MAJOR RESEARCH PROJECT

CHARIS GREEN BSc (Hons)

PARENTAL INVOLVEMENT IN ADOLESCENT MENTAL HEALTH

Section A: What is the level of agreement between parents and adolescents regarding perceptions of adolescent mental health problems and how does this effect mental health treatment? A review of theoretical and empirical literature. (6825)

Section B: Adolescent help seeking: A grounded theory of the influence of parents upon adolescent help seeking. (7998)

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Summary of MRP Portfolio

This major research project focuses on the influence of parents upon adolescent help seeking for mental health problems.

Section A: This section reviews available empirical and theoretical literature related to adolescent-parent agreement regarding perceptions of adolescent mental health problems. Findings suggested there is low levels of agreement between adolescents and parents, and that levels of agreement were related to parental involvement. Research is needed to further consider the role of parents more broadly within adolescent help seeking for mental health problems.

Section B: This study aimed to develop a theoretical framework to help explain the influence of parents upon adolescent help seeking. Eighteen participants, seven young people, six parents, and five clinicians were interviewed about their experiences of adolescent help seeking in relation to adolescent mental health. A grounded theory analysis was used to develop five categories and sixteen sub-categories. The relationships between these findings were used to create a preliminary model to show help seeking as a family journey.

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Section A

What is the level of agreement between parents and adolescents regarding perceptions of adolescent mental health problems and how does this impact upon mental health treatment?

A review of theoretical and empirical literature.

Word count: 6825

Abstract

Adolescence is a time of biological, cognitive and social changes, leaving adolescents at an increased risk of developing mental health problems that can have lasting psychological and social effects. Despite a shift towards independence, adolescents are often reluctant to seek help, and often need parents to facilitate the help seeking process. However, research has suggested that children and adolescents often hold discrepant views about their mental health problems and ideas about interventions than their parents. This previous research has focused on both children and adolescents, and does not consider the unique developmental stages of adolescence. This review aimed to search and review literature to explore adolescent-parent discrepancy in relation to adolescent mental health and treatment. Electronic databases MEDLINE, PsycINFO and Social Policy and Practice, were comprehensively searched using inclusion and exclusion criteria, resulting in sixteen papers. The studies found were quantitative in design, and reported correlations. Overall, agreement between parents and adolescents appeared to be low. Findings were discrepant regarding the influence of adolescents and parent characteristics on agreement. Levels of agreement were not found to predict service use, but were related to levels of parental involvement. Methodological critiques were considered, and recommendations for clinical practice and future research given.

(200 words)

Key words: Adolescents; Parental Involvement; Discrepancy; Adolescent Mental Health

Introduction

Research appears to consistently highlight the high prevalence of mental health problems within the adolescent population both in the UK and abroad (NHS England, 2015; Rothi & Leavey, 2006; Shanley, Reid & Evans, 2008). It has been suggested that around 20% of young people experience a mental health problem, and 10% have mental health difficulties which would reach the level of a clinical diagnosis (Meltzer, Gatward, Goodman & Ford, 2000). Mental health problems within adolescence can have lasting effects into adulthood (Steinberg, 2005).

Despite this, adolescents are argued to be reluctant to seek help, and more likely to seek help from friends and family than professional sources (Rickwood, Mazzer & Telford, 2015). Therefore, parents are said to play a strong role within the help seeking process (Costello et al., 1998; Logan & King, 2001). However, research has suggested that children and adolescents often have discrepant perspectives regarding their mental health, and goals for treatment (Achenbach, McConaughy & Howell, 1987; Reyes & Kazdin, 2005).

This review will be the first to the author's knowledge to review adolescent-parent discrepancy in relation to adolescent mental health, considering the unique developmental stages of adolescence (Yurgelun-Todd, 2007). An overview of the prevalence of mental health and help seeking within the adolescent population, parental involvement in adolescent mental health treatment, and current research into this area will be outlined. Following this, a comprehensive literature search and critical review into adolescent-parent discrepancy regarding perceptions of adolescent mental health and treatment will be presented, alongside clinical and research implications.

Adolescence and mental health

Adolescence is a developmental life stage defined by the World Health Organisation as between 10 and 19 years of age (World Health Organisation, 2016). This period of life is marked by identity development, and a move towards independence (Christie & Viner, 2005). This has been argued to be a conflictual stage for young people, who can feel torn between seeking more independence, but also still needing support from their parents or carers in developing autonomy and adjusting to adulthood (Moretti & Peled, 2004).

It is argued that the large amount of biological, cognitive and emotional changes of adolescence leave adolescents at an increased risk of mental health problems (Yurgelun-Todd, 2007), with research suggesting there is a high prevalence of mental health problems among young people and within the adolescent population (NHS England, 2015; Kessler, Berglund, Demler, Merikangas & Walters, 2005). Many mental health problems within adolescence have been found to have lasting psychological and social effects into adulthood (Steinberg, 2005). Due to this, adolescence has suggested to be an important time for mental health interventions.

Mental health service use among adolescents

However, despite this high level of mental health needs within the adolescent population, and the potential lasting impacts of adolescent emotional distress, only a small number of young people seek formal help and receive help from mental health services (Gulliver, Griffiths & Christensen, 2010). Research has found that only one third of Norwegian 15-16 year old school children with symptoms of anxiety and depression had sought help for their problems (Zachrisson, Rodje & Mykletun, 2006). In addition, within the US it was found that less than one in five adolescents accessed services for mental health problems (Merikangas et al., 2010), and around only 5% of adolescents have been found to have accessed specialist mental health treatment (Shanley, Reid & Evans, 2008). Within the

UK only 60% of young people experiencing a severe mental health problem received mental health care from services (CAMHS National Service Framework, 2004). It has therefore been argued that there is a significant discrepancy between the need for mental health services for adolescents, and the numbers of young people accessing services (Boulter & Rickwood, 2013).

Help seeking amongst adolescents

Help seeking has been defined by the World Health Organisation (2007, p.2) as

> Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community.

Within a mental health specific context help seeking has been defined as "the process of using informal and professional networks to gain support in coping with mental health problems" (Michelmore & Hindley, 2012, p. 507).

Theories of help seeking

Theories around help seeking have typically focused on working age adults, and individual characteristics predicting one's likelihood to seek help, such as Anderson (1995) and Rosenstock, Strecher and Becker (1988). However, more recently, the Network Episode Model has considered the social factors impacting on the intention to, and the action of seeking help (Pescosolido & Boyer, 1999). Costello et al. (1998) adapted this model to consider the unique factors impacting upon help seeking for children and adolescents,

considering the likelihood of young people needing an adult to facilitate their access to services.

Influences upon adolescent help seeking

Research has identified that the majority of adolescents do not seek help for mental health problems without support from others. Rickwood, Mazzer and Telford (2015) found that for younger adolescents the dominant influence on help seeking was family. This was found to shift towards the young person themselves seeking help during older adolescence and young adulthood, however, family still was found to have a substantial influence on the process. In addition, it has been argued that whilst becoming more independent from parents is an essential developmental task during adolescence, most young people who need help from mental health services need assistance from adults to seek this help (Logan & King, 2001). Research has since focused on this role of adults, including parents as 'gatekeepers', seeking help, and liaising with others to receive help for a young person (Block & Greeno, 2011).

As previously mentioned research has suggested (Costello et al., 1999; Logan & King, 2001; Rickwood, Mazzer & Telford, 2015) parents are likely to facilitate referrals into mental health services, particularly for younger adolescents. In addition, parental factors, such as parental perception of the problem, and parental perception of need have been found to be significantly associated with service use (Ryan, Jorm, Toumbourou & Lubman, 2015).

Role of parents within adolescent mental health treatment

Furthermore, in the assessment of adolescent mental health problems seeking the reports of multiple informants, and in particular that of the young person and their parents or carers are seen as a key element of best practice (Mash & Hunsley, 2005). Most evidence based treatments involve both child and parent participation to some extent (Kazdin & Weisz,

2003). In addition, NICE guidelines for young people with mental health problems highlights the importance of involving parents and family within assessment and treatment (NICE, 2005). Parents can also be key in keeping adolescents engaged within mental health treatment. A review of child and adolescents' adherence within therapy found that parents were involved in facilitating attendance and engagement within assessment and therapeutic interventions (Nock & Ferriter, 2005).

Discrepancy between parents and adolescent perceptions of mental health

However, despite research suggesting that involving parents alongside young people can have beneficial outcomes (Nock & Ferriter, 2005), there has been significant research indicating parents and adolescents often hold discrepant perceptions regarding adolescent mental health. A review conducted by Achenbach, McConaughy and Howell (1987) considered the level of discrepancy of child and adolescent emotional behavioural problems by multiple informants, and found low levels of agreement between parent and child reports of problems across a variety of measures.

A more recent review into informant discrepancy in relation to adolescent mental health also mirrored the above findings regarding parent-child discrepancy (Reyes & Kazdin, 2005). Reyes and Kazdin (2005) proposed a theoretical framework based upon these findings, the Attribution Bias Context Model, which considers the attributions that each informant has regarding the causes of the child's problem, whether the problem requires an intervention, and the informant's hopes for the outcome of assessment. They proposed that different informants are likely to have discrepant attributions in these areas, which need to be explored within the assessment process.

This disagreement is likely to lead to challenges for therapists looking to follow NICE guidelines (NICE, 2008; NICE, 2013) in creating a collaborative approach with children and

families. Hawley and Weisz (2003) found that within a clinical setting for most of a child's problems, the therapist agreed more with the parents perceptions of the problem than the child's. As parents are often the driver for referrals and engagement (Logan & King, 2001), it can be challenging for clinicians to manage differing expectations and goals between parents and young people (Diamond, Diamond & Liddle, 2000). Furthermore, research has suggested that adolescent-parent disagreement regarding adolescent emotional and behavioural problems can predict poor outcomes. Fredinand, Van der Ende and Verhulst (2004) found that in a sample of adolescents, parent-adolescent disagreement regarding these problems predicted poor outcomes for emotional and behavioural difficulties four years later.

Whilst there has been much research highlighting the discrepancy between parents and children, there has been no synthesis of the literature specifically relating to adolescent-parent discrepancy. Adolescents are in a unique stage of development that is distinct to the experience of younger children (Erikson, 1968; Newman & Newman, 2014). Notably for this review, this involves a move towards independence. Whilst parents are still argued to be vital for adolescents in developing autonomy and moving into adulthood (Moretti & Peled, 2004), it is likely that parents will be less involved within adolescent mental health care than they would be for younger children.

Review: Rationale, Aims and Scope

Rationale and aim

Whilst there has been much research highlighting the low level of agreement between parents and children (ranging from ages 5 to 18) regarding their mental health problems, to the authors knowledge there has been no review in relation to adolescents specifically. Due to the specific developmental needs of adolescents mentioned (Erikson, 1968; Moretti & Peled, 2004) and the high prevalence of mental health needs for adolescents (Kessler, Berglund, Demler, Merikangas & Walters, 2005), this appears to be an important gap in the literature base. In addition, as it appears that adolescent-parent discrepancy regarding adolescent mental health is common (Reyes & Kazdin, 2005; Yeh & Weisz, 2001) and correlated with poor emotional and behavioural outcomes (Fredinand, Van der Ende & Verhulst, 2004) this area seems particularly pertinent to explore. This review aims to rigorously search and review the current literature base in relation to discrepancy between adolescents and parents regarding adolescent mental health.

Scope

This review focused on the discrepancies between parents and adolescents perception of the young person's mental health difficulties. In line with the World Health Organisation definition of adolescence of between 10 and 19 years (World Health Organisation, 2016), the search used papers with adolescent participants between the ages of 10 and 19 years. The search focused on literature that was published following the initial review of child-parent discrepancy by Achenbach, McConaughy and Howell (1987). A clinical sample was focused upon within the review with the aim of reflecting adolescents accessing UK Child and Adolescent Mental Health Services as far as possible.

Methodology

An initial search into the research area was conducted on Google Scholar to develop search terms. Following this, the electronic databases PsychINFO, MEDline and Social Policy and Practice were systematically searched during November 2016 to January 2017. Reference lists of the papers found within these searches were also hand searched for further relevant articles.

The following search terms were used:

Table 1

Search Terms Used

Parent OR mother OR father OR carer
AND
Child* OR adolescen* OR teen*
AND
Agree* OR disagree* OR discrep* OR discordance OR concordance
AND
Mental health OR emotion*

The inclusion and exclusion criteria were as follows:

Inclusion Criteria:

-Adolescent participants aged 10-19

-Research examining disagreement between parents/carers and adolescents in relation to symptoms of adolescent mental health problems

-Research using a clinical sample that were accessing adolescent mental health services during the study

-Research published since the previous review (Achenbach, McConaughy and Howell, & 1987)

Exclusion Criteria:

-Research not directly related to adolescent-parent disagreement in relation to symptoms of adolescent mental health problems

-Research focusing on physical health issues

-Research focusing only on developmental disorders

-Research with incorrect age range or age range of participants not given

-Research including non-clinical sample

-Research examining multiple informants

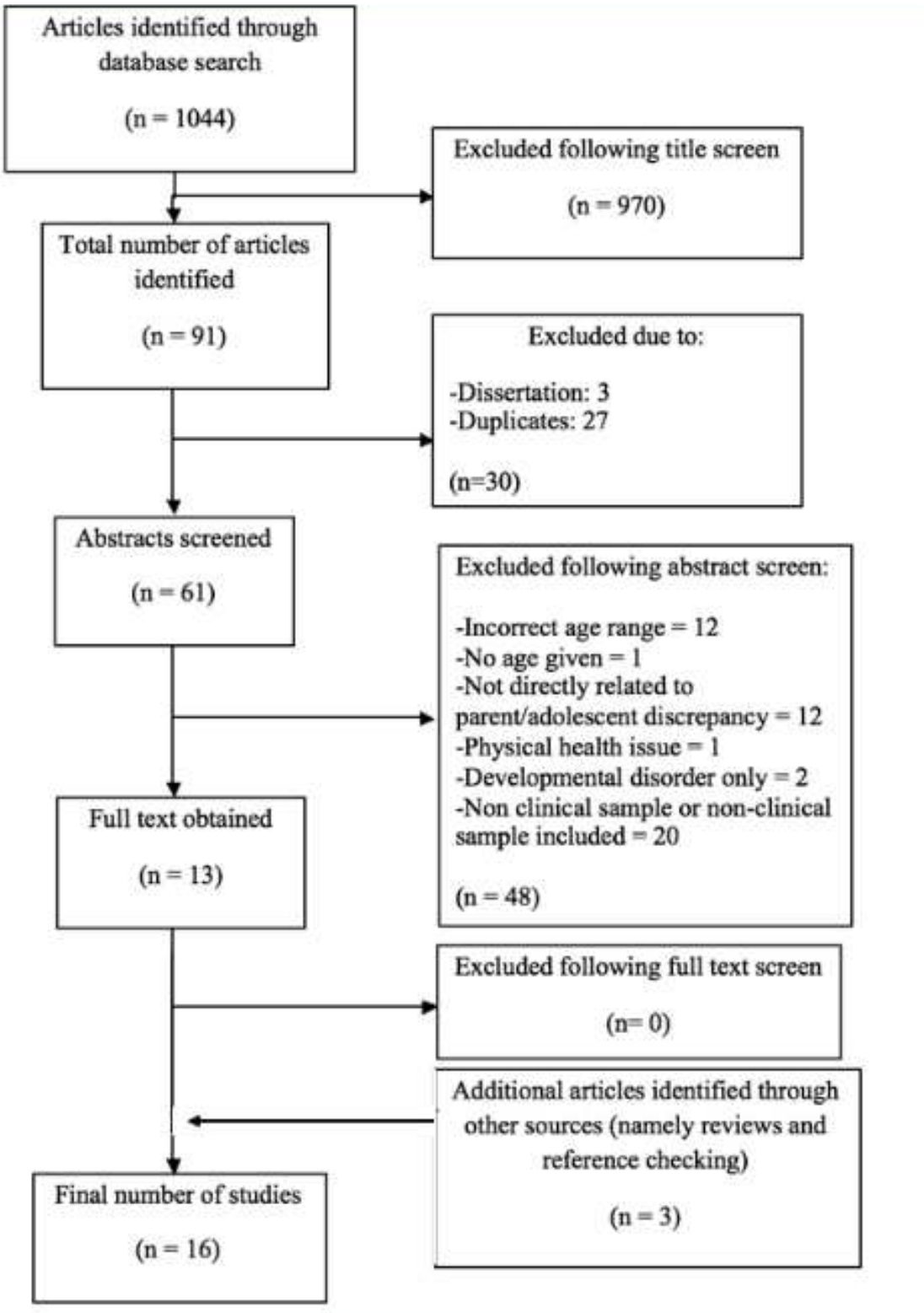


Figure 1: Flow chart demonstrating literature search process.

Review

The sixteen studies reviewed are presented in the table below. The review will begin by exploring overall levels of agreement found between parents and adolescents in relation to perceptions of adolescent mental health. Attention will then be given to factors found within the literature to have an impact upon levels of agreement. Next, findings in relation to the influence of levels of agreement between adolescents and parents upon engagement and treatment will be described. Methodological critiques will then be presented. Following this, there will be a discussion of implications of the research, both upon clinical practice and future research. Papers will be discussed using the number they have been assigned within the study summary table.

Table 2

Study Summary Table

Paper	Aims	Hypotheses:	Design, Participants and Methods	Design and Methods	Findings
Paper 1 Lauth, Arnkelsson, Magusson, Skarpheoinsson, Ferrari & Petursson (2010) Parent-youth agreement on	Aim: To evaluate parent-adolescent agreement for both symptoms reported and diagnosis within an inpatient setting.	Hypotheses not given.	N=64 parents and adolescents (11-18), inpatient ward in Iceland.	Correlational Design -Self-report quantitative measures completed by parents and adolescents separately. K-SADS-PL interviews for each adolescent and parent separately.	Findings: -Agreement between parents and adolescents was low for most diagnoses, except for social phobia and generalised anxiety disorder. -Agreement between parents and adolescents was also low for most symptoms reported, except for symptoms of social phobia.

symptoms and diagnosis: Assessment with a diagnostic interview in an inpatient clinical population.					
Paper 2 Wahlin & Deane (2012) Discrepancies between parent and adolescent perceived problem severity and influences on help seeking from mental health services.	Aim: To explore the influence of parents and others on the decision of young people to seek help from mental health services and to explore the relationship between the severity and types of adolescents' psychological problems, and how much influence from others is needed for young people to choose to access help.	Hypotheses: -Young people will perceive parents to have had the strongest influence on them accessing mental health services. -In situations in which parents see a young person's problem as more serious than a young person does, the greater the disagreement, the higher parents and young people will rate the influence of parents upon help seeking. -In situations in which parents see a young person's problem as less serious than a young person does, the greater the disagreement, the lower parents and young people will rate the influence of parents upon help seeking. -Higher ratings from parents regarding an adolescent's externalising difficulties will be related to reports from parents	N=119 adolescents (14-18) and parents attending an initial CAMHS assessment in Australia. -36% of adolescents were male, and 64% were female. -80% of parent participants were mothers, and 20% fathers or other relatives.	Cross sectional design -Self-report quantitative measures were given to parents and adolescents due to be attending an initial CAMHS assessment appointment.	Findings: -Parents found to be the most influential in young people's decision to seek help. -87% of young people said that they had been influenced by more than one source of help. -Only 12% of parents reported they had not influenced their child's help seeking decision. -20% of parents reported the young person was not included in the decision to seek help. -5% of parents reported that the decision to seek help had been entirely the decision of someone else. -5% of parents reported that they had been at all involved in the decision to seek help. -Difference found on externalising subscale; young people reported greater difficulties than their parents

		and adolescents of increased parental influence on help seeking.			
Paper 3 Williams, Lindsey & Joe (2011) Parent-adolescent concordance on perceived need for mental health services and its impact on service use.	Aim: To explore the relationship between parent-adolescent agreement on perception of need for mental health services and the level of actual service use.	Hypotheses not given.	N=108 adolescents (12-17) and parents from a community mental health service in the USA. -102 participants identified as African American, 2 as mixed race, and 2 as American Indian.	Cross sectional Design -Adolescents and parents interviewed separately about their perceived need for a counsellor or psychiatrist and completed brief depression screening tool.	Findings: -Agreement between parent and adolescent reports on the need for a counsellor was low (22% agreed on need for counsellor). -Agreement between parents and adolescent reports on need for a psychiatrist was low, but higher than that for the counsellor (42% agreed on need for psychiatrist).
Paper 4 Klaus, Mobilio & King (2009) Parent-adolescent agreement concerning adolescent's suicidal thoughts and behaviours.	Aims: -To assess the level of parent-adolescent agreement about suicidal thoughts, both currently and in the past in a sample of adolescents currently receiving inpatient treatment. -To examine parent, child and family characteristics leading to differences between parents and adolescents who agree, and those of who only parents report a problem, and for those of whom only the adolescent reports a problem.	Hypotheses: -Low to moderate agreement would be found between parent and adolescent reports of suicidal thoughts and behaviours. -Greater agreement would be related to male gender, externalising symptoms and perceived family support.	N=448 adolescents (13-17) who had recently attempted suicide or had severe suicidal ideation were recruited from two inpatient hospitals in the USA.	Correlational Design Parents and adolescents interviewed separately using DISC-IV structured diagnostic interview. Parents and adolescents completed self-report quantitative measures separately.	Findings: -Young people reported significantly higher levels of suicidality than their parents. -Parent-adolescent agreement about suicidal ideation was low. -37% of parents did not know of the adolescent reported suicidal thoughts, and 59% of parents did not know of the adolescent reported suicide plans. -The perception of family support was related to parent's knowledge of an adolescents' reported suicidality. -Parents had greater awareness of reports of adolescent suicidal ideation if either parent had previously experienced depression.

Paper 5 Thurber & Osborn (1993) Comparisons of parent and adolescent perspectives on deviance.	Aim: To examine inter-parent and parent-adolescent correspondence on scores reported in the CBCL (parent ratings) and the YSR (adolescent ratings) relating to mental health symptoms.	Hypotheses not given.	N=103 adolescents (11-17) and parents recruited from an inpatient psychiatric setting in the USA. -57 of the adolescent participants were female, and 46 male. -Of the caregivers, there were 74 pairs of biological parents, 15 pairs of adoptive parents and 14 pairs with one biological parent and one step parent.	Correlational Design: Parents and adolescents completed self-report quantitative measures separately upon admission.	Findings: -Ratings by mothers were significantly higher than that of fathers for total score, and internalising and externalising subscales. -Mothers and fathers rated boys as having more difficulties than girls on both internalising and externalising subscales. -Adolescent girls rated themselves as having increased levels of difficulties than adolescent boys. -The degree of parent-child correspondence for girls was similar to mother and father correlations. Higher correspondence was found between mother-son correlations than in father-son correlations.
Paper 6 Israel, Thomsen, Langeveld & Stormark (2007) Parent-youth discrepancy in the assessment and treatment of youth in usual clinical care setting: Consequences to parent involvement.	Aims: -To investigate the role of adolescents' and parents' reports of their emotional and interpersonal difficulties on parent involvement in the treatment process. -To explore the role of parent and adolescent discrepancy on their reports of adolescent difficulties on parental involvement.	Hypotheses not given.	N=63 adolescents (14-17) and their mothers receiving outpatient mental health care in Norway and their mothers. -35% of the adolescent sample were male and 65% female.	Correlational Design: -Adolescents and parents completed self-report quantitative measures separately during the first assessment session.	Findings: -Low to medium correlations between adolescent and mother reports. Adolescent females had higher levels of agreed responses with their mothers than adolescent males in the sample. Highest correlation was found to be that between mothers and adolescent females on reports of externalizing behaviours. -Reports from adolescents or their mothers did not significantly predict parental involvement. -Discrepancy scores between parent and adolescent reports significantly predicted both behavioural involvement of parents and parental emotional involvement.

Paper 7 Freeman, Youngstrom, Freeman, Youngstrom, & Findling (2011) Is caregiver-adolescent disagreement due to differences in thresholds for reporting manic symptoms?	Aim: To explore whether reports of 'manic symptoms' from parents and adolescents would be able to be split into 'self-reported first' and reported first by others' symptoms.	Hypotheses: 'Self-reported first' symptoms would be reported at a lower level of severity by the young people and 'reported first by others' symptoms would be reported earlier by parents.	N=459 adolescents (11-18) and their carers recruited from a community mental health team or an academic medical centre in the USA. Adolescents: 54% male. 68% African American, 25% were Caucasian and 7% 'other ethnicity'. Carers: 74% biological mothers, 5% biological fathers, 8% grandparents and 1% listed as other relatives.	Cross Sectional Design: Adolescents and their carers were interviewed separately using the K-SADS-PL tool, and completed self-report quantitative measures separately.	-Parents were more likely to report irritability earlier than young people. -Young people were more likely to report increased energy and hyperactivity at an earlier point than their parents.
Paper 8 Salbach, Klinkowski, Lenz, Pfeiffer, Lehmkuhl & Ehrlich (2008) Correspondence between self-reported and parent-reported psychopathology in adolescents with eating disorders.	Aims: -To explore if there are discrepancies in reports of adolescent mental health difficulties between adolescent and parent reports within an eating disorder clinical setting. -To further explore whether if these discrepancies exist whether they differ by eating disorder subtype.	Hypotheses not given.	N=83 female adolescents (11-18) with a diagnosis of anorexia nervosa or bulimia nervosa and their parents receiving treatment in Germany.	Correlational Design Participants were assessed using the structured inventory for anorexic and bulimic symptoms (SIAB-EX) to diagnose the subtype of eating disorder. Adolescents completed the Youth Self Report (YSR) measure, and parents completed the Child Behaviour Checklist (CBCL).	Findings: -Poor agreement found between parent and adolescent reports on the YSR and CBCL. -Level of adolescent and parent agreement was slightly higher for externalising symptoms. -Adolescents with anorexia reported significantly lower externalising problems compared with adolescents with bulimia.

Paper 9 Ford, Dyer-Friedman, Tang & Huffman (2004) Patterns of agreement between parent and child ratings of emotional and behavioural problems in an outpatient clinical setting: When children endorse more problems.	Aims: -To examine four types parent–adolescent patterns of agreement or disagreement; adolescents and parents both report problems as above clinical threshold, neither parent or adolescent reports problem as above clinical threshold, only adolescent reports problem as above clinical threshold and only parent reports problem as above clinical threshold. -To examine the ways in which factors such as age and gender of the adolescent, the adolescent's diagnosis and reported parental stress are associated to these four patterns of agreement or disagreement.	Hypotheses: -Low to moderate agreement between parents and adolescents predicted, and greater agreement predicted for externalising problems. -The 'parent only reporting problems' was expected to contain the greatest number of participants, and the 'adolescent only reporting problems' group was expected to have the smallest. -Adolescents predicted to be older in the 'disagreement groups'. -Mothers' levels of stress would be at the highest level in the 'parent only reporting problems' group, and lowest in the 'adolescent only reporting problems' group. -Adolescents in the 'adolescent only reporting problems' group were expected to have more diagnoses of depression and anxiety than other diagnoses.	N=274 adolescents (11-18) and their parents recruited from an outpatient mental health clinic in the USA. -54% of the adolescent participants were male. -77% of adolescent participants were Caucasian, 10% were Asian, 7% Hispanic, with the remaining 6% including Native American, African American adolescents.	Correlational Design Parents completed CBCL and adolescents completed the YSR separately. Parents also completed 'The Parenting Stress Index'. Clinicians administered a 'standardised evaluation record' with both parents and adolescents in order to assess the diagnosis for each adolescent.	Findings: -A modest level of agreement was found between parents and adolescents overall within the study. -Correlations for agreement between parents and adolescents for externalising problems were slightly higher than that of internalising problems. -When analysing whether the reported behaviour met clinical thresholds, the results showed that parents and adolescents both reported problems that equated to a score above clinical cut off in 53% of cases. -Most of the disagreement found within the remaining 47% was for parents reporting problems of clinical severity when the adolescents did not. Only a small number of adolescents reported problems reaching clinical thresholds when their parents did not. -Within the group of adolescents who reported clinically significant problems without the parent agreeing, the most likely diagnosis for the adolescents within this group was a mood disorder.
Paper 10 Van de Meer, Dixon & Rose (2008)	Aim: To explore parent-adolescent similarities on reported scores on the SDQ, and to examine the relationship between the	Hypotheses: -Low to moderate parent-adolescent agreement expected.	N=379 adolescents (11-18) and their parents attending an outpatient mental	Correlational Design Parents and adolescents completed the SDQ separately as part of the assessment	Findings: -23% of parent-adolescent participants both reported that the adolescent's difficulties reached

Parent and child agreement on reports of problem behaviour obtained from a screening questionnaire, SDQ.	type of disorder, age and gender on the similarity of scores between parents and adolescents.	-Higher agreement is expected for externalising than for internalising problems. -Younger adolescents were predicted to have a greater level of agreement with parents than older adolescents. -Adolescent-parent agreement predicted to be higher between adolescent females and their parents for internalising problems than adolescent males.	health clinic in Australia. -47% of adolescent participants were male.	process of the mental health clinic. Adolescents were assigned a diagnosis using ICD-10 criteria.	clinical severity from the scores reported. -46% of parent-adolescent participants agreed in their reports that the adolescent's problems did not reach clinical severity despite being given an ICD-10 diagnosis. 31% of parent-adolescent pairs disagreed within their reports on the SDQ. -Most disagreement was found to be parents reporting problems when adolescents did not. -Higher levels of agreement found with externalising problems. -No age differences found. -More adolescent males found to be in the groups in which both parents and adolescents reported a problem, or in which only parents reported a problem than adolescent females. More adolescent females were found to be in the groups in which neither the parent or adolescent reported a problem, or in which only the adolescent reported a problem.
Paper 11 Salbach, Andrae, Klinkowski, Lenz & Lehmkuhl (2009) Agreement between youth and parent reported psychopathology in a referred sample.	Aim: To investigate parent-adolescent agreement regarding symptoms of mental health problems, and to examine differences between adolescents presenting with "no disorder, one disorder or more than one disorder".	Hypotheses not given.	N=1178 adolescents (11-18) and their parents recruited from an outpatient mental health clinic in Germany.	Cross Sectional Design -Parents and adolescents completed the CBCL and YSR at the beginning of the assessment process. -Adolescents and parents were then interviewed using a semi structured interview to assign a	Findings: -For all three groups (no disorder, one disorder or multiple diagnoses) results show low levels of agreement between parent and adolescent reports of internalising difficulties and the "total problem scale". -Young people rated themselves as having lower scores on the "total problem scale" than their parents. - For the externalising scales, parent-adolescent disagreement was

				diagnosis using ICD-10 criteria.	strongest for adolescents presenting with comorbid disorders, followed by the one disorder group. The three groups did not differ in parent-adolescent disagreement on the total problem scale and internalising scale on the CBCL and YSR. -For externalising difficulties, parents and adolescents disagreed the most when adolescents had co-morbid disorders, followed by those with one disorder. There was no difference in these groups found for reports internalising difficulties.
Paper 12 Berg-Nielsen, Vika & Dahl (2003) When adolescents agree with their mothers: CBCL-YSR discrepancies related to maternal depression and adolescent self-esteem	Aims: -To examine how mothers' depression may influence their reports of adolescent mental health problems compared to adolescent self-reports. -To explore how adolescent self-esteem is related to adolescent self-reports of mental health problems, in comparison to reports from mothers.	Hypotheses not given.	N=68 adolescents (11-17) and their mothers recruited from an outpatient adolescent mental health clinic in Norway. -51% of adolescent participants were female.	Correlational Design Adolescents and their parents completed the CBCL, HADS and SPPA separately several weeks prior to completing treatment.	Findings: -Mothers with elevated levels of depression reported more internalising problems in their adolescents than adolescent self-reports. -Mothers who were experiencing depression reported a higher level of internalising difficulties in their adolescents than adolescents reported. -Adolescent's dislike of their own appearance was related to more agreement with their mothers about their internalising and externalising problems. -Adolescents dissatisfaction with their physical appearance correlated with increased agreement with their mothers regarding their mental health difficulties. -Adolescents' increased age was associated with a higher level of agreement on adolescent and mother reports of externalising difficulties.

Paper 13 Weems, Feaster, Horigian & Robbins (2011) Parent and agreement on anxiety disorder symptoms using the DISC predictive scales.	Aim: To explore the similarity between adolescent and parent ratings of anxiety symptoms.	Hypotheses: A relatively small but significant relationship between adolescent and parent ratings of anxiety symptoms reported on the DISC predictive scales expected.	N=480 adolescents (12-17) and their families receiving treatment for substance misuse in the USA. Adolescents: 79% were male. 44% Hispanic, 31% white, 23% African-American and 2% other ethnic backgrounds. Parents: 78% mothers, 14% fathers, 4% grandmothers, 1% grandfathers, and 3% other relatives.	Correlational Design The PS-DISC interview administered separately to parents and adolescents, and was used to measure anxiety symptoms from the perspective of adolescents and parents.	Findings: -Correlation between parent and adolescent scores were fairly low. -Agreement between likely diagnosis also low.
Paper 14 Mbekou, MacNeil, Gignac & Renaud (2015). Parent-youth agreement on self-reported competencies of youth with depressive and suicidal symptoms.	Aims: -To examine the agreement between parents and adolescents on competencies as reported on the CBCL and YSR. -To examine the effect of youth characteristics that may affect agreement such as age, gender and the types of problem they present with.	Hypotheses not given.	N=258 adolescents (11-18) and their parents. -84% of adolescent sample were female.	Correlational Design Parents and adolescents completed the CBCL and YSR separately.	Findings: -Agreement between scores reported on the YSR and CBCL was of weak to moderate strength on the activities and social subscales. Results did not show any informant agreement on the academic subscale across any analyses. -Strong agreement was found between adolescent males and their parents, and weak agreement between adolescent girls and their mothers.

Paper 15 Thurber & Snow (1990) Assessment of adolescent psychopathology: Comparison of mother and daughter perspectives.	Aims: -To explore how experiences of depression in mothers might influence their reports of their child's mental health problems in comparison to adolescent self-reports. -To examine the relationship between adolescent self-esteem and reports of mental health difficulties from the perspective of the adolescent and their mothers.	Hypotheses not given.	N=68 adolescents (11-17) and their mothers referred to child and adolescent mental health clinics in Norway. -51% of adolescent participants were female. -Of mothers participating the mean age was 38.5 years.	Cross Sectional Design All questionnaires (CBCL, YSR, HADS, SPPA) were completed before treatment within the clinics began. Mothers and adolescents completed the measures separately.	Findings: -Mothers experiencing symptoms of depression were more likely to report that their adolescent had internalising difficulties than the adolescent was likely to report. -An adolescent's dissatisfaction with their appearance was correlated with higher levels of agreement with their mothers regarding their difficulties. -Increased age of an adolescent was correlated with higher agreement between mothers and their young person about externalising difficulties.
Paper 16 Handwerk, Larzelere, Frimam & Soper (1999) Parent and child discrepancies in reporting severity of problem behaviours in three out of home settings.	Aim: To examine ratings of parents and adolescents across a continuum of residential placements providing therapeutic input; a youth shelter, a residential group home and an inpatient hospital setting.	Hypotheses not given.	N=238 adolescents (11-18) with emotional and behavioural difficulties placed within three residential placements in the USA; an acute care youth shelter, a youth shelter, a residential group home and an inpatient hospital setting.	Cross Sectional Design Adolescents and parents/carers completed the YSR and CBCL separately. The CBCL was either completed at the units or completed and returned by post.	Findings: -The least restrictive placement was found to have the largest discrepancy between CBCL (parent ratings) and YSR (adolescent ratings) for the externalising scale. For internalising difficulties, disagreement was higher for older adolescents than for younger adolescents.

Overall levels of agreement

In concordance with the findings for adolescents within the previous review (Achenbach, McConaughy & Howell, 1987) across the studies reviewed, within the constraints of a correlational design it was found that whilst there was variability, agreement was generally low to moderate between adolescent and parent reports.

Studies using a correlational design examining the extent of adolescent and parent agreement on adolescent functioning suggested that there was large discrepancy in reports for both symptoms and whether problems reported reached clinical thresholds. Study 1 found that adolescent and parents rarely agreed on whether an adolescent met diagnostic criteria for psychological disorders, and rarely agreed on reported mental health symptoms. In addition, study 13 found that parents and adolescents had low agreement on reports on symptoms and likely diagnosis. Worryingly, study 4 found that 59% of parents were unaware of plans their adolescents had made for suicide, and found that adolescents reported significantly higher levels of suicidal thoughts, plans and behaviours than their parents. Rather than looking at agreement between mental health symptoms and diagnoses, study 14 examined agreement between adolescents and parents on the functioning in relation to activities, social skills and academic ability in adolescents with mental health problems. They again found that agreement between parents and adolescents was low to moderate on these reports.

Several studies within the review examined whether parent and adolescent reports concurred on whether adolescent problems reached clinical thresholds. Study 9 found that parents and adolescents agreed on whether adolescent mental health problems reached the level of clinical threshold just over half of the time. It was found that the majority of this disagreement was parents reporting problems when adolescents did not. However, there was also a small group of adolescents reporting problems when their parents did not. This group of adolescents were found to be more likely to have a mood disorder than adolescents within

the other groups. Study 10 found that just under half of parents and adolescents agreed that problems did not fall within a clinical range. Around a quarter of parents and adolescents agreed that problems fell within a clinical range, leaving the remaining parents and adolescents disagreeing. Similarly, to the findings of study 10, it was found more broadly that the disagreement was mostly parents reporting problems when adolescents did not, with a small minority of adolescents reporting problems when their parents did not. Again, the results suggested that the majority of problems recognised by parents were externalising in nature.

The relationship between individual characteristics of adolescents and agreement

The reviewed papers highlighted several characteristics of adolescents that they hypothesised would be associated with adolescent-parent agreement, such as age, gender, and type of problem that the young person presents with. These characteristics will now be discussed in turn.

Age

Three of the studies (9, 10, 14) hypothesised that there would be a relationship between the age of the adolescent and the levels of agreement between parents and adolescents. Several other reviewed studies (4, 15, 16) explored the relationship between age and agreement, but did not include hypotheses. There are some conflicting theoretical explanations for these hypotheses. Theory and research has suggested that adolescents are reaching a point developmentally in which they are likely to be able to more perceptive of their problems. Cognitively, Piaget (1964) suggested that adolescents are developing the ability to think about abstract constructs and to solve more complex problems. This is supported by more recent research into adolescent brain development (Spear, 2000). In addition, research into brain development has suggested that adolescents are developing the

ability to think about their own mental states, that of others and to consider alternative perspectives. However, this is an ability that continues to develop into adulthood, and can be a challenge for adolescents. (Blakemore, 2012). This could partly explain some of the differences in perspectives between parents and adolescents.

It was found within the studies reviewed that the association between age and discrepancy varied. Study 10 found no age effects within their analysis, and argued that this could be due to the age range within the study not including younger children which had been included in much discrepancy research. In addition, study 3 found no age effects. However, study 12 found that adolescents' increased age was related to increased agreement between mothers and adolescents about externalising problems. Conversely, study 16 found that for internalising difficulties discrepancy was higher between older adolescents and parents than younger adolescents.

Gender

Two studies reviewed hypothesised that gender would be associated with parent-adolescent agreement (4, 10). It was expected that adolescent females would be more likely to report their difficulties than adolescent males, particularly internalising difficulties, due to research focusing on the different ways in which males and females seek help (Oliver, Pearson, Coe & Gunnell, 2005). In line with this hypothesis study 5 found that adolescent females reported higher levels of problems than adolescent males. However, it is not clear from this study whether this is due to adolescent females reporting greater problems than adolescent males, or whether the adolescent females within the studies were experiencing a greater level of difficulty.

Some findings in relation to gender were also discrepant within the reviewed papers. Study 6 found that adolescent females were more likely to agree with their mothers about

their problems than adolescent males. Conversely, study 14 found that there was strong agreement between adolescent males and their parents, whilst weak agreement was found between adolescent females and their parents. Study 10 found that parents were more likely to report a problem than adolescent males, whereas adolescent females were more likely to report a problem than their parents.

Agreement by type of difficulty

Several studies considered the agreement between parents and adolescents in regards to specific symptoms or diagnoses. Study 1 found that agreement between parents and adolescents was low for the majority of diagnoses, although this was not the case for some anxiety disorders. Study 7 explored whether adolescents or parents would be the first to report 'manic symptoms'. Findings suggested that adolescents and parents are likely to report different concerns in relation to who the symptom impacts upon the most. Parents were significantly more likely to report symptoms of irritability before adolescents, who were more likely to report levels of hyperactivity than their parents. Study 11 explored whether there were discrepancies between adolescents and parents in the reports of adolescent mental health difficulties for adolescents with an eating disorder. Poor agreement was found between parents and adolescents, but agreement was found to be slightly higher for externalising symptoms. Within the review agreement upon symptoms of anxiety and agreement on likely diagnosis were also found to be fairly low (study 13). In addition, low adolescent self-esteem was found to be related to higher levels of agreement between adolescents and their mothers (study 12). Lastly, it was found that for externalising problems, adolescents with more than one diagnosed mental health problem were more likely to disagree with parental reports than those with one diagnosed mental health problem or those found not to meet diagnostic criteria within the study (study 8).

The relationship between family characteristics and agreement

Several of the studies conducted further analysis to consider factors that may predict adolescent-parent disagreement. Study 5 found that reports of problems from mothers were significantly higher than that of fathers for both internalising and externalising subscales of the Child Behaviour Checklist (CBCL). In addition, it was found that there was higher agreement between mother and father reports of their daughter's problems than that on sons. For sons, mothers were found to have a higher level of agreement with their sons than fathers.

A further finding was that an adolescent's perception of family support was associated with increased parental awareness of an adolescents reported suicidal thoughts and plans (study 4). This suggests the importance of family relationships in allowing adolescents to feel secure to disclose difficulties with their mental health. In addition, the findings of this study reported that parents were more likely to be aware of adolescent suicidal ideation if either parent had experienced depression. It could be that this experience gives some parents insight into more subtle signs that their children are experiencing mental health problems. In addition, both studies 5 and 12 found that mothers with elevated levels of depression were more likely to report more internalising difficulties in their adolescents than mothers without depressive symptoms.

The relationship between adolescent-parent disagreement on engagement and service use

Three of the reviewed papers considered the relationship between parent-adolescent disagreement, adolescent engagement and mental health service use. Study 2 examined adolescent-parent discrepancy in perceptions of adolescent problem severity on adolescent help seeking. Parents were found to be significantly more influential in an adolescent's decision to seek help than other significant people in their lives. In addition, parent and adolescent reports of severity of problems on the Strengths and Difficulties Questionnaire

(SDQ) were found to be significantly discrepant on the externalising difficulties subscale. Interestingly, this discrepancy on reports of externalising problems was found to predict the help seeking process. Parents who held higher levels of concern than their children had more of an influence over the help seeking process than young people who reported less problems than their parents. These findings build upon the findings of the other reviewed papers (8, 9, 10), which suggest that parents are more likely to recognise a problem within their child that is externalising in nature, and suggests that parents who hold more concerns than their children are more likely to exert more influence in engaging their children into mental health services.

Study 3 examined the relationship between agreement on perceived need for child mental health services between parents and adolescents and actual service use in a sample of mainly African American families. It was firstly found that agreement between parent and adolescent opinions on the need for psychiatric or psychological input was low. A significant relationship was not found between this disagreement and the level of service use. However, it was found that when grouping the sample into those adolescents meeting criteria for depression and those who did not, greater discrepancy was found between parents and adolescents for adolescents with depression, with depressed adolescents reporting more symptoms than their parents. This again suggests that parents have more difficulties in recognising problems in their adolescents that do not necessarily involve observable behaviours. The authors also note the relevance of 'help negation', which suggests that people with mental health problems are less likely to seek help (study 2), and the implications for this upon an already marginalised group.

Lastly, study 6 examined the relationship between levels of agreement in the reports of adolescent mental health problems by adolescents and parents, and parental involvement in adolescent mental health treatment. Adolescents and parents were found to have low to

moderate levels of agreement in their reports, and these discrepancy scores were found to be significant predictors of both emotional and behavioural involvement within adolescent mental health treatment.

These findings suggest that adolescent parent disagreement on adolescent mental health problems can impact on both help seeking, engagement with service use, and parental involvement in adolescent mental health treatment.

Synthesis of Findings

Overall, the reviewed studies suggest low to moderate agreement across different clinical settings, including inpatient and community mental health service contexts. The association between individual characteristics, such as age, gender and type of difficulties and parent-adolescent agreement were found to vary across studies, which could reflect differences in methodologies, sample population and measures used. Parent-adolescent agreement was found to be higher for externalising difficulties than internalising difficulties, and parents were found to report higher levels of externalising problems, whilst adolescents were more likely to report higher levels of internalising problems.

Differences were found in the reports of mothers and fathers (Thurber & Osborn, 1993), however, there were very limited numbers of fathers recruited within the study, which limits the generalisability of these findings. Findings also suggested that family support can help adolescents disclose mental health difficulties and risk issues (Klaus, Mobilio & King, 2009). Parents experience of mental health difficulties predicted higher reports of severity on parental report measures, however, this did not predict greater adolescent-parent concordance. This suggests that experience of mental health difficulties may give a parent the ability to see more subtle indicators of mental health difficulties in their adolescents.

It was also found that parents who had more concern than their adolescents regarding externalising problems had greater influence over the help seeking process. A significant relationship was not found between adolescent-parent disagreement and actual levels of service use. However, the discrepancy reports between parents and adolescents were found to predict emotional and behavioural involvement by parents within treatment, with greater discrepancy predicting greater involvement.

Whilst there are limitations for each study, the findings of the papers have interesting implications for clinical practice if interpreted with caution. Further research is likely to be needed to give further insight based on these limitations.

Overview of designs and measures

The sixteen studies reviewed used either a correlational or cross sectional design. The studies all used self-report questionnaires to provide reports on adolescent functioning from parents and adolescents. The majority of the papers used the Child Behaviour Checklist (CBCL) (Achenbach & Rescorla, 2001), which asks parents to rate emotional and behavioural problems in children and adolescents across internalising and externalising problem scales, and the corresponding adolescent self-report measure the Youth Self Report (YSR) (Achenbach & Rescorla, 2001). Other measures included the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). This has both a parent and youth version, which asks for reports on child and adolescent social and emotional functioning across four domains and provides diagnostic predictions. Studies also used diagnosis specific self-report measures.

In addition to using self-report questionnaires, eight of the studies used clinician administered interviews or clinician guided assessment to assign a clinical diagnosis to

adolescent participants such as the Kiddi-Sads-Present and Lifetime Version (K-SADS-PL) and the Diagnostic Interview Schedule for Children (DISC-IV).

Methodological Critique

As most of the reviewed studies used a correlational design, the studies were assessed for quality using the NICE quality appraisal checklist for quantitative studies reporting correlations and associations (NICE, 2010). The studies using a cross sectional design were also assessed using this assessment tool as there is no validated appraisal tool for this methodology, and these studies also reported correlations. The tool awards studies a score of ++ (aspect of design has been conducted to reduce risk of bias), + (either answer to checklist question has not been answered, or all aspects of bias not identified), or – (aspects of study design where significant sources of bias may exist) for each aspect of study design, which then offers an overall score of ++, + or -. (See Appendix A for appraisal tool criteria).

Below is a table of the quality scores assigned to each study.

Table 3

Quality appraisal ratings given to each study

Paper	Quality appraisal rating
Paper 1: Lauth, Arnkelsson, Magusson, Skarpheoinsson, Ferrari & Petursson (2010) Parent-youth agreement on symptoms and diagnosis: Assessment with a diagnostic interview in an inpatient clinical population.	++
Paper 2: Whalin & Deane (2012) Discrepancies between parent and adolescent perceived problem severity and influences on help seeking from mental health services.	++
Paper 3: Williams, Lindsey & Joe (2011) Parent-adolescent concordance on perceived need for mental health services and its impact on service use.	++
Paper 4: Klaus, Mobilio & King (2009) Parent-adolescent agreement concerning adolescents' suicidal thoughts and behaviours.	++
Paper 5: Thurber & Osborn (1993) Comparisons of parent and adolescent perspectives on deviance.	+
Paper 6: Israel, Thomsen, Langeveld & Stormark (2007) Parent-youth discrepancy in the assessment and treatment of youth in usual clinical settings: Consequences to parent involvement.	+
Paper 7: Freeman, Youngstrom, Freeman, Youngstrom & Findling (2011) Is caregiver-adolescent disagreement due to differences in thresholds for reporting manic symptoms?	+

Paper 8: Salbach, Klinkowski, Lenz, Pfeiffer, Lehmkuhl & Ehrlich (2008) Correspondence between self-reported and parent-reported psychopathology in adolescents with eating disorders.	+
Paper 9: Ford, Dyer-Friedman, Tang & Huffman (2004) Patterns of agreement between parent and child ratings of emotional behavioural problems in an outpatient clinical setting: When children endorse more problems.	+
Paper 10: Van de Meer, Dixon & Rose (2008) Parent and child agreement on reports of problem behaviour obtained from a screening questionnaire, the SDQ.	++
Paper 11: Salbach, Andrae, Klinkowski, Lenz & Lehmkuhl (2009) Agreement between youth and parent reported psychopathology in a referred sample.	+
Paper 12: Berg-Nielsen, Vika & Dahl (2003) When adolescents agree with their mothers: CBCL-YSR discrepancies related to maternal depression and adolescent self-esteem.	+
Paper 13: Weems, Feaster, Horigin & Robbins (2011) Parent adolescent agreement on anxiety disorder symptoms using the DISC predictive scales.	+
Paper 14: Mbekou, MacNeil, Gignac & Renaud (2015) Parent-youth agreement on self-reported competencies of youth with depressive and suicidal symptoms.	+
Paper 15: Thurber & Snow (1990)	+

Assessment of adolescent psychopathology: Comparison of mother and daughter perspectives.

Paper 16: Handwerk, Larzelere, Frimam & Soper (1999) +

Parent and child discrepancies in reporting severity of problem behaviours in three out of home settings.

For this methodological critique, the reviewed studies will firstly be considered with the relevant points raised in line within the NICE quality appraisal checklist.

Population

Within the reviewed studies there was variation in the detail to which the papers gave details about the recruited samples. The majority of studies reviewed gave an adequate level of detail regarding the adolescent participants recruited, particularly studies 1, 2 and 3, which gave clear details about the characteristics of the adolescent sample, the population they were drawn from and the clinical context. In addition, study 3 was clear in the description of its focus of a study recruiting from a minority population ethnic group and the implications of this. Several of the studies were limited in their descriptions of the sample population. Study 15 gave very limited details regarding the population in which the sample was drawn from, such as the location or population demographics. Several studies also noted the implications of a potential sampling bias, and gave details of the percentage of those who agreed to participate from the sample pool. Study 2 reported that 50% of those invited to participate agreed to take part. They suggested that this could reflect characteristics of those who agreed, and questioned whether families with greater difficulties and fewer resources may have declined to take part.

Whilst most studies gave clear descriptions of adolescent participants, many of the studies did not give clear details regarding parent participants. Study 14 gave no demographic

details about parent participants, other than that all parent participants were mothers. In addition, whilst study 5 provided analysis on the correlations of responses between mothers and fathers, the paper did not give details regarding how many paternal and maternal participants were recruited. It is also important to note that many of the studies recruited only mothers, with several of the studies that had recruited fathers not having the numbers of father participants needed to be able to analyse their responses as a separate group. There were also limited studies regarding other carers, such as grandparents or other relatives. For example, within the sample of paper 13, 78% of parents were mothers, 14% were fathers, and only 8% were other relatives. However, most studies did recognise this as a limitation, acknowledged the difficulties of recruiting fathers, and recognised the implications of this, such as the lack of generalisability to the reports of fathers.

Relevance to the UK and the UK healthcare system

Several studies were not clear in the description of the location in which the study was conducted. Seven of the studies were conducted in the USA (3,4, 7, 9, 13, 15, 16), two in Australia (2, 10), two in Norway (6, 12), two in Germany (8, 11), one in Iceland (1) and one in Canada (14). Whilst it was possible to deduce the location of several of the studies conducted within the USA by other information within the paper, no details regarding the demographics of the area or healthcare system were reported. Studies 1, 2 and 10 gave details about the healthcare system within the area that the study was located and the clinical context. All of the studies were completed within a western cultural system, suggesting that there is a likelihood of some relevance to the UK. However, despite this there is likely to be differences in the healthcare systems within the different study locations, such as provision and cost of healthcare, which could limit the relevance of these studies to the UK healthcare system.

Outcomes

Whilst the studies measured similar constructs, they varied in the outcome measures that were used. The Child Behaviour Checklist and Youth Self Report were used in eight of the studies (1, 5, 6, 8, 9, 11, 12, 14, 15, 16) and is reported to have strong validity and reliability (Achenbach & Rescorla, 2001). Other self-report measures used such as the Strengths and Difficulties Questionnaire, Moods and Feelings Questionnaire and Beck Youth Inventories of Emotional and Social Impairment are also argued to have strong reliability and validity (Ambrosini, Metz, Bianchi, Rabinovich & Undie, 1991; Roy, Veenstra & Clench-Aas, 2008; Wood, Kroll, Moore & Harrington, 1995). In addition, diagnostic interviews used within the studies such as the K-SADS-PL and DISC-IV are argued to have high reliability and validity, high interrater agreement and criterion validity (Kaufman et al., 1997; Shaffer, Fisher, Lucas, Dulcan & Schwab-Stone, 2000). Studies 2 and 3 used measures created by the authors to examine influences on help seeking and perceived need for psychiatric and psychological care. Whilst these measures appear to relate to these constructs, it is not possible to know the level to which these measures give generalisable or valid results.

However, despite the reported strength of the outcome measures used, the self-report aspect of the measures leaves the reports open to biases such as acquiescent responding and extreme responding (Paulhus & Vazire, 2010). In addition, it is also possible that different outcome measures could lead to different responses due to the wording and subscales used. Therefore, differences between the studies could have been due to the different outcome measures used, as opposed to differences between sample or clinical context.

A further potential limitation of the studies reviewed is the diagnostically driven aspect of the measures used. These studies are likely to lack data regarding the experience of

adolescents and their families, and the experiences that do not fit into diagnostic categories. This could have given further insight into the discrepancies of parents and adolescents in relation to adolescent mental health.

Analysis

The studies varied in the number of explanatory variables used within the analysis but focused upon similar aspects of individual characteristics and family characteristics that could impact upon parent-adolescent agreement. The studies reviewed all used a significance level of <.05 and were clear in their methods of analysis, except for study 7 which did not give a clear description of the analysis. The strengths of correlations were reported within all of the studies, and did not overestimate the relationships reported.

Summary of the Critique

One important limitation of the reviewed studies is the correlational aspect of the designs. Whilst the findings of the relationships between adolescent and parent reports of adolescent mental health problems give interesting insight into the discrepancies between adolescents and parents, it is important to note that the correlational designs cannot infer causation (Field, 2013). Not all studies noted this within their study limitations.

Overall, the studies were all awarded a score of ++ or + for their internal and external validity using this appraisal tool.

Discussion

Clinical Implications

The findings of the review support previous findings (Achenbach, McConaughy & Howell, 1987; Reyes & Kazdin, 2005) suggesting that parents and adolescents often disagree about adolescent mental health problems and treatment. These findings have important implications for clinical practice.

Noticing the Problem and Seeking Help

The review findings suggested that parents are more likely to notice externalising difficulties than internalising difficulties. This links with other research reporting that parents are more likely to seek help for their adolescent with these kinds of problems (Logan & King, 2001). In addition, research has suggested that parents struggle to distinguish between 'normal' adolescent behaviour and signs that could identify a mental health problem (Sayal et al., 2010). It could be that further education for parents about adolescent mental health problems, particularly internalising problems, would support parents to recognise problems their adolescent may be experiencing. As adolescents are unlikely to seek help themselves (Rickwood, Deane, Wilson & Ciarrochi, 2005), and parents are likely to facilitate the help seeking process (Costello et al., 1998; Logan & King, 2001), it seems important to assist parents in recognising difficulties adolescents may not recognise, or may not disclose.

Assessment

The findings also support research and guidelines regarding the importance of gaining the perspectives of multiple informants in clinical assessment (Kraemer et al. 2003; NICE, 2005). In addition, the likely discrepancies between parents and adolescents highlight the importance of valuing reports from both, as both have a unique perspective upon adolescent mental health difficulties. As mentioned, developmentally adolescents are striving for

independence, and beginning to question authority and adult figures (Moretti & Peled, 2004). As it is clear that adolescents and parents often hold discrepant views about the nature of an adolescent mental health problem (Yeh & Weisz, 2001) it seems important for parents and adolescents to be given a space to individually report their experiences, as adolescents are likely to struggle to have their parents involved in this process (Thompson, Bender, Lantry & Flynn, 2007).

In addition, the findings also note the lack of awareness that parents may have regarding their adolescent's thoughts or plans of suicide. Given the prevalence of suicidal ideation during adolescence (Lewinsohn, Rohde & Seeley, 1996), and research findings that adolescents with thoughts or plans of suicide are less likely to seek help than other adolescents with other kinds of difficulties (Hawton, Rodham, Evans & Harriss, 2009) it seems particularly important to explore risk issues with adolescents that they are unlikely to have disclosed to their parents.

Engagement and Treatment

The findings also reiterate the challenges for clinicians in engaging both adolescents and families. As previously mentioned, research has suggested that parents are likely to have a key role in facilitating adolescent engagement in mental health services (Nock & Ferriter, 2005), as adolescents are often reluctant to attend therapy (Robbins, Alexander, Newell & Turner, 1996). Therefore, there appears to be clinical importance in involving both adolescents and parents despite the likely discrepancy regarding the problem, as parents are likely to continue to support young people to engage. However, this requires a delicate balance between allowing adolescents autonomy, and facilitating parental involvement.

Most evidence based treatments also involve both parents and adolescents to some extent (Kazdin & Weisz, 2003). However, research has also found that parents and adolescents are likely to have differing goals for treatment, and that alliance between parents and adolescents within treatment is related to a positive outcome (Shelef, Diamond, Diamond & Liddle, 2005). This again creates a challenge for clinicians as parents are often in a position to promote change for their adolescent and within the family. However, taking account of adolescent's goals within therapy is also vital, as therapy is more likely to be successful when it is personally meaningful to young people (Liddle, 1995). Clinically, it therefore seems important for clinicians to explore with adolescents and parents about how they can negotiate levels of involvement.

Research Implications

The review findings also have implications for future research. Whilst this review gives important insight into those adolescents and families who are using mental health services, it is also important to note the many adolescents with mental health problems who do not access help (Sawyer et al., 2007). Further research into adolescents with mental health problems that are not accessing services could give important insight regarding ways that adolescents who are not accessing help could be engaged into mental health services.

In addition, the reviewed research used correlational and cross-sectional designs. Further research using experimental methodologies could give findings that are not limited by the inability to infer any causation from correlational designs. Furthermore, research using a longitudinal design could give more understanding of how parent-adolescent agreement or disagreement regarding adolescent mental health problems may change over time, particularly over the course of treatment. This may also give insight into how adolescent-parent discrepancy changes during the developmental stage of adolescence. In addition, the

influence of developmental stages could be further explored by comparing levels of discrepancy between younger and older adolescents and their parents.

Furthermore, given research suggesting the importance of adults and parents upon the help seeking process for adolescents (Costello et al., 1998; Logan & King, 2001; Rickwood, Mazzer & Telford, 2015; Wahlin & Deane, 2012), and the findings of the review suggesting low agreement between parents and adolescents regarding adolescent mental health, further research upon the influence of parents upon the help seeking process could be useful. As the current research has relied on self-report measures, future research using qualitative designs could allow participants to share their experiences in further depth. In addition, this could also allow a greater psychological understanding that is not based solely upon mental health diagnoses.

Conclusion

This review aimed to explore discrepancy between adolescents and parents in relation to adolescent mental health and treatment. The review suggests that adolescents and parents often disagree about the nature of an adolescent's mental health problem, and whether to seek help for this. Correlational findings reiterate the importance of parents within the help seeking process for adolescents, and suggests that discrepancy between parental and adolescent views may influence this process. Whilst the findings in relation to adolescent characteristics were discrepant between the reviewed studies, the findings suggest the importance of distinguishing adolescents from children within research.

The review findings have potential clinical and research implications. Exploring adolescent and parent views, and trying to bring these together seems important throughout the help seeking and engagement process, including assessment, engagement and treatment. Negotiating parental involvement with consideration to the adolescent developmental stage, giving adolescents autonomy but allowing for some parental involvement seems vital to strong engagement. Future research could focus upon adolescents with mental health problems but not accessing mental health services, and compare experiences of older and younger adolescents. In addition, the role of parents within adolescent help seeking for mental health problems could be explored more broadly, as it appears that parents have a strong role in the process that is not fully understood.

References

Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioural and emotional problems: Implications of cross informant correlations for situational specificity. *Psychological Bulletin, 101,* 213-232. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/3562706

Achenbach, T. M., & Rescorla, L. A. (2001). Manual for the ASEBA School-Age Forms and Profiles. Retrieved from http://www.aseba.org/ordering/ASEBA%20Reliability%20and%20Validity-School%20Age.pdf

Ambrosini, P. J., Metz, C., Bianchi, M. D., Rabinovich, H., & Undie, A. (1991). Concurrent validity and psychometric properties of the beck depression inventory in outpatients adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 51-57. doi: 10.1097/00004583-199101000-00008

Anderson, R. M. (1995). Revisiting the behavioural model and access to medical care: Does it matter? *Journal of Health and Social Behaviour, 36,* 1-10. doi: 10.2307/2137284

Berg-Nielsen, T. S., Vika, A., Dahl, A. A. (2003). When adolescents disagree with their mothers: CBCL-YSR discrepancies related to maternal depression and adolescent self esteem. *Child Care, Health and Development, 29,* 207-213. doi: 10.1046/j.1365-2214.2003.00332.x

Blakemore, S. (2012). Development of the social brain in adolescence. *Journal of the Royal Society of Medicine, 105,* 111-116. doi: 10.1258/jrsm.2011.110221

Block, A. M., & Greeno, C. G. (2011). Examining outpatient treatment dropout in adolescents: A literature review. *Child and Adolescent Social Work Journey, 28,* 393-420. doi: 10.1007/s10560-011-0237-x

Christie, D., & Viner, R. (2005). Adolescent development. *BMJ, 330,* 301-304. doi: 10.1136/bmj.330.7486.301

Costello, E. J., Pescosolido, B. A., Angold, A., & Burns, B. J. (1999). A family network-based model of access to child mental health services. *Research in Community and Mental Health, 9,* 1106-1115.

Delroy, L. P., & Vazire, S. (2010). The self report method. In R. W. Robbins, R. C. Fraley & R. F. Krueger (Eds.), *Handbook of research methods in personality psychology* (pp. 224-239). New York: Guildford.

Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2000). The therapist-parent alliance in family based therapy for adolescents. *Journal of Clinical Psychology, 56,* 1037-1050. doi: 10.1002/1097-4679(200008)56:8<1037::AID-JCLP4>3.0.CO;2-4

Erikson, E. H. (1968). *Identity, youth and crisis*. New York: Norton.

Ferdinand, R. F., Van der Ende, J., & Verhulst, F. C. (2004). Parent-adolescent disagreement regarding psychopathology in adolescents from the general population as a risk factor for adverse outcome. *Journal of Abnormal Psychology, 113,* 198-206. doi: 10.1037/0021-843X.113.2.198

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. London: SAGE.

Freeman, A. J., Youngstrom, E. A., Freeman, M. J., Youngstrom, J. K., & Findling, R. L. (2011). Is caregiver adolescent disagreement due to differences in thresholds for reporting manic symptoms? *Journal of Child Adolescent Psychopharmacology, 21,* 425-432. doi: 10.1089/cap.2011.0033

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38,* 581-586. doi: 10.1111/j.1469-7610.1997.tb01545.x

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help seeking in young people: A systematic review. *BMC Psychiatry, 10*. doi: 10.1186/1471-244X-10-113

Handwerk, M. L., Larzelere, R. E., Soper, S. H., & Friman, P. C. (1999). Parent and child discrepancies in reporting severity of problem behaviours in three out of home settings. *Psychological Assessment, 11,* 14-23. doi: 10.1037/1040-3590.11.1.14

Hawley, K. M., & Weisz, J. R. (2003). Child, parent and therapist disagreement on target problems in outpatient therapy: The therapists dilemma and its implications. *Journal of Consulting and Clinical Psychology, 71,* 62-70. doi: 10.1037/0022-006X.71.1.62

Hawton, K., Rodham, K., Evans, E., & Harriss, L. (2009). Adolescents who self harm: A comparison of those who go to hospital and those who do not. *Child and Adolescent Mental Health, 14,* 24-30. doi: 10.1111/j.1475-3588.2008.00485.x

Israel, P., Thomsen, P. H., Langeveld, J., & Stormark, K. M. (2007). Parent youth discrepancy in the assessment and treatment of youth in usual clinical care settings: Consequences to parent involvement. *European Child and Adolescent Psychiatry, 16,* 138-148. doi: 10.1007/s00787-006-0583-y

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D., & Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school age children, present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 980-988. doi: 10.1097/00004583-199707000-00021

Kazdin, A. E., & Wiesz, J. R. (2003). Evidence based psychotherapies for children and adolescents. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 15,* 186-188. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2277313/

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age of onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62,* 593-602. doi: 10.1001/archpsyc.62.6.593

Klaus, N. M., Mobilio, A., & King, C, A. (2009). Parent adolescent agreement concerning adolescents' suicidal thoughts and behaviours. *Journal of Clinical Child and Adolescent Psychology, 38,* 245-255. doi: 0.1080/15374410802698412

Kraemer, H. C., Measelle, J. R., Ablow, J. C., Essex, M. J., Boyce, W. T., & Kupfer, D. J. (2003). A new approach to integrating data from multiple informants in psychiatric assessment and research: Mixing and matching contexts and perspectives. *The American Journal of Psychiatry, 160,* 1566-1577. doi: 10.1176/appi.ajp.160.9.1566

Lauth, B., Arnkelsson, G. B., Magnusson, P., Skarpheoinsson, G. A., Ferrari, P., & Petursson, H. (2010). Parent youth agreement on symptoms and diagnosis: Assessment with a diagnostic interview in an adolescent inpatient clinical population. *Journal of Physiology Paris, 104,* 315-322. doi: 10.1016/j.jphysparis.2010.09.004

Lewinsohn, P. M., Rohde, P., & Seeley, J. R. (1996). Adolescent suicidal ideation and attempts: Prevalence, risk factors and clinical implications. *Clinical Psychology: Science and Practice, 3,* 25-46. doi: 10.1111/j.1468-2850.1996.tb00056.x

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family based adolescent treatment. *Psychotherapy, 32,* 39-58. doi: 10.1037/0033-3204.32.1.39

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health service utilisation: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8,* 319-333. doi: 10.1093/clipsy.8.3.319

Martin, J. L., Ford, C. B., Dyer-Friedman, J., Tang, J., & Huffman, L. C. (2004). Patterns of agreement between parent and child ratings of emotional and behavioural problems in an outpatient clinical setting: When children endorse more problems. *Journal of Developmental and Behavioural Pediatrics, 25,* 150-155. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/15194898

Mash, E. J., & Hunsley, J. (2005). Evidence based assessment of child and adolescent disorders: Issues and challenges. *Journal of Clinical Child and Adolescent Psychology, 34,* 362-379. doi: 10.1207/s15374424jccp3403_1

Mbekou, V., Macneil, S., Gignac, M., & Renaud, J. (2015). Parent youth argreement on self reported competencies of youth with depressive and suicidal symptoms. *Canadian Journal of Psychiatry, 60,* 55-60. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4345849/pdf/cjp-2015-vol60-february-supplement-s55-s60.pdf

Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2000). *The mental health of children and adolescents in Great Britain*. Retrieved from: http://ww.dawba.com/abstracts/B-CAMHS99_original_survey_report.pdf

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the national comorbidity study, adolescent supplement. *Journal of*

the American Academy of Child and Adolescent Psychiatry, 49, 980-989. doi: 10.1016/j.jaac.2010.05.017

Michelmore, L., & Hindley, P. (2012). Help seeking for suicidal thoughts and self harm in young people: A systematic review. *Suicide and Life Threatening Behaviour, 42,* 507-524. doi: 10.1111/j.1943-278X.2012.00108.x

Moretti, M. M., & Peled, M. (2004). Adolescent-parent attachment: Bonds that support healthy development. *Paediatrics and Child Health, 9,* 551-555. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724162/

National Institute for Health and Clinical Excellence (2005). *Depression in children and young people: Identification and management*. Retrieved from: https://www.nice.org.uk/guidance/cg28/evidence

National Institute for Health and Clinical Excellence (2008). *Social and emotional wellbeing in secondary education*. Retrieved from: https://www.nice.org.uk/Guidance/PH20

National Institute for Health and Clinical Excellence (2013). *Psychosis and schizophrenia in children and young people: Recognition and Management*. Retrieved from: https://www.nice.org.uk/guidance/cg155/ifp/chapter/information-for-parents-and-carers

NHS England (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Newman, B., & Newman, P. (2014). *Development through life: A Psychological Approach*. Stamford: Cengage

Nock, M. K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. *Clinical Child and Family Psychology Review, 8,* 149-166. doi: 10.1007/s10567-005-4753-0

Oscar, M. I., Pearson, N., Coe, N., Gunnell, D. (2005). Help seeking behaviour in men and women with common mental health problems: Cross-sectional study, 186, 297-301. doi: 10.1192/bjp.186.4.297

Pescosolido, B. A., & Boyer, C. A. (1999). How do people come to use mental health services? Current knowledge and changing perspectives. In A. V. Horwitz & T. L. Scheid (Eds.), *A handbook for the study of mental health*. (392-411). New York: Cambridge University Press.

Piaget, J. (1964). Cognitive development in children: Piaget development and learning. *Journal of Research in Science Teaching, 2,* 176-186. doi: 10.1002/tea.3660020306

Reyes, A. D., & Kazdin, A. E. (2005). Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework and recommendations for further study. *Psychological Bulletin, 131,* 483-509. doi: 10.1037/0033-2909.131.4.483

Rickwood, D. J., Mazzer, K. R., & Telford, N. R. (2015). Social influences on seeking help from mental health services, in person and online, during adolescence and young adulthood. *BMC Psychiatry*. doi: 10.1186/s12888-015-0429-6

Robbins, M., Alexander, J. F., Newell, R. M., & Turner, C. W. (1996). The immediate effect of reframing on client attitude in family therapy. *Journal of Family Psychology, 10,* 28-34. doi: 10.1037/0893-3200.10.1.28

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education and Quarterly, 15,* 176-183. Retrieved from:

https://deepblue.lib.umich.edu/bitstream/handle/2027.42/67783/10.1177_1090198188015002 03.pdf?sequence=2&isAllowed=y

Rothi, D. M., & Leavey, G. (2006). Mental health help seeking and young people: A review. *Pastoral Care in Education, 24,* 4-13. doi: 10.1111/j.1468-0122.2006.00373.x

Roy, B., Veenstra, M., & Clench-Aas, J. (2008). Construct validity of the five factor strengths and difficulties questionnaire (SDQ) in pre, early and late adolescence. *Journal of Child Psychology and Psychiatry, 49,* 1304-1313. doi: 10.1111/j.1469-7610.2008.01942.x

Ryan, A. M., Jorm, A. F., Toumbourou, J. W., & Lubman, D. I. (2015). Parent and family factors associated with service use by young people with mental health problems: A systematic review. *Early Intervention in Psychiatry, 9,* 433-446. doi: 10.1111/eip.12211

Salbach, A. H., Klinkowski, N., Lenz, K., Pfeiffer, E., Lehmkuhl, U., & Ehrlich, S. (2008). Correspondence between self reported and parent reported psychopathology in adolescents with eating disorders. *Psychopathology, 41,* 307-312. doi: 10.1159/000146068

Salbach, A. H., Klinkowski, N., Lenz, K., & Lehmkuhl, U. (2009). Agreement between youth reported and parent reported psychopathology in a referred sample. *European Journal of Child and Adolescent Psychiatry, 18,* 136-143. doi: 0.1007/s00787-008-0710-z

Sawyer, M., Miller-Lewis, L., & Clark, J. (2007). The mental health of 13-17 year olds in Australia: Findings from the National Survey of Mental Health and Well-Being. Journal of Youth and Adolescence, 36, 185-194. doi: 10.1007/s10964-006-9122-x

Sayal, K., Tischler, V., Coope, C., Robotham, S., Ashworth, M., Day, C., Tylee, A., & Simonoff, E. (2010). Parental help seeking in primary care for child and adolescent help seeking concerns: A qualitative study. *British Journal of Psychiatry, 197,* 476-481. doi: 10.1192/bjp.bp.110.081448

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH diagnostic interview schedule for children version IV (DISC-IV): Description, differences from previous versions and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 28-38. doi: 10.1097/00004583-200001000-00014

Shanley, D. C., Reid, G. J., & Evans, B. (2008). How parents seek help for children with mental health problems. *Administration and Policy in Mental Health, 35,* 135-146. doi: 10.1007/s10488-006-0107-6

Shelef, K., Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of Consulting and Clinical Psychology, 73,* 689-698. doi: 10.1037/0022-006X.73.4.689

Spear, L. P. (2000). The adolescent brain and age related behavioural manifestations. *Neuroscience and Biobehavioural Reviews, 24,* 417-463. doi: 10.1016/S0149-7634(00)00014-2

Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in Cognitive Science, 9,* 69-74. doi: 10.1016/j.tics.2004.12.005

Thompson, S. J., Bender, K., Lantry, J., & Flynn, P. M. (2007). Treatment engagement: Building therapeutic alliance in home based treatment with adolescents and their families. *Contemporary Family Therapy, 29,* 39-55. doi: 10.1007/s10591-007-9030-6

Thurber, S., & Snow, M. (1990). Assessment of adolescent psychopathology: Comparison of mother and daughter perspectives. *Journal of Clinical Child Psychology, 19,* 249-253. doi: 10.1207/s15374424jccp1903_7

Thurber, S., & Osborn, R. A. (1993). Comparisons of parent and adolescent perspectives on deviance. *The Journal of Genetic Psychology, 154,* 25-32. doi: 10.1080/00221325.1993.9914718

Van der Meer, M., Dixon, A., & Rose, D. (2008). Parent and child agreement on reports of problem behaviour obtained from a screening questionnaire, the SDQ. *European Jounral of Child and Adolescent Psychiatry, 17,* 491-497. doi: 0.1007/s00787-008-0691-y

Wahlin, T., & Deane, F. P. (2012). Discrepancies between parent and adolescent perceived problem severity and influences on help seeking from mental health services. *Australian and New Zealand Journal of Psychiatry, 46,* 553-560. doi: 10.1177/0004867412441929

Weems, C. F., Feaster, D. J., Horigian, V. E., & Robbins, M. S. (2011). Parent and child agreement on anxiety disorder symptoms using the DISC predictive scales. *Assessment, 18,* 213-216. doi: 10.1177/1073191110389278

Williams, C. D., Lindsey, M., & Joe, S. (2011). Parent adolescent concordance on perceived need for mental health services and its impact on service use. *Children and Youth Services Review, 33,* 2253-2260. doi: 10.1016/j.childyouth.2011.07.011

World Health Organisation. (2007). Adolescence, social support and helpseeking behaviour: An international literature review and programme consultation with recommendations for action. Retrieved from: http://apps.who.int/iris/bitstream/10665/43778/1/9789241595711_eng.pdf

World Health Organisation. (2016). *Adolescent Development.* Retrieved from: http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/

Wood, A., Kroll, L., Moore, A., & Harrington, R. (1995). Properties of the mood and feelings questionnaire in adolescent psychiatric outpatients: A research note. *Journal of Child Psychology and Psychiatry, 36,* 327-334. doi: 10.1111/j.1469-7610.1995.tb01828.x

Yeh, M., & Weisz, J. R. (2001). Why are we at the clinic? Parent-child disagreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology, 69,* 1018-1025. doi: 10.1037/0022-006X.69.6.1018

Yurgelun-Todd, D. (2007). Emotional and cognitive changes during adolescence. *Current Opinion in Neurobiology, 17,* 251-257. doi: 10.1016/j.conb.2007.03.009

Zachrisson, H. D., Rodje, K., & Mykletun, A. (2006). Utilisation of health services in relation to mental health problems in adolescents: A population based survey. *BMC Public Health, 16*. doi: 10.1186/1471-2458-6-34

Section B

Parental Involvement: A grounded theory of the role of parents in adolescent help seeking for mental health problems.

Word count: 7,998

Abstract

Objective

There is a high prevalence of mental health problems within adolescent populations, but they are unlikely to seek help. Adults, including parents are important within this help seeking process. The study therefore aimed to develop a theory of the influence of parents upon adolescent help seeking.

Method

Eighteen semi-structured interviews were conducted with adolescents, their parents and clinicians working within Child and Adolescent Mental Health Services (CAMHS). A grounded theory analysis allowed for the in-depth exploration of participants' experiences.

Findings

A model was developed identifying help seeking as a family journey. Parents were highly influential, and parents who were able to be more available to their adolescents tended to be more involved in the help seeking process. Other adults were utilised within the help seeking process. Once adolescents were engaged with the help seeking process they were often able to then seek further help independently.

Conclusions

The findings suggest that consideration should be given to making services accessible to adolescents. CAMHS services should explore ways with adolescents to give control over parental involvement, and ways with parents to develop availability. Future research should consider the experiences of older and younger adolescents separately, and the transition into adult services.

(199) Keywords: Adolescence; mental health; help seeking; parental involvement

Introduction

Mental Health Needs in the Adolescent Population and Levels of Service Use

Within the adolescent population there is a high prevalence of mental health problems. One in ten young people were said to have a diagnosable mental health problem in England in 2014/2015 (Public Health England, 2016). It has also been suggested that half of people with a long term mental health problem first experience difficulties by the age of 14 (Kim-Cohen et al., 2003). Further research has also found that 75% of mental health problems had begun before individuals reached the age of 24 (Kessler et al., 2003). In addition, mental health problems within adolescence are argued to have a major effect upon adult life (Rickwood, Deane, Wilson & Ciarrochi, 2005). However, despite this high level of need, few adolescents access help from mental health services (Boldero & Fallon, 1995). In addition, within the UK, it was found that only 60% of adolescents experiencing a severe mental health problems received support from services (National CAMHS Review, 2007).

Models of Help Seeking

Help seeking within a mental health context has been defined as "the process of using informal and professional networks to gain support in coping with mental health problems" (Michelmore & Hindley, 2012, p. 507).

Theoretical models of help seeking have largely focused on decisions of adults to seek help for illnesses. These have traditionally focused on characteristics of individuals and demographic and structural factors to predict likeliness to seek help, such as the Healthcare Utilisation Model (Anderson, 1968; 1995). Pescosolido (1992) built upon existing theories with the Network Episode Model (NEM), which focused upon the process of seeking help, and the importance of interpersonal relationships within social networks in making decisions about accessing healthcare.

Costello, Pescosolido, Angold and Burns (1998) revised the NEM in the Network Episode Model-Revised (NEM-R), and considered ways in which this model would need to be adapted to be appropriate for young people. Whilst Pescosolido (1992) highlighted that help seeking occurs within the context of social networks and relationships, the NEM-R takes account of the difference in independence that young people have in comparison to adults in their decisions about health care (Costello, Pescosolido, Angold & Burns, 1998). This model highlights that young people are very unlikely to refer themselves for treatment, and therefore are heavily reliant on others to seek help on their behalf. Due to this reliance on others, there is less emphasis on decisions that individuals make about seeking help, and more of a focus upon the need for an adult to notice there is a problem in order to start the help seeking process.

In addition, Rickwood, Deane, Wilson and Ciarrochi (2005) viewed help seeking as a process that shifts from being a personal process, to one which heavily involves others. This begins with becoming aware that there is a problem, and feeling that this is a problem that needs professional help. This problem then must be communicated to others. Help must be available and easy to access. Lastly, the help seeker (or seekers) must feel able to seek out this help and talk about the problem to the service.

A further model for young people considers the factors that are likely to lead young people to avoid help seeking. Biddle, Donovan, Sharp and Gunnell (2007) developed the Cycle of Avoidance which highlights that young people are likely to view their distress as 'normal' and therefore not needing an intervention. They argued that this allowed young people to normalise their distress which was likely to continue even if their problems became more difficult, due to the fear of what it would mean to have a 'real' mental health problem. Therefore the level of severity for a young person to consider needing to seek help for an intervention would continue to shift until this became unmanageable.

However, whilst these models have been developed considering the developmental differences between children and adults, they do not consider the unique developmental differences between children and adolescents.

Role of Parents in Help Seeking

As the above theories of help seeking for young people have identified, young people very rarely seek help from formal mental health services without the involvement of others, and are very unlikely to refer themselves for treatment (Costello, Pescosolido, Angold and Burns, 1998). Despite the move towards independence, which is a large component of adolescent development (Allen et al., 2003), research suggests that parents continue to play a large role in supporting adolescent development and the move towards autonomy (Moretti & Peled, 2004), and in the decision to seek help (Block & Greeno, 2011). Trusted relationships have been found to play an important role in the help seeking behaviours of adolescents, which are often relationships with friends and family (Rickwood, Deane, Wilson & Ciarrochi, 2005). Furthermore, for 'in person' services, the dominant influence for children and adolescents was found to be family and parents, with between 40-55% of 15 to 17 year olds reporting that family was the major influence on their help seeking behaviour (Rickwood, Mazzer & Telford, 2015).

In addition, a recent review of literature regarding parental and family factors relating to adolescent service use found that parental burden, parental problem perception, parent perception of need and parental availability were significantly related to adolescent mental health service use (Ryan, Jorm, Toumbourou & Lubman, 2015). Logan and King (2001) aimed to use the available literature at the time to develop a model of how parents facilitate adolescent service use. Logan and King (2001) completed a literature review into the area of parental facilitation of adolescent service use, and developed an initial model based upon this literature. The model proposes that parents are key in adolescents accessing services due to

the reluctance of adolescents to seek help, and the difficulties in accessing mental health services.

Rationale for Current Study

As Logan and King (2001) argued within their model development, it is imperative to consider the unique developmental stage of adolescents within the help seeking process to build upon the understanding of research that focuses on both children and adolescents. Ryan, Jorm, Toumbourou and Lubman (2015) also highlighted that future research should focus upon adolescents as a separate group from children within the context of mental health service use. In addition, research acknowledging and exploring the new relationship that both parents and children enter once children reach adolescence has been encouraged (Moretti & Peled, 2004).

The current research highlights the high prevalence of mental health needs within the adolescent population, and also the low numbers of adolescents who receive help for their mental health difficulties. The empirical and theoretical literature emphasises the importance of social networks, and particularly adults in facilitating the help seeking process. The current literature base seems unclear as to how parents both facilitate help seeking, and influence the way that adolescents themselves seek help for their mental health. Whilst a model has been developed based upon previous literature (Logan & King, 2001), further research has not been done to develop a theoretical framework that is grounded in participants' experiences. It also seems particularly pertinent to readdress this topic in the current context of Child and Adolescent Mental Health Services (CAMHS) within the United Kingdom, given the financial constraints and service limitations currently seen widely across CAMHS.

Much of the current adolescent help seeking literature has used quantitative designs. Whilst there has been some qualitative research focusing on the role of adults within the help

seeking process (Lane, 2015), this has not yet focused upon the role of parents. Therefore, it seemed important to use a qualitative approach to develop an understanding of the influence of parents within adolescent help seeking.

Research Questions

This study aimed to develop a theory of the role of parents within adolescent help seeking for a mental health problem, and the influence of parents upon adolescents seeking help for their mental health.

The research questions were as follows:

1. What do adolescents, parents/carers and practitioners view as the role of parents in adolescent help seeking for a mental health problem?

2. What parental factors are seen as facilitating or hindering adolescent help seeking from the viewpoint of adolescents, parents/carers and practitioners?

3. What are the experiences of adolescents, parents/carers and practitioners of adolescent help seeking within a mental health context?

Method

Design Overview

The study used a qualitative research design, in order to allow for a greater level of depth of exploration within a research area that has been focused upon using mainly quantitative methodologies. A grounded theory design allows for an approach which develops a model that is based in the experiences of participants, into an area which has limited research to date (Urquhart, 2013).

Epistemological Stance

The research is based within a critical realist epistemological stance, considering that "the way that we perceive facts, particularly in the social realm, depends partly on our beliefs and expectations" (Bunge, 1993, p. 231). Using this stance, the researcher's beliefs and experiences were viewed as having an influence upon the research process, which could give further interpretation to the analysis process (Oliver, 2012).

Participants

Inclusion criteria:

- Young people aged between 13-18 years who were currently, or had been engaged within the last year with child and adolescent mental health services.
- Parents or carers of young people who were currently or had been engaged with mental health services as above.
- Parents and their young people did not have to both participate in order to be eligible for the research study.
- Clinicians who had been working within child and adolescent mental health settings for at least six months.

Exclusion criteria:

- Young people judged by the team to be at high risk of harm or distress from the project.
- Young people with a significant learning disability.

Recruitment

Participants were recruited from two CAMHS services within London, one providing outpatient Tier 4 services, and the other providing Tier 3 services. Young people and parents were recruited either by staff teams or, with ethical and R&D approval, directly by the researcher if they had given 'consent to be contacted'. Clinicians were contacted directly by the researcher. (See Appendix B for consent forms and information sheets).

Sample

Eighteen participants were recruited to the study (see Table 1 for demographic details of the sample in the order they were recruited). Younger adolescents were particularly difficult to recruit, with the main barrier expressed by parents and adolescents being uncertainty in meeting with a stranger to talk about their experiences of their mental health. It seemed perhaps older adolescents had more confidence to do this.

Table 4

Participant demographics in the order of recruitment

Participant	Gender	Age	Ethnicity
Young Person	Female	18	White British
Young Person	Male	17	White British
Clinical Psychologist	Male	25-35	White British

Clinical Psychologist	Female	30-45	White British
Parent - Mother	Female	30-45	White British
Parental Mental Health Worker	Female	45-55	Asian British
Parent - Mother	Female	25-35	Black British
Young person	Male	17	White British
Young person	Female	16	Black British
Mental Health Nurse	Female	45-55	White British
Parent - Grandfather	Male	55- 65	White British
Parent - Mother	Female	30-45	Black British
Parent – Mother and Father	Female and Male	30-45, 45-55	White British
Young person	Male	16	Asian British
Young person	Female	17	White British
Young person	Female	16	White British
Parent - Father	Male	35-45	White British
Psychiatrist	Male	45-55	Irish

Ethical Considerations

The study was given approval by the University, following which approval was given by the National Research Ethics Service and Health Research Authority. The relevant NHS trust gave research and development approval. (See Appendix C for ethical approval documentation). Careful consideration was given to potential risk and safeguarding issues given the vulnerability of the research population, and local risk and safeguarding policies were followed.

Procedure

Young people, parents and clinicians were interviewed using a semi-structured interview schedule based upon the research questions (See Appendix D). The schedule for young people had been approved by young people within the service, whilst the parent schedule was approved by a service user research service. Two young people were initially interviewed, following which the data was analysed, and further participants were then recruited based upon this, in accordance with theoretical sampling (Urquhart, 2013). For the full order of recruitment please see Table 1 above.

Data Analysis

Data analysis followed the method of Glaserian Grounded Theory using the following steps as described by Urquhart (2013). A constant comparative method was used, developing concepts from the data by coding and analysing at the same time as collecting data (Kolb, 2012). Interviews were analysed following every two interviews, with the analysis guiding further recruitment, and amendment of the interview schedule.

For a full audit trail of the analysis see Appendix E.

1. Interviews were fully transcribed, and initially analysed line by line for the first six interviews, creating open codes (for an example, see Appendix F).
2. Open codes were then refined into focused codes, focusing on those that were relevant to the research question.
3. Following this, selective coding was conducted, during which focused codes began to be organised into initial sub-categories and categories.

4. Theoretical coding then considered the relationships between categories, and began developing theoretical ideas about these relationships. Theoretical memos and initial diagrams aided the researcher's ideas about these relationships.

Recruitment ended when theoretical sufficiency (Dey, 1999) seemed to have been reached, when no further new codes relevant to the research question were drawn from the data. One further interview was completed after this point to ensure theoretical sufficiency, resulting in eighteen interviews in total.

Quality and Validity

Qualitative research guidelines taken from Yardley (2000) and Mays and Pope (2000) which can be found in Appendix G were used to evaluate the research process. The researcher acknowledged that their beliefs and experiences would influence the data analysis. A reflective research journal (excerpt in Appendix H) allowed for the exploration of the researcher's biases, and to include this within the analysis.

Focused codes, category and sub-category development was also discussed with the research supervisors until agreement was reached. The developed theory was also presented to a CAMHS team, and to two individuals with little knowledge of the area, and feedback obtained.

Results

Help seeking was conceptualised following the analysis in a preliminary model as a journey through which both parents and young people navigate. The model below identifies help seeking as a family journey, and depicts the journey of help seeking from the initial perception of the problem, to engaging with help, alongside the parents' role in this process. For clarity, the model is shown with forward movement within the help seeking journey, however, it is important to note that young people and their parents are likely to move forwards and backwards along the process at different points.

The model highlights the availability of parents as having an influence upon how ready a young person feels to seek help, and how, and to whom the young person discloses the problem to. For young people whose parents were able to be highly available to them it seemed more likely that help seeking would be a collaborative process between the parent and adolescent, or that the parent would be more forceful in facilitating help. It seemed that young people whose parents struggled to be available to them may disclose their problem to another adult, or that for these young people the problem may be noticed by another adult. However, if this was not possible it seemed that these young people would be more likely to reach a crisis point, and access help through systems such as A&E. Findings suggested that CAMHS clinicians used expertise in engaging both young people and parents, and supporting parents to be more available to their adolescent, and to support parents in engaging their young people. Once young people were engaged with help, it seemed that they then felt more confident to seek further help independently. On a broader level, the model acknowledges the wider contexts existing around the family help seeking journey, such as the family context, the current CAMHS context and the wider societal context.

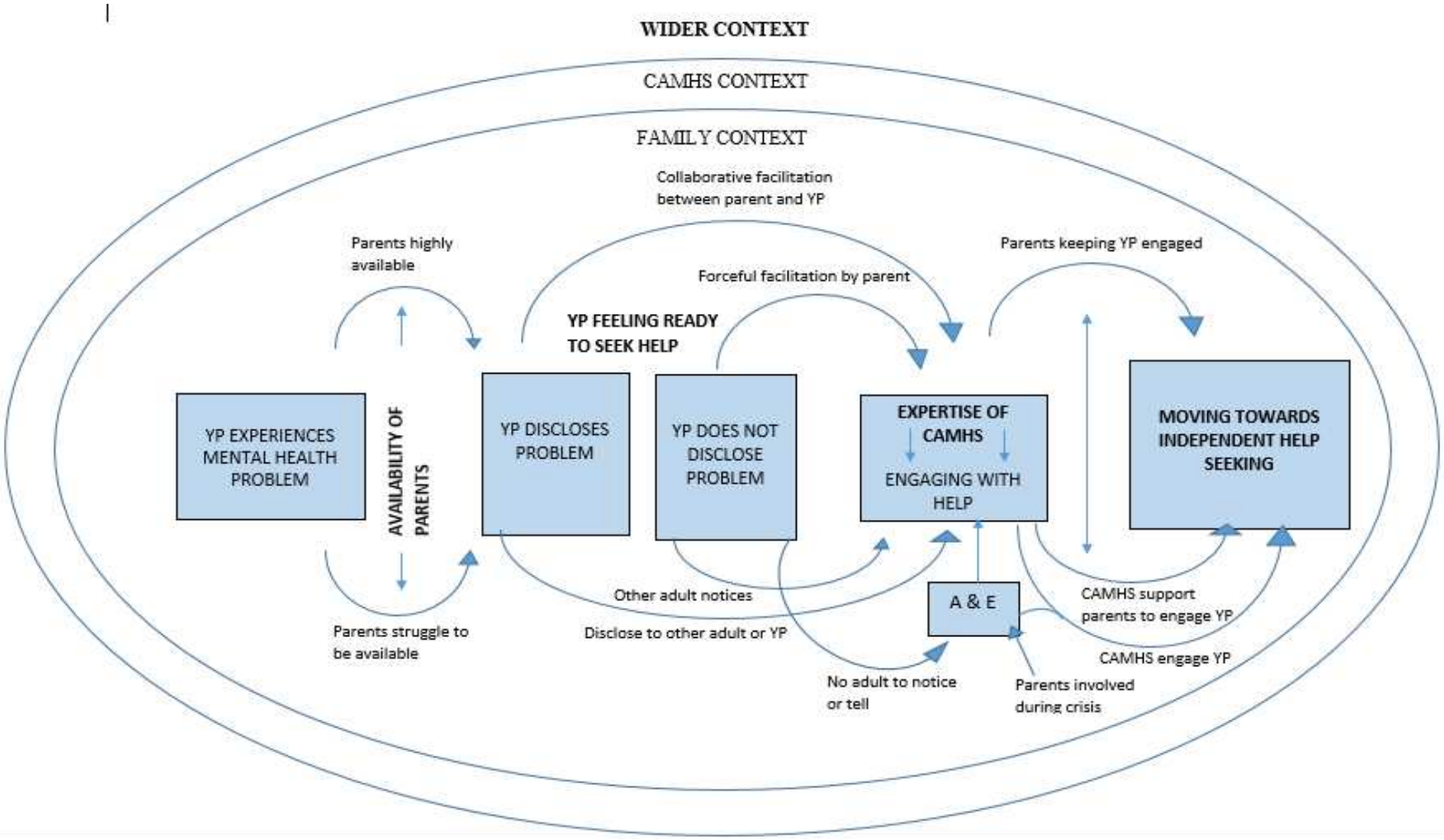


Figure 2. Preliminary model representing parental influence upon the adolescent help seeking journey.

Developed categories and their relevant subcategories can be found in the table below. All categories, subcategories and focused codes can be found in Appendix I.

Table 5

Developed categories and subcategories

Category	**Sub-Category**
Availability of parents	Emotional availability
	Parental facilitation
	Parental beliefs about help seeking
Young person feeling ready to seek help	Perception of the problem
	Young peoples' beliefs about help seeking
	Other relationships
	Young people as protectors
Expertise of CAMHS	Developing parental availability
	Control, collaboration and engagement
	Support for parents
Moving towards independent help seeking	CAMHS developing understanding of mental health and help seeking
	Adolescent development
	Reducing reliance on parents
Wider context	Family context
	CAMHS context
	Wider societal context

Category 1: Availability of Parents

Availability of parents was described as both physical and emotional availability of parents to their young people. This availability was felt to be likely to have an effect upon whether young people felt they could disclose their problems to their parents, how able parents felt to assist young people in help seeking, and to what extent parents and young people were able to collaborate within the help seeking process. There were also factors that seemed to have an effect on how available parents were able to be, and therefore how involved they were able to be within help seeking, such as their own mental health needs, beliefs around help seeking, and other stressors and contextual difficulties.

Emotional Availability

Young people found it important that their parents were able to hear their worries and feel that their parents understood the difficulties they were facing to feel confident that their parents would be able to help them;

> "Cos we've never had that relationship, I just don't think they'd be able to understand or be able to help me" (YP 6).

Clinicians identified this as containment, and considered how this could be difficult for many parents, and particularly parents with their own mental health needs;

> "It's not necessarily that straight forward, because these parents can be struggling on a day to day basis. These parents might not necessarily be in a place to contain their child's difficulties" (Clinician 2).

It seemed that for some parents it felt to them that they were able to be emotionally available to their young people;

> "He knows he can come and talk to us. I think he knows we are there for him, yeah I think he definitely does know that" (Parent 1).

For other parents this was something that was more difficult, and one parent commented on the difficulties she had had in speaking with her young person about the problem;

> "Interviewer: Did she ever speak to you about why she felt like that?
>
> "Parent 5: No not really, she tries to be flowery and butter things up, and I'm not like that, you talk straight with me or don't bother".

Parents identified challenges that they faced in trying to be available to their young person, including being unsure as to when a problem needed help, not knowing how to help if they did recognise a problem, and the emotional impact of supporting their young people with complex needs.

One challenge for many parents was knowing whether adolescent difficulties were part of 'normal teenage behaviour' or whether these were a sign of a mental health problem;

> "She was quiet and withdrawn, I didn't really think nothing of it, I thought oh maybe she was going through a stage where you know kids go through" (Parent 3).

It also seemed that there was a large emotional impact upon parents who were continuing to support their young person facing continued difficulties;

> "Well I've tried to do what they said, I've done my level best, but I've reached a point where I can't do it anymore" (Parent 5).

This seemed particularly important for lone parents, or those with limited social support.

Parental Facilitation

Clinicians noted the role that parents often had in facilitating the formal help seeking process for young people;

> "Parental involvement is almost always central to the decision to come and seek help. There are very few children and adolescents who would come off their own back" (Clinician 4).

Clinicians also noted the way that parents can model seeking help and engaging with professionals to their young people and be key within interventions;

> "About the parent just making me as accepted as possible, and you know that's great role modelling by mum really, to show just how much she must trust and to let the young person know, she's alright. It's quite powerful" (Clinician 3).

For young people who struggled to talk to adults about their problems, there were times when parents needed to be forceful in their facilitation of them accessing help;

> "Yeah then she informed the doctor. Yeah she forced me to come" (YP 7).

> "Something happened one night and I told my mum on the way to school, and she changed direction from school to hospital and went to CAMHS and said you need to talk about it" (YP 2).

Other parents found they had been able to collaborate with their young people in starting to seek formal help;

> "At that point I said, there's options. We could go and see the doctor and see if we can get referred, and again she was absolutely clear she didn't want the school to know anything. And because there was no apparent physical risk and so on it seemed best to respect that really" (Parent 6).

Several young people felt that their parents were key in facilitating their help seeking when they had reached a crisis level;

> "My mum, she'd be the one who most of the time would be taking me to A&E" (YP 1).

Parents also identified the feelings of helplessness they had in feeling unsure of how to help their young person, and trying to get their young person help;

> "I think having parents really pushing things…maybe you're doing it as a parent because there's nothing else you can do, so you know you feel as a parent you need to do something" (Parent 4).

Parental beliefs about help seeking

It seemed that parental beliefs about the help seeking process had an impact on the way in which they assisted their young person in help seeking. Some parents found that their, or other family member's experience of using mental health services made them feel more confident in facilitating the help seeking process;

> "I think the main advantage of it was that it enabled us to identify the problem, and also perhaps not be quite so initially horrified by the idea of going to see a psychiatrist" (Parent 4).

Clinicians identified that these previous experiences could support the help seeking process, or act as a barrier;

> "For a parent who has a history themselves of emotional difficulties perhaps might have a better understanding of their child's mental health difficulties. But, for example if someone has had a bad experience, they might not necessarily feel able to guide the process" (Clinician 2).

Another important element of parental beliefs around help seeking seemed to be around the feelings of judgement, blame and guilt that parents often experienced;

> "And if they're coming from feeling like they're under scrutiny from social services, if they are feeling under threat as a family maybe, maybe they're more likely to perceive CAMHS as another threatening service" (Clinician 1).

> "And of course obviously, you, wonder were there things we did wrong? Should we have picked it up earlier? You know the sort of, we've failed as parents" (Parent 4).

Another belief shared by several parents was that they were not skilled enough to help their child, and professionals would be the only ones who would be able to understand the problem;

> "They are the ones that can diagnose and help you, and put you on the right road to recovery. Because they can work it out. We can't" (Parent 5).

Category 2: YP feeling ready to seek help

Feeling ready to seek help seemed to be a key point for young people within the help seeking journey, as this helped them feel in some control, allowed them to utilise support from parents or other adults and potentially begin to engage with services. Within the interviews, several factors seemed to impact upon young people's perception of feeling ready to seek help, such as perception of the problem, beliefs about help seeking and their developmental stage.

Perception of the problem

One area that seemed key to young people feeling they needed to seek help was their perception of the problem being serious enough to need help;

> "For me it was when it was kind of affecting me every day and I couldn't cope with it anymore. I didn't really like to be at home and I didn't really like to be at school" (YP 5).

Young people also needed a way of working out if their problems were severe enough to need help;

> "No I never really spoke to anyone, I just read up about it, you know like google it, or on yahoo answers you can ask questions, or read other questions that others had asked that were similar to me (YP 6).

It seemed that for most young people, their perception of the problem was different to that of adults around them.

> "The weirdest thing about me ending up in hospital is a large part of the reason of me going was actually, I mean that was probably one of the most tame situations" (YP 2).

Beliefs about help seeking

Young people also perceived that it would be easier to share their problems if the person they approached had experience of mental health difficulties;

> "I think like, if you have someone who's gone through it, if you've got a family member that's gone through it, it's more relatable. They might have even seen, they might pick up on these things" (YP 4).

It was also reiterated by young people, the difference between seeking help for a mental health problem versus other kinds of problems;

> "That's the thing, I wouldn't care, if I hurt my foot I'd be like mum I've broke my foot, like that's not a big deal. But if I was self-harming, I couldn't be like mum I'm self-harming" (YP 6).

Similarly to several parents interviewed, for some young people it felt important to them to cope alone with their problems;

> "But for me personally, I didn't want anyone to know, I wanted to be very private, that kind of side of things" (YP 2).

Young people also spoke about the fear of stigmatisation from others if they were to talk about their mental health difficulties, and that this made it difficult to reach out to others;

> "Young people have got bad ideas about teenagers with mental health problems. But if people learnt about it it'd make it better" (YP 4).

It was also noted that reaching out to others, particularly those from a young person's peer group, could lead to being bullied;

> "You know when someone like, something happens like big, everyone's gonna keep talking about it, laughing about it" (YP 5).

There was a sense that greater awareness and education could reduce negative beliefs about those with mental health problems, therefore reducing the fear of stigmatisation;

> "I think they need to talk about it properly in schools, to say even if you do have mental health problems there's nothing to be ashamed of" (YP 4).

Other Relationships

Relationships were important to young people in feeling able to disclose problems. Linking with the previous category, young people who felt that they had parents who were highly emotional available seemed more likely to seek help from parents, whereas other young people sought help from other sources;

> "I knew I could always talk to my parents… They were very supportive. They knew they couldn't do much, but I was able to talk to them" (YP 3).

> "It was my school nurse; I went to my school nurse first… I'm not being funny but she probably saw it all the time, so she was clued up" (YP 1).

Several young people also felt that for them, having no access to an adult in which they felt comfortable to disclose their problems to had led, or would lead to crisis;

> "Like some people I know I guess can tell their parents like I'm feeling depressed, but I couldn't, so that was my only way of showing things weren't ok. I had to do something drastic to get help" (YP 6).

CAMHS clinicians seemed to be able to provide a relationship to some young people in which they felt able to talk about their problems;

> "Like a counsellor is someone you just see every week, like they're professionals, you have a relationship with them, but it's not a close relationship if you get what I mean. They're not going to say anything" (YP 4).

Young people as protectors

One theme that came from all young people interviewed, was of their hope to protect others around them from distress. Several young people felt this was a large part of why they had not disclosed their problems to their parents;

> "At first I was feeling more, what's the word, worried for how they'd feel, not that they'd feel angry, but almost like I'd let them down a bit if that makes sense" (YP 2).

Parents also felt this might be one reason why young people often found it hard to talk to them about their problems;

> "Well she told me the reason why she doesn't tell me things is because she knows it will hurt me" (Parent 3).

Category 3: Expertise of CAMHS

CAMHS clinicians had expertise in involving parents within their young person's care. It seemed clinicians were able to help develop parents' availability, facilitate involvement, help parents to engage young people into CAMHS services, to engage young people directly, and to provide support for parents.

Developing parental availability and involvement

Several parents commented on the way they had been helped by CAMHS to develop their understanding of their young person's difficulties and needs;

> "I know more now when she's struggling, I can tell by her attitude, the way she keeps her personal hygiene… I thought wow there were all these things in front of me, but I just didn't know, so it helped me know more about it" (Parent 3).

It also seemed that clinicians often found this an important part of their work with young people and families;

> "But for parents, sometimes maybe it's more about well you need to fix the behaviour… and I might be thinking well, perhaps about the function of the behaviour with them" (Clinician 1).

CAMHS clinicians were also able to facilitate parents being involved with young people's CAMHS interventions in creative ways, particularly when young people did not want their parents involved;

> "I'm not quite sure how much of it was directly family therapy, but it did provide a communication channel when he was feeling very angry with us" (Parent 4).

Clinicians also noted the importance of being available for parents;

> "I find it important to give the parent or parents the space to vent and tell me, and you know they might have very important stuff to say as well that they don't want to say in front of their child" (Clinician 4).

This availability of clinicians for parents was found very helpful by parents;

> "I can talk to our worker, not just about Amy…, and she would advise me, and say well let me come and see Amy, and you at the same time. I think that woman is very great support" (Parent 3).

Control, collaboration and engagement

Young people commented on the flexibility of clinicians in the way they had engaged them within CAMHS;

> "When I first met my worker she was like you know have to talk to me, and that. And like, she just had a normal conversation with me, like for the first couple of sessions, she didn't talk about any of my problems" (YP 5).

Having control over the way their parents were involved was felt to be very important for young people within initially seeking help, and engaging with this help. Young people found it very difficult when they felt they had little control, particularly around issues of risk;

> "They could have least said we need to tell your parents, we need to tell them about your risk, but they didn't. I just got a call from my mum" (YP 6).

It also seemed very important to CAMHS clinicians to offer a sense of control and collaboration to young people;

> "Yeah, just really clear rules, and she said although that's not what I want, I get it and I'll sign it… I think she appreciated being involved and thought about" (Clinician 3).

Clinicians noted how difficult it could be to respect a young person's wishes around parental involvement, whilst feeling that having parents involved would have a clinical benefit;

> "Now I may do that, but it might impair the actual clinical outcome for the young person… I can treat that, but would have to do so without thinking about the core systemic issues" (Clinician 4).

Clinicians also considered the difficulties they could have in engaging both parents, particularly if parents were no longer in a relationship;

> "And sometimes we can be guilty of excluding a parent if they aren't the ones where, even if they have shared parental responsibility, which ever parent the child lives with tends to get the lion's share of the communication" (Clinician 3).

Category 4: Moving towards independent help seeking

It seemed that for most young people within the study, engaging with CAMHS had helped them develop their understanding around their mental health, and to learn about help seeking. This seemed to allow young people more independence in their help seeking, making them less reliant on their parents. Older adolescents perceived themselves as

becoming more aware of their own needs, and starting to seek help from others aside from their parents.

CAMHS developing understanding of mental health and seeking help

Young people noted that engaging with CAMHS had given them more of an understanding of their difficulties;

> "I think it kind of broadened like my own horizons of what was going on, and it opened up my eyes… Because before I didn't know what mental health was" (YP 7).

This understanding seemed to change the way young people sought help; for some young people this meant seeking help earlier when things became difficult for them;

> "She's got better I suppose at pre-empting, and saying before things escalate… And I think she's got better at communicating with other adults about that as well" (Parent 2).

Adolescent development

All young people interviewed within the study were older adolescents, and had mostly begun their help seeking as younger adolescents, and therefore reflected on their earlier experiences. Young people also mostly believed that getting older had meant that they would have more understanding of their problems;

> "I think as you get older you're going to be learning about more stuff, just as I'm older I probably would recognise that there was an issue now" (YP 3).

> "Well with everything I'm much more thoughtful about everything… I've got a clearer mind to sort of, review" (YP 2).

Young people identified that adolescence was a challenging time, as they were starting to keep things private from their parents, so it could be hard to know what they should share with them;

> "You know like some of the things you don't wanna talk to your parents… You know like you face issues with relationships, like drugs, even though I didn't do drugs but you know you have friends that get involved in drugs" (YP 7).

Reducing reliance on parents

They also felt that growing older had given them more of an understanding of how to seek help independently;

> "I think like being a bit older you know how to take yourself places and be more independent and you're more aware of how to do things" (YP 6).

For some parents they found that they were able to tailor their involvement to meet the needs of their young person, and their developmental stage;

> "I mean at times I think I probably don't do much for her in that respect, less intervening and explaining. I'm trying to step back a bit because well she's got to go and do it for herself as she puts it" (Parent 2).

Some young people recognised that their parent had been able to do this, and that this had been helpful to them in being able to move towards seeking help more independently;

> "I mean my parents have always been, wanting to try and make me more self-reliant. Yeah, I mean they started it all off and then they kept it running for a bit and then let me carry on" (YP 3).

Young people and parents also acknowledged that older adolescents were beginning to share problems with others;

"He has a very serious girlfriend, so he talks to her a lot" (Parent 1).

Category 5: The Wider Context

It seemed that young people, parents and clinicians viewed the help seeking process as existing within multiple wider contexts. Within the research, the wider family, current situations for CAMHS services and wider societal awareness about help seeking were contexts which interacted with each other, and upon adolescent help seeking and parental facilitation.

Family context

It seemed that for many of the young people and parents interviewed, help seeking had been a family journey. Family beliefs about talking about problems, mental health and recovery appeared to influence the help seeking process, along with family experiences and beliefs around culture.

For some young people and parents, it felt that within their families there was a norm of talking about problems;

> "We didn't have the relationship with our parents that we've got with our sons… it felt really important to talk about what's going on" (Parent 1).

> "We are very close to our children, we do talk about a lot of things" (Parent 6).

Whereas for others it seemed that this was something that they were not used to;

> "We don't talk about things like that, it's not the way it's been" (YP 5).

There also seemed to be family beliefs around mental health and recovery which influenced the way that parents were involved in the help seeking process;

> "My mum did go through depression as well, so it's best for my mum to stay home and relax, and not go through anything tough. So my dad came with me" (YP 7).

Parents also identified that cultural experiences impacted on their beliefs about mental health and help seeking, which seemed likely to have a role in their involvement;

> "I have a partner, but I don't tell him everything, you know because where we come from, mental health ain't nothing like we think, they think like mental health is eating out of a bin" (Parent 3).

> "Yeah some of the group was good, but you've got to remember that I'm a north country lad with really firm views" (Parent 5).

Young people also identified this within their parents, and found that this could make it more difficult for them to speak to their parents about the problem;

> "But, cos, my mum came from Bangladesh, but yeah, so it's a bit different isn't it? You won't expect that back home" (YP 7).

> "Because I'm not gonna lie, coming from a black culture, things like that are looked down upon. I know it might sound a bit rude, and I don't mean this in any kind of way, but black people and mental health don't mix" (YP 4)

Clinicians also seemed very aware of the role of culture in the help seeking process, and the difficulties that this could present to parents who are concerned about their young people;

> "If you think about that a lot of parents from ethnic minority groups struggle, a lot of them, with the notion of presenting their child to what is mostly a white service" (Clinician 4).

CAMHS context and service constraints

Many of the young people, parents and clinicians interviewed commented on the current CAMHS context, and limitations of services. Parents particularly identified long waiting lists, and a disjointed referral process;

> "I just rang up several times over the summer and, you know, I was told she was 98th on the waiting list, and you know, I was kind of invited to suggest that it might be more serious because it might bump her up the list" (Parent 2).

Young people also seemed aware of the difficulties in accessing formal help for their mental health;

> "Like you're never helped when things have just started off when they're difficult, you're only helped after it gets to the worst it can possibly be" (YP 6).

The current high needs for services and limited resources raised challenges for clinicians working within CAMHS;

> "The majority of my clients, their parents have diagnosed or undiagnosed mental health problems…, it presents the dilemma of, well do I treat the parent, because that's probably where it's going to be most effective, but thinking about limited resources" (Clinician 5).

There also seemed to be difficulties for clinicians around the types of problems which receive support most quickly from CAMHS services;

> "That seems to be the story within CAMHS at the moment, which is quite political, if there's a referral that states concerns about hyperactivity, then they will almost automatically be assessed, whereas children with the same level of needs, say with anxiety might not get into the service" (Clinician 1).

Clinicians noted the high level of deprivation in the local context, and the high level of needs of many people living in the area.

> "This is such a stretched borough, it's an indication of the level of needs" (Clinician 1).

Interestingly, this was not mentioned by parents or young people, and it may be that this was noticed more by clinicians within the context of service thresholds.

Wider Societal Context

Young people seemed to find it important that there would be a wider level of awareness about mental health problems in order to make it easier for them to seek help;

> "I think education for parents should be more about the illnesses… parents need to be fully taught about them" (YP 2).

> "I think they need, you know in schools and that, they need to like talk about it properly in schools, to say if you do have mental health there's nothing to be ashamed of" (YP 4).

Clinicians also highlighted the role that education within schools could have in developing young people's awareness of mental health problems within school, and the support that could be offered there;

> "I think young people being able to access, in schools somebody who has a degree of knowledge and interest in mental health. I mean most schools have this, and you really notice it when you come to a school who doesn't prioritise these issues" (Clinician 5).

Discussion

This paper sought to develop a theoretical understanding of the role of parents within adolescent help seeking. Help seeking was conceptualised within a preliminary model as a journey that both adolescents and their parents navigated, with acknowledgment given to the interplay between parental and adolescent factors within this process. The findings suggested

that parents who were able to be consistently available to their young people were more likely to feel confident in the facilitation of the help seeking process, whether this be through collaboration with the young person or through more forceful facilitation.

It also seemed that for young people with parents who struggled to be available to them due to their own needs or other stressors, it was more likely that these young people would approach another adult for help if they felt able to do so. Young people within the study had found themselves in crisis if they did not feel that their parents were available to them, and did not have another adult to notice the problem or to confide in. CAMHS clinicians were able to engage young people within the help seeking process once they had accessed mental health services, and were also able to facilitate parental involvement. Similar themes developed from interviews across the three participant groups, suggesting consistency within the findings.

Links to previous theory and research

The study found that young people tended to have a view of their problems that was discrepant to their parents, often perceiving their problems as less concerning than their parents perceived them to be. This is concurrent with previous research suggesting that adolescents rarely agree with their parents regarding the nature and severity of their problems (Klaus, Mobilio & King, 2009; Williams, Lindsey & Joe, 2011). In accordance with the findings of Wahlin and Deane (2012), the research also suggested that this discrepancy influenced the help seeking process, with the study finding that parents and adolescents who had similar perceptions of the problem having a more collaborative help seeking style.

The findings concur with previous research suggesting the key role of parents within the help seeking process, and particularly their role in facilitating the access of services (Costello et al., 1999; Logan & King, 2001). The research particularly highlighted help

seeking as a journey, with help sought at various points, linking with previous process based help seeking models (Murray, 2005; Rickwood, Deane, Wilson & Ciarrochi, 2005). The study also highlighted the importance of support for parents within the help seeking process, in line with previous research suggesting the link between parental burden and adolescent service use (Ryan, Jorm, Toumbourou & Lubman, 2015).

Furthermore, the findings seem to relate to the influence of adolescent development within the role of parents in the help seeking process. Adolescence has been characterised as being a period of time in which young people begin to separate from their parents, and develop close relationships with both peers and within romantic relationships (Yurgelun-Todd, 2007). However, research also suggests that adolescents are still reliant upon their parents to support them through developmental changes and into adulthood (Moretti & Peled, 2004). The results of this study build upon these findings to suggest that despite adolescents beginning to confide more in friends and other relationships (Rickwood, Mazzer & Telford, 2015; Wilson & Deane, 2001), parents continue to be important in supporting adolescents in beginning, and engaging with the help seeking process.

Within the study, parental availability appeared to play a large part within the help seeking process for adolescents. Parental emotional availability has been said within the literature to refer to several dimensions, sensitivity, structuring, non-intrusiveness and non-hostility, and emphasises the importance of the way that parents signal their emotions to their children, and their understanding of their child's emotional signals (Biringen & Robinson, 1991). The dimensions of sensitivity (physical and emotional responsiveness to children's physical and emotional signals), and structuring (the ability of a parent to support their children without removing their autonomy) (Biringen, 2000) seemed of particular relevance to the current study. Parents within the study who were able to show a high level of responsiveness to their young person's emotional needs seemed more able to facilitate the

help seeking process, and were more likely to be able to collaborate with their young person in the process. It also seemed that young people who had parents who could support them while allowing them autonomy felt more confident to begin seeking help independently.

Clinical Implications

The findings from the study have implications for clinical practice for those working with adolescents and their families.

Firstly, the findings reiterate the importance of the role of adults within adolescent help seeking, and the difficulties that adolescents have in seeking help without the influence of others. It could be that developing ways to make child and adolescent mental health services more accessible to young people could facilitate more independent help seeking, such as offering information about CAMHS services in an accessible way online, and clear information for adolescents in a developmentally appropriate style about how to seek help, particularly for those who feel they do not have an adult to confide in. It could be that the provision of support within schools could be further utilised to support this.

Secondly, the findings give support to the importance of planning around the role of parents within assessment of adolescent mental health. Whilst the majority of clinicians give adolescents time on their own within assessment, young people highlighted the importance of feeling in control of this process. It could be that creating a culture of offering young people a space to plan with a clinician how their parents would be involved within the assessment process would give adolescents a feeling of control.

Lastly, the findings highlight the importance of CAMHS clinicians supporting parents where this is possible. Offering support to parents around their own mental health needs helped parents develop availability to their young person and develop relationships. The research is based within a context of financial difficulties for CAMHS services, with high

thresholds and long waiting lists. However, attention should be given to the importance of support for parents, whether this is links into adult mental health services or parent workers within CAMHS.

Research Limitations

Whilst the aim of qualitative research is not to provide results that are generalisable across populations there are important considerations regarding the sample demographics that may have influenced the findings within the study. Firstly, whilst both service context and type of participant were triangulated within the study, both CAMHS services were recruited within a similar context within South London. There is likely to be specific factors about these locations that may not be applicable to other areas, such as high levels of deprivation.

Secondly, most of the service user participants recruited were parents and young people who had engaged well within the service, meaning that the experiences of those who struggle to engage with services are likely to be lost. In addition, despite the high levels of ethnic diversity within the area of the study, the majority of participants were White British. This is perhaps a wider reflection of struggling to recruit ethnic minority groups within research, but is an important consideration for both the implications of findings and for further research.

Future Research

More research is needed to develop accessible services for adolescents. Focus groups could begin to incorporate the experiences of adolescents into the future provision of CAMHS services. Given the focus on adolescent development within the findings, it could be helpful to utilise a quantitative research design to explore the differences in the role of parents within adolescent help seeking for younger and older adolescents. Furthermore, it

would also be beneficial to explore the ways adolescents then move on as young adults within the context of the move from CAMHS to adult mental health services.

Conclusions

This study sought to develop a theoretical framework of the influence of parents upon the way adolescents seek help for their mental health. Parents were found to be highly influential in the help seeking process, particularly those parents who were able to be highly available to their young people. For adolescents with parents who struggled to be consistently available to them, other trusted adults could facilitate help seeking. Once adolescents had been engaged with help, they often found it easier to then seek further help independently. The findings have implications for clinical practice; focusing on offering choices and control to young people, providing accessible services and supporting parents. Future research would benefit from a further focus on the separate experiences of younger and older adolescents, and considering help seeking within the move from CAMHS to adult mental health services.

References

Allen, J. P., McElhaney, K. B., Land, D. J., Kuperminc, G. P., Moore, C. W., O'Beirne-Kelly, H., & Kilmer, S. L. (2003). A secure base in adolescence: Markers of attachment security in the mother adolescent relationship. *Child Development, 74,* 292-307. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332136/

Anderson, R. M. (1968). *A behavioural model of families use of health services.* Chicago: Research Series.

Anderson, R. M. (1995). Revisiting the behavioural model and access to medical care: Does it matter? *Journal of Health and Social Behaviour, 36,* 1-10. doi: 10.2307/2137284

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non help seeking amongst young adults with mental distress: A dynamic interpretative model of illness behaviour. *Sociology of Health and Illness, 29,* 983-1002. doi: 10.1111/j.1467-9566.2007.01030.x

Biringen, Z., & Robinson, J. (1991). Emotional availability in mother child interactions: A reconceptualization for research. *American Journal of Orthopsychiatry, 61,* 258-271. doi: 10.1037/h0079238

Biringen, Z. (2000). Emotional availability: Conceptualisation and research findings. *American Journal of Orthopsychiatry, 70,* 104-114. doi: 10.1037/h0087711

Boldero, J., & Fallon, B. (1995). Adolescent help seeking: What do they get help for and for whom? *Journal of Adolescence, 18,* 193-209.

Block, A. M., & Greeno, C. G. (2011). Examining outpatient treatment dropout in adolescents: A literature review. *Child and Adolescent Social Work Journey, 28,* 393-420. doi: 10.1007/s10560-011-0237-x

Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision, 35,* 207-235. doi: 10.1007/BF01075199

Children and young people in mind: The final report of the national CAMHS review. (2008). Retrieved from:

http://webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf

Costello, E. J., Pescosolido, B. A., Angold, A., & Burns, B. J. (1999). A family network-based model of access to child mental health services. *Research in Community and Mental Health, 9,* 1106-1115.

Dey, I. (1999). *Grounding Grounded Theory Guidelines for Qualitative Inquiry.* San Diego: Academic Press.

Glaser, B. G. (1992). *Emergence vs Forcing: Basics of Grounded Theory Analysis*. California: The Sociology Press.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age of onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62,* 593-602. doi: 10.1001/archpsyc.62.6.593

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,* 709-717. doi: 10.1001/archpsyc.60.7.709

Klaus, N. M., Mobilio, A., & King, C, A. (2009). Parent adolescent agreement concerning adolescents' suicidal thoughts and behaviours. *Journal of Clinical Child and Adolescent Psychology, 38,* 245-255. doi: 0.1080/15374410802698412

Kolb, S. M. (2012). Grounded theory and the constant comparative method: Valid research strategies for educators. *Journal of Emerging Trends in Educational Research and Policy Studies, 3,* 83-86. Retrieved from:

http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.301.9451&rep=rep1&type=pdf

Laible, D. J., Carlo, G., & Raffaelli, M. (2000). The differential relations of parent and peer attachment to adolescent adjustment. *Journal of Youth and Adolescence, 29,* 45-59. doi: 10.1023/A:1005169004882

Lane, C. (2015). *Youth offending teams: A grounded theory of the barriers and facilitators to young people's help seeking from mental health services.* (Unpublished doctoral dissertation). Canterbury Christ Church University, Tonbridge.

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health service utilisation: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8,* 319-333. doi: 10.1093/clipsy.8.3.319

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *Education and Debate, 320,* 50-52. doi: 0.1136/bmj.320.7226.50

Michelmore, L., & Hindley, P. (2012). Help seeking for suicidal thoughts and self harm in young people: A systematic review. *Suicide and Life Threatening Behaviour, 42,* 507-524. doi: 10.1111/j.1943-278X.2012.00108.x

Moretti, M. M., & Peled, M. (2004). Adolescent-parent attachment: Bonds that support healthy development. *Paediatrics and Child Health, 9,* 551-555. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724162/

Murray, C. (2005). Young people's help seeking: An alternative model. *Childhood, 12,* 479-494. doi: 10.1177/0907568205058607

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *The British Journal of Social Work, 42,* 371-387. doi: 10.1093/bjsw/bcr064

Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *The American Journal of Sociology, 97,* 1096-1138. Retrieved from: http://s3.amazonaws.com/academia.edu.documents/43069059/Pescosolido-AJS-1992.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1492725107&Signature=Xgh%2FCZQeVo2nR5Ue9JBBU3v8P%2Bw%3D&response-content-disposition=inline%3B%20filename%3DBeyond_Rational_Choice_The_Social_Dynami.pdf

Public Health England (2016). *The mental health of children and young people in England.* Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4,* 218-251. Retrieved from: http://ro.uow.edu.au/cgi/viewcontent.cgi?article=3159&context=hbspapers

Rickwood, D. J., Mazzer, K. R., & Telford, N. R. (2015). Social influences on seeking help from mental health services, in person and online, during adolescence and young adulthood. *BMC Psychiatry.* doi: 10.1186/s12888-015-0429-6

Rosenstock, I. M. (1966). Why people use health services. *The Milbank Quarterly, 44,* 94-124. doi: 10.1111/j.1468-0009.2005.00425.x

Ryan, A. M., Jorm, A. F., Toumbourou, J. W., & Lubman, D. I. (2015). Parent and family factors associated with service use by young people with mental health problems: A

systematic review. *Early Intervention in Psychiatry, 9,* 433-446. doi: 10.1111/eip.12211

Stiffman, A. R., Pescosolido, B., & Cabassa, L. J. (2004). Building a model to understand youth service access: The gateway provider model. *Mental Health Services Research, 6,* 189-198. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3745273/

Wahlin, T., & Deane, F. P. (2012). Discrepancies between parent and adolescent perceived problem severity and influences on help seeking from mental health services. *Australian and New Zealand Journal of Psychiatry, 46,* 553-560. doi: 10.1177/0004867412441929

Williams, C. D., Lindsey, M., & Joe, S. (2011). Parent adolescent concordance on perceived need for mental health services and its impact on service use. *Children and Youth Services Review, 33,* 2253-2260. doi: 10.1016/j.childyouth.2011.07.011

Wilson, C, J., & Deane, F. P. (2001). Adolescent opinions about reducing help seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation, 12,* 345-364. doi: 10.1207/S1532768XJEPC1204_03

World Health Organisation. (2007). Adolescence, social support and helpseeking behaviour: An international literature review and programme consultation with recommendations for action. Retrieved from: http://apps.who.int/iris/bitstream/10665/43778/1/9789241595711_eng.pdf

Urquhart, C. (2013). *Grounded theory for qualitative research.* Manchester: SAGE.

Vogel, D. L., & Wei, M. (2005). Attachment and help seeking intent. The mediating roles of psychological distress and perceived social support. *Journal of Counselling Psychology, 52,* 347-357. doi: 10.1037/0022-0167.52.3.347

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15,* 215-228. doi: 10.1080/08870440008400302

Yurgelun-Todd, D. (2007). Emotional and cognitive changes during adolescence. *Current Opinion in Neurobiology, 17,* 251-257. doi: 10.1016/j.conb.2007.03.009

Section C: Appendices

Appendix A: NICE Quality Approval Checklist (NICE, 2010)

Study identification: Include full citation details	
Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design	
Guidance topic:	
Assessed by:	
Section 1: Population	
1.1 Is the source population or source area well described? • Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?	++ + – NR NA
1.2 Is the eligible population or area representative of the source population or area? • Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? • Was the eligible population representative of the source? Were important groups underrepresented?	++ + – NR NA
1.3 Do the selected participants or areas represent the eligible population or area?	++

• Was the method of selection of participants from the eligible population well described? • What % of selected individuals or clusters agreed to participate? Were there any sources of bias? • Were the inclusion or exclusion criteria explicit and appropriate?	+ − NR NA
Section 2: Method of selection of exposure (or comparison) group	
2.1 Selection of exposure (and comparison) group. How was selection bias minimised? • How was selection bias minimised?	++ + − NR NA
2.2 Was the selection of explanatory variables based on a sound theoretical basis? • How sound was the theoretical basis for selecting the explanatory variables?	++ + − NR NA
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + − NR NA
2.4 How well were likely confounding factors identified and controlled?	++

• Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	+ – NR NA
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + – NR NA
Section 3: Outcomes	
3.1 Were the outcome measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking −)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + – NR NA
3.2 Were the outcome measurements complete? • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	++ + – NR NA
3.3 Were all the important outcomes assessed?	++

• Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	+ − NR NA
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + − NR NA
3.5 Was follow-up time meaningful? • Was follow-up long enough to assess long-term benefits and harms? • Was it too long, e.g. participants lost to follow-up?	++ + − NR NA
Section 4: Analyses	
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? • A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. • Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	++ + − NR NA
4.2 Were multiple explanatory variables considered in the analyses?	++

• Were there sufficient explanatory variables considered in the analysis?	+ − NR NA
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + − NR NA
4.6 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + − NR NA
Section 5: Summary	
5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + −
5.2 Are the findings generalisable to the source population (i.e. externally valid)? • Are there sufficient details given about the study to determine if the findings are generalisable to the source population?	++ + −

• Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	

Appendix B: Consent Forms and Information Sheets – removed from electronic copy

Information Sheets and Consent Forms for Adolescents Aged 13-15 and Parents

Information Sheets and Consent Forms for Adolescents Aged 15-18

Clinician Information Sheet and Consent Form

Appendix C: HRA, REC and University Approval – removed from electronic copy

Appendix D: Interview Schedules – removed from electronic copy

Appendix E: Audit Trail for Data Analysis

Focused Codes for Clinicians, Young People and Parents

Clinicians

Parental expectations for the service

Clinician belief parental involvement leads to better outcomes

Parental location of problem within the child

CAMHS threshold at crisis level

Parental beliefs about mental health

Balancing parent and child needs

Clinician gauging family relationships

Family norms for talking about problems

Deprivation in local context, high level of needs

Service limitations pressure clinicians

Family patterns of help seeking

Internalising behaviours noticed later than externalising

Externalising behaviours seen more quickly within service

Prevalence of parental mental health problems

Chronological age vs developmental age

Parents previous experiences of services

CAMHS expertise in recognising developmental stage rather than chronological

Parental perception of need for referral

Parental feelings of judgement by services

CAMHS seen as threatening

Beliefs about coping alone

Family beliefs about asking for help

Societal expectations of problems masking problems

Managing parental needs with limited capacity

Balancing therapeutic relationship with YP and needs of parents

Respecting wishes of YP vs clinical judgment and systemic needs

Nurturing parent-child relationships

Involving parents therapeutically

Parental expectations for treatment

Increased societal awareness of mental health problems based in medical model

Shared aim between parents and YP for happiness

Clinician aiding parental understanding of YP's needs

Clinician helping parent to recognise YP's emotional needs

Parents key in help seeking process – very few adolescents seek help alone

Mental health services often do not represent their users

Parents often brought into referral process by schools

Offering YP confidentiality is key

Being transparent with YP about what will be shared

Difficult for parents to know what to offer

Parents offering containment to YP outside of sessions

Importance of giving a space for parents

Importance of parental expertise in assessment of YP

Impact of parents own emotional needs and awareness of own needs

Parents often important in engaging YP and keeping YP engaged

Education about mental health needed in schools

Access to other adults important when parents aren't available

Need clear advertising of help sources

Ability of parents to be container for YP's distress

Parents with understanding of needs more able to see impact on child

If no adult available likely to reach crisis level

Cultural beliefs impact on help seeking

Friends with similar experiences can support YP

Involving parents who feel excluded from YP's treatment

YP reflecting parents help seeking style

YP protecting parents by not disclosing problems

Distrust in Western ideas of mental health

Giving YP clear boundaries so they know what to expect

Respecting courage taken to seek help

'Normal' teenage behaviour vs mental health problem

Hard for parents to support when feeling very overwhelmed

Parents can model help seeking and engagement to YP

Services do not always include both parents

Rely on parents to support treatment

Parents

Normal teenage behaviour vs mental health problems

Different degrees of help seeking

Parent feeling of helplessness – can only push for help

Importance of consistent parent support

Flexible involvement to meet needs of YP, moving in and out

Help given can be different to expectations

Pressure on parents to make up for service limitations

YP has to be worried enough to tell

Externalising problems easier to notice

Self-harm noticeable, showing need with self-harm

Compliant children hard to notice

Discrepancies between school and parents

Feelings of blame and judgment by services

YP learning to seek help earlier

Clinician helps YP engage and then seek help in future

YP moves towards independence in treatment and recovery

Impact of trauma

YP less concerned than adults

How parents experience moves between CAMHS teams

Emotional impact on parents of facilitating help seeking

YP mirroring parent help seeking style

Positive friendships important

Parents facilitating attendance at appointments

Professionals are the ones who can understand

Parental beliefs about expressing emotions

Hard for parents to know how to help

Family beliefs about help seeking

Parents noticed before YP

Family experience of mental health problems can allow early identification

CAMHS facilitating parental involvement even when YP did not want

Previous experience of mental health services

Uncertainty about what will happen at CAMHS

Phases of emotions as a parent

Those with previous experience of mental health problems more supportive

Adolescence difficult time developmentally

Continuity at CAMHS key for YP

CAMHS supported parents to stay involved

Increased societal awareness of mental health problems

Help seeking as a family journey

Family norms of talking about problems

YP researched help online first

Parents showing availability to YP

Disjointed referral process, hard to navigate

Parents respecting YP's privacy

Parents offering YP choices

High level of risk needed to access services

Clinicians helping parents know how to support YP

Gratitude for services received

Parents encouraging independence in adolescence

Parental expertise in knowing YP's needs

CAMHS providing future template for help seeking

In and out involvement

Availability of clinician facilitated help seeking independently

Parent journey in understanding YP's needs

Clinicians helping parent to stay engaged in process

YP

Externalising problems get help quickly

Seeking help at first point from parent

Parents and teachers noticed together

Role of education in awareness about mental health

Greater awareness of the problem when an older adolescent

Parents facilitate independence in life as grow older

Online research about help seeking

Collaboration in help seeking between parent and young person

Ability to seek help independently once engaged in CAMHS

Family norm to talk about problem

Emotional availability of parents facilitated disclosure

YP perceives parent can cope with problem

Availability of clinician facilitated YP help seeking

School noticed problem first

Increased parental awareness of mental health needed

Adolescent ability to consider future consequences

Clinicians not shocked by the problem

Parents involved during crisis

YP's understanding of CAMHS structure and moves between teams

Need containment from parent to be able to disclose problem

CAMHS giving YP control over how parents are told in crisis

Services respond quickly to crisis

Previous experiences of help

Friends with similar problems can help to cope

Secretive behaviours, hiding problem from parents

Mismatch between expectations of service and help given

YP perception that adults taken more seriously by services than YP

Duration of problem indicates severity to YP

Help not given without action

Help is hard to access

Importance of relationships in disclosing problems

Those with experience of mental health problems will understand

Physical care from parents vs emotional care

Crisis meets CAMHS thresholds

Distinction between seeking help for mental health vs other problems

YP perceives parents won't be able to cope with the problem

Lack of awareness of how to seek help

Religion can offer support but may not be enough

Other adult in family keeping parents involved

Sense of availability of parents important to disclose problem

YP wanting to protect parent

Family beliefs about mental health and recovery

Others noticing makes it easier to disclose the problem

Need those with similar cultural experiences to understand

Some cultures hold more stigma about mental health problems

Uncertainty about CAMHS, unknown service

Accessible service facilitates independence – drop in

CAMHS helped to understand the problem

YP might disappoint parent if discloses the problem

YP wants parent to think everything is ok

Parents involved with big decisions

CAMHS collaborates with YP

YP trying to protect relationships at home

Having parents has been helpful

YP perception of discharge from CAMHS

Needing help at different points throughout adolescence

Parent not able to validate YP's experience

CAMHS helped parent understand

Therapist can be trusted

Continuity in clinicians important

CAMHS gives clear boundaries

Distinction between CAMHS and home life

CAMHS helped parent know how to respond

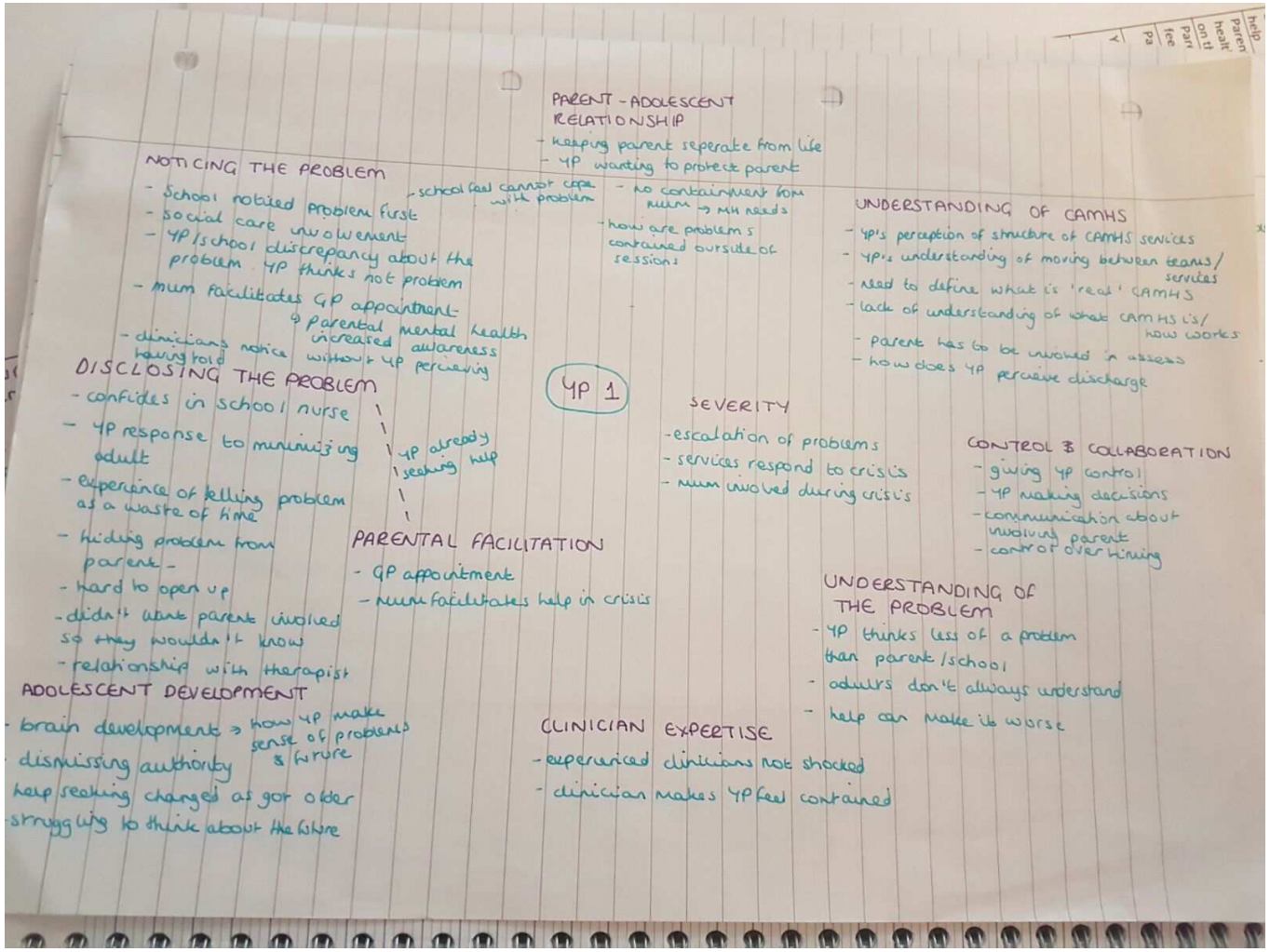
CAMHS facilitates communication between parent and YP

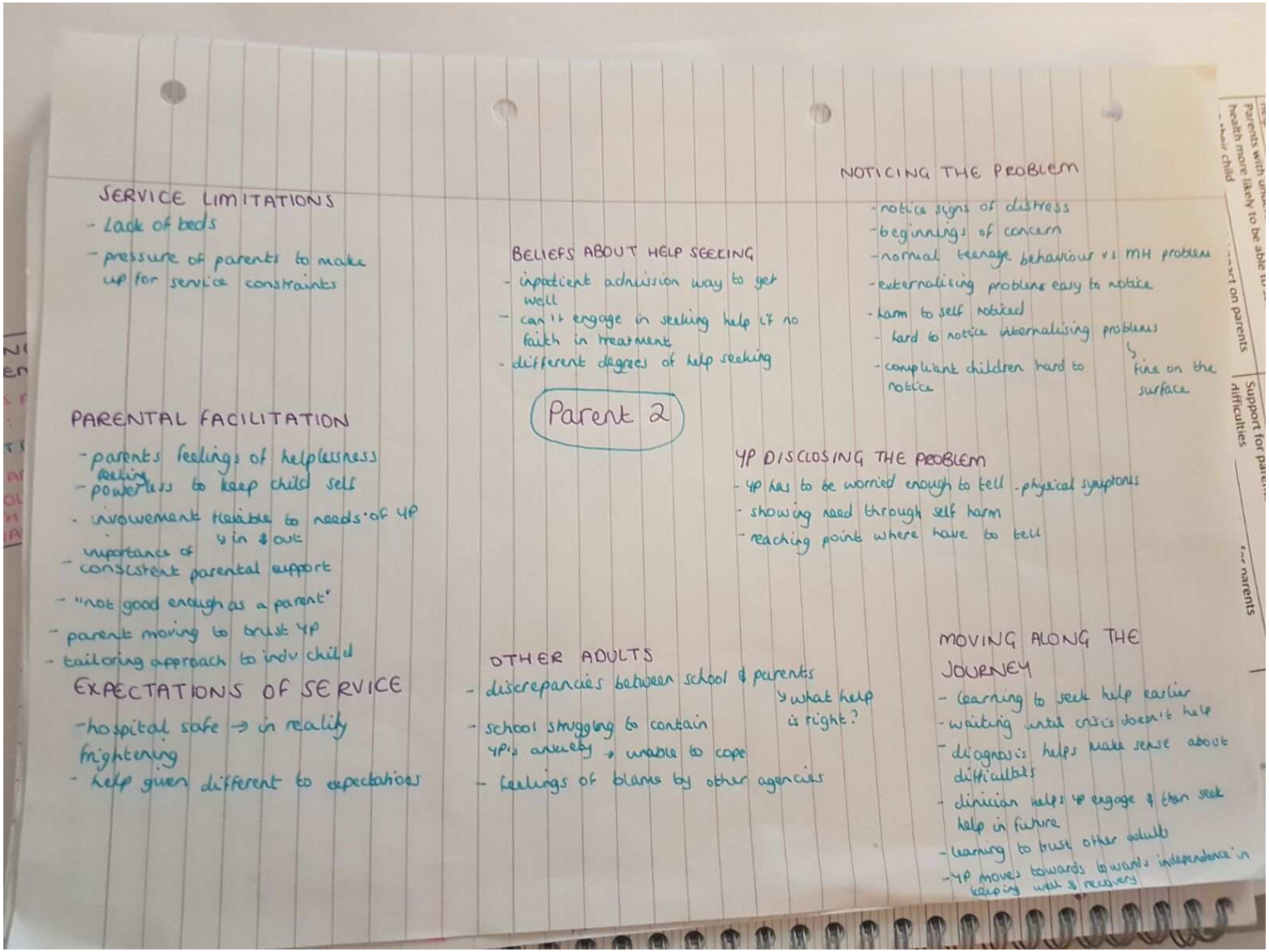
Following same help seeking style as parent

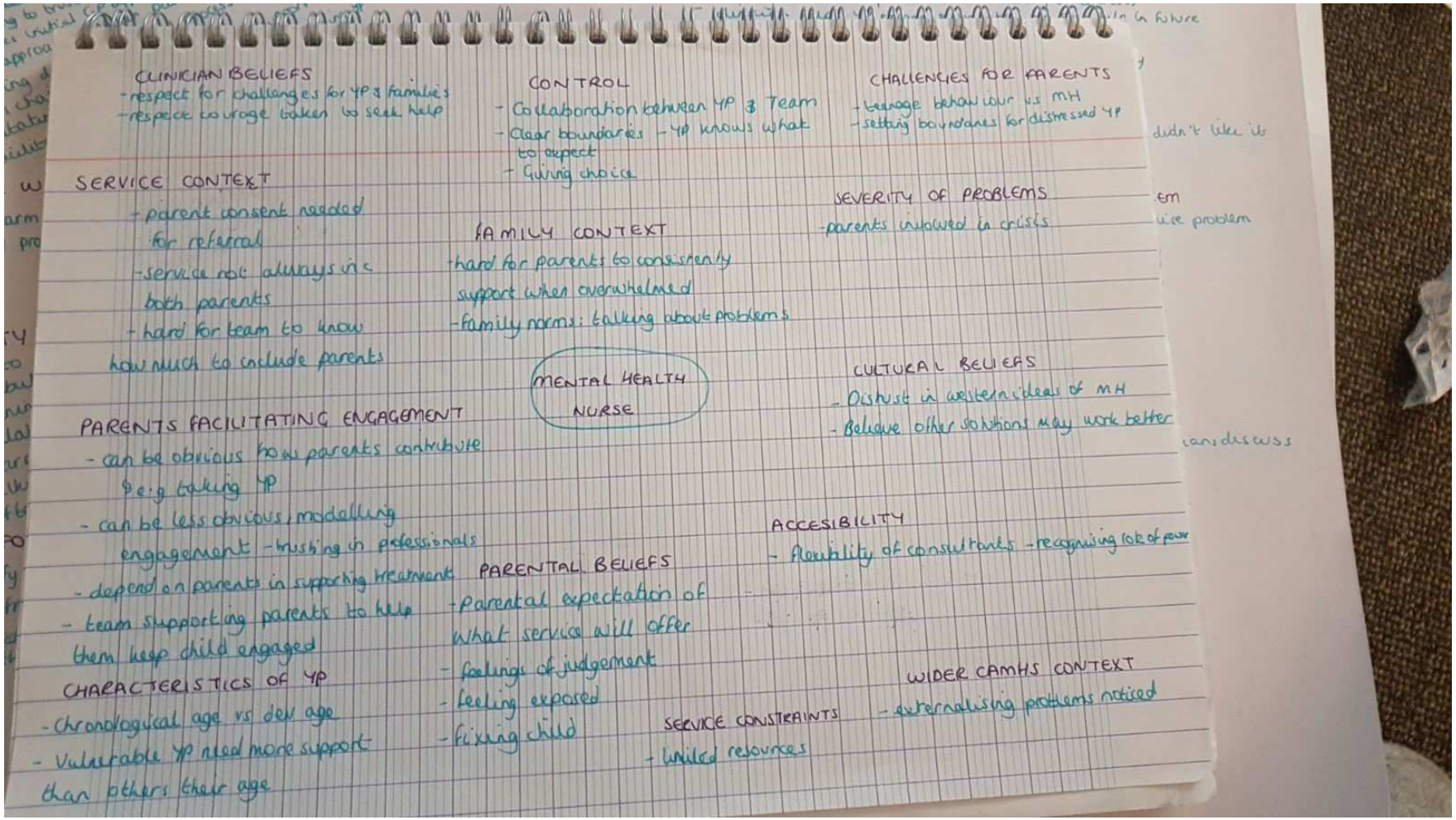
No adult to tell leads to crisis

Those with experience of mental health problems more likely to notice

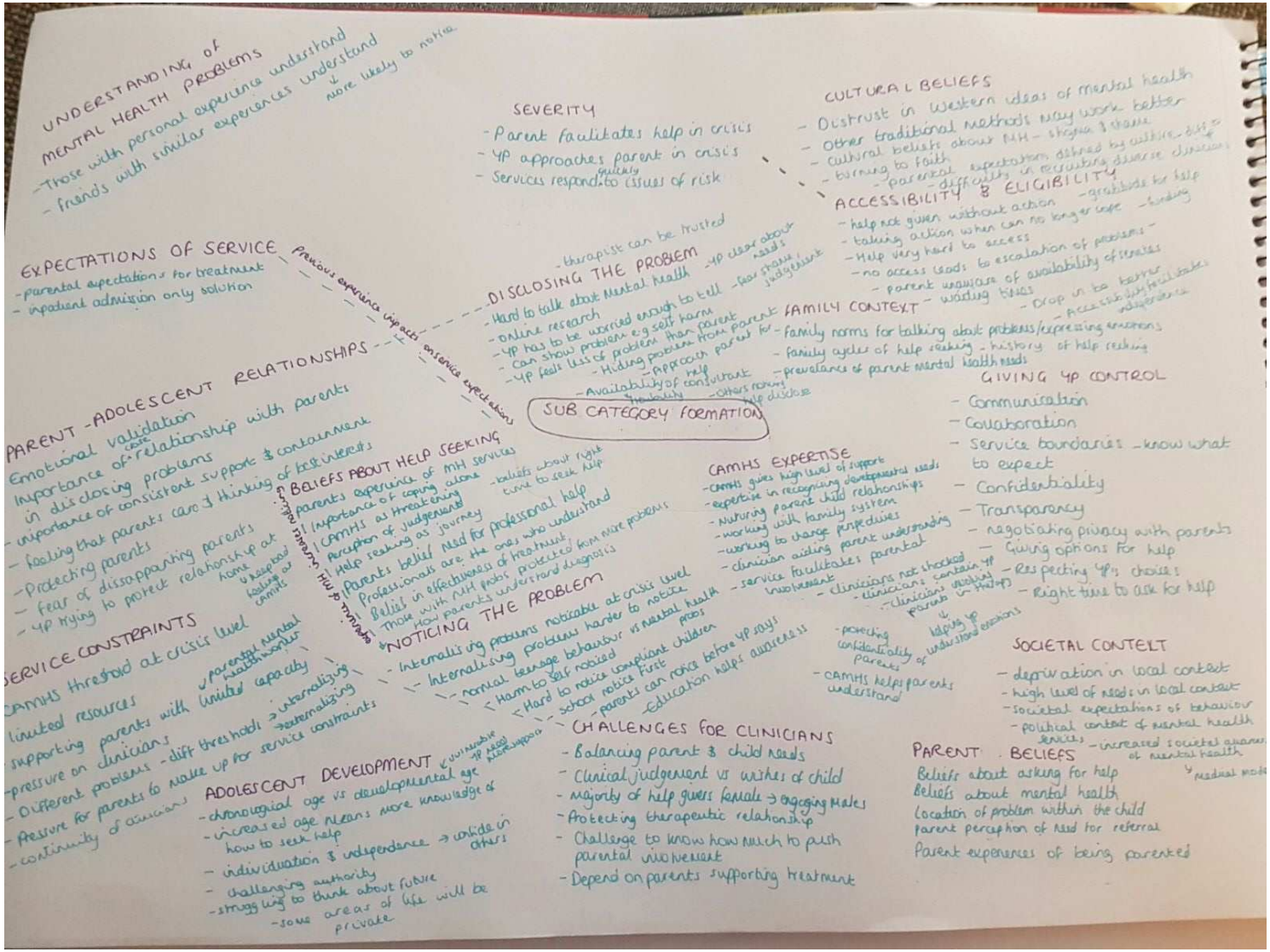
Examples of Sub Category Development

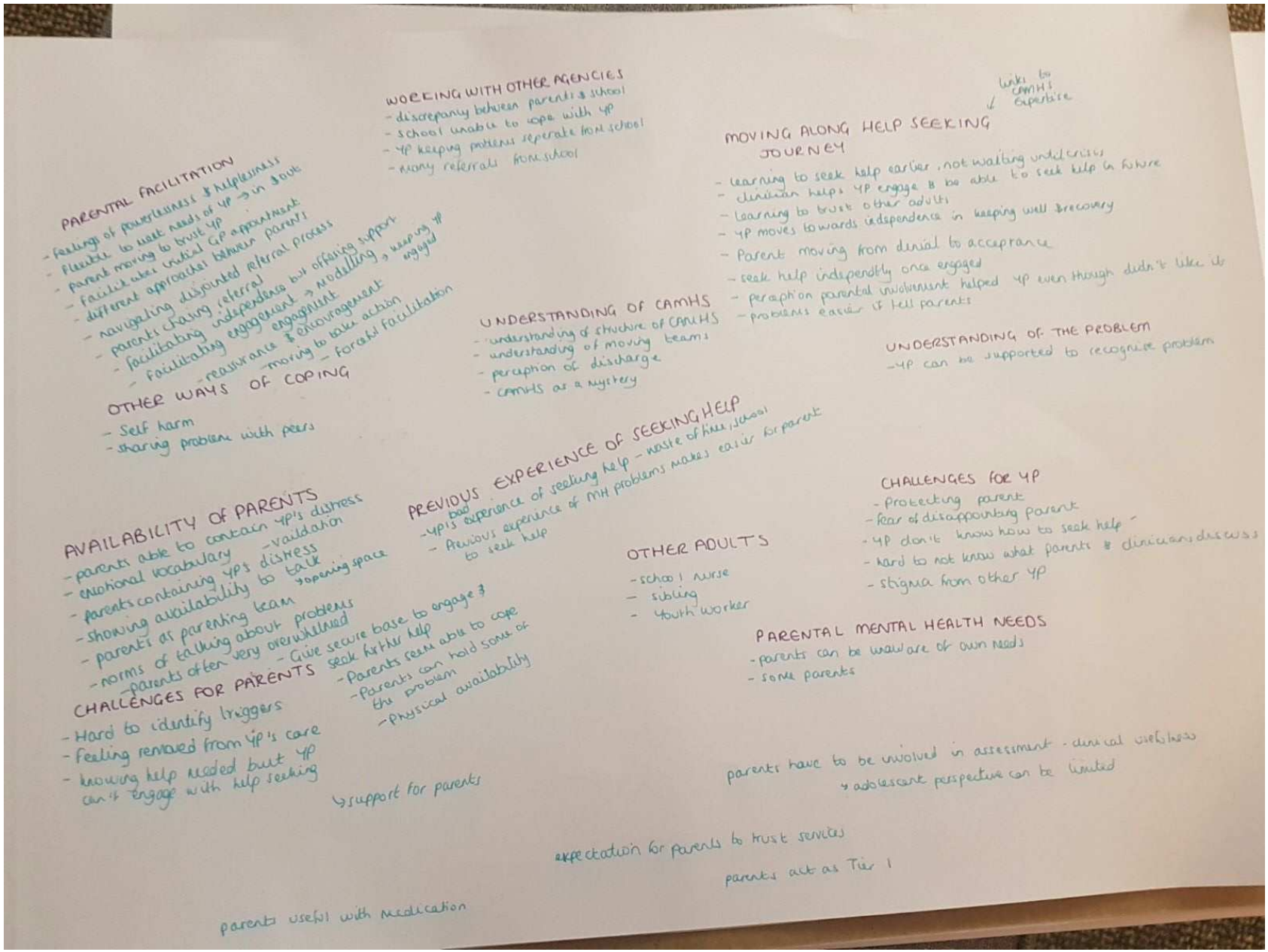



SERVICE LIMITATIONS
- Lack of beds
- pressure of parents to make up for service constraints
BELIEFS ABOUT HELP SEEKING
- inpatient admission way to get well
- can't engage in seeking help if no faith in treatment
- different degrees of help seeking
NOTICING THE PROBLEM
- notice signs of distress
- beginnings of concern
- normal teenage behaviour v.s MH problem
- externalising problems easy to notice
- harm to self noticed
- hard to notice internalising problems
- compliant children hard to notice
Parent 2
PARENTAL FACILITATION
- parents feelings of helplessness feeling
- powerless to keep child safe
- involvement flexible to needs of YP importance of
- consistent parental support
- "not good enough as a parent"
- parent moving to trust YP
- tailoring approach to indv child
YP DISCLOSING THE PROBLEM
- YP has to be worried enough to tell
- showing need through self harm
- reaching point where have to tell
- physical symptoms
EXPECTATIONS OF SERVICE
- hospital safe → in reality frightening
- help given different to expectations
OTHER ADULTS
- discrepancies between school & parents
- school struggling to contain YP's anxiety → unable to cope
- feelings of blame by other agencies
MOVING ALONG THE JOURNEY
- learning to seek help earlier
- waiting until crisis doesn't help
- diagnosis helps make sense about difficulties
- clinician helps YP engage & then seek help in future
- learning to trust other adults
- YP moves towards towards independence in keeping well & recovery

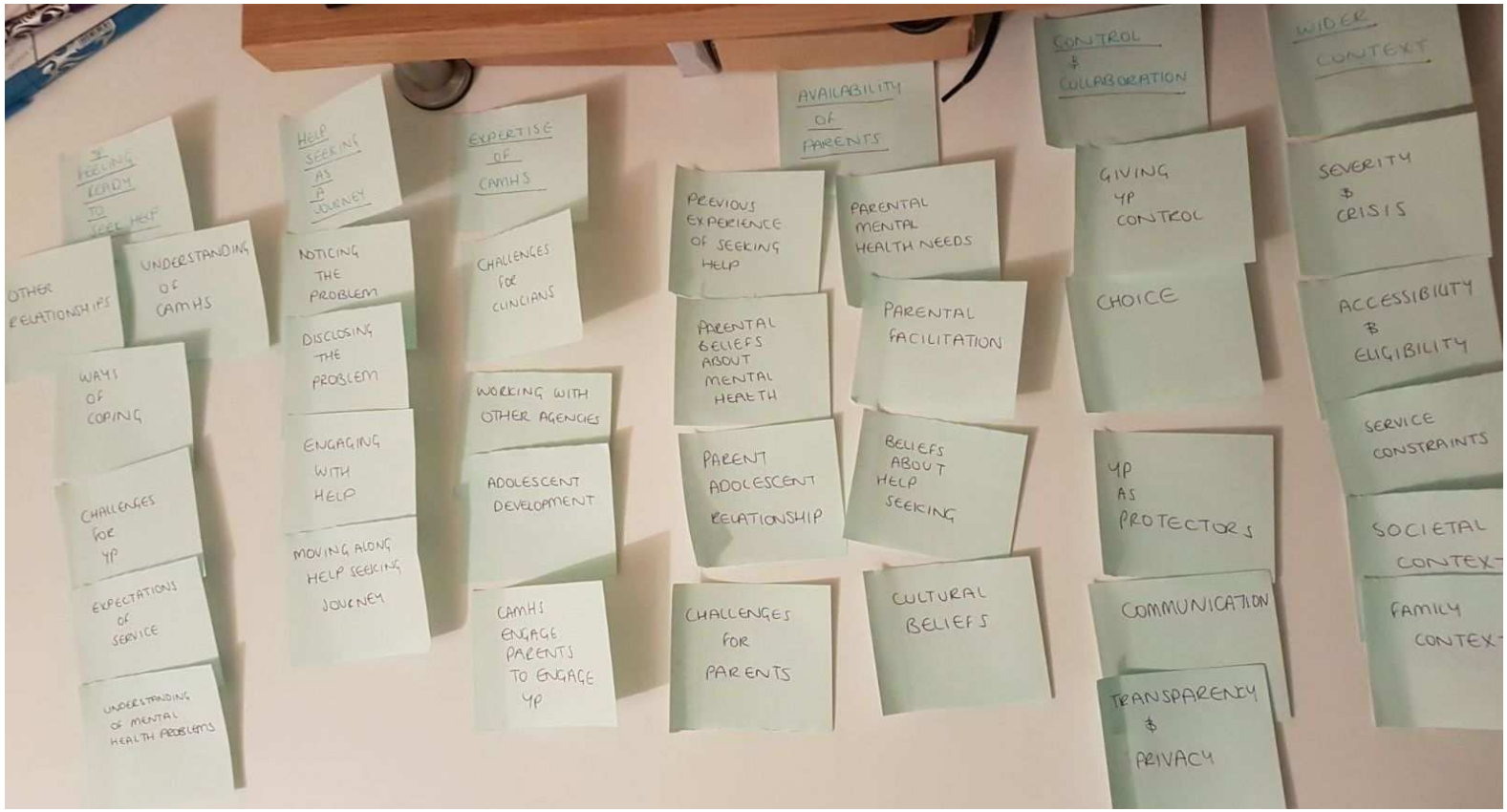

CLINICIAN BELIEFS
- respect for challenges for YP & families
- respect to rage taken to seek help
CONTROL
- Collaboration between YP & Team
- Clear boundaries - YP knows what to expect
- Giving choice
CHALLENGES FOR PARENTS
- teenage behaviour vs MH
- setting boundaries for distressed YP
SERVICE CONTEXT
- parent consent needed for referral
- service not always in c both parents
- hard for team to know how much to include parents
FAMILY CONTEXT
- hard for parents to consistently support when overwhelmed
- family norms: talking about problems
SEVERITY OF PROBLEMS
- parents involved in crisis
MENTAL HEALTH NURSE
CULTURAL BELIEFS
- Distrust in western ideas of MH
- Believe other solutions may work better
PARENTS FACILITATING ENGAGEMENT
- can be obvious how parents contribute
Being taking YP
- can be less obvious, modelling engagement - buying in professionals
- depend on parents in supporting treatment
- team supporting parents to help them keep child engaged
PARENTAL BELIEFS
- Parental expectation of what service will offer
- feelings of judgement
- feeling exposed
- fixing child
ACCESIBILITY
- flexibility of consultants - recognising role of pow
CHARACTERISTICS OF YP
- Chronological age vs dev age
- Vulnerable YP need more support than others their age
SERVICE CONSTRAINTS
- limited resources
WIDER CAMHS CONTEXT
- externalising problems noticed

Development of Sub Categories




PARENTAL FACILITATION
- feelings of powerlessness & helplessness
- flexible to meet needs of YP → in & out
- parent moving to trust YP
- facilitates initial GP appointment
- different approaches between parents
- navigating disjointed referral process
- parents chasing referral
- facilitating independence but offering support
- facilitating engagement → modelling, keeping YP engaged
- facilitating engagement & encouragement
- reassurance - moving to take action
- forceful facilitation
OTHER WAYS OF COPING
- Self harm
- sharing problems with peers
WORKING WITH OTHER AGENCIES
- discrepancy between parents & school
- school unable to cope with YP
- YP keeping problems seperate from school
- many referrals from school
UNDERSTANDING OF CAMHS
- understanding of structure of CAMHS
- understanding of moving teams
- perception of discharge
- CAMHS as a mystery
links to CAMHS expertise
MOVING ALONG HELP SEEKING JOURNEY
- learning to seek help earlier, not waiting until crisis
- clinician helps YP engage & be able to seek help in future
- learning to trust other adults
- YP moves towards independence in keeping well & recovery
- Parent moving from denial to acceptance
- seek help independently once engaged
- perception parental involvement helped YP even though didn't like it
- problems easier if tell parents
UNDERSTANDING OF THE PROBLEM
-YP can be supported to recognise problem
AVAILABILITY OF PARENTS
- parents able to contain YP's distress
- emotional vocabulary - validation
- parents containing YP's distress
- showing availability to talk - opening space
- parents as parenting team
- norms of talking about problems
- parents often very overwhelmed
CHALLENGES FOR PARENTS
- Hard to identify triggers
- Feeling removed from YP's care
- knowing help needed but YP can't engage with help seeking
- Give secure base to engage & seek further help
- Parents seem able to cope
- Parents can hold some of the problem
- physical availability
PREVIOUS EXPERIENCE OF SEEKING HELP
- YP's bad experience of seeking help - waste of time, school
- Previous experience of MH problems makes easier for parent to seek help
OTHER ADULTS
- school nurse
- sibling
- youth worker
CHALLENGES FOR YP
- Protecting parent
- fear of disappointing parent
- YP don't know how to seek help
- hard to not know what parents & clinicians discuss
- stigma from other YP
PARENTAL MENTAL HEALTH NEEDS
- parents can be unaware of own needs
- some parents
parents have to be involved in assessment - clinical usefulness & adolescent perspective can be limited
↳support for parents
expectation for parents to trust services
parents act as Tier 1
parents useful with medication

Development of Categories



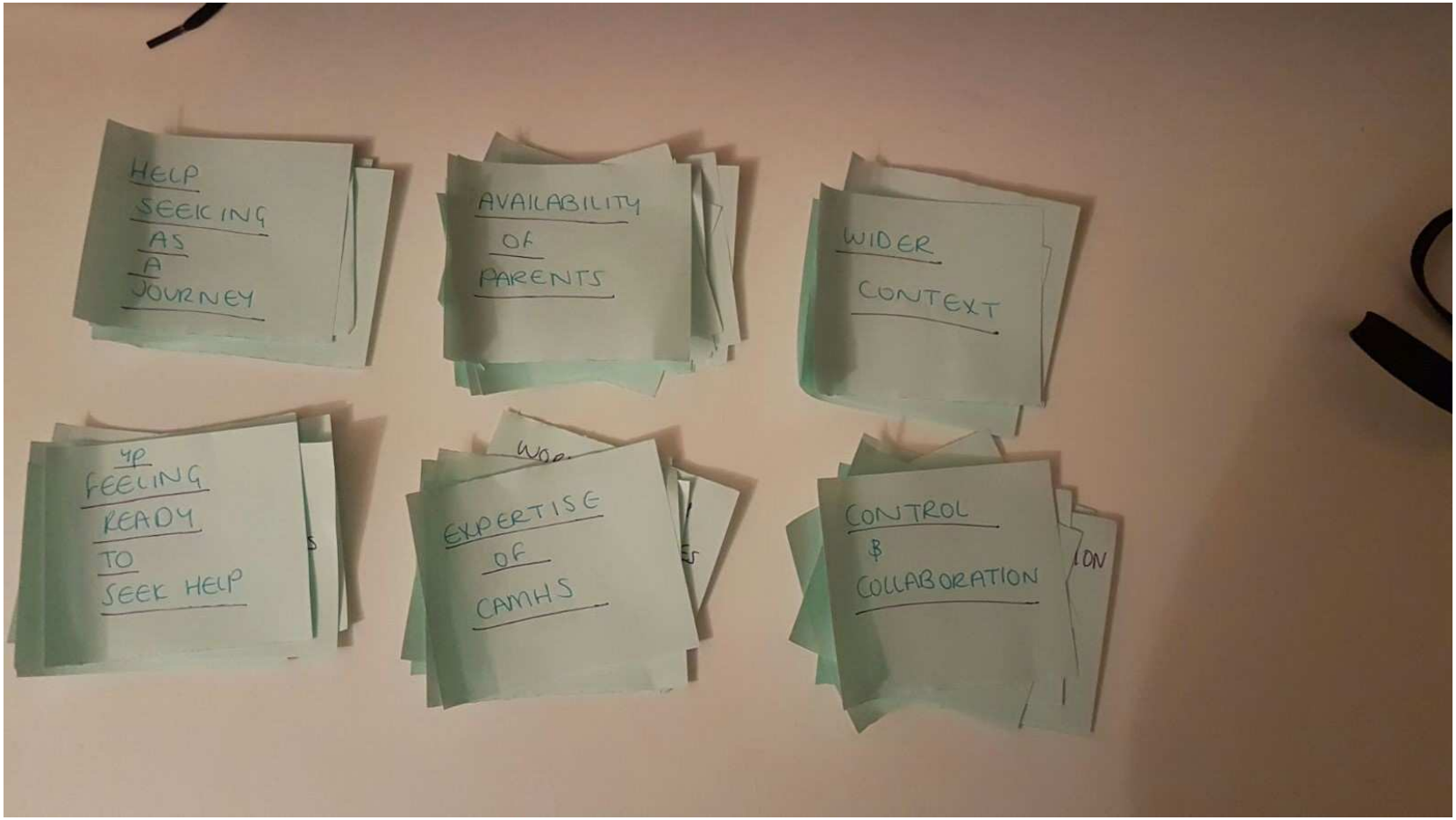
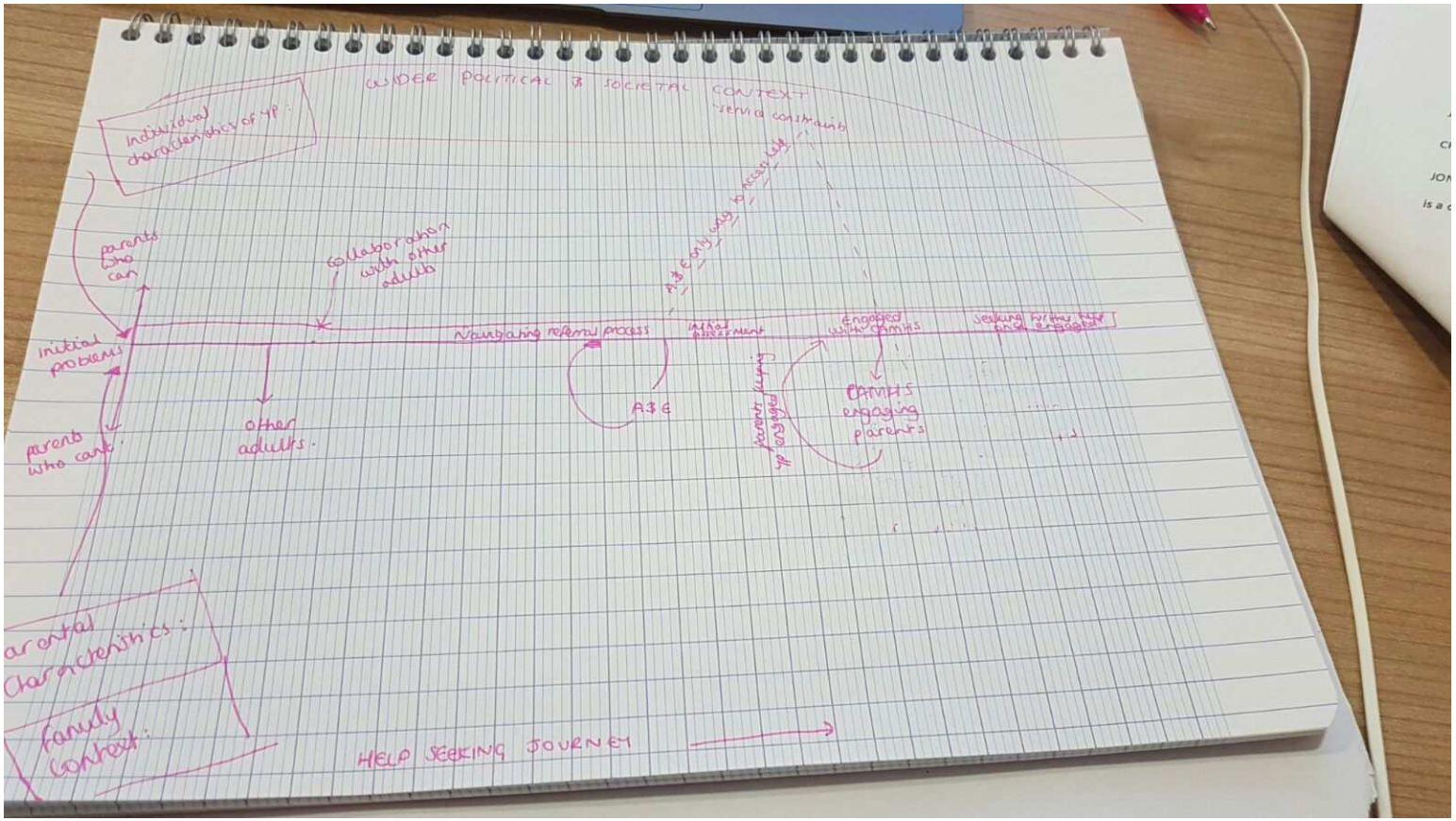
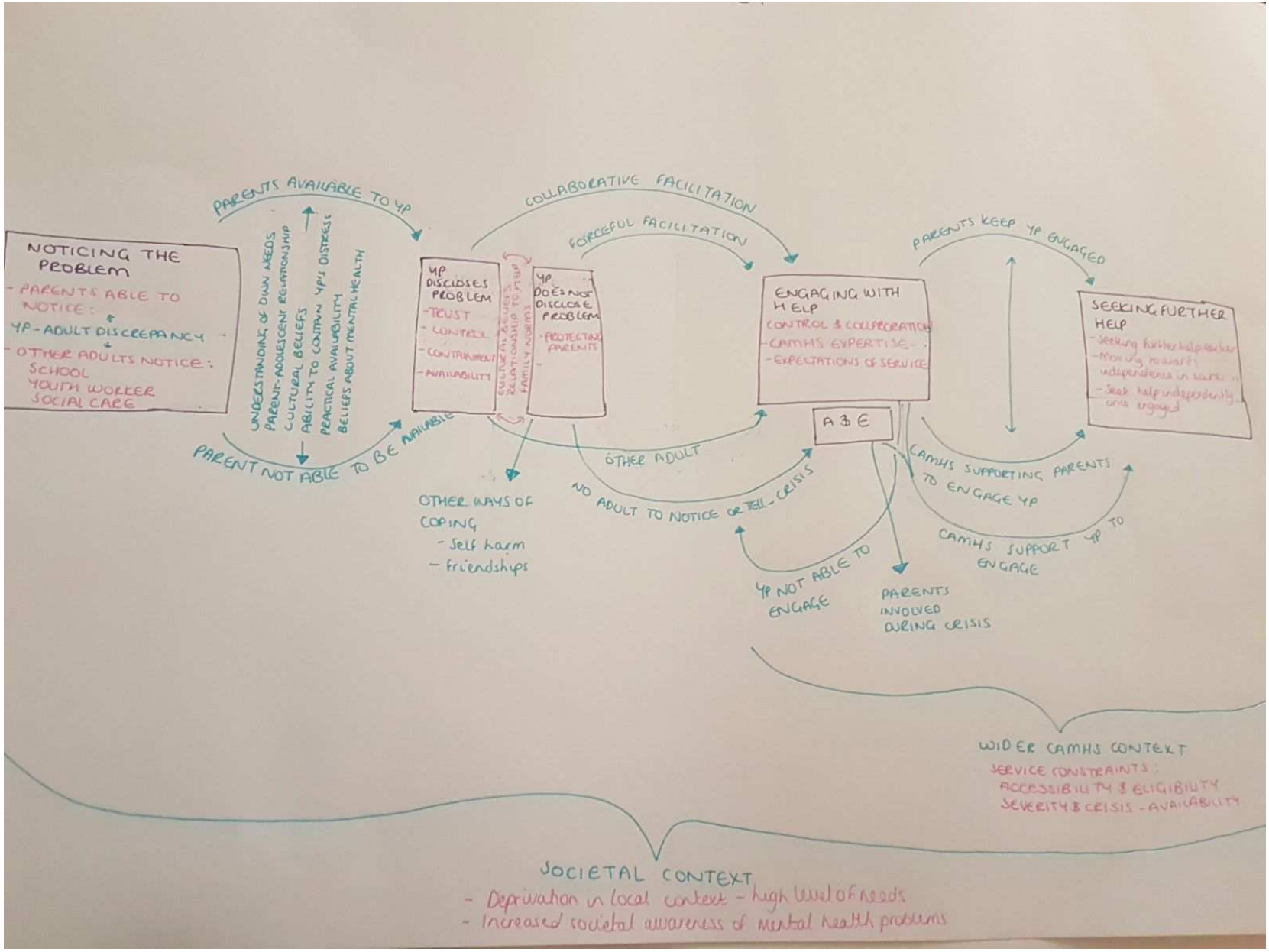

HELP SEEKING AS A JOURNEY
AVAILABILITY OF PARENTS
WIDER CONTEXT
YP FEELING READY TO SEEK HELP
EXPERTISE OF CAMHS
CONTROL & COLLABORATION

Diagram Development




NOTICING THE PROBLEM
- PARENTS ABLE TO NOTICE:
+
YP-ADULT DISCREPANCY
+
- OTHER ADULTS NOTICE:
SCHOOL
YOUTH WORKER
SOCIAL CARE
PARENTS AVAILABLE TO YP
PARENT NOT ABLE TO BE AVAILABLE
UNDERSTANDING OF OWN NEEDS
PARENT-ADOLESCENT RELATIONSHIP
CULTURAL BELIEFS
ABILITY TO CONTAIN YP'S DISTRESS
PRACTICAL AVAILABILITY
BELIEFS ABOUT MENTAL HEALTH
YP DISCLOSES PROBLEM
- TRUST
- CONTROL
- CONTAINMENT
- AVAILABILITY
CULTURAL BELIEFS
RELATIONSHIP TO HELP
FAMILY NORMS
YP DOES NOT DISCLOSE PROBLEM
- PROTECTIVE PARENTS
COLLABORATIVE FACILITATION
FORCEFUL FACILITATION
ENGAGING WITH HELP
CONTROL & COLLABORATION
- CAMHS EXPERTISE
- EXPECTATIONS OF SERVICE
A & E
PARENTS KEEP YP ENGAGED
SEEKING FURTHER HELP
- Seeking further help earlier
- Moving towards independence in care
- Seek help independently once engaged
OTHER WAYS OF COPING
- Self harm
- Friendships
OTHER ADULT
NO ADULT TO NOTICE OR TELL - CRISIS
YP NOT ABLE TO ENGAGE
PARENTS INVOLVED DURING CRISIS
CAMHS SUPPORTING PARENTS TO ENGAGE YP
CAMHS SUPPORT YP TO ENGAGE
WIDER CAMHS CONTEXT
SERVICE CONSTRAINTS:
ACCESSIBILITY & ELIGIBILITY
SEVERITY & CRISIS - AVAILABILITY
SOCIETAL CONTEXT
- Deprivation in local context - high level of needs
- Increased societal awareness of Mental health problems

Example of Research Memo – removed from electronic copy

Appendix F: Example of Coded Transcript – removed from electronic copy

Appendix G: Qualitative Research Guidelines

Mays and Pope (2000)

• Worth or relevance—Was this piece of work worth doing at all? Has it contributed usefully to knowledge?

• Clarity of research question—If not at the outset of the study, by the end of the research process was the research question clear? Was the researcher able to set aside his or her research preconceptions?

• Appropriateness of the design to the question—Would a different method have been more appropriate? For example, if a causal hypothesis was being tested, was a qualitative approach really appropriate?

• Context—Is the context or setting adequately described so that the reader could relate the findings to other settings?

• Sampling—Did the sample include the full range of possible cases or settings so that conceptual rather than statistical generalisations could be made (that is, more than convenience sampling)? If appropriate, were efforts made to obtain data that might contradict or modify the analysis by extending the sample (for example, to a different type of area)?

• Data collection and analysis—Were the data collection and analysis procedures systematic? Was an "audit trail" provided such that someone else could repeat each stage, including the analysis? How well did the analysis succeed in incorporating all the observations? To what extent did the analysis develop concepts and categories capable of explaining key processes or respondents' accounts or observations? Was it possible to follow the iteration between data and the explanations for the data (theory)? Did the researcher search for disconfirming cases?

• Reflexivity of the account—Did the researcher self consciously assess the likely impact of the methods used on the data obtained? Were sufficient data included in the reports of the study to provide sufficient evidence for readers to assess whether analytical criteria had been met?

Yardley (2000)

- Sensitivity to context - is the analysis and interpretation sensitive to the data, the social context, and the relationships (between researcher and participants) from which it emerged?
    - What was the nature of researcher's involvement (prolonged engagement, immersion in data)?
    - Does the researcher consider how he or she may have specifically influenced participants' actions (reflexivity)?
    - Does the researcher consider the balance of power in a situation?
- Completeness of data collection, analysis and interpretation

- Is the size and nature (comprehensiveness) of the sample adequate to address the research question?

- Is there transparency and sufficient detail in the author's account of methods used and analytical and interpretive choices (audit trail)? Is every aspect of the data collection process, and the approach to coding and analyzing data discussed? Does the author present excerpts from the data so that readers can discern for themselves the patterns identified?

- Is there coherence across the research question, philosophical perspective, method, and analysis approach?

- Reflexivity - does the researcher reflect on his or her own perspective and the motivations and interests that shaped the research process (from formulation of the research question, through method choices, analysis and interpretation).

- Is the research important - will it have practical and theoretical utility?

Appendix H: Excerpt from Research Journal – removed from electronic copy

Appendix I: Final Categories, Sub-Categories and Focused Codes

Category	Sub-Category	Focused Code
Availability of Parents	Emotional Availability	Parent not able to validate YP's experiences
		Need containment from parent to be able to disclose problem
		YP perceives parent cannot cope with problem
		Parents showing availability to YP
		Ability of parent to be container for YP's distress
		Physical care from parents vs emotional care
		Parents offering containment to YP outside of sessions
		High prevalence of parental mental health problems
		Impact of parents own emotional needs
		Parents with understanding of own needs more able to see impact on child
	Parental Facilitation	Parental expertise in knowing YP's needs
		Parents involved with big decisions
		Parents involved during crisis
		Parents encouraging independence in adolescence
		Parents key in help seeking process
		Parents can model help seeking and engagement to YP
		Parents facilitating attendance at appointments
		Flexible involvement of parents to meet needs of YP
		Rely on parents to support treatment

		Parents often important in engaging YP and keeping YP engaged
		Parents respecting YP's privacy
		Collaboration in seeking help between parent and YP
		Parent offering YP choices
		Difficult for parents to know what to offer
		Normal teenage behaviour vs mental health problems
		Parents feeling of helplessness
		Internalising behaviours harder to notice than externalising
		Hard for parents to support when feeling very overwhelmed
		Phases of emotions as a parent
		Emotional impact on parents of facilitating help seeking and supporting YP
	Beliefs about help seeking	Parental beliefs about mental health
		Distrust in Western ideas about mental health
		Professionals are the only ones who can understand
		Parental beliefs about expressing emotions
		Parents expectations for treatment
		Feelings of judgment and blame by services
		Parental perception of need for referral
		Parent location of problems within the child
		Parents previous experiences of mental health services and help seeking
YP feeling ready to seek help	Perception of the problem	YP less concerned than parents

		YP less concerned than school
		YP has to be worried enough to tell
		Duration of problem indicates severity to YP
	Beliefs about help seeking	Cultural beliefs impact on help seeking
		Need those with a similar cultural experience to understand
		Some cultures hold more stigma about mental health problems than others
		YP mirroring parent help seeking style
		Others noticing makes it easier to seek help
		It can be easier to show the problem than to talk about the problem
		Distinction between seeking help for mental health problems vs other problems
		Those with experience of mental health problems will understand
		Those with experience of mental health problems more likely to notice
		Beliefs about coping alone
		Impact of previous experiences of help
	Trusted relationships	Importance of relationships in disclosing problems
		No adult to tell leads to crisis
		Other adult in family keeping parents involved
		Access to other adults important when parents not available
		Disclosing problem at school
	YP as protectors	YP perceives parent will be unable to cope with problem
		YP trying to protect relationships at home

		YP perception might disappoint parent if disclose the problem
		YP wants parent to think everything is ok
Expertise of CAMHS	Developing parental availability	Clinician aiding parent understanding of YP's needs
		Clinician helping parent to recognise YP's emotional needs
		Parent journey in understanding YP's needs
		Clinicians helping parent to stay engaged in process
		Clinicians helping parents know how to support YP
		Nurturing parent-child relationships
		Involving parents who feel excluded from YP's treatment
		CAMHS facilitates communication between parents and YP
		Clinician gauging family relationships
		CAMHS supporting parents to stay involved
		Importance of giving space for parents
		Clinician belief that parental involvement leads to better outcomes for families
		Importance of parental expertise in assessment of YP
	Control, collaboration and engagment	Clinicians not shocked by the problem
		Therapist can be trusted
		CAMHS clinicians flexible
		CAMHS clinicians understand
		Continuity in clinicians important
		CAMHS expertise in recognising developmental stage

		CAMHS giving YP control over how parents informed in crisis
		Being transparent with YP about what will be shared
		CAMHS gives clear boundaries, YP know what to expect
		Offering YP confidentiality is key
		YP's perception of moves between CAMHS teams
		YP's understanding of CAMHS structure
		Uncertainty about CAMHS, unknown service
		YP's perception of discharge from CAMHS
		CAMHS works in partnership with YP
		Respecting wishes of YP vs clinical judgement and systemic needs
		Balancing therapeutic relationship with YP and needs of parents
Moving towards independent help seeking	CAMHS developing understanding of mental health and help seeking	CAMHS providing future template for help seeking
		Ability to seek help independently once engaged in CAMHS
		YP learning to seek help earlier
		Clinician helps YP engage and then seek help in future
		YP moves forward in independence in treatment and recovery
		Availability CAMHS clinicians using text and email facilitates independence
	Adolescent Development	Ability to consider future consequences
		YP belief that greater awareness of problem when older

		Adolescence difficult time developmentally
		YP beginning to keep things private from parents
	Reducing Reliance on Parents	YP beginning to disclose problems to others
		Religion can offer support
		Online research about the problem
		Positive friendships important
		Friends with similar experiences can support YP
Wider Context	CAMHS context and service constraints	Help not given without action
		Crisis meets CAMHS thresholds
		High level of risk needed to access services
		Services respond quickly to crisis
		Externalising problems seen more quickly within service
		Managing parental needs with limited capacity
		Service limitations pressure clinicians
		Referral process hard to navigate
		Help is hard to access
		CAMHS services in crisis
		Services do not always include both parents
		Accessible services facilitate independence
	Family Context	Help seeking as a family journey
		Family beliefs about help seeking
		Family beliefs about mental health and recovery

		Family patterns of help seeking
		Family norms for talking about problems
		Family experience of mental health problems can lead to early identification
	Education and awareness	Increased parental awareness of mental health needed
		Recent increased societal awareness of mental health problems
		More education about mental health needed in schools
		Increased societal awareness based in medical model

Appendix J: Author Guideline Notes for Chosen Journal

The Journal of Child and Adolescent Mental Health

Instructions for Authors

The *Journal of Child & Adolescent Mental Health* welcomes papers from all disciplines addressing child and adolescent mental health including specific focus areas such as epidemiology, mental health prevention and promotion, community-based interventions, psychotherapy, phamacotherapy, policy and risk behaviour. Sections of the journal include: Original research papers (<4 000 words); brief reports (<2 000 words); systematic reviews (<4 000 words unless by special arrangement); clinical perspectives; case series (<2 500 words); book reviews; editorials; and letters to the editor.

Editorial policy: Submission of a manuscript implies that the material has not previously been published, nor is being considered for publication elsewhere. Submission of a manuscript will be taken to imply transfer of copyright of the material to the publishers, NISC (Pty) Ltd. Contributions are accepted on the understanding that the authors have the authority for publication. Material accepted for publication in this journal may not be reprinted or published in translation without the express permission of the publishers, NISC. The Journal has a policy of anonymous peer review. Authors' names are withheld from referees, but it is their responsibility to ensure that any identifying material is removed from the manuscript. The Editor reserves the right to revise the final draft of the manuscript to conform to editorial requirements. Contributions must conform to the principles outlined in **Ethical considerations in research publication** available for download below.

Submission: Manuscripts should be submitted online at the *Journal of Child & Adolescent Mental Health*, ScholarOne Manuscripts site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Manuscript Presentation: Manuscripts should be prepared in MS Word or compatible format. Avoid creative formatting. Consult a recent copy of the journal for general layout and style. Manuscripts should be submitted in English with UK spelling. Consult the Oxford English Dictionary for language usage. *Headings:* Use sentence case for the title, and any headings. Format headings in the following styles: **First Level bold; *Second level bold italic;*** *Third level italic.* Headings should not be numbered.

Format:

Title: This should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <10 words).

Author(s) and address(es) of author(s): The corresponding author must be indicated and an email address and telephone number provided. The authors' respective addresses where the work was done must be indicated.

Abstract: For data-based contributions, the abstract should be structured as follows: *Objective* — the primary purpose of the paper, *Method* — data source, subjects, design, measurements, data analysis, *Results* — key findings, and *Conclusions* —implications, future directions. For all other contributions (except editorials, letters and book reviews) the abstract must be a concise statement of the content of the paper not exceeding 200 words. It should summarise the information presented in the paper but should not include references.

Tables and figures: Each table and figure must be numbered with Arabic numerals and must be accompanied by an appropriate stand-alone caption. Figures must not repeat data presented in the text or tables. Authors must ensure that their figures conform to the style of the journal. Pay particular attention to line thickness, font and figure proportions, taking into account the Journal's printed page size (140 mm wide x 256 mm high). Costs of redrawing figures may be charged. Please refer to **Figure Guidelines for Authors: format, style and technical considerations** available for download below. For digital photographs or scanned images the resolution should be at least 300 dpi for colour or greyscale artwork and a minimum of 600 dpi for black line drawings. These can be saved (in order of preference) in PSD, JPEG, PDF or EPS format. Graphs, charts or maps can be saved in AI, PDF or EPS format. MS Office files (Word, Powerpoint, Excel) are also acceptable but DO NOT EMBED Excel graphs or Powerpoint slides in a MS Word document, rather send the original Excel or Powerpoint files. More detailed technical information is given in **Figure Guidelines for Authors.**

Electronic reprints: Authors will be notified by e-mail when their article is available for download from the journal website.

Appendix K: End of Study Form – removed from electronic copy

Appendix L: End of Study Summary for REC and HRA – removed from electronic copy

Appendix M: End of Study Report for Parent Participants – removed from electronic copy

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Appendix N: End of Study Report for Young People – removed from electronic copy