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ADOLESCENTS, BELIEFS AND HELP-SEEKING

Section A:

Adolescents' preferences for sources of help: What influences them to seek help from formal and/or informal sources?

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Section B: Beliefs about mental health services and their role in help-seeking amongst adolescents

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Research Summaries

Part A. Adolescents have stated a preference for informal sources of help and a low preference for formal sources, especially for mental health-related concerns. There is a need to further investigate the factors that influence adolescents' preferences for sources of help not limited to mental health alone, but within the broader help-seeking literature. Thirty-six studies were included in the review based on inclusion and exclusion criteria. Age and gender differences were amongst the factors effecting help-seeking preferences. Help-seeking preferences could be understood as a complex and interactive process between various factors. The findings were discussed in relation to further research, clinical practice and policy.

Part B. Adolescents, from their lived experiences, appear to hold negative attitudes towards mental health services, and research has highlighted a gap between mental health need and service use. Beliefs are considered to be an important factor in help-seeking behaviours. This study used Interpretative Phenomenological Analysis to explore how 16- to 18- year old adolescents made sense of their beliefs about mental health services. The study used adolescents' own accounts of their experiences to explore how this sense-making impacted on their decision to seek help. Five superordinate themes emerged and were discussed in relation to theories and previous research, regarding adolescence, help-seeking and beliefs. Research, clinical practice and policy implications were considered.

Table of Contents

List of Tables	7
List of Figures.....	7
SECTION C: List of appendices of supporting material	8
<u>PART A: Literature Review</u>	
Introduction	11
<i>Definition of adolescence</i>	11
<i>Adolescents and help-seeking</i>	11
<i>Theoretical models of help-seeking</i>	12
<i>Sources of help</i>	14
<i>Aims and rationale</i>	15
Methodology.....	16
<i>Search process</i>	16
<i>Inclusion and exclusion criteria</i>	16
Methodological Critique.....	20
<i>Setting, recruitment strategy and participants sample</i>	20
<i>Research Design</i>	21
<i>Materials and Outcome Measures</i>	22
<i>Ethical considerations</i>	23
Results	24
<i>Sources of help</i>	38
<i>Variables that influenced adolescents' preferred sources of help</i>	39
Gender	39
Age.....	40
Ethnicity and culture.....	41
Population area.....	42
Sexual orientation	42
Mental health symptoms	43
Socio-economic status	44
Physical health.....	45
Bullying status.....	45
Other variables.....	46
Discussion.....	48
Implications	54
<i>Research</i>	54

<i>Clinical Practice</i>	55
<i>Policy procedures</i>	56
Conclusions.....	57
References.....	58

PART B: Empirical Paper

Introduction	73
<i>Adolescence and mental health</i>	73
<i>Adolescent help-seeking</i>	73
<i>Theoretical models of help-seeking</i>	75
<i>The development and role of belief systems</i>	76
<i>Aims and rationale</i>	77
Methods	77
<i>Design</i>	77
<i>Participants</i>	78
<i>Recruitment</i>	79
<i>Interviews</i>	80
<i>Ethical procedures</i>	81
<i>Data analysis</i>	81
<i>Quality Assurance</i>	82
Results	83
<i>Questioning the trajectory of mental health difficulties</i>	85
Am I ill enough?	85
Recovery as achievable/non-achievable.	86
What is CAMHS?	88
<i>Navigating through mental health discourses</i>	89
Societal and social media narratives	89
Professionals' portrayal or representation of services	91
The ambivalence associated with mixed messages	92
<i>Managing beliefs</i>	94
Taking responsibility for recovery.	94
Tug of war with autonomy.....	96
Adults as gate-keepers.	98
<i>Therapeutic process as a mechanism for change</i>	99
A tailored approach.....	99
Communicating acceptance.....	101
<i>The transformed view of the self and other</i>	102

Reflecting on the journey with alternative views.....	102
Increasing quality of life.....	104
Discussion.....	105
<i>Links to previous research and theory.....</i>	<i>107</i>
<i>Methodological critique.....</i>	<i>111</i>
Implications.....	112
<i>Research.....</i>	<i>112</i>
<i>Clinical practice.....</i>	<i>113</i>
<i>Public policy procedures.....</i>	<i>114</i>
Conclusions.....	114
References.....	115

List of Tables

Table 1: Summary of Studies	25
Table 2: Participant demographic details	79
Table 3: Superordinate and subthemes	84

List of Figures

Figure 1: PRISMA diagram	19
Figure 2: Help-seeking pathway	51
Figure 3: Theme process diagram	106

SECTION C: List of appendices of supporting material

Appendix A - Example of quality assurance check.....	124
Appendix B - Thematic process of studies.....	141
Appendix C - Table of studies.....	142
Appendix D - Research poster.....	167
Appendix E - Information sheet.....	168
Appendix F - Consent to contact form.....	170
Appendix G - Participant consent form.....	171
Appendix H – Interview schedule.....	173
Appendix I - Example of coded transcript.....	174
Appendix J – Example of emerging themes.....	175
Appendix K – Example of emerging themes grouped into clusters.....	176
Appendix L – Visual organisation of themes.....	178
Appendix M – Thematic mind map development.....	179
Appendix N – Example of superordinate clusters.....	180
Appendix O – Recurrent themes.....	181
Appendix P - Example of reconfigured theme.....	182
Appendix Q - Abridged research diary.....	183
Appendix R – Bracketing interview example.....	186
Appendix S – Research ethics approval letter.....	187
Appendix T – NHS ethics approval letter.....	188
Appendix U – Confirmation of capacity and capability.....	189
Appendix V – End of study form.....	190
Appendix W – Research summary report for Ethics.....	191
Appendix X - Research summary for participants.....	193
Appendix Y – Author guidelines for journal submission.....	195

Section A:

Adolescents' preferences for sources of help: What influences them to seek help from formal and/or informal sources?

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Abstract

Background. Previous research states that adolescent help-seeking behaviours are associated with individual factors such as gender and culture. This may also be dependent on the context of need. Currently, there are no reviews regarding the factors that influence help-seeking from different sources in the broader adolescent help-seeking literature. The aim of this review was to synthesise the literature regarding adolescents' preferences for sources of help, and specifically, the variables that effect adolescents' preferences for help from informal and/or formal sources.

Methods. Four databases (Web of Science, Assia, PsycINFO and Cochrane) were searched for relevant articles up to 10 years, using common search terms used in previous help-seeking reviews. Thirty-six studies met inclusion and exclusion criteria.

Results. Adolescents identified many sources of help. Preferences for help were influenced by demographic and non-demographic variables, including age, gender, culture, and mental health presentations.

Conclusion. The review highlighted that preferences for help could be understood as a complex process involving interactional effects between various factors, not limited to this review alone. Due to the cross-sectional nature of studies however, results should be interpreted with caution. Future research, clinical and policy implications were discussed in light of the findings.

Keywords: adolescents, help-seeking

Introduction

Definition of adolescence

There is a lack of consensus regarding the definition of 'adolescence' in the literature. According to the World Health Organisation (2018), adolescents are described to be between 10 to 19 years old, which can be separated into 'early adolescence' (10 to 14 years old) and 'late adolescence' (15 to 19 years old). This is consistent with the definitions outlined by the United Nations Children's Fund (2011). However, Sawyer, Azzopardi, Wickremarathne and Patton (2018) suggested expanding the term 'adolescence' to 24 years of age to take into account delayed transitions. Adolescence can instead be seen as a continuum influenced by societal and cultural factors (Curtis, 2015).

Adolescence is characterised by a stage of physical, emotional, social, and cognitive development. According to Erikson (1968), the primary task during adolescence is the separation from caregivers and the development of one's identity. Important decisions about education, peer and/or intimate relationships are made which causes long-term influences on the young person. All these changes therefore have the potential to create emotional difficulties that could impact on an individuals' mental health and quality of life.

Adolescents and help-seeking

Help-seeking is defined as an active process of which an individual actively seeks help from others (Rickwood, Deane, Wilson & Ciarrochi, 2005). Help-seeking in adolescents has been investigated in terms of mental health (e.g. Rickwood, Deane

& Wilson, 2007) and dating violence (e.g. Ashley & Foshee, 2005). However, Barker (2007) emphasised that the majority of the adolescent help-seeking literature focuses on help-seeking for reproductive and non-reproductive health concerns (e.g. McKee, Karasz & Weber, 2004). A review carried out by Rickwood and colleagues (2005), found numerous barriers to help-seeking, such as the lack of emotional competence, negative beliefs and attitudes towards professional help, as well as facilitators to help-seeking, which considered social influences and a positive past history of help-seeking. This paper was consistent with other reviews in the area (e.g. Gulliver, Griffiths & Christensen, 2010).

Individual factors have also been shown to impact on help-seeking, such as gender differences (Haavik, Joa, Hatloy, Stain & Langeveld, 2017; Lynch, Long & Moorhead, 2018; Wendt & Shafer, 2016). Leong and Zachar (1999) found that female college students held more positive attitudes towards seeking help in comparison to males. However, gender norms and help-seeking intentions and/or behaviour should also be understood in the context of culture. In a review led by Barker (2007), studies showed that internalised gender norms exist differently for adolescents living in Asia and in the Middle East, therefore, affecting the ability or opportunity for adolescents to seek help.

Theoretical models of help-seeking

A limitation of the current help-seeking literature is the lack of a unifying theory of help-seeking behaviour. A number of help-seeking models for adolescents have been developed. Rickwood et al. (2005) proposed that the help-seeking process is a 'transaction' between adolescents' internalised world and social relationships. In other words, the 'personal becomes interpersonal' (p. 8). This process begins with

the awareness of symptoms which are subject to judgement as to whether further intervention is needed. These symptoms are then articulated and expressed, and sources of help are identified. These sources of help must be easily accessible and available. A willingness is then needed from the adolescent to disclose their symptoms to that source. A limitation of this model, however, is that it is dependent on young people's ability to express or identify their internalised world, which may need formal or informal sources, for example parents, to facilitate this process.

An alternative model was proposed by Murray (2005). In the initial stage, the perceived symptoms are influenced by previous help-seeking experiences and beliefs. The next stage of the process then involves the perception that something can be done about these symptoms, the motivation and decision to act, and to identify the source of help. Contrary to previous models (e.g. Rickwood et al., 2005), Murray (2005) emphasised that help-seeking was a fluid process, in which adolescents may move back and forth those stages at any given time. Legitimisation of problems through the consideration of societal views about symptoms, was seen to be a parallel process to help-seeking.

Similarly, the 'Cycle of Avoidance' model (Biddle, Donovan, Sharp & Gunnell, 2007) placed emphasis on young peoples' understanding of 'help' and 'distress'. The authors suggested that young people perceive mental health distress as 'normal' and seek ways to help them cope. Young people also hold meanings of 'real distress' and utilise coping strategies to avoid this. However, the extent of their coping may be threatened by an event, such as a crisis. Young people associated 'real distress' with the need to seek help.

Sources of help

As emphasised in the theoretical models above (Rickwood et al., 2005; Murray, 2005), the awareness of help, and the availability and accessibility of sources are deemed to be important factors in facilitating help-seeking behaviours. Help can be sought from informal sources, such as friends and family, and formal sources, such as professional mental health services (Rickwood et al., 2005). Research has shown that adolescents have preferences for help, which may depend on the health issue in question (Marcell & Halpern-Felsher 2007). Marcell and Halpern-Felsher (2007) found that adolescents preferred to seek help from informal sources, such as friends, partners, and significant adults for non-physical health-related concerns, and physicians for physical health-related concerns. Boldero and Fallon (1995) investigated the sources of help of school-aged adolescents for a recent problem they experienced. The study found that adolescents preferred to seek help in the first instance from non-professional sources. The results suggested that the source of help was dependent on the type of problem; however, this was not explored further. This is also consistent with a study that reported children's preferences to seek help from informal sources, such as family and friends, and placed less trust towards professionals (Hill, 1999). Similarly, Biddle, Donovan, Gunnell and Sharp (2006) investigated young adult's perceptions of general practitioners (GPs) using qualitative interviews. Most participants did not appear to value GPs as a source of help, and held ideas that GPs were more suited for physical illnesses. They also perceived GPs to have a lack of knowledge regarding mental health.

However, since most adolescents preferred to seek help from informal sources. Rickwood et al. (2007) considered ways to reach out to young people through family and friends, schools, general practitioners, and youth services. There

has also been a growing literature regarding the role of online help-seeking services (Gray, Klein, Noyce, Sesselberg & Cantrill, 2005) however due to methodological issues, further research has been recommended (Kauer, Mangan & Sancu, 2014).

In support of cultural variations regarding general help-seeking behaviours (Barker, 2007), cultural norms may influence preferences for sources of help. Guo, Nguyen, Ngo, Weiss and Lau (2015) found a disparity in seeking formal help between Vietnamese Americans and European Americans. The authors considered the role of cultural values and family obligations which may have a negative impact on adolescent well-being. However, Vietnamese Americans sought help from informal sources, which may suggest distinct pathways of formal and informal help-seeking behaviours. Ashley et al. (2005) found gender and age differences in seeking sources of help for dating violence, with a preference for friends and family members. Barker (2007) highlighted that there was limited research on how adolescents decide which source of support is appropriate for their needs. Adolescents appeared to desire contacts who listen and take the problem seriously, whilst acknowledging the difficulties that speaking to family and friends can bring about their personal experiences (Idenfors, Kullfren & Renburg, 2015).

Aims and rationale

The literature to date has focused on the facilitators and barriers towards seeking help (Gulliver et al., 2010) and the circumstances of which adolescents are more or less likely to seek help (Rickwood et al., 2007). These reviews have also specifically focused on mental health. There has been a growing body of evidence to show that adolescents would prefer to seek help from informal sources, such as family and friends in the first instance (Rickwood et al., 2005; Boldero & Fallon, 1995; Hill,

1999). The literature suggests that adolescents' choice of help may be dependent on the type of problem experienced (e.g. Boldero & Fallon, 1995) and the perceived role of different sources (e.g. Biddle et al., 2006), however there have been no reviews to synthesise these findings. The aim of this literature review was to report adolescents' preferences for sources of help as part of the broader help-seeking literature, and specifically, to explore the variables that determine whether young people seek help from formal and/or informal sources.

Methodology

Search process

Four databases were searched: PsycINFO, Assia, Web of Science and Cochrane, between November 2018 to January 2019. Search terms were keywords: "help-seeking" OR "help-seeking behav*" or "health care help-seeking" AND "adolescen*" OR "young people" OR "youth" OR "teenager*". Search terms were guided by previous search terms in other reviews of help-seeking and adolescence (e.g. Divin, Harper, Curran, Corry & Leavey, 2018; Gulliver et al., 2010). Databases were searched in the last 10 years to capture the most up-to-date articles. The search process has been illustrated in Figure 1.

Inclusion and exclusion criteria

Papers were subject to inclusion criteria which were as follows:

- 1) For the purpose of this review, the term 'adolescence' was defined as between 10 to 24 years old to reflect the recent shift in recommended age for adolescence (Sawyer et al., 2018).
- 2) Studies that focussed on help-seeking for health and well-being- related concerns, that were not limited to a particular source.
- 3) Adolescents in the lay or clinical population, to investigate preferences in all aspects of the adolescent population and to reduce potential bias.
- 4) Studies between 2008 to 2018.
- 5) Studies published in peer-reviewed journals.
- 6) Studies published in the English language.
- 7) Quantitative papers that included measurable factors relating to adolescent help-seeking behaviours.

Exclusion criteria were as follows:

- 1) Studies that focused on a single and specific source of help, such as teachers, to ensure that adolescents could choose from different sources of help to reflect help-seeking behaviours as a whole.
- 2) Help-seeking for academia or career decision-making, since this might produce bias in preferences for help from academic sources, such as teachers, and limit help-seeking to these sources alone.
- 3) Studies that were not from peer-reviewed journals.
- 4) Papers out of the date range.
- 5) Commentaries, presentations, editorials, reviews, dissertations and abstract-only papers.

6) Qualitative studies. Although it was acknowledged that qualitative studies provide a richer understanding of the phenomena in question, the purpose of the review was to investigate distinct and measurable variables through the use of quantitative methodology, rather than specifically investigating individual lived experiences.

Quality assessment

Quantitative studies and mixed-method studies were appraised using the Evaluation Tool for Quantitative Research Studies (Long, Godfrey, Randall, Brettle & Grant, 2002). Studies were appraised on four areas: 1) setting, recruitment and sampling, 2) research design, 3) outcome measures and 4) ethical considerations, which formed the structure of the methodological critique (Appendix A).

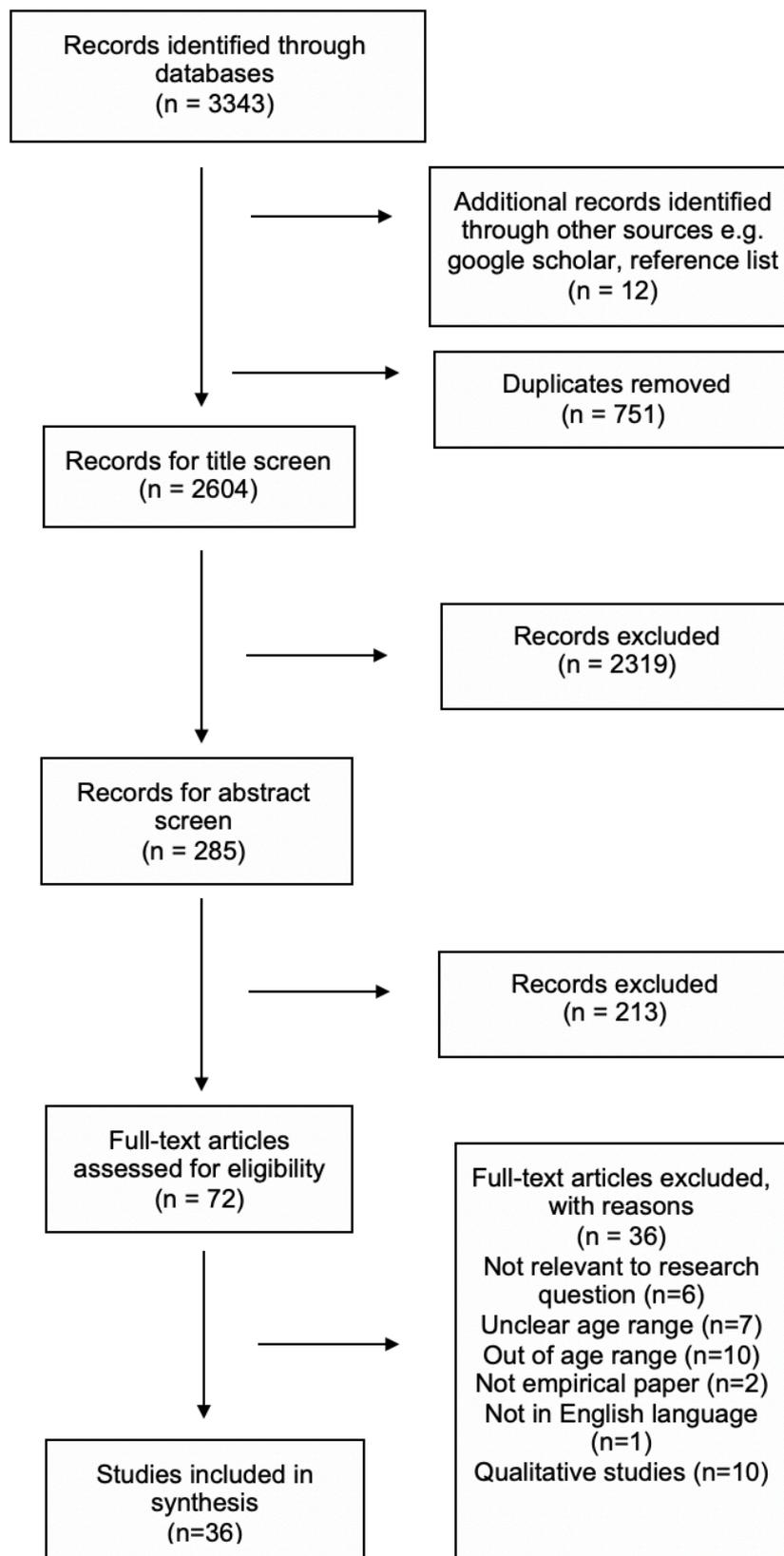


Figure 1. PRISMA diagram. This illustrates the review process.

Methodological Critique

All studies were appraised using quality assurance criteria developed by Long et al. (2002), which provided a structure for this critique. Although a few studies lacked further description of the participant sample or the phenomena in question which made the results highly interpretable (D'Avanzo et al., 2012; Doyle, Treacy & Sheridan, 2017; Muthupalaniappen, Omar, Omar, Iryani & Hamid, 2012), these studies were included in the review due to the potentially useful descriptive information that adolescents reported about their preferences for sources of help, in line with the aims of this review.

Setting, recruitment strategy and participants sample

Studies were conducted in different countries such as the UK (Leavey et al., 2011), Ireland (Swords et al., 2011), Turkey (Cakar & Savi, 2014), Jamaica (Williams, 2012), South Australia (Hernan et al., 2010) and Israel (Gilat et al., 2010) which brought a variety of sources of help in question. Additionally, dependent on the nature and aims of the studies, participants were recruited from different regions such as rural communities (e.g. Rughani et al., 2011) or large metropolitan areas (e.g. Crystal et al., 2008). Some studies lacked sufficient detail about the geographical areas of which studies were conducted, which made it difficult to get a sense of the study's generalisability.

Most studies utilised convenient sampling, with the majority of participants recruited from schools. However, some studies took a considerable amount of effort to ensure that the schools they recruited from, represented its sample population or preferred sample characteristics, through stratified or random sampling (e.g. Leshem

et al., 2015). Data collected from schools may only be representative of students who attended school at the time of recruitment. Recruitment from schools or the lay population may not represent actual help-seeking behaviours because it required adolescents to imagine their behaviour towards sources of help for a particular need. Also, due to the cross-sectional nature of designs, it was not clear as to whether those who participated in the study differed from those who did not participate. Similarly, studies that recruited from online networks (e.g. Lytle et al., 2018) may have represented those who were part of online communities and dismissed those who did not have access to online forums, or who were not in a position to feel able to disclose personal and/or sensitive information.

The cross-sectional nature of the studies allowed for large sample sizes, although some authors acknowledged that the sample size were significant limitations of their studies (Hernan et al., 2010; Leavey et al., 2011) which limited the generalisability of the results. Generally, there was a lack of inclusion and exclusion criteria with regards to the data samples. The conclusions drawn from the studies therefore cannot rule out the role of confounding variables, for example, whether participants who completed the surveys experienced mental health difficulties, and other demographic variables that were not identified in the studies. However, some studies (e.g. Watanabe et al., 2012) utilised logistic regression analysis to account for confounding variables from the demographic factors that were assessed.

Research design

The majority of studies utilised cross-sectional survey designs, of which a survey was given to participants at only one point in time. The studies varied in depth in terms of its analyses, with some studies being largely descriptive (e.g. D'Avanzo et

al., 2012). This was due to studies reporting baseline data prior to randomised controlled trials or data as part of longitudinal cross-sectional surveys. Cross-sectional surveys limit the understanding of the development of help-seeking preferences since it is assumed that help-seeking preferences do not change over time (Sedgwick, 2014). However, these designs allowed for multiple characteristics to be investigated at one time point in relation to the given topic, such as gender, age, and ethnic differences, although cause and effect cannot be inferred.

Materials and outcome measures

Vignettes were used to capture adolescents' preferences for help-seeking sources according to characters with clinical problems (Hernan et al., 2010; Swords et al., 2011; Klineberg et al., 2011; Raviv et al., 2009; Sawyer et al., 2012; Lubman et al., 2017; Yamasaki et al., 2016). Although vignettes were seen as a common procedure to explore participants' views in a safe and protective manner, the extent of its effectiveness in reflecting participants own views, intentions and behaviours, were a significant limitation. This limitation was acknowledged and discussed in most papers. Studies that sought external consultation of materials, for example, from clinical psychologists, to ascertain the validity of materials in representing clinical problems, added strength to the data (e.g. Sawyer et al., 2012; Swords et al., 2011).

Most of the outcome measures used in the studies appeared to be appropriate and relevant to the aims of the study. On the other hand, a limitation of quantitative studies is that outcome measures reflect what authors are determined to find which may not represent the actual lived experience of young people. The quality of the measures varied, from well-established questionnaires such as the General Help-Seeking Questionnaire, to single-items that were developed by the

authors for the purpose of the study. Established questionnaires, such as the General Help-Seeking Questionnaire indicated good reliability, however it was not clear whether this questionnaire was validated for certain countries (e.g. Cakar & Savi, 2014). Some studies that used single-items to assess help-seeking sources lacked further detail, and it was unclear as to how options for sources of help were decided and whether these options were relevant to the population itself. Other important sources of help may have not been identified. Furthermore, questionnaire items were open to individual interpretation due to its vagueness (e.g. Williams, 2012, Doyle et al., 2017) which limited the validity of conclusions.

All outcome measures used self-report methods. Whilst this method was easy to administer to large samples and identify prevalence of conditions, it does not exclude the possibility of social-desirability or response bias. It was unclear in some studies as to whether the researchers were present during the administration of questionnaires. Recall bias may have also occurred in studies that investigated preferred sources of help in response to retrospective events such as terrorist attacks, community violence, or self-harm, which further jeopardised the results.

Ethical considerations

The majority of studies stated ethical approval and consent processes from parents and adolescents, however a few studies failed to mention any ethical considerations which was considered a significant limitation (e.g. Findlay & Sunderland, 2014). It was concerning that given the sensitive nature of some studies, such as suicidal ideation or self-harm, there was a lack of information regarding the management of potential psychological distress. It was a strength of those studies (e.g. Sabina et al., 2014) that signposted adolescents to additional resources of help.

Results

A total of thirty-six studies were included in the review, based on inclusion and exclusion criteria. Thirty-four studies were quantitative in nature, and two studies used mixed methods. For the purpose of this review, only quantitative results were reported. Although the aim of the review was to explore the factors affecting help-seeking from the mental health and physical health literature, the majority of the studies found were based on mental health and/or well-being in general. Studies were organised into themes related to demographic or non-demographic variables (Appendix B). In this section, sources of help were firstly identified, followed by a description of variables that influenced adolescents' preferences for formal or informal sources of help. A summary of studies is provided in Table 1, and further detail of the studies can be found in Appendix C.

Author(s)	Study Design	Aims	Participants (N)	Materials/Outcome measures	Summary of findings
D'Avanzo, Barbato, Erzegovesi, Lampertico, Rapisarda and Valsecchi (2012)	Cross-sectional survey	Help-seeking preferences for mental health	672	Ad-hoc help-seeking questionnaire developed from the General Help-Seeking Questionnaire (GHSQ)	Higher propensity for informal help Significant gender differences in preferences to seek help
Boyd et al. (2011)	Cross-sectional survey	Frequency of help-seeking intentions and sources of help for mental health	201	The Centre for Epidemiological Studies – Depression Scale; The Zung Anxiety Scale; Help-seeking preferences designed by the authors	Gender and age differences in likelihood to seek formal help and informal help Accessibility/Remoteness Index of Australia (ARIA) and depression were associated with help-seeking intentions
Rughani, Deane and Wilson (2011)	Cross-sectional survey	Relationships between psychological distress, perceived benefits of help-seeking, stoicism and gender, and help-seeking intentions for formal mental health sources	778	Selected items from the: GHSQ, Utility Subscale of the Disclosure Expectations, Restrictive Emotionality Scale, Wollongong University Stoicism Scale, Hopkins Symptom Checklist 21	Doctors and 'another health care professional' were identified as formal sources of help Perceived benefits of help-seeking associated with higher intentions to seek help; no differences in intentions to seek help for psychological distress and stoicism Gender differences in help-seeking

Watanabe et al. (2012)	Cross-sectional survey	Help-seeking behavior in students who self-harm and sources of help	18104	Questionnaires developed for self-harm, help-seeking behavior and resources of help and suicidal thoughts; four items adopted from the schizophrenia section of the Diagnostic Interview Schedule for Children; General Health Questionnaire	Associations of poor help-seeking: no one to discuss distress, depression and anxiety, suicidal ideation Common sources of help were friends (no differences between presence of self-harm or not), and family (differences found for self-harm) Preferences for sources of help identified for self-harm
Muthupalaniappen, Omar, Omar, Iryani and Hamid (2012)	Cross-sectional survey	Help-seeking behaviours for adolescent smokers with emotional and behavioral problems	399	Youth Self-Report; help-seeking questionnaire developed by the authors	Adolescent smokers reported higher emotional and behavioural problems Preference to seek help from informal sources
Hedge, Hudson-Flege and McDonell (2016)	Cross-sectional survey	Factors that distinguish between adolescents who have 1) no intentions to seek help, 2) seek help from informal sources only or 3) seek help from both informal and formal sources	518	Informal help-seeking subscale, formal help-seeking subscale, dating violence, victimization or perpetration current dating status and whether adolescents had an adult to talk to about a dating relationship Items from the: Acceptability of	Significant correlations for the high informal and low professional help-seeking group: acceptability of family violence, gender, family functioning and having an adult to talk to

				Family Violence scale, Problem-solving competence scale, Center for Epidemiological Studies Depression Scale (CES-D), Social support scale from the Multidimensional Scale of Perceived Social Support; Family functioning scale from the McMaster Family Assessment Device	
Sawyer, Borojevic, Ettridge, Spence, Sheffield and Lynch (2012)	Cross-sectional survey	Effect of depressive symptoms on help-seeking intentions after adjusting for demographic characteristics and social support	5362	Help-seeking vignette; CES-D; Multidimensional Perceived Social Support Scale (MPSS)	Family and friends most commonly reported source regardless of depression levels Gender differences in help-seeking Lower intentions to seek help from family and friends with high levels of depression
Fortune, Sinclair and Hawton (2008)	Mixed methods Descriptive cross-sectional survey	Perceptions of self-harm, beliefs that help-seeking will be beneficial and the impact on motivation to seek help	5293	Help-seeking sources questionnaire	No reported gender differences or differences between adolescents who had friends who self-harmed Friends were the most common source of help for self-harm and for adolescents who had a friend who self-harmed

Goodwin, Mocariski, Marusic and Beautrais (2013)	Cross-sectional survey	Relationship between deliberate self-harm (DSH) and help-seeking behavior amongst adolescents with depressive symptoms	15686	Health behavior, help-seeking behavior, symptoms of depression and DSH	Friends were a significant source of help for youth with DSH, and were less likely to seek help from parents
Kaim and Romi (2015)	Cross-sectional survey	Willingness to seek help from youth care workers (YCW) compared to other sources and variables influencing help-seeking	211	Help-seeking questionnaire, attachment style questionnaire, self-exposure questionnaire	Non-formal and formal attributes were associated with willingness to seek help from different sources Positive correlations between willingness to seek help and age, religiosity, parents' education, economic status from different sources; negative correlations between number of siblings and willingness to seek help from parents and friends
Fry et al. (2013)	Cross-sectional survey	Help-seeking and help-giving behaviours and impact of ethnicity and nativity	1312	Help-seeking and help-giving questionnaire; history of lifetime physical, sexual relationship victimization and child sexual abuse measured using Dating Violence Inventory and Family Abuse Scale	Help-seeking behaviours: significant gender differences, but no significant differences by ethnicity and nativity Help-giving behaviours: Help-givers histories not significantly associated with help-seeking behaviour; Latinos were significantly more likely to take action for friends' relationship violence; gender and foreign-born adolescent differences in help-giving

Meinck et al. (2017)	Longitudinal cross-sectional survey	Knowledge of help for abuse, frequency of disclosure and help-seeking, outcomes reported by those who sought help and factors associated with help-seeking and receiving	3401	UNICEF Measures for National-level monitoring of orphans and vulnerable children; Juvenile Victimization Questionnaire; access to services and physical and emotional abuse questionnaires	Frequencies of sources identified Gender differences in help-seeking but no significant differences between gender and type of abuse
Crystal, Kakinuma, DeBell, Azuma and Miyashita (2008)	Cross-sectional survey	Sources of support for different contexts of need, and the association with gender, grade, and culture	2141	Support questions developed by the authors	Age differences - older youth more likely to seek help from peers Gender differences – females more likely to seek help from family or peers Cultural differences – U.S. students more likely to identify family as a source of support for a 'problem' and 'upset'
Gilat, Ezer and Sagee (2010)	Cross-sectional questionnaires	Social-cultural features of help-seeking with respect to gender, age, and subjective well-being	755	Help-seeking attitudes and subjective well-being questionnaires	Significant interactions between gender and ethnicity e.g. Arab males had significantly greater intentions to seek help from friends compared to Arab females

					Age differences - older adolescents significantly more willing to seek help from friends Subjective well-being associated with intentions to seek help from sources regardless of ethnicity
Guterman, Haj-Yahia, Vorhies, Ismayilova and Leshem (2010)	Cross-sectional survey	Frequency of help after community violence exposure, sources of help, number of sources to refer adolescents to a mental health professional and help-seeking obstacles	1835	My Exposure to Violence Scale, barriers to help-seeking in the wake of violence developed by authors	Significant cultural differences in seeking help from e.g. youth group or religious leaders, and mental health professionals for Arab adolescents compared to Jewish adolescents
Findlay and Sunderland (2014)	Cross-sectional survey	Utilization of mental health services for mental health problems or substance use, use of informal support, and associations between risk factors and help-seeking	4013	Sources of support, and demographic details collected via the Canadian Community Health Survey-Mental Health in 2012	Gender, immigration status associations in seeking help from formal and informal sources. No associations found for household income, student status on sources of help Rurality less likely to seek help from informal sources Presence of a mental disorder, traumatic child experience and substance use disorder associated with likelihood to seek professional help
Lubman et al. (2017)	Cross-sectional survey	Help-seeking behaviour, confidence and intentions to help,	2456	Adaptation of the help-seeking questionnaire	Adolescents likely to seek help from parents and health professionals for stress and

		barriers to help and recommendations of sources of help to peers with depression or alcohol problems		(AHSQ); General help-seeking questionnaire-vignette; Barriers to adolescents seeking help scale (BASH)	anxiety, health professionals for depression, friends for alcohol and drug problems Differences in suggestions for sources of help between depression and substance misuse
Leshem, Haj-Yahia and Guterman (2015)	Cross-sectional survey	Post-help seeking for exposure to community violence (ECV) in Palestinian adolescents, and the relationships between ECV, help sources, perceived help experience and willingness to seek help	1930	My Exposure to Violence Scale; Sources of help seeking from the GHSQ; Help-seeking barriers from the BASH-B or BASH; Additional questions to assess perceived help experience	Friends and family members were the most frequently reported sources of help Significant gender differences in help-seeking preferences e.g. males more likely to seek help from youth group leader and formal sources, and females more likely to seek help from friends and sisters
Yamasaki et al. (2016)	Cross-sectional survey	The identification of schizophrenia and help-seeking from friends and other sources	8770	Case vignette Recognition of mental health diagnosis and help-seeking intentions developed by the authors	'Recognising a mental health illness but not schizophrenia' (RMI) group significantly associated with seeking help from friends than 'Correctly labelling case with schizophrenia' (LSC) Significant differences in other sources of help between RMI and LSC group
Kitagawa, Shimodera, Togo, Okazaki, Nishida, and Sasaki (2014)	Cross-sectional survey	Interaction between bullying and suicidal feelings on help-seeking behaviours	9484	Bullying and victimization, suicidal feelings and actual help-seeking	Higher rate of help-seeking in victimised adolescents, compared to the 'uninvolved' (no bullying/victimisation) and

				behaviours developed by the authors	'bullying' (those who bullied others but weren't victimised) Reduced rate of help-seeking in 'Pure victims' (victimised/no bullying) with suicidal feelings (regardless of whether mild/severe) and sought significantly less help from peers and family members with serious suicidal feelings. Low formal help-seeking in pure victims
Klineberg, Biddle, Donovan and Gunnell (2011)	Vignette questionnaire design using open-ended questions Cross-sectional survey	Recognition of depressive symptoms and help-seeking differences between what one should do and actually would do	1125	Questionnaires measuring diagnosis, symptom recognition and help-seeking	Family and friends were the most common rated sources of help Gender and social class differences between what one should do versus what one would actually do in response to the vignettes
Sabina, Cuevas and Rodriguez (2014)	Cross-sectional survey	Frequencies of formal and informal help-seeking for teen dating violence and interactions between cultural variables	1525	Modified version of the Juvenile Victimization Questionnaire; Modified version used in the Sexual Assault among Latinas study to assess help-seeking; The Brief Acculturation Rating Scale for Mexican Americans; Mexican	Teens who experienced dating violence were more likely to seek informal help, especially friends Gender differences in preferences of sources of help Gender and familism significantly associated with formal help-seeking; no variables significantly associated with informal help-seeking

				American Cultural Values Scale for Adolescents and Adults to measure familism	
Raviv, Raviv, Vago-Gefen and Fink (2009)	Within-subjects design Cross sectional study	Factors affecting help-seeking for self and other referrals	415	Vignette to examine the self-other referral gap Single items associated with willingness to seek help, coping alone, psychological benefit, problem severity, comparative coping, history of help-seeking behavior, satisfaction with past counseling; BASH	Gender and age differences in self-other referral for help-seeking sources Positive correlations with seeking help from a psychologist: low comparative coping Negative correlations with seeking help from a psychologist: barriers to seeking help, problem severity or perceived benefit of psychological help
Caldeira et al. (2009)	Cross-sectional survey	Nature and prevalence of help-seeking behaviours for substance use disorder	946	National Survey on Drug Use and Health Questionnaire; Drugs Treatment Needs Survey	Most common sources of help: Alcohol education, health professionals, 12-step programs, university program or staff member No significant differences in demographics or substance use disorder severity on help-seeking behaviours

					Significant correlations: self-perceived need and social pressures
Zaki, Gross and Pachankis (2017)	Online cross-sectional survey	Frequencies of non-suicidal self-injury (NSSI), suicidal ideation, past-year help seeking among sexual minority/majority, and sources of help	482	The Deliberate Self-Harm Inventory; Brief Symptom Inventory; GHSQ	Bisexual youth were significantly more likely to seek help from a partner/significant other; lesbian youth were significantly more likely to seek help from a teacher. No other significant differences found
Scott Jr, McMillen and Snowden (2015)	Cross-sectional survey	Predictors of help-seeking from formal and informal sources, based on predisposing, enabling and need factors	55	Measures were used during the baseline in the VOYAGES study; 3 dichotomous items were used in this study to assess informal sources of help, and 1 dichotomous item was used to assess formal help	Youth sought more informal sources of help Correlations for informal sources: Lower adherence to emotional control, frequent negative social contextual experiences Correlations for formal sources: greater satisfaction with child welfare services
Lytle, Silenzio, Homan, Schneider and Caine (2018)	Descriptive cross-sectional survey	Help-seeking amongst LGBTQ youth, and associations between risk and protective factors	203	Items related to mental health disorders based on DSM-IV and ICD-10; National Comorbidity Survey; Attitudes Toward Help-seeking Short Form (ATHS-SF); Multidimensional Scale of Perceived Support	Informal and formal sources of help differed for gay men, bisexual men, bisexual women, lesbians, and queer individuals All sexual orientations with depression and/or anxiety reported greater proportions of seeking help from friends

Sheppard, Deane and Ciarrochi (2018)	Cross-sectional surveys Repeated measures	Percentage of unmet needs in adolescents with high psychological distress and help-seeking behaviours	1599	General Health Questionnaire; Perceived Need for Care questionnaire and General Help-Seeking Questionnaire (assessed as part of the ACS); single items assessed for need classification, barriers receiving needed services, help-seeking from other sources, self-management strategies and help-seeking intentions	'Need' status significantly associated with informal help-seeking e.g. 'Partially met needs' (classified as having some service use) group sought significantly more help from family or friends compared to the 'wholly unmet needs' group (no service use)
Tatar and Amram (2008)	Descriptive cross-sectional questionnaire	Help-seeking attitudes and behaviors after terrorist attacks	203	Open-ended questionnaires	Parents, friends, other family members, mental health professionals and other individuals identified as sources of help No gender differences reported
Spears, Taddeo, Daly, Stretton and Karklins (2015)	Cross-sectional survey	Relationship between cyberbullying, help-seeking and associated mental health well-being and social connectedness	2338	Mental health continuum short form; DASS-21; Social Connectedness Scale; GHSQ	Gender and age differences in help-seeking behaviours Cyberbully-victims (presence of victimisation and bullying) and cyber-victims (victimisation but no bullying) highly likely to seek help from informal sources, and unlikely to seek help from online formal sources

Doyle, Treacy and Sheriden (2017)	Mixed-methods Descriptive cross-sectional survey	Sources of help and reasons for help-seeking in adolescents	856	Lifestyle and Coping Questionnaire	Discrepancy between the requirement of help and actual help-seeking behaviour Friends and mothers were commonly reported sources of help
Swords, Hennessey and Heary (2011)	Mixed-methods Cross-sectional survey with 1 qualitative survey question	Development of beliefs about sources of help for peers with mental health problems	393	Three short vignettes (depression, ADHD and comparison); need for help and sources of help developed by the authors	Age differences for the vignette portraying ADHD compared to depression in the need for help, number of sources of help and the sources of help identified between ADHD and depression
Hernan, Philpot, Edmonds and Reddy (2010)	Cross-sectional survey	Problem recognition, barriers to accessing help from professionals and potential sources of help	74	Clinical vignette and open-ended questions	Higher preferences for informal sources of help compared to formal sources of help, and with age differences Preference to see 'other health professionals' compared to doctors
Leavey, Rothi and Paul (2011)	Mixed methods	Help-seeking concerns and beliefs, including beliefs about GPs	298	Help-seeking questionnaire developed by the	Consistent preference for mothers as a help-seeking source, but greater preference for friends for anxiety and depression

	Cross-sectional survey and focus group interviews			authors; focus group interviews	
Cakar and Savi (2014)	Cross-sectional survey	Sources of help and reasons to which adolescents do not seek professional help	252	GHSQ	Gender differences in preferences to seek informal and formal help
Williams (2012)	Cross-sectional survey	Sources of help for Jamaicans for their mental health and beliefs about the usefulness of such help	339	Questionnaire developed by the authors	<p>More likely to seek help from medical doctors</p> <p>Socio-economic status significantly associated with preferences for sources of help</p> <p>Family and friends were preferred sources of help for depression, anxiety, eating disorder, substance use disorder, ADHD and ODD; psychologist/psychiatrist were preferred sources for schizophrenia</p>

Table 1. Summary of studies.

Sources of help

All studies identified various sources of help. Informal sources included family, with some studies distinguishing between mothers (e.g. Doyle et al., 2017), fathers (e.g. Leavey et al., 2011), siblings (e.g. Meinck et al., 2017), 'other family members' (e.g. Tatar & Amram, 2008), friends (e.g. Spears et al., 2015) and partners (e.g. Zaki et al., 2017). School-based services such as teachers and school-counsellors (e.g. Swords et al., 2011), mental health services such as doctors, psychologists and psychiatrists (e.g. Williams, 2012), and legal systems such as the police or community organisations (Meinck et al., 2017) were identified as formal sources of help. Willingness to seek help from youth care workers was also reported (Kaim & Romi, 2015), since adolescents perceived them as a bridge between formal and informal sources of help.

The least mentioned sources of help were faith healers or obeah man, church, for example, clergy, and other religious sources (e.g. Scott et al., 2015) online sources and helplines (e.g. Spears et al., 2015). One study did not differentiate between informal sources of help and grouped formal sources as 'other health professionals' to include counsellors, youth workers or psychologists (Hernan et al., 2010). Specific intervention programmes were also identified as sources of help (Caldeira et al., 2009).

The general finding across all studies were that adolescents preferred to initially seek help from informal sources, and more specifically, from family and friends. Adolescents' preferences for sources of help were influenced by demographic factors or factors considered to be unique to the overarching aim of the studies.

Variables that influenced adolescents' preferred sources of help

Gender.

The studies revealed an association between gender and adolescents' preferred sources of help. Studies focused on help-seeking in response to teen dating violence or relationship violence (Sabina et al., 2014; Hedge et al., 2016; Fry et al., 2013), community violence (Leshem, Haj-Yahia & Guterman, 2015) and terrorist attacks (Tatar & Amram, 2008). Most commonly, females were likely to seek help regardless of its source compared to males. This also differed according to the context in question, for example, males were more likely to seek help from their father, group leaders and formal sources in comparison to females, after exposure to community violence. No gender differences were found amongst adolescents in relation to terrorist attacks.

Ten studies focused on sources of help in response to non-specific and specific emotional distress (e.g. D'Avanzo et al., 2012; Raviv et al., 2009; Rughani et al., 2011; Findlay & Sunderland, 2014; Lytle et al., 2018). Females were more likely to seek and recommend formal and informal help such as from their mothers, compared to males (Cakar & Savi, 2014). Generally, friends were frequently mentioned as sources of support for mental health. Studies have found that males tend to be self-reliant (Crystal et al., 2008), however these gender effects may be influenced by specific emotional distress such as depression (Sawyer et al., 2012; Klineberg et al., 2011; Lubman et al., 2017) and cyberbullying (Spears et al., 2015). Lubman et al. (2017) found that females were more likely to seek professional help for substance misuse, compared to depression, but were less confident in seeking this type of help for peers. Contrary to this evidence however, Boyd et al. (2011)

found that males were more likely to seek help from a psychologist than females which may reflect the rural population that this study investigated. In the context of abuse, there were no gender differences reported with respect to help-seeking sources, although female victims of emotional and sexual abuse were more likely to seek help overall.

Whilst gender may be perceived as a separate factor in many of the studies, one cannot dismiss the interactional effect of gender and other demographic variables in adolescents' preferred sources of help, for example, Gilat et al. (2010) found that seeking help from friends was greater in the Arab male population compared to Arab females. Additionally, there was found to be interactional effects between sexual orientation and gender for help-seeking sources (Lytle et al., 2018), which highlighted the importance of the contextual experiences of adolescents when determining their preferred sources of help.

Age.

There was also a significant correlation between age and help-seeking preferences. Kaim and Romi (2015) found that older adolescents at-risk were more willing to seek help from friends, whilst Boyd et al. (2011) reported they were more likely to seek help from a GP, compared to younger adolescents. Older adolescents were also more likely to identify online sources for help (Spears et al., 2015). It was found that younger adolescents were more willing to seek help from parents and formal sources, compared to older adolescents, regardless of ethnicity (Gilat et al., 2010).

Consistent with the idea that factors do not exist in separation, age was also observed to interact with young peoples' ability to identify a mental health condition (e.g. Swords et al., 2011). In this study, older adolescents identified more sources of

help and were likely to distinguish the sources of help needed for ADHD and depression, compared to younger adolescents.

Ethnicity and culture.

Eight studies found a correlation between ethnicity and preferred sources of help. Different ethnic backgrounds included Arab and Jewish adolescents (Gilat et al., 2010, Guterman et al., 2010), Latino communities (Caldeira et al., 2009; Fry et al., 2013) and Japanese and American students (Crystal et al., 2008). Gilat et al. (2010) found that Arab and Jewish adolescents commonly preferred to seek help from family and friends, rather than formal sources such as psychologists, counsellors and teachers. However, Arab adolescents had significantly greater intentions to seek help from mothers, teachers and educational counsellors compared to Jewish adolescents. Furthermore, Arab adolescents sought more help from acquaintances or strangers, youth groups, religious leaders, teachers and medical professionals in the context of community violence, compared to Jewish adolescents (Guterman et al., 2010). Ethnic differences were also observed in Latino communities, where multiple sources of help were sought in addition to friends (Fry et al., 2013). Crystal et al. (2008) found differences in help-seeking behaviours between US and Japanese students. US students were more likely to rely on themselves compared to Japanese students, who mentioned family as a source of support for distress and behavioural problems. Only one study (Findlay & Sunderland, 2014) investigated immigrant status, and found that foreign-born adolescents in Canada were less likely to seek professional help, than those who were born in Canada.

Interestingly, Williams (2012) found that Jamaican adolescents preferred to seek help for 'psychological problems' from medical doctors, faith healers, teachers

and guidance councillors, in ranked order. Family and friends were identified as last on the list. It is worth noting that the 'psychological problem' was intended to be a broad term not guided by a single definition and was therefore, open to interpretation. The authors suggested that these differences may be due to their cultural beliefs about the cause of psychological problems.

Population area.

Two studies focused on adolescent populations within rural or urban communities. Boyd et al. (2011) assessed the remoteness of participants locations according to the Accessibility/Remoteness Index of Australia (ARIA+). There were no differences reported in their likelihood to seek help from different sources based on location. This contradicted the study by Findlay and Sunderland (2014) who found that Canadian adolescents in rural communities were less likely to contact informal sources of help, compared to formal sources.

Sexual orientation.

Two studies investigated sexual orientation factors relating to suicidal ideation and depression or anxiety, and non-suicidal self-injury (Zaki et al., 2017; Lytle et al., 2018). All sexual orientations were associated with greater help-seeking from friends for depression or anxiety, and suicidal ideation or behaviour (Lytle et al., 2018). In line with the general preference for informal sources, partners were also identified as sources of help for bisexual youth (Zaki et al., 2017). Overall, adolescents within the lesbian, gay, bisexual, transgender and queer population preferred informal sources

of help, with exceptions for lesbian youth who reported that they would seek help from formal sources, such as a family doctor or teacher for non-suicidal self-injury.

Mental health symptoms.

Whilst some studies focused on general psychological distress, others focused specifically on symptoms of self-harm, depression, suicidal feelings and other mental health conditions (e.g. Williams, 2012; Swords et al., 2011; Leavey et al., 2011; Hernan et al., 2010). Seeking help from friends (e.g. Sawyer et al., 2012; Klineberg et al., 2011), or family (Swords et al., 2011), appeared to be common sources of help for depression, but this was dependent on the presence of self-harm (Watanabe et al., 2012; Goodwin et al., 2013) and the time frame in relation to self-harm (Fortune et al., 2008). Contradicting this evidence, Lubman et al. (2017) reported that adolescents were more likely to seek help from health professionals compared to parents and friends for depression, and parents and health professionals for stress and anxiety. Kitagawa et al. (2014) reported that suicidal feelings may act as a mediator for help-seeking in adolescents who have been bullied, with adolescents less likely to seek informal sources of help, compared to formal sources, if they experienced serious suicidal feelings. High levels of distress may affect help-seeking intentions, regardless of the perceived level of support from these sources (Klineberg et al., 2011). Findlay and Sunderland (2014) concluded that adolescents with multiple needs sought both formal and informal sources of help, for example, the presence of physical and mental health conditions, and/or a history of traumatic child experiences, which highlighted a cumulative effect.

Williams (2012) found that across all symptoms, teachers and guidance counsellors were less likely to be preferred sources of help. Mental health

professionals were also mentioned but this was not described further (e.g. Swords et al., 2011). Using a clinical vignette of depression (Hernan et al., 2010) adolescents indicated that it would be helpful for the character to see 'other health professionals' compared to a doctor; however, no further detail or distinctions were made within this category.

There was a consistent finding across studies that adolescents were least likely to seek help from professional sources compared to informal sources, but with some exceptions. Although GPs are perceived as the first point of contact for families, adolescents appeared to only consult their GP for symptoms related to physical causes, such as eating, or if adolescents held beliefs that their symptoms were biological in nature, for example, the experience of auditory hallucinations (Leavey et al., 2011).

Socio-economic status.

Two studies (Williams, 2012; Klineberg et al., 2011) found associations between social class or socio-economic status and sources of help. It was difficult to interpret whether social class had a direct effect on help-seeking behaviours, as the analysis focused on the interactional effect between gender and social class (Klineberg et al., 2011). Williams (2012) however, reported differences in help-seeking sources between low and high social-economic status but provided no further discussion about these results within a Jamaican population.

Physical health.

Muthupalaniappen et al. (2012) investigated the help-seeking behaviours of adolescent smokers with emotional and behavioural problems. Consistent with the evidence from other factors, adolescent smokers preferred to seek help from friends, parents and siblings. This was largely a descriptive study therefore it was impossible to infer any causality. It was difficult to make sense of any link between smoking itself and preferred sources of help, since this could have depended on the extent or type of emotional or behavioural problem present. Furthermore, it was unclear whether the emotional difficulties were a consequence of smoking or whether participants experienced emotional difficulties that led to smoking as a coping strategy. The authors in the study reported that only a small percentage of students who smoked admitted that they needed professional help.

Bullying status.

Two studies investigated help-seeking behaviours associated with cyberbullying or bullying (Spears et al., 2015; Kitagawa et al., 2014). Experiences with cyber bullying were classified into three groups: cybervictim, cyberbully, and cyberbully-victim. Differences were found in help-seeking preferences between groups. Consistently however, young people across all groups reported that they were highly unlikely to seek help from online formal sources, such as helplines, professionals and doctors, and were more likely to seek help from friends or parents. Low frequencies of help sought from formal sources was also identified in Kitagawa et al. (2014)'s study with a preference to seek help from peers, family members and teachers respectively.

Other variables.

Whilst the majority of studies investigated common demographic variables, other studies included factors that also had some influence into the type of help sought. Foster care youths and care leavers were more likely to seek help from informal sources than formal sources, if they had a lower adherence to emotional control and had negative social contextual experiences (Scott Jr et al., 2015). Adolescents who reported satisfaction with child warfare services were more likely to seek help from formal sources, than those who did not report satisfaction. Since these factors were investigated with black foster care males, the authors suggested that these adolescents might have had negative experiences based on gender and race, therefore, sources that were perceived as 'outsiders' to the community were seen as less trustworthy.

One study also focused on mental health literacy amongst adolescents using vignettes (Yamasaki et al., 2016). Adolescents were grouped into whether they recognised a mental health condition from the vignette, whether they correctly identified the character of the vignette as having schizophrenia or, were unable to recognise a mental health difficulty. Friends were the most common identified source of help, however those that correctly identified the character as having schizophrenia, were more likely to seek support from professional sources, compared to informal sources. These differences could be due to beliefs about the causes of schizophrenia that may be unique to individual cultures, which supported Williams (2012)'s study, or due to a perceived severity of problems (Raviv et al., 2009).

Non-formal attributes for help-seeking which included proximity, willingness to help and reliability of sources were associated with willingness to seek help from

parents, friends and youth care workers (Kaim & Romi, 2015). The authors also found correlations between sources of help and problem severity, religiosity, parents' education, economic situation and the number of siblings. In line with adolescents' willingness to seek help, Raviv et al. (2009) revealed factors associated with seeking help from formal sources, which included problem severity and past history of help-seeking. The authors also investigated the help-seeking preferences for themselves compared to what they may suggest to peers. Friends appeared to be the most recommended source of help for self and others, which indicated that friends were a trusted source for adolescents.

Two studies investigated factors that influenced help-seeking behaviours of those who experienced dating violence. Whilst the studies reported influential effects of gender, other variables such as familism where families are prioritised (Sabina et al., 2014), acceptability of family violence, family functioning and having an adult to talk to about the relationship (Hedge et al., 2016) were associated with seeking help from formal or informal sources.

Finally, one study focused on unmet needs within mental health services (Sheppard et al., 2018). Adolescents who were categorised in the 'partially met needs' group, that is, those who received input from a mental health service but still required further input such as counselling, sought more help from family and friends compared to adolescents with 'wholly unmet needs' which indicated no mental health service use.

Discussion

This review aimed to synthesise the findings of papers that investigated adolescents' preferences for sources of help from the broader help-seeking literature. Taken together, the studies provided further insight into adolescents' help-seeking preferences from different sources, with the majority of studies focussing on sources of help for mental health and/or well-being. Sources of help were measured using well-established measures or questionnaires developed specifically for the studies. Consistent with the research, adolescents preferred informal sources of help, but this was dependent on the perceived severity of illness (e.g. Boldero & Fallon, 1995; Hill, 1999). Parents and friends were significant sources of help for young people to varying degrees. In light of this, this review found that the type of source sought from young people was influenced by a number of demographic factors, such as age, ethnicity, sexual orientation, the presence of psychological distress, or bullying status, as well as other non-demographic factors.

The review reflected the literature demonstrating the impact of gender on help-seeking behaviours or intentions (Haavik et al., 2017; Lynch et al., 2018; Wendt & Shafer, 2016; Leong & Zachar, 1999). Females were more likely to seek help from both formal and informal sources compared to males. For both genders, informal sources such as family and friends were most commonly reported as sources of help, which supported previous research (Boldero & Fallon, 1995; Hill, 1999). However, this may be dependent on the situation requiring external help. For those who experienced community violence, males were more likely to seek help from formal sources, than females. This was discussed in relation to gender roles and increased accessibility to formal help agents, through involvement in religious and social-political activities (Lesham et al., 2015).

Similarly, age was associated with preferences for sources of help. Given that adolescence is a stage characterised by separation from caregivers and identity establishment (Erikson, 1968), it is likely that different sources of help are needed at different stages of adolescence, for example, older adolescents preferred to seek help from friends for depression compared to ADHD (Swords et al., 2011). This difference may demonstrate the importance of developmental stages in the help-seeking process, since ADHD is often diagnosed in school-age children (Kieling & Rohde, 2010). Additionally, it is likely that the understanding of mental health problems and potential sources of help continues to develop throughout adolescence, which may explain older adolescents' ability to distinguish between sources of help for ADHD and depression, and the number of sources they identified compared to their younger counterparts.

The findings also demonstrated the complexity of help-seeking within different cultures (Barker, 2007). Gilat et al. (2010) suggested that psychological processes such as attachment, may underlie the preferences for informal sources of help, whilst formal sources of help could be subjected to cultural variation, such as feelings of mistrust and resentment. This difference was reflected in the study by Guo, Nguyen, Ngo, Weiss and Lau (2015). Additionally, differences in formal and informal help-seeking may be explained by broader cross-national differences, such as whether adolescents are located in individualistic or collectivist countries, as well as the importance certain cultures place on family support (Crystal et al., 2008). A low preference to seek help from professional sources for foreign-born adolescents (Findlay & Sunderland, 2014), could reflect negative experiences of previous help, structural barriers to professional service use or a preference to seek help from their social support systems initially (Derr, 2016).

Whilst there were only two studies that explored the influence of population area on adolescents' preferred sources of help, these studies yielded mixed results. This could have been due to the population density, and cultural and demographic factors associated within rural locations in Australia and Canada. Boyd et al. (2011) suggested that rural areas may involve a stronger sense of community but at the same time, stigma-related attitudes may be more pronounced.

In terms of socio-economic status, there were limited studies that explored this further. Adolescents with low socio-economic status were less likely to seek professional help compared to high socio-economic status (Williams, 2012) which could represent a lack of awareness, availability or accessibility of professional services, or that adolescents held attitudes towards services as part of their broader cultural views about mental health.

Consistent with the general preference for informal help-seeking sources, seeking help from friends was associated with sexual orientation. Partners were also identified as a source of help, which reflects the literature stating the importance of relationships in adolescence (Coleman & Hendry, 2000), with older adolescents perceiving romantic relationships as more supportive than family and friends (Furman & Buhrmester, 1992). Previous literature demonstrated that bisexual individuals in comparison to heterosexual and homosexual peers, were at greater risk of mental health problems (Eisenberg & Wechsler, 2003) which may be in response to a lack of social validation for their sexual identity, stigma, discrimination or fear of disclosure. This population may therefore be faced with unique needs.

In terms of mental health presentations, the results reflected the suggestion that sources of help may depend on the type of problem (e.g. Boldero & Fallon, 1995, Marcell & Halpern-Felsher, 2007). Adolescents with depression sought help

from friends and family in the first instance, however, formal sources of help were sought with suicidal ideation and/or self-harm. In line with the 'Cycle of Avoidance' model (Biddle et al., 2007) the concept of 'real distress' may include suicidal ideation and associated self-harming behaviours, which could be perceived as requiring professional help. This review suggested that adolescents initially judge the type and seriousness of their distress before identifying appropriate sources of help. Informal or formal sources of help are sought within the context of demographic and non-demographic variables (Figure 2). Family and friends were commonly identified as initial sources of informal help.

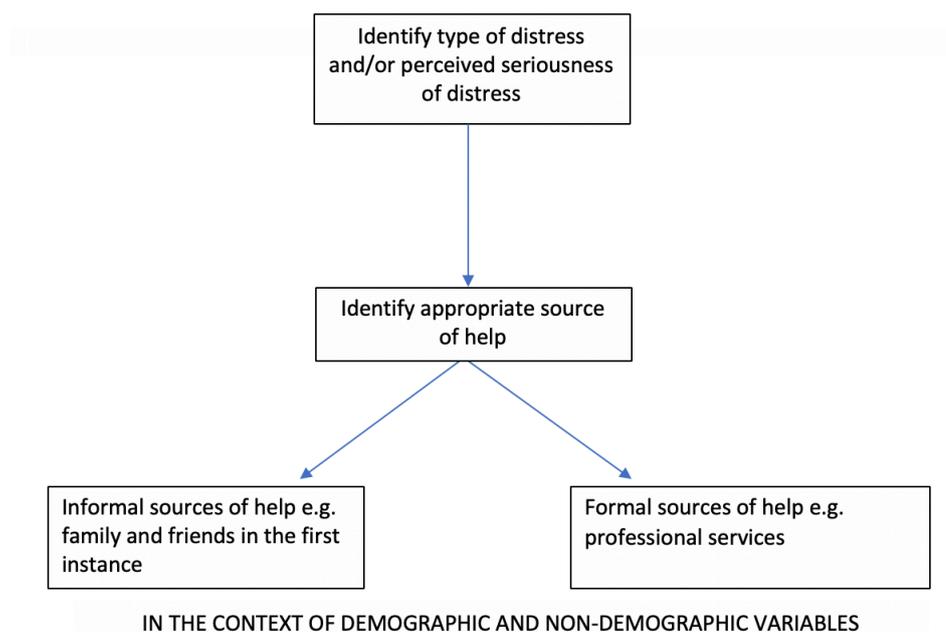


Figure 2. Help-seeking pathway.

Professionals were most likely to be a preferred source of help in relation to symptoms of schizophrenia, for example, hearing voices. These differences may be due to adolescents' views about the severity of illness that would warrant professional help, causes of mental health as biological or physical in nature or the perceived usefulness of such treatment from these sources.

Aside from mental health presentations, there were a lack of studies that met inclusion and exclusion criteria which investigated help-seeking preferences for physical health conditions, contrary to the evidence previously reported, such as sexual health (Barker, 2007). This could be due to the exclusion of qualitative interviews (e.g. Campbell, Greeson, Fehler-Cabral & Kennedy, 2015) studies that were out of the date range (McKee et al., 2004), and unclear age ranges (Bergvall & Himelein, 2014). Although it was useful to investigate the sources of help for adolescent smokers, smoking could be perceived as a lifestyle behaviour mediated or moderated by emotional and/or behavioural factors. It is likely that the demographic factors found in this review, may also relate to help-seeking for physical health conditions, for example, one study highlighted mixed findings for the effects of gender in help-seeking for reproductive concerns or flu-like symptoms (Otwombe et al., 2015). Further research is needed in this area since physical health conditions are likely to vary in complexity.

Cyberbullying is of increasing concern within the adolescent population with potential effects on well-being (Nixon, 2014). This review highlighted the lack of studies exploring help-seeking behaviours and preferences associated with cyberbullying. From this review alone however, friends and family appeared to be the most common sources of help.

As with the demographic variables in this review, other factors were investigated that reflected the individual aims of each study and its research population. Sheppard et al. (2018) investigated the role of 'unmet needs' in help-seeking behaviours. Adolescents in the 'wholly unmet needs' group sought less informal help, contrary to previous studies (e.g. Hill, 1999). However, the group represented adolescents who have not used services. It is assumed that informal sources of help are likely to have supported access to professional care (Sheppard et al., 2018). Sources of help were also investigated for participants themselves, as well as for fictional characters or peers, to explore self- and other- preferences, which could represent unique processes at play. Adolescents' preferences for sources of help could be influenced by their own previous experiences of using a particular source, whilst recommendations to friends may allow them to free themselves from bias and their preconceptions of such sources.

It is worth noting that for the purpose of this study, factors were talked about separately to highlight the effect on help-seeking preferences. The findings implied that these factors do not exist separately, and therefore, help-seeking preferences should be understood as a complex interaction of different factors that were not limited to this review alone. The cross-sectional nature of the studies allowed for multiple factors to be explored, but limited generalisability and inferences about causation and effect. Also, it's worth noting that only quantitative studies were included in this review. A richer perspective from adolescents themselves could provide further insight and understanding into the characteristics that help adolescents to decide whether to seek help from informal and formal sources.

Implications

Research

Although cross-sectional surveys are seen as useful in collecting prevalence data (Sedgwick, 2014), the collection of data is limited to one point in time. Further research could utilise collecting data from multiple time points to see how help-seeking preferences evolve over time, and to identify any trends to which adolescents seek help.

Outcome measures varied, and some measures were specifically developed by the authors for the purpose of the study. This limited the conclusions drawn from the data, since it compromised reliability and validity which were not always explicitly stated. As the help-seeking literature evolves, it would be beneficial to review the current measures available for help-seeking and develop a universal measure that could be used across studies.

Demographic data were collected from participants such as age and gender, however, to broaden the scope of help-seeking preferences, it would have been useful to further investigate other variables, such as the influence of socio-economic status and sexual orientation. For ethnicity-based studies, help-seeking sources may differ between first- and second-generation immigrants. Furthermore, whilst there was a large proportion of studies that investigated help-seeking sources according to mental health presentations, there was a lack of literature exploring sources in relation to physical health conditions. Literature has demonstrated help-seeking sources for older adults with physical health problems (e.g. Phillips & Murrell, 1994) and therefore further studies are warranted for the adolescent population.

A common finding across studies and in line with previous literature, were that adolescents were less likely to seek help from professional services. It would be worth exploring the relative value adolescents place on the characteristics of professional services, such as mental health services, that would facilitate help-seeking from a qualitative point of view. Whilst previous research investigated beliefs about mental health services (Goodwin, Savage & Horgan, 2016; Davison, Zamperoni & Stain, 2017) there is a lack of understanding about how these beliefs translate into help-seeking behaviour. The review found that severity of distress may influence professional help-seeking behaviours, which would require further exploration. Understanding how adolescents develop negative attitudes or beliefs about professional services, could provide valuable information for professionals working with adolescents. Future research may want to explore the type of information that adolescents feel able to share with parents, caregivers, and friends. Given that the majority of these studies found a preference for informal sources, it would be important to consider the role of these sources in facilitating access to formal services for help.

Clinical Practice

The review highlighted a range of factors that influence help-seeking behaviours. The preference to seek help from family and friends and other informal sources, emphasised the need to involve significant others in the care of individuals. Professional services were the least preferred option for help, but adolescents were more likely to seek help in the event of a crisis, such as self-harm and/or suicidal ideation. Clinical psychologists in particular, should be aware of the salient features

that facilitate formal help-seeking such as fostering trust in the therapeutic relationship, since this review highlighted a potential distrust towards professionals. Clinical psychologists' consideration of their own cultural background, gender, age and other factors, through reflective practice and/or self-reflexivity, and its impact on the therapeutic relationship, could be a helpful way of understanding how adolescents interact with therapists, which could facilitate disclosure. Practitioners should seek to collaboratively work with adolescents and identify their close network during assessment and treatment procedures, alongside consideration of confidentiality issues. Additionally, sessions should consider the role of demographic factors and developmental life stage in the disclosure of distress. Previous help-seeking experiences should be considered including the use of online resources, which could affect adolescents' beliefs about receiving further formal support (Reder & Fredman, 1996).

Policy procedures

Since the literature suggested that adolescents were less likely to seek help from formal sources, it is evident that policy makers ensure that adolescents' views are heard, in order to produce person-centred care according to their needs. Service-user participation can be seen as a better way to develop integrated care in mental health (Lawn, 1992) and to date, some policy documents have included children and adolescents in their workforce (Department of Health, 2015).

Furthermore, it is important not to underestimate the role of informal sources towards help-seeking. Since informal sources were largely the first preference for sources of help, the views of parents and caregivers could be included in the

workforce. Policy makers could emphasise the need for parents and caregivers to be attuned to children's distress and increase awareness of the sources of help that are available, by means of producing appropriate resources and workshops or training programmes. Services could also equip parents with skills to manage emotional difficulties. The literature suggested adolescents were aware of other sources of help but did not perceive them to be helpful in many ways, for example, teachers and GPs. Promotion of help-seeking should not be limited to mental health services alone, but to professionals who are embedded within local communities.

Teachers may be of appeal in certain situations and for certain conditions such as ADHD. The recent 'Future in Mind' paper (Department of Health, 2015) proposed that psychologists be based in schools, however the possibility of stigma, negative attitudes related to professionals, issues of confidentiality, or difficulties that may be school-related, could be perceived as barriers to engagement. For effective interventions, policy procedures should reflect the needs of children and adolescents within a school-setting.

Conclusions

This review synthesised the findings of studies that investigated the help-seeking preferences of adolescents. Family and friends were the most commonly reported sources of help, with consistent findings that adolescents were less likely to seek help from professionals where necessary. It is clear however that help-seeking should not be defined as a single process, but conceptualised as an interaction between individual characteristics, alongside attitudes and beliefs that may be culturally influenced. Whilst the studies provided descriptive insight into adolescents'

preferences for sources of help, quantitative studies were limited to cross-sectional surveys and underdeveloped measures, jeopardising the validity and reliability of the data. Implications of the studies were considered in the context of further research investigating help-seeking preferences, clinical practice, specifically in relation to practitioners working directly with adolescents, and policy procedures focussed on addressing adolescents and families' needs.

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Section B:

Beliefs about mental health services and their role in help-seeking amongst adolescents

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Abstract

Background. Mental health services remain the least preferred choice of help-seeking in adolescents. To date, there is scarce literature regarding how adolescents make sense of their beliefs about mental health services and how their sense-making has impacted on the decision to seek professional help.

Methods. Ten adolescents between 16- to 18- years old, recruited from Child and Adolescent Mental Health Services (CAMHS) in London, participated in the study. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Results. Five superordinate themes emerged: questioning the trajectory of mental health difficulties, navigating through mental health discourses, management of beliefs, the therapeutic process as a mechanism for change and the transformed view of the self and other. Thirteen subthemes were found.

Conclusions. The changing nature of beliefs was attributed to adolescents' experiences of the therapeutic relationship, which resulted in a transformed view of themselves and others. Adolescents relied on adults to facilitate the help-seeking process whilst attempting to maintain autonomy. The findings were discussed in relation to previous research and theory, and methodological limitations were acknowledged. Research, clinical practice and policy implications were described, which included further research into the role of beliefs, the importance of fostering person-centred care, and the need for age-appropriate resources to promote public awareness of CAMHS.

Keywords: adolescents, beliefs, mental health, help-seeking

Introduction

Adolescence and mental health

Adolescence is a developmental stage characterised by major decision-making and adjustment to emotional and physical changes, making identity formation a key task (Erikson, 1968). The internal changes that adolescents experience interact dynamically with external or social changes (Christie & Viner, 2005). Adolescence can therefore be a challenging period which can impact on psychological well-being (Eccles et al., 1996).

Research has indicated that 16- to 18-year olds are at risk of developing mental health difficulties compared to younger and older adolescent age groups (Harper, Dickson & Bramwell, 2014). It is suggested that 16- to 18-year olds are at a unique stage in developing awareness of their ability to control their lives, such as separating from caregivers (Rickwood, Deane, Wilson, & Ciarrochi, 2005). UK mental health services are structured for transition to adult mental health services at the age of 18 years, but research has highlighted a service gap between 16- to 18-year olds, due to the lack of agreement about the responsibility of care for young people in this age group (Singh, Paul, Ford, Kramer & Weaver, 2008).

Adolescent help-seeking

The literature states a discrepancy between mental health need and service use amongst adolescents. Barriers towards help-seeking such as the need for autonomy (Wilson & Deane, 2012), the experience of stigma (Shechtman, Vogel, Strass &

Heath, 2018) or poor mental health literacy (Gulliver, Griffiths & Christensen, 2010) were investigated. Adolescents preferred to seek help from informal sources compared to professional services (Raviv, Raviv, Vago-Gefen & Fink, 2009). Social-cultural factors, personality and parental perceptions (Guo, Nguyen, Weiss, Ngo & Lau, 2015; Rickwood & Braithwaite, 1994; Reardon et al., 2017; Sayal et al., 2010; O'Connor, Martin, Weeks & Ong, 2014) also influenced young people's help-seeking behaviours.

Adolescents' attitudes about and experiences of mental health services have also been explored (Ben-David, Cole, Spencer, Jaccard & Munson, 2017; Buston, 2002; Munson, Floersch & Townsend, 2009). Prior experience in Child and Adolescent Mental Health Services (CAMHS) was pivotal to how adolescents made sense of their experiences as a 16- to 18- year old (Harper et al., 2014). Similarly, the developmental stage of being a 16- to 18-year old appeared to be crucial in their understanding of engagement in mental health services (Jones, Hassett & Sclare, 2017). Davison, Zamproni and Stain (2017) investigated the experiences of CAMHS of 12- to 16- year old adolescents, which revealed mixed or negative views. Adolescents expressed concerns regarding stigma, limited knowledge about resources and a 'decrease in ranking' if they were to talk to professionals (Tharaldsen, Stallard, Cuijpers, Bru & Bjaastad, 2017). To date, there is little known specifically regarding beliefs about mental health services and its role in service engagement (Jones et al., 2017).

Theoretical models of help-seeking

Murray (2005) proposed a theory encompassing the perception of illness by a young person, the motivation to act, the perception that something can be done, the decision to seek help and the sources of help available. The role of prior help-seeking pathways and problem legitimisation were considered in this process.

Rickwood et al. (2005) suggested a theory consisting of an initial awareness and an appraisal of problems to be expressed to others. Available and accessible sources of help are identified which adolescents must be willing to disclose to. On the other hand, the 'Cycle of Avoidance' model (Biddle, Donovan, Sharp & Gunnell, 2007) suggested that adolescents avoid 'real' distress by normalising their symptoms and adopting coping strategies. A crisis event then shifts their distress from being 'normal' to being 'real'. As a result, help is sought but adolescents are faced with perceived consequences such as the experience of stigma or a concern that their symptoms will worsen. Stiffman, Pescosolido and Cabassa (2004) suggested the role of a gateway provider that initiates the trajectory of treatment for children and adolescents with mental health problems. Effective and individualised pathways to care are dependent on the provider's knowledge and information about resources but are subjected to their own attitudes about care. Overall, a common feature across all theories is the role of adolescents' perceptions of problems and the involvement of external sources in the help-seeking process.

The development and role of belief systems

Cromby (2012) suggested that beliefs are a complex process of 'felt thinking' (p. 951). Beliefs are constantly influenced by interaction and thought, according to its context (Billig, 1987). It is thought that the development of belief systems in children are shaped by parental behaviours, and parental behaviours are informed by parental histories of social relations (Schaffer, 2004; Cromby, 2012). Beliefs are said to be fluid in nature and readily changeable by experience (Stallard, 2005). Adult literature acknowledges that family, friends and media reports are potential sources that influence the development of beliefs (Jorm, 2000). This implies a need to understand the development of beliefs from an earlier lifespan perspective.

Reder and Fredman (1996) suggested that the pattern of interactions with helpers are influenced by previous experiences of seeking and giving help, and families may pass down these beliefs through generations. Beliefs are also perceived to play an important role in the 'Theory of Planned Behaviour' (Ajzen, 1991), where attitudes are informed by salient beliefs about the behaviour in question (Connor & Armitage, 1998).

Research has explored beliefs about the causes of mental health problems such as depression (Midgley et al., 2017), the need for help (Barker, 2007) and the sources of help for different health needs (Marcell & Halpern-Felsher, 2007). Goodwin, Savage and Horgan (2016) reviewed beliefs about mental health services in the lay population. The results revealed cultural beliefs and specific beliefs about medication, mental health professionals and accessing care. Older adolescents held positive beliefs about mental health services compared to younger adolescents.

Aims and rationale

It is evident that the 16- to 18-year old age group may present with increased risk and unclear service provision. The literature has suggested the importance of beliefs within the help-seeking process. To date, there has been no research concerned with 16- to 18- year olds' beliefs about mental health services and how these beliefs influenced the help-seeking process, from the perspectives of adolescents themselves, and from their lived experiences. This research therefore aimed to explore how adolescents' made sense of their beliefs about mental health services, based on their lived experiences, and how they understood their beliefs to have impacted on them accessing mental health services, rather than specifically looking into what their beliefs were. The research questions were as follows:

- 1) How do adolescents make sense of their beliefs about mental health services?
- 2) Where do they feel these beliefs have come from?
- 3) In what way did making sense of their beliefs impact on their decision to seek help?

Methods

Design

The study used Interpretative Phenomenological Analysis (IPA). Since IPA focuses on individual lived experiences, this allowed the researcher to explore how adolescents made sense of their beliefs about mental health services, and to explore

the impact of their sense-making on the help-seeking process (Smith, Flowers & Larkin, 2009). The idiographic approach of IPA emphasised the importance of adolescents' perspectives in understanding the phenomena in question (Lyons & Coyle, 2016).

Participants

Participants were screened for inclusion and exclusion criteria based on purposive sampling. Adolescents were eligible to participate if they were 16- to 18- years old and were currently engaged in mental health services for any length of time. Adolescents with significant learning disabilities, with active psychoses, or of whom were considered high-risk were excluded from the study. Adolescents with high-risk were determined by the clinicians' discretion of imminent self-harm or suicidal ideation or were at risk of harm to others. It is recommended by IPA that a homogeneous sample is used (Smith et al., 2009). Whilst every effort was made to ensure homogeneity across demographic factors and presenting problems, this was not always achievable given the changing nature of adolescents' needs and service structures. However, engagement in mental health services and the age range provided homogeneity, which were factors that were relevant and important for this study.

Fourteen participants were approached by clinicians. Out of fourteen participants, ten participants were interviewed for the study. Reasons for non-participation were refusal to participate, unable to contact and difficulties arranging an appointment due to the young persons' and researchers' availability.

Demographic details are illustrated in Table 1.

Table 1

Participant demographic information

<u>Participant</u>	<u>Age</u>	<u>Gender</u>	<u>Ethnicity</u>	<u>Duration in CAMHS</u>	<u>Presenting problems</u>
Alice	17	F	White British	4 years 4 months	Self-harm/suicidal ideation, low mood
Georgina	17	F	White British	4 years 1 month	OCD, phobia
Leanne	17	F	White British	2 years	Low mood, anxiety
Jenny	16	F	Black British	1 year	PTSD, low mood
Katrina	18	F	White British	9 months	Low mood, anxiety
Ella	17	F	White British	6 months	Suicidal attempt, self-harm, low mood
Brian	16	M	White British	2 years	Low mood, anxiety
Owen	17	M	White British	6 months	OCD, depression
Eve	17	F	White British	9 months	Suicidal attempt, low mood
Lauren	16	F	White British	5 months	Self-harm/suicidal ideation

Recruitment

Participants were recruited across 4 outpatient CAMHS teams, based in London, UK. The clinical supervisor of the study discussed the research with clinicians in the teams. The researcher also presented the study to the same teams during a weekly team meeting to promote recruitment of participants. Posters were also placed in the reception rooms (Appendix D).

Eligible participants were approached by their clinicians. The information sheet (Appendix E) was explained to participants in the first instance by their clinicians. If participants agreed to participate or required further information, written consent (Appendix F) or verbal consent was sought by their clinician for the researcher to contact them, and participants provided their preferred contact details. These details and the form were passed onto the researcher using a secure NHS email account. The researcher then contacted participants using their preferred method. Any questions were clarified and an appointment for the interview was arranged at a convenient time. Participants were also asked whether they would like someone to join them in the interview. Prior to the interviews, the researcher contacted the participants to gently remind them of their appointment.

Interviews

A semi-structured interview schedule was developed for the study based on the current literature of adolescent help-seeking (Appendix H). The interview schedule, information sheet and consent forms were presented at a young people's participation group at an NHS Trust, which involved 5 adolescents and a facilitator. Adolescents provided suggestions in the wording of questions and prompts. A final version of the interview schedule was developed with the academic and clinical supervisor of the study.

Interviews were held in a clinic room in CAMHS. At the beginning of the appointment, an overview of the study was provided with the information sheet, and any further questions were answered. Participants were made aware that the interview may trigger difficult feelings, therefore it was emphasised that they could

stop the interview at any time. The consent form (Appendix G) was explained, including confidentiality and anonymity, and signed by both the researcher and participant. All participants preferred to be interviewed on their own. Interviews lasted from 30 minutes to 1 hour and 15 minutes. After the interview, an opportunity for participants to ask any further questions and a verbal debrief was provided. Up to £10.00 travel reimbursement was provided where necessary. Interviews were audio-recorded on a digital audio recorder and transcribed manually. After transcription, recorded interviews were destroyed in line with the university's ethical procedures.

Ethical procedures

Ethical approval was given by the Research and Development committee (Appendix S), NHS ethics committee (Appendix T) and final approval was sought from the participating NHS Trust (Appendix U). To ensure safety for both the researcher and the participant, the clinical supervisor or the young peoples' clinicians were made aware of the interview date, time and room.

Data analysis

IPA involved reading and re-reading the transcripts to facilitate familiarity to the data (Smith et al., 2009). The researcher then coded each transcript, paying attention to descriptive, linguistic and conceptual terms (Appendix I).

Two transcripts were coded independently by the supervisors of the study and the researcher, which were discussed during supervision. Codes for two transcripts were then analysed for emergent themes and were discussed with the academic

supervisor of the study. Emerging themes from each individual transcript were derived from the codes (Appendix J) and themes were placed on a separate word document for each transcript (Appendix K).

Emerging themes and their respective quotes were printed out to be visually organised into clusters (Appendix L). A mind-map was created in the first instance to organise subthemes and to illustrate the relationships between themes (Appendix M). Clusters of subthemes were given a representative superordinate name (Appendix N). Recurrent themes were analysed across all cases (Appendix O) and a reconfiguration of themes was conducted (Appendix P). The printing of quotes alongside the themes enabled the researcher to compare the original quotes at each stage to the superordinate and subthemes.

Quality Assurance

Quality assurance was based on the criteria set out by Mays and Pope (2000) and Yardley (2000). A clear description of the methods and data collection were presented, together with examples of emerging themes throughout the process of analysis (Mays & Pope, 2000). Mays and Pope (2000) suggested respondent validation as a method of improving validity, however given the interpretative nature of the IPA approach and the 'double hermeneutic' concept, it is likely that the data would be different from each individual account of experience.

Yardley (2000) proposed characteristics of 'good quality research'. Sensitivity to context was for example, achieved by consideration of the researcher-participant context, such as the position of the researcher as a therapist, and as an outsider to the service. Commitment and rigour were ensured by prolonged engagement in the

topic which involved re-reading the transcripts several times, as well as making sense of the variations in participants' meaning-making. Transparency and coherence were adhered to by providing a detailed description of the analysis, accompanied by visual examples and reflexivity procedures, for example, the use of a bracketing interview. Finally, the study was conducted within CAMHS in an NHS Trust which allowed for implications to be discussed in the context of further research, UK service practice, and policy procedures.

Reflexivity was continuous throughout the research, which included supervision to discuss the researchers' preconceptions and assumptions. A research diary was also kept (Appendix Q) and a bracketing interview (Ahern, 2014; Fischer, 2009) was conducted with a peer trainee clinical psychologist to identify areas of bias and to consider its influence on the research process (Appendix R).

Results

Five superordinate themes emerged from the data: questioning the trajectory of mental health difficulties, navigating through mental health discourses, management of beliefs, the therapeutic process as a mechanism for change and the transformed view of the self and other (Table 2).

Table 2

Superordinate and subthemes

<u>Superordinate theme</u>	<u>Subtheme</u>
Questioning the trajectory of mental health difficulties	Am I ill enough? Recovery as achievable/non-achievable What is CAMHS?
Navigating through mental health discourses	Societal and social media narratives Professionals' portrayal and representation of services The ambivalence associated with mixed messages
Management of beliefs	Taking responsibility for recovery Tug of war with autonomy Adults as gate keepers
Therapeutic process as a mechanism for change	A tailored approach Communicating acceptance
The transformed view of self and other	Reflecting on the journey with alternative views Increasing quality of life

Questioning the trajectory of mental health difficulties

Adolescents made sense of their beliefs about mental health services by referring to beliefs about mental health, mental health services in general, and more specifically, CAMHS. This theme captured adolescents' curiosity about the trajectory of their difficulties, which included how they made sense of their illness, the potential for recovery, expectations and assumptions about the services available, and what it meant for them to be referred to or be in contact with mental health services.

Am I ill enough?

Adolescents held beliefs about their level of illness, mostly that it was deemed unworthy of requiring external help. Jenny minimised her distress as something that she thought would 'stop':

"I didn't feel like I should talk to anyone about it because I didn't think it was that serious, and that, I would eventually get over it. It's nothing. It'll eventually stop. I'll stop feeling like this" (Jenny)

Illness perceptions appeared to be exacerbated by service structures, and thus access to mental health services was not expected to occur immediately:

*"I thought if they can wait a year to see me then do I really have a problem?"
(Lauren)*

Attending CAMHS confirmed the 'seriousness' of conditions, and adolescents saw it as a sense of defect, weakness or wrongness:

"I never heard of it and I saw it as like being weak, needing help" (Georgina)

Brian's' hesitance in calling mental health services an 'insane asylum' was a reflection of how mental health services could be understood using historical terms, which meant having to admit to an unwanted identity:

"It's kind of – you know, you don't want to say like 'insane asylum' but mental health – it's kind of – you know that comparison could probably be easily made by someone who doesn't know much about it so – but it's that feeling of 'oh this, I'm not well in the head'" (Brian)

Brian understood mental health as similar to physical health. A comparison to physical health symptoms may show an underlying belief that mental health can be cured:

"It's just getting help because your mind isn't functioning properly, just as if your leg was broken, it wasn't working properly" (Brian)

Recovery as achievable/non-achievable.

Adolescents understood their beliefs about mental health services in relation to therapists and doctors who were perceived as being omniscient and omnipotent.

This represented the idea that they would then be able to 'fix' distress (e.g. *"There's a support plan being put into place, like um, because informally you don't set up plans or anything yourself, fix anything or sort anything out"* Ella) and promote successful recovery, as Katrina described:

"It sounded like utopia, where you'd go in and that'd make you great and you come out all great" (Katrina)

For Alice, CAMHS appeared to be a fantasy or a magical place that would have a significant impact on the process of recovery:

"I thought they'd be able to sit there and tell me how I feel and how to get better and it'd be very linear and very straight line like a clear road... I always just expected them to magically make me better" (Alice)

However, some adolescents described CAMHS as being 'useless' and doubted their ability to help them get better. Help was seen as unworthy of their time and professionals' time:

"I thought I was never going to get better and so there wasn't really a point and I was like 'well I'm just wasting time'" (Owen).

Recovery seemed to be influenced by how helpful adolescents perceived mental health services to be, or the idea that recovery was what gave them a sense that mental health services could be useful.

What is CAMHS?

For most participants, there was an initial lack of knowledge about CAMHS and what it entailed:

“I wasn’t aware of the CAMHS facility or I wasn’t aware of the actual CAMHS service” (Brian)

Participants responded with curiosity about CAMHS, and associated feelings:

“I was like, ‘I don’t know what it it’s going to be like, I don’t know what I’m going to do. Is it going to be like traumatic, is it going to be relieving’ stuff like that” (Ella)

A lack of knowledge about CAMHS prompted Leanne to do some research about the CAMHS building, which provoked a sense of fear:

“Is this place safe?” (Leanne)

Adolescents held ideas about wider contextual issues associated with CAMHS, such as the lack of resources to help:

“... because it’s not private obviously it’s free, so they can only afford so much things for you” (Lauren)

Structural processes rendered CAMHS as inaccessible, as with the presence of waiting lists, and a belief that therapy comes at a financial cost:

“I just thought I needed to pay, and I didn’t think I’d be able to afford it”

(Jenny)

A lack of information contributed towards an assumption about the CAMHS environment or building. Frequent responses were that CAMHS would look like a *“hospital, with the corridors and sort of, medical rooms”* (Eve). Negative connotations attached to the word ‘hospital’ could influence the emotional experience of hearing about CAMHS for the first time.

Navigating through mental health discourses

Beliefs were informed by public and professional discourses of mental health, ranging from close significant others to the narratives embedded within society. CAMHS, mental health services and mental health were frequently intertwined in participants’ recollection of how they made sense of their beliefs.

Societal and social media narratives

Portrayals of mental health and mental health services on online and media platforms were frequently mentioned. Their accounts were followed by a reflection on how they thought about it at the time versus how they felt about it now:

“...like in videos and stuff, um, like hypno stuff – yeah where they’re lying on a bench and stuff like that (laughs) I thought it’d be like that, but I’m glad it’s not”
(Owen)

For Jenny, a lack of knowledge about CAMHS appeared to make her more prone to ideas portrayed in the media:

“I just didn’t know. All I had was those movies and the TV to base my ideas off” (Jenny)

Participants commented on the lack of compassion for and understanding of mental health in society. These views impacted on how they identified themselves, with the idea that they were involuntary categorised as part of an undesirable group:

“The person that they think is crazy, and you don’t want to be in the same category as them. You think, ‘Am I?’ you start questioning yourself” (Katrina).

The labels brought a sense of stigma, and societal narratives informed adolescents perceived levels of distress and need for help:

“I think it’s a society norm thing, that being unhappy is normal and like not seeking is – like why would you seek help if it’s normal?” (Ella)

Professionals' portrayal and representation of services

Participants reported positive and negative experiences with professionals such as school counsellors and therapists. Alice saw numerous therapists since a young age and remembered the emotional experience with her initial therapist. This informed her beliefs about her next therapist, and what CAMHS represented to her:

"Whenever I heard of CAMHS or going to CAMHS I just associated it with those feelings of fear and dread" (Alice)

Professional services also included experiences with teachers as Katrina described:

"I think just experiences of teachers because they're the only people that I could really relate" (Katrina)

Participants reflected on how teachers had little understanding about mental health services and did not see mental health as a priority:

"I can only remember 1 or 2 assemblies if that, like they bring it up in assembly but then move on to something that they seem as more important" (Georgina).

In essence, school counsellors were perceived as inferior to professionals in mental health services. Others praised their schools as providing an awareness of mental health:

“Partly from school because my schools quite good. We do do assemblies and talks about mental health” (Eve)

Previous experiences of help included hospital experiences prior to the event that led to support from CAMHS. Jenny’s beliefs that CAMHS would be similar to a hospital were informed by how it was introduced to her by nurses:

“The way her voice sounded, sounded like going to CAMHS was bad, and um the way she said, ‘you’ll definitely be going’” (Jenny).

On the other hand, CAMHS was appraised highly by professionals as experienced by Katrina:

“They hyped it up in a sense” (Katrina)

This highlighted the salient verbal and non-verbal features of professional discourse, which are likely to affect adolescents’ beliefs about services.

The ambivalence associated with mixed messages

Peers and family members contributed towards how adolescents made sense of their beliefs about mental health services. Family members’ experiences of mental health services gave a sense of familiarity to the process:

“So a few of my family members, my brother and my step-sister have been here before... well the doctors referred me here and, just like said, ‘is that ok?’, and because my dad was taking my brother before, um he talking about a bit about it” (Owen)

Adolescents also mentioned parental beliefs about mental health, beliefs associated with gender roles, and the meaning this subsequently placed towards seeking professional help:

“He [dad] didn’t want to believe there was an issue. Obviously, he was more masculine in his approach whereas my mums more feminine, that’s just how the kind of two work” (Brian)

The majority of participants reported that peers had unhelpful experiences of mental health services, which resulted in reluctance to engage:

“I kept hearing about CAMHS because my friend used to go here about the same time as that, but she never came out it with like any positive experiences, so I was like ‘um... maybe I should put it in the back burner’ like that’s not the first option” (Ella)

However, two participants learnt from the positive experiences of peers:

“They said they found it helpful. It helped them and I see how it changed some of my friends” (Leanne)

For Ella, peers’ experiences of mental health services appeared to confirm the distortions she held about not being ‘ill enough’ and attributed CAMHS to being unable to help her:

“I had one friend who was in the system bounce around, and I heard about a few others who had been in the system and then come out of it and they didn’t think it was useful to them, so that also added to the idea that it’s a service that is for really ill people but even for those it’s not adequate so it won’t be useful for you” (Ella)

Managing beliefs

Managing beliefs involved a dynamic process between the role of self and the role of others which translated into help-seeking behaviours. This theme captured the internal processes associated with being an adolescent but also the need for external help to initiate and facilitate the help-seeking process.

Taking responsibility for recovery.

Adolescents’ believed they had a role in recovery. This involved approaching CAMHS with a different mindset which implied having control over the outcome:

“I think partly the reason that I had that experience was mindset, and that the fact that I was kind of permeable” (Katrina)

The idea of being ‘permeable’ suggested that Katrina was receptive to absorbing information, and that this was required to facilitate recovery. The need to express themselves was an important step towards this:

“I knew that I needed help but I couldn’t convey that enough to somebody else for them to actually refer me” (Ella)

They placed significant importance in experiencing CAMHS for themselves, despite the negative views of others or their own previous experiences:

*“He [friend] stopped going [to CAMHS] so, but I didn’t let that influence me”
(Jenny)*

Participants also mentioned the use of online resources, especially in the absence of adult support:

“I didn’t have close relationships to either of my parents or many adults so I didn’t get um, any knowledge that they might have had early enough, um... or earlier. So what I spent a lot of time trying to find out what like what was wrong, how to help myself” (Ella)

Tug of war with autonomy.

Autonomy appeared to be a continuum, between strong and rigid individual preferences for treatment prior to engaging in CAMHS, to working collaboratively with adults, for example, Alice spoke about how she refused to take medication, almost as if it were fused with her identity:

“I’ve always been very anti-medication” (Alice)

Participants also spoke about how they did not want to help themselves because of how they were feeling at the time:

*“Sometimes when you’re in that frame of mind when you’re not, where you just don’t want to be at all, it’s quite easy to just turn something down”
(Katrina)*

Maintaining autonomy was accompanied with the emotional challenges of dealing with stigma, guilt, ambivalence, fear and perceived burden on themselves and their close relationships:

“Sometimes you just don’t want to make anyone feel bad that you’ve got a problem” (Brian)

Asking for help was associated with an eventual loss of agency in the situation, and this led to a feeling of powerlessness:

“There was no reason for me to say no because there was nothing for me to lose at that point I had already lost” (Katrina)

Relinquishing control appeared to be an oscillating process between adolescents and services:

“They’d like let you if you needed to bottle it up. They’d let you bottle it up somewhat but then they would push you to not” (Georgina)

However, needing to be cared for was described as a desire at times but with conflicting feelings of having to let go of control:

“I know I was sort of hoping that someone might almost just go, I don’t to um, or just say ‘I’m worried about you, I’m going to tell someone’ which I wouldn’t have liked but I would of liked at the same time” (Lauren)

For Alice, being cared for was highly valued at a point in her life, as she reminisced about being an inpatient:

“Sometimes I do feel nostalgic about it because you would because it’s part of your life and there were good moments” (Alice)

Alice saw her care as a collaborative process, where she maintained the sense of being a 'child', and 'adults' were seen as being capable of handling the more 'adult' processes.

Adults as gate-keepers.

Adults identified distress as requiring help, with or without knowledge about mental health:

"She knows a lot about you know, clinical psychology. She studied it a few times so she was aware that there might be a problem" (Brian)

Participants spoke about the proactiveness of adults in initiating the help-seeking process, which involved parents and/or teachers. This account was in response to a crisis event where seeking help was inevitable and out of participants' control:

"I didn't seek help. It sort of got to the point where my mum sought help" (Lauren)

Even within the mental health service, Georgina's access to therapy required her psychiatrist to 'push' for it, which implied a hierarchy of control in decision-making processes or frustrating service thresholds:

"The psychiatrist was trying to push it, push through it, just to get um, some therapy" (Georgina)

Asking for help from adults was perceived as a pain-staking process that was not always available readily. Katrina described having to be assertive about her needs, “demanding” help since she described services being “inadequate” for her. This demonstrated the significance of adults and services as important sources of support, but a sense that adolescents’ voices were not easily heard.

Alongside taking initiative and accessing help for participants, adults provided encouragement and support:

“I can’t remember exactly what they said but on the side of ‘oh yeah that’s good, listen to them and keep working through it’ so I know that they encouraged it” (Lauren)

Therapeutic process as a mechanism for change

Participants valued person-centred and tailored approaches to therapy, in helping them to identify, normalise and validate their distress, resulting in a change of beliefs.

A tailored approach.

All participants highly appraised their therapist as positive and influential in their recovery. Participants valued the transparency, content and structure of the therapy they received:

“She’s the only one whose given me strategies to help me, and um, IPTA or ITPA something like that – interpersonal psychotherapy for adolescents I think – um, she was telling me what that was and how it was going to help” (Eve)

It was important for participants that their therapist ‘matched’ their own characteristics, particularly in age:

“I quite like that you’re [therapist] young... I think it’s easier to talk to” (Owen)

Katrina valued the relationship she had with her therapist and other professionals of whom she was in contact with, as superior to its content. The attachment was facilitated by the therapists’ empathy towards her:

*“The understanding is ridiculous... it’s almost more than a parent I think”
(Katrina)*

The idea that therapists are perceived as a parental figure or more, demonstrated the omniscient beliefs adolescents held about therapists, as corroborated with Alice’s account of her therapist appearing to be internalised:

“She’s always, it’s like she’s in my mind” (Alice)

Therapists’ non-judgemental, familiar, and unbiased approach and expertise were well received which facilitated a shared understanding about distress. However, the

therapeutic process was not limited to the clinic room. Two participants talked about the environment as reducing anxiety and enabling the expression of needs, such as in Leanne's account:

"Every time you turn up there's always somebody waiting at reception with a smile, so it's like a friendly face when you walk in so it's not like, nervous when you walk in" (Leanne)

Communicating acceptance.

Helpers provided a space for modelling acceptance of distress, by ways of validating adolescents' experiences:

"They're there to help you and they come and they say, 'It's ok. Look, this is a serious problem. Don't put it down, don't say it's nothing [inaudible]'. That's very helpful" (Brian)

Alice voiced how she tested the boundaries of discharge in order to seek constant validation of her distress:

"I'd be like I just want to be discharged and they'd say no, and I'd be like ok I'm still ill. It was just validating in a way" (Alice)

Validation was also associated with the presence of a diagnosis:

“I felt more validated and um, it’s kind of a relief to have a name to put to it”

(Eve)

The therapeutic relationship was also perceived as a space for helping adolescents to normalise their distress:

“I’ve showed that I have emotions. I have lots of emotions” (Georgina)

The transformed view of the self and other

Beliefs evolved as participants engaged with CAMHS which led to self-transformation and a transformed view of others, demonstrated by adolescents’ ability to positively reframe, evaluate and rationalise their initial beliefs. Acceptance of distress and acceptance of help translated into external behaviours.

Reflecting on the journey with alternative views.

Embedded in the narrative of young peoples’ account of their experiences, was a constant evaluation of their beliefs as they talked about their mental health journey. The rationalisation of experiences demonstrated this change, even in relation to the behaviour of others:

“They listened to me when I said ‘don’t tell anyone’ when maybe they shouldn’t have done, which I think is, I think maybe they might have heard

things about mental health services which told them ‘actually yeah I’m not going to tell anyone she can deal with it on her own’” (Lauren)

At the time of a crisis, Lauren confided in her peers of whom granted her desire for the information to not be shared with anyone. In hindsight, Lauren understood the behaviour of her peers to be because of their own beliefs about mental health services. Alice talked about her unhelpful experiences of numerous therapists, however she rationalised her initial belief of the ‘uselessness’ of mental health services, to take into account a more systemic perspective, and one of which was outside the helpers’ control:

“...this whole system as an umbrella term is harsh and is cruel sometimes and it’s not very nice on either end at times like if you’ve got an ill patient there’s only so much you can do” (Alice)

Distress was also positively reframed:

“You’re not going to get anxious if you care about something” (Georgina)

Introspection enabled participants to acknowledge the journey towards recovery, despite initial beliefs about the potential to be helped by services:

“...I had such a big doubt and it’s weird to think back on it now that I had those doubts because of how far I’ve come” (Owen)

Increasing quality of life.

This theme was associated with acceptance, altruistic behaviours and a change of life habits. Some adolescents understood acceptance to be facilitated by the realisation that mental health services were the 'only option' for them, and therefore they were receptive to help due to the intensity of their emotional difficulties:

"I just finally said yes to seeking help or I didn't have much choice, so I had nothing to lose so I just said, 'ok get me the help because I feel like I'm dying'"
(Owen)

The process of acceptance enabled participants to evaluate their own lives and their individual needs. This translated into external processes which included ending friendships that were no longer helpful for them:

"The people who were one day my friends but who I'm not friends with anymore were not helping me at all" (Jenny)

Jenny also described having changed her life habits, such as abstaining from social media. There was also a desire to help others, leading to altruistic behaviours:

"There was this girl in year 10 and my headteacher was like, 'Can you help this girl? She's got exactly the same thing. You're the first person that I've ever seen with this but now she's got it as well, would you mind helping her?' so every now and then I just spoke with her" (Georgina)

Discussion

This study explored how adolescents made sense of their beliefs about mental health services, based on their lived experiences, and how their making sense of these beliefs impacted on the decision to seek professional help. Given the limited research for the 16- to 18- year old group and research concerning adolescents' beliefs, this study contributes to the current adolescent help-seeking literature but sought to understand the role of beliefs in the help-seeking process.

The study found that adolescents made sense of their beliefs about mental health services with questions related to the trajectory of their mental health difficulties. Beliefs were informed by their lived experiences of having to navigate through public and professional discourses of mental health. Managing their beliefs involved the struggle between taking responsibility for recovery whilst relying on adults to seek professional help. Therapy provided a platform for change, which enabled adolescents to develop a transformed view of themselves and others. Figure 3 summarises how superordinate and subthemes may relate to one another.

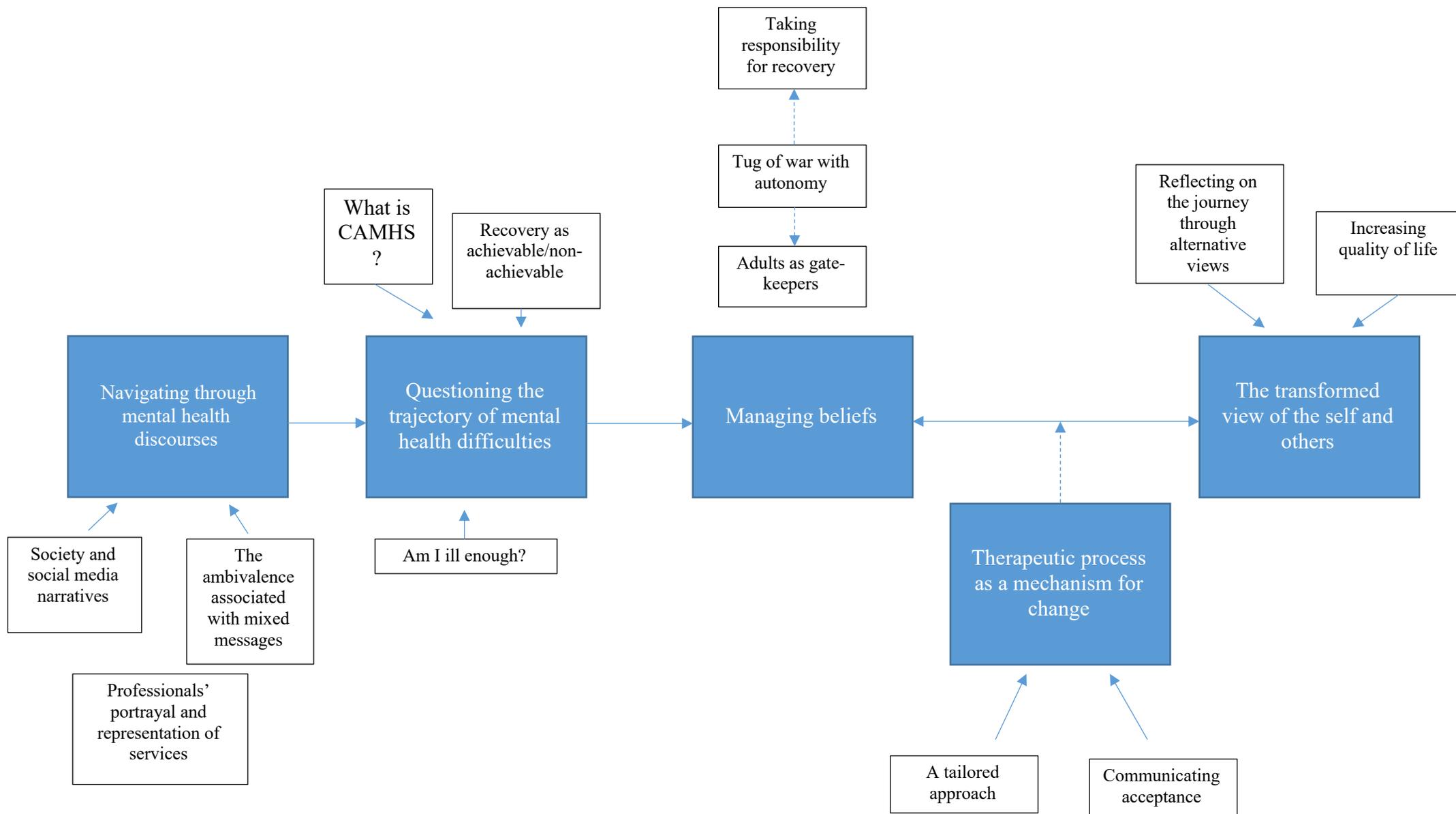


Figure 3. Process diagram. This figure illustrates the relationship between superordinate themes and subthemes.

Links to previous research and theory

The multifaceted nature of how adolescents made sense of their beliefs supported previous literature (e.g. Goodwin et al., 2016; Barker, 2007). Although cultural beliefs (Goodwin et al., 2016; Guo et al., 2015) were found to be a key factor in help-seeking behaviours, this was not considered to be an influence in participant sense making. This difference may have reflected the lack of ethnic diversity in the sample, or that cultural beliefs were not of significance to this age group, since greater importance is given to peers and their experiences (Coleman & Hendry, 2000).

The results showed that adolescents made sense of their beliefs about mental health services, with questions related to the trajectory of their mental health difficulties. Adolescents judged whether they would qualify for help based on a perceived level of distress, which supported previous theory (Biddle et al., 2007). Adolescents were unable to identify their distress as helpworthy until they reached crisis, and adults were perceived as gatekeepers towards initiating help, as proposed by Stiffman et al. (2004). The model suggested that effective care is dependent on the knowledge and information of available services. It was evident that adolescents were not aware of CAMHS and how it could be accessed, similar to previous findings (e.g. Tharaldsen et al., 2017) and parents and peers were dependent on their own experiences of such services. Information about CAMHS appeared to be limited to professionals alone.

The majority of adolescents held omnipotent and omniscient beliefs about therapists and its impact on recovery, which was contrary to previous research reporting negative beliefs about professionals (e.g. Goodwin et al., 2016, Rickwood

et al., 2005), however these studies focussed on medical professionals compared to therapists of whom have different roles.

Adolescents' sense-making of beliefs appeared to have been informed by or originated from a number of sources which supported adult literature (Jorm, 2000), and an experience of having to navigate their way through multiple public and professional discourses of mental health and mental health services. Helpers, such as parents, have their own contextual belief systems about the meanings of help (Stiffman et al., 2004). Adolescents reported peers' and family beliefs and experiences of mental health services, and for some, these family and peer accounts resulted in an ambivalence to engage with services which supported previous research (Harper et al., 2014). Adolescents also seemed to be influenced by their own experiences of receiving help (Reder & Fredman, 1996). Ben-David et al. (2017) investigated the content of messages communicated by formal and informal sources, which supported the current study, and highlighted the importance of both content and perceived tone. Additionally, Hassett and Lane (2018), identified the beliefs that youth offending workers held about CAMHS which was likely to impact on how they supported young people to accept referrals to CAMHS. Communication of others' beliefs seemed to be important factors that influence help-seeking behaviours. Adolescents also identified gender-typical beliefs surrounding masculinity (Hassett & Ibister, 2017) and psychology expertise. Experiences are influenced by social changes (Christie & Viner, 2005) evidenced by society and social media narratives about mental health and mental health services, and associated stigma, as mirrored in the study by Shechtman et al. (2018).

Managing beliefs involved an oscillating process between self and others. Adolescents' sense-making of beliefs highlighted the need for external help in

making a decision to seek support from professional services, alongside keeping a sense of autonomy and dealing with the emotional challenges, which is reflected in previous adolescent literature (Erikson, 1968; Wilson & Deane, 2012; Rickwood et al., 2005; Tharaldsen et al., 2017). In this study, there seemed to be a shift from the refusal of mental health support, defined as 'help-negation' (Rickwood et al., 2005) to the acceptance of help. Hassett and Ibister (2017) found that adolescent help-seeking was a result of guidance from external figures alongside strategies to maintain a sense of independence. Similarly, Hassett, Green and Hundel (2018) corroborated with this idea that parents play a key role in facilitating collaborative help-seeking or more forceful help-seeking. Collaborative help-seeking was understood to be part of adolescents' experiences in this study, as well as forceful help-seeking related to crisis events. Overall, participants appeared to be reliant on adults to acknowledge distress and seek professional help (Jones et al., 2017; Stiffman et al., 2004), which supported the personal to interpersonal conceptualisation of help-seeking (Rickwood et al., 2005). It could be argued that adolescents may move back and forth between stages and require external help at different times, for example, adolescents in this study needed external support to help them express their needs. The oscillating process in the management of beliefs could be considered a dynamic process that one has to navigate, which reflects the fluidity of the overall help-seeking process (Murray, 2005).

The study corroborates the idea that beliefs are readily changeable depending on ongoing experiences (Billig, 1987; Schaffer, 2004; Cromby, 2012; Stallard, 2005). The changing nature of beliefs appeared to be largely attributed to the therapeutic relationship. Research has emphasised the value of the therapeutic relationship (e.g. Harper et al., 2014) and numerous studies have highlighted the therapeutic alliance

as a predictor of therapy outcomes (e.g. Shattock, Berry, Degnan, & Edge, 2018; Ardito & Rabellino, 2011). Similarly, adolescents' experiences of CAMHS included the importance of feeling cared for, supported and listened to by staff (e.g. Davison et al., 2017).

Self-transformation, described in this study by the transformed view that adolescents held about themselves and others, reflects the post-traumatic growth literature (e.g. Wang, Lee & Yates, 2019) which states that individuals progress towards growth following adversity, and involves the relabelling of self, interpersonal relationships and a changed meaning of life (Tedeschi & Calhoun, 2004). This growth was demonstrated by adolescents' reflection of their mental health journey which included the development of alternative views. This may have been learnt through a specific therapeutic model that was experienced in CAMHS, which led to an acceptance and appreciation of experiences. The post-traumatic growth literature also acknowledges the role of personal qualities, such as openness to experience, which most adolescents referred to prior to engagement. Adolescents' accounts of self-transformation involved altruistic behaviours, which could be referred to as 'altruism born of suffering' (Staub & Vollhardt, 2008). Altruistic behaviours are seen as a consequence of experiences, psychological change and psychological processes, such as taking a greater responsibility towards preventing suffering in others. This change was shown in adolescents' reports of their attitude or behaviour towards others, such as questioning other people's behaviours and taking the time to speak with others who were experiencing similar difficulties.

Methodological critique

IPA allowed for an in-depth analysis and interpretation of adolescents' beliefs and its role in the help-seeking process, relative to reducing it to quantitative techniques which would result in a loss of richness of data, or to other qualitative analyses that would seek to explain the phenomena as a generalised inference for the adolescent population. The point of IPA was not to provide generalisable findings. IPA ensured that 16- to 18- year old experiences were uniquely identified in relation to the given aims of the study.

Participants were recruited from clinicians embedded within services therefore the role of selection bias and researcher bias could not be ruled out. Participants may have been selected on the basis of whether they could readily express themselves in an interview, and the clinician's relationship to the participants. Most adolescents that were approached by their clinicians agreed to participate. Whilst this could be perceived as an example of altruism, their participation could be rooted in the desire to please their therapists.

It is also important to consider the researcher-participant relationship. As participants understood that the researcher was a trainee clinical psychologist, this might have affected their responses and resulted in a highly appraised view of therapists, or an emphasis on the therapeutic relationship. On the other hand, adolescents may have been selective in their responses because of a perception that the researcher may judge what was being expressed. It was emphasised that the researcher was separate from the clinical teams, and ongoing reflexivity through the use of the research diary was utilised.

Implications

Research

This study elicited how adolescents made sense of their beliefs specifically in relation to mental health services. Further research could seek to identify the salient behavioural, normative or control beliefs based on the 'Theory of Planned Behaviour' (Ajzen, 1991), and beliefs that bare more power which may result in behavioural change. Based on the qualitative data, the change in beliefs could be perceived as a linear process, with the therapeutic relationship as the only mechanism for change. Although adolescents also made sense of their beliefs about mental health services according to developmental maturity and personal characteristics, this was limited to the participants who engaged with CAMHS for a longer period of time. It would be interesting to understand the development of beliefs from adolescents who were in CAMHS from a younger age, or within specific populations where young people have been cared for by services for most of their lives, for example, looked after children.

Adolescents valued the therapeutic relationship in making sense of how beliefs changed over time. Research into the therapeutic relationship has largely been based on the adult population, with scarce research investigating the therapeutic relationship with children and adolescents (DiGiuseppe, Linscott & Jilton, 1996). Research could determine the processes involved in the therapeutic relationship for this younger population, and how this may or may not change depending on demographic characteristics and presenting problems (Walter & Petr, 2006).

The study also highlighted the concept of self-transformation, which could be understood by post-traumatic growth theory (Tedeschi & Calhoun, 2004). Specific

processes that underlie growth following mental health difficulties for the adolescent population could be investigated, and the behavioural changes associated with such growth.

Clinical practice

The importance of the therapeutic relationship highlighted the need for professionals to foster non-judgemental and empathic ways of working. A tailored approach signified adolescents' preferences for therapist-client 'matching', therefore therapist characteristics should be considered during case allocation. Clinicians could also seek to work collaboratively with adolescents in helping them to maintain a sense of agency in their care. Assessment procedures could involve questions related to past help-seeking experiences, such as 'relationship-to-help' conversations (Reder & Fredman, 1996).

Adolescents also considered the mental health service environment, which included the journey to and from the clinic room and the interaction with other professionals. It is therefore important that a high quality of care is provided in all aspects of clinical practice, and for clinicians to be aware of the impact of service constraints on a young person, such as the presence of waiting lists.

Young peoples' expertise, resilience, strengths and resources could be utilised in shaping the delivery of services and research processes. There is an emerging literature for young peoples' involvement, such as peer educators (Abdi & Simbar, 2013) and in participatory action research (Yonas, Burke & Miller, 2013).

Public policy procedures

Government reports have highlighted the need for improvements to UK CAMHS, such as 'Future in Mind' (Department of Health, 2015) and the 'Five Year Forward View' (National Health Service, 2016), however further discussion is needed regarding promotion and accessibility to CAMHS services on an individual and societal level. The introduction of Children and Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT) is a step forward, however this study highlighted that access to services are limited to the amount of knowledge held by individuals who are part of a young persons' close network. It is crucial that age-appropriate resources are used to promote awareness, availability and accessibility of services across all platforms, including social media, and in education services. Educating children, adolescents, parents and/or caregivers, as well as school professionals, in mental health seems vital for prevention and continuous effective care. Training programmes could be delivered by mental health professionals and young people themselves, to local communities, workplaces and schools or colleges.

Conclusions

The study sought to understand how adolescents made sense of their beliefs in relation to help-seeking for professional services. Participants made sense of their beliefs through questioning their illness and recovery, and the accessibility and availability of mental health services. Beliefs were understood to have originated from or were informed by a number of sources, in which adolescents had to navigate their way through. Adolescents attempted to manage their beliefs by taking

responsibility but continued to struggle in maintaining autonomy. Adults were perceived as gate-keepers towards formal help-seeking. Beliefs translated into self-transformation processes, involving behaviour change. The themes were discussed in relation to the theories of adolescence and help-seeking, and the development of beliefs. Research, clinical and policy implications were discussed, highlighting the need for further research into beliefs, the importance of collaborative client-therapist relationships, and the need to increase public awareness of mental health and accessibility to mental health services.

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APPENDIX A: Example of quality assurance check

	Rughani et al 2011	Muthupalaniappen et al 2012	Hedge et al 2016	Sawyer et al 2012
1) STUDY OVERVIEW				
Strengths and weaknesses of the study, theory and policy and practice implications?	S: reliable and valid outcome measures. W: Cross-sectional therefore does not establish cause and effect; vague terms e.g. psychological distress therefore confounding variables, limited generalisability, ethical considerations lacked info	S: reports on sample size W: lack of outcome measure details e.g. reliability and validity, and lack of procedure detail	S: mentions reliability and validity of the outcome measures, adequate information about implications W: limited generisability	S: outcome measures well validated and high reliability, addresses important implications, W: limited generisability e.g. to older adolescents
2) STUDY, SETTING, SAMPLE AND ETHICS				
What was the comparison intervention?	N/A	N/A	N/A	N/A
Is there sufficient detail given of the nature of the intervention and the comparison intervention?	N/A	N/A	N/A	N/A

What is the relationship of the study to the area of the topic review?	Help-seeking and variables that affect help-seeking intentions. Variables have been previously mentioned in the background research	The link between smoking and emotional and psychological distress	Factors influencing help-seeking for dating violence - reference to dating violence and help-seeking literature	Help-seeking literature and adolescent proneness to psychological distress
Within what geographical and care setting was the study carried out?	New South wales - 2 public high schools from regional city, 1 catholic and public high school from medium sized rural town, and 3 public high schools from separate rural towns	Primary school in East Malaysia	Schools in south carolina	Schools in Australia in both metropolitan and rural regions
What was the source population?	Adolescent students	Adolescent students	Adolescent students	Adolescent students

What were the inclusion criteria?	Age range	Age range	Certain ages - 6th to 9th grade students were invited to take part, but in wave 3, the students were from grade 8 to grade 11 - mentions that older adolescents would be more familiar with dating violence and would have higher rates but does not mention any explanation for the younger age groups	12-14 years old
What were the exclusion criteria?	Not reported	Not reported	Not reported	Adolescents below 12 and above 14

How was the sample selected?	Not reported - does not say details of procedure e.g. who was involved, what was involved, how the schools were selected	Stratified cluster random sampling	Not reported - surveys just sent to 10 schools by 'local partners from a coordinating council of human service providers'	Schools were recruited via 'an expression of interest'
If more than one group of subjects, how many groups were there and how many people were in each group?	N/A	N/A	N/A	N/A
How were subjects allocated to the groups?	N/A	N/A	N/A	N/A
What was the size of the study sample, and of any separate groups?	778	399	518	5362

<p>Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn?</p>	<p>Does not report sample size in the study</p>	<p>Reports needed sample of 500 students but those not present on the day of the study and fully answered questionnaires, samples were lower therefore cannot infer definite differences in the results</p>	<p>No reported sample size</p>	<p>No reported sample size</p>
<p>Is information provided on loss to follow up?</p>	<p>Not reported</p>	<p>To an extent - just mentioned the amount of people who did not attend school that day and the amount that had not fully answered all the items on the questionnaire</p>	<p>Not reported</p>	<p>To an extent - does report those who were excluded in the sample and reported significant differences in demographic details</p>

<p>Is the sample appropriate to the aims of the study?</p>	<p>To some extent - overall adolescent intentions for psychological distress but could have sampled adolescents who have clinical diagnoses.</p>	<p>Yes - used high school students to assess smoking behaviour and psychological distress</p>	<p>Yes - use of high school students who may or may not be involved in other services, therefore gets to understand population outcomes</p>	<p>Yes - use of high school students to measure intentions</p>
<p>What are the key sample characteristics, in relation to the topic area being reviewed?</p>	<p>Adolescents and rurality</p>	<p>Adolescent smokers and presence of emotional problems</p>	<p>Adolescents and victimisation/perpetrat or dating violence</p>	<p>Adolescents, depression</p>

3) ETHICS				
Was Ethical Committee approval obtained?	Yes	Yes	Yes	Yes
Was informed consent obtained from participants of the study?	Not reported	Yes	Yes	Yes
Have ethical issues been adequately addressed?	Not adequate - Debrief mentioned on sources of help for mental health issues, but no reports of right to withdraw or gaining consent since adolescents are from age 13/14	Not adequate - No mention of debrief or how the study was explained to the adolescents	To some extent - debrief or information should someone have psychological distress was not provided	To some extent - provided privacy for individual students if needed, but did not report debrief after or signposting to services
4) GROUP COMPARABILITY AND OUTCOME MEASUREMENT				

25. If there was more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not?	N/A	N/A	N/A	N/A
How were important confounding variables controlled (e.g. matching, randomisation, in the analysis stage?)	Cross-sectional design therefore confounding variables could not be controlled e.g. religion, socio-economic status, severity of psychological distress and types of psychological distress - the term is currently vague in the study	Cross-sectional design therefore confounding variables could not be controlled e.g. emotional or behavioural disorders that are diagnosed	Cross-sectional design therefore confounding variables are not controlled e.g. age, level of psychological distress, previous experience of help-seeking	Cross-sectional design therefore confounding variables not controlled e.g. results could be because of location such as rural regions
Was this control adequate to justify the authors conclusions?	N/A	N/A	N/A	N/A
Were there other important confounding variables controlled for in the study design or analyses and what were they?	N/A	N/A	N/A	N/A
Did the authors take these into account in their interpretation of the findings?	To some extent - they mentioned psychological distress levels	No - limitation only discusses self-administration	To some extent - talked about differing attitudes towards different types of violence and previous experiences of help	To some extent - did talk about flaw of the design but not specific confounding variables

<p>Are the measures appropriate, given the outcome criteria?</p>	<p>Yes - measures are related to the specific variables being measured</p>	<p>Inconclusive - although the youth self-report appears to be measuring emotional and behavioural problems, the help seeking questionnaire was developed by the authors with no report of specific items</p>	<p>Yes - used items for specific variables</p>	<p>Yes</p>
<p>What other (e.g. process, cost) measures are used?</p>	<p>None</p>	<p>None</p>	<p>None</p>	<p>Help-seeking vignette - face validity sought</p>

Are the measures well validated?	Yes, reliability coefficients have also been reported (high reliability)	No reports of validity for the youth self-report, but does mention that the help seeking questionnaire was 'assessed' but no further details	Yes - reported validity and reliability coefficients	Yes
Are the measures of known responsive to change?	Yes, authors report its use in other studies	Unknown	Yes, correlated it with variables measured in the study and consistent with hypothesis in the literature	Unknown
Whose perspective do the outcome measures address (professional, service, user, carer?)	Self-report (students)	Self-report (students)	Self-report (students)	Self-report (students)

Is there a sufficient breath of perspective?	Yes - relevant to the study	Yes - relevant to the study	Yes - relevant to the study	Yes - relevant to the study
Are the outcome criteria useful/appropriate within routine practice?	Not routine practice, but practice overall	Yes - smoking habits and associated emotional behavioural problems, could be investigated further in medical/psychological appointments	Not routine practice, but practice overall	Yes - depression levels

Are the outcome measures useful/appropriate within routine practice?	Not routine practice, but practice overall	Not routine practice, but could be overall (not the help seeking questionnaire since lack of information provided)	Not routine but practice overall	Not routine practice but overall e.g. CES-D for epidemiological studies
What was the length of follow-up, and at what time points was outcome measurement made?	N/A	N/A	N/A	N/A
Is this period of follow-up sufficient to see the desired effects?	N/A	N/A	N/A	N/A
5) POLICY AND PRACTICE IMPLICATIONS				

<p>42. To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects?)</p>	<p>Not generalisable to other countries because poorly reported. Setting based in rural areas in Australia - not much is known or reported about how this might be similar/different to other rural places</p>	<p>Not generalisable to other countries and confined to high school population - no report of the location of high school e.g. what type of area</p>	<p>Not generalisable to the country as a whole - just generalisable to perhaps those in south carolina - adolescents from other areas in South Carolina which the authors have mentioned 'adolescents outside rural south'</p>	<p>Generalisable to community high school students - may not be generalisable to other countries or other Australian states</p>
<p>To what population are the study's findings generalisable?</p>	<p>Limited generalisability - may not generalise to students with diagnosable distress, or history of distress since the psychological distress measure only measures 7 days. Also high school students were recruited - no report of potential differences in those who were absent that day (due to illness for example) those who do not go to school</p>	<p>Limited generalisability - can't generalise to all adolescent smokers, link between smoking and social-economic status and emotional/behavioural problems? Also does not include the students who weren't in that day, adolescents who do not attend school and risk of bias due to conflicting interests</p>	<p>Limited generalisability - to older high school students, but may not be generalised to younger adolescents, or adolescents with repeated violence/severe violence and those accessing services</p>	<p>Limited generalisability - help seeking intentions may also vary within age but didn't assess older adolescents, those who aren't in school that day, those who did not complete all the measures (since significant differences were found) Expression of interest recruitment also limits generalisability to schools that perhaps have the time and resources</p>

<p>Is the conclusion justified given the conduct of the study (For example, sampling procedure, measures of outcome used and results achieved?)</p>	<p>To some extent - gives some insight into the differences, but doesn't mean that the results are due to rurality for example (since there could be subtle differences between areas, and psychological distress (would be interpreted differently for each person)</p>	<p>To some extent - says that smokers are at higher risk of developing symptoms but may not be due to smokers alone (e.g. confounding variables of socio-economic status)</p>	<p>To some extent - does provide insight into the factors that inform help-seeking from sources</p>	<p>To some extent - but cross-sectional design limits cause and effect</p>
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<p>What are the implications for policy?</p>	<p>Increase understanding of the benefits of professional help seeking (could set up innovative ways of encouraging YP to seek help in rural towns where perhaps there isnt much promotion or services available)</p>	<p>Increase in smoking cessation programmes and available services at primary health care centers should be advertised</p>	<p>Programmes to foster help-seeking for dating violence using a universal approach, to focus on strengthening relationships amongst adolescents, and opportunities to be able to do this, and adolescent recognition and evaluation of dating violence</p>	<p>To develop universal and targeted interventions which focuses on improving the quality of social support from peers and family, and encouragement from peers and family to engage and widening the scope of providing help-seeking such as through the internet, and first aid mental health</p>
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<p>What are the implications for service practice?</p>	<p>Promotion of help-seeking in adolescents - to perhaps analyse service utilisation records</p>	<p>Physicians to be aware of the effects of smoking on emotional and behavioural aspects, and to be screened for these problems</p>	<p>For professionals to understand the relationship between dating status and help-seeking intentions - perhaps be aware of this in their practice</p>	<p>Professionals at the front line to be aware of depressive levels and its link in help-seeking - to check in with adolescents, provide a safe space for them to talk</p>
<p>6) OTHER COMMENTS</p>				
<p>What were the total number of references used in the study?</p>				

<p>Are there any other noteworthy features of the study?</p>	<p>No interpretation of the results in relation to rural areas</p>	<p>Conflicting interests - convenience sampling since students at that school receive their medical treatment from a health clinic where the researchers practice - risk of bias towards 1) people who could afford this clinic (no context given), and 2) respondent bias, since the researchers could have given the questionnaires to the students or the students know who the researchers are therefore more likely to under or over report symptoms</p>	<p>None</p>	<p>Significant differences in the those who were excluded in the study e.g. more males, spoke another language at home, parents who did not have a paid employment - does not generalise to these students because could indicate differences in help-seeking intentions</p>
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APPENDIX C: Table of studies

Author(s)	Study Design	Aim	Participants	Materials used/outcome measures	Main Findings
D'Avanzo, Barbato, Erzegovesi, Lampertico, Rapisarda and Valsecchi (2012)	Cross-sectional survey	Help-seeking preferences before a mental health help-seeking intervention	672 adolescents aged 16 years old (female: 424, male: 428), recruited from 7 schools in Milan, Italy	Help-seeking questionnaire developed ad hoc starting from the General Help-seeking Questionnaire	<ol style="list-style-type: none"> 1) High preferences for close informal help (friends, father or mother, partner, psychologist and psychiatrist respectively) 2) Lower preferences for broad informal help (clergymen and help-line) 3) Significant differences in females' preferences to seek help from friends and a psychologist compared to males
Boyd et al. (2011)	Cross-sectional survey	Frequency of help-seeking intentions and preferences of sources for mental health amongst rural adolescents in Australia	201 adolescents aged between 11-18 years old (female: 127, male: 74) recruited from Australia	The Centre for Epidemiological Studies – Depression Scale; The Zung Anxiety Scale; Open-ended survey of the help-seeking preferences and intentions of rural youth (designed by the authors)	<ol style="list-style-type: none"> 1) 55.7% would seek help from a professional 2) Majority of adolescents would seek help from a school counsellor regardless of sex, age and rurality 3) Males were significantly more likely to seek help from a psychologist 4) The late adolescent group (ages 15-18 years old) significantly more likely to seek help from GP 5) 44.3% would seek help from a non-professional - friends (57.3%) and family (43.8%)

					<p>6) Early adolescence - significantly more likely to seek help from family, compared to late adolescence</p> <p>7) Accessibility/Remoteness Index of Australia (ARIA) and depression were associated with help-seeking intention</p>
Rughani, Deane and Wilson (2011)	Cross-sectional survey	The relationships between psychological distress, perceived benefits of help-seeking, stoicism and gender, with help-seeking intentions for formal mental health sources	778 adolescents aged from years 9 to 12 (female: 52%) recruited from two public high schools from a regional city, one Catholic and public high school from a medium sized rural town, and three public high schools from separate small rural towns in New South Wales, Australia	Two items from the General Help Seeking Questionnaire (GHSQ); four items from the Anticipated Utility Subscale of the Disclosure Expectations Scale; 10 items from the Restrictive Emotionality Scale; 5 items from the Wollongong University Stoicism Scale; Hopkins Symptom Checklist 21	<p>1) 17% of males and 29% of females were likely to seek help from a doctor</p> <p>2) 15% of males and 23% of females were likely to seek help from 'another health care professional' than a doctor</p> <p>3) Higher perceived benefits of help-seeking associated with higher intentions to seek help</p> <p>4) No significant differences in intentions to seek help from psychological distress and stoicism</p> <p>5) Females were more likely to seek help than males</p>
Watanabe et al. (2012)	Cross-sectional survey	Factors associated with help-seeking and associated factors in students who self-harm and	18104 students - 8620 junior high school students aged between 12-15 years and 9484 senior high school students	Authors developed questionnaires for demographic variables (gender, age, living situation, experience of	<p>1) Significant correlations of poor help-seeking: having no one to discuss psychological distress, depression and anxiety, and current suicidal ideation</p> <p>2) Most common source of help for psychological distress were friends with</p>

		their sources of help	aged between 16-18 years, recruited from central regions of Japan	being bullied, bullying student peers, violence from adults at home, having someone to speak to about psychological distress, feeling physically ill, feeling dissatisfied with current body weight, drinking alcohol, use of recreational drugs) self-harm, help-seeking behavior and resources of help, suicidal thoughts; four items adopted from the schizophrenia section of the Diagnostic Interview Schedule for Children; General Health Questionnaire	no differences between those who self-harmed and those who did not 3) Family members were second most commonly reported source of help; adolescents who self-harmed were significantly less likely to seek help from family than those who did not self-harm 4) Adolescents who self-harmed were significantly more likely to seek help from school nurses, physical or mental health professionals and 'other sources' in both school groups
Muthupalaniappen, Omar, Omar, Iryani and Hamid (2012)	Cross sectional survey	Help-seeking behaviour in adolescent smokers with emotional and	399 adolescents recruited from a government primary school in East Malaysia	Youth Self-Report; help-seeking questionnaire developed by the authors	1) Mean scores for emotional and behavioral problems were higher for smokers

		behavioral problems			<p>2) 94.7% of adolescent smokers stated that they would not seek help from a primary healthcare provider</p> <p>3) Adolescent smokers preferred to seek help from friends, parents and siblings</p>
Hedge, Hudson-Flege and McDonell (2016)	Cross sectional survey	Factors that differentiate adolescents who do not intend to seek help, seek help from informal sources only or seek help from both informal and formal sources of help	518 adolescents, grade 8 to grade 11, recruited from schools in a rural South Carolina school district	<p>Informal help-seeking subscale and the formal help-seeking subscale developed by the authors; 7 items from the Acceptability of Family Violence scale; 8 items developed by the authors to measure dating violence victimization or perpetration; 13 items from the Problem-solving competence scale; 23 items from the self-efficacy scale; 8 items from the depression scale of CES-D; social support scale from the Multidimensional</p>	<p>1) 50% of adolescents reported high intentions to seek help from informal and professional sources; 19% reported low informal and low professional help-seeking intentions; 31% reported high intentions to seek help for informal sources and low intentions to seek professional help</p> <p>2) Significant correlations for high informal/low professional help-seeking: Acceptability of family violence, gender, family functioning and having an adult to talk to (compared to the low informal and low professional help seeking group)</p>

				scale of perceived social support; family functioning scale from the McMaster Family Assessment Device; current dating status and whether adolescents had an adult to talk to about a dating relationship were single items developed by the authors	
Sawyer et al. (2012)	Cross-sectional survey	Help-seeking intentions variations by levels of depressive symptoms after controlling for demographics and social support	5362 adolescents, aged between 12-14 years (male: 53%) recruited from schools in Australia	Help-seeking vignette; Center for Epidemiological Studies Depression Scale (CES-D); Multidimensional Perceived Social Support Scale (MPSS)	<ol style="list-style-type: none"> 1) Frequency of sources of help reported: friends (80%) and family (73%), regardless of the level of depressive symptoms 2) Smaller percentage of adolescents in the high-depression group reported that they would seek help from friends and family, and were more likely to not seek help from anybody 3) Males were significantly less likely to seek help from friends, school counsellors/nurses, or telephone helplines, compared to females, and were more likely to seek help from

					<p>medical practitioners, teachers and the internet</p> <p>4) Help-seeking intentions from friends or family were significantly lower for adolescents with higher levels of depression, even after controlling for perceived support</p>
Fortune, Sinclair and Hawton (2008)	Mixed methods study Descriptive cross-sectional survey	Adolescents' perception of self-harm, the belief that help-seeking will be beneficial and the impact on motivation to seek help	5293 adolescents aged between 15 and 16 years old who had a lifetime history of deliberate self-harm, recruited from secondary schools in the UK	Help-seeking sources questionnaire	<p>1) No significant gender differences in sources of help or between those who had friends with deliberate self-harm or not</p> <p>2) Friends and family members were most commonly reported sources of help, respectively, prior to self-harm</p> <p>3) Following deliberate self-harm, seeking help from friends was more likely than family members, and for adolescents who had friends engaged with deliberate self-harm</p> <p>4) Adolescents were more likely to seek help from friends, family, a psychiatrist or psychologist and a GP post self-harm respectively</p>
Goodwin, Mocarski, Marusic and Beautrais (2013)	Cross sectional survey	The relationship between thoughts of deliberate self-harm (DSH) and help-seeking behavior	15,686 students aged between 10 to 17 years (female: 52.16%), recruited from a survey of youth in	Self-report questionnaires developed by the authors measuring health behavior, help-seeking behavior,	<p>1) Adolescents with DSH were significantly more likely to seek help from friends, less likely to seek help from parents, and more likely to seek help from a counsellor or health</p>

			grades 6 to 10 in the United States	symptoms of depression and DSH	professional, compared to adolescents without DSH
Kaim and Romi (2015)	Cross-sectional survey	Willingness to seek help from youth care workers (YCW) parents, friends and teachers, and variables that explain seeking help from these sources	211 adolescents aged between 14-18 years recruited from youth care units for adolescents at-risk	Help-seeking questionnaire developed by the authors; attachment style questionnaire; self-exposure questionnaire	<ol style="list-style-type: none"> 1) Significantly more likely to seek help from friends, parents, youth worker and teachers respectively 2) High anxiety associated with willing to seek help from friends 3) Willingness to expose oneself significantly associated with willingness to seek help across all sources 4) Non-formal attributes for help-seeking (proximity, willingness to help, reliability) significantly associated with willingness to seek help from parents, friends and YCWs, but not teachers, compared to formal attributes (expertise and professional responsibility) 5) Seeking help from YCWs more likely with higher perceived problem severity 6) Significant positive correlation between age and willingness to seek help from friends, religiosity and willingness to seek help from teachers, parents' education and willingness to seek help from parents 7) Better economic situation means low willingness to seek help from YCWs

					8) Negative correlation between number of siblings and seeking help from parents and friends
Fry et al. (2013)	Cross sectional survey	Help-seeking behaviours and help-giving behaviours, and influence of ethnicity and nativity	1312 adolescents (female: 56%, male: 44%) recruited from high schools in New York City	Help-seeking and help-giving questionnaire developed by the authors; history of lifetime physical, sexual relationship victimization and child sexual abuse measured using Dating Violence Inventory and Family Abuse Scale	<p>Help-seeking behaviours:</p> <ol style="list-style-type: none"> 1) Male victims were significantly less likely to seek help than female victims 2) No significant differences in help-seeking behavior by ethnicity or nativity 3) No association between gender and nativity and the type of source for disclosure 4) Victims were more likely to seek help from informal supports 5) Latino's were significantly less likely to ever disclose only to friends compared to disclosure to at least one adult <p>Help-giving behaviours:</p> <ol style="list-style-type: none"> 1) Adolescents responses to a friends' situation: talking to the friend, giving advice, telling them to leave their partner, talking to the friends' partner, suggesting help from an adult and talking to an adult about their friends' experience, respectively; calling a hotline for a friend and advising the friend to speak to a hotline was less commonly used 2) Help-givers histories of relationship violence or child sexual abuse not

					<p>significantly associated with help-seeking behavior</p> <p>3) Latinos were significantly more likely to take action for their friends' relationship violence but no significant difference for nativity</p> <p>4) Males were significantly less likely to give all forms of help to their friends, despite controlling for ethnicity and nativity</p> <p>5) Foreign-born adolescents were significantly less likely to talk to their friends and suggest options, controlling for ethnicity and nativity</p> <p>6) No significant difference between variables for taking action, but Latinos were significantly more likely to take action for their friends, after controlling for gender and nativity</p>
Meinck et al. (2017)	Longitudinal cross-sectional survey	Sources of help for abuse, the proportion of those who disclose and seek help, and their outcomes, and factors associated with help-seeking and receiving	3401 children, aged between 10-17 years (female: 57%) recruited from two provinces in South Africa	UNICEF Measures for National-level monitoring of orphans and vulnerable children and additional items developed by the authors, social workers and children to measure physical and emotional	<p>1) High proportion of children named at least one formal service/confidante for disclosing abuse</p> <p>2) 48.6% of children recommended help for abuse from the police, compared to adults; social workers, clinic and hospital were mentioned less often</p> <p>3) 20% of children disclosed abuse and sought help</p> <p>4) Frequency of sources mentioned: caregiver, teachers, 'other family</p>

				abuse; Juvenile Victimization Questionnaire to measure contact child sexual abuse and rape; four items developed with social workers to measure access to services	members', friends, siblings, social workers, police, community organisations, health care professionals and neighbours, respectively 5) Assistance for abuse given by police, medical/social services, 'other not specified ways' and community vigilante retribution 6) Girls and those who reported emotional and sexual abuse were more likely to seek help, but type of abuse was not associated with the source of help 7) No significant interactions between type of abuse and gender for help-seeking
Crystal, Kakinuma, DeBell, Azuma and Miyashita (2008)	Cross-sectional survey	Sources of support in different contexts, and associations with gender, grade, and culture	2141 youth (sixth, eight and tenth graders) recruited from public schools in Tokyo, Japan and Washington, DC	Support questions adapted from previous research	1) U.S. students more likely to be self-reliant compared to Japanese students 2) Older youth were more likely to report self-reliance for all activities 3) Males were more likely to rely on themselves than females 4) Older youth were more likely to rely on self in the sickness context 5) U.S. students were more likely to mention family as a source of support for 'upset' and 'problem' 6) Younger youth were more likely to rely on family 7) Females more likely to seek help from family

					<p>8) Older youth were more likely to rely on peers than younger youth</p> <p>9) Females were more likely to seek help from peers than males</p>
Gilat, Ezer & Sagee (2010)	<p>Cross-sectional questionnaires</p> <p>Qualitative analysis using open-ended questions (not reported in this review for the purpose of this study)</p>	<p>Social-cultural features of help-seeking with respect to gender, age, and subjective well-being</p>	<p>755 adolescents (395 Arab pupils; female: 49% 360 Jewish pupils; female: 51%) in the 7th and 11th grades, recruited from schools in North and Central Israel</p>	<p>Help-seeking attitude questionnaire (e.g. Raviv et al., 2000) modified for the purpose of the study; Subjective well-being questionnaire (Huebner, 1991)</p>	<p>1) Greater intentions to seek help from mothers, teachers and educational counsellors, in Arab adolescents compared to Jewish adolescents</p> <p>2) Arab males significantly more willing to seek help from friends, compared to Arab females, and Jewish female significantly more willing to seek help from friends and formal sources compared to Jewish males</p> <p>3) Significant greater intentions for younger Arab and Jewish adolescents to seek help from parents and formal sources vs. older adolescents who were significantly more willing to seek help from friends</p> <p>4) High subjective wellbeing significantly associated with a greater intention to seek help from parents; low subjective wellbeing was significantly related to greater help seeking from friends in both ethnic groups</p>

Guterman, Haj-Yahia, Vorhies, Ismayilova & Lesham (2010)	Cross-sectional survey	Frequency of help and sources of help after community violence exposure, frequency of sources to refer adolescents to a mental health professional and help-seeking obstacles	1835 adolescents in 9 th to 12 th grades (858 Arab adolescents, 977 Jewish adolescents) (full sample female: 55.1%) recruited from junior and senior high schools in Israel	My Exposure to Violence Scale (My ETV; Selfner-O'Hagan et al. 1998); Barriers to help-seeking in the wake of violence was developed by authors based on a literature review by Kuhl et al. 1997	<ol style="list-style-type: none"> 1) Significantly higher proportions of Arab adolescents than Jewish adolescents sought help from 'others', family members and parents, respectively 2) Arab adolescents significantly sought more help from acquaintances or strangers, youth group or religious leaders, teachers and medical professionals, compared to Jewish adolescents 3) Arab adolescents sought significantly more help than Jewish adolescents from a mental health professional
Findlay and Sunderland (2014)	Cross-sectional survey	Utilisation of professional mental health services for mental health or substance use, informal support, and the associations between risk factors and help-seeking	4013 adolescents aged between 15 to 24, recruited from Canada	Sources of support, and demographic details were collected via the Canadian Community Health Survey-Mental Health in 2012	<ol style="list-style-type: none"> 1) Frequency of sources of help were as follows: friend, family member, internet, discussion forums and social networks 2) Females were more likely than males to contact professional and informal sources of help 3) Immigrants were less likely to seek help from professional services compared to Canadian born adolescents, with no differences in seeking informal sources 4) No associations between household income, student status (student or not) and area (rural or population center) in the use of professional or informal support, although in rural areas, participants were less likely to seek help from informal sources

					5) Having a mental health condition, traumatic childhood experience and substance use disorder associated with likelihood to seek help from professional services
Lubman, Cheetham, Jorm, Berridge and Wilson (2017)	Cross-sectional survey	Help-seeking behaviour, confidence and intentions to help, perceived barriers to receiving help, and sources of help, as recommendations to peers with depression or alcohol problems	2456 participants aged between 14 to 15 years old (female: 1235, male: 1217) recruited from secondary schools in Australia	Actual help-seeking questionnaire (AHSQ) adapted to include mental health and substance use; General help-seeking questionnaire-vignette; Barriers to adolescents seeking help scale (BASH)	<ol style="list-style-type: none"> 1) Stress and anxiety: Adolescents were likely to seek help from parents and health professionals, compared to friends 2) Depression: Adolescents were likely to seek help from health professionals, compared to parents and friends 3) Alcohol and drug problems: Adolescents were likely to seek help from friends, compared to parents or health professionals 4) Health professionals were rated significantly more helpful than parents and friends, for stress and anxiety, depression and other problems, and teachers were rated significantly more helpful for 'other similar problems' than parents 5) No significant differences in helpfulness of sources for alcohol related problems 6) Participants who agreed/strongly agreed that the two characters in the vignette needed professional help were significantly more likely to seek help if they had a similar problem

					<p>7) Adolescents were significantly more likely to suggest help from family, formal sources, peers and the internet, respectively for depression; family, formal sources, and the internet for alcohol use</p> <p>8) Females were more likely to seek help than males, to have helped a friend help-seek in the past, and rely on health professionals as their main sources of help for depression and alcohol misuse</p> <p>9) Females were more likely to encourage a peer to seek help from formal and internet sources for depression, and from family and formal sources for alcohol misuse</p>
Lesham, Haj-Yahia and Guterman (2015)	Cross-sectional survey	Post-help seeking for community violence in Palestinian youth, and the relationships between Exposure to community violence (ECV), help-sources, perceived help experience and willingness to seek help	1930 adolescents aged between 12 to 19 years (female: 1018, male: 912) recruited from junior and senior high schools from the West Bank and East Jerusalem	My Exposure to Violence Scale (MyETV); sources of help seeking from the General Help-Seeking Questionnaire, help-seeking barriers from the BASH-B or BASH; additional questions to assess perceived help experience	<p>1) Most frequently reported help sources were as follows: friends, family members (mother, sister, uncle/aunt, brother and father) respectively</p> <p>2) Significant gender differences in help-seeking preferences with males seeking more help from their father, young group leader and formal sources (imam, priest, doctor, nurse, school counsellor, psychologist and psychiatrist), compared to girls who were more likely to seek help from friends and sisters</p> <p>3) Gender based differences in barriers to seeking help i.e. barriers most linked to</p>

					<p>social reaction for boys, and feeling that help-seeking would not provide a solution for girls</p> <p>4) Better help experience was significantly correlated with gender, higher parents' education, larger locality of residence</p> <p>5) Quantity of help sources correlated with gender, lower parents' education and smaller locality of residence</p>
Yamasaki et al. (2016)	Cross-sectional survey	The identification of schizophrenia and its association with help-seeking from friends and other sources	8770 adolescents aged between 15 to 18 years (females: 52.5%) recruited from high schools in Japan	Questionnaire items developed by the authors that assessed the recognition of mental health diagnosis and help-seeking intentions; case vignette used in previous studies	<p>1) Late adolescents in the 'recognising mental illness but not schizophrenia' (RMI) group were significantly more likely to seek help from friends, while those in the 'correctly labelling case with schizophrenia' (LSC) group were significantly less likely to seek help from friends</p> <p>2) Adolescents in the RMI group were significantly more likely to seek help from family members, teachers, school professionals, mental health services, whereas those in the LSC group would significantly seek more help from school professionals, school counsellors, and mental health services, but not family members.</p>
Kitagawa et al. (2014)	Cross-sectional survey	The interaction between bullying and suicidal feelings on help-	9484 adolescents aged between 15 to 18 years (female: 4938, males: 4546)	Questionnaire items developed by the authors to assess bullying and victimization,	<p>1) Higher rate of help-seeking in the victimised adolescents compared to the uninvolved (no bullying and no victimization) and bullying (those who</p>

		seeking behaviours	recruited from senior high schools in Japan	suicidal feelings, actual help-seeking behaviours and demographic characteristics	bullied others but weren't victimized) adolescents 2) Higher rate of help-seeking for those who had mild suicidal feelings than those who did not have any suicidal feelings 3) Significantly reduced rate of help-seeking in pure victims with mild and severe suicidal feelings (those who were victimized and did not bully others) compared with no suicidal feelings 4) Pure victims mostly sought help from friends, family members, and school teachers respectively. Formal help-seeking was low. 5) Significantly less help was sought from peers and family members in victims with serious suicidal feelings compared to those without suicidal feelings
Klineberg, Biddle, Donovan & Gunnell (2011)	Vignette questionnaire design using open-ended questions Cross-sectional survey	Identification of depressive symptoms and help-seeking differences between what one should do and actually would do	1125 adolescents aged between 16 to 24 (female: 57.2%) recruited from England	Questionnaires measuring diagnosis and symptom recognition and help-seeking in response to two vignettes portraying two levels of severity for depression	1) Speaking to family and friends were the most commonly rated responses, followed by going out and trying new things, going to see a doctor, wait to see what happens and do nothing 2) Females were significantly more likely to suggest that the vignette with severe depressive symptoms should see and would see a doctor compared to males 3) Males from lower social class were less likely to recognize severe depression or to recommend seeing a doctor for mild

					depressive symptoms compared to high social class
Sabina, Cuevas and Rodriguez (2014)	Cross sectional survey	Help-seeking for teen dating violence, reasons for not seeking help and the interactions between cultural variables	1525 adolescents aged between 12 and 18 years, recruited from a national bilingual phone survey of latino adolescents and their caregivers	Modified version of the Juvenile Victimization Questionnaire (JVQ); modified version used in the Sexual Assault among L4atinas study to assess help-seeking; The Brief Acculturation Rating Scale for Mexican Americans; Mexican American Cultural Values Scale for Adolescents and Adults to measure familism	<ol style="list-style-type: none"> 1) Females significantly correlated with formal help-seeking 2) Adolescents more likely to seek help from informal sources, with friends being the most common source of informal help and school personnel as the most common source of formal help mentioned 3) Girls were significantly more likely to seek help from formal sources - school and social services than boys 4) Gender and familism were significantly associated with formal help-seeking; no variables were significantly associated with informal help-seeking
Raviv, Raviv, Vago-Gefen and Fink (2009)	Within-subjects design Cross sectional study	To examine factors affecting help-seeking for self and others	415 adolescents in the 10 th and 12 th grade, recruited from schools in central Israel	Vignette to examine the self-other referral gap and single items associated with willingness to seek help, coping alone, psychological benefit, problem severity,	<ol style="list-style-type: none"> 1) Females were more willing to refer themselves/others to friends, vs. males; 12th graders were more willing to refer themselves/others to friends vs. 10th graders; adolescents were more willing to refer others to a friend than themselves 2) Females were more willing to refer others to a psychologist than boys; no

				<p>comparative coping, history of help-seeking behavior, satisfaction with past counseling; Barriers to adolescents seeking help (BASH)</p>	<p>significant differences between gender with regards to self-referral</p> <ol style="list-style-type: none"> 3) Adolescents were more willing to refer themselves or others to a friend compared to a psychologist 4) For both genders, service gaps (expressed desire to seek help vs. willingness to seek help for themselves) were higher for a psychologist than for a friend 5) Weak correlations between willingness to seek help from a psychologist and past experience of approaching a psychologist for self-referral and for referral of other; willingness to seek help associated with higher satisfaction from psychologists in the past for self-referral and referral of other 6) Positive correlations of help-seeking from a psychologist with problem severity or perceived benefit of psychological help for self and other 7) Negative association between intentions to seek help from a psychologist with barriers to seeking help 8) Low coping was positively associated with seeking help from a psychologist
Caldeira et al. (2009)	Cross-sectional survey	Prevalence of substance use disorders, self-change	946 adolescents aged between 17 to 19 years old (male: 46%)	National Survey on Drug Use and Health Questionnaire;	<ol style="list-style-type: none"> 1) Overall prevalence of help-seeking was low 2) Help-seeking rates were higher with alcohol and marijuana vs. alcohol only

		behaviours, perceived need for help, social pressures, and the nature and prevalence of help-seeking behaviours	recruited from a longitudinal cohort study in a mid-Atlantic university	Drugs Treatment Needs Survey	<ol style="list-style-type: none"> 3) No significant associations between self-change behaviours and help-seeking 4) Those who were encouraged to seek help were more likely to have done so, compared to non-encouraged adolescents 5) Alcohol education was the most common source of help identified, followed by health professionals, 12-step programs, university program or staff member 6) No significant differences in help-seeking based on demographics or substance use disorder severity 7) Significant correlations of help-seeking: self-perceived need and social pressures
Zaki, Gross and Pachankis (2017)	Online cross-sectional survey	Frequencies of non-suicidal self-injury (NSSI), current suicidal ideation, past-year help seeking among sexual minority and sexual majority, and sources of help	482 adolescent females between 13 to 21 years old recruited from an internet self-injury discussion forum	The Deliberate Self-Harm Inventory; Brief Symptom Inventory; The General Help-Seeking Questionnaire	<ol style="list-style-type: none"> 1) Bisexual adolescents were significantly more likely to seek help from a partner or significant other compared to heterosexual females 2) Bisexual youth were significantly more likely than questioning youth to seek help from a partner 3) Lesbian youth were significantly more likely to seek help from a teacher relative to bisexual youth 4) No others significant differences found, however all females reported seeking help from friends over the past year

Scott Jr, McMillen and Snowden (2015)	Cross-sectional survey	Predictors of seeking help, based on predisposing, enabling and need factors	55 Black male youths aged between 18 to 20 years old, recruited from the VOYAGES (Mental Health Service Use of Youth Leaving Foster Care) longitudinal study	Measures were used during the baseline in the VOYAGES study; 3 dichotomous items were used in this study to assess informal sources of help, and 1 dichotomous item was used to assess formal help	<ol style="list-style-type: none"> 1) Youth reported seeking more informal help than formal help 2) Informal sources included a family member, friend, and a minister or church-related individual, respectively 3) Lifetime mental health disorder was significantly associated with seeking informal or formal help 4) Informal sources associations: lower adherence to emotional control and negative social contextual experiences 5) Formal sources associations: child welfare services
Lytle, Silenzio, Homan, Schneider and Caine (2018)	Descriptive cross-sectional survey	Help-seeking behaviors amongst LGBTQ adolescents, and associations between risk and protective factors	203 youth aged between 18 to 24 years recruited from an online platform 'TrevorSpace'	Items related to mental health disorders based on DSM-IV and ICD-10; National Comorbidity Survey; Attitudes Toward Help-seeking Short Form (ATHS-SF); Multidimensional Scale of Perceived Support	<ol style="list-style-type: none"> 1) Higher rates of youth who had attempted/considered suicide reported seeking help from friends 2) Gay men and bisexual men reported seeking help from families; lesbian, gay men, and bisexual men reported seeking help from professional sources 3) Bisexual women reported seeking help from formal sources 4) Cisgender men and women sought more informal support from friends and professional services 5) Cisgender men and women and transgenders reported help-seeking more from friends 6) Adolescents sought more help from friends compared to school, professionals and family members across all sexual orientations

Sheppard, Deane and Ciarrochi (2018)	Cross-sectional surveys Repeated measures	Percentage of unmet needs and help-seeking behaviours for high levels of distress	1599 adolescents (median age: 17.7 years old) recruited from Catholic secondary schools in New South Wales and Queensland, Australia, who participated in the Australian Character Study (ACS)	General Health Questionnaire; Perceived Need for Care questionnaire and General Help-Seeking Questionnaire (assessed as part of the ACS); single items assessed for need classification, barriers receiving needed services, help-seeking from other sources, self-management strategies and help-seeking intentions	<ol style="list-style-type: none"> 1) The 'partially met needs' group (some service use) sought significantly more help from family/ friends, compared to the 'wholly unmet needs' group (no service use) 2) Seeking help from family/friends and the internet significantly associated with need status 3) Significantly lower intentions to seek help for the 'wholly unmet needs' group than the 'partially met needs' group
Tatar and Amram (2008)	Descriptive cross-sectional questionnaire with open-ended questions	Help-seeking attitudes and behaviors after terrorist attacks	203 students (females: 47%) between 12 to 18 years old, recruited from schools in Jerusalem	Two questionnaires asking adolescents to answer open-ended questions about their help-seeking	<ol style="list-style-type: none"> 1) Adolescents sought help after a terrorist attack from their parents, friends, other family members, mental health professionals and other individuals, respectively; no significant gender differences were found
Spears, Taddeo, Daly, Stretton and Karklins (2015)	Cross-sectional survey	Cyberbullying experiences, help-seeking behavior, mental health well-being and social connectedness	2338 young people between 12 to 18 years old. Data was collected as part of a 4-year cross-	Mental health continuum short form; DASS-21; Social Connectedness Scale; General	<ol style="list-style-type: none"> 1) Females were more likely to seek help from friends compared to males; no other significant differences in other help-seeking behaviours 2) Older adolescents (18 years old) were significantly less likely to seek help from parents, other family members, school

			sectional survey in Australia	Help-Seeking Questionnaire	professionals, vs. 12 year olds; older adolescents were significantly more likely to seek help from a partner, helpline, online formal help, self-help applications and 'to not seek help from anyone' 3) Cyber victims (victimization but no bullying) were highly likely to seek help from parents/carers, friends and siblings, in ranked order of frequency. They were highly unlikely to seek any form of online help
Doyle, Treacy and Sheriden (2017)	Mixed-methods Descriptive cross-sectional survey	Sources of help and to qualitatively explore reasons for help-seeking	856 adolescents aged between 15 to 17 years (male: 51%) recruited from post-primary schools in Dublin, Ireland	Lifestyle and Coping Questionnaire	1) One third of adolescents with a serious problem that required help, sought help 2) Most commonly reported sources of help were friends and mothers, respectively.
Swords, Hennessey and Heary (2011)	Mixed-methods Cross-sectional survey with 1 qualitative survey question	Development of beliefs about sources of help for peers with mental health problems	393 participants (male n: 206, female n: 187) aged 12 to 19 years, recruited from 20 schools in eastern region of Ireland	Three short vignettes (depression, ADHD and comparison) and 2 questions developed by the researchers to measure need for help and sources of help	1) Significant age differences for depression compared to ADHD - 12- and 14-year olds judged the clinical vignettes as in need of help vs. a comparison vignette, but the ADHD being in more need of help vs. depression; need for help did not differ between ADHD and depression for 16-year olds. 2) Significantly more sources of help reported for the vignettes from the 16-

					year-old age group. Sources of help were family, friends, teacher, doctor, and mental health professional. 16-year distinguished between sources of help for ADHD and depression.
Hernan, Philpot, Edmonds and Reddy (2010)	Cross-sectional survey	Problem recognition, barriers to accessing professional help and sources of help	74 adolescents (male n: 33, female n: 41) aged 14 to 16 years	Clinical vignette and open-ended questions	<ol style="list-style-type: none"> 1) Participants reported that it'd be more helpful to see other health professionals (OHP - counsellor, youth worker or psychologist) vs. doctors. Less than half of the sample were likely to see a doctor or OHP if they were the vignette character. 2) Significantly higher personal barriers were present for seeing a doctor rather than OHP, and personal and logistic barriers for OHP for females, than males. 3) Significantly higher preferences for informal sources of help compared to formal or external sources of help, especially for females
Leavey, Rothi and Paul (2011)	Mixed methods Cross-sectional survey and focus group interviews	Help-seeking concerns and beliefs of secondary school pupils	298 adolescents (female: 53%) for cross-sectional survey	Help-seeking questionnaire developed by the authors and focus group interviews	<ol style="list-style-type: none"> 1) Friends as a help-seeking source were preferred for anxiety and depression, but maternal help were consistently reported across all help-seeking categories, and in comparison, to fathers. Other sources of help that were less preferred where teachers, school-based professionals, telephone helpline

					and clergy. Females were more likely to seek help for their problems 2) Family doctor as a source of help mostly for food, hearing voices and feeling suicidal
Cakar and Savi (2014)	Cross-sectional survey	Who do adolescents seek help from and why they do not seek professional help	252 adolescents (males n: 120, females n: 132) aged 15 to 18 years	General Help-Seeking Questionnaire	1) Significant gender preferences for seeking help from friends and mothers, compared to fathers, other relative/family member, mental health professional, teacher, doctor, internet and 'someone else'. 2) Females significantly more likely to seek help from mothers; males significantly more likely to seek help from fathers and other relatives 3) Receiving help from mental health professionals, doctors and teachers were significantly lower for males, than females.
Williams (2012)	Cross-sectional survey	Where do young Jamaicans seek mental health support and their beliefs about the usefulness of such help	339 adolescents (male n: 146; female n: 193) from 15 to 19 years old	"Where do you go to for help" questionnaire developed by the authors	1) Adolescents significantly more likely to seek help for a 'psychological problem' from a medical doctor initially, followed by a faith healer. 2) Differences between low and high socio-economic status i.e. those in low socio-economic status preferred to seek help from teachers/guidance counsellors and were less likely to seek help from psychiatrists/psychologists.

					<p>3) Across symptoms of depression, anxiety, eating disorder, substance use disorder, ADHD and ODD, participants reported friends and family as the first choice of help, followed by a psychologist/psychiatrist. For schizophrenia, psychologist/psychiatrist was reported as first choice, but were not confident about the sources' helpfulness.</p>
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Would you like to take part in some research?

We would like your **views** about Child and Adolescent Mental Health Services (CAMHS). Your views can help us to understand how young people seek help from services.

Travel expenses will be reimbursed up to £10!
If you would like more information, please speak to your clinician
or you can email me, Kylie Pascua Leones (Trainee Clinical
Psychologist) at XXX

APPENDIX E: Participant information sheet



Participant Information Sheet (v3)

Title of the study: Beliefs about Child and Adolescent Mental Health Services (CAMHS) and its role in help-seeking amongst adolescents

Hello! My name is Kylie and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study, which is being conducted as part of my doctoral degree. Before you decide, it is important that you understand why the research is being done and what this involves.

What is the study?

We know that some young people find it hard to ask for professional help for their mental health needs. This might happen for lots of different reasons, such as the experience of being stigmatised, or a preference to seek help from family and friends.

Some young people have specific ideas about medication, psychological therapy and professionals. However, we would like to understand your experiences about mental health services, in particular what you believe or what ideas you have about mental health services, and how this relates to your decision to seek professional help.

Why have I been invited?

You have been invited to take part in the study by your clinician. There will be approximately 8-12 young people aged 16-18 years old who will also be taking part.

What do I have to do?

I will visit you in the building you usually have your appointments in, and we will have a conversation up to an hour and a half. You will be asked questions about your experiences of Child and Adolescent Mental Health Services (CAMHS), and how you came to a decision to seek professional help.

What happens after the interview?

The interview will be recorded on an audio-recorder and typed up. I will make sure that I do not add your name. After the recording has been typed up, I will delete the recording from the audio-recorder. All information which is collected from you during the research will be kept strictly confidential. This will be saved securely on a password protected file in the Christ Church Canterbury University computer. The interview script will only be accessible to me and my research supervisors. After the study finishes in 2019, the university will keep the transcripts in an encrypted CD which will be placed in a locked cabinet for 5 years. After this, the data will be destroyed.

What will happen to the results of the research study?

The results will be written up in a report which will be published for health professionals. If you would also like to know the results of the study, you can put your email address down on the consent form and I will send the results to your email. Also, we may use some quotes from our interview in the report but these will be anonymised.

Will anyone know that I participated in this study?

No, all your data will be anonymised. The data that we collect from you will be kept strictly confidential.

Do I have to take part?

No, it is up to you to decide. If you agree to take part, I will then ask you to sign a consent form.

What are the possible benefits of taking part?

I cannot promise the study will help you but the information we get from this study will add to our understanding of how young people seek professional help. This will also help us to think of ways to challenge the view of mental health services. This in turn might help young people to get appropriate support for their mental health needs.

What are the possible disadvantages and risks of taking part?

I will be asking questions around your experience of CAMHS, however there is a possibility that some questions might lead to difficult or distressing memories. If you do get upset, I can speak to your clinician, or I can arrange for the research clinician involved in this project to speak with you. There will be an opportunity to have a break during the interview. It is also okay to have a family member there with you.

What will happen if I don't want to carry on with the study?

You are welcome to withdraw anytime without your care being affected. If you withdraw from the study, we would like to use the data collected up to your withdrawal. However, if you would like for us to NOT include the information collected from you, we will delete the recording and transcripts.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns (01227927070). If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology – paul.camic@canterbury.ac.uk, tel: 01227927070

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by the NHS Research Ethics Committee.

Further information and contact details

If you would like to speak to me and find out more about the study, you can leave a message for me on a 24-hour voicemail phone line at 01227927070. Please say that the message is for me, Kylie Pascua Leones, and leave a contact number so that I can get back to you. You can also email me at k.pascua-leones368@canterbury.ac.uk.

If you agree to take part in the study, please see the next sheet.

APPENDIX F: Consent to contact form



Consent Form

I understand that the researcher can contact me to provide more information about the study, before I decide if I want to participate.

I agree for my contact details to be passed onto the researcher of the study.

Name of participant: _____ Date: _____

Name of person taking consent: _____ Date: _____

APPENDIX G: Participant consent form



Participant Consent Form

Title of Project: Beliefs about CAMHS and its role in help-seeking amongst adolescents

Name of Researcher: Kylie Pascua Leones (Trainee Clinical Psychologist)

Please read the information below. If you agree to the information, please put your initials in the boxes provided.

I confirm that I have read and understand the information sheet dated 15/03/2018 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care being affected.

I understand that my interview will be recorded on an audio recorder and the interview will be typed up anonymously, and then the recording will be destroyed. This information will be kept in a password protected file in Christ Church Canterbury University computers.

I understand and give permission for research supervisors to listen to aspects of my recording and written transcripts.

I agree that anonymous quotes from my interview may be used in published reports of the study findings.

I agree for my clinician to be informed should there be any concerns with my safety or the safety of others during the interview.

If I would like to get feedback from the results of the study, I agree to provide an email address _____ or the researcher can speak to me about other ways that I can get feedback.

If I decide to withdraw from the study, I **agree/I do not agree** (please delete as appropriate) for my data to still be used.

I **would like/do not like** (please delete as appropriate) a family member to attend the interview with me.

I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

APPENDIX H: Interview schedule



Interview schedule

Introduction

Introduce self

Introduce project (with information sheet?)

Explain consent form

- 1) Can you tell me about the first time you came to CAMHS?

Prompts: What was that like? Thoughts/feelings? What did you come in for? Who did you see? When was this?

- 2) What ideas or thoughts about CAMHS did you have beforehand?

Prompts: When and how did you first learn about mental health services? Ideas about medication, professionals, talking therapy? What do you notice now about these ideas? How do you make sense of any difference?

- 3) Where do you think these ideas or thoughts came from?

Prompts: Was it talked about in school or college, family, peers, school, media? Previous experiences of seeking and receiving help e.g. other services apart from CAMHS that are available that might have influenced contact with CAMHS

- 4) In what way do you think your beliefs about mental health services influenced your decision to seek professional help?

Prompts: What helped you to decide? Who helped you to decide? What got in the way of deciding to seek help?

APPENDIX I: Example of coded transcript

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APPENDIX J: Example of emerging themes

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Appendix K – Example of emerging themes grouped into clusters

Content of beliefs

CAMHS

Fear associated with CAMHS
Distrust in professionals
CAMHS as inaccessible
CAMHS as inaccessible
Perceived CAMHS environment
Magnitude of distress effects help-worthiness?
CAMHS structure

Medication

Medication as a last resort

Origination of beliefs

Social influence

Familiarity with CAMHS amongst family facilitates help-seeking
Parental beliefs about help
Family expertise
Social support
Parental beliefs of mental health
Friends as gatekeepers

Media/society

Different experience to media portrayal
Impact of mental health misconceptions on levels of distress
Mental health portrayal through the media

Role of self

Cognitive factors

Self-fulfilling prophecy
Confirmatory biases
Core beliefs during help-seeking
Doubt in external help reflective of self-doubt in recovery

Maintaining a sense of autonomy

Sense of control over treatment choice
Taking matters in own hands
Own decision making
Role of self in promoting change

Role of others

Adults as gatekeepers/control of others

Reliance on adults to aid recovery

Reliance on adults in process
Role of adults in initiating help
Role of parents in the sibling help-seeking
Others taking control after crisis
Professionals taking control of situation
Behaviours informed by policy
Reliance on services

Mechanisms of change

Internal processes

Re-evaluating initial doubt about CAMHS
Disconfirmation of belief about professionals through time
Confirmation of professional care
Disconfirmation of beliefs about unhelpfulness
Disconfirmed beliefs of CAMHS characteristics
Re-evaluating experience of CAMHS
Experience of mental health increases critical stance
Feeling grateful for the help
Reflection of transformation over time
Re-evaluating experience based on gained expertise
Acceptance of CAMHS
Acceptance of CAMHS help
Acceptance of CAMHS care

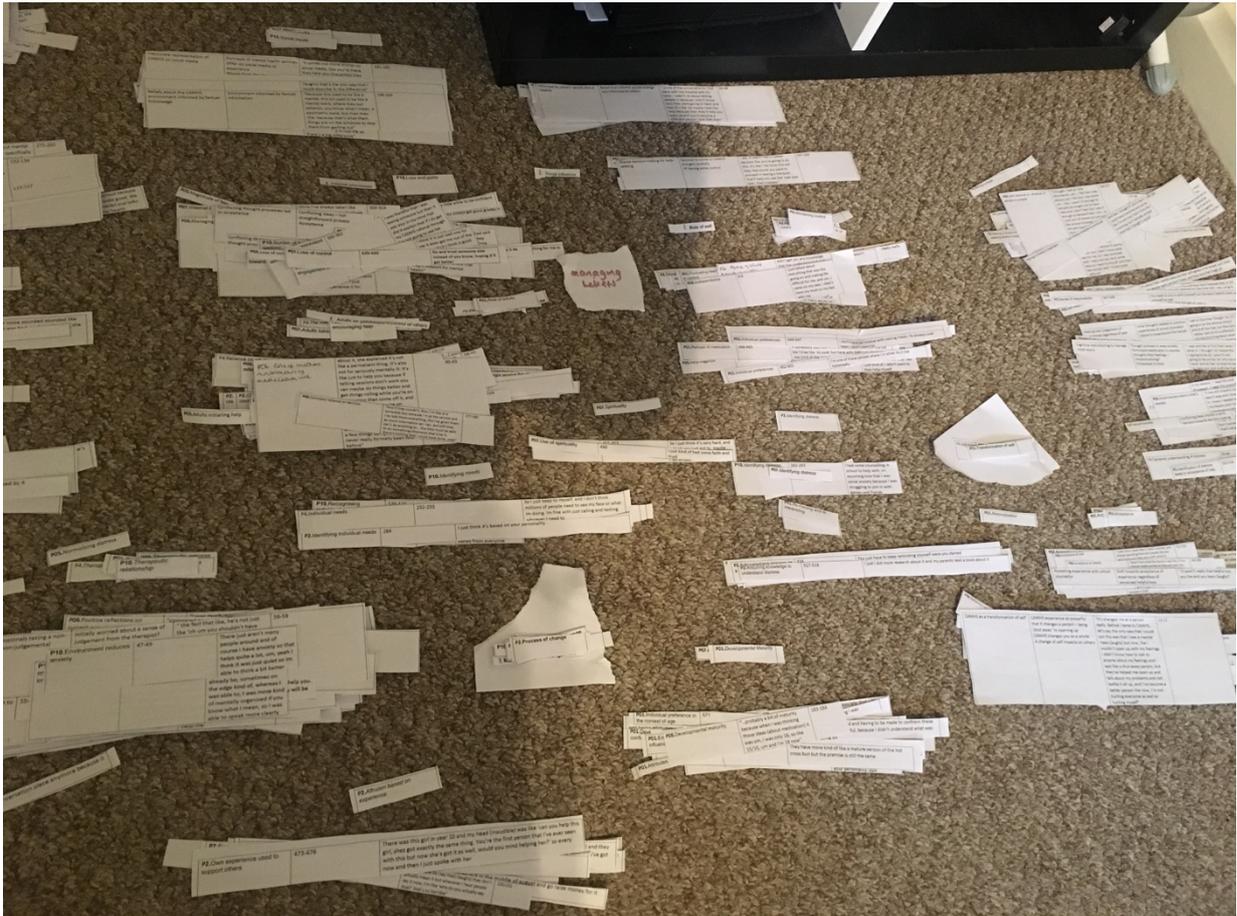
Therapeutic relationship

Therapist characteristics facilitate understanding of the self
Therapeutic relationship promotes change
Therapeutic validation
Normalising distress
Shared narrative aids understanding
Values flexibility of CAMHS

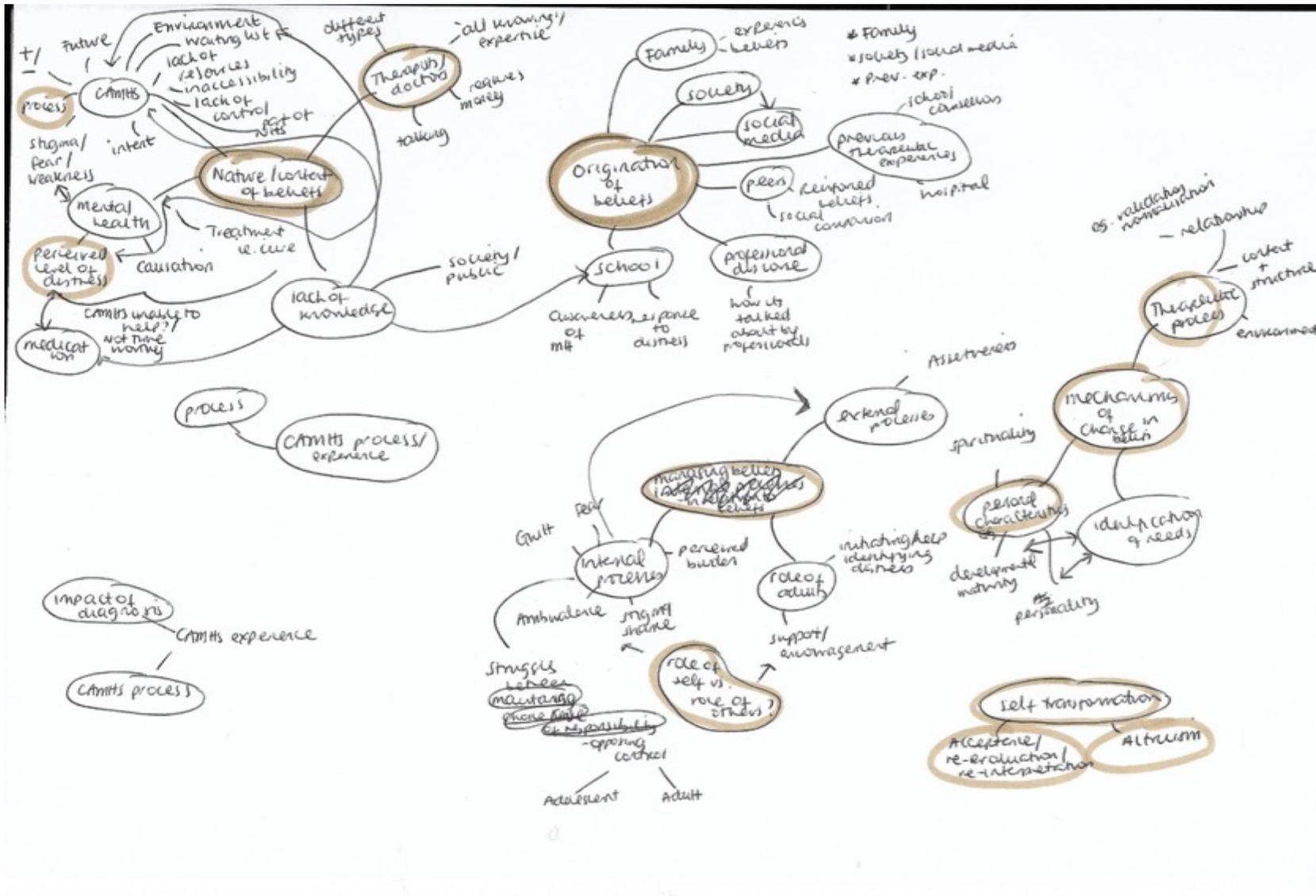
Other emerging themes:

Mental health effects everyone – mental health is relatable?
Mental health embedded in language decreases legitimacy
Legitimization of CAMHS through mental health sources
School counsellors as inaccessible
Feeling isolated
Crisis event facilitates help-seeking
Sense of guilt
Disclosure legitimises distress?
Seeking understanding from others
Experience of stigma
CAMHS information dependent on others
Fluidity of beliefs and associated emotions - initially informed by others' experience
Acquiring knowledge through work
Uncertain about process
Straightforward process

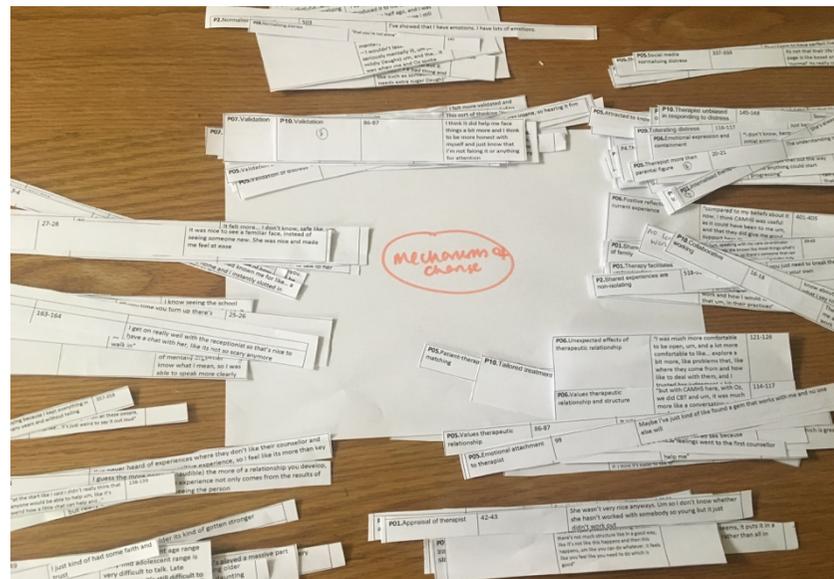
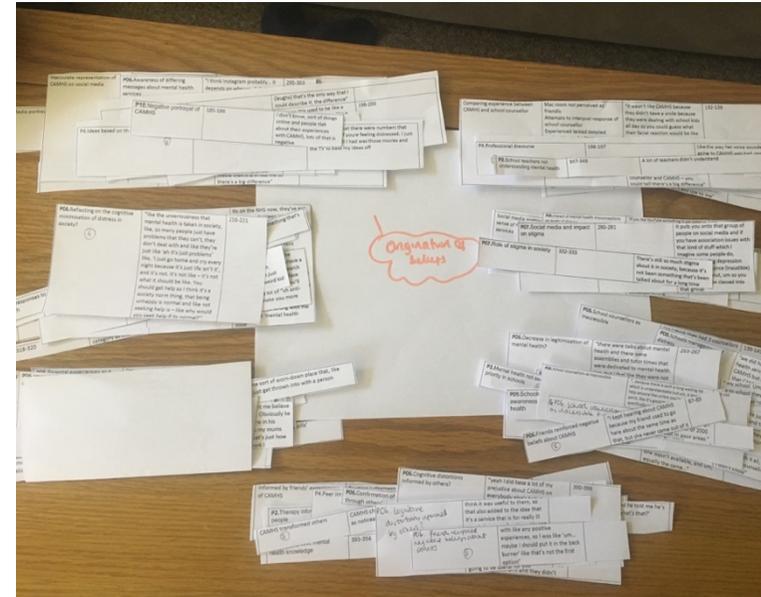
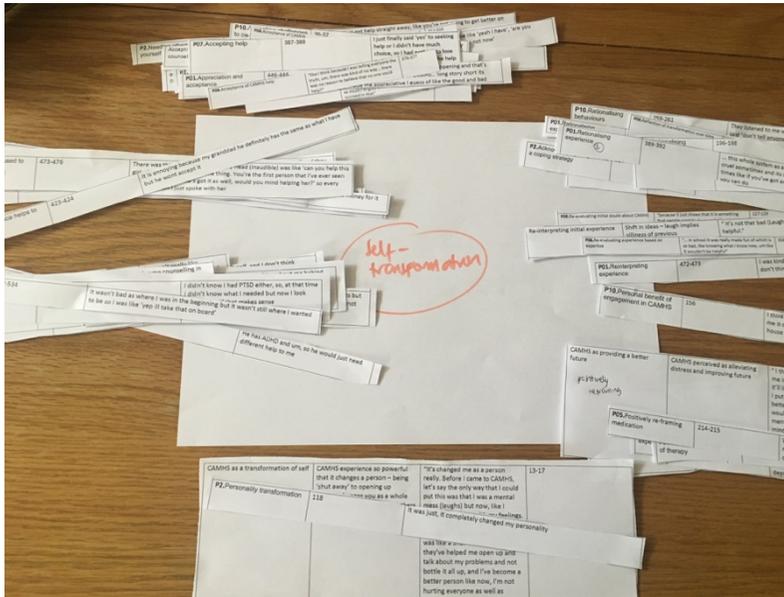
APPENDIX L: Visual organisation of themes



APPENDIX M – Thematic mindmap development



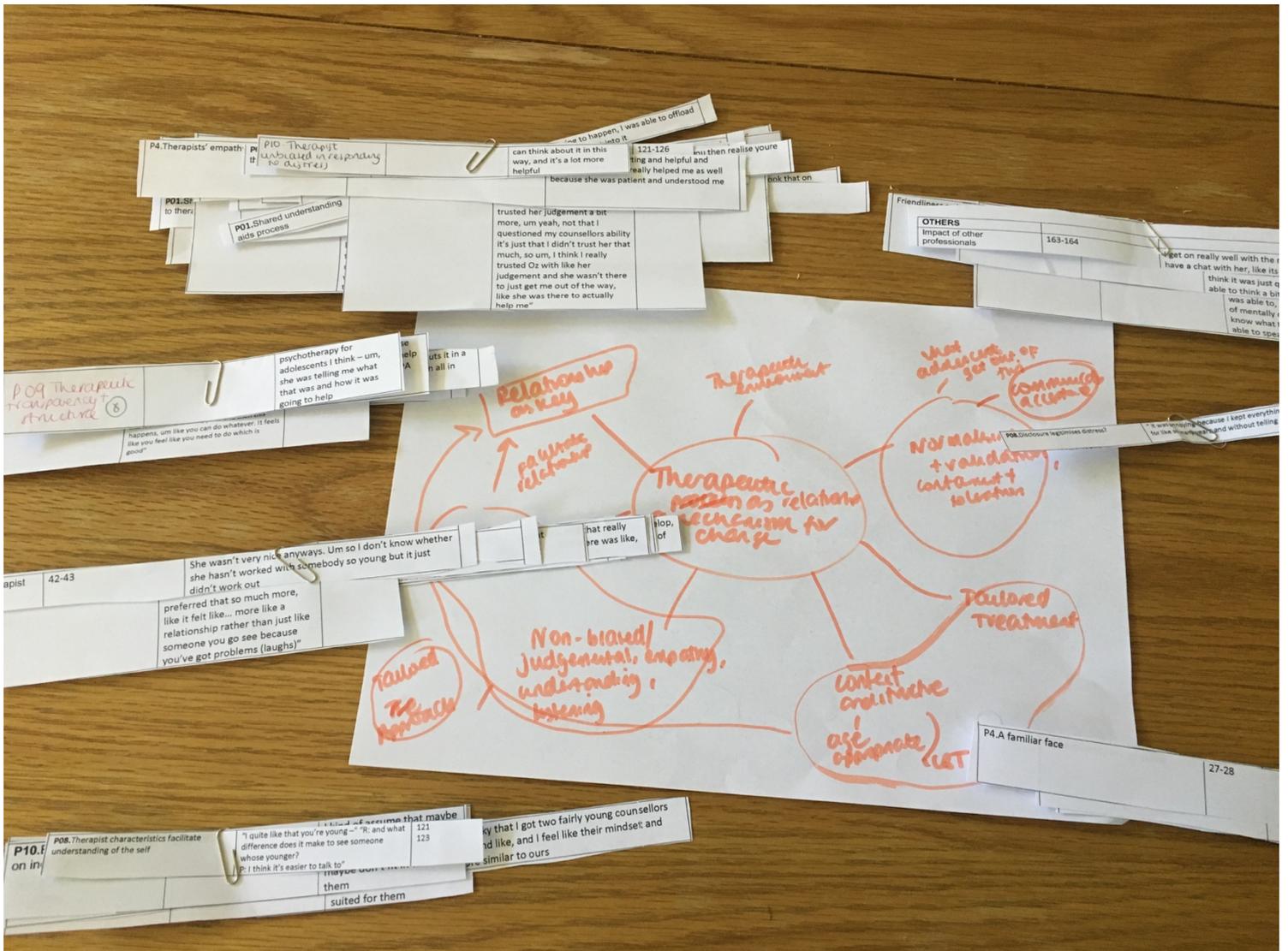
APPENDIX N – Example of superordinate clusters



APPENDIX O: Recurrent themes

Themes	1 Alice	2 Georgina	3 Leanne	4 Jenny	5 Katrina	6 Ella	7 Brian	8 Owen	9 Eve	10 Lauren	Present in over half sample?	Changed to:
A multi-faceted understanding of beliefs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
<i>Am I ill enough?</i>	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	
<i>Recovery as achievable/non-achievable</i>	Yes	No	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	
<i>What is CAMHS?</i>	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	
Origination of beliefs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
<i>Societal and social media discourses</i>	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	
<i>Previous experiences of professional services</i>	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	
<i>Beliefs and experiences of informal sources</i>	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Management of beliefs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	
<i>Taking responsibility for recovery</i>	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	
<i>Tug of war with autonomy</i>	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	
<i>Adults as gate-keepers</i>	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Mechanisms of change	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
<i>The therapeutic process</i>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	
<i>Personal characteristics</i>	Yes	Yes	No	No	No	Yes	Yes	Yes	No	No	No	
Self-transformation	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
<i>Cognitive restructuring</i>	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes	
<i>Moving towards acceptance</i>	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	
<i>Impact on quality of life</i>	Yes	Yes	No	Yes	No	No	No	Yes	No	Yes	No	
												Therapeutic relationship as a mechanism for change
												A tailored approach
												Communicating acceptance
												Cognitive processes
												An enhanced quality of life

APPENDIX P: Example of reconfigured theme



APPENDIX Q: Abridged research diary

December 2016

Met with Alex to discuss potential MRP. I would like to do an MRP focusing on children or adolescents and possibly think about the role of parental beliefs. Had an initial discussion about his project ideas and was encouraged to think about it. I decided that I would like to stick with this project idea as I felt it would be something that I would find interesting throughout the 3 years.

January 2017

I needed to think about what I wanted to explore in terms of engagement and help-seeking. I had no idea! Even if I decided to focus on beliefs and engagement I could incorporate or focus on parental beliefs. During the Christmas break I did some research from Google Scholar initially then moved to PsycInfo. Only looked at research within the last 3 years.

February 2017

Met with Alex again. Had a discussion around terminology e.g. help-seeking/engagement used interchangeably. Discussed the role of cultural beliefs. Decided to stick to adolescent beliefs because I felt that parental beliefs have already been documented, and adolescents may even elude to parental/cultural beliefs. Noticed that I had lots of fleeting ideas and I was encouraged to think specifically about what my research questions would be. Alex said it would be helpful to think of research questions in relation to the questions we might want to ask in the interviews.

March to April 2017

Sent Alex some vague ideas about the type of questions I would ask. Alex was helpful in that he reframed them in a way that made sense for IPA methodology. We also thought about overarching aims of the study and realised that this can always be changed as we come to have more ideas. I have finalised the MRP proposal form and Alex and Siobhan are happy with this.

Outcome of MRP proposal review

I am pleased to hear that my form was well-presented and there was not much to change, however I came out of the review even more confused about my project, especially it's methodology!

Meeting with Siobhan

Talked about practicalities of the project – ethics, possible recruitment pools and connections with outpatient teams, including LAC, however we acknowledged potential challenges that may arise with this. LAC however could be incorporated into general recruitment – would this jeopardise IPA's homogeneity?

Meeting with Alex

The project feels much clearer now - we decided to keep with IPA because of the individual experiences that we are interpreting rather than finding general themes to explain their experiences. In addition, we talked about the limitations of the study which was brought up in the review i.e. focusing on those who are already seeking help, but the population that we are reaching are relevant for the research questions.

No studies to date have focused on the young peoples' experiences themselves. Started to talk about the ethics process.

Ethics process

Met with R&D manager for the NHS ethics form. Got some clarity as to what is needed. Still need further clarification from Alex and Siobhan about the practicalities.

Reflections

Did some reading around core beliefs and read how beliefs are not readily accessed. I wondered what this might look like in the interviews and whether beliefs are interchanged with 'thoughts', 'ideas', and 'attitudes'. Alex and I had a discussion around the confusion about beliefs in the literature and from what I've read there is a distinction (although not clear), that beliefs cannot be seen as solely 'cognitions' but occurs in multiple layers or contexts e.g. influence of society, culture. It would be interesting to see how this plays out in the interviews.

Interviews starting August 2018

Some participants required much more prompting, and how do I balance my therapist hat vs. research hat on?

Another difficulty was figuring out what was relevant vs. irrelevant information. I prompted the young people with some further questions who would then talk about the topic plus something extra. It probably doesn't help that I'm not that good at interrupting!!

By the 3rd interview, I had this idea that it wasn't young peoples' choice to seek help from CAMHS. I thought that the word 'seek' assumes that the young person had an active part in knowing something about CAMHS and accessing help. It was dependent on how long the young person was in CAMHS – most young people so far had their first encounter with CAMHS from a referral based on other people's decision, then along the way (as they got older) the choice became clearer. I think I put a blind eye to this for the other 2 interviews, so I need to make sure I remain curious!

I also came into the interviews and even prior to conducting the research thinking that social media had a huge influence on young people's decision for their care, so was surprised when all of the young people so far mentioned that they didn't have much contact with social media prior to coming into CAMHS. Perhaps because I've grown up with social media and I see it as part of my daily life that I assumed it was the same for young people!

Meeting with Alex

I had sent Alex an example of my interviews. I thought that I didn't 'do' the interviews properly since I was aware that there were elements that weren't particularly relevant to the study that was talked about. We talked about keeping the research hat on e.g. interviews needed less summarising since this enables YP to carry on talking! – this also rings true to me for clinical sessions – but I was reassured that it was ok to ask other questions to build engagement.

January to March 2019 – Data analysis

Transcribing has been a fully immersive experience. I was struck by the positive regard they held towards CAMHS services, especially therapists. I wondered how much of an influence I had on their responses to CAMHS in the interview process?

I initially met with Alex and Siobhan to go over the codes for two transcripts. We had similar ideas as to what the transcripts were showing to us. We also talked about the description YP gave about therapy – the therapists role in this was a bit like mirroring and attunement between a mother and a baby. It made me really wonder about their previous attachments. Siobhan provided interesting insights relating to psychodynamic thinking and her experiences of working with adolescents.

I noticed the role of others as a common theme. The beginning of their journey was perhaps not in their control but what was striking was that as their journey progressed, there was elements of control in what YP felt like they needed to do e.g. making a conscious effort to make the most out of CAMHS. Reminded me about a sense of autonomy?

February to April 2019 – Data analysis and write up

Bracketing interview with peer trainee. I noticed that I saw mental health services and CAMHS as two separate things. It was also interesting when my colleague talked about the age thing – is working with adolescents/children somewhat easier for me to also relate to, just as much as it was perceived as ‘easier’ for them to relate to me? It became apparent that one participants’ views stood out for me and this was perhaps because of how much emphasis was placed on the relationship. Maybe this is something that I personally value as well.

Finalised themes across all cases. Had a think as to whether the theme ‘cognitive restructuring’ and ‘moving towards acceptance’ were mutually exclusive terms, or could be merged in some way. Did some research regarding differences with CBT and ACT. Both appear to involve cognitive processes in some way, but acceptance was more to do with acknowledging distress and learning to tolerate it or gain a new relationship with it. Is acceptance seen as a final destination?

Recurrent themes were analysed throughout all the cases. This led to two themes that did not receive confirmation for more than half of the sample. I really didn’t want to let go of a theme – personal characteristics (i.e. developmental maturity and personality). I decided to add this to the discussion rather as a result, since it may have also depended on how long adolescents were in CAMHS for.

Completed analysis. Read the reflexivity paper again to reflect on how I might write up the results. I found myself being drawn to the metaphors used in the young people’s account – maybe because I use a lot of metaphors in my clinical work too. I remember two interviews clearly but wanted to make sure that all the voices of the participants were heard in some way. Felt a sense of responsibility towards that.

APPENDIX R: Bracketing interview example

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APPENDIX S – Research ethics approval letter

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APPENDIX T – NHS ethics approval letter

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APPENDIX U – Confirmation of capacity and capability

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APPENDIX V: End of study form

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APPENDIX W: Research summary report for Ethics

Research Summary

Title: Beliefs about mental health services and their role in help-seeking amongst adolescents

Background: National Health Service (2018) statistics reported that rates of mental health difficulties were higher in 17- to 19-year old adolescents, however the literature suggests a discrepancy between mental health need and service use. No research to date has investigated adolescents' beliefs about mental health services and its role in the help-seeking process, within a clinical population.

Aims/Research questions: To explore 16- to 18- year olds beliefs about mental health services and how these beliefs have influenced the help-seeking process. The research questions were as follows:

- 1) What are adolescents' beliefs about mental health services and how do they make sense of this?
- 2) Where do they feel these beliefs have come from?
- 3) In what way do they feel that these beliefs have impacted on their decision to seek help?

Results: Ten adolescents across CAMHS were interviewed, subject to inclusion and exclusion criteria, and ethical procedures. Interpretative Phenomenological Analysis (IPA) was used. Five superordinate themes emerged from the data:

A multifaceted understanding of beliefs. Subthemes: 1) '*Am I ill enough?*', represented adolescents' perceptions about distress and whether this qualified for professional help, 2) '*recovery as achievable/non-achievable*' reflected by a description of CAMHS being omnipotent/omniscient, or a sense that CAMHS weren't useful and 3) '*what is CAMHS?*', which highlighted a lack of knowledge about services.

Origination of beliefs. Subthemes: 1) '*Societal and social media narratives*', which portrayed mental health/mental health services/CAMHS, 2) '*previous experiences of professional services*' which influenced adolescents' views about receiving further mental health support and 3) '*experiences of informal sources*' which highlighted the role of parental and peers' experiences of mental health services in how they understood their distress, and subsequent help-seeking intentions.

Management of beliefs. Subthemes: 1) '*Taking responsibility for recovery*' highlighted adolescents' awareness of their role in facilitating recovery, 2) '*tug of war with autonomy*', which reflected the need to keep a sense of individuality and agency, but at the same time acknowledging the need for adult help, and 3) adults initiated and facilitated the formal help-seeking process, which was captured in the theme '*adults as gatekeepers*'.

Therapeutic process as a mechanism for change. Two subthemes: 1) therapeutic relationship involved clinicians using '*a tailored approach*' which emphasised content,

structure, 'patient-therapist matching' and empathic ways of working, and 2) clinicians '*communicated acceptance*', by ways of validating and normalising distress.

The transformed self. Two subthemes: 1) Adolescents re-evaluated, rationalised and positively reframed their initial beliefs and experiences which was defined as '*cognitive restructuring*', and 2) a willingness to '*live an enhanced quality of life*' which reflected acceptance, appreciation and gratitude of help and experiences, a re-evaluation of life habits, and altruistic behaviours.

Research implications:

- Identify beliefs that bare more power in behavioural change.
- Seek to understand other mechanisms of change or the development of beliefs and help-seeking behaviours in other adolescent populations e.g. looked after children.
- Understanding the therapeutic relationship in relation to the child and adolescent population, and factors affecting this.
- Post-traumatic growth processes in children and adolescents following mental health difficulties, and associated behaviour changes.

Clinical practice implications:

- Non-judgemental, empathic and collaborative ways of working, whilst maintaining adolescent autonomy.
- Assessment and intervention procedures to consider the role of beliefs in the helping relationships.
- Therapeutic relationships could be facilitated by 'patient-therapist matching' and considered during case allocation.
- High standards of care not limited to the clinic room.
- Participation in service-related projects and research processes.

Implications for policy:

- Developmentally-appropriate resources across all platforms to facilitate promotion of mental health services, and accessibility.
- Mental health education for children, adolescents and their families, school professionals and workplaces through training or workshops.

References:

National Health Service. (2018). *Mental Health of Children and Young People in England, 2017: Summary of key findings*. Retrieved from <https://files.digital.nhs.uk/9B/6F123E/MHCYP%202017%20Summary.pdf>

APPENDIX X: Summary report for participants

Summary report for participants

Dear XXX,

Re: Beliefs about mental health services and their role in help-seeking amongst adolescents

Thank you for participating in my research. We met last year and talked about your journey into mental health services. As agreed, I am writing to you to let you know about my findings.

Research overview:

Research says that older adolescents are more at risk of developing mental health difficulties and, some would prefer to not seek help from mental health services. This can happen for lots of different reasons, such as the fear of being stigmatised, or a preference to seek help from family or friends. Only a small amount of research has investigated adolescents' ideas about mental health services from the perspectives of adolescents themselves. As a result, the aim of this study was to 1) understand the ideas or beliefs older adolescents have about mental health services, and 2), how these thoughts or ideas related to seeking professional help.

Key Findings:

I interviewed 10 adolescents, between 16- to 18- years old. Here are the main themes that I found:

- Before coming to mental health services, adolescents had ideas about whether they were 'ill enough' to need professional help. They were also thinking about their recovery, and whether engaging in mental health services could achieve this. Many adolescents reported not knowing about CAMHS, and what the process involves.
- The ideas adolescents had, seemed to come from society's views about mental health, mental health services and CAMHS, through online and media platforms. Ideas were also influenced by their previous experiences of professional services, such as school counsellors and therapists, and peers or family members who had experiences of mental health services.
- Adolescents spoke about taking responsibility for their recovery, for example, coming to CAMHS with an open-mind. At the same time, young people relied on adults to initiate and facilitate professional help seeking. There seemed to be a struggle to maintain a sense of control and independence, especially when they were faced with crisis situations.
- Young people reported how therapy was a key factor in helping them to understand their distress. They valued the content, structure and the personable characteristics of therapists. Therapists appeared to also help young people to validate and normalise distress.
- There was a sense of personal growth through their time in CAMHS. Most young people reported having accepted the help they received, alongside feeling appreciative and thankful for their experience. They spoke about re-

evaluating their lives in some way, and valued opportunities to help others who were having similar experiences.

Suggestions for research:

- To further identify the beliefs that lead to help-seeking behaviour.
- Looks into factors that facilitate change, other than the effects of therapy.
- To understand what helps young people to engage in therapy.
- The processes that underlie a sense of personal growth in adolescents.

Suggestions for professionals working with adolescents:

- They should work together with adolescents in their care.
- They speak to young people using a non-judgemental and empathic approach, and to be transparent about ways of working.
- To provide tailored care, taking into account both therapist and adolescents' individual characteristics such as age, that may influence engagement.
- A high standard of clinical practice should be provided in all aspects of care, not limited to the clinic room.
- They should seek to work alongside adolescents in service-related projects and research processes.
- To consider the impact of waiting lists on adolescents' sense of distress.

Suggestions for policy-makers:

- To provide age-appropriate information about mental health services across all platforms valued by adolescents, such as the media and in schools/colleges.
- To increase access and availability of mental health services, including ways to reduce waiting lists.
- Provide mental health education to young people, families, education services and workplaces through means of training and/or workshops.

Thank you for taking the time and effort to participate in my study. Without you, this research would have not been possible. If you any further questions about my study, you can speak to your clinician or contact me on k.pascua-leones368@canterbury.ac.uk.

Kindest Regards,

Kylie Pascua Leones
Trainee Clinical Psychologist
Salmons Centre for Applied Psychology

APPENDIX X – Author guidelines for journal submission

Author Guidelines

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2017: 68/124 (Pediatrics); 86/142 (Psychiatry); 85/142 (Psychiatry, Social Science); 78/127 (Psychology, Clinical).
- 5,485 institutions with access to current content, and a further 7,700 institutions in the developing world
- High international readership - accessed by institutions globally, including North America (24%), Europe (17%) and Asia-Pacific (14%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%
- Acceptance to Early View publication averages 45 days
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. [Click here](#) to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice; Narrative Matters.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Review Articles: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health.

Measurement Issues: These papers aim to evaluate evidence-based measurement tools and issues in child mental health disorders and services.

Innovations in Practice: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention

and service models.

Narrative Matters: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/camh_journal and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from the Editorial Office at ACAMH (email: publications@acamh.org)

4. Authors' professional and ethical responsibilities

Disclosure of interest form

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The *Journal* also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Note to NIH Grantees

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Recommended guidelines and standards

The *Journal* requires authors to conform to CONSORT 2010 (see **CONSORT Statement**) in relation to the reporting of randomised controlled clinical trials; also

recommended is the **Extensions of the CONSORT Statement** with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry

Clinical Trials

Nederlands Trial Register

The ISRCTN Register

UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis.

The **Equator Network** is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work **<http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields>** and on quasi-experimental **<http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research>** and mixed method designs **<http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>**

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5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use **MeSH Browser** for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

10. For referencing, *CAMH* follows a slightly adapted version of APA

Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

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Original Articles

Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,500 words including tables, figures and references.

Review Articles

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the **PRISMA statement**. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

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These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office **publications@acamh.org** with an outline proposal.

Your Measurement Issues article should be no more than 6,000 words excluding tables, figures and references and no more than 8,000 including tables, figures and references.

Innovations in Practice

Innovations in Practice promote knowledge of new and interesting developments that have an impact on evidence-based practice, intervention and service models. These might have arisen through the application of careful, systematic planning, a response to a particular need, through the continuing evolution of an existing practice or service, or because of changes in circumstances and/or technologies. Submissions should set out the aims and details of the innovation including any relevant mental health, service, social and cultural contextual factors, and give a close, critical analysis of the innovation and its potential significance for the practice of child and adolescent mental health.

Due to the short length of this article type, your Innovations in Practice article should be no more than 2,200 words including tables, figures and references and contain no more than 8 references.

Narrative Matters

Narrative Matters describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences. The topics can include aspects of child mental health service history; representations of abnormal mental states or mental illness in children and teenagers in film, literature or drama; depictions of child mental health clinicians within popular culture; ethical dilemmas in the specialty. Interest and originality are valued. If in doubt, please contact the section editor [**Gordon.Bates@nhs.net**](mailto:Gordon.Bates@nhs.net)

Due to the short length of this article type, your Narrative Matters article should be no more than 1,800 including tables, figures and references and contain no more than 8 references.

Manuscript Processing

Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE [**http://publicationethics.org/resources/guidelines**](http://publicationethics.org/resources/guidelines) and ICMJE [**http://icmje.org/**](http://icmje.org/) best practice.

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