SAGE Publications Ltd.

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S.-J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: A foundation for future health. *The Lancet*, *379*(9826), 1630–1640. https://doi.org/10.1016/S0140-6736(12)60072-5

Schoon, I., & Bartley, M. (2008). The role of human capability and resilience. *The Psychologist*, *21*.

Schoon, I., Parsons, S., & Sacker, A. (2004). Socioeconomic Adversity, Educational Resilience, and Subsequent Levels of Adult Adaptation. *Journal of Adolescent Research, 19*, 383–404. https://doi.org/10.1177/0743558403258856

Shakespeare, W., (1996). *The Winter's Tale*. (Orgel, S. ed). Oxford: Clarendon Press. (original work published, 1611).

Sharpe, H., Ford, T., Lereya, S. T., Owen, C., Viner, R. M., & Wolpert, M. (2016). Survey of schools' work with child and adolescent mental health across England: A system in need of support. *Child and Adolescent Mental Health*, *21*(3), 148–153. https://doi.org/10.1111/camh.12166

Shaw, C., Brady, L.-M., & Davey, C. (2011). *NCB Guidelines for Research With Children and Young People*.

Shelemy, L., Harvey, K., & Waite, P. (2019). Supporting students' mental health in schools: What do teachers want and need? *Emotional and Behavioural Difficulties*, *24*(1), 100–116. https://doi.org/10.1080/13632752.2019.1582742

Shevlin, M., Dorahy, M. J., & Adamson, G. (2007). Trauma and Psychosis: An Analysis of the National Comorbidity Survey. *American Journal of Psychiatry*, *164*(1), 166–169. https://doi.org/10.1176/ajp.2007.164.1.166

Shulman, E. P., Smith, A. R., Silva, K., Icenogle, G., Duell, N., Chein, J., & Steinberg, L. (2016). The dual systems model: Review, reappraisal, and

reaffirmation. *Developmental Cognitive Neuroscience*, *17*, 103–117. https://doi.org/10.1016/j.dcn.2015.12.010

Social Care, Local Government and Care Partnership Directorate, London, UK. (2014). *Closing the Gap: Priorities for Essential Change in Mental Health* [Data set]. Department of Health. https://doi.org/10.1037/e503762014-001

Solmi, M., Dragioti, E., Arango, C., Radua, J., Ostinelli, E., Kilic, O., Yilmaz, U. E., Yalcinay-İnan, M., Soares, F. C., Mariano, L., Mosillo, P., Cortese, S., Correll, C. U., Carvalho, A. F., Shin, J. I., & Fusar-Poli, P. (2021). Risk and protective factors for mental disorders with onset in childhood/adolescence: An umbrella review of published meta-analyses of observational longitudinal studies. *Neuroscience and Biobehavioral Reviews*, *120*, 565–573. https://doi.org/10.1016/j.neubiorev.2020.09.002

Somerville, L. H. (2013). The Teenage Brain: Sensitivity to Social Evaluation. *Current Directions in Psychological Science*, *22*(2), 121–127. https://doi.org/10.1177/0963721413476512

Spear, L. P. (2013). Adolescent Neurodevelopment. *The Journal of Adolescent Health*, *52*(2 0 2), S7-13. https://doi.org/10.1016/j.jadohealth.2012.05.006

Statista. (2018). *UK: Population, by age 2018*. Statista. https://www.statista.com/statistics/281174/uk-population-by-age/

Statista. (2020). *UK: Most popular social media with young adults and teens 2020*. Statista. https://www.statista.com/statistics/1059462/social-media-usage-uk-age/

Steinberg, L. (2019). *Adolescence* (12th edition). McGraw-Hill Education.

Steinberg, L., Fegley, S., & Dornbusch, S. (1993). *Negative Impact of Part-Time Work on Adolescent Adjustment: Evidence from a Longitudinal Study.* https://doi.org/10.1037/0012-1649.29.2.171

Steinberg, L., Icenogle, G., Shulman, E., Breiner, K., Chein, J., Bacchini, D., Chang, L., Chaudhary, N., Giunta, L., Dodge, K., Fanti, K., Lansford, J., Malone, P., Oburu, P., Pastorelli, C., Skinner, A., Sorbring, E., Tapanya, S., Tirado, L., & Takash, H. (2017). Around the world, adolescence is a time of heightened sensation seeking and immature self-regulation. *Developmental Science*, *21*. https://doi.org/10.1111/desc.12532

Steinberg, L., & Morris, A. S. (2001). Adolescent Development. *Annual Review of Psychology*, *52*, 83-11-.

Suldo, S., Thalji-Raitano, A., Hasemeyer, M., Gelley, C., & Hoy, B. (2013). Understanding Middle School Students Life Satisfaction: Does School Climate Matter? *Applied Research in Quality of Life*, *8*. https://doi.org/10.1007/s11482-012-9185-7

Sweeting, H., West, P., Young, R., & Der, G. (2010). Can we explain increases in young people's psychological distress over time? *Social Science & Medicine (1982)*, *71*(10), 1819–1830. https://doi.org/10.1016/j.socscimed.2010.08.012

Sweeting, H., Young, R., & West, P. (2009). GHQ increases among Scottish 15 year olds 1987–2006. *Social Psychiatry and Psychiatric Epidemiology*, *44*(7), 579–586. https://doi.org/10.1007/s00127-008-0462-6

Szas, T. (1961). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct:* Harper.

The Children's Commissioner for England. (2020). *The State of Children's Mental Health Services* (p. 32). The Children's Comissioner for England.

https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf

The Children's Commissioner for England. (2021). *The State of Children's Mental Health Services 2020/21*. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf

The Children's Society. (2020). *The Good Childhood Report 2020*. https://www.childrenssociety.org.uk/sites/default/files/2020-11/Good-Childhood-Report-2020.pdf

The Key. (2017). *State of Education Report 2017*. https://view.joomag.com/state-of-education-report-2017/0676372001494577623

The United Nations. (1989). *The United Nations Convention on the Rights of the Child*. https://downloads.unicef.org.uk/wp-content/uploads/2016/08/unicef-convention-rights-child-uncrc.pdf?_adal_sd=www.unicef.org.uk.1615891571797&_adal_ca=so%3DGoogle%26me%3Dorganic%26ca%3D(not%2520set)%26co%3D(not%2520set)%26ke%3D(not%2520set).1615891571797&_adal_cw=1615891566251.1615891571797&_adal_id=cf387fb4-44a7-482d-8e02-c2bd8e39cc96.1615891566.2.1615891566.1615891566.2ac2525a-fcd8-4351-bd18-682679254637.1615891571797&_ga=2.240992515.168804554.1615891566-288117357.1615891566

Torrance, H. (2003). Assessment of the National Curriculum in England. In T. Kellaghan & D. L. Stufflebeam (Eds.), *International Handbook of Educational*

Evaluation (pp. 905–928). Springer Netherlands. https://doi.org/10.1007/978-94-010-0309-4_51

Twenge, J. M., & Campbell, W. K. (2019). Media Use Is Linked to Lower Psychological Well-Being: Evidence from Three Datasets. *The Psychiatric Quarterly*, *90*(2), 311–331. https://doi.org/10.1007/s11126-019-09630-7

Unicef: UK. (2020). *Children in Lockdown: What Cornonavirus Means for UK Children*. https://chrishatton.blogspot.com/2020/03/covid-19-people-with-learning.html

Widnall, E., Winstone, L., Mars, B., Haworth, C., & Kidger, J. (2020). *Young People's Mental Health during the COVID-19 Pandemic: Initial findings from a secondary school survey study in South West England*. NIHR School for Public Health Research. https://sphr.nihr.ac.uk/wp-content/uploads/2020/08/Young-Peoples-Mental-Health-during-the-COVID-19-Pandemic-Report.pdf

Williams, S., Clausen, M. G., Robertson, A., Peacock, S., & McPherson, K. (2012). Methodological Reflections on the Use of Asynchronous Online Focus Groups in Health Research. *International Journal of Qualitative Methods*, *11*(4), 368–383. https://doi.org/10.1177/160940691201100405

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology* (Vol. 1, pp. 5–21). American Psychological Association.

Willig, C. (2019). What can qualitative psychology contribute to psychological knowledge? *Psychological Methods*, *24*(6), 796–804. https://doi.org/10.1037/met0000218

Wilson, C. J., & Deane, F. P. (2012). Brief report: Need for autonomy and other perceived barriers relating to adolescents' intentions to seek professional mental health care. *Journal of Adolescence*, *35*(1), 233–237. https://doi.org/10.1016/j.adolescence.2010.06.011

Winnicott, D. W. (Donald W., Winnicott, C., Shepherd, R., & Davis, M. (1986). *Home is where we start from: Essays by a psychoanalyst*. New York : Norton. http://archive.org/details/homeiswherewesta00winn

Woolfson, R., Woolfson, L., Mooney, L., & Bryce, D. (2009). Young people's views of mental health education in secondary schools: A Scottish study. *Child: Care, Health and Development*, *35*(6), 790–798. https://doi.org/10.1111/j.1365-2214.2008.00901.x

World Health Organisation. (2018). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organisation. (2020). *Adolescent mental health*. World Health Organisation. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

World Health Organisation. (n.d.). *Adolescent health*. https://www.who.int/westernpacific/health-topics/adolescent-health

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, *12*(3), 295–296. https://doi.org/10.1080/17439760.2016.1262624

Young Minds. (n.d.). *Young Minds Response to the Consultation on the Ofsted Education Framework 2019*.

https://youngminds.org.uk/media/3049/youngminds-response-to-consultation-on-draft-ofsted-inspection-framework.pdf

Young Minds And the Department of Health. (2018). *Children & Young People's Mental Health Green Paper. Student Insights Report.* Young Minds And the Department of Health. https://youngminds.org.uk/media/2527/green-paper-student-insight-report.pdf

Zhang, X., Zhu, W., Kang, S., Qiu, L., Lu, Z., & Sun, Y. (2020). Association between Physical Activity and Mood States of Children and Adolescents in Social Isolation during the COVID-19 Epidemic. *International Journal of Environmental Research and Public Health*, *17*(20). https://doi.org/10.3390/ijerph17207666

Zwaanswijk, M., & van Dulmen, S. (2014). Advantages of asynchronous online focus groups and face-to-face focus groups as perceived by child, adolescent and adult participants: A survey study. *BMC Research Notes*, *7*. https://doi.org/10.1186/1756-0500-7-756

APPENDIX A: Thematic Map 1

APPENDIX B: Thematic Map 2

APPENDIX C: Interview Schedule

What things in your life do you feel impact on your emotional wellbeing? Mental wellbeing? E.g.:

At home?	In society or the world?	About the future?
At school?	Outside school?	About the past?

What would you like school to be aware of regarding things that impact your mental health/emotional wellbeing/general wellbeing?

Do you think they/teachers are aware of those things? (In what ways could they be made aware? What could be put in place to allow these types of conversations between students and teachers?)

Do you feel safe in school? (Why? What could make you feel safer? Whose responsibility is it to make you feel safe?)

What would you like more teaching on regarding your mental health? Emotional/general wellbeing?

Do you get any teaching on those things now? Do you find it helpful? What would you change about it? What would you keep?

Are there things that you don't think teachers can help you with regarding your mental health/emotional/general wellbeing?

Who do you think should help you with these things?

Are there other places or people you go to for help with your mental health/emotional/general wellbeing? What's helpful about them?

What things do you feel protect / improve your mental health/emotional/general wellbeing?

Do you think you get enough of those things?

Do you think school could be helping you access more of those things? How might they do this?

APPENDIX D: UEL letter Stating Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Milda Perminiene

SUPERVISOR: **Trishna Patel**

STUDENT: Nadia Daer

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Adolescents' views on mental health, wellbeing and school-based support

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Milda Perminiene

Date: 23 06 2020

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Outcome - Application to register - Miss Nadia Daer

Dear Nadia,

Student number: 1032214

I am pleased to inform you that the Research, Research Degrees and Ethics Subcommittee, on behalf the Impact and Innovation Committee, has registered you for the degree of DProf.

Title of programme

Young People's Views on Mental Health, Wellbeing and Schools Based Support.

Director of Studies

Dr Trishna Patel

Supervisors

Dr Nimisha Patel

Expected completion

According to your actual date of registration, which is 01 Oct 2019, the registration period is as follows:

Minimum date: 01 Apr 2021

Maximum date: 20 Sep 2022

This is according to a full time mode of study.

I wish you all the best with your intended research degree programme. Please contact me if you have any further queries regarding this matter.

Yours sincerely,

Mrs Claire Correia

Application to register - Miss Nadia Daer

Reply | Forward

APPENDIX E: Change of Title Approval Letter

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant:	Nadia Daer
Programme of study:	Professional Doctorate in Clincial Psychology
Name of supervisor:	Dr Trishna Patel

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Young People's Views on Mental Health, Wellbeing and Schools Based Support.	The research has not changed, I just felt that 'Adolescents' better describes the target age group and 'Wellbeing' was superfluous and might, unhelpfully in this instance, suggest something different from 'mental health'.
New Title: Adolescents' Views on Mental Health and School-Based Support.	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Nadia Daer

Date: 22/3/21

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer: Trishna Patel

Date: 02/07/2021

APPENDIX F: Participant Information Letter

PARTICIPANT INVITATION LETTER

Adolescents' Views on Mental Health, Wellbeing and School-Based Support

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully. Feel free to discuss the study with others before making a decision.

Who am I?

My name is Nadia and I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research about?

Young people may experience many stressors in their daily lives leading to a range of mental health difficulties. The systems around young people (including schools and mental health services) need to be aware of these stressors in order to be able to provide young people with the right kind of support.

I am conducting research into young people's views on what *they* think impacts their mental health and wellbeing, as well as the teaching and support available in school, and ideas young people have of what could be offered or included by schools to help.

This could help local schools and mental health services design their services to best address the difficulties that young people report facing.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have I been asked to participate?

You have been invited to participate as someone aged between 16 and 18 who attends a school in London. I am interested to hear your views regardless of whether or not you have experienced mental health difficulties. You do not have to be an 'expert' in the topic area to take part in the study.

It is entirely up to you whether you decide to take part or not and you should not feel coerced. You are also free to change your mind and leave the study at any point up to three weeks after the focus groups have happened.

What will my participation involve?

If you agree to participate you will be invited to attend an online focus group with around seven other students from your school. The focus group will be an informal chat about the topic of the research. The discussion will take place over Microsoft (MS) Teams and will be recorded in MS Teams. MS Teams will produce a transcript of our conversation and the main points from this discussion will be written up in my study.

In the focus group you will be ask about your views on the things you think impact on your mental health and wellbeing and the mental health and wellbeing of young people in your area in general. I will also ask you for your views on the teaching and support with mental health and wellbeing that you get from school, and what else you think you would benefit from in terms of teaching and support.

The focus group will take place on MS Teams and will last approximately 90 minutes.

Will my participation be safe and confidential?

YES. Your privacy and safety will be respected at all times:

- You will not be personally identified by the data collected (i.e., your contributions in the focus group), in any written material produced as part of the study.
- You do not have to answer any question that you do not wish to during the focus group and can stop your participation at any time by leaving the online chat room. If you do decide to leave the chat room, none of your contributions up until that point will be used in the study.

- If anything comes up in the discussion that you would like to speak to someone about afterwards, details of who can best help will be provided and can also be found at the bottom of this letter.
- If something comes up in the discussion that makes me concerned that you or someone else might be at risk of harm, or is involved in illegal activity, I may be legally required to let someone know. I will attempt to discuss this with you first as far as possible.

What will happen to the information that I provide?

The information you provide will be recorded using the MS Team app. The app will produce a transcript of the discussion, which I will anonymise by taking out all names and any identifying details. The transcript will be stored safely and separately to any personally identifying information; your name will only appear on your consent form, and this will not be stored with the recording or transcript of the discussion. Your consent form will be stored in a password protected folder and the recording and transcript of the discussion will be stored in a separate password protected location.

The recordings of the discussion will be stored on a password protected computer. The recording will be destroyed once the study has been completed and approved by my university (approx. December 2021), but the anonymised transcripts will be securely kept for up to three years as the study may be published at a later date.

The anonymised information may be seen by and discussed with my supervisor and university examiners, and the final study may be published in academic journals or presented at conferences.

What if I want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. If you would like to withdraw, just exit the online chat room and your data will not be used in the study. Separately, you may also request to withdraw your data even after you have participated in focus group, provided that this request is made within three weeks of the data being collected (after which point data analysis will begin, and withdrawal will not be possible). If you would like to withdraw your data from the study, please email me to let me know. You do not have to provide a reason for doing so.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Nadia Daer: u1032214@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Trishna Patel School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: t.patel@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: t.lomas@uel.ac.uk

It is not anticipated that you will be adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may be challenging, distressing or uncomfortable in some way. If you are affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

SCHOOL COUNSELLOR: Your school counsellor's name is [XXX] and they can be found in the counsellor's office.

GP: You can contact your GP for advice or for a referral to see a mental health practitioner.

SAMARAITANS: Free calls can be made at any time: 116 123

MIND: provide confidential information about mental health-related services. They can be contacted from 10am-5pm, Monday-Thursday on 020 3982 9221, or by emailing: [XXX]

APPENDIX G: Participant Consent Form

CONSENT TO PARTICIPANT IN A RESEARCH STUDY

Adolescents' Views on Mental Health, Wellbeing and School-Based Support

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I understand that the researcher may contact me after the focus group to notify me if I have won a £10 Amazon voucher.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that I have three weeks from the date of the focus group to withdraw my data if I change my mind, without the need to provide a reason for doing so.

Participant's Name (BLOCK CAPITALS)

……

Participant's E-signature

……..

Researcher’s Name (BLOCK CAPITALS)

……..

Researcher’s E-signature

……

Date: ……..……..

APPENDIX H: Participant Demographics Form

DEMOGRAPHIC INFORMATION

This information helps me demonstrate who the research might be most relevant for, and how you prefer to be described.

1. How would you describe your ethnicity?

……

2. How would you describe your nationality?

……

3. How would you describe your gender?

……

4. Can you confirm that you are aged 16+?

……

5. Have you experienced mental health difficulties (e.g. anxiety, low mood etc.) in the past? YES/NO

……

6. Are you currently experiencing mental health difficulties (e.g. anxiety, low mood etc.)? YES/NO

……..

APPENDIX I: Debrief Letter

PARTICIPANT DEBRIEF LETTER

Adolescents' Views on Mental Health, Wellbeing and School-Based Support

Thank you for participating in my research study.
This letter offers information that may be relevant now that you have taken part.

What will happen to the information that you have provided?
The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

Your data will be immediately anonymised and securely stored:
The online discussion recorded via MS Teams will produce a transcript. This transcript will be made anonymous by taking out all names and any identifying details. It will be stored securely and safely; your name will only appear on your consent form, and this will not be stored with the recording or transcript of the discussion. Your consent form will be stored in a password protected folder and the recording and transcript of the discussion will be stored in a separate password protected location.

Deletion of data:

The recording of the discussion will be destroyed once the study has been completed and approved by my university (approx. December 2021), but the anonymised transcripts may be kept for up to three years as the study may be published at a later date.

Use of data:

The anonymised information may be seen by and discussed with my supervisor and university examiners, and the final study may be published in academic journals or presented at conferences.

What if you have been adversely affected by taking part?

It is not anticipated that you will be adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

SCHOOL COUNSELLOR: Your school counsellor's name is [XXX] and they can be found in the counsellor's office.

GP: You can contact your GP for advice or for a referral to see a mental health practitioner.

SAMARAITANS: Free calls can be made at any time: 116 123

MIND: provide confidential information about mental health-related services. They can be contacted from 10am-5pm, Monday-Thursday on 020 3982 9221, or by emailing: [XXX]

You are also very welcome to contact me or my supervisor if you have specific questions or concerns about the study. My email (Nadia Daer): u1032214@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact my research supervisor, Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: t.patel@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: t.lomas@uel.ac.uk

APPENDIX J: E-Advert

Psychology Research Opportunity:

a chance to contribute your views on young people's mental health and wellbeing

My name is Nadia and I'm a Trainee Clinical Psychologist conducting research at the University of East London.

I'm conducting research into what young people think impacts their mental health and wellbeing, and what schools could do to support them better.

I'm holding an online focus group for participants aged 16-18 from your school, to find out what *you* think influences your mental health and wellbeing.

Your views could help shape the mental health services in your area, and help local schools know how they could better support you.

If you would like to participate please let either [XXX] or me know and we will send you an information sheet with further details about the study. My email address is: u1032214@uel.ac.uk

To say thank you, I will be hosting a careers session for participants who would like to know more about a career in Clinical Psychology. Participants will also be entered into a prize draw to win one of four £10 Amazon vouchers.

Focus groups will be held via Microsoft Teams for about 90 minutes. Participant views and opinions will contribute to doctoral research that may be published. All views and opinions expressed will be kept anonymous

APPENDIX K: Research Journal Extracts

Focus Group 1. Reflections:
I found that discussion powerful and very moving. I felt that the participants were expressing quite a lot of pain, and distress at being under-supported. It was hard to listen without feeling emotionally involved. I think it's important to acknowledge my feelings and the extent to which they may reflect the participant's feelings/views. I am also conscious that there's a lot about the context of these participants and the discussion that took place that I don't know. I feel that my conscious sense of not wanting to add context and stick with the words and the emotion of the focus group is the best approach, but I recognise that it may be hard for me to situate this discussion.

The discussion seemed heavily weighted on two connected topics (how they are treated by their school and in a situation where they feel schoolwork is overwhelming) and they seemed to really connect with each other on these issues. I think the data was very rich on these topics and this is a benefit of focus research, but I wonder to what extent they were representative of this group at this time. Would another discussion on another day have prompted a discussion of a different factor? My motivator in doing this research was to prioritise adolescent perspectives over adult assumptions so maybe these wonderings are irrelevant. Also, I feel that they expressed how helpful it was to have this space to talk and I think that that is relevant information in itself. I wonder whether the other groups will express similar views.

Focus Group 2. Reflections:
That was a much more difficult group. The conversation didn't flow as well between the participants and I feel like they gave more short answer responses to my questions. I'm worried about how much I biased the answers therefore, and I think my questioning style became a little worse in response to the situation.

I think a few things went wrong there: the sound quality wasn't very good at times - having the participants all in one room using Teams microphones caused feedback and echos, which can be really off-putting when you're/they're trying to talk. Also, I suspect that ten participants was too many to get a good conversation going – especially in this half remote setting. I'm not sure how avoidable this was given the

surprising last-minute sign up - I'm not sure what prompted that at their end. Next week's group has four/five scheduled participants, it will be interesting to see whether it is more similar to the first group, or different again.

Focus Group 3. Reflections:
Four or five participants definitely seems to work better. The participants talked in more detail than group two and they seemed to have different priorities and a wider range of perspectives than group one – they didn't connect on any topic quite as much as group one.

But the sound quality still hindered the conversation a bit and I'm worried I will have lost some data that the microphones won't have picked up. They were clearly all together and just using one computer, which meant that different participants were different distances from the microphone. Not having as much control over the setting due to lockdown restrictions has been a limiting factor in this research. Perhaps I should have arranged these focus groups for a weekend day when they could have attended from home. I'm not sure how well that would have worked at the recruiting stage though.

I recognise that I felt the communication was best with group one: I was most powerfully moved by their descriptions and what they said felt most relevant to the research questions. But this was at least somewhat affected by the tech issues with the 2nd and 3rd groups so I need to bear in mind that my relating well with group one may influence my analysis.

APPENDIX L: Initial Codes

Academic pressure from teachers	Academic pressure on teachers/schools
Comparison with other students (academically)	Volume of academic work
Academic pressure from parents	The pressure of other's expectations
Academic pressure in immigrant families	Responsibilities/commitments outside of school aren't recognised
Work life balance	Not feeling trusted by teachers
Online learning	Favouritism by teachers
Lack of respect from teachers	Feeling criticised by teachers
Lack of freedom/autonomy	Lack of extra-curricular spaces in school
Dehumanising treatment from teachers at lunchtimes	Inadequate school meal provisions – left hungry during the day
Responses from teachers can be unpredictable	mixed sense that pressures are known and/or acknowledged by teachers
Ambivalence talking to teachers about difficulties	Lack of genuine compassion from teachers
Lack of confidentiality from teachers	Personal boundaries not respected by teachers
Teachers (as adults) should be trustworthy/respect confidentiality	School counsellors may not be well integrated
Lack of, or inconsistent support from school	school & society can be judgemental & stereotyping of adolescents, rather than nurturing
School provides physical safety	Belief that other schools likely to be worse
finances (current and future) can be a concern	Focus on getting a job

Commuting stress	Body image
lockdown may have improved family bonds, helping MH	Lockdown was detrimental to MH
Lockdown was harder on younger people	The degree of restriction wasn't the same for everyone
Worry about future success	Fear of racism re. future prospects
Social media can worsen MH	Fear of islamophobia: future prospects
Social media can fuel comparisons with others	Social media can perpetuate unhelpful goals around beauty
Social media can fuel insecurities	Social media can help normalise MH
social media can perpetuate unhelpful goals around happiness	social media is a tool for sharing knowledge and support
Teachers can't always relate to us	The people around you influence your development, actions and decisions
Older generations don't understand contemporary problems of adolescence	Teachers may relate to adolescents better if they're from the same local area or background
MH is taboo in different cultures/ethnicities	Generational difference in conceptions of mental health
Easier to talk to younger people about MH (due to generational differences in MH awareness)	Religious families may have different understandings of MH to adolescents
Keeping things bottled up can be unhelpful for mental health	Immigrant parents have different conceptions of MH
Harder for boys/men to talk about MH	Often people don't express what they're feeling
Don't always want/need to share thoughts/feelings	Stigma remains a limitation, despite improved awareness about MH
Older adolescents may be less likely to talk openly with family	Expressing thoughts/emotions helps manage mental health
Experiences for adolescents are different in different parts of the country	Older adolescents (16+) are more sure of themselves
Being with friends can ease stress	Music helps
Reading helps	Faith can provide hope

Playful extra-curricular activities help manage stress	Productive extra-curricular activities help manage stress
P.T. jobs can be motivating & rewarding	Need time/space to yourself
Support from older people is valuable	BLM movement has been positive for mental health
Taking time out from school helps	Talking helps
Talking to friends helps	Talking to mum helps
Teachers relating to us as people is highly valued	Meaningful engagement with students is highly valued
Trust and confidentiality are highly valued	Advice/guidance from teachers is valued
Praise & encouragement help with academic pressure	Support & flexibility around schoolwork is helpful
Teachers can be supportive	Teaching on MH is vague and limited
PSHE aimed to normalise MH	PSHE could have taught more life skills
School don't talk/ask about potential factors for distress	Teachers should ask how they can help us
Mental health discussions should incorporate student's views	MH teaching feels like teacher's own opinions
Learning occurs in social groups	Discussion spaces like this are helpful
Adolescent conceptions of MH	Feeling low / sad / crying /breaking down
Difficult to talk in front of each other in a focus group	102 codes

APPENDIX M: Annotated Data Extract

[redacted]Yeah, 'cause sometimes you have too much work so you can't do what you plan to do that evening or stuff like you can't have your normal personal life because you have so much work to do that night.

[redacted]: I agree with that.

[redacted]: It seems like we get pressured to have like part time jobs at the weekend and balancing that with school works difficult as well.

Researcher: Right. And how does that impact on your.. on how you feel, do you think? and your kind of wellbeing and your mental health? You're saying it feels overwhelming and it eats into your personal life time. How does that leave you feeling?

[redacted]Lately, I just feel really bad to be honest. Like I don't feel like my usual self. At school I have friends who cheer me up and make me laugh but at home it's more like I'm alone with work and stress. (chat) (liked)

[redacted]: Sometimes I feel really good and other times I'm just like don't wanna get outta bed and really sad and just just wanna cry.

[redacted]: yeh I feel like that sometimes (chat) (liked)

I just wanna be around friends to take the stress away (chat) (liked)

[redacted]: yeh defo (chat)

[redacted]: The whole fun part about school has been taken away (chat) (liked)

it's just work now (chat)

[redacted]: It makes you feel a little at ease and like distracts you a bit from all that stress (chat)

[redacted]: 100% (chat)

[redacted]: defo took it for granted :/ (chat)

Researcher: Where do you go at those times? How do you manage those feelings?

[redacted]: I normally just like listen to music or read or something.

[redacted]: Do you find yourself having to hold in any emotions because of this?

[redacted]: Uhm, yeah, sometimes like if I'm feeling a bit crappy at school then I just kinda pretend I'm alright and just get on with it.

school doesn't leave time for other things

friends are the antidote to school?

Is the problem pressure of school or loss of 'fun' time?

mental health literacy